No. 13-___

In the

Supreme Court of the United States

J.B. VAN HOLLEN, *et al.*,

Petitioners,

v.

PLANNED PARENTHOOD OF WISCONSIN, INC., *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. 42 U.S.C. § 1983 allows a person whose constitutional rights have been deprived to bring an action to redress the constitutional deprivation. Wisconsin Stat. § 253.095 requires abortion providers to have admitting privileges at a local hospital. Four abortion providers assert a claim to permanently enjoin Wis. Stat. § 253.095's local hospital admitting-privileges requirement based upon the alleged violation of the Fourteenth Amendment liberty and privacy rights of their patients. The patients are not parties to this action.

Does 42 U.S.C. § 1983 provide statutory standing for abortion providers to assert a claim based solely upon the constitutional rights of their patients?

2. In *Singleton v. Wulff*, 428 U.S. 106, 118 (1976) (opinion of Blackmun, J.), four members of the Court opined that "it generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision." No majority of the Court has endorsed the *Singleton* plurality's view regarding third-party standing. Likewise, the Court has not expressly addressed the question whether abortion providers have standing to raise the constitutional rights of their patients when challenging abortion regulations designed to protect maternal health. In these situations, the abortion providers' interest in avoiding regulation is not necessarily aligned with their patients' interest in safe, regulated abortions.

Do abortion providers have standing to assert a claim based solely upon the constitutional rights of their patients when challenging abortion regulations that are designed to protect maternal health?

3. In applying the "undue burden" analysis from *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the court of appeals created a circuit split by inventing a sliding scale test for determining "undue burden" under which "[t]he feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous." *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013).

Is the court of appeals' addition of a new legal standard consistent with the "undue burden" framework established by *Casey*?

LIST OF PARTIES

The petitioners are J.B. Van Hollen, Attorney General of Wisconsin, in his official capacity; Ismael Ozanne, District Attorney for Dane County, Wisconsin, as a representative of a class of all district attorneys in the State of Wisconsin, in his official capacity; James Barr, Mary Jo Capodice, D.O., Greg Collins, Rodney A. Erickson, M.D., Jude Genereaux, Suresh K. Misra, M.D., Michael J. Phillips, M.D., Kenneth Simons, Timothy Swan, M.D., Sridhar Vasudevan, M.D., Timothy W. Westlake, M.D., Russell Yale, M.D., and Carolyn Ogland, all members of the Wisconsin Medical Examining Board, in their official capacities; and Dave Ross, Secretary of the Wisconsin Department of Safety and Professional Services, in his official capacity.

The respondents are Planned Parenthood of Wisconsin, Inc.; Susan Pfleger, M.D.; Kathy King, M.D.; and Milwaukee Women's Medical Services, d/b/a Affiliated Medical Services.

TABLE OF CONTENTS

INDEX TO APPENDIX

TABLE OF AUTHORITIES

Cases

Constitutions and Statutes

Rule

Other Authorities

J.B. Van Hollen, Attorney General of Wisconsin, in his official capacity; Ismael Ozanne, District Attorney for Dane County, Wisconsin, as a representative of a class of all district attorneys in the State of Wisconsin, in his official capacity; James Barr, Mary Jo Capodice, D.O., Greg Collins, Rodney A. Erickson, M.D., Jude Genereaux, Suresh K. Misra, M.D., Michael J. Phillips, M.D., Kenneth Simons, Timothy Swan, M.D., Sridhar Vasudevan, M.D., Timothy W. Westlake, M.D., Russell Yale, M.D., and Carolyn Ogland, all members of the Wisconsin Medical Examining Board, all in their official capacities; and Dave Ross, Secretary of the Wisconsin Department of Safety and Professional Services, in his official capacity, respectfully petition the Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The opinion of the court of appeals is reported at 738 F.3d 786 and is reprinted at Appendix A, 1a-55a. The opinion and order of the district court granting a preliminary injunction is unreported and is reprinted at Appendix B, 56a-107a.

JURISDICTION

The judgment of the court of appeals was entered on December 20, 2013. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Section 1 of the Fourteenth Amendment to the U.S. Constitution, provides:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

42 U.S.C. § 1983 provides:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in

> any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

Wisconsin Stat. § 253.095(2) provides:

> No physician may perform an abortion, as defined in s. 253.10(2)(a), unless he or she has admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed.

STATEMENT OF THE CASE

This case presents opportunities for the Court to address a novel issue regarding statutory standing under 42 U.S.C. § 1983, to clarify the scope of Article III standing when abortion providers assert a claim based solely upon the rights of their patients, and to determine the constitutionality of a new abortion regulation designed to protect maternal health. This new law is not unique to Wisconsin. *See Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406 (5th Cir. 2013), *application to vacate stay of injunction denied*, ____ U.S. ____, 134 S. Ct. 506 (2013).

On Friday, July 5, 2013, Wisconsin Governor Scott Walker signed into law 2013 Wisconsin Act 37 ("Act 37"), which requires a physician to have admitting privileges at a hospital within 30 miles of the location where the abortion is performed. The requirement is intended to ensure that physicians are held accountable for the continued care of their patients when complications arise during an abortion. Most, but not all, physicians at the abortion clinics in Wisconsin have the required local admitting privileges. Those who do not would have to obtain admitting privileges to continue legally providing abortions. Act 37 went into effect on Monday, July 8, 2013.

The respondents are two physicians and two abortion clinics. They filed this 42 U.S.C. § 1983 action seeking a permanent injunction against Act 37's admitting-privileges requirement. The relevant legal claim is based solely upon an alleged violation of the Fourteenth Amendment liberty and privacy rights of the respondents' patients. *See* 28 U.S.C. § 1331 (federal question jurisdiction). Specifically, the respondents alleged in Count III of their complaint that the admitting privileges requirement

> violates [the respondents'] patients' right to liberty and privacy as guaranteed by the due process clause of the Fourteenth Amendment to the U.S. Constitution. It is an unreasonable health regulation, and it has the unlawful purpose and effect of

> imposing an undue burden on women's right to choose abortion.

App. C, 127a, ¶ 53. (A copy of the respondents' complaint is found in Appendix C, 108a-141a). The respondents' patients are not parties to this action.

On July 5, 2013, the respondents filed suit and moved for a temporary restraining order. On July 8, 2013, the district judge granted a temporary restraining order enjoining the law.

On August 2, 2013, the district judge entered a preliminary injunction holding that the respondents would suffer irreparable harm and that they had a substantial likelihood of success on the merits of their claim. App. B, 56a-107a. The district judge based his permanent injunction ruling only on the respondents' claim that the admitting-privileges requirement violates the Fourteenth Amendment rights of their patients, *id.*, 57a, n.1, even though the respondents' patients are not parties to this action.

The petitioners appealed the preliminary injunction ruling. *See* 28 U.S.C. § 1292(a)(1). They argued that the respondents lack both statutory standing and Article III standing to pursue a claim based solely upon the federal constitutional rights of patients who are not parties to this action. On the merits of the preliminary injunction ruling, the petitioners asserted that the admitting-privileges requirement has a rational basis—preserving maternal health—and that it does not create an undue burden on the right to an abortion.

In an opinion authored by Circuit Judge Richard A. Posner, the court of appeals affirmed the district court.

In doing so, the court of appeals held that the respondents have standing to assert the constitutional rights of their patients and that 42 U.S.C. § 1983 provides a statutory basis for a physician to assert a claim in federal court based solely upon an alleged violation of his patient's rights. App. A, 15a-19a.

With respect to the respondents' likelihood of success on the merits, the court of appeals framed the *Casey* "undue burden" standard as follows: "[t]he feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous." App. A, 26a. Under this framework, the court of appeals held that the "medical grounds thus far presented ('thus far' being and important qualification given the procedural setting—a preliminary injunction proceeding) are feeble, yet the burden great because of the state's refusal to have permitted abortion providers a reasonable time within which to comply." *Id.* The court of appeals also underscored the fact that the law, although signed on a Friday, required compliance by the next Monday. *Id.*, 4a.

The case was remanded to the district court and is now being litigated. A trial is scheduled for May 27 through 30, 2014.

REASONS FOR GRANTING THE PETITION

This Court should grant the petition to both clarify whether abortion providers may assert the rights of their patients when challenging an abortion regulation designed to protect maternal health and to resolve a circuit split.

First, the Court has never addressed whether an abortion provider has statutory standing to pursue a claim under 42 U.S.C. § 1983 based solely upon an alleged violation of the constitutional rights of that provider's patients. Section 1983 was never intended by Congress to serve as a statutory vehicle to assert in federal court the violation of another person's constitutional rights.

Second, the Court should clarify whether abortion providers have standing to assert the constitutional rights of their patients when challenging abortion regulations aimed at protecting maternal health. The interests of abortion providers and their patients are not aligned when considering regulations aimed at improving maternal health. Abortion providers seek to avoid regulation to maximize the availability of abortion, whereas abortion-seeking women desire to avoid regulations that impose an undue burden on the right to an abortion but may favor regulation aimed at improving maternal health. When abortion providers challenge regulations aimed at improving maternal health, their interests are not aligned as to automatically create third-party standing to assert the rights of their patients.

Third, the court of appeals' decision has created a circuit split regarding whether regulations requiring abortion providers to have admitting privileges constitute an "undue burden" on the right to an abortion under *Casey*. The court of appeals' holding that the medical grounds for such regulations were "feeble" is contrary to the decisions of other circuits, including the Fourth, Fifth, and Eighth Circuits. Further, the court of appeals imposed a new and unwarranted undue burden test in which the burden is judged by the strength of the medical rationale for the law, thereby finding the regulation likely to be an undue burden because of the allegedly "feeble" medical justification for it.

Finally, the Court is not precluded from reviewing this case merely because it is an appeal from a preliminary injunction. *See, e.g.*, *El Paso Natural Gas Co. v. Neztsosie*, 526 U.S. 473 (1999); *Int'l Primate Protection League v. Adm'rs of Tulane Educ. Fund*, 500 U.S. 72 (1991). The questions presented are important and deserve the Court's attention now. Resolution now will also favor judicial economy.

I. THIS CASE PRESENTS A NOVEL ISSUE REGARDING STATUTORY STANDING UNDER 42 U.S.C. § 1983.

This case presents a novel issue regarding statutory standing under 42 U.S.C. § 1983. It gives the Court an opportunity to decide an important question of federal law regarding statutory standing

doctrine in the context of a claim that is based solely on the constitutional rights of third parties. *See* Sup. Ct. R. 10(c). The crux is whether 42 U.S.C. § 1983 provides a statutory cause of action for a physician to pursue a claim based solely upon an alleged violation of the constitutional rights of his patients.

In *Davis v. Passman*, the Court distinguished between the concepts of "standing" and whether a plaintiff has a "cause of action":

> s*tanding* is a question of whether a plaintiff is sufficiently adversary to a defendant to create an Art. III case or controversy, or at least to overcome prudential limitations on federal-court jurisdiction, see *Warth v. Seldin,* 422 U.S. 490, 498, 95 S.Ct. 2197, 2204, 45 L.Ed.2d 343 (1975); *cause of action* is a question of whether a particular plaintiff is a member of the class of litigants that may, as a matter of law, appropriately invoke the power of the court.

442 U.S. 228, 239 n.18 (1979) (emphasis in original). The Court has since noted that "statutory standing" and the existence of a cause of action are "closely connected" and "sometimes identical" questions. *Bond v. U.S.*, ____ U.S. ____, 131 S. Ct. 2355, 2362 (2011); *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 96-97 and n.2 (1998); *see also Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 831 (1999) (noting

that statutory standing "may properly be treated before Article III standing").

Grounded in statutory standing, the petitioners' 42 U.S.C. § 1983 argument in this case has been based upon the language of 42 U.S.C. § 1983, namely, the limiting words "to *the* party injured." 42 U.S.C. § 1983 (emphasis added). The statute is unambiguous. It makes relief available to plaintiffs for constitutional violations as to *the* party injured and no one else. In the words of Professor Currie, 42 U.S.C. § 1983

> plainly authorizes suit by anyone alleging that *he* has been deprived of rights under the Constitution or federal law, *and by no one else*. It thus incorporates, *but without exceptions*, the Court's "prudential" principle that the plaintiff may not assert the rights of third parties.

David P. Currie, *Misunderstanding Standing*, 1981 Sup. Ct. Rev. 41, 45 (emphasis added); *see also Jaco v. Bloechle*, 739 F.2d 239, 241 (6th Cir. 1984) ("By its own terminology, the statute grants the cause of action 'to the party injured.' Accordingly, it is an action *personal* to the injured party.").

Section 1983, by its very words, does not permit a person to pursue a claim based upon the alleged violation of the constitutional rights of a third party. The statute was never intended to permit one to assert the constitutional rights of another, and even

the Seventh Circuit has previously held that it is a "settled point of law" that "§ 1983 claims are personal to the injured party." *Ray v. Maher*, 662 F.3d 770, 773 (7th Cir. 2011). The other circuits that have addressed the question seem to be in universal agreement, in a split of opinion from that of the appellate court here, that the answer is No.[1] Nothing in 42 U.S.C. § 1983 suggests that claims concerning abortion rights should be treated differently than other constitutional claims. Had Congress intended to provide a distinction for abortion rights claims so as to grant them expanded bases for standing, it could easily have amended the law. It has not done so.

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[1] *McKelvie v. Cooper*, 190 F.3d 58, 64 (2d Cir. 1999); *Claybrook v. Birchwell,* 199 F.3d 350, 357 (6th Cir. 2000) (a § 1983 claim is "entirely personal to the direct victim of the alleged constitutional tort . . . only the purported victim, or his estate's representative(s), may prosecute a section 1983 claim"); *Bates v. Sponberg*, 547 F.2d 325, 331 (6th Cir. 1976) ("42 U.S.C. s 1983 offers relief only to those persons whose federal statutory or federal constitutional rights have been violated"); *Advantage Media, L.L.C. v. City of Eden Prairie*, 456 F.3d 793, 801 (8th Cir. 2006) ("On an overbreadth challenge Advantage would also be barred from collecting § 1983 damages which are available only for violations of a party's own constitutional rights."); *Hunt v. City of Los Angeles*, 638 F.3d 703, 710 (9th Cir. 2011) ("Where a plaintiff challenges an ordinance based on the violation of third parties' rights, however, § 1983 damages are not available because there has been no violation of the plaintiff's own constitutional rights."); *Outdoor Media Group, Inc. v. City of Beaumont,* 506 F.3d 895, 907 (9th Cir. 2007) ("'§ 1983 damages which are available only for violations of a party's own constitutional rights.'"); *Archuleta v. McShan,* 897 F.2d 495, 497 (10th Cir. 1990) (it is a "well-settled principle that a section 1983 claim must be based upon the violation of plaintiff's personal rights, and not the rights of someone else").

The district judge and the court of appeals refused to hold that 42 U.S.C. § 1983 creates no statutory cause of action for a physician to assert the rights of his patient. In a terse rejection, the court of appeals held: "But nearly all the cited cases in which doctors and abortion clinics were found to have had standing had been filed pursuant to section 1983, and the justiciability of such cases is not in question." App. A, 19a. The court of appeals' cursory treatment of the statutory standing issue did not attempt to reconcile its earlier holding in *Ray*, nor address the weight of authority from other circuits.

This Court can and should conclusively resolve the question whether 42 U.S.C. § 1983 creates a statutory cause of action for a physician to pursue a claim in federal court based solely upon an alleged violation of the constitutional rights of his patients. Although many of this Court's abortion precedents appear to have involved claims brought under 42 U.S.C. § 1983, no decision has addressed this issue. As a result, they are not precedential on the question of whether 42 U.S.C. § 1983 creates statutory standing for a physician to assert a claim on behalf of a patient. *See Webster v. Fall*, 266 U.S. 507, 511 (1925) ("Questions which merely lurk in the record, neither brought to the attention of the court nor ruled upon, are not to be considered as having been so decided as to constitute precedents."). The district court's decision appears to create a split of authority based upon a review of the other cases which have looked at this issue. This Court should resolve this important issue of statutory standing.

II. THIS CASE PRESENTS AN OPPORTUNITY FOR THE COURT TO CLARIFY WHETHER ABORTION PROVIDERS CAN RAISE THE RIGHTS OF THEIR PATIENTS IN CHALLENGING ABORTION REGULATIONS.

This case also presents the Court with an opportunity to clarify the scope of an abortion provider's ability to challenge abortion regulations based solely upon the constitutional rights of women allegedly affected by those regulations. This question differs from the question of statutory standing, and is instead focused on prudential limitations on standing.

The normal rule is that "one may not claim standing in this Court to vindicate the constitutional rights of some third party." *Barrows v. Jackson*, 346 U.S. 249, 255 (1953). In a plurality opinion, the Court held in *Singleton* that this prudential rule did not apply to abortion providers challenging a regulation that prohibited Medicaid funds from being spent on abortions. *See Singleton v. Wulff,* 428 U.S. 106, 117-18 (1976) (opinion of Blackmun, J.). The *Singleton* plurality reasoned that the abortion providers should be able to raise the rights of their patients because of: (1) the close relationship between a physician and his patient; and (2) the fact there would be little lost in effective

advocacy due to the difficulties women face in bringing challenges themselves. *Id.*[2]

The reasoning of the *Singleton* plurality opinion, however, does not apply when abortion providers challenge regulations aimed at protecting maternal health. The close relationship factor relied upon by the *Singleton* plurality loses its force because abortion providers and potential patients do not share a commonality of interest.

Abortion providers cannot "reasonably be expected properly to frame the issues and present them with the necessary adversarial zeal." *Sec'y of State of Md. v. Joseph H. Munson Co., Inc.*, 467 U.S. 947, 956 (1984). The relevant issue in a challenge to an abortion regulation is whether it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877. In the context of regulations like the one at issue, abortion providers will not necessarily frame the issues properly regarding whether the regulations impose an undue burden on women. Instead, they will be motivated to challenge even laws that satisfy the demands of *Casey* due to the costs and burdens that the laws will create for their abortion practices. This

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[2]Justice Stevens did not join this part of the plurality's opinion because he did not think that this reasoning would necessarily apply when abortion providers did not raise their own constitutional rights and when their financial interest (*i.e.*, Medicaid funding) was not at issue. *See Singleton*, 428 U.S. at 121-22 (Stevens, J., concurring in part).

situation presents a conflict of interest between abortion providers and their patients.

Some lower courts have treated *Singleton*'s plurality opinion as recognizing abortion providers' ability to assert their patients' constitutional rights without questioning whether patients agree with providers that abortion regulations are burdensome. *See, e.g.*, *N.Y. State Nat'l Org. for Women v. Terry*, 886 F.2d 1339, 1348 (2d Cir. 1989); *Planned Parenthood Ass'n of Cincinnati, Inc. v. City of Cincinnati*, 822 F.2d 1390, 1396 (6th Cir. 1987). In this case, the court of appeals assumed away all conflicts of interest between abortion providers and their patients by holding that Wisconsin women "are (or would be, if they were plaintiffs) seeking the same thing the clinics are seeking (with greater resources): invalidating the statute." App. A, 18a. It is quite a leap of logic to presume that abortion-seeking women—especially those who are unidentified in this case—would universally *oppose* a local admitting-privileges requirement that is designed to ensure continuity of care when abortion complications arise.

Under the court of appeals' reasoning, all constitutional problems with third-party standing vanish when the court *ignores* any potential conflict of interest by assuming that women would make the same arguments that abortion providers are making. This assumption is not based in fact and must be examined by this Court. For example, abortion providers have challenged state laws that require

abortions to be performed by licensed physicians even though it is reasonable that women would find such a regulation acceptable and not an undue burden on their rights. *See Mazurek v. Armstrong*, 520 U.S. 968 (1997) (per curiam).

The *Singleton* plurality's position regarding standing is an exception to a general rule and should be cabined within appropriate limitations. Abortion providers may be unique in their ability to challenge regulations aimed at protecting their customers by asserting their customers' constitutional rights. While an exception to the general rules of third-party standing may make some sense when the *right* to an abortion is at stake—as the *Singleton* plurality imagined it would be if Medicaid funding were cut—it does not make sense for regulations that stop well short of outright bans on abortion and rather focus upon the women's health and well-being.

Importantly, the question in this case is not whether Wisconsin women will lose all access to abortion, but whether the secondary effects of the admitting-privileges requirement creates an undue burden on Wisconsin women's right to an abortion. The alleged parade of horribles that the respondents believe will lead to severely diminished access to abortion in Wisconsin goes away if most of the respondents' doctors are able to secure local admitting privileges. Given that the alleged burdens on abortion-seeking women stem from closures of abortion clinics or diminished availability of abortion

that will result from the lack of privileges, the abortion providers could conceivably make their case for invalidating Act 37 stronger if they intentionally do *not* secure admitting privileges. Highlighting this conflict of interest, the respondents indicated during oral argument before the court of appeals that they would continue challenging Act 37 even if all of their physicians secured local admitting privileges.

The Court should grant the petition to develop clear limitations on an abortion providers' right to represent the interests of their patients. Abortion cases will proceed differently depending on whether abortion-seeking women or abortion providers control the litigation. When maternal health regulations are challenged, abortion providers' interests may not be aligned with their patients' interests, raising a prudential standing issue that this Court should resolve.

III. THIS CASE PRESENTS AN OPPORTUNITY FOR THE COURT TO RESOLVE A CIRCUIT SPLIT REGARDING ADMITTING-PRIVILEGES REQUIREMENTS.

The court of appeals' decision holding that the respondents have a likelihood of success on the merits of their challenge to Act 37's admitting-privileges requirement directly conflicts with decisions in the Fourth and Eighth Circuits, as well as an interim decision from the Fifth Circuit. Under Supreme Court Rule 10(a), there is a

compelling reason to grant the petition because the Seventh Circuit has "entered a decision in conflict with the decision of [several other] United States court[s] of appeal[] on the same important matter . . . [so] as to call for an exercise of this Court's supervisory power."

Until the Seventh Circuit's recent ruling, each court of appeals to address a challenge to an admitting-privileges requirement has upheld it, holding that admitting-privileges requirements are rationally related to the state's interest in maternal health. In direct opposition to these decisions, the Seventh Circuit held that the medical basis for Act 37 was "feeble." App. A, 26a-27a. The court of appeals applied a novel interpretation of the "undue burden" standard from *Casey* in which "[t]he feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous." App. A, 26a-27a. The Seventh Circuit's test is contrary to the *Casey* standard and creates conflict with other circuits.

In *Women's Health Center of West County v. Webster*, 871 F.2d 1377 (8th Cir. 1989), abortion providers challenged a new state law requiring them to maintain surgical privileges at a hospital with obstetrical and gynecological care. The Eighth Circuit found "no difficulty in concluding that [the state law] rationally relate[d] to the state's legitimate interest in ensuring that prompt backup

care is available to patients who undergo abortions in outpatient clinics." *Id.* at 1381. Further:

> The State of Missouri, 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.

Id. The court referenced this Court's decision in *Connecticut v. Menillo*, 423 U.S. 9 (1975), which held that states could require abortion providers to be licensed physicians. *Women's Health*, 871 F.2d at 1382.

In *Greenville Women's Clinic v. Commissioner*, 317 F.3d 357 (4th Cir. 2002), the Fourth Circuit upheld similar admitting-privileges requirements under a rational basis test. The Fourth Circuit referenced the Eighth Circuit's ruling in *Women's Health* and concluded that "requirements of having admitting privileges at local hospitals and referral arrangements with local experts are so obviously beneficial to patients . . . , that, on a facial challenge, [the court could not] conclude that the statute denies the abortion clinics due process." *Greenville*, 317 F.3d at 363.

Finally, in *Planned Parenthood of Greater Texas Surgical Health Services, v. Abbott,* 734 F.3d 406,[3] the Fifth Circuit—in an interlocutory decision staying a permanent injunction—held that there are indeed significant state interests to withstand rational basis scrutiny for a very similar admitting-privileges requirement.[4] The Fifth Circuit found that the "State offered more than a 'conceivable state of facts that could provide a rational basis' for requiring abortion physicians to have hospital admitting privileges." *Id.* at 411 (footnote omitted). Some of those reasons included that the "requirement fosters a woman's ability to seek consultation and treatment for complications directly from her physician, not from an emergency room provider," that it "would assist in preventing patient abandonment by the physician who performed the abortion and then left the patient to her own devices to obtain care if complications developed," among other bases. *Id.*

The court of appeals in this case ignored these decisions by severely discounting any medical benefit that will be achieved by an admitting-privileges requirement. The court opined

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[3]This Court declined to vacate the Fifth Circuit's decision staying a permanent injunction. *See* 134 S. Ct. 506 (2013).

