No. 14-50928

In the United States Court of Appeals for the Fifth Circuit

WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS D/B/A REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; AND LENDOL L. DAVIS, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS,
Plaintiffs-Appellees,

v.

DAVID LAKEY, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES; MARI ROBINSON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD,
Defendants-Appellants.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division
Case No. 1:14-cv-284-LY

EMERGENCY MOTION TO STAY FINAL JUDGMENT PENDING APPEAL AND MOTION FOR EXPEDITED CONSIDERATION

GREG ABBOTT
Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
(512) 936-1700

JONATHAN F. MITCHELL
Solicitor General

JAMES D. BLACKLOCK
Deputy Attorney General
for Legal Counsel

BETH KLUSMANN
MICHAEL P. MURPHY
Assistant Solicitors General

Counsel for Appellants

Nature of Emergency

At 4:45 P.M. on Friday—three days before the law was to take effect—the district court enjoined multiple provisions of Texas House Bill 2 in a sweeping order that fails to recognize or apply the binding precedents of this Court and the Supreme Court. Without so much as mentioning the "large fraction" standard that applies in this Circuit to pre-enforcement facial challenges to abortion regulations, the district court's judgment facially invalidates HB2's requirement that abortion clinics meet the regulatory standards for ambulatory surgical centers. The court also blocked HB 2's admitting-privileges requirement—previously upheld by this Court—as applied to the plaintiff abortion clinics. Beyond that, the court's judgment seems to bar enforcement of the admitting-privileges requirement of HB 2 on a statewide basis, even though the plaintiffs did not ask for this relief and could not plausibly have asked for it after this court's decision in *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 748 F.3d 583 (5th Cir. 2014) (*Abbott II*), which overturned the district court's previous statewide injunction against the admitting-privileges law.

In holding these provisions unconstitutional, the district court failed even to mention (much less follow) precedent from the Supreme Court and this Court regarding the applicable legal test for facial challenges to abortion regulations—the "large fraction" test. In its place, the district court substituted its own "significant number" test, which has no basis in existing law. The district court also refused to apply this Court's recent holding that travel distances of 150 miles do not consti-

tute an undue burden. *See Abbott II*, 748 F.3d at 599. And in contravention of the Supreme Court's instructions in *Mazurek v. Armstrong*, 520 U.S. 968 (1997), the district court purported to find an improper legislative purpose based not on the actions or statements of legislators (of which there was no evidence at trial), but on legal positions taken by the State's counsel in litigation and rules adopted by an executive-branch state agency. All of these precedents were cited repeatedly by the State, yet the district court failed to follow any of them.

This Court should not countenance the district court's failure to recognize and apply the law of the Supreme Court and this circuit. Allowing this judgment to remain in effect pending appeal would not only perpetuate legal error—it would give effect, even if only for a short time, to a lower court's decision to ignore the precedent of this Court and the Supreme Court. The judgment should be stayed immediately pending appeal.

* * *

On July 18, 2013, the Governor signed into law House Bill 2 (HB2).[1] HB2 contains four provisions regulating abortions: it bans abortion after 20 weeks post-fertilization, requires drug-induced abortions to follow the protocol established by the FDA, requires abortion practitioners to hold admitting privileges at a hospital within 30 miles of where the abortion is performed, and requires abortion clinics operating after September 1, 2014, to meet the standards of ambulatory surgical centers (ASCs). HB2 includes a "comprehensive and careful severability provi-

[1] Act of July 12, 2013, 83d Leg., 2d C.S., ch. 1, 2013 Tex. Gen. Laws 4795.

sion," *Abbott II*, 748 F.3d at 589, which requires reviewing courts to sever not only the textual provisions of HB2, but also the statute's applications to individual abortion providers and patients. *See* HB2, § 10(b). HB2 was scheduled to take effect on October 29, 2013.

On September 27, 2013, the plaintiffs filed a lawsuit that challenged only the admitting-privileges requirement and the regulations of abortion-inducing drugs. The plaintiffs demanded total, across-the-board invalidation of the admitting-privileges requirement, and declined to request a more limited remedy that would enjoin the admitting-privileges law only as applied to abortion practitioners who could prove that the law would impose an "undue burden" on their patients. The district court enjoined the admitting-privileges requirement across the board, but a motions panel stayed that decision pending appeal. *See Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (5th Cir. 2013) (*Abbott I*). The merits panel reversed the district court, rejecting the plaintiffs' facial challenge to HB2's admitting-privileges requirement. *See Abbott II*, 748 F.3d at 600.

On April 2, 2014, the plaintiffs filed a second lawsuit that renews their challenge to the admitting-privileges rule. This time the plaintiffs sought only a limited remedy that would enjoin the admitting-privileges law as applied to two abortion clinics: Whole Woman's Health in McAllen and Reproductive Services in El Paso. The current lawsuit also challenges HB2's ambulatory-surgical-center requirements (which the plaintiffs never challenged in the previous lawsuit), seeking both

facial invalidation and, as a fallback option, as-applied relief limited to the McAllen and El Paso clinics.

The State's ambulatory-surgical-center rules (ASC rules) are codified at 25 Texas Administrative Code §§ 135.1-135.56, and they comprise many different types of regulations, all of which are severable from each other. *See id.* § 139.9(b) ("[E]very provision, section, subsection, sentence, clause, phrase, or word in this chapter and each application of the provisions of this chapter remain severable from every other provision, section, subsection, sentence, clause, phrase, word, or application of this chapter.").

The district court held a four-day trial on August 4–7, 2014. The parties stipulated that at least seven abortion clinics would meet the State's ASC requirements and remain open after September 1, 2014, and further stipulated that Planned Parenthood intended to open a new ASC abortion clinic in San Antonio. *See* Joint Stip. to Facts (doc. 154) ¶¶ 1-3. The parties did not stipulate that these would be the only abortion clinics operating in Texas after September 1, and they did not stipulate that no other abortion clinic ASCs would emerge before or after September 1.[2] But the plaintiffs have litigated their case on the assumption that these eight facilities will be the only remaining abortion clinics in Texas.

[2] The district court's opinion incorrectly states that the parties stipulated that these eight clinics would be the "only" clinics in the State. Mem. Op. (doc. 198) 7. The stipulation was carefully worded to avoid that concession. The State did not stipulate that no new ASC abortion clinics would open before or after September 1, 2014, and it was the plaintiffs' burden to prove with evidence that Planned Parenthood and other abortion providers who are not parties to this lawsuit would not be opening any new ASC clinics in Texas. The plaintiffs provided no evidence of this.

At trial, the plaintiffs tried to establish an "undue burden" by arguing that the ASC law would increase driving distances for some abortion patients. Their expert Daniel Grossman opined that 930,000 women of reproductive age will live more than 150 miles from an abortion clinic after the ASC rules take effect. *See* Grossman Direct (doc. 163), at ¶ 23; *see also* Plfs.' Proposed Findings of Fact and Conclusions of Law (doc. 136), FOF ¶ 66; *see also* Mem Op. 9 (adopting Grossman's numbers).[3] But the plaintiffs encountered an insurmountable obstacle in their quest for *facial* invalidation of the ASC law: They could not prove that the ASC law would subject a "large fraction" of the State's abortion patients to unduly burdensome driving distances—and the Supreme Court (and this Court) have repeatedly held that an abortion regulation cannot be *facially* invalidated unless it imposes an undue burden "in a large fraction of relevant cases." *Gonzales v. Carhart*, 550 U.S. 124, 167-68 (2007); *see also Abbott II*, 748 F.3d at 588-89, 591, 598; *Abbott I*, 734 F.3d at 414. The defendants presented unrebutted expert testimony that that 83% of Texas women would live within 150 miles of an ASC abortion clinic—and an additional 6–7% live outside that range for reasons unrelated to HB2. As *Abbott II* holds that driving distances of 150 miles or fewer are not an "undue burden," 748 F.3d at 598, that means that no more than 1 out of 10 abortion patients could possibly claim an "undue burden" on account of increased travel distances. That is not

[3] Grossman's 930,000 number is misleadingly large, because it includes women who live in areas of the State (such as Lubbock, Amarillo, and Midland/Odessa) where the absence of an abortion clinic within 150 miles pre-dates HB2 and has nothing to do with HB2. And of course, most of these 930,000 "women of reproductive age" will never seek an abortion.

a "large fraction," and the plaintiffs did not argue that this could satisfy the "large fraction" test.

On Friday, August 29, 2014, at 4:45 P.M., the district court issued a memorandum opinion and final judgment. The opinion concludes that the ambulatory-surgical-center standards should be facially invalidated as an "undue burden," but it does not find or even assert that the law will impose an undue burden on a "large fraction" of the State's abortion patients—and it conducts no analysis of the "fraction" of patients that will encounter undue burdens on account of the ASC law. Indeed, the "large fraction" test is not even mentioned in the district court's opinion—even though the State had repeatedly cited the passages from *Gonzales*, *Abbott I*, and *Abbott II* that forbid facial invalidation absent proof of an undue burden on a "large fraction" of patients to whom the law is relevant. *See, e.g.*, Defs.' Post-Trial Br. (doc. 184) 8-9, 15-17. The district court also ignored this Court's clear instruction that driving distances of 150 miles to obtain an abortion does not constitute an undue burden.

The district court's opinion also holds that the ASC statute was enacted with the "purpose" of imposing an undue burden on abortion patients, although it cites no evidence of the legislature's motives for enacting HB2, despite the Supreme Court's clear statement that such evidence is required to support an unconstitutional-purpose finding. *See Mazurek*, 520 U.S. at 972 (rejecting purpose challenge to abortion regulation due to the lack "of any evidence suggesting an unlawful motive on the part of the Montana Legislature"). And the district court declared the

ASC standards unconstitutional as applied to drug-induced abortions, because "any medical justification for the requirement is at its absolute weakest in comparison with the heavy burden it imposes." Mem. Op. 18. Near the end of the opinion, the district court notes HB2's severability clause and holds that the State may enforce its ASC standards against "currently licensed ambulatory-surgical-center abortion providers in Texas" and "new abortion providers that begin offering abortion services after September 1, 2014." Mem. Op. 19.

As for the admitting-privileges law, the district court's opinion holds that it is "constitutionally impermissible" "as applied to the Rio Grande Valley and El Paso clinics." Mem. Op. 16. But then the opinion concludes with the following paragraph:

> However, when the two provisions [ASC and admitting privileges] are considered together, they create a scheme that effects the closing of almost all abortion clinics in Texas that were operating legally in the fall of 2013. Thus, the overall effect of the provisions is to create an impermissible obstacle as applied to all women seeking a previability abortion. The court will thus enjoin the enforcement of both provisions on the basis that they act together to create an undue burden on a woman seeking a previability abortion by restricting access to previously available legal facilities.

