

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION**

PLANNED PARENTHOOD OF GREATER TEXAS §
SURGICAL HEALTH SERVICES, PLANNED §
PARENTHOOD CENTER FOR CHOICE, §
PLANNED PARENTHOOD SEXUAL §
HEALTHCARE SERVICES, PLANNED §
PARENTHOOD WOMEN’S HEALTH CENTER, §
WHOLE WOMAN’S HEALTH, AUSTIN §
WOMEN’S HEALTH CENTER, KILLEEN §
WOMEN’S HEALTH CENTER, §
SOUTHWESTERN WOMEN’S SURGERY §
CENTER, WEST SIDE CLINIC, INC., ROUTH §
STREET WOMEN’S CLINIC, HOUSTON §
WOMEN’S CLINIC, each on behalf of itself, its §
patients and physicians, ALAN BRAID, M.D., §
LAMAR ROBINSON, M.D., PAMELA J. §
RICHTER, D.O., each on behalf of themselves and §
their patients; §

Plaintiffs, §

v. §

GREGORY ABBOTT, Attorney General of Texas; §
DAVID LAKEY, M.D., Commissioner of the Texas §
Department of State Health Services; MARI §
ROBINSON, Executive Director of the Texas §
Medical Board; DAVID ESCAMILLA, County §
Attorney for Travis County; CRAIG WATKINS, §
Criminal District Attorney for Dallas County; §
DEVON ANDERSON, District Attorney for Harris §
County; MATTHEW POWELL, Director of the §
Lubbock County Criminal District Attorney’s Office; §
JAMES E. NICHOLS, County Attorney for Bell §
County; JOE SHANNON, JR., Criminal District §
Attorney for Tarrant County; RENÉ GUERRA, §
Criminal District Attorney for Hidalgo County; §
SUSAN D. REED, Criminal District Attorney for §
Bexar County; ABELINO REYNA, Criminal District §
Attorney for McLennan County; JAIME ESPARZA, §
District Attorney for El Paso County; each in their §
official capacities, as well as their employees, agents, §
and successors, §

Defendants. §

CIVIL ACTION

CASE NO. 1:13-cv-862

**COMPLAINT AND APPLICATION FOR PRELIMINARY AND PERMANENT
INJUNCTION**

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:

I. PRELIMINARY STATEMENT

1. Plaintiffs are Texas health care providers who bring this civil rights action, seeking a declaratory judgment and preliminary and permanent injunctive relief, on behalf of themselves, their physicians, and their patients seeking abortions, under the United States Constitution and 42 U.S.C. § 1983, to challenge portions of Texas House Bill No. 2 (“the Act”),¹ which has the purpose and effect of forcing health centers throughout the state to stop providing abortions. Act of July 18, 2013, 83rd Leg., 2nd C.S., ch. 1, Tex. Gen. Laws. The Act imposes medically unwarranted and burdensome requirements that will dramatically reduce access to abortion in Texas. The Act’s requirements are also unconstitutionally vague and unintelligible. Rather than protecting women’s health, the Act will harm Texas women. It will also violate Plaintiffs’ and their patients’ rights guaranteed by the Fourteenth Amendment to the United States Constitution.

2. The Act requires that all physicians have “active admitting privileges” at a hospital providing obstetrical or gynecological health care services not further than 30 miles from the location at which an abortion is performed or induced (the “admitting privileges requirement”), requires providers to follow the now-outdated medication abortion regimen approved by the U.S.

¹ A copy of the Act is attached hereto as Exhibit 1. The Act adds sections 171.0031, 171.041-048, and 171.061-064 to the Texas Health and Safety Code. The Act amends sections 245.010 and 245.011 of the Texas Health and Safety Code. The Act amends sections 164.052 and 164.055 of the Texas Occupations Code.

Food and Drug Administration in 2000 (the “medication abortion restrictions”), and mandates that “the minimum standards for an abortion facility must be equivalent to the minimum standards . . . for ambulatory surgical centers” (the “ambulatory surgical center requirement”).²

3. The Act was signed by Governor Rick Perry on July 18, 2013. The admitting privileges and medication abortion restrictions take effect October 29, 2013. *See* Act at sec. 12.

4. If the medication abortion restrictions and admitting privileges requirement are allowed to take effect on October 29, more than one-third of the state’s licensed abortion facilities will be forced to stop offering abortions altogether, eliminating services entirely in Fort Worth, Harlingen, Killeen, Lubbock, McAllen, and Waco. Other facilities will be forced to decrease the number of abortions they provide. Many women will be unable to obtain a medication abortion. This will be devastating for Texas women, particularly low-income women, women who are victims of rape or abuse, women who need abortions later in pregnancy, and those who live outside of major metropolitan areas. As a practical matter, women living west of Interstate 35 and East of El Paso will not have real access to abortions. At least 1 in 12 women will have to travel more than 100 miles to obtain abortion care. As a result, some women will be unable to obtain abortion care.

5. These requirements, individually and taken together, violate the constitutional rights guaranteed to both Plaintiffs and their patients by the Fourteenth Amendment to the United States Constitution. Preliminary and permanent injunctive relief is necessary to protect the health of the women of Texas and the constitutional rights of Plaintiffs and their patients.

² The Act’s ambulatory surgical center requirement does not go into effect until September 1, 2014, and the Texas Department of State Health Services, which is required to promulgate regulations implementing the ambulatory surgical center requirement by January 1, 2014, has not yet done so. *See* Act at sec. 11. Plaintiffs, in this action, do not challenge the ambulatory surgical center requirement. Nor do plaintiffs, in this action, challenge that portion of Section 3 of the Act which adds Subchapter C to Chapter 171 of the Texas Health and Safety Code.

II. JURISDICTION AND VENUE

6. Jurisdiction is conferred on this Court by 28 U.S.C. §§ 1331 and 1343(a)(3).

7. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of this Court.

8. Venue is appropriate under 28 U.S.C. § 1391(b)(1) because some Defendants reside in this district.

III. PLAINTIFFS

9. Plaintiff Planned Parenthood of Greater Texas Surgical Health Services ("PP Greater Texas") provides a range of reproductive health care services, including contraception and medication and surgical abortions at licensed abortion facilities in Dallas and Waco, and at licensed ambulatory surgical centers ("ASCs") in Austin and Fort Worth. Some, but not all, of the physicians providing abortions for PP Greater Texas have admitting privileges at hospitals within 30 miles of its facility in Dallas, but none of its physicians have privileges within 30 miles of any of the three other facilities. Thus, if the Act takes effect, PP Greater Texas will be unable to offer abortions in Waco, where it is the only abortion provider, or Austin and Fort Worth, where it is the only provider licensed as an ASC and therefore, the only provider able to provide abortions at 16 weeks of pregnancy or greater. PP Greater Texas provides medication abortions through 63 days gestation, as measured from the first day of the woman's last menstrual period ("LMP"), using an evidence-based protocol different from the one that appears on the Food and Drug Administration ("FDA") final printed labeling ("FPL") for the drug mifepristone. PP Greater Texas sues on its own behalf and on behalf of its patients seeking abortions, and its physicians.

10. Planned Parenthood Center for Choice (“PP Houston”) provides a range of reproductive health care services, including contraception and medication and surgical abortions at a licensed ASC in Houston. PP Houston provides medication abortions through 63 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. Until approximately a month ago, PP Houston offered medication, but not surgical, abortions at its Stafford health center, and it would again but for the Act. PP Houston sues on its own behalf and on behalf of its patients seeking abortions, and its physicians.

11. Planned Parenthood Sexual Healthcare Services (“PP San Antonio”) provides a range of reproductive health care services, including abortions, at three licensed abortion facilities in San Antonio. At one facility, PP San Antonio offers both surgical and medication abortions. At the other two, it offers medication abortion only. If the medication abortion provisions of the Act are allowed to take effect, PP San Antonio will stop providing abortions altogether at those two facilities. PP San Antonio provides medication abortions through 63 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. PP San Antonio sues on its own behalf and on behalf of its patients seeking abortions, and its physicians.

12. Planned Parenthood Women’s Health Center (“PP Lubbock”) provides surgical and medication abortions through 63 days LMP using an evidence-based protocol different from the one on the mifepristone FPL at its licensed abortion facility in Lubbock. PP Lubbock is the only abortion provider in that city. PP Lubbock does not, and cannot, employ a physician with admitting privileges within 30 miles from its health center, and therefore, if the admitting privileges requirement takes effect, abortion services will no longer be available in Lubbock. Even if the admitting privileges requirement were enjoined, the Act’s medication abortion

provisions would force PP Lubbock to cease providing medication abortions. PP Lubbock sues on its own behalf and on behalf of its patients seeking abortions, and its physicians.

13. Plaintiff Whole Woman's Health ("WWH") provides a range of reproductive health care services, including contraception and medication and surgical abortions at its licensed abortion facilities in Austin, Beaumont, Fort Worth, McAllen, and San Antonio, and at its licensed ambulatory surgical center in San Antonio. Some, but not all of the physicians providing abortions for WWH have admitting privileges at hospitals within 30 miles of the locations at which they provide abortions. If the admitting privileges requirement of the Act is allowed to take effect, WWH will stop providing abortions altogether at its Fort Worth, McAllen, and San Antonio facilities. WWH provides medication abortions through 63 days LMP using an evidence-based protocol different from the one on the mifepristone FPL at each of its locations. WWH sues on its own behalf and on behalf of its patients seeking abortions, and its physicians.

14. Plaintiff Austin Women's Health Center ("AWHC") and Killeen Women's Health Center ("KWHC") provide a range of reproductive health services, including medication and surgical abortions at licensed abortion facilities in Austin and Killeen. Neither of the physicians providing abortions at KWHC have admitting privileges at a hospital within 30 miles of KWHC and, therefore, if the Act is allowed to take effect, abortions will no longer be available in Killeen, as KWHC is the only provider there. AWHC and KWHC provide medication abortions through 63 days LMP at each location using an evidence-based protocol different from the one on the mifepristone FPL. AWHC and KWHC sue on their own behalf and on behalf of their patients seeking abortions, and their physicians.

15. Plaintiff Southwestern Women's Surgery Center ("SWSC") provides a range of reproductive health services, including medication and surgical abortions at its ambulatory

surgical center in Dallas. Some, but not all, of the physicians providing abortions for SWSC have admitting privileges at hospitals within 30 miles of the facility. SWSC provides medication abortions through 63 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. SWSC sues on its own behalf and on behalf of its patients seeking abortions, and its physicians.

16. Plaintiff West Side Clinic, Inc. (“West Side”) provides a range of reproductive health services, including medication and surgical abortion services at its licensed abortion facility in Fort Worth. The sole physician providing abortions at West Side does not have privileges at a hospital within 30 miles of the facility, and therefore if the admitting privileges requirement is allowed to take effect, it will stop providing abortions. West Side provides medication abortions through 49 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. West Side sues on its own behalf and on behalf of its patients seeking abortions, and its physician.

17. Plaintiff Routh Street Women’s Clinic (“Routh Street”) provides a range of reproductive health services, including medication and surgical abortions at its licensed abortion facility in Dallas. Only one of the two physicians providing abortions at Routh Street has admitting privileges at a hospital within 30 miles of the facility. If the admitting privileges requirement is allowed to take effect, Routh Street will be forced to provide far fewer abortions than it currently is able to perform. Routh Street provides medication abortions through 49 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. Routh Street sues on its own behalf and on behalf of its patients seeking abortions, and its physicians.

18. Plaintiff Houston Women’s Clinic provides a range of reproductive health services, including medication and surgical abortions at its licensed abortion facility in Houston. Houston

Women's Clinic provides medication abortions through 49 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. Houston Women's Clinic sues on its own behalf and on behalf of its patients seeking abortions, and its physician.

19. Plaintiff Alan Braid, M.D. is a physician licensed to practice medicine in the State of Texas and is board-certified in obstetrics and gynecology. Dr. Braid owns Alamo Women's Reproductive Services, PLLC, a licensed abortion facility in San Antonio where he provides a range of reproductive health services including medication and surgical abortions. Dr. Braid provides medication abortions through 63 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. Dr. Braid sues on his own behalf and on behalf of his patients seeking abortions.

20. Plaintiff Lamar Robinson, M.D. is a physician licensed to practice medicine in the State of Texas with over 28 years of experience in reproductive health care, including abortion. Dr. Robinson provides medication and surgical abortions at his licensed abortion facility in Dallas, Abortion Advantage, and in several other locations in Texas, including at facilities operated by other Plaintiffs. Dr. Robinson does not have admitting privileges at any hospital, and therefore if the admitting privileges requirement takes effect, he will be forced to stop providing abortion care. Dr. Robinson provides medication abortions through 56 or 63 days LMP, depending on the facility, using an evidence-based protocol different from the one on the mifepristone FPL. Dr. Robinson sues on his own behalf and on behalf of his patients seeking abortions.

21. Plaintiff Pamela J. Richter, D.O., is a physician licensed to practice medicine in the State of Texas and has been providing reproductive health care, including abortion, for over 20 years. She is currently providing a range of reproductive health services including surgical and

medication abortions at El Paso Reproductive Services. Dr. Richter does not have admitting privileges at any hospital, and therefore if the admitting privileges requirement takes effect, she will be forced to stop providing abortion care. Dr. Richter provides medication abortions through 66 days LMP using an evidence-based protocol different from the one on the mifepristone FPL. Dr. Richter sues on her own behalf and on behalf of her patients seeking abortions.

IV. DEFENDANTS

22. Defendant Gregory Abbott is the Attorney General of Texas. He is empowered to assist county and district attorneys in the prosecution of misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—in Texas. He is sued in his official capacity and may be served with process at 209 West 14th Street, 8th Floor, Austin, Texas 78701.

23. Defendant David Lakey, M.D., is the Commissioner of the Texas Department of State Health Services (“the Department” or “DSHS”). The Department is generally charged with enforcement of the provisions of Chapter 171 of the Texas Health and Safety Code. Tex. Health & Safety Code § 171.005. Commissioner Lakey is sued in his official capacity, and may be served with process at 1100 West 49th Street, Austin, Texas 78756-3199.

24. Defendant Mari Robinson is the Executive Director of the Texas Medical Board (“the Board”). The Board is empowered to undertake disciplinary proceedings against a physician who violates certain requirements of the Act. *See* Act at sec. 3 (*to be codified at* Tex Health & Safety Code §171.062); *see also* Act at sec. 6 (*to be codified at* Tex. Occ. Code § 164.052(a)). Ms. Robinson is sued in her official capacity, and may be served with process at 333 Guadalupe, Tower 3, Suite 610, Austin, Texas 78701.

25. Defendant David Escamilla is the County Attorney for Travis County. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act

at sec. 2—occurring in Travis County. He is sued in his official capacity, and may be served with process at 314 West 11th Street, Room 300, Austin, Texas 78701.

26. Defendant Craig Watkins is the Criminal District Attorney for Dallas County. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in Dallas County. He is sued in his official capacity, and may be served with process at 133 North Riverfront Boulevard, LB 19, Dallas, Texas 75207.

27. Defendant Devon Anderson is the District Attorney for Harris County. She is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in Harris County. She is sued in her official capacity, and may be served with process at the District Attorney’s Office of Harris County, Criminal Justice Center, 1201 Franklin Street, Houston, Texas 77002.

28. Defendant Matthew Powell is the Director of the Lubbock County Criminal District Attorney’s Office. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in Lubbock County. He is sued in his official capacity, and may be served with process at the Lubbock County Court House, 904 Broadway Street, 2nd Floor, Lubbock, Texas 79408.

29. Defendant James E. Nichols is the County Attorney for Bell County. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in Bell County. He is sued in his official capacity and may be served with process at the Bell County Justice Center, 1201 Huey Road, Belton, Texas 76513.

30. Defendant Joe Shannon, Jr. is the Criminal District Attorney for Tarrant County. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in Tarrant County. He is sued in his official capacity, and may be

served with process at the Tim Curry Criminal Justice Center, 401 West Belknap Street, Fort Worth, Texas 76196-0201.

31. Defendant René Guerra is the Criminal District Attorney for Hidalgo County. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in Hidalgo County. He is sued in his official capacity, and may be served with process at 100 North Closner Blvd., Room 303, Edinburg, Texas 78539-3563.

32. Defendant Susan D. Reed is the Criminal District Attorney for Bexar County. She is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in Bexar County. She is sued in her official capacity, and may be served with process at 101 West Nueva Street, 4th Floor, San Antonio, Texas 78205-3406.

33. Defendant Abelino Reyna is the Criminal District Attorney for McLennan County. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in McLennan County. He is sued in his official capacity, and may be served with process at 219 North 6th Street, Suite 200, Waco, Texas 76701.

34. Defendant Jaime Esparza is the District Attorney for El Paso County. He is responsible for prosecuting misdemeanors—and therefore criminal violations of the Act, *see* Act at sec. 2—occurring in El Paso County. He is sued in his official capacity, and may be served with process at El Paso County Courthouse, 500 East San Antonio Avenue, Room 201, El Paso, Texas 79901-2419.

V. FACTUAL ALLEGATIONS

Challenged Provisions of the Act

35. Section 2 of the Act, described above as the admitting privileges requirement, mandates that a physician performing or inducing an abortion “must, on the date the abortion is

performed or induced, have active admitting privileges at a hospital” that is not further than 30 miles from the location of the abortion and that provides obstetrical or gynecological health care services. Any physician who violates these provisions commits a Class A misdemeanor offense punishable by a fine of up to \$4,000, in addition to being subject to license revocation, and rendering the abortion facility subject to license revocation. *See* Act at sec. 2 (*to be codified at* Tex. Health & Safety Code § 171.0031, Tex. Occ. Code § 164.055(a)); 25 Tex. Admin. Code § 139.32.