[4]Act 37 imposed a much more stringent time frame for compliance than Texas' law. Texas' Senate Bill 5 was not to take effect until the "91st day after the last day of the legislative session," unless two-thirds of the members of each house of Texas' State Legislature voted to approve it. *See* 2013 Texas Senate Bill No. 5, § 12.

that the medical grounds were "feeble," which allowed it to sustain the preliminary injunction under its novel and unwarranted gloss onto the *Casey* undue burden standard by holding that "[t]he feebler the medical grounds, the likelier the burden, even if slight, to be 'undue' in the sense of disproportionate or gratuitous." App. A, 26a. The Seventh Circuit departed from the rational basis analysis of other circuits. Instead, the court invented a new sliding scale test that evaluates *how rational* the medical grounds for a regulation are, not just *whether* they are rational.

The court of appeals' decision stands in stark contrast to the decisions of other circuits. By using its new sliding scale test, the Seventh Circuit broke with persuasive decisions in other jurisdictions. The end result of these conflicting decisions is that women seeking abortions in Wisconsin are subject to diminished continuity of care, lower safety standards, and possible physician abandonment at a time of extreme vulnerability. Allowing this circuit split to remain is untenable; delay leaves women less safe in one state than in others. This Court's intervention is necessary to remedy this disparity in safety and protection between states in different circuits.

IV. THE PROCEDURAL POSTURE IS NO IMPEDIMENT TO GRANTING THE PETITION.

Although the decision below affirmed a preliminary injunction order, review by this Court is

necessary now. This Court has recognized that "there is no absolute bar to review of nonfinal judgments of the lower federal courts" and that the interlocutory character of a decision affects only the calculation as to whether certiorari should be granted. *See, e.g.*, *Mazurek*, 520 U.S. at 975 (summarily reversing an interlocutory order). When "there is some important and clear-cut issue of law that is fundamental to the further conduct of the case and that would otherwise qualify as a basis for certiorari, the case may be reviewed despite its interlocutory status." Stephen M. Shapiro, et al., SUPREME COURT PRACTICE 283 (10th ed. 2013).

This case presents several pressing issues—two of standing and one of a clear circuit split—in which the considerations as to whether to grant certiorari weigh heavily in favor of immediate review. First, the questions of standing determine whether the respondents can maintain a claim based solely upon the constitutional rights of their patients at all. Second, allowing the circuit split to persist with respect to admitting-privileges requirements will subject the women of Wisconsin to diminished standards and practices compared to other states while this case is litigated. If the respondents do not have standing—statutory or constitutional—to assert the rights of their patients, the district court has no jurisdiction over the trial that is fast approaching in May 2014. Moreover, allowing the district court to conduct a trial with an incorrect standard of law set by the Seventh Circuit will result in a flawed decision.

The procedural posture of the case should not preclude this Court's immediate review, particularly where the erroneous appellate decision will necessarily lead to the district court's application of flawed standards and principles of law.

CONCLUSION

The Court should grant the petition for a writ of certiorari to resolve important statutory and constitutional standing issues and to resolve a circuit split over a new abortion regulation.

Respectfully submitted,

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APPENDIX

APPENDIX A

In the
United States Court of Appeals
For the Seventh Circuit

No. 13-2726

PLANNED PARENTHOOD OF WISCONSIN, INC., et al.,

Plaintiffs-Appellees,

v.

J.B. VAN HOLLEN, Attorney General of Wisconsin, et al.,

Defendants-Appellants.

Appeal from the United States District Court for the Western District of Wisconsin.
No. 3:13-cv-00465-wmc — **William M. Conley**, *Chief Judge.*

ARGUED DECEMBER 3, 2013 — DECIDED DECEMBER 20, 2013

Before POSNER, MANION, and HAMILTON, *Circuit Judges.*

POSNER, *Circuit Judge.* On July 5 of this year, the Governor of Wisconsin signed into law a statute that the Wisconsin legislature had passed the previous month. So far as relates to this appeal, the

statute prohibits a doctor, under threat of heavy penalties if he defies the prohibition, from performing an abortion (and in Wisconsin only doctors are allowed to perform abortions, Wis. Stat. § 940.15(5)) unless he has admitting privileges at a hospital no more than 30 miles from the clinic in which the abortion is performed. Wis. Stat. § 253.095(2).

A doctor granted admitting privileges by a hospital be- comes a member of the hospital's staff and is authorized to admit patients to that hospital and to treat them there; that is the meaning of "admitting privileges." Of course any doctor (in fact any person) can bring a patient to an emergency room to be treated by the doctors employed there (these days called "hospitalists"), and all Wisconsin abortion clinics already have transfer agreements with local hospitals to streamline the process. A hospital that has an emergency room is obliged to admit and to treat a patient requiring emergency care even if the patient is uninsured. 42 U.S.C. § 1395dd(b)(1).

Planned Parenthood of Wisconsin and Milwaukee Women's Medical Services (also known as Affiliated Medical Services)—the only entities that operate abortion clinics in Wisconsin—filed suit (joined by two physicians affiliated with these clinics, whom we'll largely ignore in an effort to simplify our opinion) challenging the constitutionality of the new statute under 42 U.S.C. § 1983, which provides a tort remedy for violations of federal law by state employees. The suit was filed promptly on July 5 and simultaneously with the filing the plaintiffs

moved in the district court for a temporary restraining order. The court granted the motion on July 8 and later converted it to a preliminary injunction against enforcement of the statute pending a trial on the merits. The sparse evidentiary record ends on August 2, the day the preliminary injunction was granted. The defendants—the Attorney General of Wisconsin and other state officials involved in enforcing the statute (we refer to the defendants collectively as the "state")—have appealed. 28 U.S.C. § 1292(a)(1).

Discovery is continuing in the district court, but the judge has stayed the trial (originally set for November 25) pending resolution of this appeal. The stay had been requested by the defendants, and in granting it the judge explained that "(1) the stay will not prejudice plaintiffs; and (2) a stay may simplify or clarify the issues in question and streamline the case for trial. Except for the lingering uncertainty (which will not be eliminated until this matter is resolved through final appeal), plaintiffs are not prejudiced by the stay now that an injunction is in place. As plaintiffs acknowledge, additional time may allow them to develop the record as to their ability to obtain admitting privileges at local hospitals. Furthermore, the Seventh Circuit's review of the preliminary injunction order will likely provide guidance to this court and the parties on the law and its application to the facts here. If anything, it would be inefficient for this court to address the merits of plaintiffs' claims until obtaining this guidance from the Seventh Circuit" (citations omitted).

All we decide today is whether the district judge was justified in entering the preliminary injunction. Evidence presented at trial may critically alter the facts found by the district judge on the basis of the incomplete record compiled in the first month of the suit, and recited by us.

Although signed into law on July 5, a Friday, the statute required compliance—the possession of admitting privileges at a hospital within a 30-mile radius of the clinic at which a doctor performs abortions—by July 8, the following Monday. So there was only the weekend between the governor's signing the bill and the deadline for an abortion doctor to obtain those privileges. There was no way the deadline could have been met even if the two days hadn't been weekend days. It is unquestioned that it takes a minimum of two or three months to obtain admitting privileges (often a hospital's credentials committee, which decides whether to grant admitting privileges, meets only once a month), and often it takes considerably longer. Moreover, hospitals are permitted rather than required to grant such privileges.

All seven doctors in Wisconsin who perform abortions but as of July 8 did not have visiting privileges at a hospital within a 30-mile radius of their clinic applied for such privileges forthwith. But as of the date of oral argument of this appeal—five months after the law would have taken effect had it not been for the temporary restraining order—the application of one of the doctors had been denied and none of the other applications had been granted.

Had enforcement of the statute not been stayed, two of the state's four abortion clinics—one in Appleton and one in Milwaukee—would have had to shut down because none of their doctors had admitting privileges at a hospital within the prescribed 30-mile radius of the clinics, and a third clinic would have lost the services of half its doctors. The impossibility of compliance with the statute even by doctors fully qualified for admitting privileges is a compelling reason for the preliminary injunction, albeit a reason that diminishes with time. There would be no quarrel with a one-year deadline for obtaining admitting privileges as distinct from a one-weekend deadline, and if so that might seem to argue for a one-year (or even somewhat shorter) duration for the preliminary injunction. But there should be no problem in getting the case to trial and judgment well before July 8, 2014. The plaintiffs are ready to go to trial. The defendants contemplate very limited discovery. Furthermore there are more reasons for the preliminary injunction than just the impossibility of compliance with the statute within the deadline set by the statute.

The stated rationale of the Wisconsin law is to protect the health of women who have abortions. Most abortions—in Wisconsin 97 percent—are performed in clinics rather than in hospitals, and proponents of the law argue that if a woman requires hospitalization because of complications from an abortion she will get better continuity of care if the doctor who performed the abortion has admitting privileges at a nearby hospital. The plaintiffs disagree. They argue that the statute

would do nothing to improve women's health—that its only effect would be to reduce abortions by requiring abortion doctors to jump through a new hoop: acquiring admitting privileges at a hospital within 30 miles of their clinic. No documentation of medical need for such a requirement was presented to the Wisconsin legislature when the bill that became the law was introduced on June 4 of this year. The legislative deliberations largely ignored the provision concerning admitting privileges, focusing instead on another provision—a requirement not challenged in this suit that a woman seeking an abortion obtain an ultrasound examination of her uterus first (if she hadn't done so already), which might induce her to change her mind about having an abortion. Wis. Stat. § 253.10(3)(c)(1)(gm).

No other procedure performed outside a hospital, even one as invasive as a surgical abortion (such as a colonoscopy, or various arthroscopic or laparoscopic procedures), and even if performed when the patient is under general anesthesia, and even though more than a quarter of all surgery in the United States is now performed outside of hospitals, Karen A. Cullen et al., "Ambulatory Surgery in the United States: 2006," *Centers for Disease Control and Prevention: Na- tional Health Statistics Reports* No. 11, Sept. 4, 2009, p. 5, www.cdc.gov/nchs/data/nhsr/nhsr011.pdf (visited Dec. 19, 2013, as were the other websites cited in this opinion), is required by Wisconsin law to be performed by doctors who have admitting privileges at hospitals within a specified, or indeed any, radius of the clinic at which the procedure is performed. That is true even for gynecological

procedures such as diagnostic dilation and curettage (removal of tissue from the inside of the uterus), hysteroscopy (endoscopy of the uterus), and surgical completion of miscarriage (surgical removal of fetal tissue remaining in the uterus after a miscarriage, which is to say a spontaneous abortion), that are medically similar to and as dangerous as abortion—or so at least the plaintiffs argue, without contradiction by the defendants. These procedures, often performed by the same doctors who perform abortions, appear to be virtually indistinguishable from abortion from a medical standpoint.

An issue of equal protection of the laws is lurking in this case. For the state seems indifferent to complications from non-hospital procedures other than surgical abortion (especially other gynecological procedures), even when they are more likely to produce complications. The rate of complications resulting in hospitalization from colonoscopies, for ex- ample, appears to be three to six times the rate of complications from abortions. Compare Cynthia W. Ko et al., "Serious Complications Within 30 Days of Screening and Surveillance Colonoscopy Are Uncommon," 8 *Clinical Gastroenterology & Hepatology* 166, 171–72 (2010), with two studies cited in an amicus curiae brief filed by the American College of Obstetricians and Gynecologists, Tracy A. Weitz et al., "Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver," 103 *Am. J. Public Health* 454, 457–58 (2013), and Kelly Cleland et al., "Significant Adverse Events and Outcomes After

Medical Abortions," 121 *Obstetrics & Gynecology* 166, 169 (2013). Wisconsin's annual report on abortions suggests a higher incidence of complications but it is unclear whether they all require hospitalization and it still is lower than the reported incidence of complications from colonoscopies. Wisconsin Department of Health Services, "Reported Induced Abortions in Wisconsin, 2012" (Aug 2013), www.dhs.wisconsin.gov/publications/p4/p45360-12.pdf. It is possible that because of widespread disapproval of abortion, abortions and their complications may be underreported—some women who experience such complications and are hospitalized may tell the hospital staff that the complications are from a miscarriage. But as yet there is no evidence in the record of such undercounting. The state's own report on abortions, just cited, lists (at table 9 of the report) only 11 complications out of the 6,692 abortions of Wisconsin residents reported in 2012—a rate of less than 1.6 tenths of 1 percent (1 per 608 abortions). And the report does not indicate how many of the complications involved hospitalization or whether 6,692 was an undercount of the number of abortions.

We asked the state's lawyer at oral argument what evidence he anticipated producing at the trial on the merits. He did not mention evidence of alleged undercounting of abortions, but only that the state was looking for women in Wisconsin who had experienced complications from an abortion to testify. He did not mention any medical or statistical evidence. This may explain why the trial, originally scheduled for November 25, only four and a half

months after the suit was filed, was expected to last only a couple of days. And it is why we think it most unlikely that the trial can't be completed well before the one-year anniversary of the date of the statute's enactment.

The district judge said in a footnote in his opinion that while he would "await trial on the issue, … the complete absence of an admitting privileges requirement for clinical [i.e., outpatient] procedures including for those with greater risk is certainly evidence that Wisconsin Legislature's only *purpose* in its enactment was to restrict the availability of safe, legal abortion in this State, particularly given the lack of any demonstrable medical benefit for its requirement either presented to the Legislature or [to] this court" (emphasis in original). A fuller enumeration of considerations based on purpose would include the two-day deadline for obtaining admitting privileges, the apparent absence of any medical benefit from requiring doctors who perform abortions to have such privileges at a nearby or even any hospital, the differential treatment of abortion vis-à-vis medical procedures that are at least as dangerous as abortions and probably more so, and finally the strange private civil remedy for violations: The father or grandparent of the "aborted unborn child" is entitled to obtain damages, including for emotional and psychological distress, if the abortion was performed by a doctor who violated the admitting-privileges provision. Wis. Stat. § 253.095(4)(a). Yet if the law is aimed *only* at protecting the mother's health, a violation of the law could harm the fetus's father or grandparent only if

the mother were injured as a result of her abortion doctor's lacking the required admitting privileges. But no proof of such injury is required to entitle the father or grandparent to damages if he proves a violation and resulting emotional or psychological injury to himself.

However, the purpose of the statute is not at issue in this appeal. In urging affirmance the plaintiffs reserve the issue for trial, arguing to us only that the law discourages abortions without medical justification and imposes an undue burden on women. And the state on its side does not defend the statute as protecting fetal life but only as protecting the health of women who have abortions.

Wisconsin's statute is not unique. Six states have laws nearly identical to Wisconsin's: Ala. Code § 26-23E-4; Miss. Code. § 41-75-1(f); Mo. Stat. § 188.080; N.D. Cent. Code § 14- 02.1-04(1); Tenn. Code § 39-15-202(h); Tex. Health & Safety Code § 171.0031(a)(1). Five more have similar though less stringent requirements relating to admitting privileges for abortion doctors: Ariz. Rev. Stat. § 36-449.03(C)(3); Fla. Stat. § 390.012(3)(c)(1); Ind. Code § 16-34-2-4.5; Kan. Stat. § 654a09(d)(3); Utah Admin. Code R432-600-13(2)(a). The plaintiffs argue that such laws, which are advocated by the right to life movement, are intended to hamstring abortion. The defendants deny this. We needn't take sides. Discovering the intent behind a statute is difficult at best because of the collective character of a legislature, and may be impossible with regard to the admitting-privileges statutes. Some Wisconsin

legislators doubtless voted for the statute in the hope that it would reduce the abortion rate, but others may have voted for it because they considered it a first step toward making invasive outpatient procedures in general safer.

As now appears (the trial may cast the facts in a different light), the statute, whatever the intent behind it (if there is a single intent), seems bound to have a substantial impact on the practical availability of abortion in Wisconsin, and not only because of the unreasonably tight implementation deadline. Virtually all abortions in Wisconsin are performed at the plaintiffs' four clinics; no other clinics in the state perform abortions and hospitals perform only a small fraction of the state's abortions; and a significant fraction of the clinics' doctors don't have admitting privileges at hospitals within 30-mile radii of their clinics.

What is more, because few doctors in Wisconsin perform abortions, those who do often work at more than one clinic, so that the statute would require them to obtain admitting privileges at multiple hospitals. And whether any of the hospitals would give these doctors admitting privileges is unknown. It is true that federal law prohibits hospitals that receive federal funding, including Catholic hospitals, from denying admitting privileges merely because a doctor performs abortions. 42 U.S.C. § 300a-7(c)(1)(B) (the "Church Amendments"). Yet Wisconsin State Senator Mary Lazich, one of the authors of the admitting-privileges law, was seemingly unaware of the Church Amendments, as

were indeed officials of the largest Catholic hospitals in Wisconsin, which before they were informed of the amendments were emphatic that their religious beliefs would preclude their granting admitting privileges to doctors who perform abortions. Akbar Ahmed, "Abortion Ruling Mired in Confusion," *Milwaukee Journal Sentinel*, July 27, 2013, p. A1, www.jsonline.com/news/statepolitics/court-file-shows-confusion-over-wisconsin-abortion-regulation-law-b9961373z1-217196251.html#ixzz2mcyeJ5ba. In the words of the chief medical officer of one such hospital, "Wheaton Franciscan Healthcare is a ministry of the Catholic church.… For that reason, if it's known to us that a doctor performs abortions and that doctor applies for privileges at one of our hospitals, our hospital board would not grant privileges." *Id.*

So not only would allowing the new law to go into effect on July 8 have wreaked havoc with the provision of abortions in Wisconsin because of the months it would have taken for the doctors who perform abortions to obtain admitting privileges within the prescribed radii of their clinics; in addition their requests for such privileges would have encountered resistance at Catholic hospitals—and perhaps at other hospitals as well, given the widespread hostility to abortion and the lack of any likely benefit to a hospital from granting such privileges to an abortion doctor.

The criteria for granting admitting privileges are multiple, various, and unweighted. They include how frequently the physician uses the hospital (that is,

the number of patient admissions), the quantity of services provided to the patient at the hospital, the revenue generated by the physician's patient admissions, and the physician's membership in a particular practice group or academic faculty ("closed staff" arrangements). Barry R. Furrow et al., *Health Law* § 14-15, pp. 707–08 (2d ed. 2000); Elizabeth A. Weeks, "The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Members," 36 *J. Health L.* 247, 249–52 (2003). The absence of definite standards for the granting of admitting privileges makes it difficult not only to predict who will be granted such privileges at what hospitals and when, but also to prove an improper motive for denial. Akbar Ahmed, "Hospitals Can't Deny Privileges," *Milwaukee Journal Sentinel*, Aug. 7, 2013, p. A1, www.jsonline.com/news/statepolitics/wisconsin-attorney-general-says-hospitals-cant-deny-admitting-privileges-to-abortion-doctors-b997046- 218608951.html, points out for example that according to the Senior Counsel of the National Women's Law Center, "in other states that have recently passed privileges requirements for abortion providers, religiously affiliated hospitals have denied the doctors' applications by citing their failure to meet other standards, such as admitting a certain number of patients per year. In Mississippi, a Baptist hospital did not provide doctors at an abortion clinic with an application for privileges because none of its staff would write letters in support of the doctors, according to a court affidavit provided by the clinic's attorneys at the Center for Reproductive Rights."

Pretext aside, a common and lawful criterion for granting admitting privileges (though it has been criticized by the American Medical Association, see AMA, "Opinion 4.07— Staff Privileges," www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/ opinion407.page) is the number of patient admissions a doctor can be expected to produce for the hospital—the more the better, as that means more utilization of hospital employees and resources and hence more fees for the hospital. But the number of patient admissions by doctors who perform abortions is likely to be negligible because there appear to be so few complications from abortions and only a fraction of those require hospitalization—probably a very small fraction. An even smaller fraction will still be near the hospital at which the doctor has admitting privileges when the complication arises. The state does not dispute the district court's finding that "up to half of the complications will not present themselves until after the patient is home."

But what is certain and also not disputed by the state is that banning abortions by doctors who cannot obtain the requisite admitting privileges within the span of a weekend is bound to impede access to abortions. It would have created (had it not been for judicial intervention) a hiatus of unknown duration (but duration measured in months rather than in weeks or days) in which a critical number of the few doctors who perform abortions in Wisconsin would have been forbidden to do so, under threat of heavy penalties if they disobeyed.

There cannot have been a felt sense of urgency on the state's part for making the law effective too abruptly to allow compliance with it. It has been 40 years since *Roe v. Wade*, 410 U.S. 113 (1973), was decided, legalizing (most) abortion throughout the United States, and it could not have taken the State of Wisconsin all this time to discover the supposed hazards of abortions performed by doctors who do not have admitting privileges at a nearby hospital. The state can without harm to its legitimate interests wait a few months more to implement its new law, should it prevail in this litigation.

One reason it can wait is that its expressed concern about the hazards resulting from abortions performed by doctors who don't have admitting privileges at a nearby hospital has intersected a movement in the hospital industry (an industry in ferment, as everyone now knows) to restrict admitting privileges on economic grounds. See Weeks, *supra*, at 248–49, 252–53 ("for example, hospitals may refuse to grant initial or continuing staff privileges to physicians who own or have other financial interests in competing healthcare entities, refer patients to competing entities, have staff privileges at any other area hospitals, or fail to admit some specified percentage of their patients to the hospital"); Peter J. Hammer & William M. Sage, "Antitrust, Health Care Quality, and the Courts," 102 *Colum. L. Rev.* 545, 567–68 and n. 58 (2002). The trend in the hospital industry is for the hospital to require the treating physician to hand over his patient who requires hospitalization to physicians employed by the hospital, rather than allowing the treating physician to continue participating in the

patient's treatment in the hospital. Wisconsin is trying to buck that trend—but only with regard to abortions, though there is no evidence that the complications to which abortion can give rise require greater physician continuity than other outpatient procedures. And there is no evidence that women who have complications from an abortion recover more quickly or more completely or with less pain or discomfort if their physician has admitting privileges at the hospital to which the patient is taken for treatment of the complications.

The state devotes most of its briefing in this court not to the merits but instead to arguing that the plaintiffs cannot be allowed to maintain this suit because *their* rights have not been violated. The state does not deny that they may be injured by the statute. But it argues that no rights of theirs have been violated but only rights of their patients, if it is true (which of course the defendants deny) that the statute is a gratuitous interference with a woman's right to an abortion.

Yet the cases are legion that allow an abortion provider, such as Planned Parenthood of Wisconsin or Milwaukee Women's Medical Services, to sue to enjoin as violations of federal law (hence litigable under 42 U.S.C. § 1983) state laws that restrict abortion. See, e.g., *Isaacson v. Horne*, 716 F.3d 1213, 1221 (9th Cir. 2013) ("recognizing the confidential nature of the physician-patient relationship and the difficulty for patients of directly vindicating their rights without compromising their privacy, the Supreme Court has entertained both broad facial

challenges and pre-enforcement as-applied challenges to abortion laws brought by physicians on behalf of their patients"); Richard H. Fallon, Jr., "As-Applied and Facial Challenges and Third-Party Standing," 113 *Harv. L. Rev.* 1321, 1359–61 (2000). The reason for allowing such third-party standing in the present case is different from but analogous to the reason that persuaded the Supreme Court, beginning with *Roe v. Wade*, to waive the mootness defense to a suit by a pregnant woman challenging a state law restricting abortion. The suit could not be litigated to judgment before she gave birth; and so if mootness were allowed as a defense, restrictions on abortion could not effectively be challenged by the persons whose rights the restrictions infringe. That was a practical bar to insisting on first-party standing. The bar in this case is the extraordinary heterogeneity of the class likely to be affected by the statute. If two of the four abortion clinics in the state close and a third shrinks by half, some women wanting an abortion may experience delay in obtaining, or even be unable to obtain, an abortion yet not realize that the new law is likely to have been the cause. Those women are unlikely to sue. Other women may be able to find an abortion doctor who has admitting privileges at a nearby hospital, yet incur costs and delay because the law has reduced the number of abortion doctors and hence access. The heterogeneity of the class is likely to preclude class action treatment; and while one or a handful of women might sue, the entire statute would be unlikely to be enjoined on the basis of such a suit.

The principal objection to third-party standing is that it wrests control of the lawsuit from the person or persons primarily concerned in it. See, e.g., *Main Street Organization of Realtors v. Calumet City*, 505 F.3d 742, 746 (7th Cir. 2007); 13A Charles A. Wright, Arthur R. Miller & Edward H. Cooper, *Federal Practice & Procedure* § 3531.9.3, pp. 720–26 (3d ed. 2008). For an extreme example, imagine that if A broke his contract with B, a stranger to both of them could sue A for breach of contract, leaving B out in the cold. But that is not a problem in a case such as this. Wisconsin women who have or want to have an abortion are not seeking damages from the state, and so are not losing control over their legal rights as a result of litigation by clinics and doctors. They are (or would be, if they were plaintiffs) seeking the same thing the clinics are seeking (with greater resources): invalidating the statute.