Mem. Op. 21. This appears to invalidate the admitting-privileges law across the board, or at least as applied to all "previously available legal facilities."[4] But the

[4] It is not clear from the district court's opinion whether "previously available legal facilities" refers to abortion clinics that were open immediately before the district court's ruling, or those that were open immediately before the admitting-privileges law took effect, or those that were open at any point in time before the district court's ruling.

plaintiffs had not even asked the court for statewide relief against the admitting-privileges law; they brought an as-applied challenge that sought relief only for the McAllen and El Paso clinics. *See Jackson Women's Health Org. v. Currier*, No. 13-60599, 2014 WL 3730467, at *9 (5th Cir. July 29, 2014) (holding that district court may not facially enjoin admitting-privileges law when the plaintiffs brought only an as-applied challenge). Of course, a holding invalidating the admitting-privileges requirement across the board would squarely contradict this Court's ruling in *Abbott II*. If interpreted that way, the district court's order openly flouts this Court's ruling and provides relief that not even the plaintiffs thought could be requested in this case.

The district court's judgment largely tracks the opinion, although there are some discrepancies. The judgment first declares that the statute requiring abortion clinics to comply with the State's ASC standards is unconstitutional "[a]s to all abortion facilities in the State," with exceptions for previously licensed ASCs and abortion clinics opening after September 1, 2014. *See* Final Judgment (doc. 199) 3. The judgment also states that the ASC statute is unconstitutional "[a]s applied to the provision of medical abortion."[5] *Id.* The judgment then declares that the admitting-privileges statute "is unconstitutional as applied to Plaintiffs Whole Woman's

[5] The judgment does not mention the administrative regulations that require abortion clinics to comply with the State's ASC rules, *see* 25 Tex. Admin. Code § 139.40, §§ 135.1-135.56, nor does it mention the administrative regulations requiring abortion practitioners to hold hospital-admitting privileges, *see id.* § 139.56. In what appears to be an oversight, the judgment does not declare the administrative regulations unconstitutional or enjoin the State's officers from enforcing them.

Health and Sherwood Lynn with respect to the operation of an abortion facility in McAllen, Texas, and Plaintiffs Nova Health Systems and Pamela Richter with respect to the operation of an abortion facility in El Paso, Texas." *Id.*

But the judgment may actually swallow all of these caveats, because it also declares that "the two portions of Texas Health and Safety Code, Sections 245.010(a) [ASC] and 171.0031(a)(1) [admitting privileges], create an impermissible obstacle *as applied to all women seeking a previability abortion.*" Final Judgment 3 (emphasis added). The simplest reading of this language is that it purports to blocks the State from enforcing the ASC and admitting-privileges statutes against *any* abortion provider—present or future—that performs previability abortions, even though the final paragraph in the court's opinion seems to say that the laws would be blocked only to the extent they "restrict[] access to *previously available* legal facilities." Mem. Op. 21 (emphasis added). Again, this relief was not even requested by the plaintiffs and it cannot be squared with *Abbott II*. The judgment concludes by enjoining the state defendants from "enforcing the above-listed portions of sections of the Texas Health and Safety Code to the extent stated herein." Final Judgment 3.

Texas respectfully seeks a stay of the judgment pending appeal. The emergency arises from the district court's decision to issue its ruling at 4:45 P.M. on the Friday before the ASC requirements take effect, and Texas requests emergency relief so that its law may take effect without delay. The emergency has been compounded by the district court's inexplicable decision to enter what seems to be a statewide in-

junction against HB2's admitting-privileges law despite this Court's clear ruling to the contrary and despite the plaintiffs' failure to request that relief. Texas has filed a motion for a stay in the district court, *see* Fed. R. App. P. 8(a)(2)(A)(i), but we do not expect the district court to stay its decision and respectfully ask this Court to act without waiting for the district court.

Because the district court issued its ruling only 15 minutes before the close of business on Friday, and because the request for a stay presents multiple legal issues, the State recognizes that it will not be possible for this Court to rule before the ASC law is scheduled to take effect on September 1, 2014. Texas nevertheless asks the Court to decide this motion by the close of business on Friday, September 5, 2014, or as soon as possible thereafter. Texas also asks this Court to immediately stay—without awaiting a response from the plaintiffs—the portion of the judgment that seems to be intended to invalidate the admitting-privileges law on its face. That relief is patently improper when the plaintiffs brought only an as-applied challenge and did not ask for statewide relief against the admitting-privileges law, *see Jackson Women's Health Org.*, 2014 WL 3730467, at *9, and the State is suffering immediate injury from a purported statewide injunction against a law that has already taken effect and that has already been upheld by this Court, *see Abbott II*, 748 F.3d at 599-600. Finally, the State requests expedited consideration of this appeal, regardless of whether the Court grants or denies the stay.

CERTIFICATE OF INTERESTED PERSONS

Counsel of record certifies that the following persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

Plaintiffs	Plaintiffs' Counsel
• Whole Woman's Health • Austin Women's Health Center • Killeen Women's Health Center • Nova Health Systems d/b/a Reproductive Services • Sherwood C. Lynn, Jr., M.D. • Pamela J. Richter, D.O. • Lendol L. Davis, M.D.	Jan Soifer Patrick J. O'Connell O'CONNELL & SOIFER LLP Janet Crepps Stephanie Toti Esha Bhandari Natasha Lycia Ora Bannan David P. Brown CENTER FOR REPRODUCTIVE RIGHTS J. Alexander Lawrence Betre M. Gizaw Marissa P. Harris Colic M. O'Brien Kiersten A. Fletcher MORRISON & FOERSTER LLP John H. Bucy II

Former Plaintiffs	Former Plaintiffs' Counsel
• Abortion Advantage • Lamar Robinson, M.D.	Same as Plaintiffs' Counsel listed above

Defendants	Defendants' Counsel
• David Lakey, M.D., Commissioner of the Texas Department of State Health Services • Mari Robinson, Executive Director of the Texas Medical Board	James D. Blacklock Jonathan F. Mitchell Andrew S. Oldham Beth Klusmann Philip Lionberger Michael P. Murphy Andrew B. Stephens Esteban S.M. Soto Enrique Varela Shelley N. Dahlberg Erika M. Kane OFFICE OF THE ATTORNEY GENERAL

Former Defendants	Former Defendants' Counsel
• David Escamilla • Jaime Esparza • Rene Guerra • James E. Nichols • Susan D. Reed • Joe Shannon, Jr. • Craig Watkins	None

/s/ Jonathan F. Mitchell
JONATHAN F. MITCHELL
Counsel for Appellants

ARGUMENT AND AUTHORITIES

I. THE COURT SHOULD STAY THE DISTRICT COURT'S JUDGMENT PENDING APPEAL

In deciding whether to stay a final judgment pending appeal, a court must consider four factors: "(1) whether the stay applicant has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies." *Abbott I*, 734 F.3d at 410 (citations and internal quotation marks omitted). Texas's application satisfies this test.

A. The District Court's Decision To Facially Invalidate The State's Ambulatory-Surgical-Center Requirements Is Likely To Be Reversed.

The district court's decision to facially invalidate the ASC standards cannot be sustained for a simple reason: There is no finding or claim in the district court's opinion that HB2 will unduly burden a "large fraction" of Texas abortion patients. And no such finding from the district court could have survived appellate review. Unrebutted evidence at trial conclusively proved that the vast majority of Texas abortion patients live within 150-mile driving distances of Austin, Dallas, Fort Worth, Houston, or San Antonio—and each of these cities will host at least one ASC abortion provider after September 1, 2014. There is no basis for concluding that the ASC standards impose an "undue burden" on any patient living within reasonable driving distances of those cities, and there is no way for the plaintiffs to

show that a "large fraction" of patients will encounter undue burdens when the vast majority of the State's population lives near an ASC abortion clinic.

The district court's opinion is careful to avoid any claim that the ASC rules will unduly burden a "large fraction" of the State's abortion patients. Instead, the opinion makes vague assertions that a "significant number" of patients will experience increased travel distances. *See* Mem. Op. 9 ("[A] *significant number* of the reproductive-age female population of Texas will need to travel considerably further in order to exercise its right to a legal previability abortion.") (emphasis added); *id.* at 11 ("[T]he court concludes that the practical impact on Texas women due to the clinics' closure statewide would operate for a *significant number* of women in Texas just as drastically as a complete ban on abortion."). That is not a basis on which a court may *facially* invalidate an abortion law. Even if a "significant number" of patients will encounter undue burdens or substantial obstacles, that cannot justify facial invalidation under this Court's precedents unless that "significant number" amounts to a "large fraction" of Texas's abortion patients. The Court could not have made this more clear in *Abbott I* and *Abbott II*. *See Abbott I*, 734 F.3d at 414 ("The question in a 'large fraction' analysis would be whether the requirement imposes an undue burden on a large fraction of women in Texas seeking an abortion."); *Abbott II*, 748 F.3d at 600 ("[T]he regulation will not affect a significant (much less 'large') fraction of such women."). The district court did not undertake this inquiry, opting instead to replace this Court's "large fraction" standard with a more plaintiff-friendly "significant number" test. That alone warrants a stay of the district court's ruling.

The district court was not unaware of the rulings from this Court that require a "large fraction" analysis. Its refusal to acknowledge or apply the "large fraction" test stems from the fact that the evidence at trial could not support a finding that a "large fraction" of the State's abortion patients would encounter undue burdens on account of the ASC rules. The plaintiffs' expert Daniel Grossman opined that HB2 will increase driving distances for abortions, but the plaintiffs did not dispute the methodology or conclusions of the defendant's expert, Todd Giberson, who demonstrated that even under the worst-case scenario envisioned by the plaintiffs, 83% of Texas women will still live within 150 miles of an ASC abortion clinic—and another 6–7% live outside that range for reasons unrelated to HB2. Giberson Direct (doc. 175(3)) at 6-7. *Abbott II* holds that driving distances of 150 miles or fewer are not an "undue burden," 748 F.3d at 599, and that means that at least 90% of Texas women will not encounter an "undue burden" caused by HB2. 10% does not qualify as a "large fraction," and facial invalidation is particularly inappropriate because nearly all of that 10% resides in either the El Paso or Rio Grande Valley areas, which can be addressed by the Plaintiffs' as-applied challenges rather than by statewide invalidation. *See Abbott I*, 734 F.3d at 415; Giberson Direct (doc. 175(3)) at 11.