36. That portion of Section 3 of the Act which adds Subchapter D to Chapter 171 of the Texas Health and Safety Code, described above as the medication abortion restrictions, provides that a physician cannot “give, sell, dispense, administer, provide, or prescribe an abortion-inducing drug” to a patient unless “the provision, prescription, or administration . . . satisfies the protocol tested and authorized by the United States Food and Drug Administration as outlined in the final printed label of the abortion-inducing drug.” The only exception to the FDA requirement is that a “person may provide, prescribe, or administer the abortion-inducing drug in the dosage amount prescribed by the clinical management guidelines defined by the American Congress of Obstetricians and Gynecologists [(“ACOG”)] Practice Bulletin as those guidelines existed on January 1, 2013.” In addition, this Section of the Act not only mandates that a physician examine the patient before prescribing an “abortion-inducing drug,” but also that only physicians may give, dispense, administer, or provide such a drug to a woman. The physician must also ensure that a follow-up visit is scheduled “to occur not more than 14 days after the administration or use of the drug” at which “the physician must: (1) confirm that the pregnancy is completely terminated; and (2) assess the degree of bleeding.” Any violation of the medication abortion restrictions subjects a physician to administrative and disciplinary penalties, including

possible license revocation. *See* Act at sec. 3 (*to be codified at* Tex. Health & Safety Code § 171.064).

Abortion Background

37. Legal abortion is an incredibly safe medical procedure; it is one of the safest procedures in contemporary medical practice. Major complications from abortion are extremely rare. Abortion through the 21st week of pregnancy is significantly safer than continuing a pregnancy to term and giving birth.

38. Women seek abortions for a variety of medical, psychological, emotional, familial, economic, and personal reasons. Approximately one in three women in the United States 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 for them, and/or in a supportive relationship with a partner so their children will have two parents.

39. The vast majority of abortions in Texas are performed in the first trimester or first 13.6 weeks of pregnancy LMP. Over half of the abortions reported by the Texas Department of State Health Services for Texas residents during each of the years from 2001 through 2008 occurred at eight or fewer weeks LMP and over three-fourths of the procedures were performed at ten weeks LMP or earlier.

40. Abortions may be performed by surgical or medical means. In the United States, women obtaining medication abortions generally receive two prescription drugs: mifepristone and misoprostol. Mifepristone, commonly known as “RU-486” or by its commercial name Mifeprex, works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Under current practice, the patient takes the mifepristone at her health care facility and approximately 24 to 48 hours later at a location of her choosing, she takes a second

medication, misoprostol (known commercially as Cytotec), which causes the uterus to contract and expel its contents, thereby completing the abortion. Used together, these two medications—mifepristone and misoprostol—provide an extremely safe and effective method of abortion. Medication abortions are typically available through 63 days LMP.

41. The other means of abortion is referred to as “surgical,” although this is something of a misnomer because the term “surgical” generally refers to procedures requiring an incision, which “surgical” abortion is not. Surgical abortions are almost always done in an outpatient setting. Surgical abortion procedures are done through insertion of instruments through the vagina and into the uterus. The procedure is short in duration, typically lasting about five to eight minutes for a first trimester abortion.

42. Many physicians in Texas who provide abortions do so at more than one location. In less populous areas, abortion services are often only provided on a limited basis, and a physician is present in the facility only on the days when abortions are performed. These physicians may travel from other locations to provide abortion services.

43. Some physicians maintain other practices in addition to their abortion practice and are available to the abortion facilities they work with only on a limited basis. This results in some facilities utilizing several physicians, each on a part-time basis.

44. It is difficult to recruit physicians to work in abortion facilities because of hostility towards abortion, and because physicians who provide abortions have been the target of protests and violence against themselves and their families. Many physicians who provide abortions therefore cannot live in the same community as the health centers at which they work, for fear of such harassment. As a result, many abortion facilities do not have local physicians willing to

work there and are only able to provide abortion services because physicians living elsewhere are willing and able to travel to the health center.

Existing Regulatory Framework for Abortion in Texas

45. In Texas, abortions are performed primarily in clinics licensed as abortion facilities or licensed ambulatory surgical centers. The clinics that Plaintiffs operate are licensed abortion facilities or ambulatory surgical centers. There are currently approximately thirty-six licensed facilities in Texas that perform approximately 80,000 abortions altogether every year.

46. The provision of abortion services in Texas is subject to extensive regulation. First, a woman must undergo a mandatory state-directed counseling session provided in part by the physician who will perform the procedure at least 24 hours before the abortion. Unless she lives more than 100 miles from any abortion provider, this session must take place in person. *See* Tex. Health & Safety Code § 171.012 *et seq.*

47. The woman must also undergo a mandatory ultrasound, and the physician who is to perform the abortion must show and describe the ultrasound image to the woman. If the woman lives within 100 miles of any abortion provider, she must wait 24 hours after the ultrasound before undergoing the procedure. *Id.* She may waive the 24-hour waiting period by certifying that she lives more than 100 miles from any licensed abortion provider. *Id.*

48. Any facility where ten or more abortions are performed in a month must be licensed as an abortion facility. Tex. Health & Safety Code § 245.003. Licensed abortion facilities are subject to extensive regulations addressing patient care, infection control, personnel, physician qualifications, emergency protocols, recordkeeping, reporting, and physical plant requirements. *See* Tex. Health & Safety Code § 171.001 *et seq.*; 5 Tex. Admin. Code § 139.41 *et seq.* All

abortion facilities are subject to unannounced on-site inspections by the Texas Department of State Health Services at least once per year. 5 Tex. Admin. Code § 139.31.

49. Any abortion where the gestational age is 16 weeks or greater must be performed in an ambulatory surgical center or in a hospital licensed to perform the abortion. Tex. Health & Safety Code § 171.004. Like all ASCs, these facilities are subject to extensive regulations addressing patient care, infection control, personnel, physician qualifications, emergency protocols, recordkeeping, reporting, and physical plant requirements. *See* 25 Tex. Admin. Code § 135.

The Impact of the Admitting Privileges Requirement

50. If allowed to take effect on October 29, the admitting privileges requirement will force over one-third of the state's approximately thirty-six licensed facilities where abortions are performed to stop providing those services, thereby dramatically reducing abortion access throughout the state. It will cause the sole abortion facilities in Lubbock, Waco, Killeen, Harlingen, and McAllen to cease providing abortions and all three providers in Fort Worth to stop, thereby completely eliminating abortion services in those cities and forcing women—especially those in west Texas—to travel enormous distances in order to access abortion services, which will prevent some women from obtaining an abortion. At least 1 in 12 women would have to travel more than 100 miles to obtain abortion care. Even for those facilities that can stay open, not all of their physicians have, or will have privileges as of October 29, meaning that they will be forced to serve more women with fewer providers, which is likely to force women to wait for an abortion, which, in turn, increases the risk of the procedure.

51. The admitting privileges requirement is medically unwarranted because abortion care is so safe that it very rarely requires hospitalization, and even in those rare instances where

hospitalization follows, Plaintiffs' current practices are more than adequate to ensure patient safety and comport with the standard of care for outpatient procedures.

52. Serious complications from abortion are exceedingly rare. Nationwide, less than 0.3% of abortion patients experience a complication that requires hospitalization. In the vast majority of cases, complications can be safely and appropriately managed at the health center.

53. All licensed abortion facilities are already required to have written discharge instructions which they must provide to each patient. Those instructions must contain a list of complications that warrant contacting the facility, and a statement of the facility's plan to respond to the patient in the event of any of the listed complications. The patient also must be able to contact the facility and reach a health care professional on a 24-hour basis by telephone answering machine or service. 25 Tex. Admin. Code § 139.57.

54. Existing regulations of abortion facilities also require that they "have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital," as well as a "working arrangement" with a physician with admitting privileges at a local hospital "to ensure the necessary back up for medical complications." 25 Tex. Admin. Code § 139.56(a). Similarly, ambulatory surgery centers must have written transfer agreements with a hospital to effect immediate transfer of patients, unless all of the physicians performing surgery have admitting privileges at a local hospital. 25 Tex. Admin. Code § 135.4(c)(11)(B).

55. In the unlikely event that a patient experiences a serious complication that requires hospitalization while at Plaintiffs' abortion facilities, Plaintiffs would transfer her by ambulance to a nearby hospital that is accepting patients.

56. If a patient experiences a complication after she has left the facility following a surgical abortion, or during a medication abortion (which would not occur at the health center), and she contacts the provider, in most cases her concerns or complications can be addressed over the telephone by a qualified health care professional, or through a return visit to the health center. In the rare instances where additional or after-hours care is necessary, Plaintiffs will refer the patient to a local emergency room.

57. Whether the abortion provider has admitting privileges at that hospital does not affect the quality of care that the patient receives. Hospital emergency rooms are capable of handling any complications arising from abortion, and will involve an appropriate specialist, such as an obstetrician-gynecologist, if needed. Continuity of care can be maintained by direct telephone communication between the abortion provider and the emergency room physician, but does not require that the abortion provider have admitting privileges. This is standard medical practice and will ensure that the emergency room physician is aware of the extent of the complication, prior treatment, and medication received.

58. Many of Plaintiffs' patients travel substantial distances to receive abortion care at their facilities. If a patient experiences a serious complication when she is not at the facility, the appropriate course of action would be for her to go to the nearest emergency room. For many of these patients, the nearest emergency room would not be one within 30 miles of the abortion facility, rendering it irrelevant whether her physician has admitting privileges at a hospital within 30 miles of the facility.

59. Many physicians providing abortions in Texas, including some physician Plaintiffs and some physicians who work with the provider Plaintiffs, do not have admitting privileges at a hospital within 30 miles of the abortion facility. Whether or not a physician has privileges is

dictated in part by the nature of his or her practice. Physicians who, in addition to providing abortions, also maintain active obstetric or gynecological practices, may frequently utilize hospital services and therefore maintain privileges. Because abortion provision is so safe, however, physicians who primarily perform abortions only rarely have a patient that needs to go to the hospital, and therefore often do not have admitting privileges. In some instances, physicians may have privileges in one location, but not in another location where they travel to perform abortions on a part-time basis.

60. The admitting privileges requirement of the Act effectively gives local hospitals veto power over Plaintiffs' ability to provide abortion care to women in Texas. The physicians applying for privileges cannot control whether any local hospital will grant their applications, and accordingly cannot control whether they are in compliance with the Act. Hospitals in Texas have broad discretion to set the qualifications for their medical staff and in the granting of privileges, and can thereby grant or refuse privileges on the basis of their own rules and regulations. *See* Tex. Health & Safety Code § 241.101. Accordingly, the admitting privileges requirement makes Plaintiffs' ability to provide abortion services subject to the discretion of local hospitals.

61. Hospitals within Texas have varying requirements for privileges. Some require a certain number of patient admissions each year, some require physicians to reside within a certain distance from the hospital, others limit privileges to physicians who are directly employed by or under contract with the hospital, while still others require board certification. These criteria, unrelated to a physician's ability to provide high-quality abortion care, may nonetheless preclude him or her from obtaining privileges.

62. Shortly after the Act was signed into law and in many cases before it was signed, the physician Plaintiffs and the physicians who provide abortions at the provider Plaintiffs who do not have privileges within 30 miles of their facilities began the process of applying for privileges.

63. Prior to submitting an application for privileges, a physician must first request an application, or possibly a “pre-application,” from the hospital, along with a copy of the by-laws or other documents specifying the requirements for privileges.

64. Once an application for privileges is submitted, hospitals in Texas, by law, are granted up to 170 days from receipt of an application to inform a physician about the decision on the application. *See* Tex. Health & Safety Code § 241.101(k).

65. Plaintiffs are undertaking efforts to obtain privileges for themselves and physicians who work at their facilities, but not all of them have been able to secure privileges at this time. Indeed, for some it is unlikely that they will even receive notice as to whether their application is granted until well after the Act takes effect.

66. Compliance with the admitting privileges provision is complicated by the fact that the Act requires “active admitting privileges,” but this term is not defined in the Act. Many hospitals have different levels of medical staff, including “Active” medical staff and Courtesy or Consulting staff, all of whom can admit patients. It is unclear whether the Act requires physicians to become members of a hospital’s “Active” medical staff or rather requires them to have admitting privileges that are “active” in the sense of being current and unexpired. Thus, Plaintiffs cannot be sure if the privileges they have or are seeking to obtain will bring them into compliance with the admitting privileges requirement. Becoming a member of “Active” staff may require a larger minimum number of patient admissions per year, greater involvement with hospital affairs, being a full-time hospital staff member, and in many cases, serving as a

provisional staff member for at least one year, making it burdensome or impossible for many physicians who work at Plaintiffs' facilities to gain "Active" status, and certainly to do so by October 29.

The Impact of the Medication Abortion Restrictions

67. Under current practice, and for the past decade, Texas women with gestational ages through at least 63 days LMP have had the option of choosing between a surgical procedure that takes place in the health center (surgical abortion) or a procedure using medications alone, which can be completed at a private location of the woman's choosing (medication abortion). Both are extremely safe and effective procedures.

68. The Act dramatically restricts women's access to medication abortion. While the Act's medication abortion restrictions are written in an unclear and unintelligible manner, they seem to ban the procedure entirely after 49 days LMP, denying women a safe and effective procedure for no medical reason. For some women with certain medical conditions, the Act's denial of access to medication abortion will significantly threaten their health. For women with gestational ages through 49 days LMP who choose medication abortion, the Act seems to force them to have an outdated, less effective procedure that will have increased side effects. It also greatly increases the cost of the procedure and imposes unnecessary burdens, some of which also pose risks to their health.

69. Women choose medication abortion for a variety of reasons. Many women choose medication abortion because they fear any operation, even surgical abortion, which, as discussed above, does not require an incision. Some women fear or do not wish to undergo even the moderate anesthesia that may be given in conjunction with surgical abortion. Medication abortion, which does not require instruments to be placed in the vagina, may be less traumatic for

victims of rape, or women who have experienced sexual abuse or molestation. Additionally, many women prefer medication abortion because they can complete a medication abortion in the privacy of their homes, with the company of loved ones, and at a time of their choosing. For some women, their provider may offer only medication abortion.

70. In 2000, the U.S. Food and Drug Administration approved the drug mifepristone for use as an abortion-inducing drug in the United States. As part of that approval, as with all medications, the FDA approved a Final Printed Labeling (“FPL”), which is an informational document that provides physicians with guidance about the use for which the drug sponsor requested and received FDA approval. Based on the clinical trials submitted in support of the application for approval, the manufacturer proposed, and the FDA approved, an FPL for mifepristone that reflects the regimen used in those trials, in which the patient takes 600 mg of mifepristone orally, returns to the health center approximately 36 to 48 hours later to take 400 µg of misoprostol orally, and then returns approximately 14 days later for a follow-up visit. Those trials found that regimen to be safe and effective through 49 days LMP, and the FPL, therefore, reflects that gestational age limit.

71. Mifepristone is the only medication that has received FDA approval for marketing as an abortion-inducing drug, and therefore, the only medication with an FPL describing an abortion regimen.

72. It is standard medical practice for physicians to prescribe FDA-approved drugs in dosages and for indications that were not specifically approved or contemplated by the FDA, particularly when supported by adequate study. The FDA has repeatedly acknowledged that use of such evidence-based regimens that vary from an FPL is common and is sometimes required by good medical practice.

73. The FDA has never required that prescribers of mifepristone follow any particular regimen and has never imposed a gestational age limit on its use.

74. By the time that mifepristone was approved in 2000, newer research showed that a lower dose of mifepristone (200 mg instead of 600 mg) combined with a different dose and route of self-administered misoprostol was an equally safe regimen and was effective through at least 63 days LMP. This research also showed that varying the route of misoprostol administration decreased side effects. Based on this research, from the time that mifepristone was approved, the overwhelming majority of abortion providers in the United States offered their patients a regimen different from the one on the FPL through at least 63 days LMP.

75. Today, the regimen most commonly used across the country, including in Texas, involves 200 mg of mifepristone taken orally at the health center followed approximately 24 to 48 hours later by 800 µg of misoprostol which the woman self-administers at home buccally (between her cheek and gum).

76. More than one million American women have now safely used an alternative evidence-based mifepristone regimen to terminate their pregnancies. ACOG, the World Health Organization, and the Royal College of Obstetricians and Gynecologists have all endorsed use of an alternative regimen through 63 days LMP. Medication abortion is also increasingly prevalent, chosen by more women each year.

77. The evidence-based regimens used by Plaintiffs have been shown to be more effective than the FPL regimen, both having a lower rate of ongoing pregnancies and requiring fewer surgical interventions to complete the procedure. The alternative regimens have a number of other advantages. *First*, they are effective for longer in pregnancy, allowing medication abortions to be performed through at least 63 days LMP, which in turn allows many more

women to avail themselves of that method. Those additional weeks are significant because many women do not detect their pregnancies until close to 49 days LMP. *Second*, self-administration of misoprostol eliminates a trip to the health center, allows the woman greater control over the timing of the procedure, and ensures that she experiences the bleeding and cramping that follows in a location of her choosing. *Third*, the lower mifepristone dosage reduces the cost of the procedure significantly. *Fourth*, the alternative regimens have lower incidence of side effects than the regimen that appears on the FPL.

78. The Act allows physicians to follow the regimen set forth in the FPL, but this regimen is outdated and it denies women the benefit of advances in the science of medication abortion that began even prior to the approval of mifepristone by the FDA, and that are described above. Specifically, because the FPL regimen is limited to 49 days LMP, the Act imposes a complete ban on medication abortion after that point, with no exceptions. In addition, under the FPL, women must return to the facility to take the misoprostol, rather than taking it at a location of their choosing one to two days later. Under the FPL, women must take 600 mg of mifepristone, rather than the 200 mg taken under evidence-based protocols. And, under the FPL, women are directed to ingest 400 µg of misoprostol orally, whereas the evidence-based protocols have women take 800 µg buccally or vaginally.

