UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients, and WILLIE PARKER, M.D., M.P.H., M.Sc., on behalf of himself and his patients, Plaintiffs, v. MARY CURRIER, M.D., M.P.H. in her official capacity as State Health Officer of the Mississippi Department of Health, and ROBERT SHULER SMITH, in his official capacity as District Attorney for Hinds County, Mississippi, Defendants.	)	Case No. 3:12-CV-00436-DPJ-FKB

SUPPLEMENTAL MEMORANDUM OF LAW IN FURTHER SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I. Introduction

Absent a preliminary injunction from this Court, Plaintiffs will either have to close or operate in clear violation of the Admitting Privileges Requirement[1] in Mississippi House Bill 1390 ("the Act") when this Court's temporary restraining order expires. The balance of equities clearly favors granting a preliminary injunction to relieve the urgency of the problem created by

[1] The Admitting Privileges Requirement provides that all physicians associated with an abortion facility must have "admitting privileges and staff privileges to replace local hospital on-staff physicians." Miss. H.B. 1390 § 1, *to be codified at* Miss. Code Ann. § 41-75-1(f).

the Mississippi Department of Health's decision to immediately enforce the Act, before any of the local hospitals have completed their review of the applications submitted by the Clinic's physicians. If one of the local hospitals grants privileges to the Clinic's physicians during the period that the Act is preliminarily enjoined, that urgency will be relieved pending final resolution on the merits. If all of the local hospitals deny privileges, it will then be even more clear that the Act has not only the purpose, but the effect, of denying reproductive freedom to the women of Mississippi. In the interim, the State will suffer no harm.

Although the State argues that an injunction should be denied so that the administrative procedure can go forward, that procedure serves no useful function in light of the current situation. This is not a scenario where there is room for debate through the administrative process about whether a licensee is in compliance with a law or regulation. It is undisputed that the doctors do not have admitting privileges and cannot receive them unless a third-party—a local hospital—chooses to grant them. Unless a hospital grants the applications, the Clinic's license will be revoked at the end of the administrative process, if not sooner. In the meantime, Plaintiffs will be required to choose between closing down or knowingly violating state law in order to stay open, while incurring the burden and expense of defending against charges of misconduct in an administrative proceeding. Further, if they choose to stay open, Plaintiffs would run the additional risks that the State might choose to impose further penalties at some later point in time for Plaintiffs' conduct now, with a state court interpreting the term "status quo" in Miss. Code Ann. § 41-75-23 to permit such penalties. These uncertainties can easily be avoided by a preliminary injunction pending resolution of the merits, or at least until one of the hospitals has granted the Clinic physicians' applications for admitting privileges.

II. Immediate Enforcement of the Admitting Privileges Requirement Will Cause Irreparable Harm to Plaintiffs and their Patients.

In its order granting emergency relief against enforcement of the Act, the Court directed the parties to submit supplemental briefing regarding: (1) the change in circumstances resulting from the Clinic's receipt of a renewal license; and (2) the extent to which the threat of commencing administrative proceedings due to Plaintiffs' current state of non-compliance with the Act constitutes irreparable harm. Order dated July 1, 2012, Dkt. No. [17].

A. The Department's Commitment to Immediately Enforce the Admitting Privileges Requirement Forces Plaintiffs into An Untenable Position.

Renewal of the Clinic's license resolves one of the two insurmountable problems prompting Plaintiffs to file this litigation: the Department's demand, on June 25, 2012, that the Clinic provide written proof of compliance with the new law on or before July 1, 2012 as a condition of license renewal. Absent a license, the Clinic could not operate. The Clinic's receipt of a renewal license from the Department, the day after this litigation was filed, removed this obstacle.[2]

The second problem persists. The Department's last-minute decision, on June 22, 2012, to enforce Mississippi House Bill 1390 ("the Act") immediately—rather than after promulgating amended rules that would take effect in mid-August—means that Plaintiffs cannot operate in compliance with the laws as of July 1, but for this Court's order restraining enforcement of the

[2] Plaintiffs' procedural due process claim is not affected by the Department's renewal of the Clinic's license. That claim stemmed from the Department's abrupt reversal, on June 22, 2012, of its earlier decision to promulgate rules to implement the Act, which would have delayed its effective date until mid-August and given Plaintiffs a more reasonable amount of time to obtain privileges – a process involving third parties over which they have no control. Because the Department's decision to immediately enforce the Admitting Privileges Requirement will substantially interfere with Plaintiffs' protected property interests in continued operation, it violates Plaintiffs' procedural due process rights. *See* Pls.' Mem. of L. in Supp. of Pls.' Mot. for TRO and/or Prelim. Inj., Dkt. No. [6] at 19-21. Plaintiffs are not required to exhaust their administrative remedies prior to bringing a procedural due process claim under 42 U.S.C. § 1983, particularly because such remedies would not cure the procedural due process violation. *See Bowlby v. City of Aberdeen*, 681 F.3d 215, 220-22 (5th Cir. 2012) (squarely holding that exhaustion of administrative remedies is not required prior to a procedural due process claim).

Act. Plaintiffs do not know when, if ever, they will be able to comply with the Admitting Privileges Requirement. If it is permitted to take effect, Plaintiffs cannot operate without risking penalties for knowingly violating that section of the statutes, regulations, and standards governing abortion facilities and ambulatory surgical facilities. *See* Miss. Code Ann. §§ 41-75-25, 41-75-26(1) (imposing penalties including misdemeanor liability, fines, and license revocation for any licensed health care professional); *see also* Reply in Supp. of Pls.' Mot. for TRO and/or Prelim. Inj., Dkt. No. [12] ("Pls.' Reply Br.") at 3. Thus, immediate enforcement forces Plaintiffs to choose between two untenable options: continuing to provide abortion care, violating a law they have challenged as unconstitutional and risking penalties; or ceasing to provide lawful medical procedures. The Admitting Privileges Requirement will accordingly have a "chilling" effect that threatens the availability of abortion care in Mississippi and so creates an unconstitutional *de facto* ban. *See* Pls. Mem. L. in Supp. of Pls' Mot. for TRO and/ or Prelim. Inj., Dkt. No. [6] ("Pls.' PI Br."). *Cf., e.g., Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1465 (8th Cir. 1995) (striking a statute creating strict civil liability for abortion providers because of the "chilling" effect it would have on providers).

B. Plaintiffs Have Shown they Will Experience Irreparable Injury without Preliminary Injunctive Relief.

In order to show irreparable harm justifying injunctive relief, Plaintiffs "need show only a significant threat of injury from the impending action, that the injury is imminent, and that money damages would not fully repair the harm." *Humana, Inc. v. Jacobson*, 804 F.2d 1390, 1394 (5th Cir. 1986) (footnotes and citations omitted). Plaintiffs clearly meet this standard.

1. Plaintiffs Have Shown a Significant Threat of Injury.

As discussed below, the administrative proceedings that the Department has promised to initiate immediately upon the Act's taking effect are not the only penalties that Plaintiffs face.

Combined with the prospect of criminal and disciplinary penalties, enforcement of the Admitting Privileges Requirement will have a "chilling" effect on the provision of abortion care in Mississippi. Courts have repeatedly held that such a *threat* of a constitutional rights violation is irreparable injury justifying preliminary injunctive relief. *E.g., Ingebretsen v. Jackson Pub. Sch. Dist.*, 88 F.3d 274, 280 (5th Cir. 1996) (finding irreparable injury because a statute posed a substantial threat to the plaintiff's constitutional rights); *Deerfield Med. Ctr. v. City of Deerfield Beach*, 661 F.2d 328, 338 (5th Cir. 1981) (same); *Pro-Choice Miss. v. Thompson*, Case No. 3:96CV596BN, Bench Op. at 27 (annexed as Ex. D to Pls.' PI Br.); *see* Pls.' Reply Br. at 4-5 (collecting cases); Pls.' PI Br. at 21-22 (same).

Defendants have repeatedly insisted that Plaintiffs do not risk irreparable harm from immediate enforcement of the Act because at least sixty days will pass before the Clinic is *ordered* to close.[3] *See* Defs.' Resp. in Opp. to Mot. for Prelim. Inj., Dkt. No. [10]. But it does not take a formal order to force the Clinic to close; the prospect of criminal and disciplinary liability for violating the Admitting Privileges Requirement will accomplish the same result. Further, whether the Department revokes the Clinic's license next week or in sixty days, the risk to Plaintiffs exists *now* because the Clinic and its staff will be in violation of the Admitting

[3] Even though Defendants have assured Plaintiffs and this Court that they would not seek to initiate any criminal prosecutions during the pendency of the licensure revocation process, they have made no such commitments about what they will do at the end of that process about conduct in the interim. *See* Def. Smith's Resp. in Opp. to Pls.' Mot. for Prelim. Inj. and/or TRO, Dkt. No. [15], at 2 (committing not to prosecute "while [the Clinic's] compliance with licensure requirements is being reviewed by the state Department of Health"); Def. Currier's Resp. to Pls.' Reply to Resp. in Opp. to Pl.'s Mot. for Prelim. Inj. and/or TRO, Dkt. No. [16], at 1 (stating that the Department "has no intention to request that any other entity press criminal charges … until the administrative process … is completed"). These assurances are "no solace" to Plaintiffs. *Cf. Women's Med. Ctr of Nw. Houston v. Bell*, 248 F.3d 411, 422 (5th Cir. 2001) (fact that penalties for violation of challenged law had not yet been imposed did not protect against future imposition). A commitment to delay prosecution is not the same as a commitment to forego it. *See Richmond Med. Ctr. for Women v. Gilmore*, 11 F. Supp. 2d 795, 809 (E.D. Va. 1998) ("The defendants argue that the plaintiffs cannot, as a matter of law, sustain any irreparable injury because the Commonwealth Attorneys have sworn they will not prosecute [the plaintiff physicians for performing a particular type of abortion procedure]. Those affidavits are a statement of current intent, and are not binding on the Commonwealth Attorneys….").