The plaintiffs' only response to Giberson was to say that 930,000 women of reproductive age will live outside the 150-mile boundary. Grossman Direct ¶ 24; *see also* Plfs.' FOF/COL, FOF ¶ 66.[6] The district court took the same tack, eschewing

[6] As we have noted, this 891,888 number is misleadingly high because it includes women who live in populated areas, such as Lubbock, Amarillo, and Midland/Odessa, where the absence of an abortion clinic within 150 miles is not even alleged to be caused by HB2. *See* Giberson Direct at 6-7; *see* note 3, *supra*. When Grossman's number is stripped of these populations, it amounts to lit-

any "large fraction" analysis and relying on what it described as a "significant number" of patients who will encounter greater driving distances. Mem. Op. 9, 11. But a law cannot be *facially* invalidated unless the plaintiffs prove an undue burden on a "large fraction" of the State's abortion patients—not a large (or "significant") raw number. The plaintiffs and the district court gave up on trying to prove a "large fraction" in the face of Giberson's undisputed testimony. That compelled a judgment for the State on the facial challenge.[7]

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tle more than the total number of reproductive-age women who reside in the El Paso and Rio Grande Valley areas. Those areas were the subject of the plaintiffs' regional, as-applied challenges. Thus, , there is no evidence that even a significant number—much less a large fraction—of women outside those two regions fall outside the 150-mile distance due to HB 2. Facial invalidation was particularly inappropriate where there is no evidence whatsoever of substantial obstacles outside of two discrete regions that could be addressed by as-applied relief.

[7] The district court claimed, without explanation, to find more "indicia of reliability" in Grossman's numbers than in Giberson's. Mem. Op. at 9 n.4. The court made this finding despite the plaintiffs' failure to seriously dispute Giberson's calculations and despite the fact that Grossman's and Giberson's numbers are not materially in conflict. *Compare* Grossman Direct (doc. 163), at ¶ 23 (estimating that 930,000 "women of reproductive age in Texas" would live "more than 150 miles from a clinic providing abortion in Texas") *with* Giberson Direct (doc. 175(3)) at 11 (estimating that 891,888 Texas women aged 15–44 would live 150 miles from an abortion clinic). Thus, Giberson used census-block level analysis normally used for redistricting purposes to determine with precision the number of residents within 150 miles of the relevant clinic addresses. Giberson Direct (doc. 175(3)) at 6. Grossman's analysis employed county-wide calculations of affected populations, much less precise than census-block calculations employed by Giberson. The numbers ended up being similar. The difference between Grossman's number (930,000) and Giberson's number (891,888) is 38,112, which amounts to .72% of reproductive-age Texas women. Thus, substituting Grossman's numbers for Giberson's adds less than 1% to the fraction of the population that will fall outside the 150-mile range due to HB 2. egardless of which experts' numbers are used, the fraction of Texas abortion patients who fall outside of 150 miles of a clinic because of HB 2 is not large.

The district court's statewide relief is also precluded by HB2's "comprehensive and careful severability provision," *Abbott II*, 748 F.3d at 589, which requires courts to sever not only the provisions of HB2, but also the statute's applications to individual abortion providers. *See* HB2, § 10(b). The district court was obligated to sever and leave in place any applications of HB2 that were not proven to impose an "undue burden" on abortion patients. The plaintiffs produced no evidence that the closure of non-ASC abortion clinics in Austin, Dallas, Houston, or San Antonio would impose an "undue burden" on patients, and the closures of those clinics will not contribute to increased driving distances when ASC clinics remain available in those cities. The district court suggests (although it does not find) that clinic closures may leave the remaining providers unable to handle the statewide demand for abortion. Mem. Op. 11. But the plaintiffs presented no evidence that the seven or eight ASC abortion clinics lack the capacity to handle the statewide demand, and they did not propose a finding of fact to this effect. Findings or suggestions of insufficient capacity must be based on trial evidence, not conjecture. *Abbott II*, 748 F.3d at 604 (explaining that courts "must base decisions on facts, not hypothesis and speculation"). Without citing any evidence provided by the plaintiffs (because there was none), the district court simply asserted that the State's claim that the eight remaining clinics could satisfy statewide demand "stretches credulity." Mem. Op. 11. That approach improperly shifts the burden of proof to the State. *See Abbott II*, 748 F.3d at 597 ("[T]he burden of proving the unconstitutionality of abortion regulations falls squarely on the plaintiffs."). The plaintiffs bore the burden to prove that the remaining clinics could not satisfy demand, and they did not

even attempt to carry that burden. And even if there were evidence of insufficient capacity, there must *additional* evidence and findings that these problems will unduly burden a "large fraction" of the State's abortion patients. There is nothing of the kind in this record.

None of the remaining discussion in the district court's opinion can justify facial validation of the ASC rules. Its purported findings are vague, conclusory, and unsupported by any references to trial evidence. Yet a finding of "undue burden" must be based on evidence in the trial record; a trial court cannot simply assert that an "undue burden" exists based on its own conjecture. *See Abbott II*, 748 F.3d at 604; *Lopez v. Current Dir. of Tex. Econ. Dev. Comm'n*, 807 F.2d 430, 434 (5th Cir. 1987) ("[T]he clearly erroneous standard requires that an appellate court be able to discern the evidentiary basis for a trial court's factual finding. Only if the district court specifies which evidence it adopted and which evidence it rejected in making its finding can we properly and effectively apply the clearly erroneous standard." (citation omitted)); *Collins v. Baptist Mem'l Geriatric Ctr.*, 937 F.2d 190, 194 (5th Cir. 1991) ("Rule 52(a) exacts neither punctilious detail nor slavish tracing of the claims issue by issue and witness by witness, but it does require findings that are explicit and detailed enough to enable us to review them under the applicable standard." (quotation marks omitted)). Much of what the district court says is irrelevant to the undue-burden inquiry, such as its beliefs regarding the medical need for the law, its beliefs regarding whether the burdens are "appropriately balanced by a credible medical or health rationale," or the relative health risks of abortion compared to other procedures. Mem. Op. 15. The district court has already found

that the State had a rational basis for enacting the ASC requirements. Indeed, the court repeated that holding in this order. Mem. Op. 6. Once rational-basis review is satisfied, the *only* remaining question is whether those requirements have the purpose or effect of imposing a "substantial obstacle" in the path of patients seeking previability abortions—and that has nothing to do with the medical justification for the law. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992); *see also Gonzales*, 550 U.S. at 164 (federal courts are not to serve as "the country's ex officio medical board"). And it has long been settled that States may impose abortion-specific regulations without extending those requirements to other, more dangerous procedures. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 67 (1976) (requirement of written consent for abortion not unconstitutional even though not imposed on other surgical procedures). Most importantly, however, the district court fails to make the finding that needs to be made for facial invalidation: That the ASC requirements will unduly burden a "large fraction" of the State's abortion patients.

The plaintiffs undertook a "heavy burden" in bringing a facial challenge against HB2's ambulatory-surgical-center standards, and they were required to prove that each of these standards will impose an "undue burden" on a "large fraction" of the State's abortion patients. *See Gonzales*, 550 U.S. at 167-68. The plaintiffs did not attempt to make this showing, and the district court granted relief only by changing the legal standard established by this Court for facial challenges to abortion laws and brushing aside this Court's clear instructions regarding permissible driving distances. The State is likely to succeed on its appeal of this decision.

B. There Is No Evidence Whatsoever That The Texas Legislature Had An Unconstitutional Motive In Enacting The ASC Statute.

The district court held that the Texas legislature enacted the ASC statute for the "purpose" of imposing an undue burden on abortion patients, but there are no findings or evidence to support that conclusion. The legislature's stated purpose in enacting HB2 was to improve patient safety. *See, e.g.*, Senate Comm. on Health & Human Servs., Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. (2013) ("H.B. 2 seeks to increase the health and safety" of abortion patients and to provide them with "the highest standard of health care"). Courts are not permitted to second-guess a legislature's stated purposes absent clear and compelling evidence to the contrary. *See Kansas v. Hendricks*, 521 U.S. 346, 361 (1997) ("[W]e ordinarily defer to the legislature's stated intent."); *Flemming v. Nestor*, 363 U.S. 603, 617 (1960) ("[O]nly the clearest proof could suffice to establish the unconstitutionality of a statute on [the] ground of [improper legislative motive]."). Here, there is zero evidence—let alone "clear[] proof"—that the purpose for enacting HB2 was anything other than the purpose stated by the Legislature.

The district court's claim that the ASC requirement "was intended to close existing licensed abortion clinics" is refuted by the fact that HB2 gave abortion clinics a 14-month grace period to conform to the ASC rules. The legislature would not have provided this allowance if its purpose was to "close existing licensed abortion clinics," as the district court claimed. And not a single witness at trial testified regarding the motivations of any member of the legislature. No expert opined that the legislature had acted with the purpose of imposing unconstitutional "undue bur-

dens" on abortion patients, and no fact witness testified about any legislative communications or statements that might reveal a constitutionally impermissible motive on the part of the legislature. As in *Mazurek*, 520 U.S. at 972, "[o]ne searches the [district court's] opinion in vain for any mention of any evidence suggesting an unlawful motive on the part of the [Texas] Legislature."

The district court thought it could infer an unconstitutional purpose from the Department of State Health Services' alleged decision to deny "grandfathering" or "waivers" to previously existing clinics; the district court declared that this subjected abortion clinics to "disparate and arbitrary treatment." Mem. Op. 16. But the district court's claim that the State has discriminated against abortion clinics by refusing to "grandfather" or exempt pre-existing clinics from the ASC requirements is simply incorrect. *See id.* Abortion clinics are treated no differently from any other medical building that seeks to be licensed as an ASC, and no medical building in Texas gets exempted from an ASC licensing requirement because it happened to be in use before it sought to obtain an ASC license. There is one provision of the Texas Administrative Code that exempts *previously licensed ASCs* from complying with changes to the ASC construction requirements that were adopted June 18, 2009. *See* 25 Tex. Admin. Code § 135.51(a). But this grandfathering provision applies equally to abortion-clinic ASCs and non-abortion ASCs—so long as those abortion clinics were licensed as ASCs before June 18, 2009. The State does not require *previously licensed ASCs* to tear down their previously approved buildings and construct new ones whenever the State tweaks provisions in the ASC building code. And the State has exempted the abortion clinics that obtained ASC

licenses before June 18, 2009, from the 2009 construction requirements—just as it has exempted every other previously licensed ASCs in the State from those specific requirements.[8]

At the same time, *every* medical building in Texas (including abortion clinics) that seeks to be licensed as an ASC after June 18, 2009, must comply with the post-2009 requirements. The State never gives a blanket exemption from its ASC requirements simply because a building was used for medical purposes before it sought to obtain an ASC license. For the district court to assert that the State *must* provide this blanket exemption to pre-existing abortion clinics—when this allowance is not extended to any other building that seeks to become licensed as ASC—is untenable. And it is surely wrong for the district court to accuse the state of engaging in "disparate and arbitrary treatment" when it treats abortion clinics exactly the same as any other building that seeks to be licensed as an ASC. The "disparate and arbitrary treatment" accusation is clearly erroneous and cannot support an unconstitutional-purpose finding. And in any event, this alleged arbitrary treatment was a post-enactment decision of the Department of State Health Services, not the Texas Legislature. There is no basis on which to infer a *pre-enactment* Legislative motive from the *post-enactment* behavior of a regulatory agency that is not subject to

[8] DSHS did not adopt 25 Texas Administrative Code § 135.51(a) by reference into the new abortion facility regulations because those regulations apply only to *licensed abortion clinics* that must now meet ASC standards post-HB2. Abortion clinics that are licensed as ASCs are governed by the ASC rules in 25 Texas Administrative Code § 135 and are fully subject to section 135.51(a)(1)'s grandfathering provision.

the day-to-day oversight of the Legislature. *See Mazurek*, 520 U.S. at 972 (demanding proof of *legislative* motive to sustain purpose challenge to abortion statute).