79. The Act is even more restrictive than the FPL because it requires that any “abortion-inducing drug,” as defined in the Act, be given by a physician. *See* Act at sec. 3 (*to be codified at* Tex. Health & Safety Code §§ 171.061(2), 171.063(a)(1)). The FDA has required only that mifepristone be provided under the supervision of the physician and has placed no restrictions on misoprostol. In addition, the Act requires “[t]he physician who gives, sells, dispense, administers, provides, or prescribes the abortion-inducing drug” to do certain things at the

follow-up visit, which must be “not more than 14 days after administration or use of the drug”. *Id.* § 171.063(3). The FPL discusses a follow-up visit, but it does not require that a physician be involved at all.

80. In addition to the FPL regimen, the medication abortion restrictions allow physicians to provide “an abortion-inducing drug in the dosage amount prescribed by the clinic management guidelines defined by the American Congress of Obstetricians and Gynecologists Practice Bulletin as those guidelines existed on January 1, 2013.” *See* Act at sec. 3. However, this provision does not provide adequate guidance as to how to comply with the Act.

81. ACOG’s Practice Bulletin of Clinical Management Guidelines related to Medical Management of Abortion does not “prescribe” any specific “dosage amount,” but does state among its highest level of recommendations that: “Compared with the FDA-approved regimen, mifepristone-misoprostol regimens using 200 mg of mifepristone orally and 800 µg of misoprostol vaginally are associated with a decreased rate of continuing pregnancies, decreased time to expulsion, fewer side effects, improved complete abortion rates, and lower cost for women with pregnancies up to 63 days of gestation based on LMP.” It further states that: “A patient can administer misoprostol safely and effectively, orally or vaginally, in her home as part of a medical abortion regimen.”

82. The ACOG recommendation is not limited to a “dosage amount,” but rather describes a regimen that uses a different route of administration for the misoprostol than the FPL, as well as a different gestational age limit. The language of the Act does not reflect the content of the ACOG Guideline, and as a result, it is not clear which parts of the Guideline a physician can rely on to deviate from the FPL.

83. The Act's ban on medication abortion after 49 days LMP will be particularly dangerous for some women with certain medical conditions who face a greater risk of both complications and failure from a surgical abortion rather than a medication abortion. These women include those who have an anomaly of the reproductive and genital tract, such as large uterine fibroids or cervical stenosis, which makes accessing the pregnancy inside the uterus as part of a surgical abortion difficult or impossible. The Act makes no exception for women with these medical conditions.

84. In addition to prohibiting all medication abortion after 49 days, the Act will make it difficult or impossible for many women seeking medication abortions through 49 days to do so. That is because, under the Act, in order to have a medication abortion, a woman will be required to make four separate trips to an abortion facility over the course of two weeks. Texas law prior to enactment of the Act required that unless she lives more than 100 miles from any abortion provider, the "physician who is to perform the abortion" provide certain information to the woman in person at least 24 hours before the procedure (visit 1). Tex. Health & Safety Code § 171.012. The woman must return at least 24 hours later to take the mifepristone (visit 2) and then two days after that to take the misoprostol (visit 3). Additionally, the Act requires "[t]he physician who gives, sells, dispenses, administers, provides, or prescribes the abortion-inducing drug" to see the woman during a follow-up visit which must be "not more than 14 days after administration or use of the drug" (visit 4). Act sec. 3 (*to be codified at* Tex. Health & Safety Code § 171.063(e)).

85. The Act will increase the required number of visits to an abortion provider, because Texas women who currently choose medication abortion and live within 100 miles of an abortion facility either make three visits (for the mandatory counseling, to take the mifepristone, and for a

follow-up), or only two visits if they have their follow-up at a different location. And if they live more than 100 miles from an abortion provider, they can have a medication abortion with one visit, which under the Act, would become three. Each trip to a facility will require additional travel and time away from home, children, and work, which will be particularly difficult for low-income women, women who live in rural areas, and women who are victims of abuse.

86. The Act will deprive women of the benefits of the newer regimens, and greatly increase both the cost and the burden of a medication abortion. The increased burden and cost will come with no medical benefit and indeed, with some medical harm.

87. Due to the limited availability of physicians who perform abortions in Texas, physicians often provide abortion services at more than one location. In such cases, a physician may be available at a particular abortion facility for only one or two days a week. It will be difficult, and in some cases impossible, to ensure that at these locations the same physician is available for each of the required visits for a medication abortion.

88. Some Texas abortion facilities currently offer only medication abortion. If the Act's restrictions take effect, many of these facilities will cease providing abortions altogether and women who would have gone to those facilities will have to travel elsewhere. Other facilities that offer both surgical and medication abortion will be unable to offer medication abortion due to the onerous requirements Texas has placed on women and providers.

CLAIMS FOR RELIEF

COUNT I

(Patients' Substantive Due Process/Admitting Privileges and Medication Abortion)

89. The allegations of paragraphs 1 through 88 are incorporated as though fully set forth herein.

90. The challenged provisions of Texas House Bill No. 2—the admitting privileges requirement and the medication abortion restrictions—violate Plaintiffs’ patients’ right to liberty and privacy as guaranteed by the Due Process Clause of the Fourteenth Amendment to the United States Constitution, standing alone, together, and in conjunction with burdens imposed by existing Texas law, because they are medically unwarranted health regulations and they impose an undue burden on women seeking abortions.

91. In order to protect the constitutional rights of their patients, Plaintiffs file this suit against Defendants for declaratory judgment and for preliminary and permanent injunctive relief pursuant to 42 U.S.C. § 1983.

COUNT II
(Vagueness/Admitting Privileges)

92. The allegations of paragraphs 1 through 91 are incorporated as though fully set forth herein.

93. The admitting privileges requirement of Texas House Bill No. 2 violates the rights of Plaintiffs under the Due Process Clause of the Fourteenth Amendment to the United States Constitution because in not defining the meaning of “active admitting privileges,” it fails to give Plaintiffs fair notice of the requirements of the Act and leaves them subject to arbitrary and discriminatory enforcement.

94. In order to protect their constitutional rights and those of their physicians and patients, Plaintiffs file this suit against Defendants for declaratory judgment and for preliminary and permanent injunctive relief pursuant to 42 U.S.C. § 1983.

COUNT III
(Procedural Due Process/Admitting Privileges)

95. The allegations of paragraphs 1 through 94 are incorporated as though fully set forth herein.

96. The admitting privileges requirement of Texas House Bill No. 2 violates the right to procedural due process guaranteed to Plaintiffs and their physicians by the Fourteenth Amendment to the United States Constitution because it deprives physicians of a constitutionally adequate opportunity to attempt to comply.

97. In order to protect their constitutional rights and those of their physicians and patients, Plaintiffs file this suit against Defendants for declaratory judgment and for preliminary and permanent injunctive relief pursuant to 42 U.S.C. § 1983.

COUNT IV
(Substantive Due Process – Unlawful Delegation/Admitting Privileges)

98. The allegations of paragraphs 1 through 97 are incorporated as though fully set forth herein.

99. The admitting privileges requirement of Texas House Bill No. 2 violates rights secured to Plaintiffs, their physicians, and patients, under the Fourteenth Amendment to the United States Constitution. The admitting privileges requirement makes Plaintiffs' physicians' ability to perform abortions contingent on obtaining privileges at local hospitals, and thereby unconstitutionally allows a private entity to set criteria that physicians must meet in order to provide an abortion.

100. In order to protect their constitutional rights and those of their physicians and patients, Plaintiffs file this suit against Defendants for declaratory judgment and for both preliminary and permanent injunctive relief pursuant to 42 U.S.C. § 1983.

COUNT V
(Vagueness/Medication Abortion)

101. The allegations of paragraphs 1 through 100 are incorporated as though fully set forth herein.

102. The medication abortion restrictions of Texas House Bill No. 2 violate the rights of Plaintiffs under the Due Process Clause of the Fourteenth Amendment to the United States Constitution because the Act's reference to "the dosage amount prescribed by the clinic management guidelines defined by the American Congress of Obstetricians and Gynecologists Practice Bulletin as those guidelines existed on January 1, 2013," fails to give Plaintiffs fair notice of the requirements of the Act and subjects them to arbitrary and discriminatory enforcement.

103. In order to protect their constitutional rights and those of their physicians and patients, Plaintiffs file this suit against Defendants for declaratory judgment and for both preliminary and permanent injunctive relief pursuant to 42 U.S.C. § 1983.

REQUEST FOR RELIEF

Plaintiffs respectfully request that this Court:

A. Issue a declaratory judgment that the admitting privileges requirement and the medication abortion restrictions of Texas House Bill No. 2 are unconstitutional and unenforceable;

B. Issue preliminary and permanent injunctive relief restraining Defendants, and their employees, agents, and successors in office from enforcing the admitting privileges requirement and the medication abortion restrictions of Texas House Bill No. 2;

- C. Grant Plaintiffs attorneys' fees, costs and expenses pursuant to 42 U.S.C. § 1988; and/or
- D. Grant such other and further relief as this Court may deem just, proper, and equitable.

Dated: September 27, 2013

Respectfully submitted,

/s/R. James George, Jr.

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*Application for admission *pro hac vice* forthcoming

**Application for admission to the Western District of Texas pending

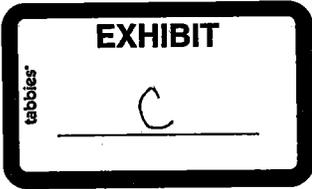
IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

PLANNED PARENTHOOD OF GREATER TEXAS)	
SURGICAL HEALTH SERVICES, and on behalf of)	
its patients and physicians, <i>et al.</i> ,)	
)	
Plaintiffs,)	CIVIL ACTION
v.)	
)	CASE NO. 1:13-cv-862
GREGORY ABBOTT, Attorney General of Texas, in)	
his official capacity, <i>et al.</i> ,)	
)	
Defendants.)	

DECLARATION OF ANDREA FERRIGNO

Andrea Ferrigno declares and states the following:

1. I am the Corporate Vice President of Whole Woman’s Health (“WWH”), where I have worked since January 2004.
2. Whole Woman’s Health provides a range of reproductive health care services, including contraception and medication and surgical abortions at its licensed abortion facilities in Austin, Beaumont, Fort Worth, and McAllen, and at its licensed abortion facility and licensed ambulatory surgical center in San Antonio.
3. I am familiar with the requirements of Texas House Bill No. 2 and specifically the requirements that all physicians who perform an abortion “have active admitting privileges at a hospital that . . . is located not further than 30 miles from the location at which the abortion is performed or induced [] and provides obstetrical or gynecological health care services” (the “admitting privileges requirement”) and that “abortion-inducing drugs” may only be given, dispensed, provided, and administered by a physician in a way that “satisfies the protocol tested and authorized by the United States Food and Drug Administration as outlined in the final



printed label of the abortion-inducing drug” and/or “in the dosage amount prescribed by the clinical management guidelines defined by the American Congress of Obstetricians and Gynecologists Practice Bulletin as those guidelines existed on January 1, 2013” (the “medication abortion restrictions”).

4. I provide this declaration in support of Plaintiffs’ Motion for a Preliminary Injunction against enforcement of Texas House Bill No. 2’s admitting privileges requirement and medication abortion restrictions.

5. My primary job responsibility at Whole Woman’s Health is to ensure compliance with all regulations relating to the provision of abortion and other services provided by WWH. I work closely with the Director of Medical Services to ensure that WWH meets performance standards. I also help to manage the San Antonio ambulatory surgical center, and am responsible for the recruitment of physicians to work at WWH’s clinics in Texas.

6. In addition to my regular job responsibilities, I am now taking primary responsibility for ensuring compliance with the admitting privileges requirement, including identifying appropriate hospitals and preparing and submitting applications on behalf of WWH’s physicians.

7. WWH currently has a roster of eleven physicians in total for all its clinics in Texas. In San Antonio, we have three physicians who provide abortions, none of whom have admitting privileges at a local hospital. In Fort Worth, we have two physicians who provide abortions, and none of them have admitting privileges. In McAllen we have one physician who provides abortions and he does not have admitting privileges at any local hospital. In Austin we have three regular physicians who provide abortions, only two of whom currently have admitting privileges at local hospitals (deemed “courtesy admitting” and “active medical staff” respectively). Of those two physicians, one of them only provides medication abortions and

therefore will have a significantly reduced case load or will not provide any abortions at all if the medication abortion restrictions go into effect, as very few women will then choose medication abortions over surgical abortions. In Beaumont we have one physician who provides abortions and he has admitting privileges at a local hospital (deemed "active admitting"). If none of our physicians receive admitting privileges by October 29, 2013, we will be forced to close the clinics at Fort Worth and McAllen, and both the San Antonio abortion facility and the ambulatory surgical center in San Antonio would be unable to provide abortion services on weekdays. We are determining whether we can add a physician who currently has admitting privileges at a local hospital (deemed "active staff") to our San Antonio clinic. This physician could only work on weekends in San Antonio and could therefore only see a limited number of patients, and would not address our need for a physician with admitting privileges who could work in San Antonio during the weekdays.

8. After the passage of Texas House Bill No. 2, I immediately began the process of complying with the admitting privileges requirement. I identified all of the hospitals within 30 miles of each of our clinics, using, among other sources, information available from the Internet. In my experience, most hospitals do not provide information on their website about how to obtain an application for admitting privileges or about their requirements for credentialing and privileges. Therefore, it is necessary to either call or email the hospital and try to reach an individual in either a credentialing department or in the obstetrics/gynecology department.

9. After identifying the relevant local hospitals for each WWH clinic, I contacted all of them by telephone. Many of the hospitals never returned my telephone call requesting application information. Some of them returned my telephone calls only after I called multiple times.

10. Of the hospitals that did return my telephone call, many referred me to another individual or department. Others provided me with what could be called an “application request form” or a “pre-application” which I was required to complete and submit before receiving the actual application for admitting privileges. Some of the hospitals I contacted use an external credentialing agency. In one such case, the hospital requested that I send the CVs of the physicians seeking privileges to them so they could conduct a background check, which took them about four days. Only after the background check was complete did they pass on the physicians’ information to the external credentialing agency, which in turn sent me an application for admitting privileges. In the case of at least three hospitals, I have been verbally discouraged from pursuing an application by a hospital staff member because of hostility against abortion providers among members of the hospital’s governing board. Each of the initial steps of contacting a hospital, having my call or email returned, submitting “pre-applications” or initial information for background checks, and then receiving the application for admitting privileges itself can take several days. In total, it has in some cases taken weeks from the time I first contact a hospital to the time when I receive the application form for admitting privileges.

11. Some of the delay in preparing applications for admitting privileges has been caused by hospital staff members refusing to provide information about the credentialing requirements or the hospital’s by-laws along with the application form. Without this information, I have no way to know whether our physicians seeking privileges will even meet the hospital’s requirements. For example, some hospitals require that a physician live within a certain distance of the hospital, or that the physician be board certified. Others require a certain minimum number of hospital admissions or in-hospital procedures per year. Not all of our physicians can satisfy these requirements in every case. Many of our physicians are not board certified because

they completed their medical training at a time when board certification was not a common practice. Thus, those of our physicians seeking admitting privileges who are not board certified will not qualify at any hospital requiring board certification before granting privileges. It is therefore impossible to prepare an application for admitting privileges without first knowing the hospital's requirements as outlined in its by-laws.

12. For each application for admitting privileges that I have received from a hospital, the physician needs to specify the type of medical staff position sought (e.g. "active staff" or "courtesy staff with admitting privileges"), and the categories of medical staff vary by hospital. For example, some hospitals restrict their "active" category of medical staff to those physicians who will "regularly" use the hospital facilities and admit patients there—in other words, to those physicians whose practices are primarily conducted through the hospital. Several of the hospitals I have identified use the title "courtesy staff" or "courtesy staff with privileges" to describe those physicians whose practice is primarily conducted outside the hospital, but who still have the authority to admit patients to the hospital and provide them with care in the hospital. For example, one hospital in the San Antonio area requires physicians on their staff to have completed 100 deliveries in the past two years, and at least 25 major ob/gyn surgeries. Even for their "courtesy staff" who are able to admit patients, many hospitals require a certain minimum number of patient admissions per year. Most WWH physicians primarily provide abortions at WWH clinics and do not maintain a regular obstetrics and gynecological practice. Because the incidence of patient complications is so rare at WWH clinics, those physicians will not be able to meet any minimum admission requirements at hospitals that require them. At the time of application, most hospitals require that a physician submit a "case log" showing the number of hospital procedures a physician has completed in the last 24 months. Some hospitals have a

requirement that the case log consist of only those cases completed at a Joint Commission-accredited hospital, further limiting WWH physicians' ability to satisfy annual admission requirements.

13. Once I receive an application for admitting privileges from a hospital, it can take several days or longer to prepare each application before submitting it. The physician must submit the 20-page "Texas Standardized Credentialing Application" with each individual application for privileges, along with the specific hospital's application. These applications together require copies of licensing certificates, copies of the medical degree, copies of any board certification, copies of vaccination records, practice information, Continuing Medical Education information, and hospital affiliation information. I have had to schedule blood tests and vaccinations for WWH physicians who do not have vaccination records available. Each application also requires a peer reference, which can take substantial time to obtain because it comes from a third party. Lastly, for each application, there must be a specified "designated alternate" physician who will attend to the applicant's patients when the applying physician is unavailable. Most of the hospitals our physicians are applying to require that the designated alternate physician currently have admitting privileges at the same hospital. It can be difficult to identify a designated alternate physician at each hospital where we are seeking admitting privileges, because many physicians are unwilling to serve as the designated alternate, due to hostility towards abortion providers, or because of perceived pressure from conservative hospital governing boards against serving as a designated alternate to abortion providers. I have heard from some physicians that they are worried about having their admitting privileges taken away if they agree to serve as a designated alternate for any of our physicians.