Anyway there is an alternative ground for standing, unrelated to third-party standing, in this case. The Supreme Court held in *Doe v. Bolton*, 410 U.S. 179, 188 (1973) (the companion case to *Roe v. Wade*), that doctors (two of the plaintiffs in this case are doctors) have first-party standing to challenge laws limiting abortion when, as in *Doe v. Bolton* and the present case as well, see Wis. Stat. §§ 253.095(3), (4), penalties for violation of the laws are visited on the doctors. See also *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 903–04, 909 (1992); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62 (1976); *Karlin v. Foust*, 188 F.3d 446, 456 n. 5 (7th Cir. 1999); *Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d

463, 465 (7th Cir. 1998); 13A Wright, Miller & Cooper, *supra*, pp. 748–50. The state argues that none of these precedents governs because none of them "grapple[d] with whether [42 U.S.C.] § 1983 creates a cause of action for abortion providers or clinics to assert the rights of their patients." But nearly all the cited cases in which doctors and abortion clinics were found to have had standing had been filed pursuant to section 1983, and the justiciability of such cases is not in question.

Apart from the issue of standing just discussed, the legal principles applicable to our consideration of the appeal are not in contention between the parties. The task of the district court asked to grant a preliminary injunction is "to estimate the likelihood that the plaintiff will prevail in a full trial and which of the parties is likely to be harmed more by a ruling, granting or denying a preliminary injunction, in favor of the other party, and combine these findings in the manner suggested in such cases as *Abbott Laboratories v. Mead Johnson & Co.*, 971 F.2d 6, 12 (7th Cir. 1992): 'the more likely it is the plaintiff will succeed on the merits, the less the balance of irreparable harms need weigh towards its side; the less likely it is the plaintiff will succeed, the more the balance need weigh towards its side.'" *Kraft Foods Group Brands LLC v. Cracker Barrel Old Country Store, Inc.*, 735 F.3d 735, 740 (7th Cir. 2013); see also *NLRB v. Electro–Voice, Inc.,* 83 F.3d 1559, 1568 (7th Cir. 1996); *Grocery Outlet Inc. v. Albertson's Inc.*, 497 F.3d 949, 951 (9th Cir. 2007) (per curiam); *O Centro Espirita Beneficiente Uniao Do Vegetal v. Ashcroft*, 389 F.3d 973, 1028–29 (10th Cir. 2004) (en banc) (per curiam), affirmed, 546 U.S.

418 (2006); *Novartis Consumer Health, Inc. v. Johnson & Johnson–Merck Consumer Pharmaceuticals Co.*, 290 F.3d 578, 597 (3d Cir. 2002). This formulation is a variant of, though consistent with, the Supreme Court's recent formulations of the standard, in such cases as *Winter v. National Resources Defense Council, Inc.*, 555 U.S. 7, 20 (2008): "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest."

Because of the uncertainty involved in balancing the considerations that bear on the decision whether to grant a preliminary injunction—an uncertainty amplified by the unavoidable haste with which the district judge must strike the balance—we appellate judges review his decision deferentially.

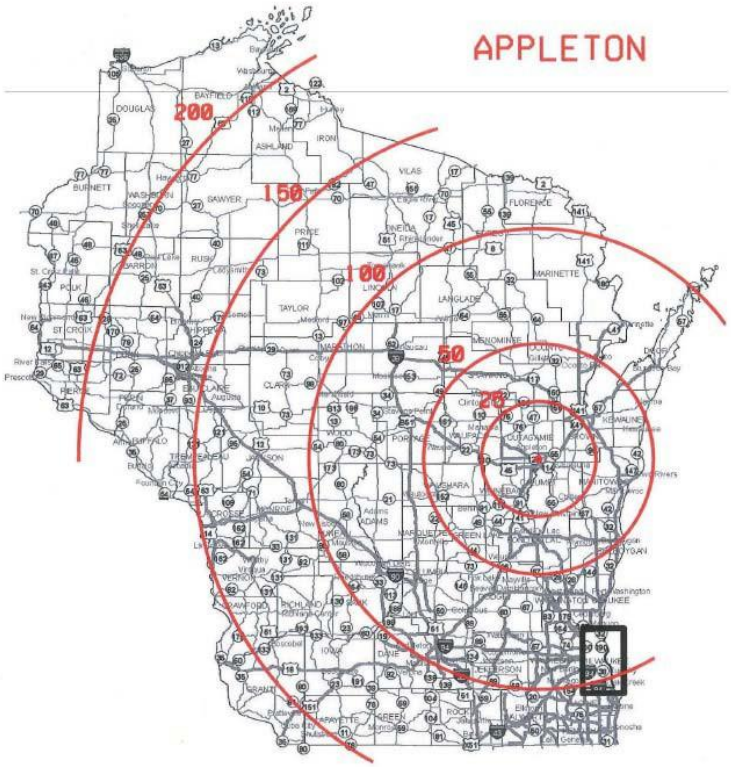
The state concedes that its only interest pertinent to this case is in the health of women who obtain abortions. But it has neither presented evidence of a health benefit (beyond an inconclusive affidavit by one doctor concerning one abortion patient in another state, as we'll see), or rebutted the plaintiffs' evidence that the statute if upheld will harm abortion providers and their clients and potential clients.

And it is beyond dispute that the plaintiffs face greater harm irreparable by the entry of a final judgment in their favor than the irreparable harm that the state faces if the implementation of its

statute is delayed. For if forced to comply with the statute, only later to be vindicated when a final judgment is entered, the plaintiffs will incur in the interim the disruption of the services that the abortion clinics provide. With the closure of two and a half of the state's four abortion clinics if their doctors fail to obtain admitting privileges, including one clinic responsible for half the abortions performed in the state, their doctors' practices will be shutdown completely unless and until the doctors obtain visiting privileges at nearby hospitals. Patients will be subjected to weeks of delay because of the sudden shortage of eligible doctors—and delay in obtaining an abortion can result in the progression of a pregnancy to a stage at which an abortion would be less safe, and eventually illegal.

Some patients will be unable to afford the longer trips they'll have to make to obtain an abortion when the clinics near them shut down—60 percent of the clinics' patients have incomes below the federal poverty line. One of the clinics that will close is Planned Parenthood's clinic in Appleton, which, as shown in the accompanying map, is in the approximate center of the state. The remaining abortion clinics are in Madison or Milwaukee, about 100 miles south of Appleton. A woman who lives north of Appleton who wants an abortion may (unless she lives close to the Minnesota border with Wisconsin and not far from an abortion clinic in that state) have to travel up to an additional 100 miles each way to obtain it. And that is really 400 miles—a nontrivial burden on the financially strapped and others who have difficulty traveling long distances to obtain an abortion, such as those who already have

children. For Wisconsin law requires two trips to the abortion clinic (the first for counseling and an ultrasound) with at least twenty-four hours between them. Wis. Stat. § 253.10(3)(c). When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered.



The state has made no attempt to show an offsetting harm from a delay of a few months in the implementation of its new law (should it be upheld after a trial). States that have passed similar laws

have allowed much longer implementation time than a weekend—for example, Mississippi has allowed 76 days, Alabama 114 days, Texas 103, and North Dakota 128. See 2012 Miss. Gen. Laws 331 (H.B. 1390), enjoined, *Jackson Women's Health Org. v. Currier*, 940 F. Supp. 2d 416, 424 (S.D. Miss. 2013); 2013 Ala. Legis. Serv. 2013-79(H.B. 57), enjoined, *Planned Parenthood Southeast, Inc. v. Bentley*, No. 2:13cv405-MHT, 2013 WL 3287109, at *8 (M.D. Ala.June 28, 2013); 2013 Tex. Sess. Law Serv. 2nd Called Sess. Ch. 1 (H.B. 2), permanent injunction stayed pending appeal, *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 734 F.3d 406 (5th Cir. 2013); 2013 North Dakota Laws Ch. 118 (S.B. 2305), enjoined, *MKB Management Corp. v. Burdick*, No. 1:13-cv-071, 2013 WL 3779740, at *2 (D.N.D. July 22, 2013).

Is there such urgency to implementing the law, because Wisconsin is rife with serious complications from abortion and requiring admitting privileges to hospitals within short distances of abortion clinics is essential to preventing such complications? As noted earlier, the state has presented no evidence of either reason for the weekend deadline. Complications of abortion are estimated to occur in only one out of 111 physician-performed aspiration abortions (the most common type of surgical abortion); and 96 percent of complications are "minor." Weitz et al., *supra*, p. 457; cf. Cleland et al., *supra*. The official Wisconsin figure, cited earlier, is much lower: one complication per 608 abortions. Few complications require hospitalization; studies cited earlier found that only 1 in 1,915 aspiration abortions (0.05%) and 1 in

1,732 medical abortions (0.06%) result in complications requiring hospitalization. Weitz et al., *supra*, p. 459; Cleland et al., *supra*, p. 169 table 2.

What fraction of these hospitalizations go awry because the doctor who performed the abortion did not have admitting privileges at the hospital to which the woman was taken is another unknown in a case in which thus far the state has been chary in the presentation of evidence. True, one doctor, who said he's been treating complications from abortions for 29 years, furnished the defendants with an affidavit describing a case in which, he opines, a woman with a complication from an abortion *might* have avoided a hysterectomy had her abortion doctor, who did not have admitting privileges, remained in closer touch with her. That is the only evidence in the record that any woman whose abortion results in complications has ever, anywhere in the United States, been made worse off by being "handed over" by her abortion doctor to a gynecologist employed by the hospital to which she's taken. One (doubtful) case in 29 years is not impressive evidence of the medical benefits of the Wisconsin statute. And we note that as a protection for Wisconsin women who have abortions, abortion clinics—uniquely, it appears, among outpatient providers of medical services in Wisconsin—are required to adopt the transfer protocols, mentioned earlier, which are intended to assure prompt hospitalization of any abortion patient who experiences complications serious enough to require hospitalization. See Wis. Admin. Code Med. § 11.04(g).

The defendants argue that obtaining admitting privileges operates as a kind of Good Housekeeping Seal of Approval of a physician. But that benefit does not require that the hospital in which he obtains the privileges be within a 30-mile radius of the clinic. Cf. *Women's Health Center of West County, Inc. v. Webster*, 871 F.2d 1377, 1378–81 (8th Cir. 1989) (upholding an admitting privileges requirement with no geographic restriction). Several abortion doctors in Wisconsin who lack admitting privileges at hospitals within 30 miles have them at hospitals beyond that radius. Yet they are not excused by the statute from having to obtain the same privileges from a hospital within 30 miles.

Furthermore, nothing in the statute requires an abortion doctor who has admitting privileges to care for a patient who has complications from an abortion. He doesn't have to accompany her to the hospital, treat her there, visit her, call her, or indeed do anything that a doctor employed by the hospital might not do for the patient.

Also the statute does not distinguish between surgical and medical abortions. The latter term refers to an abortion induced by a pill given to the patient by her doctor: she takes one pill in the clinic, goes home, and takes a second pill a few days later to complete the procedure. (The first pill ends the fetus's life, the second induces the uterus to expel the remains.) Her home may be far from any hospital within a 30-mile radius of her doctor's clinic, but close to a hospital outside that radius. If she calls an ambulance, the paramedics are likely to

take her to the nearest hospital—a hospital at which her doctor is unlikely to have admitting privileges. Likewise in the case of surgical abortions when complications occur not at the clinic, during or immediately after the abortion, but after the patient has returned home: because of distance she may no longer have ready access to the hospitals near the clinic at which the abortion was performed, even though she may live near a hospital at which the doctor who performed her abortion does not have admitting privileges.

The cases that deal with abortion-related statutes sought to be justified on medical grounds require not only evidence (here lacking as we have seen) that the medical grounds are legitimate but also that the statute not impose an "undue burden" on women seeking abortions. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, *supra*, 505 U.S. at 874, 877, 900–01 (plurality opinion); *Stenberg v. Carhart*, 530 U.S. 914, 930, 938 (2000); cf. *Mazurek v. Armstrong*, 520 U.S. 968, 972–73 (1997) (per curiam). The feebler the medical grounds, the likelier the burden, even if slight, to be "undue" in the sense of disproportionate or gratuitous. It is not a matter of the number of women likely to be affected. "[A]n undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, *supra*, 505 U.S. at 877 (plurality opinion). In this case the medical grounds thus far presented ("thus far" being an important qualification given

the procedural setting—a preliminary-injunction proceeding) are feeble, yet the burden great because of the state's refusal to have permitted abortion providers a reasonable time within which to comply.

And so the district judge's grant of the injunction must be upheld. But given the technical character of the evidence likely to figure in the trial—both evidence strictly medical and evidence statistical in character concerning the consequences both for the safety of abortions and the availability of abortion in Wisconsin—the district judge may want to reconsider appointing a neutral medical expert to testify at the trial, as authorized by Fed. R. Evid. 706, despite the parties' earlier objections. Given the passions that swirl about abortion rights and their limitations there is a danger that party experts will have strong biases, clouding their judgment. They will still be allowed to testify if they survive a *Daubert* challenge, but a court-appointed expert may help the judge to resolve the clash of the warring party experts. And the judge may be able to procure a genuine neutral expert simply by directing the party experts to confer and agree on two or three qualified neutrals among whom the judge can choose with confidence in their competence and neutrality. If either side's party experts stonewall in the negotiations for the compilation of the neutral list, the judge can take disciplinary action; we doubt that will be necessary.

We emphasize in conclusion that the trial on the merits may cast the facts we have recited, based as they are on the record (by no means slim, however,

though entirely documentary) of the preliminary-injunction proceeding, in a different light. That record—all we have—requires that the district judge's grant of the preliminary injunction be, and it hereby is,

AFFIRMED.

MANION, *Circuit Judge*, concurring in part and in the judgment.

I agree with the court that the temporary restraining order and the subsequent preliminary injunction were appropriate. The Wisconsin law at issue requires abortion doctors to obtain admitting privileges at a hospital no more than 30 miles from the clinic in which the abortion is performed. 2013 Wis. Act 37, § 1 (codified at Wis. Stat. § 253.095(2)). As I explain below, the legislature had a rational basis to enact the law. However, the law was signed by the governor on a Friday and took effect the following Monday. The law's immediate effective date made it impossible for the doctors employed at the various clinics providing abortion services to seek and obtain admitting privileges at a nearby hospital. The injunctive relief has now been in place for nearly half a year, so abortion doctors have had plenty of time to secure admitting privileges. However, in this appeal, Wisconsin has only argued that the original entry of the injunction was error, so whether the injunction *remains* appropriate will be decided on remand. I also agree with the court about third-party standing. There is no need for the parties to dwell on this issue.

As the court notes, at this juncture, "the Seventh Circuit's review of the preliminary injunction order will likely provide guidance to the court and the parties on the law and its application to the facts here." Maj. Op. at 3. The court has expressed rather extensive guidance for the district court on remand. At this point, I hope to offer some of my own observations on the legitimate interests that are

furthered by the requirements of Wisconsin Act 37 and the nature of the burdens that the requirements may impose on access to abortion.

The Two-Part Test for Laws Regulating the Provision of Abortions

"Where it has a rational basis to act, and it does not impose an undue burden, the State may" regulate the provision of abortions. *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007). Thus, legislation regulating abortions must past muster under rational basis review *and* must not have the "practical effect of imposing an undue burden" on the ability of women to obtain abortions. *See Karlin v. Foust*, 188 F.3d 446, 481 (7th Cir. 1999); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 411 (5th Cir. 2013), application to vacate stay of injunction denied, 134 S. Ct. 506 (Nov. 19, 2013).

Step 1: Rational Basis

At the first step, we must presume that the admitting- privileges requirement is constitutional, and uphold it so long as the requirement is rationally related to Wisconsin's legiti- mate interests. *See St. John's United Church of Christ v. City of Chicago*, 502 F.3d 616, 637–38 (7th Cir. 2007) (quoting *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985)). Wisconsin asserts that its admitting-privileges requirement furthers its legitimate interests in protecting the health of mothers and in maintaining the professional standards applicable to abortion doctors. *Carhart*,

550 U.S. at 157; *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992). The question, then, is whether Wisconsin's adoption of the admitting-privileges requirement is rationally related to these interests. "Under rational basis review, 'the plaintiff has the burden of proving the government's action irrational,' and "[t]he government may defend the rationality of its action on any ground it can muster, not just the one articulated at the time of decision.'" *RJB Props., Inc. v. Bd. of Educ. of Chicago*, 468 F.3d 1005, 1010 (7th Cir. 2006) (quoting *Smith v. City of Chicago*, 457 F.3d 643, 652 (7th Cir. 2006)).

The court suggests that Wisconsin must come forward with medical evidence that the admitting-privileges requirement furthers the State's legitimate interests. Maj. Op. at 23. But, under rational basis review, Wisconsin's legislative choice "may be based on rational speculation unsupported by evidence or empirical data." *F.C.C. v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993). States have "broad latitude" to regulate abortion doctors, "even if an objective assessment might suggest that" the regulation is not medically necessary. *Mazurek v. Armstrong*, 520 U.S. 968, 973 (1997) (quotation marks and emphasis omitted). Thus, the Supreme Court has rejected as misguided arguments that an abortion law is unconstitutional because the medical evidence contradicts the claim that the law has any medical basis. *Id.*; *see also Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 169 (4th Cir. 2000) ("[T]here is no requirement that a state refrain from regulating abortion facilities until a public-health problem manifests itself. In *Danforth*, for example, the [Supreme] Court upheld health measures that

'may be helpful' and 'can be useful.'" (quoting *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 80–81 (1976))). In sum, Wisconsin need offer only "a 'conceivable state of facts that could provide a rational basis' for requiring abortion physicians to have hospital admission privileges." *Abbott*, 734 F.3d at 411 (quoting *F.C.C.*, 508 U.S. at 313).

The Medical Professions' Support for Admitting Privileges

In 2003, the American College of Surgeons issued a statement on patient-safety principles that reflected a consensus in the surgical community "on a set of 10 core principles that states should examine when moving to regulate office-based procedures."[1] These principles were based on a document that was unanimously agreed to by medical associations of every stripe, including the American Medical Association and the American College of Obstetricians and Gynecologists. Core Principle #4 provides that "[p]hysicians performing office-based surgery must have admitting privileges at a nearby hospital, a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital." Unsurprisingly, the National Abortion Federation has specifically

[1] *See* American College of Surgeons, *Statement on Patient Safety Principles for Office-based Surgery Utilizing Moderate Sedation/Analgesia, Deep Sedation/Analgesia, or General Anesthesia*, Bulletin of the American College of Surgeons, Vol. 89, No. 4 (Apr. 2004), available at http://www.facs.org/fellows_info/statements/st-46.html (last visited on Dec. 12, 2013, as were the other websites cited in this opinion).

recommended that "[i]n the case of emergency, the doctor should be able to admit patients to a nearby hospital (no more than 20 minutes away)." National Abortion Federation, *Having an Abortion? Your Guide to Good Care* (2000) (pamphlet), available at http://web.archive.org/web/20000619200916/http://www.prochoice.org/pregnant/goodcare.htm (internet archive of NAF website on June 19, 2000) (hereinafter, "*NAF Guide to Good Care*"). This should be sufficient to establish that Wisconsin's admitting-privileges requirement is reasonably designed to promote the state's legitimate interest in women's health. And, as the court recognizes, Wisconsin is one of twelve states adopting such a requirement. Maj. Op. at 9.

The Benefits of Admitting Privileges in an Emergency Situation

Further, the parties agree that at least a small number of abortions result in complications that require hospitalization.[2] Wisconsin offers doctors' declarations establishing that the admitting-privileges requirement expedites the admission process and avoids miscommunications between the patient and the hospital in situations where swift treatment is critical. *See* J.A. 149–50, ¶¶ 12–19 (Decl. of Dr. James Anderson); 175–76, ¶ 14 (Decl. of Dr. Matthew Lee); 184, ¶ 9 (Decl. of Dr. Linn); 237–38, ¶¶ 6–12 (Decl. of Dr. David C. Merrill); 332–33, ¶¶ 25–31 (Decl. of Dr. John Thorp); *see also* Darrell J. Solet, MD, et al., *Lost in Translation: Challenges and Opportunities to Physician-to-Physician Communication During Patient Handoffs*, 80 Academic Medicine 1094, 1097 (Dec. 2005) (observing, in the context of patient transfers, that "poor communication in medical practice turns out to

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[2] The exact percentage is in dispute, but at least .3% of abortions result in complications requiring hospitalization. In Wisconsin, this amounts to a woman requiring hospitalization as a result of an abortion or attempted abortion every 16 days. As the court recognizes, however, this percentage is likely artificially low due to under-reporting. Maj. Op. at 7. When a woman is admitted to a hospital without a request for admission from an abortion doctor, the social stigmas associated with abortion will likely cause her to report her complications as arising from a miscarriage or other mishap rather than a botched abortion. *See also Abbott*, 734 F.3d at 412 (quoting Dr. John Thorp regarding "the 'unique nature of an elective pregnancy termination and its likely under-reported morbidity and mortality'"); J.A. 183, ¶ 6 & n.1 (Decl. of Dr. Linn).

be one of the most common causes of error"). After all, the abortion doctor is better acquainted with his patient's medical history and is in a better position to quickly diagnose complications resulting from the procedure. *See* J.A. 238, ¶ 12 (Decl. of Dr. Merrill); 332, ¶ 25 (Decl. of Dr. Thorp). Additionally, the admitting-privileges requirement ensures "that a physician will have the authority to admit his patient into a hospital whose resources and facilities are familiar to him … ." *Women's Health Ctr. of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989) (quotation marks omitted).

The Oversight Function of the Admitting-Privileges Requirement

Moreover, "[t]he requirement that physicians performing abortions must have hospital admitting privileges helps to ensure that credentialing of physicians beyond initial licensing and periodic license renewal occurs."[3] *Abbott*, 734 F.3d at 411. Thus, Wisconsin's admitting-privileges requirement

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[3] The court expresses doubts about this justification because Wisconsin requires that the hospital be within 30 miles of the clinic at which the doctor performs the abortions. "Under rational basis review, however, the [selected means] need not be the most narrowly tailored means available to achieve the desired end." *Zehner v. Trigg*, 133 F.3d 459, 463 (7th Cir. 1997); *see also* American College of Surgeons, *supra* note 1 ("Physicians performing office-based surgery must have admitting privileges at a *nearby* hospital, a transfer agreement with another physician who has admitting privileges at a *nearby* hospital, or maintain an emergency transfer agreement with a *nearby* hospital.") (emphasis added); *NAF Guide to Good Care* (recommending admitting privileges at a hospital "no more than 20 minutes away").

adds an extra layer of protection for *all* of the patients of abortion doctors. Indeed, every circuit to address the issue has held that admitting-privileges requirements further states' legitimate interests. *Abbott*, 734 F.3d at 412 ("We have little difficulty in concluding that, with regard to the district court's rational basis determination, the State has made a strong showing that it is likely to prevail on the merits."); *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control,* 317 F.3d 357, 363 (4th Cir. 2002) ("These requirements of having admitting privileges at local hospitals and referral arrangements with local experts are so obviously beneficial to patients."); *Webster,* 871 F.2d at 1381 (Missouri's admitting-privileges requirement "furthers important state health objectives.").

Admitting Privileges and Other Outpatient Surgeries

The court emphasizes the fact that Wisconsin has not imposed an admitting-privileges requirement on doctors who perform outpatient procedures other than abortion. But the plaintiffs bear the burden of proof and have offered no evidence that doctors in those other fields have a lack of admitting privileges—as do abortion doctors—which would necessitate a legislative response. Moreover, there is no mandate that state legislatures uniformly regulate medical procedures—or regulate medical procedures with higher or even the highest incidents of complications. States "may select one phase of one field and apply a remedy there, neglecting the others." *Williamson v. Lee Optical of Okla. Inc.*, 348 U.S. 483, 489 (1955). Finally, Wisconsin had a

perfectly good reason for addressing abortion first—namely, the Gosnell scandal.

The Dr. Kermit Gosnell Scandal

There has been no high-profile exposure of substandard care by doctors who perform outpatient procedures other than abortion. However, just a few weeks prior to the enactment of Wisconsin's admitting-privileges requirement, there was a shocking revelation of terrible conditions and procedures at an abortion clinic that received nationwide attention. On May 13, 2013, a Philadelphia abortion doctor, Dr. Kermit Gosnell, was convicted of three counts of first-degree murder for the death of three infants delivered alive but subsequently killed at his clinic. The record in this appeal contains articles extensively discussing the egregious health care practices at Dr. Gosnell's clinic leading up to his conviction. These include bloody floors and unlicensed employees conducting gynecological examinations and administering painkillers, resulting in the death of a patient. *See* J.A. 154 (Joann Loviglio, *Abortion Doctor Suspended After Philadelphia Raid: 'Deplorable' Conditions Reported At Kermit Gosnell's Office*, The Huffington Post, Feb. 23, 2010, http://www.huffingtonpost.com/2010/02/23/abortion-doctor-suspended_n_473963.html). In addition, media reports circulated that, among other things, Dr. Gosnell physically assaulted and performed a forced abortion on a minor and left fetal remains in a

woman's uterus causing her excruciating pain.[4] Although these details were first publicized after Dr. Gosnell's arrest in 2011, the case did not garner national attention until his trial in March 2013. Unsurprisingly, the case provoked shock and outrage, prompting a heightened concern for the health of women seeking abortions. In addition to Dr. Gosnell's case, Wisconsin identifies numerous other examples of egregious and substandard care by abortion providers and clinics. *See* Appendix to the Concurrence; J.A. 154–56.