Privileges Requirement as soon as it takes effect. This risk constitutes irreparable harm to Plaintiffs and their patients and is sufficient to warrant injunctive relief.

Defendants have argued that the time allowed for a hearing and a final Department of Health decision in Miss. Code Ann. § 41-75-11, and the words "status quo" in Miss. Code Ann. § 41-75-23, obviate the need for a preliminary injunction. This is not accurate. Section 41-75-11 provides for a hearing and a final determination by the Department of Health. It does not say that the status quo shall be maintained during that process. Section 41-75-23 addresses the availability of an appeal to Chancery Court from a licensure revocation order issued by the Department of Health. It states that "[p]ending final decision of the matter, the status quo of the applicant or licensee shall be preserved, unless a court orders otherwise in the public interest." Miss. Code Ann. § 41-75-23. Indeed, some might argue that because the phrase "status quo" is not in § 41-75-11, the Clinic cannot operate during the administrative process, and that "status quo" in § 41-75-23 refers to the situation in place after the Department of Health renders a final decision revoking the clinic's license. Even if these two sections of law allow the Clinic to continue to operate through the administrative process and pending a final disposition in the state courts, they do not guarantee that the Clinic, its physicians and its staff would be free from all risk of liability for their conduct during the period in which the administrative process and any appeal progress. The Department will continue to be pressured to close the Clinic during the administrative process, and even if that is not done, arguments by various *amicus curiae* may well be made to the state courts that the public interest requires closing the Clinic before the case is concluded.

Moreover, in light of the particular circumstances here, where state officials have made no secret of their desire to close the Clinic and have actively exerted pressure to accomplish that

result, neither §§ 41-75-11 nor 41-75-23 eliminates the uncertainty that surrounds this case, and neither prevents the distinct possibility of irreparable harm to the Plaintiffs. Indeed, in enjoining a Department of Health regulation requiring a written transfer agreement with a local hospital, Judge Barbour did not even mention these sections, and the administrative procedures they establish, though they were in place, let alone consider them as a reason to deny preliminary injunctive relief. *See Pro-Choice Mississippi*, Case No. 3:96CV596BN, Bench Op. at 20-21 (annexed as Ex. D to Pls.' PI Br.) (holding that "there is widespread public opposition and protest to abortions in this state," that "as a practical matter, local pressure can and will be brought upon hospitals to deny these written transfer agreements to abortion providers, " and "the hospitals then would have third-party vetoes over whether the abortion providers can obtain a license from the State of Mississippi.").

Further, even if the Clinic is allowed to stay open, and whether or not admitting privileges are ultimately obtained, arguments may be made at the conclusion of the process that penalties can be imposed on the Plaintiffs retroactively. While the words "status quo" in § 41-75-23 would seem to preclude that sort of retroactive imposition, with no Mississippi case law construing the statute and given the controversy surrounding this case, that risk cannot be discounted. Moreover, even if it could be guaranteed that the clinic could stay open without suffering any potential penalties pending completion of the process described in § 41-75-11 and § 41-75-23, the Plaintiffs are still placed in the difficult position of knowingly violating state law in order to stay open. Even though there is an administrative process, they are still violating a state criminal law *unless that state law is enjoined*. Citizens should not be required to disobey a statute in order to exercise their rights under the United States Constitution. Given that the Admitting Privileges Requirement likely is unconstitutional, it should be enjoined so that the

Plaintiffs are not in the position of either having to close or having to knowingly disobey the statute as the price for staying open.

Additionally, even if the administrative licensure revocation proceeding were the only penalty Plaintiffs would face upon the Admitting Privileges Requirement taking effect, such a proceeding constitutes a "significant threat of irreparable injury." In evaluating irreparable injury, courts have focused on the *consequences* of enforcement of a law challenged as unconstitutional, and have been less concerned about the *nature* of enforcement as administrative, civil, or criminal. For example, in *Shamloo v. Mississippi State Board of Trustees of Institutes of Higher Learning*, 620 F.2d 516 (5th Cir. 1980), the Fifth Circuit held that preliminary injunctive relief should issue to halt ongoing disciplinary proceedings against the students who were challenging the statute. *Id.* at 525. Notably, the court's analysis was not affected by the fact that the penalties imposed on the students were exclusively administrative; rather, the court focused on the impact that enforcement had on their constitutional rights. Similarly, in *Ingebretsen v. Jackson Public School District*, 88 F.3d 274, the Fifth Circuit found irreparable injury where the challenged statute would have infringed on students' First Amendment rights, even though the only apparent enforcement of the statute would have been disciplinary. *Id.* at 278.

Likewise, a district court in Louisiana held that the threat that the defendant administrative agency would initiate administrative proceedings to decertify the plaintiff nursing home was irreparable injury. *Rayford v. Bowen*, 715 F. Supp. 1347, 1350-51 (W.D. La. 1989). That court specifically rejected the defendant federal agency's argument that no irreparable injury existed because no nursing home had yet been decertified. *Id*. at 1350-51. The court explained that the *threat* of decertification constituted irreparable injury:

> If the plaintiffs had to wait until they were prosecuted in order to obtain a preliminary injunction, no one could ever enjoin the Government. The plaintiffs would have to wait until they were prosecuted and then use the illegality of the Government's actions as a shield rather than as a sword. . . . The plaintiffs do not need to wait until it is too late to test the constitutionality of [the challenged statute]. . . . The defendants have made it abundantly clear that the sword of decertification hangs over the plaintiffs' heads.

Id. at 1351. Accordingly, the court granted preliminary injunctive relief.

Whether Defendants initiate administrative proceedings alone or in addition to criminal and disciplinary penalties, Plaintiffs and their patients face irreparable injury. *Cf. Shamloo*, 620 F.2d at 525; *Rayford*, 715 F. Supp. at 1351. Further, because the end result of licensure proceedings is revocation of the Clinic's license, the administrative proceedings threaten the constitutional rights of women in Mississippi to obtain abortion care, justifying preliminary injunctive relief. *Cf. Deerfield Med. Ctr.*, 661 F.2d at 338; *Women's Med. Ctr of Nw. Houston v. Bell*, 248 F.3d 411, 422 (5th Cir. 2001) (affirming district court's finding of irreparable harm based on threat to women's constitutional right to privacy).

Further, administrative proceedings will force the Clinic to endure the burden and expense of defending itself from charges that it is engaged in conduct that jeopardizes its patients' health. When the Admitting Privileges Requirement takes effect, Dr. Parker will, likewise, be exposed to reputational harms associated with the same charges. Even if these harms might be remedied by monetary relief in the ordinary case, they are not remediable here because of the Eleventh Amendment bar discussed below. *Cf. DFW Metro Line Serv. v. Sw. Bell Tel. Co.*, 901 F.2d 1267, 1269 (5th Cir. 1990).

Finally, Defendants' last-minute insistence on immediately instituting administrative proceedings should be considered in context. The Department of Health's initial response to the Act was to begin the process of promulgating amended rules to implement the new law, which

would have taken effect in mid-August. *See* Pls.' PI Br. at 8. However, the Act's sponsor—one of several elected officials who have openly stated a desire to end abortion through the Act—publicly pressured the Department to enforce the new law immediately upon its effective date. It was only after that pressure that the Department reversed its position and began seeking immediate enforcement. *Id.* This is a strong indication that immediate enforcement—at a time when compliance is practically impossible—is a crucial component of the purpose animating the Admitting Privileges Requirement. In other words, the immediate implementation of administrative proceedings will operationalize the constitutional violations at issue here; it is a part and parcel of the attempted closure of the Clinic and subsequent elimination of abortion access in Mississippi, in violation of the Constitution.

Thus, Plaintiffs have demonstrated that enforcement of the Admitting Privileges Requirement presents a "significant threat of injury." *Cf. Humana, Inc.*, 804 F.2d at 1394.