The district court also thought that the "dearth of credible evidence" that abortions in ASCs have "better patient health outcomes" is evidence of unconstitutional purpose. That line of argument was squarely rejected *Mazurek*, which the district court did not cite:

> Respondents claim in this Court that the Montana law must have had an invalid purpose because "all health evidence contradicts the claim that there is any health basis" for the law. Brief in Opposition 7. Respondents contend that "the only extant study comparing the complication rates for first-trimester abortions performed by [physician-assistants] with those for first-trimester abortions performed by physicians found no significant difference." *Ibid.* But this line of argument is squarely foreclosed by *Casey* itself. In the course of upholding the physician-only requirement at issue in that case, we emphasized that "[o]ur cases reflect the fact that the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others.*" 505 U.S., at 885 (emphasis added)."

520 U.S. at 973. So too here. A State may conclude that abortions should be performed only in licensed ASCs, even if an "objective assessment might suggest" that non-ASCs are also up to the task. The district court's disagreement with the legislature's policy judgment is not grounds for an unconstitutional-purpose finding, any more than it was in *Mazurek*. Federal courts are not to act "the country's *ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States." *Gonzales*, 550 U.S. at 164. And even if the district court were correct to note the "dearth of credible evi-

dence" on the medical benefits of an ASC requirement, the legislature may still have believed in good faith that the ASC law would improve the standard of care for abortion patients. The plaintiffs bore the burden of producing "the clearest proof" to the contrary, and they produced no evidence on this score.

Finally, the arguments from the State's lawyers concerning the availability of abortions in New Mexico has nothing to do with the *legislature's* purpose in *enacting* HB2. *See* Mem. Op. 16-17. The State's lawyers are tasked with defending the law in court, and it is their duty to present all reasonable arguments that might rebut the plaintiffs' "undue burden" claims. It is not tenable for the district court to use an argument advanced in the State's brief—written more than a year after HB2 was enacted—as evidence of the legislature's "true purpose" in enacting HB2. Post-hoc litigating positions taken by government lawyers are not relevant to the purposes or motivations of the lawmaking body that enacted HB2.

C. The District Court's Refusal To Sever The Ambulatory-Surgical-Center Requirements Is Likely To Be Reversed.

The district court's facial invalidation of the ASC standards should also be stayed because the district court refused to enforce the severability requirements of 25 Tex. Admin. Code § 139.9. Section 139.9(b) requires courts to sever each of the discrete ASC rules incorporated into the abortion regulations:

> Consistent with the intent of the Legislature, the department intends, that with respect to the application of this chapter to each woman who seeks or obtains services from a facility licensed under this chapter, every provision, section, subsection, sentence, clause, phrase, or word in this chapter and each application of the provisions of this chapter

> remain severable from every other provision, section, subsection, sentence, clause, phrase, word, or application of this chapter.

25 Tex. Admin. Code § 139.9(b). The district court (and the plaintiffs) refused to acknowledge the severability of the State's ASC rules and insisted on treating all of the State's ASC rules as a non-severable package that stands or falls together. But federal courts must enforce severability clauses in state abortion provisions. *See Leavitt v. Jane L.*, 518 U.S. 137, 138-39 (1996) (holding that "[s]everability is of course a matter of state law" and rebuking the Tenth Circuit for refusing to enforce a state abortion statute's severability clause); *Abbott II*, 748 F.3d at 589 ("Federal courts are bound to apply state law severability provisions. . . . Even when considering facial invalidation of a state statute, the court must preserve the valid scope of the provision to the greatest extent possible."). And section 139.9 required the court to limit its relief to the specific ASC requirements that would allegedly cause abortion clinics to close and impose an "undue burden" on abortion patients.

It was indefensible for the district court to enjoin the State from enforcing *all* of its ambulatory-surgical-center rules against the plaintiffs. The plaintiffs complained about only two provisions in the State's ASC rules: the building-design requirements in 25 Texas Administrative Code § 135.52, and the nursing-staff requirements in 25 Texas Administrative Code § 135.15(a). *See* Plfs.' Trial Br. (doc. 185) at 8 ("It is the construction and nursing requirements that form the basis of Plaintiffs' challenge."). The plaintiffs admitted that most of the remaining ASC standards were "comparable to" or *less* stringent than the existing state regulations for abortion clinics. *See* Plfs.' Trial Br. at 7-8. And many of the ASC requirements are

entirely benign and cannot plausibly be characterized as an unconstitutional "undue burden." *See, e.g.*, 25 Tex. Admin. Code § 135.5 (protections for patient medical records); *id.* at § 135.52(h)(4) (prohibiting asbestos-tainted insulation); *id.* at 135.52(e)(1)(F) (requiring "[a] liquid or foam soap dispenser" at "each handwashing facility.").

In addition, the plaintiffs did not allege or prove that any ASC rule other than section 135.52 would cause an abortion clinic to close. And they did not introduce any evidence that their clinics (or other clinics) are unable to comply with the remaining ASC requirements—including the nursing-staff requirements of section 135.15(a). Amy Hagstrom Miller, for example, testified that Whole Woman's Health's clinics do not meet "ASC construction standards," but she never testified that her clinics are unable to comply with the nursing-staff requirements, the fire prevention and safety requirements, or any of the ASC "operating requirements." Hagstrom Miller Direct (doc. 171) ¶ 22. And the district court did not make any findings that these requirements will cause any abortion clinic to close or impose an "undue burden." Its opinion discussed only the building and construction requirements of the State's ASC rules, and its relief should have been limited to those specific requirements. Mem. Op. 9 (stating that the ASC requirement forces clinics to meet "enhanced standards for new construction").

The plaintiffs think that the courts may enjoin *all* of section 135.52's requirements (and every remaining ASC rule) if *some* of its requirements will cause their clinics to close. Section 139.9 and *Abbott II* prohibit that type of remedy. The relief

must be limited to the specific ASC requirements that will cause the plaintiffs' clinics to close and thereby result in an alleged "undue burden" on abortion patients.

D. The District Court's Decision To Enjoin The ASC Requirements As Applied To Medication Abortions Is Likely To Be Reversed.

The district court also enjoined the ASC standards as applied to medication abortions. Its entire rationale consists of this single conclusory sentence: "[A]ny medical justification for the requirement is at its absolute weakest in comparison with the heavy burden it imposed." Mem Op. 18. That is not a basis on which a court can enjoin a state abortion law.

The "undue burden" test does not permit courts to balance the "burden[s]" of a law against its "medical justification." Once a law passes rational-basis review, the sole remaining question is whether it imposes a "substantial obstacle" in the path of patients seeking pre-viability abortions. *See Abbott II*, 748 F.3d at 597. This is not a balancing test; it is an inquiry that looks exclusively to the burdens imposed on abortion patients. The district court also failed to make any findings or refer to any trial evidence regarding the supposed lack of "medical justification" or "heavy burden." Medication abortion has *higher* complication rates than surgical abortion, *see Abbott II*, 748 F.3d at 602, so it was certainly rational for the legislature to subject it to the same health-and-safety regulations.

E. The District Court's Apparent Decision To Enjoin The Admitting-Privileges Requirement Statewide Is Likely To Be Reversed.

The plaintiffs sought only as-applied relief against the State's admitting-privileges law, limited to two abortion clinics: one in El Paso, and one in McAllen. Compl. (doc. 1) ¶¶ 138-51. Remarkably, the district court not only enjoined the State from enforcing the admitting-privileges law against to those two clinics, it included language in its judgment that appears to be intended to facially invalidate the admitting-privileges law. Final Judgment 3. The district court took this step even though the plaintiffs never asked for this relief, and even though the parties never briefed or argued whether this relief was appropriate or even permissible. By granting statewide relief that no party had requested, the district court effectively reinstated its original judgment from October 28, 2013—the judgment that panels of this Court unanimously stayed (and unanimously reversed) in *Abbott I* and *Abbott II*.

The State respectfully asks the Court to stay this aspect of the district court's judgment immediately. First, the plaintiffs never asked the court for statewide injunctive relief against the admitting-privileges law, and the law of this Court forbids district courts to facially invalidate a statute when a litigant brings only an as-applied challenge. *See Jackson Women's Health Org.*, 2014 WL 3730467, at *9. Second, the plaintiffs could not have sought facial invalidation of the admitting-privileges law because that claim would be barred by res judicata. The plaintiffs have already litigated and lost their facial challenge to HB2's admitting-privileges law. *See Abbott II*, 748 F.3d at 599-600. They cannot take a second bite at the apple,

and the district court cannot give them a second bite at the apple by *sua sponte* enjoining the admitting-privileges law on a statewide basis. Third, the district court did not attempt to explain how this remedy could be permissible under this Court's binding pronouncements in *Abbott I* and *Abbott II*. Each of those rulings held unequivocally that the admitting-privileges law could not be invalidated on its face—and that *no* abortion law can be enjoined on a statewide basis absent proof that the law would impose an undue burden on a "large fraction" of abortion patients. Yet the district court apparently thought it could facially invalidate HB2's admitting-privileges law without discussing *Abbott I* and *Abbott II*—and without mentioning the "large fraction" test that must be satisfied before an abortion law can be enjoined on a statewide basis.