On June 4, 2013, Wisconsin Act 37, which contained the admitting-privileges requirement at issue in this appeal and also contained an ultrasound requirement, was introduced in the Wisconsin Senate. On June 12, the Act passed in the Senate. On June 13, the Act passed in the Assembly, where it was returned to the Senate and presented to the governor for his signature on July 3. On July 5, the Act was signed into law by the governor. This timeline demonstrates that Wisconsin legislators promptly responded to their constituents' concerns. Wisconsin Act 37 was a response to the dangers (graphically illustrated by Dr. Gosnell's case) to women's health and the right to freely exercise their choice.

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[4] Jessica Hopper, *Alleged Victim Calls Philadelphia Abortion Doc Kermit Gosnell a 'Monster'*, ABC News, Jan. 25, 2011, http://abcnews.go.com/US/alleged- victim-calls-philadelphia-abortion-doctor-kermit-gosnell/story?id=12731387&singlePage=true

The Interaction Between the Act's Admitting-Privileges and Ultrasound Requirements

In addition, the admitting-privileges requirement furthers the Act's ultrasound requirement. *See* Wis. Stat. § 253.10(3)(c). Performing an ultrasound allows an abortion doctor to get a clear picture of the woman's pregnancy—including the gestational age and size of the unborn child, whether there are twins, whether the heart is beating,[5] and the orientation of the unborn child within the uterus—which allows the doctor to anticipate any likely complications. The law requires that, absent an emergency, the woman receive an ultrasound at the clinic or elsewhere. Accordingly, regardless of where

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[5] Detecting a heartbeat enables the abortion doctor to determine whether the unborn child is still alive—a serious concern in light of the prevalence of miscarriages. *See* National Institute of Health, National Library of Medicine, *Miscarriage*, http://www.nlm.nih.gov/medlineplus/ency/article/001488.htm ("Among women who know they are pregnant, the miscarriage rate is about 15-20%."). Determining whether there is a beating heart is a crucial component to ensuring that a woman receives quality care. For example, if more than seven weeks have passed since the last menstrual cycle ("LMC"), and there is no fetal heartbeat, then the unborn child is almost certainly naturally deceased—although a pregnancy test will continue to generate a positive result. In that situation, the woman must be fully informed about whether an abortion is still necessary because state-subsidized private health insurance and Medicaid—which in most cases do not cover an abortion—will generally cover the procedure for removing the remains. *See* Wis. Stat. Ann. § 632.8985 (prohibiting coverage of abortions by health plans offered through health benefit exchanges); Wis. Stat. Ann. § 20.927 (prohibiting state or municipal subsidies for the performance of abortions).

the ultrasound is performed, important and easily determinable facts about the pregnancy are available to the abortion doctor. Additionally, the ultrasound must be explained to the woman so that she can exercise her right to choose while fully informed.[6] These benefits conferred by the ultrasound requirement are secured by the oversight function of the admitting-privileges requirement. Specifically, hospitals extending admitting privileges are given a role in ensuring that the new requirements for the protection of women's health and choice are observed by abortion doctors—to prevent a substandard abortion care crisis in Wisconsin.

Additionally, many abortion-seeking patients face uniquely challenging circumstances not faced by other surgery patients. Many are young and vulnerable. Some may be pressured by angry, disappointed parents or by a putative father shirking responsibility. And, as the court remarks, there is wide-spread social disapproval of abortion. Maj. Op. at 7. So the woman is likely seeking absolute privacy and has had little or no external consultation or advice. A legislature could rationally speculate that a surgical procedure commonly undergone by young and vulnerable patients under

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[6] Wisconsin may also hope that a woman who sees the ultrasound picture of her unborn child and hears the heart beating will choose to carry the unborn child to term. But because the ultrasound requirement is not challenged in this case, Wisconsin does not assert its legitimate interest in fetal life here. *See Carhart*, 550 U.S. at 145 (recognizing "that the government has a legitimate and substantial interest in preserving and promoting fetal life" pre-viability).

the influence of either direct or social pressures is in greater need of regulation.

In summary, "[t]he State 'may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.'" *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 430–31 (1983) (quoting *Roe v. Wade*, 410 U.S. 113, 163 (1973)). That is what Wisconsin has done in this case, and its decision to do so by means of an admitting-privileges requirement is certainly rational.

Step 2: Undue Burden

The court also suggests that the admitting-privileges requirement imposes significant burdens on women's ability to obtain abortions. At this second step, we must determine "whether the [admitting privileges requirement has] the practical effect of imposing an undue burden" on women's abortion rights. *Karlin*, 188 F.3d at 481. We cannot find the requirement unconstitutional unless the plaintiffs can show that the requirement "will have the likely effect of preventing a significant number of women for whom the regulation is relevant from obtaining abortions." *Id.* In this case, because the requirement applies to all abortion doctors in the state, it affects all Wisconsin women who may seek abortions.[7] *See Abbott*, 734 F.3d at 414. Therefore, the question is whether the requirement prevents "a significant number of" women from obtaining

[7] Thus, the district court erred because it limited its review to women living in the areas near the clinics that may be closed.

abortions. At this step too, the plaintiffs have the burden of proof. *See Karlin*, 188 F.3d at 485; *Bryant*, 222 F.3d at 171.

In suggesting that Wisconsin's admitting-privileges requirement imposes an undue burden, the court emphasizes that it will temporarily force two abortion clinics to stop providing abortions and another clinic to cut the number of doctors by half, which could cause delays for women seeking abortions. Of course, this effect will only last until the doctors at these clinics obtain admitting privileges in accordance with the law.[8] Regardless, more than 70% of women in Wisconsin who seek abortions live in the southern counties near Milwaukee and Madison, where clinics will continue operating. *See* J.A. 292. Thus, to the extent the remaining clinics are unable to quickly adjust for the decreased supply of legally qualified abortion doctors, most Wisconsin women seeking abortions can travel to clinics in Illinois. Indeed, women living in the northern part of Wisconsin can seek abortions in Minnesota. For example, both Minneapolis and

[8] The undue burden analysis is not concerned with any burden the law may place on abortion doctors, except insofar as the law burdens women's ability to obtain abortions. Any burden on women will vanish once abortion doctors obtain admitting privileges.

Duluth have abortion clinics.[9] Thus, the admitting-privileges requirement itself will likely not prevent any woman from obtaining an abortion if she wishes to do so. *See Bryant*, 222 F.3d at 163, 170–72 (holding that "increased costs, delays in the ability to obtain abortions, decreased availability of abortion clinics, [and] increased distances to travel to clinics" do not constitute an undue burden). Any delays are merely the incidental effects of abortion doctors' obligation to come into compliance with the admitting-privileges requirement. The fact that the requirement "has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it." *Casey*, 505 U.S. at 874. And here, we are affirming the district court's decision to give abortion doctors a

[9] The district court thought that the availability of abortions in cities near the Wisconsin border was irrelevant. Although the Wisconsin law does not affect doctors performing abortions in Minnesota, the availability of near-but-out-of-state abortions at least speaks to whether the admitting-privileges requirement has the "practical effect" of preventing a "significant number" of women from obtaining abortions. In our economy, crossing state lines to obtain services at a nearby urban center is common. Thus, state lines are unlikely to affect a woman's decision about where to get an abortion and the availability of abortion at out-of-state clinics should be considered in the undue burden analysis.

reasonable amount of time to obtain admitting privileges.[10]

The court is also concerned by the fact that (because of Wisconsin's 24-hour waiting law) some Wisconsin women live around 100 miles from the closest abortion clinic—namely, those living in north-eastern Wisconsin—and consequently, will have to traverse that distance four times to obtain

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[10] Now that some months have passed, Wisconsin abortion doctors have had sufficient time to come into compliance with the admitting-privileges requirement. The court suggests that disapproval for abortion may interfere with abortion doctors' abilities to obtain admitting privileges at sectarian hospitals. Maj. Op. at 10–11. However, "Lutheran and Jewish hospitals in Milwaukee allow abortions." J.A. 185, ¶ 13 (Decl. of Dr. James G. Linn). Furthermore, "[w]hile Catholic hospitals do not permit abortions to be performed at their facilities, they do allow abortion providers staff membership." *Id.* ("I know for a fact that Catholic hospitals in Milwaukee have or have had abortion providers on their medical staffs."). Although federal law prohibits sectarian hospitals from discriminating against abortion doctors when awarding admitting privileges, it seems reasonable that—in light of Catholic social teaching—Catholic hospitals would wish to grant admitting privileges to abortion doctors so that women injured by abortions would have better access to the compassionate medical care needed in that delicate circumstance.

abortions (if they cannot afford to spend the night at a local hotel).[11] The court suggests that the time and costs of that travel will prevent a "significant number" of Wisconsin women from obtaining abortions. But the costs of traveling up to 100 miles on four different occasions pale in comparison to the cost of an abortion. The costs of travel are undoubtedly inconvenient, but an inconvenience—even a "severe inconvenience"—"is not an undue burden." *Karlin*, 188 F.3d at 481; *see also Casey*, 505 U.S. at 874 ("The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it."); *Bryant*, 222 F.3d at 163, 170–72.

Moreover, in reversing a district court's decision to preliminarily enjoin Texas's admitting-privileges requirement, the Fifth Circuit recently held that "[a]n increase in travel distance of less than 150 miles for some women is not an undue burden on abortion rights." *Abbott*, 734 F.3d at 415. Texas also imposes a 24-hour waiting requirement (which applies to any woman who lives within 100 miles of the clinic). *See* Tex. Health & Safety Code § 171.012(a)(4). Thus, under *Abbott*, Texas women could face an increase in travel distance of almost

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[11] The number of women who seek abortions living in the areas near the closed clinics is apparently very small compared to those living near the clinics that will continue to operate. Thus, the admitting-privileges requirement likely only will compel a few rural women to drive longer distances. So it is far from clear that a "significant number" of women will be prevented from obtaining abortions.

400 miles. If an *increase* in travel distance of almost 400 miles is not an undue burden, it is difficult to see how a *total* travel distance of about 400 miles could be. *See also Bryant*, 222 F.3d at 170–71 (finding that admitting-privileges requirement imposed no undue burden where, *inter alia,* an abortion clinic was still operating "some 70 miles away"); *Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595, 605 (6th Cir. 2006) (concluding, in an as-applied challenge to abortion regulation, that an increase in travel distance of 45 to 55 miles is not an undue burden).

In summary, the plaintiffs "have not demonstrated that the [admitting-privileges requirement] would be unconstitutional in a large fraction of relevant cases." *Carhart*, 550 U.S. at 167-68. The other circuits to address this issue have reached the same conclusion. *See Abbott*, 734 F.3d at 416, 419; *Bryant*, 222 F.3d at159, 173.

Conclusion

The decision to have an abortion is, for many women, "the most difficult decision they will ever make." Lizz Winstead, *Abortion Is a Medical Procedure*, The Huffington Post, Nov. 11, 2012, http://www.huffingtonpost.com/lizz-winstead/abortion-is-a-medical-procedure_b_2064176.html. Therefore, when a woman enters an abortion clinic, she has a right to expect excellent care from a qualified doctor. One key component of quality care is the use of an ultrasound, which furnishes the abortion doctor with important and easily determinable facts about the

pregnancy related to the woman's health and exercise of her free choice. For example, an ultrasound allows a determination of whether there is a fetal heartbeat, the gestational age and size of the unborn child, and whether there are twins.[12] An ultrasound is also material to the costs of the procedure inasmuch as it may reveal that an abortion is no longer necessary (if the unborn child is no longer alive) and because clinics base the cost of the abortion procedure on the unborn child's gestational age.

The admitting-privileges requirement has an indisputable benefit when emergency care is needed. If serious complications arise, then the woman should be able to call her clinic and speak with the doctor who treated her. If that physician has admitting privileges, he or she can direct the woman to the hospital and meet her there, or at least contact the hospital and notify the proper admitting personnel to describe the possible causes of the woman's symptoms. Then, upon arrival at the hospital, the woman would be able to receive immediate care. And, if necessary, the hospital's doctor could contact the abortion doctor to confidentially obtain further details. Indeed, by requiring abortion doctors to commit to continued care, the admitting-privileges requirement prevents a situation where a hospital doctor is not fully aware of medical concerns because the patient does not

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[12] If the ultrasound reveals twins, this result may cause a woman to reconsider or at least reflect on an unexpected circumstance. In either case, the ultrasound furthers her health and ability to make a fully informed decision.

wish to disclose that she had an abortion. Relatedly, the ability to obtain any followup care from same doctor furthers a patient's interest in privacy—a significant concern given the social stigma associated with abortion. Moreover, the admitting-privileges requirement furthers the state's interest in preventing crises of substandard care. By entrusting hospitals with an oversight function, the requirement guards against worst-case scenarios.

The notion that abortion doctors will be unable to obtain admitting privileges is a fiction. Some already have them.[13] Even sectarian hospitals, apart from their legal duties, are interested in providing compassionate care to women who need it. Some hospitals may not allow elective or discretionary abortions to be performed on their premises, but even these hospitals have every reason to grant admitting privileges to abortion doctors in order to ensure that women in need receive adequate—as well as compassionate—medical care.

At trial, testimony from a technician who routinely performs ultrasounds on pregnant

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[13] According to the plaintiffs, Planned Parenthood's Milwaukee-Jackson clinic would be able to remain open even if the admitting-privileges requirement went into effect. Thus, at least one abortion doctor at that clinic must have admitting privileges at a nearby hospital. But Affiliated Medical Services' clinic, which will allegedly close for lack of abortion doctors with admitting privileges, is only 1.3 miles away from Planned Parenthood's Milwaukee-Jackson clinic. So any claim that abortion doctors at AMS will be unable to obtain admitting privileges because of recalcitrant local hospitals is all but meritless

women—those who anticipate and look forward to having a baby as well as those who are considering terminating an unwanted pregnancy—would be beneficial. A neutral technician could explain the value an ultrasound provides for women's health in order to further illustrate the oversight benefit of the admitting-privileges requirement.

Wisconsin's admitting-privileges requirement is rationally related to the State's legitimate interests and should not create an undue burden to Wisconsin women's right to abortion. But Wisconsin's failure to include a reasonable time for compliance merited a preliminary injunction. Therefore, I concur in part and concur in the judgment.

Appendix to the Concurrence

Dr. Soleiman Soli in Pennsylvania. *See* Mark Scolforo, *Two Abortion Clinics Closed After Reports*, The Washington Times, Mar. 10, 2011, http://www.washingtontimes.com/news/2011/mar/10/2-abortion-clinics-closed-after-reports/ (two abortion clinics shut down when inspection revealed expired drugs, uncalibrated medical equipment, and untrained personnel; a network of abortion care providers described the clinics as "women exploiters").

Dr. Andrew Rutland in California. *See* C. Perkes, *Abortion Doctor Gives Up License Over Death*, Orange County Register, Jan. 25, 2011, http://www.ocregister.com/articles/rutland-285561-death-license.html (woman died where clinic "was not equipped to handle emergencies" and the abortion doctor "failed to recognize [an allergic] reaction, adequately attempt resuscitation or promptly call 911." The doctor had previously given up his license "after allegations of . . . scaring patients into unnecessary hysterectomies, botching surgeries, lying to patients, falsifying medical records, over-prescribing painkillers and having sex with a patient in his office.").

Dr. Albert Dworkin in Delaware. *See* Steven Ertelt, *Hearing: Delaware Abortionist Helped Kermit Gosnell Avoid Law,* LifeNews, Mar. 16, 2011, http://www.lifenews.com/2011/03/16/hearing-delaware-abortionist-helped-kermit-gosnell-avoid-law/ (doctor complicit in Kermit Gosnell's violations has license suspended).

Dr. James Pendergraft in Florida. *See* Steven Ertelt, *Abortion Practitioner James Pendergraft Loses Florida License a Fourth Time*, LifeNews, Jan. 1, 2009, http://www.lifenews.com/2009/01/01/ state-5339/ (abortion doctor's license suspended for fourth time for entrusting drug administration to unlicensed employee, previous suspensions included a botched abortion that resulted in the unborn child being shoved into the abdominal cavity and requiring that the woman receive a hysterectomy).

The Gentilly Medical Clinic for Women and the Hope Medical Group for Women in Louisiana. *See* Steven Ertelt, *Abortion Business in Louisiana Loses License for Poor Health, Safety Standards*, LifeNews, Jan. 20, 2010, http://www.lifenews.com/ 2010/01/20/state-4743/ (clinic lost license for operating without trained nurse or proper drug license); P. J. Smith, *Louisiana Abortion Clinic Shut Down for Ignoring "Most Basic" Medical Practices*, LifeNews, Sep. 7, 2011, http://www.lifesitenews.com/ news/archive/ldn/2010/sep/10090707 (clinic's operations suspended for failing to observe "the most basic medical practices" including "provid[ing] women a physical examination prior to abortions" or "follow[ing] necessary protocols for the administration of anesthesia and monitoring their clients' vital signs").

Drs. Romeo Ferrer, George Shepard, Leroy Carhart, and Nicola Riley in Maryland. *See*, *respectively*, Steven Ertelt, *Pro-Lifers Want Maryland Practitioner Disciplined, Killed Woman in Botched Abortion*, LifeNews, June 1, 2010, http://www.lifenews.com/2010/06/01/state-5145/ ("Board of Physician's Peer Reviewers concluded the

woman's death resulted from Ferrer's failure to meet the standard of quality care in violation of state law."); Steven Ertelt, *Troubled Abortion Biz Sees Two Practitioners Lose Medical Licenses*, LifeNews, Sept. 3, 2010, http://www.lifenews.com/2010/09/03/state-5416/ (transfer of patient of botched abortion in a rental car to a clinic in another state leads to the discovery, and suspension, of two doctors circumventing state law); *Authorities: Woman Died from Abortion Complications,* June 12, 2013, http://www.usatoday.com/story/news/nation/2013/02/21/woman-late-term-abortion-bled- todeath/1935799/ (Dr. Carhart is under investigation for the death of Jennifer Morbelli, a 29 year-old school teacher who underwent a late-term abortion); The order is available at http://abortiondocs.org/wp-content/uploads/2013/05/ Nicola-Riley-MD-Permanent-Revocation-May-6-2013.pdf (order permanently revoking Dr. Nicola Riley's medical license Maryland after she failed to call for emergency help for a critically injured abortion patient and transported her to the hospital in the backseat of a rental car).

Dr. Steven Brigham in Maryland, New Jersey, and Pennsylvania. *See N.J. Targets Abortion Doctor Steven Brigham's License*, Lehigh Valley Live, Sept. 9, 2010, http://www.lehighvalleylive.com/phillipsburg/index.ssf/2010/09/nj_targets_abortion_doctor_ste.html (New Jersey seeks to take doctor's license after Maryland already took his license for risky interstate abortion scheme).

Dr. Rapin Osathanondh in Massachusetts. *See* Denise Lavoie, *Doctor Gets 6 Months in Abortion Patient Death*, Associated Press, Sep. 14, 2010, http://www.msnbc.msn.com/id/39177186/ns/us_news-crime_and_courts/t/doctor-gets-months-abortion-patientdeath/ (doctor sentenced to six months in jail for involuntary manslaughter because "he failed to monitor [abortion patient] while she was under anesthesia, delayed calling emergency services when her heart stopped, and later lied to try to cover up his actions.").

Dr. Alberto Hodari in Michigan. *See Schuette Files Suit to Close Unlicensed Abortion Clinic*, Office of the Attorney General, State of Michigan, Mar. 29, 2011, http://www.michigan.gov/ag/0,4534,7-164--253426--,00.html (Michigan Attorney General sues to close abortion clinic for failing to comply with health and safety rules applicable to surgical outpatient facilities).

Drs. Salomon Epstein and Robert Hosty in New York. *See* Steven Ertelt, *Practitioner Denies He Botched Legal Abortion That Killed Hispanic Woman*, LifeNews, Mar. 1, 2010, http://www.lifenews.com/2010/03/01/state-4858/ (New York police investigate doctor after 37-year-old patient dies in botched abortion); http://operationrescue.org/pdfs/Hosty%20revocation.pdf (eventually, responsibility for the death Dr. Epstein was investigated for was attributed to another doctor at the clinic, Dr. Hosty, whose license was revoked in this order); Southwestern Women' Options in New Mexico, *see* Jeremy Kryn, *New 911 Call from New Mexico Abortion Clinic Exposes*

Pattern of Emergencies, LifeNews, Oct. 20, 2011, http://www.lifesitenews.com/news/new-911-call-from-new-mexico-abortion-clinic-exposes-pattern-of-emergencies ("A recording of a 911 call . . . highlights the continuing danger [at] an Albuquerque abortion clinic . . . . The call is the eleventh emergency call [from the clinic] in less than two years . . . ." it was transcribed as follows, "'Uh, we have a 31-year-old female who underwent an abortion today. She's continuing to bleed. We need to transfer her to the hospital, please' . . . . 'The bleeding is persistent. It will not stop.'").

Dr. Tami Lynn Holst Thorndike in North Dakota. *See* Denise Burke, *North Dakota Abortionist Practices With Expired License*, Americans United for Life, Nov. 8, 2010, http://www.aul.org/2010/11/north-dakota-abortionist-practices-with- expired-license/ ("[A] North Dakota abortionist is being investigated for practicing with an expired license.").

Drs. Robert E. Hanson Jr., Margaret Kini, Douglas Karpen, Pedro J. Kowalyszyn, Sherwood C. Lynn Jr., Alan Molson, Robert L. Prince, H. Brook Randal, Franz Theard, and William W. West, Jr. of Whole Women' Health in Texas. *See* Steven Ertelt, *Tenth Texas Abortion Practitioner Under State Investigation*, LifeNews, Aug. 24, 2011, http://www.lifenews.com/2011/08/24/ tenth-texas-abortion-practitioner-under-state-investigation/ (abortion center investigated for "illegal dumping of patient records and medical waste").

Dr. Thomas Walter Tucker II in Alabama and Mississippi. *See Abortion Doctor Suspended for Improper Drug Storage*, Orlando Sentinel, Apr. 24, 1994, http://articles.orlandosentinel.com/1994-04-24/news/9404240462_1_abortion-doctor-tucker-licensing (Dr. Tucker lost his medical license for drug-storage violations, and was subsequently found liable for $10 million in a medical malpractice case involving the death of an abortion patient. *See Former Abortion Doctor Ordered to Pay $10 Million*, Sun Herald, Dec. 8, 1996, 1996 WLNR 256209).

Dr. Mi Yong Kim in New York and Virginia. *See* Operation Rescue, *Troubled Virginia Abortion Clinic Puts Bleeding Botched Abortion Patient in Hospital,* LifeSiteNews, Apr. 20, 2012, http://www.lifesitenews.com/news/troubled-virginia-abortion-clinic-puts-bleeding-botched-abortion-patient-in/ (patient put in hospital after abortion at clinic run by a doctor whose license had been surrendered. The surrender order available at http://abortiondocs.org/wp-content/uploads/2012/04/Kim-VA-License-Surrender05182007.pdf.).

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

PLANNED PARENTHOOD OF WISCONSIN, INC., SUSAN PFLEGER, M.D., FREDRIK BROEKHUIZEN, M.D., and MILWAUKEE WOMEN'S MEDICAL SERVICES d/b/a AFFILIATED MEDICAL SERVICES,

Plaintiffs, OPINION & ORDER

v. 13-cv-465-wmc

J.B. VAN HOLLEN, ISMAEL OZANNE, JAMES BARR, MARY JO CAPODICE, D.O., GREG COLLINS, RODNEY A. ERICKSON, M.D., JUDE GENEREAUX, SURESH K. MISRA, M.D., GENE MUSSER, M.D., KENNETH.B. SIMONS, M.D., TIMOTHY SWAN, M.D., SRIDHAR VASUDEVAN, M.D., OGLAND VUCKICH, M.D., TIMOTHY W. WESTLAKE, M.D., RUSSELL YALE, M.D., and DAVE ROSS,

Defendants.

On June 14, 2013, the Wisconsin Legislature passed Section 1 of 2013 Wisconsin Act 37 ("the Act"), which among other things requires physicians

providing abortion services in Wisconsin to have admitting privileges at a hospital within 30 miles of their clinic. Plaintiffs are all providers of abortion services in Wisconsin, who assert that requiring admitting privileges at a local hospital violates the Fourteenth Amendment of the United States Constitution.[1] The court previously issued an order temporarily restraining defendants from enforcing this provision of the Act on July 8, 2013, and after briefing and oral argument, extended that restraining order by way of an interim preliminary injunction on July 17, 2013. (Dkt. ##21, 61, 80.)