2. Injury to Plaintiffs and Their Patients Is Imminent.

Injury need not be immediate to be "imminent"; indeed, the timing of the injury is less important than the certainty of its occurrence. Here, too, courts have focused on the impact of the threatened injury, without regard to whether the injury would arise from civil, criminal and/or administrative enforcement. For example, the Fifth Circuit has held that the certainty that the federal Department of Health and Human Services would enforce regulations allowing withdrawal of all Medicare funding was sufficiently "imminent" to justify preliminary injunctive relief. *Humana, Inc.*, 804 F.2d at 1394 (holding that Humana was not required to go through administrative enforcement proceedings before obtaining preliminary injunction); *accord Women's Med. Ctr. of Nw. Houston*, 248 F.3d at 422; *Ingebretsen*, 88 F.3d at 278 (plaintiff was not required to delay his constitutional challenge until after his constitutional rights were violated

by enforcement of the challenged statute); *Rayford*, 715 F. Supp. at 1351; *see also Doe v. Bolton*, 410 U.S. 179, 188 (1973) (holding that i) plaintiff physicians had standing to challenge the constitutionality of state abortion statutes "despite the fact that the record does not disclose that any one of them has been prosecuted, or threatened with prosecution;" and ii) plaintiff physicians "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief"). Here, without injunctive relief, penalties for violating the Admitting Privileges Requirement will hang, like a sword of Damocles, over Plaintiffs from the moment that the Act takes effect. This is true of the administrative proceedings that Defendants have repeatedly committed to implement the moment the Admitting Privileges Requirement takes effect, just as it is of the other penalties discussed above. Thus, Plaintiffs have shown that injury is "imminent."

3. Plaintiffs and their Patients Have No Adequate Remedy at Law.

Threatened injury is "irreparable" if it cannot be compensated by monetary relief. *Deerfield Med. Ctr.*, 661 F.2d at 338. The two categories of injury Plaintiffs face cannot be remedied by money damages. First, as to the reputational and economic harms flowing from charges of violating the law, Plaintiffs and their patients cannot be compensated with monetary relief because the Eleventh Amendment prohibits recovery of damages from state officials. *Edelman v. Jordan*, 415 U.S. 651, 667-68 (1974). Thus, the financial expenses Plaintiffs would incur in defending against enforcement of the Admitting Privileges Requirement, as well as their reputational injury from wrongful accusations of conduct jeopardizing patient health, could not be recovered if Plaintiffs ultimately prevail in their challenge to the Act's constitutionality. Second, as to the harms to the constitutional rights of themselves and their patients, it is well-settled that money damages are no remedy. *See, e.g.*, *Deerfield Med. Ctr.*, 661 F.2d at 338 ("the right of privacy must be carefully guarded for once an infringement has occurred it cannot be

undone by monetary relief"). Plaintiffs' injuries, accordingly, are not compensable by monetary damages and are properly deemed "irreparable."

III. Plaintiffs Have Shown that the Balance of Hardships Tips In Their Favor and that Injunctive Relief Is In the Public Interest.

While Plaintiffs will suffer irreparable harms if the Admitting Privileges Requirement is allowed to take effect, Defendants will suffer no harm at all. *See* Pls.' PI Br. at 22-23. The balance of hardships thus weighs heavily in favor of preliminary injunctive relief.

The public interest would be served by an injunction against enforcement of the Act, as it is always served by restraints against unconstitutional laws. *See* Pls.' PI Br. at 23. In addition, by allowing Plaintiffs to press those claims before they are forced to defend against charges of non-compliance in administrative proceedings, injunctive relief would serve the important policy interests motivating the passage of 42 U.S.C. § 1983. Among other things, that statute was intended to ensure that the federal judiciary plays the "paramount role" in protecting constitutional rights, and to protect plaintiffs against being forced to raise their constitutional claims in a defensive posture as part of administrative and/or state proceedings. *Steffel v. Thompson*, 415 U.S. 452, 472-73 (1974); *see also Patsy v. Bd. of Regents*, 457 U.S. 496, 504, 515 (1982).

Preliminary injunctive relief against the Act would also serve the public interest because of the specific circumstances here. There is strong evidence that the Admitting Privileges Requirement is motivated by a desire to close down the Clinic and end abortion in the State, in defiance of the Constitution and with a disregard for the rights of individuals. There is, correspondingly, a strong public interest in defending individual rights and the structure of federalism against the assault launched by the Act. The reasoning of a district court in Nebraska

that enjoined a law it determined was motivated by a comparably unconstitutional purpose is particularly apt:

> The public interest in preserving the separation of powers, the supremacy of the United States Constitution, concepts of federalism, and the liberty and privacy interests of individuals in exercising responsible stewardship and personal dominion of their own bodies, all weigh heavily in favor of the granting of injunctive relief.

Planned Parenthood of the Heartland v. Heineman, 724 F. Supp. 2d 1025, 1049 (D. Neb. 2010).

IV. Conclusion

For the foregoing reasons, and for the reasons set forth in Plaintiffs' prior briefing in this case, preliminary injunctive relief is proper and should issue to prevent enforcement of the Act.

Respectfully submitted this 6th day of July, 2012,

/s/ Michelle Movahed
Michelle Movahed*
NY Bar #4552063
IL Bar #6291836
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3600 Phone
(917) 637-3666 Fax
mmovahed@reprorights.org

Robert B. McDuff, MS Bar #2532
McDuff & Byrd
767 North Congress Street
Jackson, MS 39202
(601) 969-0802 Phone
(601) 969-0804 Fax
rbm@mcdufflaw.com

*Admitted *pro hac vice* by Order dated June 29, 2012

ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I hereby certify that a true and accurate copy of the foregoing has been served on the following counsel through the Court's ECF system:

P. Roger Googe, Jr.
Benjamin G. Bryant
Office of the Attorney General
Civil Litigation Division
PO Box 220
Jackson, MS 39205-0220
(601) 359-3822 Phone
(601) 359-2003 Fax
rgoog@ago.state.ms.us

ATTORNEYS FOR DEFENDANTS

This the 6th day of July, 2012.

/s/ Michelle Movahed
Michelle Movahed*
NY Bar #4552063
IL Bar #6291836
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3600 Phone
(917) 637-3666 Fax
mmovahed@reprorights.org

*Admitted *pro hac vice* by Order dated June 29, 2012

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients, and WILLIE PARKER, M.D., M.P.H., M.Sc., on behalf of himself and his patients, Plaintiffs, v. MARY CURRIER, M.D., M.P.H. in her official capacity as State Health Officer of the Mississippi Department of Health, and ROBERT SHULER SMITH, in his official capacity as District Attorney for Hinds County, Mississippi, Defendants.	)	Case No. 3:12-CV-00436-DPJ-FKB

SUPPLEMENTAL DECLARATION OF SHANNON BREWER-ANDERSON IN SUPPORT OF PLAINTIFFS' MOTION FOR TEMPORARY RESTRAINING ORDER AND/OR PRELIMINARY INJUNCTION

I, Shannon Brewer-Anderson, declare under penalty of perjury that the following statements are true and correct:

1. I am the Director at Jackson Women's Health Organization (the "Clinic"). As Director, I am responsible for all aspects of the Clinic's operation, including its interactions with the Mississippi Department of Heath regarding the Clinic's license.

2. The Clinic was found in full compliance will all applicable laws and regulations in both of its most recent inspections by the Department of Health.

3. On April 12, 2012, following the Department's inspection of the Clinic, it concluded that the Clinic was "in compliance with all applicable laws."

4. Similarly, in its most recent inspection on June 18, 2012, prompted by complaints from anti-choice activists regarding the closure of a clinic in another state owned by Diane Derzis, the Clinic's current owner, the Department again concluded that the Clinic is "in compliance with all applicable laws." A true and correct copy of that report is attached to this Declaration.

5. Accordingly, the Department of Health's continuous and rigorous inspections of the Clinic have all concluded that it is in full compliance with all applicable laws and regulations, and the Clinic has continuously remained license since it was first required to do so.

6. Applications for hospital privileges on behalf of Dr. Doe and Dr. Parker have now been submitted to all of the area hospitals that have permitted them to apply.

7. As of now, none of the hospitals have responded to these applications for privileges. I do not know when we will hear back from any of the hospitals, and none of them have guaranteed that they will make a determination regarding the submitted applications within a particular time period.

I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: July 09, 2012

Shannon Brewer-Anderson

ATTACHMENT A

PRINTED: 06/27/2012
FORM APPROVED

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25JW	A. BUILDING _____ B. WING _____	06/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JACKSON WOMEN'S HEALTH ORGANIZATION	2903 NORTH STATE STREET JACKSON, MS 39216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments COMPLAINT INVESTIGATION #MS00010596 The licensure survey of 06/22/2012 indicated compliance with "The Minimum Standards of Operation of Abortion Facilities." No licensure violations were noted. The facility met the requirements for a Level 1 Abortion Facility.	M 000		

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director — (X6) DATE: 6/30/2012

STATE FORM 6899 1EFZ11 If continuation sheet 1 of 1

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients, and WILLIE PARKER, M.D., M.P.H., M.Sc., on behalf of himself and his patients, Plaintiffs, v. MARY CURRIER, M.D., M.P.H. in her official capacity as State Health Officer of the Mississippi Department of Health, and ROBERT SHULER SMITH, in his official capacity as District Attorney for Hinds County, Mississippi, Defendants.	)	Case No. 3:12-CV-00436-DPJ-FKB

REBUTTAL DECLARATION OF DANIEL A. GROSSMAN, M.D.
IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

DANIEL A. GROSSMAN, M.D., declares under penalty of perjury that the following statements are true and correct:

1. I provide the following facts and opinions as an expert in obstetrics and gynecology and the provision of abortion. I am Board-certified in obstetrics and gynecology and serve as a Senior Associate with Ibis Reproductive Health, a nonprofit organization that conducts clinical and social science research concerning sexual and reproductive health. I am also an Assistant Clinical Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the

University of California, San Francisco. In addition, I am a Fellow of the American College of Obstetricians and Gynecologists ("ACOG"), the nation's leading association of medical professionals specializing in obstetrics and gynecology. I am also a Fellow of the Society of Family Planning. A copy of my curriculum vitae, which summarizes my background, experience, and publications, is attached hereto as Attachment A.