14. The following is the current status of pending applications on behalf of WWH

physicians at each of our clinics. For each hospital, our physicians have submitted applications seeking the highest level of staff membership they are qualified for that will allow them to admit patients.

- a. In Fort Worth, one of our physicians does not meet the facial requirements of any of the local hospitals we have identified and is therefore not planning to apply for admitting privileges and is preparing to retire because of the admitting privileges requirement. The other two physicians who currently provide abortions in Fort Worth each meet the facial requirements for admitting privileges at two hospitals, and I have submitted those four applications, in addition to a fifth application for one of those two physicians. We do not have any other WWH physician available who would meet the facial requirements of the hospitals we have identified in the Fort Worth area. I have also submitted an application at one hospital in the Fort Worth area for a WWH physician who meets the facial requirements and who currently provides abortions in the San Antonio clinic. Two of the physicians in the WWH roster who would otherwise qualify for privileges in the Baylor Health Care System hospitals in Fort Worth will not be able to apply because we cannot find a doctor already in the Baylor system willing to serve as the designated alternate physician, as required.
- b. In San Antonio, two of our physicians have submitted applications for admitting privileges at the same three local hospitals, at each of which they meet the facial requirements. A third physician is in the process of submitting applications at two of those three hospitals, and at an additional hospital.
- c. In McAllen, we are not sure if any of our physicians meet the requirements for

admitting privileges at any local hospital but have nonetheless submitted applications for three physicians at the same local hospital.

15. Although WWH is seeking additional physicians that either have or could obtain privileges, I do not think that we will be able to recruit enough physicians to prevent discontinuing or reducing services. WWH already struggles to keep enough physicians to meet the needs of our patients. One reason for this is that several of the physicians travel long distances to work at more than one WWH clinic on different days of the week. Our physicians have to stay at a clinic location for at least two consecutive days because of the required 24-hour waiting period law in Texas, to enable them to see the same patients on two consecutive days. Several of the WWH physicians have retired from their practices and do not work full time. In addition, physicians without admitting privileges may be reluctant to apply for them. For example, one of the current WWH physicians is reluctant to apply for privileges to any hospital whose requirements he does not clearly meet because he is concerned that a denial will have to be disclosed on future applications and will have a negative effect on those applications.

16. I do not expect to be able to recruit local physicians who already have admitting privileges at local hospitals to work in any of WWH's clinics. It is difficult to recruit local physicians to perform abortions at our clinics, because of the hostility they can face from the community, such as protestors outside of their regular practice offices who may disrupt their other patients' appointments, and because of fears of violence directed against them and their families. One of the physicians we successfully recruited changed his mind about working with WWH after the murder of Dr. George Tiller by an anti-abortion activist. Some of WWH's vendors have been targeted by protestors in the past and have had their other business relationships put in jeopardy because of their decision to work with WWH. Some physicians are

fearful of having their hospital admitting privileges denied or revoked if they start performing abortions. For these reasons, it will likely be impossible to recruit local physicians if none of our existing physicians can satisfy the admitting privileges requirement. While I frequently seek to recruit doctors from out of state, even if I am successful, there is often a delay before the physician can begin work while he or she obtains a Texas medical license, a delay that will likely be increased by the need to secure admitting privileges.

17. WWH clinics have an emergency protocol in place to ensure the safety of our patients in the rare event of complications requiring hospitalization. If a patient requires a transfer to a hospital, the physician will direct a staff member to call for an ambulance and prepare the patient for the transfer. The staff member will also call the hospital where the patient is being taken—usually speaking with the obstetrics and gynecology emergency staff—to provide information, as dictated by the physician, about the patient's age, vitals, hemoglobin, and the reasons for the transfer. If appropriate, WWH staff will also establish an IV port. The physician will remain with the patient until the transfer is completed. The physician will then be placed on the telephone with the hospital emergency room admitting staff and with his or her backup physician (the physician with local admitting privileges with whom he or she is required to have a working relationship to assist with complications) and provide the backup physician with information about the patient. The backup physician can then meet the patient when she arrives at the hospital or will be asked to remain on call for the patient, as necessary. If the WWH physician does not have any other patients at the clinic that day, he or she will also travel to the hospital with the patient. Copies of the woman's medical records will be sent to the hospital with the emergency medical services team. If the physician does not go to the hospital, usually a WWH administrator or staff member will travel to the hospital with the woman to facilitate

communication between the hospital's attending physician and the WWH physician, and to explain the medical records as necessary.

18. In the last five years, from all WWH Texas licensed abortion clinics and the ambulatory surgical center combined, there have been approximately 8-10 patients transferred to a hospital. Most hospital transfer patients do not ultimately require surgery, but rather are kept for observation as a precaution. WWH also tracks how many patients our clinic staff or physicians refer to an emergency room after they have left a WWH clinic. In some cases, women will go to a hospital on their own after leaving a WWH clinic, because they do not realize that their symptoms are a normal part of the abortion procedure. In such cases, the hospital will usually refer the woman back to the WWH clinic for further treatment.

19. WWH clinics provide medication abortions through 63 days gestational age (as measured from the last menstrual period ("LMP")). Our physicians prescribe 200 mg of mifepristone, followed 24-48 hours later with the administration of misoprostol at home.

20. The Whole Woman's Surgical Center, WWH's ambulatory surgical center in San Antonio, currently provides surgical abortions up to 24.6 weeks LMP, although this practice will change once Texas House Bill No. 2 goes into effect, banning abortions after 22 weeks LMP (or after 20 weeks "probable post-fertilization age"). It is the only facility in the state south of Austin where women can get an abortion at this gestational age. Many of the patients at the San Antonio ambulatory surgical center seeking abortions at this gestational age come from the Rio Grande Valley; they may be referred from the WWH clinic in McAllen, from other abortion facilities, from oncology physicians (if they are patients who have cancer), or from maternal-fetal medicine. If we cannot staff any physician with admitting privileges at the San Antonio clinic, there will be no later abortion services for the women in this vast geographic region.

21. Our McAllen clinic currently serves the Rio Grande Valley. Dr. Lester Minto, who owns Reproductive Services of Harlingen, the only abortion clinic in Harlingen, has publicly stated that he will close that clinic on October 29 because of the admitting privileges requirement. If we are forced to close the McAllen clinic, therefore, there will be no abortion services for women at all in this region closer than Corpus Christi—a distance of approximately 150 miles. The clinic in Corpus Christi is not an ambulatory surgical center, and therefore women referred from maternal-fetal medicine physicians at gestational ages requiring that abortions be done in an ambulatory surgical center will not be able to access abortion services in this region at all.

22. In sum, if the admitting privileges requirement goes into effect on October 29, 2013, and none of our physicians who have applied for admitting privileges receive them by that date, we will have no physicians to serve our clinics in McAllen, Fort Worth, and San Antonio, except for possible weekend coverage in San Antonio. We will only be able to provide our patients with medication abortions through 49 days LMP, and those patients will have to return to the clinic to obtain misoprostol, imposing a hardship on those patients who live far from our clinics and do not have the financial resources to make separate trips.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 30, 2013



Andrea Ferrigno

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION**

PLANNED PARENTHOOD OF GREATER TEXAS)
SURGICAL HEALTH SERVICES, and on behalf of)
its patients and physicians, *et al.*,)

Plaintiffs,)

v.)

GREGORY ABBOTT, Attorney General of Texas, in)
his official capacity, *et al.*,)

Defendants.)

CIVIL ACTION

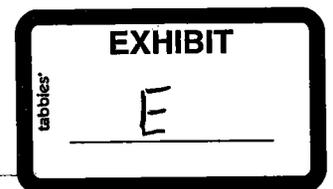
CASE NO. 1:13-cv-862 LY

DECLARATION OF ANGELA MARTINEZ

Angela Martinez declares and states the following:

1. I am the Clinic Director of Planned Parenthood Women's Health Center (PPWHC) in Lubbock, Texas. In this capacity, I am responsible for the day-to-day operations of PPWHC's health center located in Lubbock. I interact with our patients every day, both in reviewing their financial situations to see if they are eligible for assistance and in conducting the patient education portion of the informed consent process. I also supervise staff members who are engaged in these activities.

2. I provide this declaration in support of Plaintiffs' Motion for a Preliminary Injunction against enforcement of 1) Texas House Bill 2's (H.B.2) requirement that all physicians who perform abortions "have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced [] and provides obstetrical or gynecological health care services"; and 2) H.B.2's requirement that "abortion-



inducing drugs” only be provided by a physician in a way that “satisfies the protocol tested and authorized by the United States Food and Drug Administration [FDA] as outlined in the final printed label of the abortion-inducing drug.”

3. Planned Parenthood Women’s Health Center provides surgical abortions up to 12 weeks (as measured from the first day of the woman’s last menstrual period (LMP)) and medication abortions through 63 days LMP. Among our patients who are less than 63 days pregnant, about 48 percent choose a medication abortion. At this time, the physician who provides those services lives in Houston, where he can also see patients, and flies in once a week to provide services for two days at a time.

4. We are the only remaining abortion provider in west Texas, except in El Paso, which is approximately 350 miles away. The next closest providers to Lubbock are in Fort Worth, Austin, Waco, and Killeen, each of which is 300 to 400 miles away, as providers in Midland, Abilene, and San Angelo have all closed in recent years. Since these clinics closed, we have been inundated with patient calls. We currently are scheduling patients up to a month in advance, although we try to accommodate patients who need to come sooner.

5. The majority of women who seek our abortion services are low income. Nearly half of them qualify for private financial assistance because their income is below the federal poverty line. Most are parents, and many must travel over 100 miles to reach us. They often have trouble obtaining use of a car and the resources to pay for gas, permission from their employer to take the necessary time off, and/or childcare. Many of those who do not live more than 100 miles from an abortion provider are already struggling to meet Texas legal requirements that they come to the clinic to receive counseling and an ultrasound 24 hours prior to their procedure. Patients frequently cancel appointments at the last minute because the arrangements they made fell

through, and often we have to refer these women elsewhere because their pregnancy is, or is soon to be, past 12 weeks.

6. If a woman comes to us who is more than 12 weeks pregnant, we inform her of the nearest provider who can help her, which may be up to five hours away. Many times, I have heard from a patient that this additional distance (on top of all the other hurdles) will make it impossible for her to obtain an abortion.

7. If H.B.2 goes into effect, we will be forced to cease providing abortion services altogether because we will be unable to hire a physician with admitting privileges within 30 miles of our health center, as the law requires. There are only two hospitals within that area that provide obstetrical or gynecological services: a university hospital and a Catholic hospital. We reached out to the university hospital, and were informed that it only grants privileges to providers who teach and do regular rounds. This would not be possible for our physician, who is in Lubbock only two days per week. Similarly, the Catholic hospital requires providers to reside locally. (Even if this requirement were flexible, and I have no reason to think that it is, this hospital is part of an organization that is publicly and actively opposed to abortion.)

8. There is another hospital nearby that provides limited services. It is not clear to us whether this hospital provides obstetrical or gynecological services as H.B.2 requires, but at any rate, we have attempted to reach out to it, and have received no response.

9. Nor is there any possibility that we could find a local physician. Lubbock is a small and very conservative community. Anti-abortion protesters harass health center employees every day the center is open. They shout insults at us every day, take pictures of us (and take down license plate information), refer to employees by name, and have protested outside employees' homes and posted pictures of employees online with their names. Because physicians are the

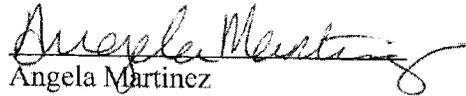
biggest target of antiabortion harassment and violence, I cannot imagine a local physician being willing to risk his or her safety in this way. Indeed, I am unaware of any Lubbock physician ever having performed abortions. Our site is the only location that I am aware of where abortions have been offered in Lubbock, and for the time it has been a Planned Parenthood facility, as well as for decades before, the physicians who performed abortions have travelled here from another part of the state, most frequently from Dallas.

10. I also understand that H.B.2 may limit medication abortions in the state to through 49 days LMP and require that, to obtain a medication abortion, a woman make four trips to the health center (the second and third of which must be two days apart), each time seeing a physician, within a two-week period. As a practical matter, there is no way we could meet these requirements because, as mentioned above, our physician can only be here once a week for two consecutive days. Therefore, even if we had a physician with admitting privileges within 30 miles of our health center (which we do not and will not), H.B. 2 will separately force us to stop offering medication abortions, a procedure which approximately 48 percent of our patients choose.

11. In sum, the medication abortion restrictions in H.B.2 would force us to cease offering that type of abortion, and the privileges requirement in H.B.2 would force us to cease providing abortion services altogether. Because we are the sole remaining provider between El Paso and I-35, the result would be that many women would have to drive hundreds of miles further to obtain an abortion. Based on my familiarity with our patients and their already-difficult situations, I believe that this change would be extraordinarily difficult for almost all of our patients, and could prevent many of them from obtaining an abortion at all.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 27, 2013


Angela Martinez

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

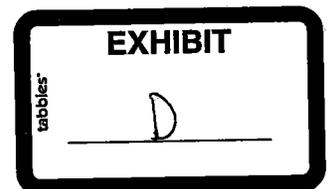
PLANNED PARENTHOOD OF GREATER TEXAS)	
SURGICAL HEALTH SERVICES, and on behalf of)	
its patients and physicians, <i>et al.</i> ,)	
)	
Plaintiffs,)	CIVIL ACTION
v.)	
)	CASE NO. 1:13-cv-862
GREGORY ABBOTT, Attorney General of Texas, in)	
his official capacity, <i>et al.</i> ,)	
)	
Defendants.)	

DECLARATION OF DARREL JORDAN, MD

Darrel Jordan, MD, declares and states the following:

1. I am the Chief Medical Officer of Planned Parenthood of Greater Texas (PPGT). PPGT is the parent corporation to two separate entities that provide reproductive health care services in Austin, Dallas, Fort Worth, Paris, Tyler, Waco, and surrounding communities. One of those entities, Plaintiff Planned Parenthood of Greater Texas Surgical Health Services (PPGTSHS), provides abortion at four locations in Austin, Dallas, Fort Worth, and Waco. If the admitting privileges requirement takes effect on October 29, 2013, all locations except Dallas will be forced to close their doors.

2. I am board-certified in obstetrics and gynecology. I received my medical degree from the University of Texas Health Science Center in San Antonio, and completed my Obstetrics and Gynecology internship and residency at Saint Paul Medical Center in Dallas.



3. I provide the following facts in support of Plaintiffs' Motion for a Preliminary Injunction against enforcement of Texas House Bill 2's requirement that all physicians who perform abortions "have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced [] and provides obstetrical or gynecological health care services."

4. As explained below, this new requirement cannot be satisfied before HB 2 takes effect on October 29, 2013, because most hospitals take several months, at least, to consider an application for privileges. Even if time were not a factor, the requirement will be difficult or impossible to satisfy for some of the health centers where we provide abortions, and therefore will probably force us to cease abortion services at some or all of these centers. Moreover, the requirement forces our providers to apply to multiple hospitals and risk multiple rejections for reasons wholly unrelated to their qualifications or competence, which will seriously and unfairly compromise their career prospects. (Some hospitals require that when a physician applies for future hospital privileges, s/he must disclose all previous denied hospital privilege applications, and previous denied privileges can be treated as a significant adverse factor.)

5. I reside in the Dallas area. I currently am on the active staff, and therefore have admitting privileges, at two hospitals there: Medical City Dallas Hospital and North Central Surgical Center. However, I come up for recertification at both hospitals in 2014, and I may well be unable to continue as an active staff member there, or even continue to have privileges, because I admit so few patients. The Medical City Dallas Hospital requires 18 admissions to be on the active staff and two admissions to maintain courtesy privileges. The North Central Surgical Center requires 24 admissions per year. In previous years, I met these requirements because I maintained a private practice that included performing in-hospital hysterectomies and

other gynecological surgical procedures. However, I had to phase out that practice in November 2012 because of my full-time responsibilities as Chief Medical Officer of PPGT.

6. There are five physicians who currently perform abortions at PPGTSSHS's four centers in Dallas, Fort Worth, Waco and Austin. Three of us have privileges in the Dallas area, but none of us has privileges elsewhere. One provider lives in Austin, but none live in Fort Worth or Waco.

7. As soon as the admitting privileges requirement was enacted—indeed, before that date—we began actively searching for hospitals with obstetrics or gynecological departments that might grant us these privileges in the Fort Worth, Austin, and Waco areas. We have filed several applications, in all three locations. However, because hospital procedures for considering such applications involve multiple levels of review by committees that meet infrequently, the privileging process is lengthy. Thus, it is extremely unlikely that we will have these privileges before the new statutory requirement goes into effect on October 29, 2013.

8. Even after October 29, 2013, it is unlikely that we will be able to obtain the necessary privileges, for a variety of reasons discussed below. Many hospitals have general requirements that we cannot meet. Some require the doctor to live locally, and this is a problem because we cannot find a local provider (particularly in more socially conservative areas, for reasons explained below). Some others require a minimum number of admissions annually, which we often cannot meet because abortion is such a safe procedure, with an extremely low incidence of complications that would require hospitalization.

9. Even if we met these requirements, some hospitals would not grant privileges to any abortion provider because they are affiliated with religious institutions that disapprove of abortion or because their staff or leadership oppose abortion. In fact, the Catholic Church has

issued a directive to health care providers, including its large network of hospitals, barring them from providing abortions or “cooperating” with the provision of abortion and cautioning them “to be concerned about the danger of scandal in any association with abortion providers.” United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* ¶45 (5th ed. 2009).