With the benefit of additional time to consider the parties' factual submissions and law, the court remains convinced that preliminary relief is warranted. More specifically, applying the two-part test articulated by the United States in *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 846 (1992), the court concludes that (1) defendants are not likely to succeed in demonstrating that the admitting privileges requirement is reasonably related to maternal health; and (2) plaintiffs are likely to succeed in demonstrating that the

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[1] Although not the focus of this opinion, plaintiffs assert two other causes of action. First, plaintiffs claim that the Act violates the nondelegation doctrine because "the state has failed to provide any standards to govern whether admitting privileges should be granted," and "had also empowered the hospitals with the final authority to deny the Plaintiffs the ability to pursue their chosen businesses and occupations." (Pls.' Br. (dkt. #3) 19.) Second, plaintiffs argue that the Act violates plaintiffs' procedural due process rights by preventing physicians and clinics providing abortion services from pursuing their professions and businesses respectively. (*Id.* at 36-37.)

admitting privileges requirement will unduly burden women's access to abortion services in Wisconsin, at least in the near term. Accordingly, the court will grant plaintiffs' motion for preliminary injunction prohibiting defendants' enforcement of the Act's admitting privileges requirement pending a decision on the merits or proof of a material change in circumstances.

FACTS

In its previous order, the court recited plaintiffs' alleged facts and addressed defendants' brief oral responses during the court's hearing on July 8th. After careful consideration of plaintiffs' proposed findings of facts, defendants' written responses, supporting affidavits and other evidence, as well as the parties' representations and concessions at the July 17th preliminary injunction hearing, the following summarizes the factual record as it stands today.

A. The Parties

Plaintiffs consist of two health care clinics -- Planned Parenthood of Wisconsin ("PPW") and Milwaukee Women's Medical Services d/b/a Affiliated Medical Services ("AMS") -- and two physicians who are affiliated with these clinics. Plaintiff Susan Pfleger, M.D., is a licensed Wisconsin physician, board-certified ob-gyn with over twenty years of experience. She performs abortions at PPW's Milwaukee-Jackson center and was scheduled to provide abortions at Appleton North beginning in July. She does not have admitting privileges at a

hospital located within 30 miles of either the Appleton North or Milwaukee-Jackson clinic. Plaintiff Fredrik Broekhuizen, M.D., is the Medical Director of PPW. All plaintiffs sue on their own behalf, as well as on behalf of their patients.

PPW provides comprehensive, outpatient health care services to thousands of women in Wisconsin. PPW currently operates 24 health centers throughout Wisconsin and provides abortion services at three of those centers: (1) Appleton North (where it performs surgical abortions to 13.6 weeks of pregnancy); (2) Milwaukee-Jackson (where it performs surgical abortions to 17 weeks and medication abortions to 9 weeks); and (3) Madison East (where it performs surgical abortions until 18.6 weeks).[2] Last year PPW provided approximately 4,000 abortions. (7/17/13 Hearing Tr. (dkt. #73) 66.) None of PPW's physicians who provide abortions in Appleton currently have admitting privileges at a hospital within thirty miles of the health center.[3]

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[2] All measurements are from the woman's last menstrual period ("LMP").

[3] Defendants contend that two unnamed Appleton-based physicians may have admitting privileges, but do not provide evidence in support. (Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 14.) Instead, defendants cite to declarations stating that Dr. Pfelger had privileges at Aurora Sinai Medical Center in Milwaukee as recently as the end of 2011. While Dr. Pfelger now plans to provide abortions at PPW's Appleton clinic, any past admission to a Milwaukee hospital obviously does not satisfy the Act's 30 mile radius requirement for that clinic. Plaintiffs did acknowledge at the PI hearing that the "majority" of their physicians had admitting privileges at hospitals, just

Two of PPW's physicians who perform approximately half of the abortions in Milwaukee (one of whom is Dr. Pfleger) also do not have local hospital admitting privileges.

AMS provides comprehensive, outpatient health care services, including abortion services, at its clinic in Milwaukee.[4] AMS provides medication abortions to 9 weeks and surgical abortions to 22 weeks (and, infrequently, beyond that time period). AMS provides approximately 3,000 abortions per year. AMS's physicians do not have admitting privileges within 30 miles of its clinic to satisfy the Act's requirements. PPW and AMS provide almost 97% of all abortions in Wisconsin on an annual basis out of their combined four clinics.[5]

Defendants consist of the Attorney General J.B. Van Hollen, the Dane County District Attorney Ismael Ozanne, the Department of Safety and Professional Services Secretary Dave Ross, and the thirteen members of the Wisconsin Medical Board.

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not within a 30-mile radius of a clinic where they are providing abortions. (7/17/13 Hearing Tr. (dkt. #73) 29.)

[4] Until very recently, there were five clinics in Wisconsin where women can obtain abortions -- the four described above and a fifth in Green Bay. That clinic, however, ceased providing abortion services as of August 1, 2013, for reasons unrelated to the Act. (Declaration of Robert K. DeMott, M.D. (dkt. #56).)

[5] Based on aggregate 2011 figures reporting 7,249 abortions, these two entities account for roughly 96.57% performed in state. (Declaration of Laura Ninneman ("Ninneman Decl."), Ex. A (dkt. #47-1) 11, *also available at* http://www.dhs.wisconsin.gov/publications/P4/P45360-11.pdf.)

The court previously granted plaintiffs' unopposed motion to certify a class of 71 elected district attorneys representing each of Wisconsin's counties, with District Attorney Ozanne as the class representative.[6] All defendants are sued in their official capacity.

B. Recent Abortion Statistics in Wisconsin

In 2011, the most recent calendar year for which statistics are available, there were 7,249 reported abortions in Wisconsin, of which Wisconsin residents accounted for 7,019 or 97% and Michigan residents accounts for 144 or roughly 2%. (Ninneman Decl., Ex. A (dkt. #47-1) 11.)[7] The other surrounding states of Iowa, Illinois and Minnesota, account for another 75 combined or roughly 1%. (*Id.*) In 2011, 2,763 abortions were performed on women residing in

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[6] To clarify the record, the court finds that certification of the defendant class is appropriate pursuant to Fed. R. Civ. P. 23(b)(2). All four of the requirements of subsection (a) are met and that the class has "acted or refused to act on grounds that apply generally to the class, so that injunctive relief or corresponding declaratory relief is appropriate." *See* 1 Joseph M. McLaughlin, *McLaughlin on Class Actions* § 4.46 (9th ed. 2012) ("The decisions allowing certification of a defendant class under Rule 23(b)(2) generally involve actions to enjoin a group of local public officials from enforcing a locally administered state statute of similar administrative policies.") (citing cases).

[7] In addition to the abortions performed in-state, Minnesota reports that in 2012, 742 Wisconsin residents obtained abortions in Minnesota. (Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 59 (citing to "Induced Abortions in Minnesota-January-December 2013: Report to the Legislature" (July 2013), *available at* http:www.health.state.mn.us/divs/chs/abrpt/2012abrpt.pdf).)

Milwaukee County and 937 on women residing in Dane County (where Madison is located), which together represents approximately half of the abortions performed in the State. (*Id.* at 23-24.) Nearly 40% of patients at PPW's Milwaukee-Jackson clinic come from counties outside of the Milwaukee area. More than 80% of the patients who obtain abortions in PPW's Appleton health center come from outside Outagamie County, where the health center is located. In 2011, 251 abortions were performed on women residing in Outagamie County, while 373 and 206 were performed on women in surrounding counties Brown and Winnebago respectively. (*Id.* at 23-24.)[8]

C. The Act

Codified at Wis. Stat. § 253.095, the Act provides in pertinent part:

> SECTION 1. 253.095 of the statutes is created to read:
>
> 2253.095 Requirements to perform abortions. (1) Definition. In this section, "abortion" has the meaning given in s. 253.10 (2) (a).[9]

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[8] Exhibit B to Ninneman's declaration is a map showing the three-year annual average number of reported induced abortions by County of Residence, for Wisconsin Residents, from 2009-2011. (Ninneman Decl., Ex. B (dkt. #47-2).)

[9] Abortion is defined as "the use of an instrument, medicine, drug or other substance or device with intent to terminate the pregnancy of a woman known to be pregnant." Wis. Stat. §

(2) Admitting privileges required. **No physician may perform an abortion, as defined in s. 253.10 (2) (a), unless he or she has admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed**.

(3) Penalty. Any person who violates this section shall be required to forfeit not less than $1,000 nor more than $10,000. No penalty may be assessed against the woman upon whom the abortion is performed or induced or attempted to be performed or induced.

(4) Civil remedies. (a) Any of the following individuals may bring a claim for damages, including damages for personal injury and emotional and psychological distress, against a person who performs, or attempts to perform, an abortion in violation of this section:

1. A woman on whom an abortion is performed or attempted.

2. The father of the aborted unborn child or the unborn child that is attempted to be aborted.

3. Any grandparent of the aborted unborn child or the child that is attempted to be aborted.

253.10(2)(a). The definition encompasses the abortions performed by plaintiffs.

> (b) A person who has been awarded damages under par. (a) shall, in addition to any damages awarded under par. (a), be entitled to not less than $1,000 nor more than $10,000 in punitive damages for a violation that satisfies a standard under s. 2895.043 (3).
>
> (c) A conviction under sub. (3) is not a condition precedent to bringing an action, obtaining a judgment, or collecting the judgment under this subsection.
>
> (d) Notwithstanding s. 814.04 (1), a person who recovers damages under par. (a) or (b) may also recover reasonable attorney fees incurred in connection with the action.
>
> (e) A contract is not a defense to an action under this subsection.
>
> (f) Nothing in this subsection limits the common law rights of a person that are not in conflict with sub. (2).

(Emphasis added.) Physicians also face investigation and professional discipline, up to and including potential license revocation, by the Medical Examining Board if they perform an abortion in violation of the Act. Wis. Stat. § 448.02(3); Wis. Admin. Code § MED 10.02(2)(z).

The Act was introduced in the Wisconsin Legislature on June 4, 2013, and opposed by the State's leading medical associations, including the Wisconsin Medical Society, Wisconsin Association of Local Health Departments and Boards, Wisconsin

Academy of Family Physicians, Wisconsin Hospital Association, and the Wisconsin Public Health Association. [10]Devoid of any documentation of a medical need or purpose in Wisconsin, the Governor nevertheless signed the Act on July 5, 2013. The Act took effect on July 7, 2013, but was enjoined by this court the following day on July 8, 2013.

Until the passage of the Act, the State of Wisconsin has not required hospital admitting privileges for any group of physicians performing an outpatient procedure.[11] Surgical abortion is

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[10] Without record support, defendants question whether these medical organizations are "neutral." (Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 9.) Defendants also challenge the independence of a national medical society, the American College of Obstetricians and Gynecologists, based on Dr. Matthew Lee's assertion that ACOG "has become an advocate of unrestricted abortion and its opinions on abortion must be viewed through this lens." (Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 9 (citing Declaration of Matthew Lee, M.D. (dkt. #42) ¶ 16.) Dr. Lee, however, provides no support for his characterization. Defendants also point to Dr. Thorp's declaration, in which he cites to a 1993 statement of the Executive Board of ACOG, reaffirmed in 2011, that "[t]he College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability" as proof of ACOG's bias. (Declaration of John Thorp, Jr., M.D., M.H.S. (dkt. #50) ¶ 39.) In a supplemental declaration, Dr. Laube, a former President of ACOG, stated that "ACOG has never taken the position that all regulation of abortion is inappropriate, in contrast to the American Association of Pro-Life Obstetricians & Gynecologists, of which Dr. Lee is a member, which asserts that women should not be allowed to voluntarily terminate a pregnancy under any circumstance." (Supplemental Declaration of Dr. Laube ("Laube Suppl. Decl.") (dkt. #59) ¶ 8.)

analogous to other gynecological and non-gynecological outpatient surgical procedures.[12] (Declaration of Douglas Laube, M.D. ("Laube Decl.") (dkt. #4) ¶¶ 14-15.) Specifically, a first-trimester

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[11] Defendants purport to dispute this finding of fact, but as support merely direct the court to Wis. Stat. § 50.36(3g)(c), which provides:

> (c) If a hospital grants a psychologist hospital staff privileges or limited hospital staff privileges under par. (b), the psychologist or the hospital shall, prior to or at the time of hospital admission of a patient, identify an appropriate physician with admitting privileges at the hospital who shall be responsible for the medical evaluation and medical management of the patient for the duration of his or her hospitalization.

If anything, this provision cuts against defendants, since it really is requiring that psychologists with staff privileges hand off their patient to hospital medical staff upon admission to be "responsible for the medical evaluation and medical management" of the patient. Indeed, this provision is not unlike a similar provision for nurse midwives. *See* Wis. Admin. Code § SPS 182.03. Regardless, the plain language of the statute does not *require* a psychologist, psychiatrist or other physician to have admitting privileges at a hospital, much less at one within a certain distance of a clinic where an outpatient procedure is performed. In any event, at the July 17, 2013, hearing, defendants effectively conceded that there are no comparable admitting privileges requirements in Wisconsin. (7/17/13 Hearing Tr. (dkt. #73) 54.)

[12] Defendants dispute this fact, pointing to Dr. Anderson's challenge to Dr. Laube's comparison of surgical abortion to a vasectomy, since a vasectomy is performed outside of the abdominal cavity. (Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 78.) Still, defendants do not dispute -- and cannot dispute -- that virtually identical gynecological procedures are performed in an outpatient setting without any admitting privileges requirement.

surgical abortion is nearly identical to a diagnostic dilation and curettage (or D&C) or surgical completion of miscarriage, and a second-trimester abortion is similar to a hysteroscopy, which is a gynecological procedure that uses endocscopy for diagnostic and operative purposes. Both of these procedures can be performed in an outpatient setting by gynecologists without hospital admitting privileges.

D. Barriers in Timely Obtaining Admitting Privileges

There are eight hospitals within 30 miles of the Appleton North clinic and 16 hospitals within 30 miles of the abortion clinics in Milwaukee. By virtue of membership in a hospital's medical staff, admitting privileges allow physicians to admit patients for care in that hospital. In written affidavits, plaintiffs represent that they are working diligently since learning of the Act to review admitting requirements and obtain applications from all potentially relevant hospitals, but are still only in the early stages of what will likely be a months-long application process. During the July 17th PI hearing, plaintiffs represented that at least some of their physicians have already submitted applications for privileges with local hospitals. (7/17/13 Hearing Tr. (dkt. #73) 19.)

Plaintiffs represent, and defendants' declarants generally agree, that the process of applying for privileges and receiving a decision typically takes months. (Declaration of James Anderson, M.D. ("Anderson Decl.") (dkt. #39) ¶ 11 (describing

admitting privileges process as "rigorous," requiring "2-3 months of information gathering and review").) Nevertheless, defendants raise the possibility of "emergency" admitting privileges as an option. (*See* Declaration of Matthew Lee, M.D. ("Lee Decl.") (dkt. #42) ¶ 10).)[13] Plaintiffs respond credibly that such privileges involve emergencies from the hospital's perspective, not from the physician's. (7/17/13 Hearing Tr. (dkt. #73) 20.)[14] Even if a possibility, the Act provides no grace period to allow physicians or clinics providing abortion services reasonable time to obtain the necessary admitting privileges for so-called "emergency" or other reasons, including the health of the patient.

Even if timing were not an issue, plaintiffs further contend that it is (at best) uncertain whether the physicians providing abortion services in Appleton and Milwaukee will be able to obtain the required admitting privileges. Plaintiffs note numerous barriers that typically militate against their being granted such privileges, including (1) the "common practice" of extending privileges only to

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[13] Defendants also cite to a provision of the administrative code in support allowing for "temporary" admitting privileges. (*See* Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 32 (citing Wis. Admin. Code § DHS 124.12 ("Temporary staff privileges may be granted for a limited period if the individual is otherwise properly qualified for membership on the medical staff.").) Unfortunately, there is no indication when these privileges would be granted or under what circumstances.

[14] This understanding appears consistent with state law, which refers to "emergency" staff privileges "during a period of a state of emergency related to public health declared by the governor." Wis. Stat. § 50.36(3d)(a).

physicians who can guarantee a minimum number of hospital admissions each year, (2) residency requirements, (3) requirements that physicians be members of approved practice groups and (4) political, ideological or religious impediments. (*See* Laube Decl. (dkt. #4) ¶¶ 26-33; Christensen Decl. (dkt. #6) ¶ 22; Declaration of Fredrik Broekhuizen, M.D. ("Broekhuizen Decl.") (dkt. #7) ¶ 22).) Specific to a residency requirement, plaintiffs represent that PPW is unable to satisfy *any* residency requirement for its Appleton Clinic because the majority of its physicians travel from elsewhere in Wisconsin to provide care. (Declaration of Teresa A. Huyck ("Huyck Decl.") (dkt. #5) ¶ 21.)[15]

Defendants challenge each of these claimed barriers to obtaining admitting privileges, pointing to declarations of physicians submitted in opposition to plaintiffs' motion for preliminary injunction, largely describing personal experiences at their respective hospitals.[16] As for the minimum

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[15] Whether this barrier is short term (*i.e.,* the clinic is not currently staffed by local physicians) or long term (*i.e.,* the clinic has been unable, despite concerted effort, to find physicians who are willing to reside locally and provide these services) is unclear on the current record.

[16] Both sides criticize the neutrality of the other sides' respective experts before this court. Purely on a paper record, without the benefit of live testimony, the court is not in a position to determine whether these alleged biases undermine the credibility of any expert's testimony, although based on disinterest, qualifications and familiarity with abortion services and hospital care specific to Wisconsin, plaintiffs' experts -- who include representatives of nationally-recognized, credential-issuing medical societies and chairs of relevant

admissions requirement, Dr. Merrill represents that despite "not admitt[ing] a single patient over the past 2-1/2 years" at the four hospitals for which he has privileges, his "privileges are still active and there has been no question of my status at these hospitals." (Declaration of David C. Merrill, M.D., Ph.D. ("Merrill Decl.") (dkt. #46) ¶ 20.) Dr. Lee further averred that at his hospital, Wheaton Franciscan -- St. Joseph, "courtesy" staff appointments may be available for physicians that have "low inpatient usage." (Lee Decl. (dkt. #42) ¶ 11; *see also* Declaration of James G. Linn, M.D. ("Linn Decl.") (dkt. #43) ¶ 12.) Drs. Merrill and Lee also aver that their respective hospitals do not have residency requirements, nor is Dr. Merrill aware of such a requirement at other hospitals. (Merrill Decl. (dkt. #40) at ¶¶ 20, 22; Lee Decl. (dkt. #42) ¶ 11.)

As for the ideological, religious or political barriers, defendants point to the so-called "Church Amendments," 42 U.S.C. §300a-7, which in pertinent part prohibits "discriminat[ion] in the extension of staff or other privileges to any physician or other health care personnel, because he performed or assisted in the performance of a lawful sterilization procedure or abortion." Defendants also point out that one of the plaintiffs, Dr. Broekhuizen, actually has admitting privileges at Columbia -- St. Mary's Hospital, a Catholic institution. (Linn Decl. (dkt. #43) ¶ 13.) Drs. Lee and Merrill both also aver that they are unaware of any "absolute bar at religiously affiliated Wisconsin hospitals against competent

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practice areas at the state's two medical schools -- would appear to have the upper hand.

abortion providers seeking or receiving admitting privileges." (Lee Decl. (dkt. #42) ¶ 13; Merrill Decl. (dkt. #46) ¶ 22.)[17]

E. Impact of Act's Admitting Privileges Requirement on Abortion Services in Wisconsin

Dr. Christensen, a board-certified obstetrician-gynecologist, with nearly forty years of experience performing abortions, and the co-owner of plaintiff AMS, avers that AMS currently has two active physicians, with Dr. Christensen providing occasional medical care when those two physicians are not available. Neither of AMS's two active physicians, nor Dr. Christensen, has admitting privileges within 30 miles of its Milwaukee clinic. Dr. Christensen further represents that if the Act is "not immediately blocked, AMS will have no choice but to discontinue providing abortion care and shut down immediately." (Declaration of Dennis Christensen, M.D. ("Christensen Decl.") (dkt. #6) ¶ 6.) In addition to this direct injury to AMS's staff and owners, Dr. Christensen avers that many women seeking abortions in Wisconsin will face significant burdens and delay, while some may be

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[17] Recently, plaintiffs submitted a motion for leave to file a supplemental declaration, in which plaintiffs' counsel attaches a news article which purports to challenge Dr. Lee's representation that his hospital would not reject a physician's application for admitting privileges solely on the basis that the physician performs abortions. (Suppl. Decl. of Lester Pines, Ex. A (dkt. #78-2).) Defendants oppose the court's consideration of this declaration on hearsay and timeliness grounds. (Defs.' Opp'n (dkt. #79).) The court agrees and does not consider it for purposes of the preliminary injunction motion.

precluded from obtaining abortions altogether, including women who are more than 18.6 weeks pregnant and for whom AMS provides the only outpatient option in Wisconsin.

PPW's President and Chief Executive Officer Teresa A. Huyck represents that all of the doctors providing abortion services in Appleton North and two of its physicians providing services in Milwaukee do not have the necessary admitting privileges under the Act. Huyck further represents that because of the difficulty in obtaining such privileges and/or in recruiting physicians with the necessary privileges, the Act will force PPW to close its Appleton North health center and reduce by roughly one-half abortions performed at its health center in Milwaukee-Jackson.

In response to these proposed facts, defendants purport to "put[] Plaintiffs to their proof," but do not challenge the substance of plaintiffs' assertion that the Act will cause two of four clinics to close and cut the capacity of a third clinic by fifty percent. During the preliminary injunction hearing, defendants similarly did not dispute plaintiffs' assertion that the Act would close down two clinics at least in the short-term, choosing to focus instead on whether these closures and diminished access would constitute an undue burden on women seeking abortions in Wisconsin. (7/17/13 Hearing Tr. (dkt. #73) 58-60.) Defendants also assert that women seeking abortions post-18.6 weeks would still have inpatient options for obtaining an abortion, albeit only for a "severe or lethal fetal anomaly." (Defs.' Resp. to Pls.' PFOFs (dkt. #90) (citing Declaration of

John Thorp, Jr., M.D., M.H.S. ("Thorp Decl.") (dkt. #50) ¶ 42).)

Plaintiffs represent that 60% of PPW's abortion patients are at or below the federal poverty line. (Huyck Decl. (dkt. #5), ¶ 32.)[18] Moreover, the cost and difficulty associated with travel for the two visits to health centers required under current Wisconsin law will be amplified with the closure of the Appleton clinic, given its relative proximity to Northeast Wisconsin and the Upper Peninsula of Michigan. The abortion providers in its Milwaukee-Jackson and Madison health centers are already overburdened and do not have the ability to provide abortions on additional days, thus resulting in wait times, again at least in the near term, that exceed the current two to three weeks for the initial counseling appointment and another one to two weeks for the abortion appointment. Any increase in the wait times poses increased medical risks for women seeking abortions, including losing the medication abortion option for those occurring early in the first trimester or losing the abortion option altogether for those approaching viability.[19]

Defendants also challenge whether the increased travel distance to Madison or Milwaukee will create a substantial burden on women residing in Northern

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[18] For a family of four, the federal poverty line is set at an annual income of $23,550. Poverty Guidelines, *available at* http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines.

[19] Because of the increased travel burdens and delays, Huyck represents that some women will either be forced to carry pregnancies to term or will resort to unsafe options.

Wisconsin or the Upper Peninsula. With the closure of the Appleton clinic, however, defendants acknowledge that certain patients will be required to travel up to an additional 100 miles one way to either Madison or Milwaukee. Keeping in mind that women are required to travel for at least two appointments, defendants calculate that the additional 400 miles translates to an additional 16 gallons of gasoline at an approximate cost of $56. (Defs.' Resp. to Pls.' PFOFS (dkt. #51) ¶ 86.) With certain non-profit organizations providing funding for Wisconsin women seeking abortions, defendants contend that the $56 cost of closure of the Appleton clinic will not substantially burden even poorer women for whom that clinic would have been their closest option. Defendants contend that, at most, the closures will constitute a "severe inconvenience," which is not enough to satisfy *Casey*'s "undue burden" test. (7/17/13 Hearing Tr. (dkt. #73) 59.)

F. Health Risks Associated with Abortions

Among other evidence, plaintiffs offer the declaration of Douglas Laube, M.D, to address the health risks associated with abortion procedures, based on his expertise in obstetrics and gynecology and the provision of abortions services. Dr. Laube has been board-certified in obstetrics and gynecology since 1976 and licensed to practice medicine in Wisconsin since 1993. From 1993 to 2006, Dr. Laube served as the Chairman of the Department of Obstetrics and Gynecology at the University of Wisconsin. He has also served as an officer of the American College of Obstetricians and Gynecologists ("ACOG"), including as its President for 2006-2007.

Dr. Laube opines that the admitting privileges "requirement is medically unjustified and will have serious consequences for women's health in Wisconsin." (Laube Decl. (dkt. #4) ¶ 7.)