If the district court actually intended to facially invalidate the admitting-privileges requirement, the court's actions border on defiance of this Court. Its judgment reinstates a remedy that this Court specifically disapproved in *Abbott I* and *Abbott II*—and it imposes this remedy even though no party had requested it. The Court should immediately stay this aspect of the district court's judgment.

F. The District Court's Decision To Enjoin The Admitting-Privileges Law As Applied To El Paso and McAllen Is Likely To Be Reversed.

The plaintiffs' as-applied challenges to the admitting-privileges law are barred by res judicata. The plaintiffs challenged the admitting-privileges requirement in the earlier HB2 lawsuit, and they could have sought as-applied relief for the McAllen and El Paso clinics in that proceeding. But the plaintiffs in the initial HB2

lawsuit eschewed any request for as-applied relief against the admitting-privileges law, and forced the courts to choose between total invalidation of HB2's admitting-privileges requirement or no relief. *See* Compl. (doc. 1) ¶¶ 5, 90, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 1:13-cv-862-LY (W.D. Tex.); *see also* Trial Transcript, Volume 3 (doc. 101), *Abbott*, No. 1:13-cv-862-LY, at 29:5-8 ("[U]nder *Casey*, the proper remedy is facial invalidation."), and 59:4-6 ("[T]he appropriate remedy here is . . . facial invalidation."). Having lost that gambit, the plaintiffs cannot turn around and file a new lawsuit seeking the more limited, as-applied relief that they should have asked for in the original proceeding. *See In re Howe*, 913 F.2d 1138, 1144 n.10 (5th Cir. 1990) ("A party may not avoid the preclusive affect of res judicata by asserting a new theory or a different remedy.").

The doctrine of res judicata blocks any claims for which: (1) the parties are identical to or in privity with the parties in a previous lawsuit; (2) the previous lawsuit has concluded with a final judgment on the merits; (3) the final judgment was rendered by a court of competent jurisdiction; and (4) the same claim or cause of action was involved in both lawsuits. *See Petro-Hunt, L.L.C. v. United States*, 365 F.3d 385, 395 (5th Cir. 2004). The plaintiffs and the district court do not contest the first three elements of the State's res judicata defense.[9] But the district court

[9] Doctors Lynn and Davis were not parties to the earlier proceeding, but they were in privity with Whole Woman's Health and Austin Women's Health Center, which sued on their behalf. *See* Compl. ¶¶ 13-14, *Abbott*, No. 1:13-CV-862-LY (stating that clinics were suing "on behalf of" their "physicians"). And Reproductive Services is in privity with Dr. Richter, who sued in the initial lawsuit challenging HB2. *Id.*, ¶ 21.

held that the plaintiffs' serial challenges to the admitting-privileges law do *not* involve the "same claim or cause of action" because the plaintiffs' current lawsuit "relies on facts that occurred after judgment was rendered in the previous lawsuit and that were not considered by either this court or the appellate court." *See* Order on Defs.' Mot. to Dismiss (doc. 148) at 7. The district court noted that the plaintiffs only recently learned that the McAllen and El Paso physicians would "ultimately be unable to obtain admitting privileges despite efforts to secure them." *Id.* at 8. The district court also relied on the plaintiffs' allegation that an increased number of McAllen patients attempted self-abortion after the McAllen clinic ceased offering abortions on November 1, 2013. *Id.*

The district court erred by allowing these new factual allegations to overcome the State's res judicata defense. A litigant cannot establish a new "claim" or "cause of action" simply by alleging new facts that arose after judgment in the previous lawsuit. The test is whether the claims in the first and second lawsuits arise from the same "transaction" or "series of connected transactions." *Petro-Hunt*, 365 F.3d at 395-96. This transactional test is satisfied so long as the plaintiffs' claims arise from the "same nucleus of operative facts." *In re Southmark Corp.*, 163 F.3d 925, 934 (5th Cir. 1999). And new factual allegations establish a different *nucleus* of *operative* facts only when the new facts are "significant" and create "new legal conditions." *Hernandez v. City of Lafayette*, 699 F.2d 734, 737 (5th Cir. 1983); *Jackson v. De Soto Parish School Board*, 585 F.2d 726, 729 (5th Cir. 1978).

The formal rejection of the doctors' applications for hospital admitting privileges does not create "new legal conditions" or establish a different "nucleus of

operative fact." It was uncontested at the time of the first lawsuit that the doctors at Reproductive Services in El Paso and Whole Woman's Health in McAllen lacked hospital admitting privileges and would cease providing abortions once HB2 took effect on October 29, 2013. *See* Compl. ¶ 21, *Abbott*, 1:13-CV-862-LY ("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."); *id.*, ¶ 13 ("If the admitting privileges requirement of the Act is allowed to take effect, WWH will stop providing abortions altogether at … McAllen."); ¶ *id.*, ¶ 50 ("If allowed to take effect on October 29, the admitting privileges requirement . . . will cause the sole abortion facilities in . . . McAllen to cease providing abortions."). The plaintiffs could have used those uncontested facts—if combined with proof that closure of the El Paso or McAllen clinics would impose an "undue burden" on abortion patients—to seek as-applied relief that would keep those clinics open until an abortion practitioner secured the required admitting privileges. The district court did not consider this as-applied relief because the plaintiffs never asked for it, choosing instead to insist on facial invalidation as their only requested remedy.

The rejection of the doctors' applications does not create "new legal conditions" because it does not expand the claims or relief that the plaintiffs could have sought in the initial lawsuit. It would be a different situation if the doctors *had* the required admitting privileges during the first trial, but the hospitals unexpectedly pulled their privileges after entry of final judgment. But the plaintiffs do not deny that their as-applied claims were ripe in the earlier lawsuit—all they had to do was

ask the court for an injunction limited to the El Paso and McAllen clinics. Instead, the plaintiffs refused to request as-applied relief as a fallback option and made a tactical decision to force the courts into an all-or-nothing choice. Res judicata prohibits them from seeking that relief now.[10]

G. The Remaining Factors Favor The State.

The State will suffer irreparable injury absent a stay because the district court's injunction prevents the State from enforcing a duly enacted statute. *See Abbott I*, 734 F.3d at 419 ("When a statute is enjoined, the State necessarily suffers the irreparable harm of denying the public interest in the enforcement of its laws."); *see also Maryland v. King*, 133 S. Ct. 1, 3 (2012) (Roberts, C.J., in chambers). For this reason, a federal court should never enjoin state officials from enforcing a state law absent a clear showing that the law is invalid. *See Ex Parte Young*, 209 U.S. 123, 166 (1908) ("[N]o injunction ought to be granted unless in a case reasonably free from doubt."). And appellate courts should not hesitate to stay a district court's injunction if this clear showing has not been met.

A stay pending appeal is also in the public interest. The statutory policy of the Legislature "is in itself a declaration of the public interest." *Virginian Ry. Co. v. Sys. Fed'n No. 40*, 300 U.S. 515, 552 (1937). If the Court agrees with the State that it is likely to prevail in its appeal, then a stay pending appeal is by definition in the

[10] The alleged increase in self-abortions is likewise insufficient to establish a different "nucleus" of operative facts. The plaintiffs presented no admissible evidence of this at trial, and the district court did not make any finding that self-abortion increased after its judgment in the initial HB2 trial.

public interest. *See Berman v. Parker*, 348 U.S. 26, 32 (1954) ("Subject to specific constitutional limitations, when the legislature has spoken, the public interest has been declared in terms well-nigh conclusive."). Finally, the El Paso and McAllen clinics will not suffer any injury if this Court stays the district court's facial invalidation of the ASC requirement without staying the as-applied relief afforded to the plaintiff clinics. And although the remaining plaintiffs may suffer injury if the Court stays the injunction even in part, those concerns cannot outweigh the other three factors if this Court concludes that the State has made a strong showing that it will prevail on the merits of its appeal. *See Abbott I*, 734 F.3d at 419.

II. The Court Should Expedite This Appeal.

The State respectfully requests expedited consideration of this appeal, regardless of whether the Court grants or denies the request for a stay. This Court has granted expedited consideration when district courts have enjoined state officials from enforcing the State's duly enacted laws. *See, e.g.*, *Abbott*, No. 13-51008; *Voting for Am., Inc. v. Steen*, No. 12-40914; *Tex. Med. Providers v. Lakey*, No. 11-50814. The issues in this case are equally important and worthy of expedited review.

Conclusion

The emergency motion for stay pending appeal and the motion for expedited consideration should be granted.

Respectfully submitted.

Greg Abbott
Attorney General of Texas

Daniel T. Hodge
First Assistant Attorney General

James D. Blacklock
Deputy Attorney General for Legal Counsel

/s/ Jonathan F. Mitchell
Jonathan F. Mitchell
Solicitor General

Beth Klusmann
Michael P. Murphy
Assistant Solicitors General

Office of the Attorney General
P.O. Box 12548 (MC 059)
Austin, Texas 78711-2548
(512) 936-1700

Counsel for Appellants

Certificate of Service

I certify that this document has been filed with the clerk of the court and served by ECF or electronic mail on August 31, 2014, upon:

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'Connell & Soifer LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

John H. Bucy, II
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan
David P. Brown
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org
dbrown@reprorights.org

J. Alexander Lawrence
Morrison & Foerster LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

Betre M. Gizaw
Marissa P. Harris
Morrison & Foerster LLP
2000 Pennsylvania Ave., NW, Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com

Colin M. O'Brien
Morrison & Foerster LLP
370 17th Street, Suite 5200
Denver, CO 80202
(303) 592-2252
(303) 592-1510
cobrien@mofo.com

/s/ Jonathan F. Mitchell
Jonathan F. Mitchell
Counsel for Appellants

Certificate of Electronic Compliance

Counsel also certifies that on August 31, 2014, this brief was transmitted to Mr. Lyle W. Cayce, Clerk of the United States Court of Appeals for the Fifth Circuit, via the court's CM/ECF document filing system, https://ecf.ca5.uscourts.gov/.

Counsel further certifies that: (1) required privacy redactions have been made, 5th Cir. R. 25.2.13; (2) the electronic submission is an exact copy of the paper document, 5th Cir. R. 25.2.1; and (3) the document has been scanned with the most recent version of Symantec Endpoint Protection and is free of viruses.

/s/ Jonathan F. Mitchell
Jonathan F. Mitchell
Counsel for Appellants

Certificate of Conference

On August 29, 2014, counsel for the plaintiffs indicated by way of e-mail that they oppose this motion and intend to file an opposition.