10. Our Fort Worth center, which is licensed as an ambulatory surgical center (ASC), is just slightly more than 30 miles from the seven Dallas-area hospitals where two of my colleagues and I have privileges. We have applied to multiple hospitals in Fort Worth. One application was denied because of a local residency requirement. Another was denied because the provider for whom we applied is not board-certified in obstetrics and gynecology. (This is often the case for providers who began practicing before board certification became a qualification sought by hospitals and health care plans.) Another hospital has asked us through back channels not to apply for privileges. Similarly, we were informed by a contact at another hospital that, because of anti-abortion sentiment within the governing board, we would have no chance of obtaining privileges there.

11. Hostility to abortion also makes it impossible to hire a new doctor who lives in Fort Worth and has privileges at a local hospital. Because Fort Worth is a small and extremely socially conservative community, any resident who is known to perform abortions faces routine harassment, social and professional ostracism, and even a significant risk of violence (all of which extend to his or her family as well).

12. In Waco, to our knowledge, there are only three hospitals within 30 miles of our health center that have obstetrics or gynecological departments. As in Fort Worth, there is strong anti-abortion sentiment locally in Waco, which makes it virtually impossible to find local

providers and may make it very difficult to obtain local admitting privileges. One of the three in-range hospitals is Catholic, and indicated to us that it would not even consider any application by an abortion provider. (As explained above, Catholic directives oppose any association with abortion providers and this hospital expressly adheres to those directives.) At a second hospital, we were told we must contact a certain staff member before applying; we have placed two calls to that staff member, and to date, he has not returned our multiple messages. I applied to the third of these, which recently rejected my application. The rejection letter was confusing; it stated that I had failed to meet the hospital's qualifications but did not specify which requirement(s), and at the same time requested further information, including a case log of all the medical procedures I have performed at the hospitals where I currently have admitting privileges. I am in the process of reapplying, but am waiting for the case log from North Central Surgical Center, which I requested weeks ago.

13. In Austin, where our health center is also licensed as an ASC, we have several applications for privileges pending, but have not been given any indication of when these might be decided. I am optimistic that one will be granted, although I cannot be certain of that, and as of today, none have been granted.

14. In sum, as things stand today, if the admitting privileges requirement were allowed to take effect on October 29, PPGTSSHS would be able to provide abortion services at only one of its four health centers that currently offer that service – in Dallas. We would have to cease providing those services at our health center in Waco and our two ASCs in Austin and Fort Worth. This would be difficult for the women of Waco because we are the only abortion provider located there. And it would cause particular hardship for our patients with gestational ages at 16 weeks or greater as measured from the first day of their last menstrual period (LMP);

Texas law permits those procedures only in ASC, and PPGTSSHS has the only ASCs in both Austin and Fort Worth, which are two of the only six total ASCs providing abortion in the state.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 30, 2013



Darrel Jordan, MD

English and Spanish on family planning, fertility, contraception, and demography. A complete copy of my curriculum vitae is attached as Exhibit 1.

3. I provide the following facts and opinions as an expert in sociology, reproductive health, demography, and the effect of limiting access to reproductive health care on women in the state of Texas. The opinions expressed below are based on my years of experience as a sociologist and the work of the Texas Policy Evaluation Project (“TxPEP”), as well as my review of the relevant literature.

4. I provide these opinions in support of Plaintiffs’ Motion for a Preliminary Injunction against enforcement of Texas House Bill 2’s requirement that all physicians who perform abortions “have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced [] and provides obstetrical or gynecological health care services.”

Summary of Findings

5. TxPEP has compared the current spatial distribution and capacity of abortion providers with the distribution and capacity of abortion providers should the admitting privileges requirement go into effect. Our conclusion is that the admitting privileges requirement will substantially negatively affect the ability of Texas women to obtain abortion care in two ways.

6. First, because at least one third of currently licensed clinics will stop providing abortions entirely, many women will be forced to travel significant distances to reach the nearest abortion provider. Over one in twelve Texas women who seek an abortion, or nearly 9%, will have to travel more than 100 miles to reach the nearest abortion provider. For those women who live in particular areas of the state, these

distances will be significant. For instance, the single abortion provider in Lubbock will shut down, leaving no provider between El Paso in the west and San Antonio in the east. Some women in the Panhandle will have to travel more than 350 miles to seek an abortion. The burdens of these trips are magnified by the patchwork of state requirements that may force women to make multiple trips to a clinic. Some women who would otherwise have gotten an abortion will be prevented from doing so by these burdens.

7. Second, those clinics that will remain open will have reduced capacity (health centers often have more than one doctor, and not all of the doctors who currently practice at a particular location will be able to secure privileges), and they will see a sharp increase in the demand for their services (because other clinics in the area have shut down). This reduction in supply and increase in demand will mean that the delays to obtain an appointment with many providers will increase, and some providers may turn patients away entirely. Many women may find it impossible to obtain abortion care in a timely fashion or indeed at all. Abortion is of course a time-sensitive procedure: having to wait a few weeks may make it impossible for women to get an abortion. Under current law, abortions at 16 weeks or more can only be performed in Texas in ambulatory surgery centers (ASCs). Only six abortion clinics in Texas are licensed as ASCs; of those six, three will stop providing abortion care as a direct result of the admitting privileges law, leaving only three providing abortions: one in Dallas, one in Houston, and one in San Antonio. The ASC in San Antonio will have severely reduced capacity and might not be able to provide even limited services until December. This reduction in the capacity of abortion providers in the state of Texas will present an insurmountable obstacle to some Texas women seeking abortions. Those women will be forced by the effects of this law to

carry unwanted pregnancies to term, or attempt to end the pregnancy themselves, possibly through unsafe means. We calculate that the shortfall in capacity due to the admitting privileges requirement will prevent at least 22,286 women from obtaining a safe and legal abortion in the next year, or, in other words, nearly one in three women.

Methodology

8. TxPEP conducted our analysis at the county level. The county is the smallest area for which the locations of women who have received abortion services are available. For consistency, we also aggregated providers by county.

9. The first question we addressed is the number of women seeking an abortion whose distance from a provider would increase after implementation. We used Texas Department of State Health Services (“DSHS”) records on the county of residence of all women who received an abortion in 2011.¹ We associated each of these women with the nearest open provider at the three time points—2011, the present, and a future in which the admitting privileges requirement has gone into effect. We determined which providers were or would be providing services at each point in time using all available sources of information, including the DSHS list of providers, information provided by the plaintiffs about their own facilities, and key informants. *See* Table 1 (all figures and tables attached in Exhibit 2).

10. Texas Health and Safety Code § 171.012 generally requires that a woman receive an ultrasound in person 24 hours prior to an abortion from her abortion provider. However, this rule is waived for women who live more than 100 miles from a clinic. Using the Legislature’s acknowledgement that 100 miles is a burdensome distance to

¹ We exclude the small number of women whose record did not have a valid county listed.

travel for abortion care as a guide, we focused on the women who would have to travel this distance or more at two time points: now and after implementation. We also assumed that the number of women seeking an abortion at each of these times would remain at the 2011 levels.² This is a conservative assumption because the state of Texas has drastically reduced its funding for family planning in the two years beginning in October 2011; it is instead likely to be the case that significantly more women have and will experience unintended pregnancies. We assessed distance as the distance between the center of the county of residence and the center of the county of the nearest provider.

11. Performing this calculation in the counties having at least one provider currently open, 2,440 women who will seek abortions annually reside more than 100 miles from the nearest provider. Next, we performed the same calculation using the locations of the providers that we expect will still be offering abortion care should the new legislation requiring admitting privileges be implemented. In that scenario, 5,971 women will reside more than 100 miles from the nearest provider—an increase of 145% over the current situation. If the number of women receiving abortion care from each county remains constant, over one in twelve Texas women who seek an abortion will be more than 100 miles from a provider. Figure 1 shows the number of women who would have to travel 100 miles or more because of the law by counties. Figure 2 shows the increase in distance to the nearest abortion provider in each county due to implementing the admitting privileges requirement. In multiple counties, this additional distance exceeds 400 miles.

² 2011 is the last year for which there are complete records of women receiving abortions.

12. The preceding analysis involved projecting the women who received abortions in 2011 onto the map of providers who will continue to perform abortions after implementation of the law. But doing so raises two important questions. The first is whether the reduced numbers of providers would actually be able to provide this volume of abortion care. Table 3 shows past and projected provision of abortion services by county. There are only seven counties that will have an abortion provider after implementation of the new law. We describe the projected demand based on 2011 volume and estimated capacity in each county below:

a. Bexar County

In 2011, the eight clinics then open in Bexar County were the nearest providers for 6,969 women seeking abortion. Three of these clinics have already closed. Of the remaining five clinics currently open, two will close after the law is implemented, and one will have extremely limited capacity. After the admitting privileges requirement is implemented, the projected demand is 7,006 abortions per year. We estimate that 2,000 abortions could be provided by the one Planned Parenthood affiliate in the county that will remain open. Two additional clinics will remain open, but one will have severely limited capacity. We estimate that together these two clinics could provide 2,250 abortions annually, yielding a county capacity of 4,250. The projected volume will thus exceed capacity by 2,750 abortions annually. Additionally, because the clinic in Nueces County is unlikely to be able to meet the needs of all the women seeking abortion from the Rio Grande Valley, the Bexar County providers may need to perform more abortions than the number estimated by our procedures. If women from the Rio Grande Valley do

travel to Bexar County to seek abortion care, the additional volume will result in a greater than expected shortfall in capacity.

b. Dallas County

The five clinics in Dallas County were the nearest providers for 14,947 women seeking abortion in 2011. After the requirement is implemented, two of these five will close and the projected volume will increase dramatically by 51% to 22,598. The capacity of the remaining providers is estimated to be only 12,500 abortions per year, which is barely more than half the projected volume. The projected volume will exceed capacity by 10,098 abortions per year.

c. El Paso County

The two clinics in El Paso County were the nearest providers for 2,230 women seeking abortion in 2011. After the requirement is implemented, one of these clinics will close, while the projected volume will increase by 50% to 3,337. The capacity of the sole remaining provider, based on 2011 volume, was only 800 abortions per year. The projected volume will exceed capacity by about 2,500 abortions per year.

d. Harris County

The nine clinics in Harris County were the nearest providers for 19,181 women seeking abortions in 2011. Since then, an additional clinic has opened. After the requirement is implemented, three or four of these ten providers will close and the projected volume will increase by 16% to 22,258. Given the reduction in the number of clinics, we doubt the remaining clinics will be able to meet the projected demand.

e. Jefferson County

No change.

f. Nueces County

The single clinic in Nueces County was the nearest provider for 1,623 women seeking abortion in 2011. After the requirement is implemented, the clinic is expected to stay open but the projected volume this clinic would need to deliver would be 4,573 abortions. This 182% increase in volume is due to the closure of the two clinics in the Rio Grande Valley. As noted above, it seems very unlikely that this single clinic will be able to meet this projected demand.

g. Travis County

The four clinics in Travis County were the nearest providers for 6,118 abortions in 2011. After the requirement is implemented, three of the four clinics are expected to stay open, while we project the volume to increase 26% to 7,719. The volume of the clinic that will close is about 1,800 abortions per year. This means that the projected volume for the county will exceed capacity by 3,401 abortions per year.

In summary, in five of the seven counties, there will be a substantial increase in the projected volume of services required due to closure of clinics in other counties that will no longer have a provider. Moreover, there will be a substantial reduction in the capacity to provide services in four of these five counties. One of the two counties not projected to experience a substantial increase in volume or loss of capacity, Jefferson County, has a relatively small volume of abortions. The other, Bexar County, will experience a loss in capacity and may in fact see a surge in demand due to the loss of the

clinics in the Rio Grande Valley and the inability of the Nueces County provider to nearly triple its volume. All told, the projected demand for abortion care statewide is 68,889, and the expected capacity after implementation of the law is only 43,850. The implication is that 25,039 women will not be able to access abortion care in the state, even if they could travel the long distances necessary to access the nearest clinic with capacity to serve them. Eighty-nine percent of this deficit, or 22,286 abortions, is due to closures that will occur as a result of the implementation of the challenged provision.

13. Finally, the last and most challenging question concerns the number of women who will be unable to obtain an abortion because of the increase in distance to a provider and the loss of capacity. These women may be forced to carry the pregnancy to term or attempt to end the pregnancy themselves, possibly through unsafe means.

14. Limited access to abortion providers, and abortion provider closings in particular, are associated with reduced abortion service provision and lower abortion rates, an increase in the distance women must travel to obtain an abortion, and an increase in out-of-state travel for abortion care.³ Several studies have shown that communities with higher travel distance to an abortion provider have lower abortion rates, implying that some women who would seek an abortion cannot access one. Furthermore, the burden of travel is higher for younger women, women of color, and low-income women, who have fewer resources to overcome the increased cost of further

³See Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 J. of Policy Analysis and Management 775 (2011); Sharon Dobie et al., *Abortion Services in Rural Washington State, 1983-1984 to 1993-1994: Availability and Outcomes*, 31 Fam. Plan. Persp. 241 (1999); Theodore J. Joyce et al., *Back to the Future? Abortion Before & After Roe* (Nat'l Bureau of Econ. Res., Working Paper No. 18338, Aug. 2012); Theodore Joyce, *The Supply-Side Economics of Abortion*, 365 New Eng. J. Med. 1466 (2011).

travel.⁴ The restrictions will likely have the greatest impact on these vulnerable populations that do not have the resources to travel to clinics in a distant city or out of state. Data from our research in Texas indicate that approximately 40% of women seeking abortion are at or below 100% of Federal Poverty Guidelines.

15. One of the negative health effects of these restrictions is undoubtedly a rise in attempts to self-induce abortion, and prior research has indicated that young age is a risk factor for attempting abortion self-induction.⁵ In 2012, TxPEP conducted a survey with 318 women seeking abortion in six cities across Texas. We found that 7% of women reported taking something on their own in order to try to end their current pregnancy before coming to the abortion clinic. This proportion was even higher—about 12%—among women at clinics near the Mexican border. By comparison, a nationally representative survey of abortion patients in 2008 found that 2.6% reported ever taking something to attempt to self-induce an abortion over the course of their lives.⁶ The rate of attempted self-induction was thus significantly higher in Texas than nationwide even before the current restrictions go into place. We anticipate that abortion self-induction will become even more common in the state as access to clinic-based abortion becomes more limited. While abortion is a very safe procedure when performed by a physician, women who attempt to self-induce may put themselves at risk of hemorrhage or uterine

⁴ See Robert W. Brown & R. Todd Jewell, *The Impact of Provider Availability on Abortion Demand*, 14 *Contemp. Econ. Policy* 95 (1996); R. Todd Jewell & Robert W. Brown, *An Economic Analysis of Abortion: The Effect of Travel Cost on Teenagers*, 37 *Soc. Sci. J.* 113 (2000); James D. Shelton et al., *Abortion Utilization: Does Travel Distance Matter?* 8 *Fam. Plan. Persp.* 260 (1976).

⁵ Daniel Grossman et al., *Self-induction of Abortion Among Women in the United States*, 18 *Reprod Health Matters* 136 (2010).

⁶ Rachel K. Jones, *How Commonly Do US Abortion Patients Report Attempts to Self-Induce?* 204 *Am. J. Obstetrics & Gynecology* 1 (2011).

rupture.⁷ Women frequently use a variety of less effective and more dangerous methods to end a pregnancy on their own, including taking herbs or self-inflicting abdominal trauma.⁸

16. Women's health will also be negatively impacted by a rise in the number of second-trimester abortions in Texas caused by delays accessing care. Even if the remaining clinics were somehow able to meet the demand of women seeking abortion, and women were able to travel the long distances, women will need to wait longer to obtain an appointment. This will push women later in pregnancy, when the procedure is associated with a higher risk of complication⁹ and is more expensive, creating even more obstacles for low-income women. Women will also have to spend a longer period of time saving up to pay for increased travel costs, which can in turn further delay the timing of a procedure. Having to raise money for travel and procedure costs is a common reason why women end up presenting beyond the gestational age limit of a clinic.¹⁰

17. The legal landscape in Texas makes this delay particularly burdensome. Current law requires that all abortions at 16 weeks or more be performed in a facility licensed as an ambulatory surgical center. There are currently only six ASCs which perform abortions throughout the state: two in Houston and one each in San Antonio, Austin, Fort Worth, and Dallas. If the admitting privileges restriction goes into effect, three of these will stop providing abortions, leaving only two ASCs fully open in Dallas

⁷ Premila Ashok et al., *Midtrimester Medical Termination of Pregnancy: A Review of 1002 Consecutive Cases*, 69 *Contraception* 51 (2004).

⁸ See Grossman, *supra* note 5.

⁹ Linda Bartlett, et al., *Risk factors for Legal Induced Abortion-Related Mortality in the United States*. 103 *Obstetrics & Gynecology* 729 (2004).

¹⁰ Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*. 87 *Contraception* 3 (2013).

and Houston, and very reduced services in San Antonio. A few weeks' delay in obtaining an abortion, through increased cost, logistical difficulties, or a clinic's inability to see a patient, could force a woman to travel even greater distances; a few more weeks' delay due to those same factors could mean she is unable to obtain an abortion at all.

18. Many women will find the barriers to abortion care too great to overcome and will end up continuing their pregnancies, despite their desire to terminate. Others may attempt to self-induce abortion and fail. All of these women will end up carrying a pregnancy to term and delivering a child they do not want or feel they cannot care for.