In support of this conclusion, Dr. Laube cites studies demonstrating that legal abortion is one of the safest medical procedures in the United States, while the risk of death associated with childbirth is 14 times higher. (Laube Decl. (dkt. #4) ¶ 8.) The risk of death related to abortion overall is less than 0.7 deaths per 100,000 procedures or 0.000007%. (*Id.*) (As a point of comparison, Dr. Laube states that the risk of death from fatal anaphylactic shock following use of penicillin in the United States is 2.0 deaths per 100,000 uses or 0.00002%. (*Id.*)) Nationally, less than 0.3% of women even require hospitalization because of an abortion complication. Because of this low risk, Dr. Laube represents that abortions are regularly performed safely in outpatient settings; indeed, 90% of abortions in the United States are performed on an outpatient basis. (*Id.* at ¶ 9.)

Defendants challenge these statistics, asserting that "[t]he data associated with medical reports regarding abortions is imprecise and incomplete." (Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 43 (citing Thorp Decl. (dkt. #50) ¶¶ 14-19).) Dr. Thorp posits that the complication rates range from 2-10%, but fails to cite to any studies in support of his estimate. (Thorp Decl. (dkt. #50) ¶ 20.) Dr. Merrill similarly fails to site to *any* studies, but estimates that the risk of a woman experiencing complications from an

abortion that requires hospitalization to be 0.3 to 0.5%. (Merrill Decl. (dkt. #46) ¶ 13.)[20]

State reporting records suggest that the risks are even lower. In 2011, there were 25 complications out of the 7,250 abortions completed in Wisconsin, which represents a total 0.35% complication rate, without any information as to what portion of those reported 25 complications actually required hospitalizations. (Ninneman Decl., Ex. A (dkt. #47-1) 15.) Plaintiffs' own hospitalization rates are also lower than those cited by Dr. Laube. (Pls.' PFOFs (dkt. #17) ¶ 49 (citing Broekhuizen Decl. (dkt. #7) ¶ 11 (describing PPW's Milwaukee-Jackson hospitalization rate over the last two calendar years at 0.22% and reporting no hospitalizations at Appleton North over the same period); Christiansen Decl. (dkt. #14) ¶ 14 (stating that AMS has transferred two patients per year on average for the last eight years, which represents a hospitalization rate of less than 0.1% in 2012 based on 3,000 patients).)

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[20] While Merrill's estimate is in line with Laube's, both the declarations of Dr. Thorp and Dr. Merrill stand in stark contrast to the detailed statistics referenced in Dr. Laube's declaration. (Laube Decl. (dkt. #4) nn.1, 3 & 4).) Even crediting defendants' general assertion that abortion complications are "underreported" (*see* Anderson Decl. (dkt. #39) ¶ 25; Merrill Decl. (dkt. #46) ¶ 13), defendants offer no evidence suggesting that hospitalization as a result of abortion complications substantially exceeds the 0.3% cited in Dr. Laube's declaration. Likely for this reason, defendants rely on the 0.3% to 0.5% range for hospitalization rates in calculating their estimate that a woman is hospitalized for abortion complications every 16 to 21 days in Wisconsin. (Defs.' Opp'n (dkt. #38) 4.)

G. Role of Admitting Privileges

In the rare situations requiring hospitalization, Dr. Laube further avers that "whether the abortion provider has admitting privileges at that hospital is completely irrelevant to providing optimal care." (Laube Decl. (dkt. #4) ¶ 17.) As Dr. Laube explains, the abortion provider can contact the ob/gyn at that hospital, who can admit the patient if necessary. To ensure continuity of care, Drs. Broekhuizen and Christiansen both stated in their respective declarations that plaintiffs' physicians would alert the ER and provide as much information as necessary to the on-call physicians.

ACOG guidelines recognize that clinics performing abortions should have arrangements in place for transferring patients who require emergency treatment, but explicitly reject the notion that physicians performing abortions need to have admitting privileges at a hospital. (Laube Decl. (dkt. #4) at ¶ 25.) Such a requirement also runs counter to the current hospital care model, which increasingly relies on dedicated staff physicians or "hospitalists," including an on-call ob-gyn, rather than the outdated model that relies on physicians who provide outpatient care with hospital privileges. (*Id.* at ¶ 26.) Dr. Laube explains that under the modern model, "more and more highly qualified and proficient outpatient providers must hand off the care of their patients experiencing complications at the hospital

door. This is not patient abandonment, but the way that good medicine is practiced today." (*Id.* at ¶ 33.)[21]

Dr. Laube's view is consistent with that of Dr. Stephen W. Hargarten, who is board certified in emergency medicine and Chairman of the Department of Emergency Medicine College of Wisconsin in Milwaukee since 199. Dr. Hargarten provided a rebuttal declaration in which he describes emergency medicine in Wisconsin, and specifically describes the routine "hand off" of patient care from other physicians who do not have admitting privileges at his hospital and the routine involvement of an on-call ob-gyn if the circumstances require. (Declaration of Stephen W. Hargarten, MD, MPH ("Hargarten Decl.") (dkt. #54) ¶¶ 2, 8, 10-11.)

In response, defendants now posit several reasons for the requirement, which fall into three broad categories: (1) credentialing, (2) continuity of care, and (3) accountability / peer review. *First*,

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[21] In his supplemental declaration, Dr. Laube also points out that

> [a]bandoning a patient would violate MEB 10.02(2)(j) because it would be a "practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public." If those physicians who perform abortions were 'abandoning' their patients, with the scrutiny under which abortion clinics operate in this state, surely there would have been a substantiated finding by the Medical Examining Board ("MEB") regarding such conduct. I am unaware that there has ever been such a finding by the MEB.

(Laube Suppl. Decl. (dkt. #59) ¶ 12.)

defendants contend that admitting privileges serve a "regulatory" or "credentialing" function. (Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 40 (noting Dr. Linn's statement that privileges perform a "regulatory function and ensure high standards" and Dr. Anderson's statement that "credentialing is a 'time-proven method to ensure that those doing life-impacting surgical procedures are qualified to do so").) Any interest in ensuring the quality of physicians performing abortions is not furthered by the Act's requirement that admitting privileges be at a hospital within a 30-mile radius of where the abortion is performed.[22] Indeed, defendants acknowledge that the majority of physician providers of abortions have privileges at *some* hospital within Wisconsin, just not within the required 30-mile radius.

If the Act's real purpose was to improve the quality of physicians providing abortion services, it could have been addressed directly through board certification, training, and licensing requirements, not indirectly through an admitting privileges requirement, especially where there is a demonstrated, substantial variation in the

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[22] Defendants cite to the Eighth Circuit's decision in *Women's Health Ctr. of W. County, Inc. v. Webster*, 871 F.2d 1377 (8th Cir. 1989), in support for their argument that the admitting privileges requirement advances maternal health. In that case, however, the admitting privileges requirement had *no* geographical restriction, making the link between the requirement and credentialing was more tenable.

requirements necessary for such privileges among hospitals across the state.[23]

Second, defendants argue that admitting privileges will further continuity of care between the physician and hospital, which is critical in managing complications. However, defendants have so far failed to establish any credible link between admitting privileges at a nearby hospital and furthering continuity of care because of obvious, practical limitations on the likely impact of this requirement, undisputed trends in hospital care away from participation by outside physicians in hospitals, and the utter lack of a similar requirement for *any* other (including substantially more dangerous) outpatient medical procedures advocated by a hospital, medical group or medical society, much less adopted by the Wisconsin Legislature. (7/17/13 Hearing Tr. (dkt. #73) 69-70.)

As an initial matter, the rate of complications is very low and the rate of those complications requiring hospitalization is even lower. (*See* discussion *infra* Facts Part F.) The record in this case to date establishes extremely low hospitalization rates arising out of abortion

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[23] By this observation, the court does not mean to suggest the State must adopt the least restrictive or even the most direct means to a legitimate end, but rather that the Legislature's roundabout approach makes the defendants' articulated rationale more suspect. To the extent the Legislature actually intended to delegate quality control of abortion providers to the varied, changing standards at hundreds of hospitals around the state, plaintiffs' challenge to the Act based on the nondelegation doctrine would also gain substantial traction.

procedures, especially when considered relative to other outpatient procedures, whether gynecological or unrelated procedures like colonoscopy.[24] Of those requiring hospitalization after an abortion, up to half of the complications will not present themselves until after the patient is home given the number of complications arising from early-term abortions induced by medication which occur after the patient has left the clinic (Laube Decl. (dkt. #4) ¶ 12) and some portion of the surgical ones which can also present after the procedure. For those patients -- a substantial portion of whom travel out of their home county to obtain abortion services -- it is unlikely that the appropriate location for hospitalization will be anywhere near the clinic where the abortion was performed.

Even for those patients whose complications present at the clinic or who are likely to be within its thirty-mile radius when complications present, it is uncertain at best that the most appropriate hospital will be the one for which an abortion provider has admitting privileges, even taking into consideration that an EMT may consider the physician's or patient's preference for treating hospital in making a decision as to where to take the patient. (*See* Defs.' Resp. to Pls.' PFOFs (dkt. #51) ¶ 56.) If, for example, a physician providing abortion services obtained

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[24] Like abortion procedures, serious complications from a colonoscopy "are uncommon," but roughly on par with abortion. American Society for Gastrointestinal Endoscopy Standards of Practice Committee, Guideline: *Complications of colonoscopy*, 74 GASTROINTESTINAL ENDOSCOPY 745-46 (2011) (overall serious adverse rate was 0.28%, typically due to related polypectomy or use of anesthesia).

admitting privileges at a hospital 29 miles from the abortion clinic, it is unlikely that the EMT would send a patient requiring emergency treatment to *that* hospital if another, suitable hospital was available nearby.

In discussing continuity of care, defendants' experts also express concern about an abortion providers' inability to properly manage emergencies in the absence of an admitting privileges requirement. As defendants point out, Wisconsin law already requires abortion providers to

> [h]ave arrangements with a hospital approved under subch. II of ch. 50, Stats., for admission of patients needing hospital care. Such hospital shall be located sufficiently near the facility used so that the patient could be transferred to and arrive at the hospital within 30 minutes of the time when hospitalization appears necessary.

Wis. Admin. Code § MED 11.04(g). Indeed, this requirement is consistent with ACOG's recommendation that physicians providing abortion services should have arrangements in place for transferring patients who require emergency treatment.[25]

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[25] Defendants cite to two Fourth Circuit cases, *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000), and *Greenville Women's Clinic v. Comm'r, S. Car. Dep't of Health & Envtl. Control*, 317 F.3d 357 (4th Cir. 2002), in support of their argument that the admitting privileges requirement furthers maternal health. The pertinent regulation at issue in those

Telling, the Act in question does not require that the physician who provided abortion services actually accompany his or her patient to the hospital, provide treatment of the patient at the hospital, or in any way facilitate the hand-off of the patient to emergency doctors or other specialists. On the other hand, without admitting privileges, abortion providers in Wisconsin are free to accompany patients to the hospital, communicate with the emergency physicians, and ensure that the patient is properly handed-off. Indeed, as previously discussed, taking steps to ensure continuity of care between clinicians and hospitals is already the expected practice in Wisconsin generally.

In addition to these practical limitations, the admitting privileges requirement also runs counter to current hospital practices in Wisconsin, which seek dedicated staff physicians or hospitalists to provide inpatient care. Defendants' declarants mention the importance of communication between the abortion provider, emergency room physicians and specialists treating patients with complications, but fail to explain adequately how admitting privileges will aid in communication or the effective hand-off of patients dealing with complications. As

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cases required that "[s]taff at abortion clinics must have admitting privileges at a local hospital *or* have documented arrangements for emergency transfer to a hospital," 222 F.3d at 161 (emphasis added). The South Carolina regulation ultimately upheld by the Fourth Circuit is, therefore, not only substantially in line with ACOG's standards, but also more clearly tied to the purpose of insuring emergency care for women seeking abortion services while leaving more flexibility for those providing services to comply.

explained in Dr. Hargarten's declaration in support of plaintiffs' motion for preliminary injunction, emergency room physicians are trained to address complications arising from an abortion and will involve on-call specialists when needed. Moreover, while other states may have a shortage of ob-gyns at hospitals, Dr. Hargarten is not aware of any shortage of this specialty in Wisconsin.

Most telling of all is defendants' inability -- despite repeated opportunities and prompting by this court -- to provide a single example of the recognized importance of local admitting privileges for *any* other clinical or outpatient procedure than abortion anywhere in Wisconsin, and not just by a governmental entity, but by any medical group or society. (7/17/13 Hearing Tr. (dkt. #73) 69-70.) The reason for this would appear obvious: were a procedure sufficiently dangerous as to require, or even have a substantial risk of, hospitalization, it would likely be performed in a hospital. The fact that procedures demonstrably more dangerous (by a factor of ten or more), including procedures requiring general anesthesia, are performed in outpatient facilities underscores defendants' present failure, and likely inability, to meet their burden of proof that a reasonable relationship exists between admitting privileges and continuity of care.[26]

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[26] The court will await trial on the issue, but the complete absence of an admitting privileges requirement for clinical procedures including for those with greater risk is certainly evidence that Wisconsin Legislature's only *purpose* in its enactment was to restrict the availability of safe, legal abortion in this State, particularly given the lack of any demonstrable

Third, defendants argue that the admitting privileges requirement will ensure accountability through subsequent peer review in cases of mismanaged health care or patient abandonment. The court cannot discount the possibility that if there were a rare, tragic circumstance where a woman's complications from an abortion procedure were not adequately addressed at a hospital, it may be subject to peer review. Still, the hospital would almost certainly review its procedure regardless of the abortion provider's admitting privileges, and while the hospital would not have the sanction of denying continued admitting privileges available to someone lacking them in the first place, should blame be ultimately placed on the provider, the hospital is not without far more effective means to affect a physician's or clinic's ability to conduct a medical practice, including recommending that the State revoke a license to practice medicine.

OPINION

I. Standing

Defendants devote much of their opposition brief challenging plaintiffs' standing to assert the Fourteenth Amendment rights of their patients, whether as physicians who provide women abortions or as organizations that operate facilities where abortion services are provided. The Seventh Circuit has repeatedly ruled otherwise: the standing of physicians and clinics to assert the rights of their

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medical benefit for its requirement either presented to the Legislature or this court.

patients in the abortion context "is not open to question." *Planned Parenthood of Wis. v. Doyle*, 162 F.3d 463, 465 (7th Cir. 1998); *see also Karlin v. Foust*, 188 F.3d 446, 456-57 (7th Cir. 1999) (both citing *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62 (1976)). Whether, as defendants argue, *Hollingsworth v. Perry*, 133 S. Ct. 2652 (2013), or some other development in the law may alter the Seventh Circuit's definitive holdings in *Doyle* and *Karlin* is not for this court to say, but rather for the Seventh Circuit. As explained in the court's TRO opinion and order and the subsequent PI hearing, the court remains satisfied in the meantime that plaintiffs have standing to pursue the constitutional claims of their abortion patients under current law and, in turn, that this court has subject matter jurisdiction over those claims.

II. Motion for Preliminary Injunction

As directed by the Seventh Circuit, this court applies a sliding scale in weighing whether preliminary relief is warranted. *See, e.g., Hoosier Energy Rural Elec. Coop., Inc. v. John Hancock Life Ins. Co.,* 582 F.3d 721, 725 (7th Cir. 2009) ("[T]he more net harm an injunction can prevent, the weaker the plaintiff's claim on the merits can be while still supporting some preliminary relief."); *Girl Scouts of Manitou Council, Inc. v. Girl Scouts of USA, Inc.*, 549 F.3d 1079, 1100 (7th Cir. 2008) ("The more likely it is that [the moving party] will win its case on the merits, the less the balance of harms need weigh in its favor."). To win a preliminary injunction, therefore, "a party must show that it has (1) no adequate remedy at law and will suffer

irreparable harm if a preliminary injunction is denied and (2) some likelihood of success on the merits. If the moving party makes this threshold showing, the court weighs the factors against one another, assessing whether the balance of harms favors the moving party or whether the harm to the nonmoving party or the public is sufficiently weighty that the injunction should be denied." *Am. Civil Liberties Union of Ill. v. Alvarez*, 679 F.3d 583, 589 (7th Cir. 2012) (quoting *Ezell v. City of Chi.*, 651 F.3d 684, 694 (7th Cir. 2011) (internal quotations omitted)). Here, the balance weighs heavily in plaintiffs' favor.

A. Likelihood of Success on the Merits

Plaintiffs raise three constitutional challenges to the Act. In line with its opinion granting plaintiffs' motion for temporary restraining order, the court will focus on plaintiffs' challenge to the Act based on the Fourteenth Amendment rights of the plaintiffs' *patients*, which (in this court's view at least) is the strongest of their claims and justifies a continuing injunction pending a definitive ruling on the merits.

1. Standard of Review

Women have a fundamental liberty interest, protected by the due process clause of the Fourteenth Amendment of the United States Constitution, in obtaining an abortion. *Roe v. Wade*, 410 U.S. 113, 154 (1973); *Planned Parenthood of Se. Penn. v. Casey,* 505 U.S. 833, 846 (1992) (reaffirming the central holding in *Roe v. Wade*). As the United States Supreme Court has repeatedly explained, this

right is not absolute. *Roe*, 410 U.S. at 154; *Casey*, 505 U.S. at 877-78. State interests in maternal health and the protection of fetal life can justify regulations. *Id.* In this lawsuit, the State maintains that the requirement for admitting privileges is "reasonably directed to the preservation of maternal health." (Defs.' Opp'n (dkt. #38) 36-37 (quoting *Casey*, 505 U.S. at 900-01).) See *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 430-31 (1983), *reversed on other grounds Casey*, 505 U.S. at 870; *Doe v. Bolton*, 410 U.S. 179, 195 (1973) (describing the burden as that of the state).[27]

Plaintiffs argue for a heightened standard of review, since the state regulation implicates a fundamental right (Pls.' Br. (dkt. #3) 26 & n.10), but the court finds no basis for applying this standard of review, except perhaps to the extent that the burden falls on the State to demonstrate that the regulation is "reasonably related" to a legitimate state interest. Contrary to defendants' reading of the *Casey* and *Gonzales* decisions, this still makes the court something more than a rubber stamp of any rationale defendants now articulate to explain the

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[27] The court reads *Casey* to require that where a challenged regulation is "designed to foster the health of a woman seeking an abortion," the state's reason for adopting the regulations must similarly be health-related, as compared to regulations that are "designed to persuade the woman to choose childbirth over abortion." *Casey*, 505 U.S. at 878. In briefing and at the preliminary injunction hearing, defendants' counsel conceded that (1) the only state interest at issue here is the health of women seeking abortions in Wisconsin, and (2) it is defendants' burden to prove the admitting privileges requirement is reasonably related to that interest. (7/17/13 Hearing Tr. (dkt. #73) 45, 52, 54.)

Wisconsin Legislature's requirement of admitting privileges at a hospital within 30 miles of outpatient abortions.

Certainly, the Supreme Court appears to have stepped back from requiring a "compelling state interest" to justify any limitation on access to abortion articulated some forty years ago in *Roe v. Wade*, 410 U.S. at 149, 156. How far back remains open to debate. *Roe* itself acknowledged that the government could impose basic health safeguards -- such as requiring that a procedure be performed by a qualified health professional -- as long as no limit is placed on a woman's access to abortion itself. *Id.* at 154. In *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), Justice O'Connor provided the fifth vote for affirmance of a Missouri statute that, among other things, directed physicians to perform fetal viability tests at 20 weeks, concluding in her concurrence that this testing requirement did not impose an "undue burden" on a woman considering an abortion. *Id.* at 530 (O'Connor, J., concurring). With *Casey*, the Supreme Court expressly adopted this new, arguably less rigorous "undue burden" standard, acknowledging the government's latitude to regulate abortion even during the first trimester for reasons of maternal health or fetal viability. 505 U.S. at 875-76. Still, as in *Webster*, the Court declined to overrule *Roe v. Wade*.

In two, more recent 5-4 decisions considering an intact D&E abortion (sometimes referred to as a "partial birth abortion") -- the first striking down a Nebraska law prohibiting the procedure in *Sternberg v. Carhart*, 530 U.S. 914 (2000), in which Justice

Kennedy vigorously dissented, and the second upholding a federal ban adopted after extensive testimony and congressional findings in *Gonzales v. Carhart*, 550 U.S. 124 (2007), in which Justice Kennedy wrote for the majority -- the Court still did not overrule *Roe* (or *Casey* or even *Sternberg*). *Gonzales*, 550 U.S. at 145-46, 157-58. As to the procedure itself, Justice Kennedy noted that prohibited intact D&E abortions "occur in the second trimester" and, in graphic detail, were found by Congress to be "a brutal and inhumane procedure." *Id.* at 134-40, 157. Ultimately, Justice Kennedy found that the question of constitutionality came down to whether the government's unquestioned interest in "potential life" and "protecting the integrity and ethics of the medical profession," *Id.* at 157 (quoting *Casey*, 505 U.S. at 873, and *Washington v. Gluckserg*, 521 U.S. 702, 731 (1997), respectively), outweighed any health risks to women by the prohibition of this procedure. *Id.* at 159.

As Justice Kennedy explained, where the government "has a rational basis to act" and the restriction "does not impose an undue burden," the government "may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interest in regulating the medical profession in order to promote respect for life, including life of the unborn." *Gonzales*, 550 U.S. at 158. The Court in *Gonzales* deferred to Congress's findings that (1) the prohibited method of abortion had a "disturbing similarity to the killing of a newborn infant," and (2) the prohibition would not "impose significant health risks on women" despite the existence of conflicting medical evidence. *Id.* at

158, 162. Accordingly, the burden of the prohibition was held not to be "undue," at least where alternatives are "available to the prohibited procedure that have extremely low rates of medical complications" and are "generally the safest method of abortion during the second trimester." *Id.* at 164.

In reaching this result, the *Gonzales* Court emphasized that it did "not in circumstances here, place dispositive weight on Congress' findings." *Id.* at 165. "The Court retains an independent constitutional duty to review factual findings where constitution rights are at stake." *Id.* As the Seventh Circuit had previously explained, this requires "lower courts to undertake an individualized inquiry into the effects of the regulations challenged . . . , even if those regulations are virtually identical to those upheld in *Casey*." *Karlin v. Foust*, 188 F.3d 446, 484 (7th Cir. 1999). In the end, under the Supreme Court's jurisprudence, a woman's right to an abortion remains fundamental to the point of the fetus's viability, but may be regulated through means related to legitimate state interests, including maternal health, fetal viability and medical integrity and ethics, unless the regulation is unduly burdensome. Accordingly, it remains incumbent on district courts to consider: "(1) whether the . . . requirement was reasonably related to a legitimate state interest and (2) whether the [requirement] had the practical effect of imposing an undue burden." *Karlin*, 188 F.3d at 481.

2. Reasonable Relationship of Admitting Privileges to Maternal Health

In considering whether defendants are likely to succeed in demonstrating a reasonable link between the admitting privileges requirement at issue here and maternal health, this court is bound "to review factual findings where constitutional rights are at stake." *Gonzales*, 550 U.S. at 165. "Uncritical deference" to legislative fact findings is "inappropriate." *Id.* at 166. On the other hand, "[c]onsiderations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends." *Id.*

Here, there are *no* legislative findings. Indeed, while defendants submitted the legislative record in support of their opposition to plaintiffs' motion, the record contains no testimony from a physician or other medical expert about whether, how, or why the admitting privileges requirement would further women's health. (7/17/13 Hearing Tr. (dkt. #73) 42.) On the contrary, the record contains only physicians and medical organizations speaking against the bill. (*See* Affidavit of Jeffrey R. Renk, Ex. A (dkt. #48-1) 1 (noting Appearance against Senate Bill 206 by Dr. Tosha Wetterneck of the Wisconsin Medical Society).)

Defendants are, therefore, left to submit after-the-fact declarations by individual physicians purporting to provide a medical justification for this requirement in the Act. While the court considers this evidence in determining whether the State is

likely to succeed in proving that an absolute requirement of local admitting privileges is reasonably related to maternal health, it obviously falls well short of the detailed record and formal factfinding considered by the Supreme Court in *Gonzales*.

For reasons previously discussed, defendants are unlikely to establish as a matter of fact that there is a reasonable relationship between the admitting privileges requirement and maternal health. Defendants' position may have some merit if they could articulate a *single, actual* instance where a provider's lack of admitting privileges had been a factor in an abortion patient's negative outcome or the ability to properly consider or sanction a responsible provider for such an outcome in Wisconsin. When pressed at the hearing, defendants were unable to even provide an example where an abortion provider's refusal to assist with continuity of care led to further complications. (7/17/13 Hearing Tr. (dkt. #73) 48-49.)[28] All defendants have presented to date are conclusory statements about patient "abandonment" on the part of defendants' experts. As Dr. Laube points out if abandonment were an issue, surely there would be documented findings by the State of Wisconsin Medical Examining Board. (Suppl. Laube Decl. (dkt. #59) ¶

[28] Defendants offered Dr. Linn's examples. (Linn's Decl. (dkt. #43) ¶ 9.) In the first case, the abortion provider failed to take steps to insure a proper transfer of the patient to the hospital's care. In the second case, the provider stayed with the patient through admitting and surgery at the hospital. But in neither case does Dr. Linn opine that the patient's need for hysterectomy was necessarily affected.