/s/ Jonathan F. Mitchell
Jonathan F. Mitchell
Counsel for Appellants

APPENDIX

Appendix Table of Contents

Part 1 - Documents Filed in the District Court

Part 2 - Relevant Statutes and Regulations

A

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

WHOLE WOMAN'S HEALTH, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS D/B/A REPRODUCTIVE SERVICES, AND SHERWOOD C. LYNN, JR., M.D., PAMELA J. RICHTER, D.O., AND LENDOL L. DAVIS, M.D., EACH ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS,	§	
V.	§	CAUSE NO. 1:14-CV-284-LY
DAVID LAKEY, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, IN HIS OFFICIAL CAPACITY, AND MARI ROBINSON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD, IN HER OFFICIAL CAPACITY, DEFENDANTS.	§	

MEMORANDUM OPINION
INCORPORATING FINDINGS OF FACT AND CONCLUSIONS OF LAW

Plaintiffs Whole Woman's Health, Austin Woman's Health Center, Killeen Woman's Health Center, Nova Health Systems d/b/a Reproductive Services, Dr. Sherwood Lynn, Jr., Dr. Pamela Richter, and Dr. Lendol Davis (collectively "Plaintiffs"), all providers of abortion services, bring this action on behalf of themselves and their patients against David Lakey, M.D., Commissioner of the Texas Department of State Health Services and Mari Robinson, Executive Director of the Texas Medical Board, each in their official capacities (together the "State"). Plaintiffs seek declaratory and injunctive relief nullifying two requirements of Texas law recently imposed by the Texas Legislature

and the rules that implement such law. Act of July 12, 2013, 83rd Leg., 2nd C.S., ch. 1, 2013 Tex. Gen. Laws 4795; ("House Bill 2" or the "act") (codified at Tex. Health & Safety Code Ann. §§ 171.0031, 245.010(a) (West Supp. 2014); *see also* 38 Tex. Reg. 9577-93 (adoption of proposed rules), 25 Tex. Admin. Code §§ 139.40, .53(c), .56(a).

The act's "admitting-privileges requirement" provides, in part, 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 located not further than 30 miles from the location at which the abortion is performed or induced." Tex. Health & Safety Code Ann. § 171.0031(a)(1); 25 Tex. Admin. Code §§ 139.53(c), .56(a). The "ambulatory-surgical-center requirement" provides, in relevant part, that by September 1, 2014, "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Tex. Health & Safety Code Ann. § 245.010(a); 25 Tex. Admin. Code § 139.40.

The admitting-privileges requirement was the subject of a pre-enforcement facial challenge brought by several abortion providers, including some of the plaintiffs in this case. This court permanently enjoined enforcement of the requirement on October 28, 2013. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F.Supp.2d 891 (W.D. Tex. 2013). The United States Court of Appeals for the Fifth Circuit stayed the injunction, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott* (*Abbott I*), 734 F.3d 406 (5th Cir. 2013), and ultimately reversed this court's judgment, concluding that the admitting-privileges requirement is constitutional on its face. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott* (*Abbott II*), 748 F.3d 583 (5th Cir. 2014).

Now, Whole Woman's Health and Lynn challenge the admitting-privileges requirement as applied to an abortion facility operated by Whole Woman's Health in McAllen, Texas (the "McAllen clinic"). Nova Health Systems and Richter challenge the admitting-privileges requirement as applied to an abortion facility operated by Nova Health Systems in El Paso, Texas (the "El Paso clinic"). All Plaintiffs challenge the ambulatory-surgical-center requirement on its face and as applied to the provision of medication abortion; Whole Woman's Health and Lynn challenge the ambulatory-surgical-center requirement as applied to the McAllen Clinic; and Nova Health Systems and Richter challenge the ambulatory-surgical-center requirement as applied to the El Paso Clinic. This court has federal-question jurisdiction. *See* 28 U.S.C. §§ 1331, 1343(a). Plaintiffs occupy substantially the same position as the plaintiffs in the previous action before this court and thus have standing to assert these claims. *Abbott II*, 748 F.3d at 589.

Before trial, the court granted in part the State's motion to dismiss and dismissed several of Plaintiffs' claims with prejudice. *Whole Woman's Health v. Lakey*, No. 1:14-CV-284-LY (W.D. Tex. Aug. 1, 2014) (order on motion to dismiss). Specifically, the court dismissed Plaintiffs' equal-protection, improper-delegation-of-lawmaking-authority, and arbitrary-and-unreasonable-state-action claims. *Id.* As a result, the following claims remain: (1) the admitting-privileges requirement, as applied to the McAllen and El Paso clinics, violates the Due Process Clause of the Fourteenth Amendment with regard to women in the Rio Grande Valley and West Texas and (2) the ambulatory-surgical-center requirement, facially in regard to all Texas women and, as applied to the McAllen and El Paso clinics specifically, with regard to women in the Rio Grande Valley and West Texas, violates the Due Process Clause of the Fourteenth Amendment. The court will also consider

whether the act as a whole operates to place before the women of Texas a substantial obstacle to an abortion of a nonviable fetus.

Both parties waived a jury, and the court conducted a bench trial on these issues that commenced on August 4, 2014. All parties were represented by counsel and appeared either individually or by counsel.

Having carefully considered the parties' briefs, stipulations, exhibits, trial testimony, arguments of counsel, and the applicable law, the court concludes: (1) the act's ambulatory-surgical-center requirement places an unconstitutional undue burden on women throughout Texas and must be enjoined; (2) the act's ambulatory-surgical-center and admitting-privileges requirements, as applied to the McAllen and El Paso clinics, place an unconstitutional undue burden on women in the Rio Grande Valley, El Paso, and West Texas and must be enjoined; and (3) the act's ambulatory-surgical-center and admitting-privileges requirements operate together to place an unconstitutional undue burden on women throughout Texas and must be enjoined. In so deciding, the court makes the following findings of fact and conclusions of law.[1]

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[1] In making these findings and conclusions, the court has considered the record as a whole. The court has observed the demeanor of the witnesses and has carefully weighed that demeanor and the witnesses' credibility in determining the facts of this case and drawing conclusions from those facts. Further, the court has thoroughly considered the testimony of both sides' expert witnesses and has given appropriate weight to their testimony in selecting which conclusions to credit and upon which not to rely. *Garcia v. Kerry*, 557 Fed.Appx. 304, 309 (5th Cir. 2014) ("It is settled law that the weight to be accorded expert opinion evidence is solely within the discretion of the judge sitting without a jury. In a bench trial, the district court is not obligated to accept or credit expert witness testimony.") (citing *Pittman v. Gilmore*, 556 F.2d 1259, 1261 (5th Cir. 1977); *Albany Ins. Co. v. Anh Thi Kieu*, 927 F.2d 882, 894 (5th Cir. 1991)). All findings of fact contained herein that are more appropriately considered conclusions of law are to be so deemed. Likewise, any conclusion of law more appropriately considered a finding of fact shall be so deemed.

I. LAW GOVERNING ABORTION REGULATIONS

"The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce." *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 846 (1992). The Supreme Court has written of this interest held by individual women:

> [T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

Casey, 505 U.S. at 852.

Still, after over 40 years, this basic right—among the most contested and controversial of all rights protected by our Constitution—is layered with myriad limitations and qualifications. *See Jackson Women's Health Org. v. Currier*, No. 13-60599, – F.3d –, 2014 WL 3730467, *4 (5th Cir. July 29, 2014). A state may regulate a woman's right to an abortion consistent with that state's interest in protecting the health of the mother and the potential life of the unborn. *Casey*, 505 at 846. However, a law is unconstitutional if it imposes an undue burden on a woman's right to an abortion. "A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus . . . . [A] statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice

cannot be considered a permissible means of serving its legitimate ends." *Id.* at 877. The undue-burden standard is "the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty." *Casey*, 505 U.S. at 876. In reaching a determination of whether a law imposes an undue burden, this court looks to the entire record and factual context in which the law operates. *See id.* at 887–95 (looking to factual context in striking down Pennsylvania's spousal-notification provision); *Currier*, 2014 WL 3730467 at *9.

The Supreme Court added rational basis review to the judicial evaluation of abortion regulations in *Gonzales v. Carhart.* 550 U.S. 124, 158 (2007) ("Where it has a rational basis to act, *and* it does not impose an undue burden, the State may use its regulatory power. . . .") (emphasis added); *see also Currier*, 2014 WL 3730467 at *4; *Abbott II*, 748 F.3d at 590. Bound by the Fifth Circuit's holding in *Abbott II*, this court held that both the ambulatory-surgical-center requirement and the admitting-privilege requirement, as applied to the El Paso and Rio Grande Valley clinics, surmount the low bar of rational-basis review. *Whole Woman's Health v. Lakey*, No. 1:14-CV-284-LY (W.D. Tex. Aug. 1, 2014) (order on motion to dismiss); *Abbott II*, 748 F.3d at 595-96; *Currier*, 2014 WL 3730467 at *4. Despite the finding of a rational-basis, however, this court must determine whether the act places an undue burden before a woman seeking a legal abortion. *Casey*, 505 U.S. at 876-78; *see Gonzales*, 550 U.S. at 156; *see also Abbott II*, 748 F.3d at 597 ("Even though the State articulated rational bases for this law, and even though its purpose was not impugned, [the plaintiff] could succeed if the effect of the law substantially burdened women's access to abortions in Texas.").

II. DISCUSSION

The parties presented competing evidence at trial, largely through expert-witness declarations and cross examination.[2] The experts' testimony substantially contradicted each other and, predictably, reached opposing conclusions.[3] Such is the nature of expert testimony.

Of more value to the court are the parties' stipulated facts. After September 1, 2014, only seven facilities and a potential eighth will exist in Texas that will not be prevented by the ambulatory-surgical-center requirement from performing abortions. These remaining abortion facilities will be located along the I-35 and I-45 corridors; there will be one facility in Austin, two in Dallas, one in Fort Worth, two in Houston, and either one or two in San Antonio. No other abortion facility licensed by the State of Texas currently satisfies the ambulatory-surgical-center requirement of the act; therefore, each of the currently licensed facilities that are not ambulatory surgical centers will be prohibited from performing abortions effective September 1, 2014, without complying with the new requirements. Additionally, there are 433 licensed ambulatory surgical centers in Texas, 336 of which are "considered to be an existing licensed [ambulatory surgical center]" and are apparently either "grandfathered" or enjoying the benefit of a waiver of some or all of the requirements of ambulatory-surgical-center certification due to these centers' earlier licensure

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[2] To the extent that the State objects to Plaintiffs' designation of the State's experts' deposition testimony, that objection is overruled.