2. The opinions expressed below are based on my years of experience in the field of obstetrics and gynecology; my research, writing, teaching, and clinical experience in abortion care; and my review of the medical literature.

3. I provide these opinions in support of Plaintiffs' Motion for a Preliminary Injunction against enforcement of Mississippi House Bill 1390's requirement that all physicians "associated with" an abortion care facility obtain "admitting privileges and staff privileges to replace local hospital on-staff physicians." I believe this requirement is medically unjustified. I also believe that any possible benefit this requirement might provide is dramatically outweighed by the serious consequences for women's health if this requirement results in abortions being generally unavailable in Mississippi.

Safety of Abortion

4. Legal abortion is one of the safest medical procedures in the United States. The risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication is more common among women having live births than among those having abortions.[1]

5. To effectively assess the risks related to abortion, it is important to put them in context. Women who seek abortions are pregnant, and pregnancy, itself, is risky. Three percent

[1] Raymond, Elizabeth G., and Grimes, David A., *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet & Gynecol. 215 (Feb. 2012).

of all women who deliver vaginally have a prolonged hospital admission or early re-admission to the hospital. For cesarean delivery, the figure is three times higher, about 9 percent.[2] More than 30 percent of American women have a major abdominal operation (cesarean) for delivery.[3]

6. By contrast, serious complications from abortion are rare. These include uterine perforation, hemorrhage, infection and anesthetic complications. The risk of a woman experiencing a complication requiring hospitalization is extremely low. The risk of death related to abortion overall is 0.7 deaths per 100,000 procedures, which is roughly comparable to the risk of death following a miscarriage.

7. The risk of death from fatal anaphylactic shock following use of penicillin in the United States is 2.0 deaths per 100,000 uses.[4]

8. Abortion is analogous to other outpatient gynecological procedures in terms of risks, invasiveness, instrumentation, and duration. In these respects, first-trimester abortions are similar to diagnostic dilation and curettage, endometrial biopsy and surgical completion of miscarriage. And in these respects second-trimester abortions are similar to laparoscopy and hysteroscopy.

9. Abortion is also comparable to non-gynecological outpatient surgical procedures in terms of risk, invasiveness, instrumentation, and duration. For example, first-trimester abortion is comparable in these respects to vasectomy.[5] Non-gynecological procedures comparable in

---

[2] Hebert PR, Reed G, Entman SS, Mitchel EF Jr, Berg C, Griffin MR. Serious maternal morbidity after childbirth: prolonged hospital stays and readmissions. Obstet Gynecol 1999;94:942-7

[3] Hamilton BE, Martin JA, Ventura SJ. Births: preliminary data for 2006. Natl Vital Stat Rep 2007;56:1-18

[4] Neugut, AI, Ghatak AT, Miller RL. Anaphylaxis in the United States: an investigation into its epidemiology. Arch. Intern. Med. 2001; 161:15-21.

[5] Grimes DA, Satterthwaite AP, Rochat RW, Akhter N. Deaths from contraceptive sterilization in Bangladesh: rates, causes, and prevention. Obstet Gynecol 1982;60:635-40.

these respects to second-trimester abortions include sigmoidoscopy[6] and operative colonoscopy.[7] These outpatient procedures, like abortion, may cause hemorrhage, infection, vasovagal reactions (i.e. a negative reaction to anesthesia), injury to organs, and sometimes death.

Management of Complications

10. It is extremely common for physicians to cover for each other in the event a patient needs to be hospitalized. This is part of the reality of contemporary medical practice around the country, including the use of hospitalists to provide inpatient care. In the ob/gyn context, for example, a pregnant woman who experiences a complication, like pre-eclampsia, that requires emergency care will often be cared for in the hospital by a physician who is not her regular physician. In fact, the physician who cares for her in the hospital may not even be affiliated with the physician who has been providing her prenatal care. Obstetrician "laborists" now exist that only provide inpatient obstetric care, while a community obstetrician manages the pregnant patient as an outpatient.[8]

11. Regardless of whether a patient's usual physician has privileges at the hospital where she seeks care, it is standard practice for hospital staff to contact the patient's usual physician (assuming the patient gives her permission) if they have questions about the patient or need further information about her medical history. It is also standard practice for the referring physician to call the emergency room physician to inform the hospital staff about the patient.

12. Many of the complications associated with abortion can be appropriately and safely managed by monitoring the patient outside of a hospital setting. For example, most cases of non-

[6] Gatto NM, Frucht H, Sundararajan V, Jacobson JS, Grann VR, Neugut AI. Risk of perforation after colonoscopy and sigmoidoscopy: a population-based study. J Natl Cancer Inst 2003;95:230-6.

[7] Viiala CH, Zimmerman M, Cullen DJ, Hoffman NE. Complication rates of colonoscopy in an Australian teaching hospital environment. Intern Med J 2003;33:355-9.

[8] http://www.oblaborist.org/

severe hemorrhage are managed in the clinic setting with uterotonics, medications that increase the tone of uterine contractions and reduce bleeding. Mild infection is also usually treated as an outpatient with oral and/or injected antibiotics. In the rare circumstances where an abortion patient experiences a complication that requires hospitalization, the physician who provides her abortion may not be the appropriate physician to manage her care in the hospital, regardless of whether the physician has privileges there. For example, in the very rare case of uterine perforation with intestinal injury, it is critical that the patient be managed by a skilled general surgeon. I am a board-certified obstetrician-gynecologist, but I cannot manage a severe bowel injury that might occur during some of the procedures I perform, such as cesarean section or hysterectomy. I rely on my colleague general surgeons to manage this complication, just as they rely on me to evaluate gynecologic pathology they might encounter during surgery they perform.

13. Similarly, if a woman who lives far from the facility where she obtained her abortion does experience a complication that requires hospitalization, she should not travel to be treated at a hospital near that facility. Instead, she should go to the hospital nearest to her to make sure she is treated as quickly as possible.

Access to Legal Abortion Is Vital to the Protection of Public Health

14. It is extraordinarily important for women to have meaningful access to legal abortion. Women of childbearing age who do not have access to the procedure face significantly increased risks of death and poor health outcomes.

15. When women are forced to travel long distances for care, many will delay obtaining an abortion until they can find the money or arrange transportation. Delaying abortions until later in pregnancy drives up risks of complications and death.[9]

[9] Bartlett LA, Berg CJ, Shulman HB, Zane SB, Green CA, Whitehead S, Atrash HK. Risk factors for legal induced abortion-related mortality in the United States.
Obstet Gynecol. 2004 Apr;103(4):729-37.

16. When legal abortion is unavailable or difficult to access, some women turn to illegal, and unsafe, methods to terminate unwanted pregnancies.[10]

17. Other women, deprived of access to legal abortion, forego the abortions they would have obtained if they could and, instead, carry unwanted pregnancies to term. These women are exposed to increased risks of death and major complications from childbirth, and they and their newborn are at risk of complications during pregnancy and after delivery.[11]

18. The importance to women's health of easy access to safe, legal abortion cannot be overstated. Major medical and public health organizations have recognized this. For example, the American College of Obstetricians and Gynecologists opposes bans on abortion and has called "intervention of legislative bodies into medical decision making … inappropriate, ill advised, and dangerous."[12] The American Medical Association similarly opposes legislation that impedes women's ability to access abortion.[13] The American Public Health Association not only opposes government actions that impede women's access to safe, legal abortion, it encourages performance of abortions by advance practice clinicians in order to improve women's access to abortion. [14] The World Health Organization (WHO) has documented that restrictions on access to abortion harm women's health, noting, "Safe abortion services, as provided by law, therefore

---

[10] Grossman D, Holt K, Peña M, Lara D, Veatch M, Córdova D, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. Reprod Health Matters. 2010 Nov;18(36):136-46.

[11] Gipson JD, Koenig MA, Hindin MJ. The effects of unintended pregnancy on infant, child, and parental health: a review of the literature. Stud Fam Plann 2008;39(1):18-38.

[12] American College of Obstetricians and Gynecologists. Abortion policy. http://www.acog.org/publications/policy_statements/sop0009.htm, accessed July 19, 2005

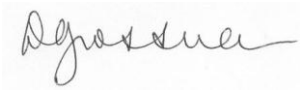
[13] American Medical Association. H-5.998 Public funding of abortion services. http://www0.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/H-5.998.HTM&s_t=abortion&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=9&, accessed October 21, 2008.