12.) At this stage, defendants have failed to present *any* evidence that patient abandonment post-abortion is even a legitimate concern in Wisconsin. On this record, the admitting privileges requirement remains a solution in search of a problem.

Defendants' principal response to this lack of evidence is to point to language in *Gonzales* that state legislatures have "wide discretion in areas where there is medical and scientific uncertainty." (Defs.' Opp'n (dkt. #38) 65 (citing *Gonzales*, 550 U.S. at 163-64); *see also* Defs.' Sur-Reply (dkt. #65) 5-6.) This assumes there is, in fact, a "documented medical disagreement." *Gonzales*, 550 U.S. at 162. The State's submissions to date fail to establish a credible, medical disagreement about the benefit of requiring admitting privileges at a hospital within 30-miles of an abortion procedure, especially in light of the unanimous criticism of this requirement by medical associations, including the American College of Obstetricians and Gynecologists. *See City of Akron*, 462 U.S. at 431 (considering whether the regulation "departs from accepted medical practice"). Moreover, *Gonzales* involved the weighing of medical uncertainty with respect to the potential negative impact on women's health by prohibiting the intact D&E procedure against the state's compelling interests in respecting the life of the unborn and in the integrity and ethics of the medical community. Here, there is no other legitimate state interest or interests at play which would counter-balance any

arguable uncertainty in the medical community as to the medical rationale underlying this regulation.[29]

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[29] In their sur-reply brief, defendants also cite to *A Woman's Choice-East Side Women's Clinic v. Newman*, 305 F.3d 684, 693 (7th Cir. 2002), for the proposition that "it is an abuse of discretion for a district judge to issue a pre-enforcement injunction while the effects of the law (and reasons for those effects) are open to debate." (Defs.' Sur-Reply (dkt. #65) 5.) This case is distinguishable from *A Woman's Choice* for at least two reasons. First, the informed consent provision, including a two-visit requirement, at issue in that case posed certain difficulties in understanding and measuring its impact on women's access to abortion that are not present here. As the Ninth Circuit explained in *Tucson Woman's Clinic v. Eden*, 379 F.3d 531 (9th Cir. 2004),

> [i]n the context of a law purporting to promote fetal life, whatever obstacles that law places in the way of women seeking abortions logically serve the interest the law purports to promote -- fetal life -- because they will prevent some women from obtaining abortions. By contrast, in the context of a law purporting to promote maternal health, a law that is poorly drafted or which is a pretext for anti-abortion regulation can both place obstacles in the way of women seeking abortions *and* fail to serve the purported interest very closely, or at all.

Id. at 540. In other words, in a case challenging a "persuasion" regulation, the plaintiff would need to prove an undue burden separate from the intended effect to decrease the number of women opting for abortions. Such a challenge is not present here. Second, the procedural posture of *A Woman's Choice-East Side Women's Clinic* also distinguishes that case from the present action. In that case, the majority concluded that the district court had erred in finding plaintiff's evidence sufficient to establish undue burden. Here, at this stage in the proceeding, the court need only conclude either that (1) defendants are not likely to succeed in demonstrating the requirement is reasonably related to maternal health *or* (2)

The Supreme Court's caution that abortion providers should be treated the same as other members of the medical community cuts both ways. *Gonzales*, 550 U.S. at 163 ("The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community.") While abortion providers are singled out in certain ways (*e.g.,* reporting and informed consent requirements) *because* of the State's interest in persuading women to carry pregnancies to term or for some other reason unrelated to women's health, where, as here, the only interest at stake is maternal health, the exclusive application of the admitting privileges requirement to abortion providers borders on the irrational. Indeed, as discussed, the claimed connection between the admitting privileges requirement and maternal health is stretched to breaking when one considers other outpatient procedures, both gynecological and nongynecological in nature, that carry the same or even more serious risks and have no admitting privileges requirement.

No one disputes that credentialing of physicians, continuity of care and accountability and peer review of abortion procedures all may further women's health, just as they would for other medical procedures, making them proper areas of regulation by the State. Specifically, each component may better equip physicians to handle complications. But defendants have failed to meet their burden of proof

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plaintiffs are likely to succeed in demonstrating that the regulation poses an undue burden to find preliminary relief appropriate.

by connecting the dots between these components of quality patient care and the admitting privileges requirement. Even under a more lenient standard of review, the "reasonably related" requirement -- that a regulation must be reasonably related to the State's legitimate interest in maternal health -- still has significance particularly in light of the *Gonzales* Court's description of the lower court's role in reviewing factual findings that underlay a regulation impinging on a fundamental constitutional right. Based on the record before the court to date, the court concludes that the State is not likely to succeed in demonstrating that the admitting privileges requirement is reasonably related to maternal health.

3. Undue Burden

Even if defendants could meet their burden of establishing a reasonable relationship between the admitting privilege restriction and maternal health, the court further finds that plaintiffs are likely to succeed in demonstrating that the regulation poses an "undue burden" on women seeking abortion services in Wisconsin because it will have the effect (if not also the purpose) of presenting a "substantial obstacle" to the provision of those services, at least in the near term. *Casey*, 505 U.S. at 878.

As previously discussed, the protection of a woman's fundamental right to an abortion from *undue* burden comes directly from the Supreme Court's decision in *Casey*:

> The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause.

Casey, 505 U.S. at 874.[30]

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[30] *Casey* also delineated the proper focus of an undue burden challenge. In finding a spousal notification provision unconstitutional, the Court explained that "[t]he proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894; *see also Gonzales*, 550 U.S. at 167-68 (plaintiffs must demonstrate that the regulation "would be unconstitutional in a large fraction of *relevant* cases" (emphasis added) (citing *Casey*)); *Karlin*, 188 F.3d at 481 (explaining that the court should focus on the "practical impact of the challenged regulation and whether it will have the likely effect of preventing a significant number of women for whom the regulation is relevant from obtaining abortions"). In so holding, the Court rejected the state's argument that the spousal notification provision at issue could not constitute an undue burden because the statute affects fewer than one percent of women seeking abortions. Here, defendants make a similar argument in asserting that the focus of plaintiffs' challenge should be on all Wisconsin women seeking abortions, since the admitting privileges requirement applies to all abortion providers in the state. *Casey*, however, instructs that the Act "must be judged by reference to those for whom it is an actual rather than irrelevant restriction." 505 U.S. at 895. Here, that would seem to be women seeking abortions who are impacted by the closure of PPW's Appleton clinic and the AMS clinic, and

In order to demonstrate that the admitting privileges requirement creates a substantial obstacle to a woman seeking an abortion in Wisconsin, plaintiffs initially must demonstrate that the Act threatens closure of their respective clinics. As described above in the fact section, plaintiffs have submitted sufficient evidence to demonstrate that at least in the short-term, enforcement of the admitting privileges requirement will close PPW's Appleton clinic and AMS's clinic and will reduce PPW's Milwaukee clinic by half. In light of the record to date, the court finds that if the Act's admitting privileges requirement is enforced, there will be no abortion providers in the State of Wisconsin north of Madison and Milwaukee, at least in the near term, and likely through the expedited trial of this case in November. Plaintiffs have also put forth sufficient evidence to demonstrate that there are longer-term barriers to admitting privileges. Only time will tell whether these barriers are surmountable.

Plaintiffs identify three substantial obstacles to abortion services in Wisconsin imposed by the Act's admitting privilege requirement: (1) geographical limitation on the location of abortion clinics in the state; (2) significant reduction in access to abortions across the state; and (3) the elimination of abortion

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the reduction of capacity of the PPW Milwaukee clinic. The question is what percentage of those women will be *substantially* impacted. Even if the defendants are right that the relevant question is the impact on all women seeking abortions in Wisconsin, plaintiffs have offered sufficient proof to conclude that the impacts on a still significant minority of that population are also likely to be substantial in the near term for reasons explained elsewhere in this opinion.

services after 19 weeks (but still before viability). In response, the State points to the continued availability of abortion services in Madison, Milwaukee and clinics in other states. Appleton is the closest facility for a patient traveling from Northeast and North-Central Wisconsin and the Upper Peninsula of Michigan, which itself could entail a trip of 100 miles or more. While some patients in these areas may find travel to Madison or Milwaukee to be easier and faster than to Appleton (depending on their proximity to major highways and road conditions), adding *another* 100 miles or more to Madison or Milwaukee may well be prohibitive for a substantial fraction of patients currently served by the Appleton location. While defendants focus solely on the additional cost of gasoline associated with up to an *additional* 400 miles of travel (assuming the required minimum of two round-trips before an abortion may be performed in Wisconsin), this math ignores other significant costs -- both tangible and intangible -- associated with this additional distance. Along with gas, there are certainly other tangible costs to consider in reducing geographical access to a substantial portion of Northern Wisconsin and the Upper Peninsula of Michigan including payment for childcare and overnight accommodations and lost earnings. These costs are amplified given that the majority of patients are at or below the federal poverty line.

Then there are the less tangible, increased costs measured by the stress and worry attendant with prolonged trips (and additional delays due to car trouble or weather issues) for women attempting to obtain an abortion without a parent, spouse, or

employer finding out. As District Judge Thompson recently explained in a decision enjoining a similar admitting privileges requirement in Alabama, "that a woman has some conceivable opportunity to exercise her right does not mean that a substantial obstacle to the exercise of that right is not imposed; nor can a serious burden be ignored because some women of means may be able to surmount this obstacle while poorer women . . . cannot." *Planned Parenthood Se., Inc. v. Bentley*, No. 2:13cv405-MHT, 2013 WL 3287109, at *4 (M.D. Ala. June 28, 2013).

Even if women in more remote areas of Wisconsin are able to travel to Madison, Milwaukee or to an out-of-state clinic, the closings and reduction in services overall will likely result in significantly longer wait periods for women throughout the state seeking abortions for some time to come -- pushing women past the nine week period allowed for medication abortions or pushing women completely out of the pre-viability window. Other courts -- including other federal district courts reviewing identical admitting privileges requirements -- have found that the elimination of a substantial portion of abortion providers in a state constitutes a substantial obstacle to a woman's right to seek an abortion. *See, e.g., Okpalobi v. Foster*, 190 F.3d 337, 357 (5th Cir. 1999) (affirming district court's finding that regulation's effect of closing clinics that provided approximately 80% of all abortions in the state constituted an undue burden); *Bentley*, 2013 WL 3287109, at *7 (granting temporary restraining order where admitting privileges requirement would close three of five clinics in the State of Alabama); *Jackson Womens' Health Org. v. Currier*, No.

3:12cv436–DPJ–FKB, 2013 WL 1624365, at *5 (S.D. Miss. Apr. 15, 2013) (granting preliminary injunction after finding an undue burden where state admitting privileges requirement would close the only known abortion provider in Mississippi); *see also Tucson Woman's Clinic v. Eden,* 379 F.3d 531, 541 (9th Cir. 2004) ("A significant increase in the cost of abortion or [decrease in] the supply of abortion providers and clinics can, at some point, constitute a substantial obstacle to a significant number of women choosing an abortion.").[31]

Here, based on the most recent annual statistics, it appears that AMS alone accounts for approximately 41% of abortions performed in Wisconsin.[32] Assuming the number of abortions performed in PPW facilities is evenly split between Madison, Appleton and Milwaukee, the closure of the Appleton facility and the reduction of services at the Milwaukee facility, could further reduce the availability of abortion services in Wisconsin by an

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[31] While the *Casey* Court affirmed the 24-hour waiting period provision in that case, the Court nonetheless noted that it was a "closer question" than the informed consent provision and labeled the district court findings as to the practical effect of at least two visits to a doctor "troubling in some respects." *Casey*, 505 U.S. at 885-86. This language would suggest that at some point delays and increased travel, along with the practical difficulties of increased travel, could cross the line and become an undue burden.

[32] AMS performs approximately 3000 abortions per year; in 2011, there were 7249 abortions reported in Wisconsin.

additional 28%.[33] At least in the near term, this would have the effect of reducing the availability of in-state abortion services by 69%.

Defendants point to cases where courts have found that the closure of an abortion clinic was not an undue burden. (See Defs.' Opp'n (dkt. #38) 47-49.) All involve instances where (1) the clinic or an individual doctor affected by the regulation was one among many, and/or (2) alternative clinics were within a relatively close distance. As a result, these closures represented a relatively small or even no decrease in the availability of abortion services. *See Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595, 598 (6th Cir. 2006) (finding closure of one clinic did not impose an undue burden where other clinics located within 45 to 55 miles); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157, 161 (4th Cir. 2000) (threatening closure of a single provider where other providers located approximately 70 miles away).

Nor is this case like those where courts have simply noted the existence of significant travel distances because of the remote location of a clinic. *See Planned Parenthood, Sioux Falls v. Miller*, 860 F. Supp. 1409, 1414 (D.S.D. 1994) (finding undisputed that "[a]pproximately 17 percent of the total South Dakota women receiving abortions travel 300 miles or more each way"); *Utah Women's Clinic, Inc. v. Leavitt*, 844 F. Supp. 1482, 1491 (D. Utah

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[33] PPW performs approximately 4000 abortions per year. This percentage assumes services will be cut by half based on a complete closure of the Appleton clinic and 50% decrease in the capacity of PPW's Milwaukee clinic.

1994), *rev'd on other grounds*, 75 F.3d 564 (10th Cir. 1995) (noting that women in Alaska have to travel 800 miles to access a clinic). Plaintiffs here are not demanding that a state be compelled to "provide abortion clinics in close proximity to every woman's home." *Leavitt*, 844 F. Supp. at 1491. Rather, plaintiffs have evidence that the state adopted a regulation having the immediate effect of *substantially decreasing* access to abortion services to a significant percentage of women in Wisconsin and the Upper Peninsula of Michigan.

Moreover, the closure of AMS's Milwaukee clinic will mean *no* clinics in Wisconsin providing abortion services to women, at least on an outpatient basis, for still non-viable fetuses past 18.6 weeks LMP. As Dr. Christensen explained in his declaration, "many fetal abnormalities are not diagnosed until 20 weeks LMP or later" and, therefore, women seeking abortion care based on these diagnoses will not have access to an in-state provider if AMS closes. (Christensen Decl. (dkt. #6) ¶ 12.) This would result in a "patchwork system where constitutional rights are available in some states but not others." *Jackson Women's Health Org.*, 2013 WL 1624365 at *5. While defendants would challenge this impact, suggesting that ob/gyns could step in and provide late term, pre-viability coverage in hospitals, the State's own reporting data demonstrates that the provision of abortion services is largely only available from the

named plaintiffs in this lawsuit.[34] At least based on the current record, plaintiffs have established that the closure of AMS's clinic will effectively foreclose abortion services past 18.6 weeks LMP in Wisconsin.

Defendants rightly point out that most, if not all of these impacts, might be avoided if defendants can obtain admitting privileges from a hospital within 30 miles each of the locations where abortions are performed before these closures are required or sufficiently soon to make their reopening a realistic possibility. But there is no dispute that plaintiffs are *not* in compliance with the admitting privileges now. Moreover, the evidence to date makes it seem likely that they will not be for months, if at all, despite efforts to expedite these privileges. In the meantime, it would seem inevitable that there will be a substantial disruption in the timely and orderly provision of abortion services to women in Wisconsin and the Upper Peninsula of Michigan.

At least at the preliminary injunction stage, the court considers these obstacles in access to abortion services and undue burden in light of the dubious benefits to women's health of the admitting privileges restriction in Wisconsin. Even if there were some evidence that the admitting privileges

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[34] Indeed, attempts at increased access to late-term abortion services have met substantial opposition. *See* Judith Davidoff, *Madison Surgery Center will not offer second-trimester abortions*, The Capital Times, Dec. 14, 2010, *available at* http://host.madison.com/news/local/health_med_fit/madison-surgery-center-will-not-offer-second-trimester-abortions/article_8a1e5d32-070c-11e0-be05-001cc4c03286.html (last visited July 30, 2013).

requirement would actually further women's health, any benefit is greatly outweighed by the burdens caused by increased travel, decreased access and, at least for some women, the denial of an in-state option for abortion services.

III. Irreparable Injury, Balance of Harms and Public Interest

As reflected in the immediate section above, there will almost certainly be irreparable harm to those women who will be foreclosed from having an abortion in the near term, either because of the undue burden of additional travel or the late stage of pregnancy, as well as facing *increasing* health risks caused by delay in difficult pregnancies, being forced to consider an unregulated, illegal abortion as an option. Since defendants to date have failed to demonstrate any reasonable relationship between maternal health and imposing this restriction, there is no meaningful counterweight recognized by the United States Supreme Court to justify the Act's immediate enforcement. Given the substantial likelihood of success on the merits and of irreparable harm, the public's interest is best served by imposing a preliminary injunction on enforcement of the admitting privileges requirement until this court can address its merits after trial.

ORDER

IT IS ORDERED that:

1) Plaintiffs' motion for leave to file supplemental declaration (dkt. #78) is DENIED;

2) plaintiffs' motion for preliminary injunction (dkt. #2) is GRANTED; and

3) defendants are enjoined from enforcing the hospital admitting privileges requirement in Section 1 of 2013 Wisconsin Act 37 pending a trial to be held in November 2013.

Entered this 2nd day of August, 2013.

BY THE COURT:

/s/ _____

WILLIAM M. CONLEY
District Judge

APPENDIX C

THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN

PLANNED PARENTHOOD OF WISCONSIN, INC.
302 N. Jackson Street Milwaukee, WI 53202

SUSAN PFLEGER, MD
302 N. Jackson Street Milwaukee, WI 53202

FREDRIK BROEKHUIZEN, MD
302 N. Jackson Street Milwaukee, WI 53202

MILWAUKEE WOMEN'S MEDICAL SERVICES
d/b/a AFFILIATED MEDICAL SERVICES
1428 N. Farwell Avenue Milwaukee, WI 53202

Plaintiffs,

v. Case No.: 13-CV-465

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Attorney General of Wisconsin, in his official capacity
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Madison, WI 53702

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District Attorney for Dane County,
in his official capacity and as representative of a class of all District Attorneys in the State of

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DAVE ROSS,
Secretary of the Department of Safety and Professional Services, in his official capacity
55 N. Dickinson St., Madison, WI 53703

Defendants

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiffs, by and through their undersigned attorneys, bring this Complaint against the above-named Defendants, their employees, agents, and successors in office, and in support thereof allege the following:

PRELIMINARY STATEMENT

1. This action for declaratory and injunctive relief is brought under the U.S. Constitution and 42

U.S.C. § 1983 to challenge the constitutionality of Section 1 of 2013 Wisconsin Act 37 (Senate Bill 206), to be codified at Wis. Stat. § 253.095 ("Act").[1] The Act will unconstitutionally restrict the availability of abortion services in Wisconsin by imposing a medically unnecessary requirement that all physicians who perform abortions have "admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed." Wis. Stat. § 253.095(2). If allowed to take effect, the Act would require Plaintiff Affiliated Medical Services to shut down entirely, and would strip Plaintiff Planned Parenthood of Wisconsin of the ability to provide abortions in Appleton (resulting in the closure of that health center) and severely curtail its ability to provide abortions in Milwaukee. This will make abortion unavailable in Wisconsin after 19 weeks of pregnancy, leave all areas north of Madison without an abortion provider, and severely restrict the availability of abortions in the remainder of the State.

2. The Act was rushed through the Wisconsin Legislature, passing less than 10 days after its introduction on June 4, 2013. The Act, moreover, takes immediate effect on July 8, 2013, even though there is no way for Plaintiffs to obtain the necessary privileges (or even attempt to obtain them) so quickly, in violation of their due process rights under the Fourteenth Amendment. Moreover, by making their ability to provide abortions contingent on their physicians' obtaining admitting privileges at local hospitals, the Act

[1] A copy of the Act is attached hereto as Exhibit A.

unconstitutionally delegates standardless and unreviewable authority to private parties – the hospitals – also in violation of Plaintiffs' due process rights.

3. In violation of the rights of Plaintiffs' patients, moreover, the Act will eliminate all abortions after nineteen weeks of pregnancy, leave the state with no abortion provider north of Madison, and significantly restrict the availability of services elsewhere in the State, with no health benefit. The purpose and effect of the requirement, which is wholly unnecessary and unreasonable, is to impose a substantial obstacle in the path of women seeking abortion prior to viability, in violation of their constitutional right to privacy.

4. The Act imposes sanctions in the form of civil forfeitures as well as potential civil liability on any person who violates it. In addition, if Plaintiff Pfleger or any other physicians continue to provide abortions without complying with the Act, they would jeopardize their medical licenses.

5. The Act threatens irreparable injury to Plaintiffs and their patients. In addition to violating their constitutional rights, the Act will force Plaintiffs to close clinics and eliminate staff and will cause injury to their livelihoods, as well as their ability to pursue their businesses and professions. The requirement, moreover, will threaten the health of Wisconsin women seeking abortions, and deprive women of their constitutionally protected right to obtain a previability abortion. No remedy is available to them at law.

JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction over Plaintiffs' federal claims under 28 U.S.C. § 1331 and 28 U.S.C. §§ 1343(a)(3)-(4).

7. Plaintiffs' action for declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2201 and 2202 and by Rules 57 and 65 of the Federal Rules of Civil Procedure.

8. Venue is proper pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events giving rise to this action occurred in this district, and the Defendants, who are sued in their official capacities, carry out their official duties at offices located in this district.

PARTIES

A. Plaintiffs

9. Plaintiff Planned Parenthood of Wisconsin, Inc. ("PPW") is a Wisconsin non-profit corporation headquartered in Milwaukee, Wisconsin. PPW provides comprehensive reproductive health care, including family planning services, testing and treatment for sexually transmitted infections, cancer screening and treatment, pregnancy testing and all options counseling, at 24 health centers throughout the state. PPW has provided care in Wisconsin since 1935. At three of its health centers – Milwaukee-Jackson, Madison East, and Appleton North – PPW

also provides abortion services. PPW has provided abortions at the Appleton North health center since 1991. PPW sues on its own behalf and on behalf of its staff and patients.

10. Plaintiff Susan Pfleger, MD, is a board-certified medical doctor specializing in obstetrics and gynecology with over 20 years of experience. She provides abortions at PPW's Milwaukee-Jackson health center and is scheduled to begin to provide abortions in Appleton North in July. Plaintiff Pfleger sues on her own behalf and on behalf of her patients.

11. Plaintiff Fredrik Broekhuizen, MD, is a board-certified medical doctor specializing in obstetrics and gynecology. He is the Medical Director of PPW. Plaintiff Broekhuizen sues on his own behalf and on behalf of his patients.

12. Plaintiff Milwaukee Women's Medical Services d/b/a Affiliated Medical Services ("AMS") provides comprehensive, outpatient reproductive health care services, including abortion services, at its clinic in Milwaukee. AMS sues on its own behalf and on behalf of its staff and patients.

B. Defendants

13. J.B. Van Hollen is the Attorney General of the State of Wisconsin. As Attorney General, Defendant Van Hollen has statutory authority to prosecute forfeitures as a special prosecutor when requested by a district attorney (*see* Wis. Stat. § 978.045) and may assert that he has the

independent authority to prosecute forfeiture actions for alleged violations of the Act. He is sued in his official capacity.

14. Ismael Ozanne is the elected District Attorney for Dane County, Wisconsin. As District Attorney, Defendant Ozanne has the authority to prosecute violations of the Act. *See* Wis. Stat. §§ 978.05(1) & (2). He is sued in his official capacity and as a representative of a class of the 71 elected district attorneys representing each of Wisconsin's counties. Forfeiture actions under the Act could be brought in any county. The class is so numerous that joinder of all members as defendants is impracticable. The named defendant Ismael Ozanne, the Dane County District Attorney, will fairly and adequately protect the interests of the class. Certification of a class of district attorneys with Ismael Ozanne as the class representative is therefore warranted.

15. Defendants James Barr, Mary Jo Capodice, DO, Greg Collins, Rodney A. Erickson, MD, Jude Genereaux, Suresh K. Misra, MD, Gene Musser, MD, Kenneth B. Simons, MD, Timothy Swan, MD, Sridhar Vasudevan, MD, Sheldon A. Wasserman, MD, Timothy Westlake, MD, and Russell Yale, MD, are all members of the Medical Examining Board of Wisconsin. The Medical Examining Board has the authority to impose disciplinary sanctions, up to and including medical license revocation, on Wisconsin physicians for unprofessional conduct, which is defined to include violations of state law. *See* Wis. Stat. § 448.02(3); Wis. Admin. Code MED § 10.02(2)(z). The above-

listed defendants are sued in their official capacities as members of the Medical Examining Board.