19. The requirement for physicians to have hospital privileges within 30 miles of their place of work will result in the closure of many clinics in the state, causing significant barriers to care for women seeking abortion. These restrictions are thus likely to severely burden Texas women's access to abortion care and negatively impact their health.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 1, 2013

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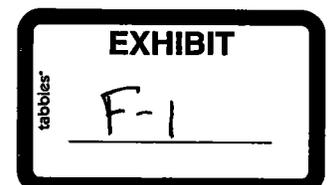
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- 1976 - 1979 Staff Associate, International Review Group of Social Science Research on Population and Development, El Colegio de México
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International Outreach Committee of the Population Association of America, 1996-2002
Editorial Advisory Committee, International Family Planning Perspectives, 1994-2000
Board of Directors, Population Communications International, 1994-2000
Editorial Advisory Committee, Papeles de Población, 2002-
Editorial Advisory Board, Estudios Demográficos y Urbanos, 2002-2011
Board of Directors, Population Association of America, 2004-2006
Committee for Robert Lapham Prize, Population Association of America, 2007- 2009
Nominating Committee, Society of Family Planning, 2009-

Professional Associations:

International Union for the Scientific Study of Population (IUSSP)
Population Association of America (PAA)
Brazilian Population Studies Association (ABEP)
Mexican Demographic Society (SOMEDE)
Latin American Population Association (ALAP)
Society of Family Planning (SFP)

Fellowships:

Ritchie H. Reed Fellowship in Population and Economics, The Population Council, 1973-1975.
Fulbright Teaching and Research Fellowship, University of Campinas, Brazil, 1994-1996.
Faculty Research Assignments, Univ. of Texas, Spring 1995, Fall 2001, and Spring 2008.
Faculty Research Leave, Lozano Long Institute of Latin American Studies, U. Texas, Fall 2008.
Big XII Faculty Fellowships, U. of Texas-Colorado U., Fall 2001, Spring 2007, Spring 2009.

Research and Training Grants Support (since 2001):

Principal Investigator – Demand for Postpartum Contraception in Texas, Society of Family Planning, 20013-2015, \$120,000.

Principal Investigator – Evaluating the Impact of Reproductive Health Legislation Enacted by the 82nd Texas Legislature, Anonymous Foundation, 2011-2014, \$1,901,368.

Principal Investigator – Postpartum Contraception in the United States, Population Research Center, 2010-2011, \$12,000.

Principal Investigator – Oral Contraceptive Use Along the US-Mexico Border, NICHD, ARRA Supplement to R01HD047816, 2009-2011, \$164,158.

Principal Investigator -- Unmet Demand for Surgical Sterilization among Mexican Origin Women, Society of Family Planning, 2009-2011, \$120,000.

Principal Investigator – Oral Contraceptive Use Along the US-Mexico Border, NICHD, R01HD047816-01A1, 2005-2012, \$2,129,977.

Principal Investigator - Demographic Change and Economic Wellbeing at the Local Level in Mexico and Brazil, The John D. and Catherine T. MacArthur Foundation, 2005-2009, \$250,000.

Principal Investigator - Childbearing Preferences in Times of Crisis: Economic and Sociocultural Processes and Explanations (Doctoral Dissertation Research: Sara Yeatman), NSF Award No. 0623543, 2006-2007, \$7,495.

Principal Investigator - Training Grant in Population Studies, NICHD, 5T32-HD007081-27, 2003-2008, \$1,093,237.

Co-Investigator - Project on Religion and Economic Change, Metanexus Institute, \$500,000, 2005-2008 (R. Woodberry, PI).

Principal Investigator - The Fertility Transition in Brazil: 1960-2000, NICHD, R01HD041528-01A1, 2002-2007, \$540,000 (direct costs).

Co-Principal Investigator (with R. Hummer and B. Roberts) - Center for the Study of Urbanization and Internal Migration in Developing Countries, The Andrew Mellon Foundation, 2000-2003, \$510,000; 2003-2005, \$450,000.

Principal Investigator - Preservation, Integration and Dissemination of Public-Use Microdata Series-Brazil, Subcontract with Univ. of Minnesota (NSF grant to S. Ruggles, P.I.), 2000-2003, \$140,100 in direct costs.

Principal Investigator - Research and Training Program in Quantitative Analysis for Brazilian Social Scientists, The Ford Foundation, 2000-2002, \$130,000; 2003-2006, \$195,000.

Principal Investigator - Research and Training in Latin American Population Issues, The William and Flora Hewlett Foundation, 2000-2003, \$360,000; 2004-2006, \$360,000.

Principal Investigator - Sterilizations, Cesareans, and Contraceptive Choice, NICHD, R01-HD33761, 1996-2002, \$502,641 (direct costs).

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"Interest in Over-the-Counter Access to Oral Contraceptives among Women in the United States," *Contraception*, forthcoming, 2013 (with Daniel Grossman, Kate Grindlay, Rick Li, James Trussell, and Kelly Blanchard).

"Hypertension Among Oral Contraceptive Users in El Paso, Texas," forthcoming, *Journal of Health Care for the Poor and Underserved*, forthcoming, 2013 (with Kari White, Kristine Hopkins, Jon Amastae, and Daniel Grossman).

"Lessons for Border Research: The Border Contraceptive Access Study," in *Uncharted Terrains: New Directions in Border Research Methodology, Ethics, and Practice* edited by Anna Ochoa O'Leary, Colin M. Deeds, and Scott Whiteford, University of Arizona Press, forthcoming, 2013 (with Jon Amastae, Dan Grossman, Kristine Hopkins, Michele Shedlin, and Kari White).

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Table 1. Counties with an abortion provider by period

County	Any 2011	Any now	Any post
Bell	Y	Y	N
Bexar	Y	Y	Y
Brazos	Y	N	N
Cameron	Y	Y	N
Dallas	Y	Y	Y
El Paso	Y	Y	Y
Fort Bend	Y	N	N
Harris	Y	Y	Y
Hidalgo	Y	Y	N
Jefferson	Y	Y	Y
Lubbock	Y	Y	N
McLennan	Y	Y	N
Midland	Y	N	N
Nueces	Y	Y	Y
Tarrant	Y	Y	N
Taylor	Y	N	N
Tom Green	Y	N	N
Travis	Y	Y	Y

Table 2. Projected abortions to women living at least 100 miles from nearest provider

	Abortions
Present	2,440
Post law	5,971



Table 3. Past and projected provision of abortion services by county

County	Annual estimated provision 2011	Annual estimated provision present	Annual estimated demand after law is implemented	% increase	Change in capacity 2011 to post law	Estimated capacity post law	Capacity deficit post law
Bell	1,192	1,317					
Bexar	6,969	7,000	7,006	1%	Lose 5 of 8 providers, with one remaining provider at extremely limited capacity	4,250	2,756
Brazos	957						
Cameron	786	786					
Dallas	14,947	14,999	22,598	51%	Lose 2 of 5, with one remaining provider at 1/3 prior capacity	12,500	10,098
El Paso	2,230	2,256	3,337	50%	Lose 1 of 2 providers	800	2,537
Fort Bend	2,317						
Harris	19,181	21,748	22,258	16%	Lose 3 or 4 of 10 providers	19,000	3,258
Hidalgo	2,164	2,164					
Jefferson	1,398	1,398	1,398	0%	No change	1,400	
Lubbock	1,077	2,015					
McLennan	716	1,286					
Midland	543						
Nueces	1,623	1,623	4,573	182%	No change	1,600	2,973
Tarrant	6,044	6,130					
Taylor	399						
Tom Green	228						
Travis	6,118	6,167	7,719	26%	Lose 1 of 4 providers	4,300	3,419
State	68,889	68,889	68,889	0%		43,850	25,039

Note: It assumes that women obtain abortion care in the county with the nearest provider. It also assumes a constant number of women from each county receiving abortion care in Texas in 2011, the present, and after implementation of the admissions privileges requirement.

Figure 1. Women having to travel more than 100 miles due to admitting privileges requirement

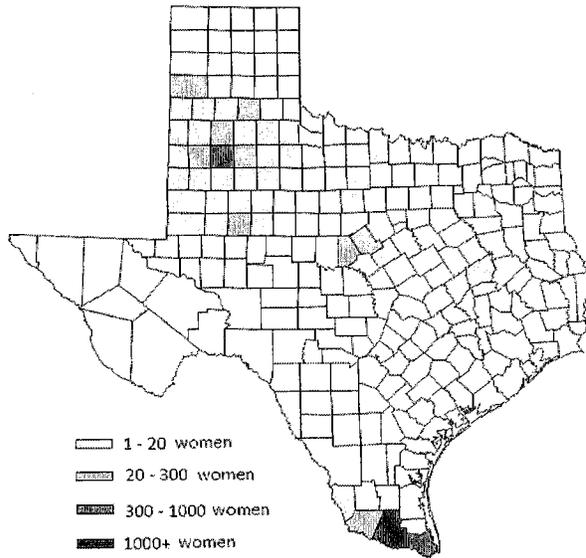
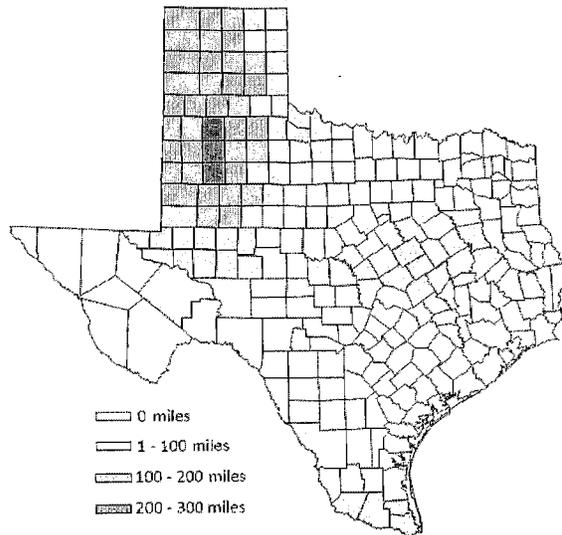


Figure 2. Additional distance women would have to travel due to admitting privileges requirement



**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION**

PLANNED PARENTHOOD OF GREATER TEXAS)
SURGICAL AND SEXUAL HEALTH SERVICES,)
and on behalf of its patients and physicians, *et al.*,)

Plaintiffs,)

v.)

GREGORY ABBOTT, Attorney General of Texas, in)
his official capacity, *et al.*,)

Defendants.)

CIVIL ACTION

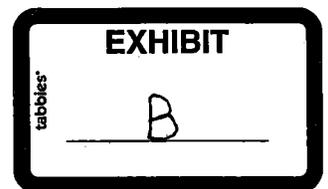
CASE NO. 1:13-cv-862-LY

DECLARATION OF DR. PAUL M. FINE

Paul M. Fine, MD, declares and states the following:

1. I am board-certified in obstetrics and gynecology and a Fellow of the American Congress of Obstetricians & Gynecologists. I am a Professor in the Departments of Obstetrics & Gynecology and Urology at the Baylor College of Medicine in Houston, where I have been on the faculty since 1979. I am the Medical Director of Planned Parenthood Gulf Coast and Planned Parenthood Center for Choice, Inc., which is a Plaintiff in this case. I am also the Medical Director of Emergency Medical Services (“EMS”) for three cities in Galveston County, Texas. A copy of my curriculum vitae is attached hereto as Exhibit 1.

2. I provide the following facts and opinions as an expert in obstetrics and gynecology; the provision of abortion, including medication abortion; the treatment of abortion complications; and general emergency medical services and transfers. The opinions expressed below are based on my years of experience in the field of obstetrics and gynecology; my



teaching, clinical, and research experience in abortion care; my involvement in the provision of emergency medical services; and my review of the medical literature.

3. I have nearly four decades of experience providing abortions, teaching abortion methods, and supervising the provision of abortion services in hospital and outpatient settings. I was involved in the original United States trials of mifepristone and misoprostol (the medications used for medication abortion, as explained below). I have been on staff at approximately twelve hospitals. I also treat and teach about the treatment of the rare complications that can occur after abortion.

4. I provide these opinions in support of Plaintiffs' Motion for a Preliminary Injunction against enforcement of Texas House Bill 2's requirements that:

- all physicians who perform abortions "have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced [] and provides obstetrical or gynecological health care services;" and
- "abortion-inducing drugs" may only be given, dispensed, provided, or administered by a physician in a way that "satisfies the protocol tested and authorized by the United States Food and Drug Administration as outlined in the final printed label of the abortion-inducing drug" and/or "in the dosage amount prescribed by the clinical management guidelines defined by the American Congress of Obstetricians and Gynecologists Practice Bulletin as those guidelines existed on January 1, 2013."

5. I believe these requirements are medically unnecessary, in that that they will not improve patient health and safety. In fact, they are contrary to the usual medical standard of care and will have serious negative consequences for women's health in Texas.

Abortion Methods and Their Safety

6. There are generally two methods of performing abortions used in the United States: surgically, using various methods depending on the gestational age of the fetus, or medically, by administering certain drugs. This latter method is available in Texas today through 63 days after the first day of the woman's last menstrual period ("LMP").

7. Surgical abortion involves the use of instruments to evacuate the contents of the uterus. Despite the term "surgical," it involves no incision into the woman's skin or other bodily membrane, and is not what a layperson might typically think of as "surgery." Surgical abortions are almost always performed in an outpatient setting, most often at a clinic or office. The procedure itself is typically performed in a room with an examination or operating table, on which the woman will lie on her back with her hips and knees flexed and thighs apart in the lithotomy position, most often with her feet or legs in stirrups. The woman may be given a sedative prior to the procedure. After adequate dilation of the woman's cervix, the physician will insert instruments through her vagina and cervix in order to empty the contents of the uterus. The procedure is short in duration, with a first-trimester abortion (up to 13.6 weeks LMP) typically lasting about five to eight minutes.

8. The types of complications that may occur following a surgical abortion include infection, bleeding, uterine perforation, and retained tissue. In the vast majority of cases, these types of complications can be, and are, resolved in an outpatient setting—that is, at the clinic where the abortion was performed—without the need for any hospital treatment.

9. Surgical abortion is analogous to other gynecological procedures that also routinely take place in outpatient settings in terms of risks, invasiveness, instrumentation, and duration. For example, first-trimester surgical abortions are nearly identical to diagnostic or therapeutic

dilation and curettage on a non-pregnant woman and surgical completion of spontaneous miscarriage; both of these procedures involve stretching open the cervix and removing the lining of the uterus and uterine contents by suction and/or sharp instruments. Surgical abortion is also comparable to non-gynecological outpatient surgical procedures in terms of risk, invasiveness, instrumentation, and duration. For example, abortion is comparable in these respects to colonoscopy with removal of polyps. All of these procedures can be, and are, safely performed by physicians without admitting privileges.

10. Up to nine weeks of pregnancy (or 63 days LMP), in addition to surgical abortion, Texas women today may choose to end their pregnancies using medications. Currently, the medications most commonly used for this purpose in the United States are mifepristone and misoprostol. Mifepristone (also known as “RU-486” or by its trade name Mifeprex) terminates a pregnancy by blocking progesterone, a naturally produced hormone that prepares the lining of the uterus for a fertilized egg and helps maintain pregnancy. Without progesterone, the pregnancy cannot continue and the lining of the uterus softens and breaks down and the embryo detaches from the uterine lining. Approximately 24 to 48 hours after the woman takes mifepristone, she takes the second drug, misoprostol (also known as a prostaglandin or by its trade name Cytotec) which causes the uterus to contract and expel the embryo or fetus and other products of conception. This same regimen is offered to women with gestational ages up to 9 weeks (through 63 days) LMP who have a spontaneous abortion (i.e., miscarriage) with retained tissue as alternative to surgical management with dilation & curettage (“D&C”).

11. Medication abortion requires no anesthesia or sedation. Many women take only over-the-counter medication to control whatever pain they experience. The bleeding and cramping the misoprostol causes occur only after the patient has left the clinic and is at home. The types of

complications that may occur following medication abortion include infection, bleeding, and retained tissue. In the vast majority of cases, these types of complications can be, and are, handled in an outpatient setting without the need for any hospital treatment.

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

13. Although abortion is very safe and the risk of complications from an abortion is incredibly low, both the morbidity (risk of major complications) and mortality rates for abortion increase with advancing gestational age. Approximately 90 percent of all abortions performed in the United States occur during the first trimester and almost two-thirds (61 percent) occur at eight weeks LMP or less. Moreover, very early abortions (6 weeks gestation or less) have become more prevalent, essentially doubling from 14 percent of all abortions in 1992 to 30 percent in 2006.²

14. Because the risk of complications from abortion is so low, the vast majority of abortions are performed in an outpatient setting, usually in a clinic or office, and this can be done safely and effectively without any need for the performing physician to have admitting privileges at a local hospital. Over 90% of abortions in the United States are performed in outpatient settings.³

¹ Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstet. & Gynecol.* 215, 216 (Feb. 2012).

² Karen Pazol, et al., Centers for Disease Control and Prevention (CDC), *Abortion surveillance – United States, 2006*, 58 *Morbidity and Mortality Weekly Report* 1–35 (2009); Sonya Gamble, et al., CDC, *Abortion surveillance – United States, 2005*, 57 *Morbidity and Mortality Weekly Report* 57: 1–32 (2008).

³ Rachel Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 *Persp. on Sexual & Reprod. Health* 41, 46 (2011).

15. To effectively assess the risks related to abortion, it is important to put them in context. Women who seek abortions are pregnant, and pregnancy, itself, is risky. Three percent of all women who deliver vaginally have a prolonged hospital admission or early re-admission to the hospital. For cesarean delivery, the figure is three times higher, about 9%.⁴ More than 30% of American women have a major abdominal operation (Cesarean) for delivery.⁵

16. By comparison, the risk of a woman experiencing some type of complication after an abortion is extremely low: only 2.5% of women obtaining first-trimester surgical abortions experience minor complications, which are handled at the health center.⁶ The risk of a woman experiencing a complication that requires hospitalization is even lower: less than 0.3%, or ten times less than from a live vaginal birth.⁷

17. In terms of maternal mortality, which is thankfully a rare occurrence in this country, abortion is dramatically safer than continuing a pregnancy to term. The risk of death related to abortion overall is less than 0.7 deaths per 100,000 procedures, which is roughly comparable to the risk of death following a miscarriage. As I noted above, this is approximately fourteen times lower than the woman's risk of death in childbirth. By way of contrast, the risk of death from fatal anaphylactic shock following use of penicillin in this country is 2.0 deaths per 100,000 uses.⁸

⁴ Patricia Hebert, et al., *Serious Maternal Morbidity After Childbirth: Prolonged Hospital Stays and Readmissions*, 94 *Obstet. & Gynecol.* 942, 944 (1999).