[14] American Public Health Association. Policy statement. The need for state legislation protecting and enhancing women's ability to obtain safe, legal abortion services without delay or government interference. Policy number LB-07-02. http://www.apha.org/NR/rdonlyres/07CE6E31-2C49-4607-85A2-7B23E1F73BD5/0/C1LB0702onabortion.pdf

need to be available, provided by well trained health personnel supported by policies, regulations and a health systems infrastructure, including equipment and supplies, so that women can have rapid access to these services."[15]

19. There is a nationwide shortage of physicians willing to provide abortion care to the women who need it. House Bill 1390 imposes medically unnecessary and hard-to-satisfy restrictions on physicians who are willing to provide abortions to women in Mississippi, increasing the obstacles and correspondingly diminishing the number of providers. It will, therefore, be extremely harmful to women's health and well-being.

[15] World Health Organization. Safe abortion: technical and policy guidance for health systems. Geneva: World Health Organization, 2003.



Daniel A. Grossman, M.D.

Dated: July 9, 2012

ATTACHMENT A

September 20, 2011

DANIEL A. GROSSMAN, M. D., F. A. C. O. G.

Ibis Reproductive Health
1330 Broadway, Suite 1100
Oakland, CA 94612
Phone: 510-986-8941; Fax: 510-986-8960
Email: dgrossman@ibisreproductivehealth.org

Current position

Senior Associate, Ibis Reproductive Health, San Francisco

Education

Sept. 1985-May 1989	Yale University-Molecular Biophysics and Biochemistry	B.S., 1989
Sept. 1989-June 1994	Stanford University School of Medicine	M.D., 1994
June 1994-June 1998	Resident and Administrative Chief Resident, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco	

Licenses/Certification

1996-Present	California medical licensure (A60282)
2001-Present	Board-certified, American Board of Obstetrics and Gynecology

Principal positions held

Aug. 1998-Feb. 2003	
Aug. 2005-Present	Physician, St. Luke's Women's Center, San Francisco, CA
May 2003-Aug. 2005	Health Specialist, The Population Council Regional Office for Latin America and the Caribbean, Mexico City
Aug. 2005-Present	Senior Associate, Ibis Reproductive Health

Other positions held concurrently

Aug. 1998-Feb. 2003	Director of Medical Student Education, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-Feb. 2003	Vice Chair, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-Present	Assistant Clinical Professor, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco

Honors and awards

1988	Howard W. Hilgendorf Jr. Fellowship, Yale University
1988	Robin Berlin Memorial Prize, Yale University
1989	Magna cum laude, Yale University
1990	Medical Scholars Award, Stanford University
1990	Peter Emge Traveling Fellowship, Stanford University
1991-1992	Foreign Language and Area Studies Fellowship, Stanford University
1994	Dean's Award for Research in Infectious Diseases, Stanford University

Honors and awards (continued)

2007 Ortho Outstanding Researcher Award, Association of Reproductive Health Professionals
2009 Visionary Partner Award, Pacific Institute for Women's Health
2010 Scientific Paper Award, National Abortion Federation

Key words/areas of interest

Abortion, medication abortion, second trimester abortion, contraception, over-the-counter access to oral contraception, integration of family planning into HIV care and treatment, Latina reproductive health in the US, misoprostol and self-induction of abortion, Mexico, Peru, Bolivia, Dominican Republic, South Africa, Kenya

PROFESSIONAL ACTIVITIES

Clinical activities

St. Luke's Women's Center: Since August 2005, I have worked as a consultant at St. Luke's Women's Center, where my clinical activities focused on general obstetric and gynecology care, including providing abortion up to 20 weeks' gestation, as well cervical dysplasia care (including office-based LEEP). In addition to providing outpatient services, I staffed Labor and Delivery and provided gynecologic coverage for the emergency room. Since August 2010, I have only been providing inpatient coverage for St. Luke's Women's Center.

PROFESSIONAL ORGANIZATIONS

Memberships

2000-Present: Fellow, American College of Obstetrics and Gynecology
2006-Present: Fellow, Society of Family Planning
2004-Present: American Public Health Association
2004-2011: Association of Reproductive Health Professionals
2004-Present: International Consortium for Medical Abortion
2006-Present: Liaison Member, Planned Parenthood Federation of America National Medical Committee
2005-Present: Consorcio Latinoamericano contra el Aborto Inseguro (Latin American Consortium against Unsafe Abortion)
2004-Present: Working Group on Oral Contraceptives Over-the-Counter

Service to professional organizations

2008-Present: Society of Family Planning, reviewer of fellow research protocols, reviewer of grant proposals, abstract reviewer for annual meeting
2007-Present: American Public Health Association, Governing Councilor (2007-2009, 2010-2012), Section Secretary (2008-2009), abstract reviewer for annual meeting
2005-Present: Consorcio Latinoamericano contra el Aborto Inseguro, member of Coordinating Committee
2006-Present: Working Group on Oral Contraceptives Over-the-Counter, working group coordinator and member of steering committee
2010-Present: Member, Committee on Practice Bulletins-Gynecology, ACOG
2010-Present: Steering Committee member, International Consortium for Medical Abortion

SERVICE TO PROFESSIONAL PUBLICATIONS

2004-Present Ad hoc reviewer for Obstetrics and Gynecology (5 papers in past 5 years), American Journal of Public Health (2 papers in past 3 years), Reproductive Health Matters (6 articles in past 4 years), Expert Review of Obstetrics and Gynecology (1 review in past year), and Women's Health Issues (4 articles in past 2 years)

INVITED PRESENTATIONS (Selected)

International

Reducing Maternal Mortality due to Abortion: Potential Impact of Misoprostol in Low-resource Settings. XVIII FIGO World Congress of Gynecology and Obstetrics, Kuala Lumpur, 2006 (oral presentation and session chair).

Mortality and morbidity following second trimester abortion. International Consortium for Medical Abortion Conference on Second Trimester Abortion, London, 2007 (invited talk).

Abortion research developments. Future of abortion: controversies and care, London, 2008 (invited talk).

Integration of family planning into HIV care in Western Kenya. What do providers think? XIX FIGO World Congress of Gynecology and Obstetrics, Cape Town, South Africa, 2009 (oral presentation)

Cost-effectiveness of alternative strategies for first-trimester abortion in Mexico City. XIX FIGO World Congress of Gynecology and Obstetrics, Cape Town, South Africa, 2009 (oral presentation and session chair)

National

How useful are routine follow-up visits after first trimester abortion? National Abortion Federation 27th Annual Meeting, New Orleans, 2004 (oral presentation).

Validation of a semi-quantitative urine pregnancy test: an alternative technology to rule-out ongoing pregnancy after medical abortion. National Abortion Federation Annual Meeting, Montreal, 2005 (oral presentation).

Women's experiences crossing from Mexico to San Diego to access safe, legal abortion services. American Public Health Association Annual Meeting, Philadelphia, 2005 (oral presentation).

Self-screening for contraindications to oral contraceptive use: evidence for the safety of over-the-counter provision. Annual meeting of the Association of Reproductive Health Professionals and the Society of Family Planning, Minneapolis, 2007 (oral presentation). Received the Ortho Outstanding Researcher Award for this presentation.

Medical abortion with misoprostol alone: from Latin America to the U.S. National Abortion Federation Annual Meeting, Boston, 2007 (panel presentation).

Women's perspectives on abortion: evidence from Latin America. National Abortion Federation Annual Meeting, Minneapolis, 2008 (panel presentation).

Provider perspective: What do clinicians and pharmacists think about OTC provision of OCs? Annual meeting of the American Public Health Association, San Diego, 2008 (invited talk).

Second trimester surgical and medical abortion in South Africa. Annual meeting of the National Abortion Federation, Portland, OR, 2009 (oral presentation)

Contraceptive knowledge and use among Latinas. Annual meeting of the National Abortion Federation, Portland, OR, 2009 (panel presentation).

National invited presentations (continued)

Self-induced abortion with misoprostol: from Latin America to the US. National Network of Abortion Funds Organizing Summit, Chicago, 2009 (invited talk).

Abortion self-induction among women living in San Francisco, Boston, New York City, and a border city in Texas: A qualitative analysis. Annual meeting of the American Public Health Association, Philadelphia, PA, 2009 (oral presentation).

Knowledge regarding oral contraceptive use, risks and benefits among clinic and pharmacy users in El Paso, Texas, and the impact of written information. Annual meeting of the American Public Health Association, Philadelphia, PA, 2009 (oral presentation).

Are women who obtain oral contraceptives over the counter in Mexico more likely to be contraindicated for use? Results from a cohort study in El Paso, Texas. Reproductive Health 2009, Los Angeles, CA, 2009 (oral presentation).

Evaluation of a program providing medication abortion via telemedicine in Iowa. Annual meeting of the National Abortion Federation, Philadelphia, 2010 (oral presentation). Received the Scientific Paper Award for this presentation.

Latinas' knowledge about abortion laws and services in San Francisco, Boston and New York City. Annual meeting of the American Public Health Association, Denver, CO, 2010 (oral presentation).

Regional and other invited presentations

Medical abortion with misoprostol alone: from Latin America to the Mission. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, 2007.

The safety, efficacy and acceptability of over-the-counter provision of combined oral contraceptives. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, 2007.

The safety, efficacy and acceptability of over-the-counter provision of combined oral contraceptives. Annual meeting of the Washington State Obstetrical Association, Seattle, 2008 (invited talk).