[3] The credibility and weight the court affords the expert testimony of the State's witnesses Drs. Thompson, Anderson, Kitz, and Uhlenberg is informed by ample evidence that, at a very minimum, Vincent Rue, Ph.D., a non-physician consultant for the State, had considerable editorial and discretionary control over the contents of the experts' reports and declarations. The court finds that, although the experts each testified that they personally held the opinions presented to the court, the level of input exerted by Rue undermines the appearance of objectivity and reliability of the experts' opinions. Further, the court is dismayed by the considerable efforts the State took to obscure Rue's level of involvement with the experts' contributions.

dates or compliance with other regulatory schemes. *See* 25 Tex. Admin. Code § 135.51(a). Finally, Reproductive Services of Harlingen has not provided abortion services since the admitting-privileges requirement of the act took effect.

The evidence introduced by the parties at trial further reveals the breadth and effect of House Bill 2. Texas contains nearly 280,000 square miles, is ten percent larger than France, and is home to the second highest number of reproductive-age women in the United States. Such women account for approximately 5.4 million of over 25 million Texas residents. In recent years, the number of abortions reported in Texas has stayed fairly consistent at approximately 15-16% of the reported pregnancy rate, for a total number of approximately 60,000-72,000 legal abortions performed annually.

Before the enactment of House Bill 2, there were more than 40 licensed abortion facilities providing abortion services throughout Texas. That number dropped by almost half leading up to and in the wake of enforcement of the admitting-privileges requirement that went into effect in late-October 2013. Clinics closed throughout the state, leaving no abortion provider in McAllen, Harlingen, Lubbock, Midland, San Angelo, Beaumont, Stafford, Killeen, or Waco. If allowed to go into effect, the act's ambulatory-surgical-center requirement will further reduce the number of licensed abortion-providing facilities to, at most, eight. On September 1, 2014, abortion providers will remain only in Houston, Austin, San Antonio, and the Dallas/Fort Worth metropolitan region. Abortion clinics where doctors were previously able to comply with House Bill 2's admitting-privilege requirement will close in Corpus Christi, San Antonio, Austin, El Paso, Houston, and Dallas.

Between November 1, 2012 and May 1, 2014, the decrease in geographic distribution of abortion facilities has required a woman seeking an abortion to travel increased distance. The number of women of reproductive age living in a county more than 50 miles from a Texas abortion clinic has increased from approximately 800,000 to over 1.6 million; women living in a county more than 100 miles from a provider increased from approximately 400,000 to 1,000,000; women living in a county more than 150 miles from a provider increased from approximately 86,000 to 400,000; and the number of women living in a county more than 200 miles from a provider from approximately 10,000 to 290,000. If not enjoined, the ambulatory-surgical-center requirement will further increase those numbers: after September 1, 2014, approximately 2 million women will live further than 50 miles, 1.3 million further than 100 miles, 900,000 further than 150 miles, and 750,000 further than 200 miles. Even presuming a wide margin of error in these calculations,[4] the inference is straightforward: the cumulative effect of clinic closures and the lessened geographic distribution of abortion services in the wake of the act's two major requirements is that a significant number of the reproductive-age female population of Texas will need to travel considerably further in order to exercise its right to a legal previability abortion.

The ambulatory-surgical-center requirement imposes extensive new standards on abortion facilities by requiring them to meet enhanced standards for new construction. *See* 25 Tex. Admin. Code § 139.40. The requirement applies equally to abortion clinics that only provide medication abortion, even though no surgery or physical intrusion into a woman's body occurs during this

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[4] The court finds the estimates provided by the State's expert, Todd Giberson, to be a less reliable assessment of the true impact on the reproductive-age women of Texas because, in part, his calculations were based on distances measured from abortion providers in New Mexico, El Paso, McAllen, and Lubbock. The court finds fewer overall indicia of reliability in Giberson's conclusions than those of Plaintiffs' expert Dr. Grossman.

procedure. The standards prescribe electrical, heating, ventilation, air conditioning, plumbing, and other physical plant requirements as well as staffing mandates, space utilization, minimum square footage, and parking design. Notably, grandfathering of existing facilities and the granting of waivers from specific requirements is prohibited for abortion providers, although other types of ambulatory-surgical facilities are frequently granted waivers or are grandfathered due to construction dates that predate the newer construction requirements.

According to both sides' experts, the cost of coming into compliance for existing clinics is significant. If a clinic is able to make renovations to comply, those costs will undisputedly approach 1 million dollars and will most likely exceed 1.5 million dollars. Some existing clinics cannot comply due to physical size limitations of their sites. The cost of acquiring land and constructing a new compliant clinic will likely exceed three million dollars. Adapting existing clinics statewide will presumably present similarly high costs and that, although some variance is to be expected, the cost of constructing a new, compliant facility elsewhere in the state is likewise prohibitive. Combined with evidence of operational costs and profit margins associated with operating an abortion facility, the court concludes that few, if any, new compliant abortion facilities will open to meet the demand resulting from existing clinics' closure. Existing clinics, unable to meet the financial burdens imposed by the new regulatory regime, will close as a result.

The clinic closings attributable to the act's two requirements will undeniably reduce meaningful access to abortion care for women throughout Texas. Even assuming every woman in Texas who wants to obtain an abortion after September 1, 2014, could travel to one of the four metropolitan areas where abortions will still be available, the cumulative results of House Bill 2 are that, at most, eight providers would have to handle the abortion demand of the entire state. Based

on historical data pertaining to Texas's average number of abortions, and assuming perfectly equal distribution among the remaining seven or eight providers, this would result in each facility serving between 7,500 and 10,000 patients per year. Accounting for the seasonal variations in pregnancy rates and a slightly unequal distribution of patients at each clinic, it is foreseeable that over 1,200 women per month could be vying for counseling, appointments, and follow-up visits at some of these facilities. That the State suggests that these seven or eight providers could meet the demand of the entire state stretches credulity.

Even if the remaining clinics could meet the demand, the court concludes that the practical impact on Texas women due to the clinics' closure statewide would operate for a significant number of women in Texas just as drastically as a complete ban on abortion. The State argues that the Fifth Circuit has established a *de facto* "safe harbor" of 150 miles and that no abortion regulation that increases travel distance alone could act as an undue burden on the right to previability abortion. *Abbott II*, 748 F.3d at 598; *Abbott I*, 734 F.3d at 415; *Currier*, 2014 WL 3730467 at *12. But here, the record conclusively establishes that increased travel distances *combine* with practical concerns unique to every woman. These practical concerns include lack of availability of child care, unreliability of transportation, unavailability of appointments at abortion facilities, unavailability of time off from work, immigration status and inability to pass border checkpoints, poverty level, the time and expense involved in traveling long distances, and other, inarticulable psychological obstacles. These factors combine with increased travel distances to establish a *de facto* barrier to obtaining an abortion for a large number of Texas women of reproductive age who *might* choose to seek a legal abortion. The court further concludes that women in the border communities of the Rio Grande Valley and El Paso will be affected most heavily due to longer travel distances (in some

cases exceeding 500 miles), higher-than-average poverty levels, and other issues uniquely associated with minority and immigrant populations.

Women living in other areas of Texas will be similarly affected. It is impossible to conclusively measure the individualized factors that act on each woman's decision to seek or forgo an abortion due to the procedure's relative unavailability. Such decisions necessarily "involve personal decisions concerning not only the meaning of procreation but also human responsibility and respect for it." *Casey*, 505 U.S. at 853. It is also impossible to divine exactly how many women in Texas may be affected by any individual factor or combination of factors to the point of not being able to exercise their right to obtain an abortion.

The act operates in conjunction with Texas's other regulations on abortion, some of which provide significant burdens in their own right. For example, a woman living fewer than 100 miles from a licensed facility is required to wait 24 hours from her initial consultation and make another trip to the facility to complete the procedure. Tex. Health & Safety Code Ann. § 171.012 (West 2014). Even if a woman lives further than 100 miles, she must wait a minimum of two hours from her initial consultation before completing the procedure, adding time to her total time away from work or family responsibilities and complicating the scheduling of the abortion procedure. *Id.* The proverbial "last straw" that encumbers a woman's choice to have an abortion is unknowable to anyone other than that individual woman. It is equally implausible for a plaintiff in a case such as this to conclusively establish factors that act uniformly upon all women across a state as large and diverse as Texas.

A financially disadvantaged woman, now living 50 miles from the nearest abortion clinic may be just as heavily burdened by practical concerns which combine with travel distance, as a

woman now living 200 miles away. It is overly simplistic and reductionist to conclude that absolute distances or theoretical travel times measured under ideal circumstances act identically on a population as diverse as Texas's. They simply do not. It is equally unrealistic to conclude that absolute travel distance is the only meaningful obstacle raised by House Bill 2's elimination of more than 30 previously operating abortion facilities. The act's two requirements erect a particularly high barrier for poor, rural, or disadvantaged women throughout Texas, regardless of the absolute distance they may have to travel to obtain an abortion. A woman with means, the freedom and ability to travel, and the desire to obtain an abortion, will always be able to obtain one, in Texas or elsewhere. However, *Roe*'s essential holding guarantees to all women, not just those of means, the right to a previability abortion.

The court concludes that the act's ambulatory-surgical-center requirement, combined with the already in-effect admitting-privileges requirement, creates a brutally effective system of abortion regulation that reduces access to abortion clinics thereby creating a statewide burden for substantial numbers of Texas women. The obstacles erected for these women are more significant than the "incidental effect of making it more difficult or more expensive to procure an abortion." *Casey*, 505 U.S. at 874. The court concludes that the overall lack of practical access to abortion services resulting from clinic closures throughout Texas as a result of House Bill 2 is compelling evidence of a substantial obstacle erected by the act.

The court also concludes that the severity of the burden imposed by both requirements is not balanced by the weight of the interests underlying them. The primary interest proffered for the act's requirements relate to concerns over the health and safety of women seeking abortions in Texas. To the extent that the State argues that the act's requirements are motivated by a legitimate interest in

fetal life, the court finds those arguments misplaced. In contrast to the regulations at issue in *Casey*, the act's challenged requirements are solely targeted at regulating the performance of abortions, not the decision to seek an abortion. Here, the only possible gain realized in the interest of fetal life, once a woman has made the decision to have a previability abortion, comes from the ancillary effects of the woman's being unable to obtain an abortion due to the obstacles imposed by the act. The act creates obstacles to previability abortion. It does not counsel against the decision to seek an abortion.

The great weight of the evidence demonstrates that, before the act's passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure. Giving appropriate weight to the experts' conflicting testimony, the court concludes that concerns over incomplete complication reporting and underestimated complication rates are largely unfounded and are without a reliable basis. Abortion, as regulated by the State before the enactment of House Bill 2, has been shown to be much safer, in terms of minor and serious complications, than many common medical procedures not subject to such intense regulation and scrutiny. Additionally, risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities. Plaintiffs have demonstrated that women will not obtain better care or experience more frequent positive outcomes at an ambulatory surgical center as compared to a previously licensed facility.