⁵ Brady Hamilton, et al., *Births: Preliminary Data for 2011*, 61 *Nat'l Vital Stat. Rep.* 1, 2 (2012).

⁶ Karen Meckstroth & Maureen Paul, *First-Trimester Aspiration Abortion*, in *Management of Unintended and Abnormal Pregnancy* 135, 136 (Maureen Paul, et al., eds., 2009).

⁷ Stanley Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, in *A Clinician's Guide to Medical and Surgical Abortion* 11, 21 (Maureen Paul, et al., eds., 1999).

⁸ Alfred Neugut, et al., *Anaphylaxis in the United States: An Investigation into its Epidemiology*, 161 *Archives of Internal Med.* 15, 18 (2001).

Management of Abortion Complications and Lack of Need for Admitting Privileges

18. As I have stated above, most of the complications associated with abortion can be appropriately and safely managed by monitoring and/or treating the patient in the abortion clinic. For example, most cases of non-severe hemorrhage are managed in the clinic with uterotonic medications that increase the tone of the uterine muscle causing the uterus to contract and reduce or stop the bleeding. The woman can then be sent home with oral uterotonic medications to take for several more days. Women with mild infections are also usually treated on an outpatient basis with oral and/or injected antibiotics. In the case of a missed abortion or an incomplete abortion with retained tissue, the physician can provide the necessary follow-up treatment, which may involve administration of medicine or another suction procedure to empty the uterus, in the outpatient clinic.

19. It is extremely unlikely that a patient will experience a serious complication at the clinic that requires emergent hospitalization. If such a rare complication occurs, the patient needs to be transferred by ambulance to a hospital, but whether the abortion provider has admitting privileges at that hospital does not affect the quality of care that the patient receives. At the hospital, an emergency room physician will decide if it is necessary to involve an ob/gyn in the patient's care, and if so, he or she will contact the ob/gyn on call at that hospital, and that ob/gyn can admit the patient if necessary. All ob/gyns, regardless of whether they perform abortions, are qualified to manage the care of a patient experiencing a complication from an abortion, and to refer the patient, where necessary, to the appropriate subspecialist. Moreover, continuity of care can be maintained by direct telephone communication between the abortion provider and the emergency room physician, but does not require that the abortion provider have admitting privileges. This is standard medical practice and will ensure that the emergency room

physician is aware of the extent of the complication, prior treatment, and medication received. Additionally, when a patient is transported by ambulance from the clinic to the hospital, a copy of the clinic records is sent with the patient giving details of procedures performed, medications given, and events that transpired at the clinic.

20. Even if the abortion provider had privileges at a local hospital, the provider often has little ability to control where the Emergency Medical Technicians (“EMTs”) take the patient. The provider might prefer for the patient to go to the hospital where he or she has privileges or close relationships with other doctors, but in reality, the EMTs will take that patient to the closest hospitals as they determine the emergency warrants, following the EMS departmental written protocol, or where the family might request. And, if the emergency room where the provider seeks to send a patient is full and not accepting transfers, which can happen, then the patient will also be sent elsewhere.

21. The admitting privileges requirement is also unnecessary and irrelevant to providing optimal care because of the distances some women travel to obtain an abortion. Although abortion has a very low complication rate, the complications that can occur frequently arise only after a patient has left the clinic and returned home. If, after discharge from the abortion clinic, a woman who lives outside the area where she obtained her abortion experiences a complication that requires hospital treatment, it make no sense for her to travel to be treated at a hospital near the abortion clinic just because her abortion provider has admitting privileges there. She would go to the hospital emergency room that is closest to her home. In an emergency or potential emergency situation, no physician, or EMT, would countenance going further than necessary just to get to a hospital where her provider has privileges. For example, if a woman travels to Houston from Columbus, Wharton, Liberty, or Bay City for an abortion and experiences a

problem when she returns home, the fact the physician who performed the procedure has privileges at a Houston hospital would do her no good.

22. Similarly, if a patient who obtains a medication abortion experiences a complication that requires a hospital visit, the complication will never occur when the patient is in the clinic, but rather when she is away from the clinic, and most likely at home. For example, if a medication abortion patient experiences bleeding that requires a transfusion, which is the most common of the rare complications from a medication abortion, it will occur one to three weeks after the procedure. In those cases, a physician should refer that patient to the hospital nearest to her to make sure she is treated as quickly as possible.

23. It is my opinion that admitting privileges are also irrelevant to providing optimal care in the event of a complication because the physician who provides the abortion may not be the appropriate physician to manage the patient's care in the hospital, regardless of whether the physician has privileges there. Given that abortions have such a low complication rate, abortion providers may, depending on their practice, only rarely perform the types of surgeries, including laparoscopy, open laparotomy, and hysterectomy, that might be necessary to treat a complication requiring surgery, while the on-call ob/gyn at the hospital will have more experience doing these procedures and is also familiar with the systems in that hospital.

24. Moreover, the physician performing the abortion might not have the relevant expertise to treat the patient. For example, in the very rare case of uterine perforation with a vascular or bowel injury, it is critical that the patient be treated by the appropriate subspecialist (general or vascular surgeon). A woman with a cardiac or lung condition may need treatment from a cardiologist or pulmonologist. I rely on my colleagues to manage these complications and conditions, just as they rely on me to evaluate gynecologic pathology they might encounter

during surgery they perform. Given how specialized the practice of medicine has become, particularly in a hospital setting, such handoffs to the appropriate specialists are common and necessary across medicine.

25. In addition, in those rare cases when an abortion patient, after discharge, goes to a hospital emergency room because of concerns or complications, she can often be treated by the emergency room physician and released without being admitted. Emergency room physicians are qualified to initially evaluate and treat most complications that could arise after the abortion procedures that Plaintiffs perform, and when necessary, they have immediate access to consultation with the ob/gyn on-call. Such skills are the same as those needed for the treatment of spontaneous miscarriages, which are often treated in hospital emergency rooms. If additional care is necessary, the on-call physicians at those hospitals can provide it. Moreover, it is my experience that many of those women who visit ERs after an abortion do so because of concerns they are having about their symptoms in cases where the ER visit is not actually medically necessary. In those cases, the ER physician can evaluate, counsel, and release those patients.

26. Accordingly, the professional standards of the American Congress of Obstetricians & Gynecologists (“ACOG”), Planned Parenthood Federation of America (“PPFA”), and the National Abortion Federation (“NAF”), while recognizing that clinics that perform abortions should have arrangements in place for transferring patients who require emergency treatment, do not require that the physician performing abortions have admitting privileges at a hospital.⁹ ACOG has explicitly stated on more than one occasion that admitting privileges are not

⁹ *Guidelines for Women's Health Care: A Resource Manual* 433 (Paula Hillard, et al., eds. 2007) (ACOG) (“Clinicians who perform abortions in their offices, clinics, or freestanding ambulatory care facilities should have a plan to provide prompt emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment.”); *2013 Clinical Policy Guidelines* 55 (NAF Dec. 2012) (“Protocols for the management of medical emergencies must be in place. These protocols must include indications for emergency transport and written, readily available directions for contacting external emergency assistance (i.e., an ambulance.”); Clinical Program Structure I-A-1, PPFA Manual of Medical Standards & Guidelines 12 (June 2012) (affiliates must have the “ability to transfer a client without delay to a hospital”).

necessary to the provision of safe abortion care and has opposed laws that make abortion access contingent on the availability of such privileges.¹⁰

27. The admitting privileges requirement of HB 2 is particularly unnecessary because Texas law already requires that abortions at 16 weeks LMP or greater be performed in a licensed ambulatory surgical center (“ASC”). Under the regulations established by the Department of State Health Services, all ASCs are already required to have a written transfer agreement with a hospital *or* the physicians who perform procedures there must have admitting privileges at a local hospital. Thus, Texas law already regulates transfer of care arrangements for all abortions at 16 weeks or later. While I believe that these requirements are unnecessary for any abortion provider, there is no reason to place a more onerous requirement on doctors who perform abortions prior to 16 weeks, including providers who do no surgery at all (*e.g.*, provide only medication abortion), than is placed on providers of much more risky surgeries performed in ASCs, as I discuss below.

Contemporary Medical Practice and Admitting Privileges

28. In my opinion, the admitting privileges requirement in HB 2 is completely at odds with the reality of contemporary medical practice around the country, including the trend of dividing ambulatory and hospital care. Indeed, hospitals now typically have their own dedicated staff physicians, and in many cases, only those physicians who have truly hospital-based practices actually have and maintain admitting privileges.

¹⁰ See *Statement on State Legislation Requiring Admitting Privileges for Physicians Providing Abortion Services*, ACOG, Apr. 25, 2013, available at http://www.acog.org/About_ACOG/News_Room/News_Releases/2013/Hospital_Admitting_Privileges_for_Physicians_Providing_Abortion_Services (“ACOG opposes laws or other regulations that require abortion providers to have hospital admitting privileges.”); ACOG, *Analysis of the Possible FDA Mifepristone Restrictions* (July 27, 2000) at 3 (“Privileges at a hospital are not necessary for prescribing [medication abortion] safely. . . . The prescribing physician does not need to be in the emergency room or to be the admitting physician if a patient requires follow-up emergency care. Women experiencing miscarriages and spontaneous abortions frequently require the same services and care and appropriately receive this care at their physicians’ offices.”).

29. The admitting privileges requirement is at odds with the development of inpatient “hospitalists,” who are hospital-based physicians who provide only inpatient care. For example, obstetrician/gynecologist hospitalists, called “laborists,” now practice providing only inpatient obstetric care during delivery, while a community obstetrician provides prenatal care and treats the pregnant woman as an outpatient.¹¹ This in-hospital “laborist” would also provide ob/gyn consultation and care to the emergency room physician as needed for care of a patient having an abortion complication.

30. Similarly, even where a hospital’s staff physicians are not solely hospitalists, if a pregnant woman experiences a complication, like pre-eclampsia, that requires emergency care, she will often be cared for in the hospital by the physician on call and not her regular physician. In fact, if the nearest hospital to the woman is one where her ob/gyn does not have privileges, the physician who cares for her in an emergency may not even be affiliated with the physician who provides her prenatal care.

31. It is extremely common for physicians to cover for each other and refer to other physicians as necessary to treat the patient. It is also well understood in medicine that while a physician must be properly trained and qualified to perform the procedures he or she performs, he or she need not be properly trained and qualified to handle all of the potential consequences and complications of those procedures. All physicians, at some point, must (and should) refer their patients to another specialist, or a subspecialist, to ensure quality of care.

32. In fact, referring a patient to an emergency room to handle complications, where the outpatient provider lacks admitting privileges, is common throughout outpatient medicine even outside the abortion context. I treat patients who have come to our hospital because of complications from non-abortion gynecological surgeries performed in outpatient settings, and

¹¹ *The Role of Laborist in Patient Care*, available at <http://www.oblaborist.org/> (last visited June 5, 2013).

we provide high quality care to those patients without a need for the surgeon who performed the procedure to have admitting privileges. For example, hysteroscopy and diagnostic dilation and curettage on nonpregnant women and surgical management of spontaneous abortion (“miscarriage”) are frequently performed in outpatient settings, and if there are complications, such as a uterine perforation, during such a procedure, the patient will be transferred to the hospital ER and may need follow-up surgery. Similarly, there has been an increase in physicians’ use of anesthesia, even general anesthesia, in outpatient clinic or office settings. Complications from general anesthesia are much more common than complications from abortion, and when patients experiencing those complications must be transferred to the ER, they will receive high quality care at the hospital. It is not necessary for the physician who performs the outpatient procedure or administers the anesthesia to have admitting privileges at the hospital. Certified nurse anesthetists frequently provide general anesthesia in the office or clinic setting and they obviously do not have admitting privileges.

33. Physicians frequently perform surgeries in ambulatory surgery centers (“ASCs”) that are generally more complicated and riskier than abortions. In the field of gynecology, those procedures can include laparoscopy, laparoscopic hysterectomy, and vaginal hysterectomy. Such procedures also usually involve general anesthesia with the patient paralyzed and intubated under the care of either an anesthesiologist or certified nurse anesthetist, which by itself is also much riskier than office-type procedures such as abortion and miscarriage management. In this regard, it appears that House Bill 2 singles out physicians who perform abortions by imposing an unnecessary admitting privileges requirement, while physicians who provide riskier treatments in an outpatient setting are not required by the State to have admitting privileges.

34. Due to the trends in granting privileges, there is an increasing divide between ambulatory and hospital-based care, which means that more and more 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.

35. Furthermore, I understand that HB 2 requires doctors who perform abortions to have “active admitting privileges,” but I do not understand which of two meanings “active” might have in this context, given my understanding of the terminology surrounding hospital staff and admitting privileges.

36. On the one hand, the word “Active” is a term of art used in the bylaws of most hospitals to delineate a particular category of medical staff (“staff”), usually the highest level of membership in a hospital’s staff. This is the case at Ben Taub Hospital, where I have privileges, and it is also true in many other hospitals in Texas, including those twelve hospitals where I have been on staff. In order to have admitting privileges, a physician must be a member of the hospital’s staff. Physicians who are “Active” members of the hospital staff are allowed to vote on hospital issues and hold office at the hospital, while a physician who is a “Courtesy” staff member can usually admit patients to the hospital, but is not permitted to vote or hold office at the hospital. Becoming an “Active” staff member is more difficult, and often a physician is not eligible to become a member of the “Active” staff unless (s)he has “Provisional” staff status for an extended period of time (such as one year), after which time the hospital engages in peer review of the physician’s work to decide whether to invite him or her to join the hospitals “Active” staff.

37. On the other hand, the phrase “active admitting privileges” might be used to describe admitting privileges that are current and up-to-date (and not, *e.g.*, lapsed or suspended). In this

usage, a physician who is a Courtesy staff member with admitting privileges at a hospital may have “active admitting privileges,” in the sense that (s)he could admit patients, but (s)he would not be a member of the “Active” medical staff under the hospital’s bylaws.

38. While any admitting privileges requirement is medically unnecessary and inconsistent with the standard of care, interpreting the word “active” to mean that physicians who perform abortions must become full members of the hospital staff at the highest level of participation, as opposed to requiring abortion providers to have “current” privileges that allow him or her to admit patients, would be especially problematic. It would mean that a physician could not perform abortions unless (s)he has the capacity to vote on hospital-related issues—a requirement that has absolutely no connection whatsoever to patient welfare or competent medical practice. And it would also make the admitting privileges requirement substantially more burdensome, in that fewer doctors could become members of a hospital’s “Active” staff, and even those that could potentially do so would be unable to do so for some time.

Medication Abortion Practice Today Using Evidence-Based Medicine

39. Clinical testing of mifepristone began abroad in 1982, and the drug was licensed in France and China in 1988. In 1996, a U.S.-based organization filed a New Drug Application (“NDA”) with the U.S. Food and Drug Administration (“FDA”), requesting approval of mifepristone for distribution in the United States. The FDA does not itself test medications. Rather, it reviews studies submitted by the applicant (known as “clinical trials”). In the case of mifepristone, the clinical trials involved fewer than 3000 women who took 600 mg of mifepristone orally and returned to the clinic approximately 36 to 48 hours later to take 400 µg of misoprostol orally. Those trials (in which, as I noted above, I was involved) showed that that regimen was safe and effective for abortions through 49 days LMP.

40. In September 2000, the FDA approved the NDA, and as part of that approval, as with all medications, approved a Final Printed Labeling (“FPL”), which is an informational document that provides physicians with guidance about the use for which the drug sponsor requested and received FDA approval. The mifepristone label, therefore, describes the regimen used in the clinical trials.¹² Mifepristone is the only medication that has received FDA approval for marketing as an abortion-inducing drug, and therefore, the only medication with an FPL describing an abortion regimen. The FDA has never required that mifepristone be used in a specific dosage, within a specific gestational age range, or following a specific regimen.

41. By the time that mifepristone was made available in the United States, newer research had been conducted showing that a lower dosage of mifepristone (200 mg) combined with a different dosage of misoprostol (800 µg), which the woman administered herself by placing the pills in her vagina (i.e., vaginal administration) was an equally safe regimen and was effective through 63 days LMP. This research also showed that changing the route of misoprostol administration decreased side effects. Based on this research, from the time that mifepristone medication abortion became available in the United States, the overwhelming majority of abortion providers offered their patients an evidence-based regimen different from the one on the FPL through 63 days LMP. The regimens used have changed over time in response to further research.

42. For more than the past five years, the evidence-based regimen most commonly used across the country, including in Texas, involves 200 mg of mifepristone taken orally at the clinic, followed approximately 24 to 48 hours later by 800 µg of misoprostol, which the woman self-

¹² The FPL says that Day One, the patient reads the Medication Guide, signs the Patient Agreement, and receives three 200 mg tablets of Mifeprex, taken orally at the health care facility; Day Three, the patient returns to the health care facility and, unless the abortion has already occurred, receives two 200 mg of misoprostol taken orally; and Day 14, approximately fourteen days after the mifepristone was administered, the patient returns to the health facility to confirm that a complete termination of pregnancy has occurred.

administers at home by placing it in her buccal pouch (i.e., between her cheek and gum). This evidence-based regimen is very safe and highly effective through 63 days LMP with results superior to and side effects fewer than the FDA FPL regimen which, unfortunately, is based on outdated studies from the mid 1990s (which I participated in).