Self-induced abortion with misoprostol: from Latin America to the U.S. Grand rounds presentation in the Department of Obstetrics and Gynecology, University of Michigan School of Medicine, Ann Arbor, 2009 (invited talk).

OTHER PROFESSIONAL SERVICE

2007	Member of the International Planned Parenthood Federation Safe Abortion Action Fund Technical Review Panel (London)
2007-2009	Steering committee member of the California Microbicide Initiative
2002-2004	Member, Medical Development Team, Marie Stopes International (London)

TEACHING

FORMAL SCHEDULED CLASSES:

Qtr	Academic Yr	Institution Course Title	Teaching Contribution	Class Size
S	2004-05	Mexican National Institute for Public Health; Introduction to Reproductive Health	Lecturer; 2 lectures	20
S	2005-06	Harvard School of Public Health; PIH502 International reproductive health issues: Moving from theory to practice	Lecturer; 1 lecture	10
S	2006-07	Harvard School of Public Health; PIH502 International reproductive health issues: Moving from theory to practice	Lecturer; 2 lectures	15
S	2007-08	Harvard School of Public Health; PIH502 International reproductive health issues: Moving from theory to practice	Lecturer; 2 lectures	10
W	2008-09	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 2 lectures	22
W	2009-10	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 1 lecture	17

POSTGRADUATE and OTHER COURSES

Guest lecturer in "Qualitative Research Methods in Public Health," CUNY School of Public Health, September 2011

Women's health from a global perspective. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? (UCSF CME course organized by the Department of Obstetrics, Gynecology and Reproductive Sciences), San Francisco, 2007.

TEACHING AIDS

Contributed to the development of a training slide set on medical abortion in Spanish, 2004

Developed pocket cards on emergency contraception for use by community health workers in the State of Mexico, 2005

Reviewed and provided input on a manual on gynecologic uses of misoprostol published by the Latin American Federation of Obstetric and Gynecologic Societies (FLASOG), 2005

Grossman D. Medical methods for first trimester abortion: RHL commentary (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005. Exerpt available at: http://www.rhlibrary.com/Commentaries/htm/Dgcom.htm.

TEACHING AIDS (continued)

Grossman D. Medical methods for first trimester abortion: RHL practical aspects (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005.

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AWARDS AND GRANTS

CURRENT

1 R01 HD047816-01A1 (Co-PI) 09/01/05-06/30/11
NICHD
Oral Contraceptive Use along the US/Mexico Border

Research Award (Co-PI) 01/01/10-12/31/12
University of California at San Francisco (subcontract from grant from the Bill and Melinda Gates Foundation)
The Effect of Integrating Family Planning Services in the Context of HIV Care and Treatment in Nyanza Province, Kenya

Research Award (PI) 07/01/10-06/30/11
Anonymous donor
E-medicine provision of medical abortion

Research Award (Co-PI) 11/18/08-11/17/12
The William and Flora Hewlett Foundation
Planning grant for the OCs OTC working group

Research Award (Co-PI) 10/18/05-10/17/10
The William and Flora Hewlett Foundation
Ibis General Support

Research Award (Co-PI) 11/1/06-10/31/12
Anonymous donor
Reducing the effects of unsafe abortion in Latin America

Research Award SFP3-4 (PI) 09/01/09-08/31/11
Society of Family Planning
Cervical priming before D&E in South Africa

Research Award (PI) 06/01/07-08/31/11
The Wallace Alexander Gerbode Foundation
Reproductive health among Latinas
Barriers to reproductive health services among US military servicewomen

PAST (selected)

Research Award (PI) 08/01/07-06/30/10
IPPF Safe Abortion Action Fund
Improving second trimester abortion services in South Africa

PAST AWARDS (continued)

Research Award (Co-PI) 01/01/09-12/31/09
University of California at San Francisco (subcontract from grant from the Tides Africa Fund)
The Effect of Integrating Family Planning Services in the Context of HIV Care and Treatment in Nyanza Province, Kenya

Research Award SFP1-5 (PI) 09/01/07-04/30/09
Society of Family Planning
Abortion Self-induction Among Low-income Women in San Francisco, Boston and New York: A Quantitative and Qualitative Study

Research Award (Co-PI) 05/01/07-04/30/09
University of California at San Francisco (subcontract from grant from CDC, President's Emergency Plan for AIDS Relief)
The Effect of Integrating Family Planning Services in the Context of HIV Care and Treatment

Research Award (Clinical monitor) 10/2002-9/2007
University of California at San Francisco (Bill & Melinda Gates Foundation)
Preventing HIV by Protecting the Cervix: Re-examining the Diaphragm, an Inexpensive, Widely Available, Woman-Controlled, Physical Barrier of the Cervix.

Research Award (PI) 12/1/05-12/31/07
The Population Council
Acceptability of Female-Controlled Barrier Methods to Prevent Bacterial STIs Among Vulnerable Populations in the Dominican Republic

Research Award (Co- PI) 9/1/03-12/31/06
The Mary Wohlford Foundation
General Support

PEER REVIEWED PUBLICATIONS

1. Laudon M, Grossman DA, Ben-Jonathan N. Prolactin-releasing factor: cellular origin in the intermediate lobe of the pituitary. Endocrinology, 1990 Jun; 126(6):3185-92.
2. Grossman DA, Witham ND, Burr DH, Lesmana M, Rubin FA, Schoolnik GK, Parsonnet J. Flagellar serotypes of Salmonella typhi in Indonesia: relationships among motility, invasiveness, and clinical illness. Journal of Infectious Diseases, 1995 Jan; 171(1):212-6.
3. MacIsaac L, Grossman D, Balistreri E, Darney P. A randomized controlled trial of laminaria, oral misoprostol, and vaginal misoprostol before abortion. Obstetrics and Gynecology, 1999; 93(5, pt.1):766-770.
4. Weitz T, Foster A, Ellertson C, Grossman D, Stewart F. "Medical" and "surgical" abortion: rethinking the modifiers. Contraception 2004; 69(1):77-8.
5. Grossman D, Ellertson C, Grimes DA, Walker D. Routine follow-up visits after first-trimester induced abortion. Obstetrics and Gynecology 2004; 103(4):738-45.

PEER REVIEWED PUBLICATIONS (continued)

6. Lafaurie MM, Grossman D, Troncoso E, Billings DL, Chávez S. Women's perspectives on medical abortion in Mexico, Colombia, Ecuador and Peru: a qualitative study. Reproductive Health Matters 2005;13(26):75-83.
7. Grossman D, Ellertson C, Abuabara K, Blanchard K. Barriers to contraceptive use present in product labeling and practice guidelines. American Journal Public Health 2006;96(5):791-9.
8. Yeatman SE, Potter JE, Grossman DA. Over-the-counter access, changing WHO guidelines, and the prevalence of contraindicated oral contraceptive use in Mexico. Studies in Family Planning, 2006; 37(3):197–204.
9. Pace L, Grossman D, Chavez S, Tavara L, Lara D, Guerrero R. Legal Abortion in Peru: Knowledge, attitudes and practices among a group of physician leaders. Gaceta Medica de Mexico, 2006; 142(Supplement 2):91-5.
10. Lara D, Abuabara K, Grossman D, Diaz C. Pharmacy provision of medical abortifacients in a Latin American city. Contraception, 2006;74(5):394-9.
11. Tinajeros F, Grossman D, Richmond K, Steele M, Garcia SG, Zegarra L, Revollo R. Diagnostic accuracy of a point-of-care syphilis test when used among pregnant women in Bolivia. Sexually Transmitted Infections 2006;82 Suppl 5:v17-21.
12. Clark W, Gold M, Grossman D, Winikoff B. Can mifepristone medical abortion be simplified? A review of the evidence and questions for future research. Contraception 2007;75:245-50.
13. Garcia SG, Tinajeros F, Revollo R, Yam EA, Richmond K, Díaz-Olavarrieta C, Grossman D. Demonstrating public health at work: A demonstration project of congenital syphilis prevention efforts in Bolivia. Sexually Transmitted Diseases 2007;34(7):S37-S41.
14. Harper CC, Blanchard K, Grossman D, Henderson J, Darney P. Reducing Maternal Mortality due to Abortion: Potential Impact of Misoprostol in Low-resource Settings. International Journal of Gynecology and Obstetrics 2007;98:66-9.
15. Díaz-Olavarrieta C, Garcia SG, Feldman BS, Martinez Polis A, Revollo R, Tinajeros F, Grossman D. Maternal syphilis and domestic violence in Bolivia: A gender-based analysis of implications for partner notification and universal screening. Sexually Transmitted Diseases 2007;34(7):S42-S46.
16. Grossman D, Berdichevsky K, Larrea F, Beltran J. Accuracy of a semi-quantitative urine pregnancy test compared to serum beta-hCG measurement: a possible tool to rule-out ongoing pregnancy after medication abortion. Contraception 2007;76(2):101-4.
17. Lara D, van Dijk M, Garcia S, Grossman D. La introducción de la anticoncepción de emergencia en la norma oficial mexicana de planificación familiar (The introduction of emergency contraception into the official Mexican family planning norms). Gaceta Médica de México 2007;143(6): 483-7.
18. Grossman D, Blanchard K, Blumenthal P. Complications after second trimester surgical and medical abortion. Reproductive Health Matters 2008;16(31 Supplement):173-82.
19. Grossman D, Fernandez L, Hopkins K, Amastae J, Garcia SG, Potter JE. Accuracy of self-screening for contraindications to combined oral contraceptive use. Obstetrics and Gynecology 2008; 112(3):572-8.