16. Defendant Dave Ross is the Secretary of the Department of Safety and Professional Services. The Department of Safety and Professional Services has the statutory authority to commence investigations into the conduct of licensed professionals, in particular, physicians, to determine if they have violated any state law, rule, or regulation that governs the practice of medicine. *See* Wis. Stat. § 440.03; *id.* § 448.02. He is sued in his official capacity.

FACTUAL ALLEGATIONS

A. Abortion in Wisconsin

17. Legal abortion is one of the safest procedures in contemporary medical practice. Abortion complications are exceedingly rare: nationwide, less than 0.3% of abortion patients experience a complication that requires hospitalization. Plaintiffs' hospitalization rates are even lower.

18. On information and belief, there are only five clinics in Wisconsin where women can obtain safe abortions. Plaintiff PPW operates three of those health centers, in Appleton, Madison, and Milwaukee. The fourth clinic is AMS's clinic in Milwaukee. The fifth clinic, in Green Bay, will cease to provide abortion services as of August 1, 2013, for reasons unrelated to the Act.

19. Women seek abortions for a variety of reasons, including familial, medical, financial, and personal. Some women have abortions to preserve their life or their health; some because they have become pregnant as a result of rape; and others because they choose not to have biological children. Some women who seek abortions, particularly those who seek them after 18-20 weeks of pregnancy, do so because the fetus has been diagnosed with a medical condition or anomaly.

20. Approximately one in three women in this country will have an abortion by age 45. Most women having abortions (61%) already have at least one child, and 66% plan to have children when they are older, financially able to provide necessities for them, and/or in a supportive relationship with a partner so their children will have two parents.

21. Even though abortion is extremely safe, Plaintiffs are prepared to provide high quality care in the rare event of complications. In fact, most complications related to abortion are safely and appropriately managed in the clinic setting.

22. In the exceedingly rare event that a patient needs to be transferred via ambulance from one of the health centers to a hospital, the EMTs who take charge of the patient will transport her to the closest hospital, at their discretion. Consistent with the recognized standard of care and to ensure continuity of care, Plaintiffs' physicians will communicate with the emergency room physician and/or the on-call ob-gyn at the hospital where the patient is received, and those hospital physicians

will involve other physicians at the hospital as is necessary and appropriate.

23. Complications from abortion are not only rare, but the few complications that do occur may not present until after a patient has left the clinic. Plaintiffs provide their patients upon discharge with phone numbers to call if they experience complications or have concerns at any time, day or night, after they have left the clinic. In most cases, the patients' concerns or complications can be addressed over the phone by a qualified health care professional, or through a return visit to the clinic. In the rare instances where additional or after hours care is required, Plaintiffs' staff will refer the patient to a local emergency room, as is also consistent with the standard of care.

24. More than 80% of the patients who obtain abortions at PPW's Appleton North health center come from outside Outagamie County, where the health center is located; nearly 40% of the abortion patients at PPW's Milwaukee-Jackson health center come from counties outside the Milwaukee area. A significant number of AMS's patients also come from outside the Milwaukee area. In the rare event of a complication that occurs after the patient has left the clinic, the patient will be referred, consistent with the standard of care, to a hospital in her area, rather than a hospital near the clinic, making it completely irrelevant whether the abortion provider has admitting privileges at a hospital close to the clinic.

25. In contemporary medical practice, there is an increasing divide between inpatient and outpatient medicine, with inpatient care handled more and more often by physicians who regularly or even exclusively provide care in hospital settings. In the exceedingly rare event of an abortion complication that requires hospitalization, the physician who provides the abortion may not in fact be the appropriate physician to manage the patient's care in the hospital.

26. Requiring abortion providers to have hospital admitting privileges, therefore, does not increase patient safety and is medically unnecessary.

B. The Act and Its Impact

27. Despite the lack of medical necessity for an abortion provider to have admitting privileges near the clinic, the Act was rushed through the legislature, and, on July 5, 2013, Governor Walker signed it into law. The Act will take effect on July 8, 2013.

28. The Act provides that no physician may perform an abortion "unless he or she has admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed." Wis. Stat. § 253.095(2). "Abortion" is defined as "the use of an instrument, medicine, drug or other substance or device with intent to terminate the pregnancy of a woman known to be pregnant," *id.* § 253.10(2)(a), which encompasses the abortions that Plaintiffs perform.

29. Any "person" who violates the Act is subject to civil forfeiture penalties of between $1,000 and $10,000. *Id.* § 253.095(3).

30. Plaintiffs could also be subject to civil suits for damages for "personal injury and emotional and psychological distress" as a result of performing or attempting to perform an abortion in violation of the Act. *Id.* § 253.095(4). The Act provides that such suits may be brought by a "woman on whom an abortion is performed or attempted," the "father of the aborted unborn child or the unborn child that is attempted to be aborted," or "any grandparent of the aborted unborn child or the child that is attempted to be aborted." *Id.*

31. If Plaintiffs Pfleger or Broekhuizen fail to comply with the Act and Wisconsin Administrative Code MED § 10.02(2)(z) (and Wis. Stat. § 448.02(3)), they face investigation by the Department of Safety and Professional Services, which conducts investigations of and issues complaints against physicians suspected of violating Wisconsin's statutes and administrative rules related to the practice of medicine, and may be subjected to professional discipline thereafter by the Medical Examining Board, up to and including license revocation.

32. The Act was opposed by the leading medical associations, including the Wisconsin Medical Society, Wisconsin Association of Local Health Departments and Boards, Wisconsin Academy of Family Physicians, Wisconsin Hospital

Association, and the Wisconsin Public Health Association.

33. None of the physicians who provides abortions at PPW's Appleton North health center has admitting privileges at a hospital within 30 miles of the health center. Two of the physicians who provide abortions at PPW's Milwaukee-Jackson health center, including Plaintiff Pfleger, also do not have admitting privileges at a hospital within 30 miles of that health center; these two physicians provide approximately half of the abortions at that health center. The physicians who perform abortions for Plaintiff AMS also lack privileges within 30 miles of AMS's clinic.

34. Although Plaintiffs have worked diligently since they learned of the Act to attempt to obtain applications and bylaws from the potentially relevant hospitals, they have not been able to obtain those materials from every hospital, nor have they had the time to consider whether they can meet the various hospitals' requirements or assess where they should submit applications. While Plaintiffs' physicians, including Plaintiff Pfleger, have begun the process of submitting applications, they do not have enough time to complete this process, nor to allow the hospitals to consider and decide those applications before the Act takes effect. The process of applying for privileges and receiving a decision from a hospital on such an application can and generally does take months.

35. It is not yet clear whether Plaintiffs' physicians who do not currently have privileges that

meet the Act's requirements will eventually be able to obtain them. It is common for hospitals to grant privileges only to physicians who can guarantee at least a minimum number of hospital admissions each year (meaning a certain number of their patients will *require* hospitalization), and/or who reside and/or practice near the hospital, so that they can provide on-call coverage for their fellow staff-physicians and otherwise participate as a member of the hospital staff. Such a requirement relating to number of hospital admissions each year would be impossible for Plaintiffs' physicians to satisfy, because abortion is a very safe procedure and complications requiring hospitalization are extremely rare. And in the case of PPW's physicians providing abortions in Appleton, it would be impossible to satisfy a residency requirement, as PPW's physicians travel from elsewhere in Wisconsin to provide care in this under-served area.

36. Some hospitals also require physicians applying for privileges to submit one or more letters of reference from a physician in the same specialty who already has privileges at that hospital and/or to identify a physician who already has privileges at that hospital who will provide back-up care if necessary. These requirements are also difficult, if not impossible, for Plaintiffs' physicians to satisfy because they may not have relationships with doctors in the same specialties at the relevant hospitals, and even if they did, they likely will be unable to identify any physicians willing to publicly support their applications because of their fear of being harassed by anti-abortion activists and fear for their physical safety.

37. Additionally, some hospitals, for political, ideological, or religious reasons, may be unwilling to grant admitting privileges to physicians whose practice includes providing abortion services.

38. If the Act takes effect, Plaintiff AMS will shut down entirely. Plaintiff Planned Parenthood of Wisconsin will be unable to provide abortions in Appleton (resulting in the closure of that health center) and will be required to severely curtail abortions in Milwaukee. The Act, therefore, will make abortion unavailable in Wisconsin after 19 weeks of pregnancy, leave all areas north of Madison without an abortion provider, and severely restrict the availability of abortions in the remainder of the State.

39. After the closures of AMS and Appleton North (as well as the Green Bay provider on August 1), only two abortion clinics will remain – PPW's Milwaukee-Jackson (operating on a reduced schedule) and Madison East health centers.

40. If the Act is allowed to go into effect, these two remaining health centers will have difficulty managing the increased volume of patients. Patients trying to access services at those health centers would experience very significant scheduling delays: up to two or three weeks, or longer, to schedule the initial counseling appointment, and another one to two weeks more for the abortion procedure.

41. If they can schedule an appointment at one of the remaining centers, women who would

have obtained an abortion at PPW's Appleton North health center would be forced to travel a significant distance – some more than 200 miles roundtrip – and they will need to make that trip twice because of a state law requirement that requires two trips (the first for counseling and then a second visit, at least 24 hours later, for the abortion) to obtain an abortion in the state.

42. Wisconsin does not require other similarly-situated health care providers to have admitting privileges at a local hospital. Physicians perform similar outpatient procedures in their offices without admitting privileges. Nor are physicians who provide services at ambulatory surgery centers, in which more complicated and riskier procedures are regularly performed, required to have them.

C. Irreparable Injury

43. Plaintiffs and their patients will suffer irreparable harm from the violation of their constitutional rights if the Act goes into effect.

44. The Act will force Plaintiffs to close health centers and eliminate staff positions, and will prevent them from providing comprehensive reproductive health care to their patients, with resulting loss of patients and patient trust. Plaintiff Pfleger will suffer loss of income and injury to her ability to practice her profession and provide comprehensive health care to her patients.

45. The Act will jeopardize women's health, shutting down health centers that provide abortions

without medical justification, and severely limiting the availability of abortions in the state.

46. Women will lose access in Wisconsin to safe abortion after 19 weeks of pregnancy. In some cases, due to significant delays in scheduling an abortion because of the reduced availability of abortion in the state, women who are earlier in their pregnancies will also be unable to obtain abortions; even those who can be seen in time will still face significant and possibly dangerous delays. For still other women, the additional travel required to the remaining providers will increase the costs and delay the abortion. Although abortion is one of the safest surgical procedures, the risk of complications (as well as the cost of the procedure) increases as the pregnancy advances. Given that many of Plaintiffs' patients are low-income, the increased costs alone will make it impossible for some women to obtain an abortion.

47. The Act will therefore irreparably harm Plaintiffs' patients in two ways: threatening the health of women seeking abortions, and depriving women of their constitutionally protected right to obtain a pre-viability abortion.

CLAIMS FOR RELIEF

COUNT I
(Procedural Due Process)

48. The allegations of paragraphs 1 through 47 are incorporated as though fully set forth herein.

49. The Act violates Plaintiffs' rights not to be deprived of liberty and property without due process of law in violation of the Fourteenth Amendment to the U.S. Constitution.

COUNT II
(Due Process – Non-Delegation)

50. The allegations of paragraphs 1 through 47 are incorporated as though fully set forth herein.

51. The Act violates the rights of Plaintiffs to due process under the Fourteenth Amendment to the U.S. Constitution. It makes Plaintiffs' ability to maintain their businesses and pursue their chosen professions contingent on physicians' obtaining admitting privileges at local hospitals, and thereby unconstitutionally delegates standardless and unreviewable authority to private parties.

COUNT III
(Substantive Due Process – Right to Privacy)

52. The allegations of paragraphs 1 through 47 are incorporated as though fully set forth herein.

53. The Act violates Plaintiffs' patients' right to liberty and privacy as guaranteed by the due process clause of the Fourteenth Amendment to the U.S. Constitution. It is an unreasonable health regulation, and it has the unlawful purpose and effect of imposing an undue burden on women's right to choose abortion.

COUNT IV
(Substantive Due Process)

54. The allegations of paragraphs 1 through 47 are incorporated as though fully set forth herein.

55. The Act violates Plaintiffs' due process rights by requiring them to comply with the Act's admitting privileges requirement, which is not rationally related to any legitimate state interest.

COUNT V
(Equal Protection)

56. The allegations of paragraphs 1 through 47 are incorporated as though fully set forth herein.

57. The Act violates equal protection by treating Plaintiffs differently from other similarly situated health care providers without a sufficient state interest.

WHEREFORE, Plaintiffs respectfully request that the Court:

1. declare Section 1 of 2013 Wisconsin Act 37 (Senate Bill 206), to be codified at Wis. Stat. § 253.095, unconstitutional under the Fourteenth Amendment to the United States Constitution;

2. without bond, enjoin Defendants, their employees, agents, and successors in office from enforcing Wis. Stat. § 253.095;

3. award Plaintiffs costs and attorneys' fees pursuant to 42 U.S.C. § 1988; and

4. grant Plaintiffs such other, further, and different relief as the Court may deem just and proper.

Respectfully submitted this 5th day of July 2013.

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**motion for admission pro hac vice forthcoming*

EXHIBIT A TO COMPLAINT

State of Wisconsin

2013 Senate Bill 206
Date of enactment: **July 5, 2013**
Date of publication*: **July 6, 2013**

2013 WISCONSIN ACT 37
An Act ***to repeal*** 253.10 (3) (c) 1. g.; ***to amend*** 253.10 (3) (c) (intro.), 253.10 (3) (c) 5., 253.10 (3) (d) 1., 253.10 (3m) (a) (intro.), 253.10 (5) and 253.10 (6) (b); and ***to create*** 253.095, 253.10 (3) (c) 1. gm., 253.10 (3) (em), 253.10 (3g), 253.10 (6) (am) and 253.10 (6) (dm) of the statutes; **relating to:** requirements to perform abortions, requiring an

*Section 991.11, Wisconsin Statutes: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication."

ultrasound before informed consent for an abortion, and providing a penalty.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

Section 1. 253.095 of the statutes is created to read:

253.095 Requirements to perform abortions.

(1) Definition. In this section, "abortion" has the meaning given in s. 253.10 (2) (a).

(2) Admitting privileges required. No physician may perform an abortion, as defined in s. 253.10 (2) (a), unless he or she has admitting privileges in a hospital within 30 miles of the location where the abortion is to be performed.

(3) Penalty. Any person who violates this section shall be required to forfeit not less than $1,000 nor more than $10,000. No penalty may be assessed against the woman upon whom the abortion is performed or induced or attempted to be performed or induced.

(4) Civil remedies. (a) Any of the following individuals may bring a claim for damages, including damages for personal injury and emotional and psychological distress, against a person who performs, or attempts to perform, an abortion in violation of this section:

1. A woman on whom an abortion is performed or attempted.

2. The father of the aborted unborn child or the unborn child that is attempted to be aborted.

3. Any grandparent of the aborted unborn child or the child that is attempted to be aborted.

(b) A person who has been awarded damages under par. (a) shall, in addition to any damages awarded under par. (a), be entitled to not less than $1,000 nor more than $10,000 in punitive damages for a violation that satisfies a standard under s. 895.043 (3).

(c) A conviction under sub. (3) is not a condition precedent to bringing an action, obtaining a judgment, or collecting the judgment under this subsection.

(d) Notwithstanding s. 814.04 (1), a person who recovers damages under par. (a) or (b) may also recover reasonable attorney fees incurred in connection with the action.

(e) A contract is not a defense to an action under this subsection.

(f) Nothing in this subsection limits the common law rights of a person that are not in conflict with sub. (2).

(5) Confidentiality in court proceedings. (a) In every proceeding brought under this section, the court, upon motion or sua sponte, shall rule whether the identity of any woman upon whom an abortion was performed or induced or attempted to be performed or induced shall be kept confidential unless the woman waives confidentiality. If the court determines that a woman's identity should be kept confidential, the court shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to safeguard the woman's identity from public disclosure. If the court issues an order to keep a woman's identity confidential, the court shall provide written findings explaining why the woman's

identity should be kept confidential, why the order is essential to that end, how the order is narrowly tailored to its purpose, and why no reasonable less restrictive alternative exists.

(b) Any person, except for a public official, who brings an action under this section shall do so under a pseudonym unless the person obtains the written consent of the woman upon whom an abortion was performed or induced, or attempted to be performed or induced, in violation of this section.

(c) This section may not be construed to allow the identity of a plaintiff or a witness to be concealed from the defendant.

Section 2. 253.10 (3) (c) (intro.) of the statutes is amended to read:

253.10 **(3)** (c) *Informed consent.* (intro.) Except if a medical emergency exists and subject to sub. (3g), a woman's consent to an abortion is informed only if all of the following first take place:

Section 3. 253.10 (3) (c) 1. g. of the statutes is repealed.

Section 4. 253.10 (3) (c) 1. gm. of the statutes is created to read:

253.10 **(3)** (c) 1. gm. That the pregnant woman is required to obtain an ultrasound that meets the requirements under sub. (3g), if she has not already had an ultrasound that meets those requirements. The physician, or other qualified physician, shall provide to the pregnant woman a list of providers that perform an ultrasound at no cost to the woman, as described in par. (em) 1.

Section 5. 253.10 (3) (c) 5. of the statutes is amended to read:

253.10 **(3)** (c) 5. The woman certifies in writing on a form that the department shall provide, prior to

performance or inducement of the abortion, that the information that is required under subds. 1. and 2. has been provided to her in the manner specified in subd. 3., that the ultrasound required under sub. (3g) has been performed or that requirement is waived under sub. (3m) (a), that she has been offered the information described in par. (d) and that all of her questions, as specified under subd. 4., have been answered in a satisfactory manner. The physician who is to perform or induce the abortion or the qualified person assisting the physician shall write on the certification form the name of the physician who is to perform or induce the abortion. The woman shall indicate on the certification form who provided the information to her and when it was provided and who performed the ultrasound and when it was performed, unless the ultrasound requirement is waived under sub. (3m) (a). If the ultrasound required under sub. (3g) was performed at a facility other than the facility where the physician who is to perform or induce the abortion is located, the woman shall provide to the physician who is to perform or induce the abortion the certification form described under sub. (3g) (d).

Section 6. 253.10 (3) (d) 1. of the statutes is amended to read:

253.10 **(3)** (d) 1. Geographically indexed materials that are designed to inform a woman about public and private agencies, including adoption agencies, and services that are available to provide information on family planning, as defined in s. 253.07 (1) (a), including natural family planning information, to provide ultrasound imaging services, to assist her if she has received a diagnosis that her unborn child has a disability or if her pregnancy is

the result of sexual assault or incest and to assist her through pregnancy, upon childbirth and while the child is dependent. The materials shall include a comprehensive list of the agencies available, a description of the services that they offer and a description of the manner in which they may be contacted, including telephone numbers and addresses, or, at the option of the department, the materials shall include a toll-free, 24-hour telephone number that may be called to obtain an oral listing of available agencies and services in the locality of the caller and a description of the services that the agencies offer and the manner in which they may be contacted. The materials shall provide information on the availability of governmentally funded programs that serve pregnant women and children. Services identified for the woman shall include medical assistance for pregnant women and children under s. 49.47 (4) (am) and 49.471, the availability of family or medical leave under s. 103.10, the Wisconsin works program under ss. 49.141 to 49.161, child care services, child support laws and programs and the credit for expenses for household and dependent care and services necessary for gainful employment under section 21 of the Internal Revenue Code. The materials shall state that it is unlawful to perform an abortion for which consent has been coerced, that any physician who performs or induces an abortion without obtaining the woman's voluntary and informed consent is liable to her for damages in a civil action and is subject to a civil penalty, that the father of a child is liable for assistance in the support of the child, even in instances in which the father has offered to pay for an abortion, and that adoptive parents may pay the

costs of prenatal care, childbirth and neonatal care. The materials shall include information, for a woman whose pregnancy is the result of sexual assault or incest, on legal protections available to the woman and her child if she wishes to oppose establishment of paternity or to terminate the father's parental rights. The materials shall state that fetal ultrasound imaging and auscultation of fetal heart tone services are obtainable by pregnant women who wish to use them and shall describe the services. The materials shall include information on services in the state that are available for victims or individuals at risk of domestic abuse.

Section 7. 253.10 (3) (em) of the statutes is created to read:

253.10 **(3)** (em) *Ultrasound materials and form.* 1. The department shall compile a list of facilities, including the names, addresses, and phone numbers, that provide ultrasounds at no cost. The department shall make this list available to the public and shall provide the list to every facility that performs or induces an abortion.

2. The department shall provide to every facility that performs ultrasounds at no cost a list of the requirements under sub. (3g).

3. Any facility that intends to perform ultrasounds on pregnant women who are seeking to have abortions performed or induced shall create a form on which a physician at that facility certifies that the requirements under sub. (3g) are satisfied and provides a date the requirements under sub. (3g) are satisfied.

Section 8. 253.10 (3g) of the statutes is created to read:

253.10 **(3g)** Performance of ultrasound. (a) Except as provided under sub. (3m) and except in a medical emergency and before a person may perform or induce an abortion on a pregnant woman, the physician who is to perform or induce the abortion, or any physician requested by the pregnant woman, shall do all of the following, or shall arrange for a person who is qualified to perform an ultrasound to do all of the following:

1. Perform an obstetric ultrasound on the pregnant woman using whichever transducer the woman chooses after the options have been explained to her. A facility that offers ultrasounds at no cost to satisfy the requirements of this subsection shall have available transducers to perform both transabdominal and transvaginal ultrasounds.

2. Provide a simultaneous oral explanation to the pregnant woman during the ultrasound of what the ultrasound is depicting, including the presence and location of the unborn child within the uterus, the number of unborn children, and the occurrence of the death of an unborn child, if such a death has occurred.

3. Display the ultrasound images so that the pregnant woman may view them.

4. Provide to the pregnant woman a medical description of the ultrasound images, including the dimensions of the unborn child and a description of any external features and internal organs that are present and viewable on the image.

5. Provide a means for the pregnant woman to visualize any fetal heartbeat, if a heartbeat is detectable by the ultrasound transducer type chosen by the woman under subd. 1., and provide to the

pregnant woman, in a manner understandable to a layperson, a simultaneous oral explanation.

(b) No person may require a pregnant woman to view the ultrasound images that are required to be displayed for and reviewed with her or to visualize any fetal heartbeat. No person, including the pregnant woman, may be subject to any penalty if the pregnant woman declines to view the displayed ultrasound images or to visualize any fetal heartbeat.

(c) The requirement under par. (a) does not apply if the physician, in a writing that is placed in the woman's medical record, certifies that the pregnant woman is undergoing a medical emergency and certifies the medical condition that constitutes the medical emergency.

(d) A physician other than a physician at the facility where the abortion is to be performed or induced may do or arrange for the performance of the activities necessary to satisfy the requirements of this subsection. A physician at a location other than the facility where the abortion is to be performed or induced who does or arranges for the performance of the activities under par. (a) shall certify on a form described under sub. (3) (em) 3. that the requirements of this subsection are satisfied and shall provide the date on which the requirements are satisfied.

(e) No person who has been convicted of a crime under ss. 940.22, 940.225, 948.02, 948.025, or 948.05 to 948.14 may perform any ultrasound that is required under this subsection.

Section 9. 253.10 (3m) (a) (intro.) of the statutes is amended to read:

253.10 **(3m)** (a) (intro.) A woman seeking an abortion may waive the 24-hour period required under sub. (3) (c) 1. (intro.) and L. and 2. (intro.) and may waive all of the requirements under sub. (3g) if all of the following are first done:

Section 10. 253.10 (5) of the statutes is amended to read:

253.10 **(5)** Penalty. Any person who violates sub. (3), (3g) (a), or (3m) (a) 2. or (b) 2. shall be required to forfeit not less than $1,000 nor more than $10,000. No penalty may be assessed against the woman upon whom the abortion is performed or induced or attempted to be performed or induced.

Section 11. 253.10 (6) (am) of the statutes is created to read:

253.10 **(6)** (am) Any of the following individuals may bring a claim for damages, including damages for personal injury and emotional and psychological distress, against a person who attempts to perform or performs an abortion in violation of sub. (3g):

1. A woman on whom an abortion is performed or attempted.

2. The father of the aborted unborn child or the unborn child that is attempted to be aborted.

3. Any grandparent of the aborted unborn child or the unborn child that is attempted to be aborted.

Section 12. 253.10 (6) (b) of the statutes is amended to read:

253.10 **(6)** (b) A person who has been awarded damages under par. (a) or (am) shall, in addition to any damages awarded under par. (a) or (am), be entitled to not less than $1,000 nor more than $10,000 in punitive damages for a violation that satisfies a standard under s. 895.043 (3).

Section 13. 253.10 (6) (dm) of the statutes is created to read:

253.10 **(6)** (dm) A district attorney or the attorney general may institute an action for injunctive relief against any person who performs or attempts to perform an abortion in violation of sub. (3g).