43. The practice of developing new protocols, using different dosages, or using medications for entirely different uses than for which they were approved by the FDA when they are supported by adequate study, is not unique to mifepristone. This practice is common in medicine and is called “off-label” or “evidence-based” use. The American Medical Association has stated that up to 20 percent of all drugs are prescribed off-label and among some classes of cardiac drugs, off-label use can be as high as 46 percent.¹³ For example, this is how aspirin came to be used to prevent heart attacks and Wellbutrin, approved by the FDA as an anti-depressant, came to be used as a smoking cessation drug. Misoprostol, the second drug used in the medication abortion regimen, is another example. It was approved by the FDA as a drug to reduce the incidence of gastric ulcers in patients taking non-steroidal anti-inflammatory drugs such as ibuprofen and is labeled for that use. However, besides being routinely used as part of medication abortion, it is widely used in obstetrics to ripen the cervix prior to induction of labor and also to stop postpartum hemorrhage.

44. In almost all such cases, the label for the drug never reflects even the most common, accepted “off-label” uses. That is because only the manufacturer of a drug (in the case of mifepristone, there is only one manufacturer) can apply to have a drug relabeled, the process is very expensive (the manufacturer has to submit and perhaps conduct new research to support the

¹³ AMA National Task Force on CME Provider/Industry Collaboration Fact Sheet, On-Label and Off-Label Usage of Prescription Medicines and Devices (available at <http://www.ama-assn.org/resources/doc/cme/fact-sheet-4.pdf>).

application and pay a large application fee), and there is simply no incentive for the manufacturer to do so, as off-label use is so prevalent and so rarely restricted.

45. In the case of mifepristone, extensive research demonstrates that the alternative evidence-based regimens are every bit as safe as – and indeed, superior to – the regimen that appears on the FPL. In contrast to the approximately 2500 women who participated in the clinical trials, more than one million American women have now safely used an alternative, evidence-based mifepristone regimen to terminate their pregnancies.

46. The alternative evidence-based regimens are more effective, with both a lower rate of ongoing pregnancies and fewer surgical interventions necessary to complete the procedure. There are also fewer side effects such as nausea and vomiting. The FPL regimen has been shown to result in an ongoing pregnancy in approximately one percent of cases, and as many as eight percent of women following the FPL regimen will have a surgical procedure following the medications. Using much larger data sets, the off-label, evidenced-based regimen described above that most providers, including in Texas, use will result in ongoing pregnancy in only 0.5 percent of cases, and only two percent of women have had a surgical procedure following the medications.¹⁴ Given its superiority, there is no medical or empirical basis for banning the off-label, evidence-based use, and certainly none for requiring the less effective FPL in its place.

47. The alternative regimens have a number of other advantages. *First*, they are effective for longer in pregnancy, allowing medication abortions to be performed at least through 63 days LMP and many more women to avail themselves of that method, thus avoiding an undesired surgical procedure. Those additional weeks are significant because many women do not detect their pregnancies until close to 49 days LMP. *Second*, self-administration of misoprostol (which

¹⁴ The reasons why a woman may have a surgical procedure include ongoing pregnancy, bleeding (often due to retained tissue), and patient request.

has been studied and proven safe) eliminates a trip to the clinic for the misoprostol, allows the woman greater control over the timing of the procedure, and ensures that she experiences the bleeding and cramping that follows in a location of her choosing and with her husband, partner, or other supporting loved ones present. *Third*, the lower mifepristone dosage reduces the cost of the procedure significantly. *Fourth*, the alternative regimens have lower incidence of side effects than the regimen that appears on the FPL, as mentioned above.

48. These advantages of, and the safety of, the alternative evidence-based regimens are widely acknowledged. In fact, ACOG, the World Health Organization, and the Royal College of Obstetricians and Gynecologists have all endorsed use of an evidence-based alternative regimen through 63 days.

49. Mifepristone medication abortion is also increasingly prevalent. For example, of those women eligible for either surgical or medication abortion (meaning that they had a gestational age of 63 days LMP or less and no other contraindication) at a Planned Parenthood health center nationwide, in 2008, an estimated 53 percent of them (more than 97,000 women) chose to have a mifepristone medication abortion rather than a surgical procedure. I believe that this is representative of Texas as well; about that time, over 50% of eligible patients at Planned Parenthood in Waco chose medication abortion. Currently, at Planned Parenthood Center for Choice, although we offer abortions throughout the entire first trimester and into the second trimester, approximately 1/3 of all of our abortion patients choose medication abortion (which is only offered through 63 days), which is about 10 to 12 women per day, five days a week.

50. Far more than many other medical procedures, abortion has a very private, emotional component to it. Women seeking abortions are trying to manage their feelings about an unwanted pregnancy. In my experience, women have many different and personal reasons for

deciding to terminate a pregnancy that is not right for them. Issues regarding her age, economic situation, familial situation (including her children and her partner), and emotional and physical health all may play a part in both why a woman is having an abortion and why she chooses the procedure that she does.

51. Based on my own extensive experience and the literature, it is my opinion that once women are counseled about both medication and surgical abortion, most demonstrate a strong and clear preference for the type of procedure that they choose and are satisfied with that method. I believe that women know their own needs and desires and choose the abortion method that is best for them.

52. One of the most common reasons that women choose medication abortion is that they feel that it allows them to exert a greater degree of personal control over the procedure and over their bodies, compared to a surgical abortion. Many women like that they have an active role in the process of a medication abortion, which they also find more “natural.”

53. As explained above, in a medication abortion, the woman takes the mifepristone at the clinic, but the contents of the uterus will be expelled later. This means that patients can undergo the procedure largely at a time and location of their choice, most often in their own homes. For many women, this feels more private than being surrounded by the clinic staff. It also means that they can have the support of the people they want around them. At many clinics, partners, family, and friends are not allowed into the procedure rooms when a woman has a surgical abortion.

54. Some women fear the invasive nature of a surgical abortion or the loss of control that comes from sedation or anesthesia. For women with these anxieties, medication abortion is highly preferable. Additionally, some Texas physicians do the medication abortion out of their

regular office, eliminating the need for the woman to pass through a crowd of harassing protesters often found outside of abortion clinics. There are also some women – particularly those who have been victims of rape, sexual abuse, or molestation – for whom having to lie on the table and have instruments inserted into their vaginas is particularly traumatic. In my experience, medication abortion is particularly beneficial for these women where products of conception is not required as evidence for criminal prosecution.

55. Some women have a medical condition that can make first-trimester surgical abortion extremely difficult – and in some cases, impossible. These circumstances include situations that make it difficult for the provider to access the pregnancy inside the uterus. Such cases may include women who are extremely obese, have uterine fibroids distorting normal anatomy, have a uterus that is very flexed, or have certain uterine anomalies, such as a bicornate uterus (a malformation where the upper portion forms two “horns” making the uterus appear somewhat heart-shaped). For these women, surgical abortion poses much higher risks of failed abortion, as well as complications such as perforation of the uterus. Medication abortion, therefore, is a significantly safer choice.

56. Another circumstance where medication abortion may be significantly safer is when it is very difficult to dilate the woman’s cervix. This occurs when women have a condition called a stenotic cervix (an abnormally small cervical opening, often caused by scarring from prior surgeries). It may also happen when a woman has undergone female genital mutilation. Forcing some of these women to have surgical rather than medication abortions would put them at greater risk of damage to their cervix as well as other complications, such as uterine perforation.

The Texas Law's Unnecessary and Burdensome Limits on Medication Abortion

57. HB 2 would significantly decrease the availability of medication abortion in Texas with no patient benefit. In fact, as I explain below, the new restrictions on medication abortion in HB 2 would reverse decades of medical advances for Texas women and threaten their health.

58. Under the Act, physicians face administrative and criminal penalties, including possible license revocation, if they “give, sell, dispense, administer, provide, or prescribe an abortion-inducing drug” to a patient unless “the provision, prescription, or administration . . . satisfies the protocol tested and authorized by the United States Food and Drug Administration as outlined in the final printed label of the abortion-inducing drug.” Tex. Health & Safety Code §§ 171.063(a), 171.064. The only exception to this prohibition is that:

A person may provide, prescribe, or administer the abortion-inducing drug in the dosage amount prescribed by the clinical management guidelines defined by the American Congress of Obstetricians and Gynecologists Practice Bulletin as those guidelines existed on January 1, 2013.

Id. § 171.063(b).

59. I do not understand what this law means when it says that doctors may “provide, prescribe, or administer” abortion-inducing drugs in the “dosage amount prescribed by” the ACOG guidelines. ACOG has a Practice Bulletin of Clinical Management Guidelines related to Medical Management of Abortion which was adopted in 2005 and reaffirmed in 2011 and which is attached hereto as Exhibit 2. This Bulletin does not “prescribe” any specific “dosage amount,” but does list the following among its highest level of recommendations, which are “based primarily on good and consistent scientific evidence”:

- Compared with the FDA-approved regimen, mifepristone-misoprostol regimens using 200 mg of mifepristone orally and 800 µg of misoprostol vaginally are associated with a decreased rate of continuing pregnancies, decreased time to expulsion, fewer side effects, improved complete abortion

rates, and lower cost for women with pregnancies up to 63 days of gestation based on LMP.

- A patient can administer misoprostol safely and effectively, orally or vaginally, in her home as part of a medical abortion regimen.

60. The ACOG recommendation quoted above is not limited to a “dosage amount” – it is a regimen that uses a different route of administration for the misoprostol than the FPL (vaginal rather than oral), as well as a different gestational age limit (63 rather than 49 days LMP). But it is not clear if H.B. 2 allows anything other than the “dosage amounts” in the ACOG recommendation – meaning that a doctor would have to follow the route of administration and the gestational age limit on the FPL (i.e., oral misoprostol and a 49 day limit).

61. While H.B. 2 seems to say this, it seems it cannot possibly mean this, as 200 mg mifepristone orally, followed by 800 µg of misoprostol orally (which is the route of administration for the misoprostol on the FPL) is a completely untested regimen that has never been endorsed by ACOG, and no study that I am aware of has considered such a regimen. It would be irresponsible of physicians to experiment with an untested regimen on patients, and therefore, this reading would render the ACOG exception meaningless. Presumably, the Legislature meant to allow something with the ACOG exception, but it is not clear.

62. Moreover, it makes no sense as a matter of medicine that the Legislature would endorse only the dosage amount in the ACOG recommendation. If it believed that ACOG makes good medical recommendations, why not allow everything AGOC has recommended, including use through 63 days LMP and self-administration of misoprostol? And why limit me to the Practice Bulletin as it existed in January 2013? Bulletins such as these are often updated with newer, more comprehensive research, but the Legislature seems to have said that only any

recommendations from prior to January 2013 are good, freezing medical practice in time, and denying me and my patients the best medical practices available in the future.

63. If the ACOG exception not does not allow vaginal or buccal administration of misoprostol and limits provision of mifepristone to 49 days, or if there is no clarification of what it means, women will be left with only the FPL regimen – as many physicians would not want to risk the significant penalties for violating the Act. This would be a huge disservice to Texas women as it would result in a ban on medication abortion entirely after 49 days LMP because, as I noted above, mifepristone is the only abortion-inducing drug that has a FPL related to abortion and the regimen on the FPL is limited to 49 days.

64. If H.B. 2 does ban medication abortion after 49 days LMP, it will have taken away a safe option using medication alone – if a woman with a gestational age past 49 days LMP chooses abortion, she must have a surgical procedure. There is no medical reason for this because, as I describe above, hundreds of thousands of American women have safely had mifepristone medication abortions with gestational ages of 50 through 63 days LMP. Indeed, mifepristone medication abortion has been shown to be safe and effective, and is beginning to be provided, through 70 days LMP. Rather than protecting women's health, the Act actively harms women by depriving them of advances in medicine made over the past twenty years.

65. For those women I identified above with specific medical conditions that make surgical abortion significantly more risky, the Act's ban after 49 days LMP is much worse. It will mean that they will be subjected to significant – and unnecessary – health risks.

66. For women with gestational ages through 49 days LMP, the Act does not ban medication abortion entirely, but leaves them with an inferior protocol and places significant barriers in their path. That is because unless the ACOG exception allows self-administration of

misoprostol, in order to have a medication abortion under the new rules, a woman would be required to make three or four separate trips to her provider over the course of two weeks. This is because Texas Health & Safety Code § 171.012 requires that the “physician who is to perform the abortion” provide certain information to the woman in person at least 24 hours before the procedure unless she lives more than 100 miles from an abortion provider (visit 1). The woman must return at least 24 hours later to take the mifepristone (visit 2) and two days later to take the misoprostol (visit 3), which, unless the ACOG exception allows for self-administration, must each be administered by a physician because they are each an “abortion-inducing drug” under the Act’s definitions. *See* Tex. Health & Safety Code §§ 171.061(2), 171.063(a)(1).¹⁵ Finally, the Act requires “[t]he physician who gives, sells, dispense, administers, provides, or prescribes the abortion-inducing drug” to do certain things at the follow-up visit, which must be “not more than 14 days after administration or use of the drug” (visit 4). *Id.* § 171.063(3).

67. Today, some Texas women who choose medication abortion make three visits (for the mandatory counseling, to take the mifepristone, and for a follow-up), but others travel to the abortion provider only once (if she lives further than 100 miles from an abortion provider) or twice (for the counseling visit and to take the mifepristone) if they are able to arrange their follow-up appointment, involving an ultrasound or a blood test, at a location nearer to their homes. There is no medical justification for requiring women to return to a health center to take the misoprostol, and there is none for requiring a physician – and certainly not the same physician – to administer it. Medications prescribed by physicians are routinely and safely administered by other trained health professionals.

¹⁵ It is not clear to me if this could be a different physician or must be same physician she saw for the first two visits.

68. Not only is there no medical reason, but it is also contrary to good medical practice, to require women to make three or four trips to the health center to obtain a medication abortion. In particular, requiring that the woman visit the health center to take the misoprostol *harms* women because it is unpredictable when the misoprostol will take effect and how long the bleeding will last. Some women will begin to bleed and cramp as soon as 30 minutes after they take the misoprostol. Others may not start bleeding for hours. For some women, the bleeding will last an hour or two. For others, it could be much longer. It is far better for women to experience these symptoms in the comfort of her own home, with her family or partner, rather than in a car (possibly while driving) or bus while they are traveling home from the health center, which in Texas could involve great distances.

69. In this way, requiring the FPL regimen would take away the major advantage that propels many women to choose medication abortion in the first place – that they can time these symptoms and be in a comfortable place with the support of loved ones of their choosing when they occur. Requiring the FPL would also significantly increase the cost of the procedure both because the woman will have to take two extra mifepristone pills, each of which cost approximately \$80, and because the provider will have to staff the extra visits.

70. It will impose other burdens too, which for some women would be costly. In my experience, it is hard for many women to access the clinic, so making them come in four times in a two-week period – for the 24-hour counseling meeting, to take the mifepristone, to take the misoprostol, and for the follow-up visit – would be very difficult for many of them. This is especially true for young women, low-income women, women who are victims of domestic violence, women with child care responsibilities, and women with job commitments, as each trip to the clinic will require additional travel and time away from home, children, and work.

71. If faced with a more expensive, less private option that requires four trips to the health center – and especially if the procedure is limited to 49 days LMP, many women will no longer have the option of, or choose, medication abortion. And if too few women choose it, it is foreseeable that many providers will simply stop providing it.

72. Perhaps most importantly, all of these changes and burdens on women come with absolutely no medical benefit flowing from them. For all of these reasons, I believe that the medication abortion restrictions in H.B. 2 do not advance women's health in any way. To the contrary, HB 2 turns back the clock on more than 20 years' worth of research and experience, and I believe that it would have a significant negative impact on the health of Texas women.

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

73. As I mentioned above, women seek abortions for a variety of medical, familial, economic, and personal reasons. More than 60% of women who seek abortions are mothers who have decided that they cannot parent another child at this time,¹⁶ 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.¹⁷ Approximately one in three women in this country will have an abortion in their lifetimes.¹⁸

74. It is extraordinarily important for women to have meaningful access to legal abortion. Women of childbearing age who do not have access to the procedure face significantly increased risks of death and poor health outcomes. For example, when women are forced to travel long distances for care, many will delay obtaining an abortion until they can find the money or arrange transportation. While abortion is a safe procedure, the risks from abortion increase as

¹⁶ Rachel Jones, et al., *Characteristics of U.S. Abortion Patients, 2008*, Guttmacher Inst. 1, 8 (2010).

¹⁷ Stanley Henshaw & Kathryn Kost, *Abortion Patients in 1994-1995: Characteristics and Contraceptive Use*, 28 *Fam. Plan. Persp.* 140, 144 (1996).

¹⁸ Rachel Jones & Megan Kavanaugh, *Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion*, 117 *Obstet. & Gynecol.* 1358, 1365 (2011).

the pregnancy advances. Thus, delaying abortions until later in pregnancy increases the risks of complications.¹⁹

75. When legal abortion is unavailable or difficult to access, some women turn to illegal, and unsafe, methods to terminate unwanted pregnancies.²⁰

76. Other women, deprived of access to legal abortion, forgo the abortions they would have obtained if they could and, instead, carry unwanted pregnancies to term. These women are exposed to increased risks of death and major complications from childbirth, and they and their newborns are at risk of complications during pregnancy and after delivery.²¹

77. There is a nationwide shortage of physicians willing to provide abortions to the women who need it. HB 2 imposes medically unnecessary and hard-to-satisfy restrictions on physicians who are currently willing to provide abortions to women in Texas, increasing the obstacles and correspondingly diminishing the number of providers. It will, therefore, be extremely harmful to the health and well-being of women in Texas.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 25, 2013


Paul M. Fine, MD

¹⁹ Linda Bartlett, et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 *Obstet. & Gynecol.* 729, 735 (2004).

²⁰ Daniel Grossman, et al., *Self-Induction of Abortion Among Women in the United States*, 18 *Reprod. Health Matters* 136 (2010).

²¹ Jessica Gipson, et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 *Stud. Fam. Plan.* 18 (2008).