PEER REVIEWED PUBLICATIONS (continued)

20. Grossman D. Should the oral contraceptive pill be available without prescription? Yes. British Medical Journal 2008;337:a3044.
21. Levin C, Grossman D, Berdichevsky K, Diaz C, Aracena B, Garcia S, Goodyear L. Exploring the economic consequences of unsafe abortion: implications for the costs of service provision in Mexico City. Reproductive Health Matters 2009;17(33):120–132.
22. Hu D, Grossman D, Levin C, Blanchard K, Goldie SJ. Cost-Effectiveness Analysis of Alternative First-Trimester Pregnancy Termination Strategies in Mexico City. BJOG 2009;116:768–779.
23. Goodman S, Gordon R, Eckhardt C, Osborne S, Grossman D, Spiedel JJ. Beyond education and training: making change stick. Contraception 2009;79(5):331-3.
24. Távara-Orozco L, Chávez S, Grossman D, Lara D, Blandón MM. Disponibilidad y uso obstétrico del misoprostol en los países de América [Availability and obstetric use of misoprostol in Latin American countries]. Revista Peruana de Ginecologia y Obstetricia 2009;54:253-263.
25. Lara DK, Grossman D, Muñoz J, Rosario S, Gomez B, Garcia SG. Acceptability and use of female condom and diaphragm among sex workers in Dominican Republic: Results from a prospective study. AIDS Education and Prevention 2009;21(6):538-551.
26. Grossman D, Fernandez L, Hopkins K, Amastae J, Potter JE. Perceptions of the safety of oral contraceptives among a predominantly Latina population in Texas. Contraception 2010;81(3):254-60. (NIHMS155993)
27. Potter JE, White K, Hopkins K, Amastae J, Grossman D. Clinic versus Over-the-Counter Access to Oral Contraception: Choices Women Make in El Paso, Texas. American Journal of Public Health 2010;100(6):1130-6. (NIHMS 221745)
28. Phillips K, Grossman D, Weitz T, Trussell J. Abortion coverage and health reform: bringing evidence to bear. Contraception 2010;82(2):129-30.
29. Hu D, Grossman D, Levin C, Blanchard K, Adanu R, Goldie SJ. Cost-Effectiveness Analysis of Unsafe Abortion and Alternative First-Trimester Pregnancy Termination Strategies in Nigeria and Ghana. African Journal of Reproductive Health 2010;14(2)85-103.
30. Grossman D, Holt K, Peña M, Veatch M, Gold M. Winikoff B, Blanchard K. Abortion self-induction in the US. Reproductive Health Matters 2010;18(36):136–146.
31. Grossman D, Grindlay K. Alternatives for follow-up after medication abortion: A systematic review. Contraception 2011;83(6):504-10.
32. Liang S-Y, Grossman D, Phillips K. Women's current out-of-pocket expenditures and dispensing patterns for oral contraceptives. Contraception 2011;83(6):528-36.
33. Blanchard K, Bostrom A, Montgomery E, van der Straten A, Lince N, de Bruyn G, Grossman D, Chipato T, Ranjee G, Padian N. Contraception use and effectiveness among women in a trial of the diaphragm for HIV prevention. Contraception 2011;83(6):556-63.
34. Grossman D, White K, Hopkins K, Amastae J, Shedlin M, Potter JE. Contraindications to Combined Oral Contraceptives Among Over-the-Counter versus Prescription Users. Obstet Gynecol 2011;117(3):558–65.

PEER REVIEWED PUBLICATIONS (continued)

35. Potter JE, McKinnon S, Hopkins K, Amastae J, Shedlin MG, Powers DA, Grossman D. Continuation of prescribed compared with over-the-counter oral contraceptives. Obstet Gynecol 2011;117(3):551–7.
36. Grindlay K, Yanow S, Jelinska K, Gomperts R, Grossman D. Abortion restrictions in the US military: Voices from women deployed overseas. Women's Health Issues 2011;21(4):259-64.
37. Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine. Obstetrics and Gynecology 2011;118(2 Pt 1):296-303.
38. Holt K, Grindlay K, Taskier M, Grossman D. Unintended pregnancy and contraceptive use among women in the US military: A systematic literature review. Military Medicine 2011;176(9):1056-64.
39. Harris LH, Grossman D. Confronting the challenge of unsafe second-trimester abortion. Int J Gynaecol Obstet 2011;115(1):77-9.
40. Grossman D. Over-the-counter access to oral contraceptives. Expert Review of Obstetrics and Gynecology 2011; 6(5):501-8.
41. Grossman D, Constant D, Lince N, Alblas M, Blanchard K, Harries J. Surgical and medical second trimester abortion in South Africa: a cross-sectional study. BMC Health Serv Res. 2011;11(1):224.
42. Foster DG, Higgins J, Karasek D, Ma S, Grossman D. Attitudes toward unprotected intercourse and risk of pregnancy among women seeking abortion. In press at Women's Health Issues.
43. Foster DG, Karasek D, Grossman D, Darney P, Schwarz EB. Interest in using intrauterine contraception when the option of self-removal is provided. In press at Contraception.

NON-PEER REVIEWED PUBLICATIONS

Review articles

1. Levin C, Grossman D, Garcia SG. Unsafe abortion costs in Mexico City. In: Institute of Development Studies. id2 health focus: unsafe abortion. 2007.
2. Grossman D. Should oral contraceptives be sold over-the-counter? Yes. Contemporary OB/GYN 2008;53(9):63-73.

Book and chapters

1. Grossman D, Díaz Olavarrieta C. Manejo del dolor en la atención posaborto (Pain management in the post-abortion care setting). In: Billings DL, Vernon R. Avances en la atención posaborto en América Latina y el Caribe: Investigando, aplicando y expandiendo. Mexico City: The Population Council. 2007.
2. Lafaurie MM, Grossman D, Troncoso E, Billings DL, Chávez S, Maira G, Martinez I, Mora M, Ortiz O. El aborto con medicamentos en América Latina: Las experiencias de las mujeres en México, Colombia, Ecuador y Perú. Bogota, 2005.

Other publications

1. Grossman D. Medical methods for first trimester abortion: RHL commentary (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update

Software Ltd, Oxford, 2005. Exerpt available at: http://www.rhlibrary.com/Commentaries/htm/Dgcom.htm.

2. Grossman D. Medical methods for first trimester abortion: RHL practical aspects (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005.
3. Potter JE and Grossman D. Make birth control available to immigrants. Op-ed in the Austin Statesman 2010. Available at http://www.statesman.com/opinion/potter-grossman-make-birth-control-available-to-immigrants-896651.html.
4. Grossman D. Female active duty soldiers face many barriers to care. RH Reality Check 2010. Available at: http://www.rhrealitycheck.org/blog/2010/12/08/study-female-active-duty-soldiers-face-many-barriers-care.

LANGUAGES

Fluent in Spanish, conversant in French.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients, And WILLIE PARKER, M.D., M.P.H., M.Sc., on behalf of himself and his patients, Plaintiffs, v. MARY CURRIER, M.D., M.P.H. in her official capacity as State Health Officer of the Mississippi Department of Health, and ROBERT SHULER SMITH, in his official capacity as District Attorney for Hinds County, Mississippi, Defendants.	)	Case No. 3:12-CV-00436-DPJ-FKB

***AMICUS CURIAE* MEMORANDUM OF GOVERNOR PHIL BRYANT IN OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

Governor Phil Bryant signed House Bill 1390 into law on April 16, 2012, after the Mississippi House of Representatives and Mississippi Senate passed the bill by votes of 80–37 and 45–6, respectively. In connection with signing the bill, Governor Bryant reiterated his opposition to abortion and commitment to an "abortion-free" Mississippi; however, he also made clear that he supported this bill because its requirements will protect patient health and safety. As explained below, House Bill 1390 addresses a valid public health concern by ensuring continuity of care in the event that complications follow an abortion. It does so by extending to

abortion clinics the same admitting-privileges requirement that already applies to other out-patient surgery facilities. This extension was necessary to close a loophole in the state's current admitting-privileges rule that permitted plaintiffs to comply with the letter of the rule without actually ensuring continuity of care. Given the valid medical reasons for House Bill 1390's admitting-privileges requirement, Governor Bryant's or other individual lawmakers' views on abortion in general—or this bill in particular—cannot render the requirement unconstitutional.

I. Governor Bryant Opposes Abortion But Also Supported House Bill 1390 For Public Health Reasons.

Governor Bryant has long made clear that he is pro-life and opposed to abortion. He believes that *Roe v. Wade* was wrongly decided and should be overruled because nothing in the Constitution grants a right to end the life of an unborn child. Governor Bryant has said this for years. Accordingly, it should be no surprise to anyone that he has vowed to "continue to work to make Mississippi abortion-free." [Doc. No. 1, at ¶ 19 (quoting Phil West, *Mississippi Senate Passes Abortion Regulation Bill*, THE COMMERCIAL APPEAL, Apr. 4, 2012)].

Contrary to plaintiffs' suggestions, however, that comment lacks legal significance. To begin with, Governor Bryant has also made clear that he supports *the law at issue in this case* for public health reasons. Indeed, in the very article that plaintiffs selectively quote, Governor Bryant is first quoted as stating that "*[t]his legislation* is an important step to strengthening abortion regulations and protecting the health and safety of women." West, *supra* (emphasis added). The Governor's statement upon signing the bill similarly reiterated his *general* opposition to abortion while at the same time citing the public health reasons for *this law*:

> I believe that all human life is precious, and as governor, I will work to ensure that the lives of the born and unborn are protected in Mississippi. *This bill* requires all physicians associated with an abortion clinic in Mississippi to be board-certified or eligible in obstetrics and gynecology. *To further protect patient safety in the event*

> *of a complication during the procedure*, this bill also requires the physician to have staff and admitting privileges at a local hospital.[1]

Governor Bryant's statements regarding House Bill 1390, which amends Miss. Code Ann. § 41-75-1, are consistent with the overall purpose of Title 41, Chapter 75 of the Mississippi Code: "The purpose of this chapter is to protect and promote the public welfare by providing for the development, establishment and enforcement of certain standards in the maintenance and operation of ambulatory surgical facilities and abortion facilities which will ensure safe, sanitary, and reasonably adequate care of individuals in such facilities." Miss. Code Ann. § 41-75-3.

To be sure, when asked about the possibility that plaintiffs might fail to comply with House Bill 1390's safety-related licensure requirements, Governor Bryant commented: "If it closes that clinic, then so be it."[2] Put simply, the Governor is not concerned that enforcement of a valid, medically justified licensure requirement may result in the closure of a clinic that does not comply. But Governor Bryant's lack of sympathy for the abortion clinic is hardly a reason to strike down the requirement. The nature of the "burden," if any, that House Bill 1390 imposes on the "right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," which is held to include a right to an abortion, *see Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992), is not dependent on the statements of individual lawmakers. Given House Bill 1390's valid health-related justifications (*see infra*) and overwhelming legislative support, neither Governor Bryant's general opposition to abortion nor other isolated statements of a few individual lawmakers render the law unconstitutional. *Cf. Mazurek v. Armstrong*, 520 U.S. 968, 973 (1997) ("[T]hat an anti-abortion group drafted the …

---

[1] *Governor Phil Bryant Signs House Bill 1390*, Apr. 16, 2012 (emphasis added), *available at* http://www.governorbryant.com/governor-phil-bryant-signs-house-bill-1390/.

[2] Emily Wagster Pettus, *Miss. May Be Only State Without Abortion Clinic*, AP, June 30, 2012, *available at* http://abcnews.go.com/US/wireStory/miss-state-abortion-clinic-16685749.

law … says nothing significant about the legislature's purpose in passing it."); *Crawford v. Marion County Election Bd.*, 553 U.S. 181, 204 (Stevens, J.) ("[I]f a nondiscriminatory law is supported by valid neutral justifications, those justifications should not be disregarded simply because partisan interests may have provided one motivation for votes of individual legislators."); *see also ACLU v. Praeger*, 815 F. Supp. 2d 1204, 1215 (D. Kan. 2011) ("Where a law can be viewed as having a rational purpose other than simply obstructing the right to abortion, the court cannot presume that an invalid purpose actually motivated the legislature to adopt the law, let alone that the invalid purpose was the legislature's predominant motive.").

II. House Bill 1390 Promotes Continuity Of Care In The Event Of Emergency Complications By Extending To Abortion Facilities The Same Admitting-Privileges Requirement That Already Applies To Other Out-Patient Surgical Facilities.

Title 41, Chapter 75 of the Mississippi Code establishes health and safety standards for "abortion facilities," such as the clinic at issue in this case, and "ambulatory surgical facilities." Miss. Code Ann. § 41-75-3. An "ambulatory surgical facility" is a healthcare facility the primary purpose of which is "providing elective surgical treatment of 'outpatients' whose recovery, under normal and routine circumstances, will not require 'inpatient' care." *Id.*, § 41-75-1(a). In other words, it is a surgical facility at which, like an abortion facility, "[t]he patient … arrive[s] … and expect[s] to be discharged on the same day." *Id.*, § 41-75-1(d).

As plaintiffs acknowledge [Doc. No. 6, at p.18], state law *already* requires all physicians associated with "ambulatory surgical facilities" to have admitting privileges at a local hospital. *See* Miss. Admin. Code § 15-16-1:42.9.7 ("Rule 42.9.7"). The primary purpose of an admitting-privileges requirement is to ensure continuity of care, *i.e.*, if there are complications from the out-patient procedure that require hospital admission, the same physician can continue treating the patient following admission to the hospital.

House Bill 1390 simply extends the same admitting-privileges requirement to abortion facilities. Whereas Rule 42.9.7, *supra*, had required that "one physician member performing abortion procedures in the facility … have admitting privileges in at least one local hospital," House Bill 1390 now requires that *all* doctors associated with the facility have such privileges. The admitting privileges requirement serves the same purpose in the abortion context that it does in the context of other out-patient procedures, and it was certainly reasonable for the Legislature to conclude that it should apply equally in both contexts. As the Eighth Circuit put it, "[t]he State …, in exercising its police powers to protect the well-being of its citizens, has undoubted authority to regulate the conditions under which surgical procedures are performed. *Such legitimate state regulation of surgical procedures is not rendered unconstitutional because it is specifically applied to abortion.*" *Women's Health Ctr. of West County, Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989) (emphasis added) (upholding a law requiring that doctors who perform abortions have admitting privileges where the state imposed similar requirements on all doctors performing out-patient surgeries). Thus, contrary to plaintiffs' arguments [*see* Doc. No. 6, at p.18], the fact that other out-patient surgical facilities are also subject to an admitting-privileges requirement is strong evidence that House Bill 1390 *is* a valid public health regulation.

Moreover, while plaintiffs repeatedly assert that complications following an abortion are "rare" [*see* Doc. No. 1, ¶¶ 36-37], they do not deny that such complications occur and can be serious and even life-threatening. *See Webster*, 871 F.2d at 1381 (crediting expert testimony that abortion involves risks of serious complications and holding that an admitting-privileges requirement "furthers important state health objectives"). The admitting-privileges requirement protects patient safety in the event of such complications, and "[c]onsiderations of marginal safety, including the balance of risks, are within the legislative competence when," as in this

case, "the regulation is rational and in pursuit of legitimate ends." *Gonzalez v. Carhart*, 550 U.S. 124, 166 (2007).

Finally, if the existing—and unchallenged—requirement that "one physician member performing abortion procedures in the facility" (Rule 42.9.7, *supra*) is a valid health regulation, it necessarily follows that House Bill 1390's admitting-privileges requirement is also valid. Experience has shown that the valid goal of ensuring continuity of care cannot be achieved simply by requiring that *some member of the clinic's staff* have admitting privileges. Rather, it is essential that the *treating physician* have admitting privileges. In this case, plaintiffs admit that "the *only* physician providing abortion to women at the Clinic on a regular basis" does "*not* have privileges at a local hospital." [Doc. No. 1, ¶ 47 (emphasis added)]. Moreover, it appears that the only physician associated with the clinic who does have admitting privileges [Doc. No. 1, ¶ 34] does not perform *any* abortions.[3] House Bill 1390 was thus necessary to address a loophole that existed under prior law that permitted a clinic to satisfy the letter of the rule's admitting-privileges requirement[4] without actually ensuring or even promoting continuity of care.

[3] *See, e.g.*, Elizabeth Waibel, *Dr. Carl Reddix Talks About Political Realities*, JACKSON FREE PRESS, May 30, 2012 (Q: "But you don't do abortions yourself, do you?" A: "Correct. So all I'm doing is being a repository such that my colleagues won't have to lessen the number of people who call them and the clinic has someone that's designated that they can call."), *available at* http://www.jacksonfreepress.com/news/2012/may/30/dr-carl-reddix-talks-about-political-realities/.

[4] As a matter of fact, it does not appear that the clinic was or is in compliance with the requirement that "one physician member *performing abortion procedures in the facility* … have admitting privileges in at least one local hospital." Rule 42.9.7 (emphasis added). As noted above, it seems that the only physician associated with the facility who does have admitting privileges does *not* perform abortions.

CONCLUSION

For the reasons discussed above and in the memorandum and supporting declarations filed today by Defendant Mary Currier, House Bill 1390 is a valid public health measure, and plaintiffs' motion for a preliminary injunction should be denied.

July 9, 2012

Respectfully submitted,

s/Jack L. Wilson

Jack L. Wilson (MS Bar # 101482)
Office of the Governor
Post Office Box 139
Jackson, MS 39205
Telephone: (601) 359-3150
Email: Jack.Wilson@governor.ms.gov

CERTIFICATE OF SERVICE

I hereby certify that on July 9, 2012, I electronically filed the foregoing document with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

s/Jack L. Wilson
Jack L. Wilson (MS Bar # 101482)
Office of the Governor
Post Office Box 139
Jackson, MS 39205
Telephone: (601) 359-3150
Email: Jack.Wilson@governor.ms.gov