Many of the building standards mandated by the act and its implementing rules have such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary. Furthermore, the court concludes that it is unlikely that the stated goal of the requirement—improving women's health—will actually come to pass. Higher health risks

associated with increased delays in seeking early abortion care, risks associated with longer distance automotive travel on traffic-laden highways, and the act's possible connection to observed increases in self-induced abortions almost certainly cancel out any potential health benefit associated with the requirement. The court finds no particularized health risks arising from abortions performed in nonambulatory-surgical-center clinics which countenance the imposition of the ambulatory-surgical-center requirement on the provision of all abortions. The imposition of such requirements is even weaker in the context of medication abortions, where no surgery is involved.

Similarly, the court finds that, as applied to Plaintiff abortion providers in the Rio Grande Valley and El Paso, the interests underlying the admitting-privileges requirement fall short in many of the same ways when compared to the burden the requirement imposes on women in those areas. Evidence related to patient abandonment and potential improved continuity of care in emergency situations is weak in the face of the opposing evidence that such complications are exceedingly rare in Texas, nationwide, and specifically with respect to the Plaintiff abortion providers. Additional objectives proffered for the requirement, such as physician screening and credentialing are not credible due, in part, to evidence that doctors in Texas have been denied privileges for reasons not related to clinical competency. At most, the court finds the credentialing rationale weak and speculative. The court concludes that the heavy burden imposed on the women of West Texas, El Paso, and the Rio Grande Valley by the admitting-privileges requirement is not appropriately balanced by a credible medical or health rationale.

After thorough consideration of the severity of the burdens presented by the act's two requirements, the court concludes that the requirements, independently and when viewed as they operate together, have the ultimate effect of erecting a substantial obstacle for women in Texas who

seek to obtain a previability abortion. In other words, the obstacles imposed by the act's ambulatory-surgical-center requirement, with regard to women throughout Texas, and the act's admitting-privileges requirement combined with the ambulatory-surgical-center requirement, as applied to the Rio Grande Valley and El Paso clinics, are constitutionally impermissible.

An abortion regulation is also violative of a woman's right to an abortion if it was adopted with the purpose of erecting a substantial obstacle to a woman's ability to choose a previability abortion. *Gonzales*, 550 U.S. at 156. Because the act's two requirements have the effect of creating an undue burden, an additional finding that the act was passed with the purpose of erecting a substantial obstacle is not required in order to declare the act unconstitutional. However, the court concludes, after examining the act and the context in which it operates, that the ambulatory-surgical-center requirement was intended to close existing licensed abortion clinics. The requirement's implementing rules specifically deny grandfathering or the granting of waivers to previously licensed abortion providers. This is in contrast to the "frequent" granting of some sort of variance from the standards which occur in the licensing of nearly three-quarters of all licensed ambulatory surgical centers in Texas. Such disparate and arbitrary treatment, at a minimum, suggests that it was the intent of the State to reduce the number of providers licensed to perform abortions, thus creating a substantial obstacle for a woman seeking to access an abortion. This is particularly apparent in light of the dearth of credible evidence supporting the proposition that abortions performed in ambulatory surgical centers have better patient health outcomes compared to clinics licensed under the previous regime.

Finally, the court finds the suggestion of an impermissible purpose in one of the State's arguments relating to the El Paso clinic. In arguing that the act does not impose an undue burden,

the State posits that El Paso and West Texas residents may easily seek previability abortions in neighboring New Mexico, a state without a requirement that abortions be performed in an ambulatory surgical center. *Currier*, 2014 WL 3730467 at *9. If the State's true purpose in enacting the ambulatory-surgical-center requirement is to protect the health and safety of Texas women who seek abortions, it is disingenuous and incompatible with that goal to argue that Texas women can seek abortion care in a state with lesser regulations. If, however, the State's underlying purpose in enacting the requirement was to reduce or eliminate abortion in parts or all of Texas, the State's position is perfectly congruent with such a goal.

House Bill 2's ambulatory-surgical-center requirement burdens Texas women in a way incompatible with the principles of personal freedom and privacy protected by the United States Constitution for the 40 years since *Roe v. Wade*. Through strict regulations that will result in an unprecedented percentage of licensed abortion facilities closing across the state, the requirement will severely limit access to abortion care for untold numbers of women throughout the state. When viewed in the context of the other state-imposed obstacles a woman faces when seeking an abortion in Texas–including a sonogram requirement, a waiting period, and the reduced number of abortion-performing physicians resulting from the admitting-privilege requirement–the court is firmly convinced that the State has placed unreasonable obstacles in the path of a woman's ability to obtain a previability abortion. These substantial obstacles have reached a tipping point that threatens to "chip away at the private choice shielded by *Roe*," *Stenberg v. Carhart,* 530 U.S. 914, 952 (2000) (Ginsburg, J., concurring), and effectively reduce or eliminate meaningful access to safe abortion care for a significant, but ultimately unknowable, number of women throughout Texas.

Likewise, for women living in the Rio Grande Valley, El Paso, and West Texas, the admitting-privileges and ambulatory-surgical-center requirements, acting in conjunction as applied to the McAllen clinic and the El Paso clinic, impose an undue burden on the right to a previability abortion. The evidence is even stronger that the requirements will affect a substantial number of women living in these communities, and the act's two requirements are unconstitutional as applied to the Plaintiff abortion providers in those two cities. Finally, the court concludes that the ambulatory-surgical-center requirement imposes an undue burden specifically as applied to the provision of medication abortions, where any medical justification for the requirement is at its absolute weakest in comparison with the heavy burden it imposes.

In order to fashion a remedy consistent with the conclusions reached above, the court "must consider the proper place of [the act's] comprehensive and careful severability provision." *Abbott II,* 748 F.3d at 589. "Federal courts are bound to apply state law severability provisions . . . [and] must preserve the valid scope of the provision to the greatest extent possible" even when considering facial invalidation of a statute. *Id.* The State urges that the Texas Legislature expressed its intent that "every application of this statute to every individual woman shall be severable from each other." Act § 1(b). The State further argues that the act's severability clause, which states, in part:

> All constitutionally valid applications of this Act shall be severed from any applications that a court finds to be invalid, leaving the valid applications in force, because it is the legislature's intent and priority that the valid applications be allowed to stand alone. Even if a reviewing court finds a provision of this Act to impose an undue burden in a large or substantial fraction of relevant cases, the applications that do not present an undue burden shall be severed from the remaining provisions and shall remain in force, and shall be treated as if the legislature had enacted a statute limited to the persons, group of persons, or circumstances for which the statute's application does not present an undue burden . . . .

Act § 10(b), operates to preclude a facial challenge to the act under existing abortion-regulation jurisprudence.

This plainly cannot be so. A state's legislature cannot purport to act to abrogate the rights guaranteed by the United States Constitution. The court further notes the sheer impossibility of severing "every application of this statute to every individual woman." However, because this court is bound to apply the severability clause contained in the act when crafting a remedy for the successful facial challenge to the ambulatory-surgical-center requirement, the court will leave in place all applications for which the statute's application does not present an undue burden. The court concludes that the ambulatory-surgical-center requirement does not act as an undue burden on Texas women when applied to the currently licensed ambulatory-surgical-center abortion providers in Texas. The requirement also does not act as an undue burden on new abortion providers that begin offering abortion services after September 1, 2014, and which were not previously licensed abortion providers. In all other applications, the court finds that the ambulatory-surgical-center requirement imposes an undue burden on Texas women of reproductive age.

III. CONCLUSION

Examining separately the ambulatory-surgical-center and admitting-privileges requirements of House Bill 2, the court will render a final judgment:

(1) Declaring that the ambulatory-surgical-center requirement is unconstitutional because it imposes an undue burden on the right of women throughout Texas to seek a previability abortion. The court will enjoin enforcement of the provision consistent with the act's severability clause.

(2) The court will render a final judgment that the admitting-privileges requirement, as applied to the Plaintiff McAllen and El Paso clinics, is unconstitutional because it, in conjunction with the ambulatory-surgical-center requirement, imposes an undue burden on the right of women in the Rio Grande Valley, El Paso, and West Texas to seek a previability abortion. The admitting-privilege-requirement will be enjoined as applied to the McAllen and El Paso clinics.

(3) The court will render a final judgment that the act's ambulatory-surgical-center requirement, as applied to the provision of medication abortions, is unconstitutional because it imposes an undue burden on women seeking a previability abortion. The court will therefore enjoin the ambulatory-surgical-center requirement as applied to the provision of medication abortions.

However, when the two provisions are considered together, they create a scheme that effects the closing of almost all abortion clinics in Texas that were operating legally in the fall of 2013. Thus, the overall effect of the provisions is to create an impermissible obstacle as applied to all women seeking a previability abortion. The court will thus enjoin the enforcement of both provisions on the basis that they act together to create an undue burden on a woman seeking a previability abortion by restricting access to previously available legal facilities.

SIGNED this 29th day of August, 2014

LEE YEAKEL
UNITED STATES DISTRICT JUDGE

B

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

WHOLE WOMAN'S HEALTH, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS D/B/A REPRODUCTIVE SERVICES, AND SHERWOOD C. LYNN, JR., M.D., PAMELA J. RICHTER, D.O., AND LENDOL L. DAVIS, M.D., EACH ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS,	§	
V.	§	CAUSE NO. 1:14-CV-284-LY
DAVID LAKEY, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, IN HIS OFFICIAL CAPACITY, AND MARI ROBINSON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD, IN HER OFFICIAL CAPACITY, DEFENDANTS.	§	

FINAL JUDGMENT

Before the court is the above-styled and numbered cause. On May 12, 2014, upon joint motion of the parties, the court dismissed from this action Defendants Travis County Attorney David Escamilla, El Paso District Attorney Jaime Esparza, Hidalgo County Criminal District Attorney Rene Guerra, Bell County Attorney James E. Nichols, Bexar County Criminal District Attorney Susan Reed, Tarrant County Criminal District Attorney Joe Shannon, Jr., and Dallas County Criminal District Attorney Craig Watkins, each in their official capacities, and their employees, agents, and successors. On August 1, 2014, the court dismissed Plaintiffs Whole Woman's Health, Austin

Woman's Health Center, Killeen Woman's Health Center, Nova Health Systems d/b/a Reproductive Services, and Sherwood C. Lynn, Jr., M.D., Pamela J. Richter, D.O., and Lendol L. Davis, M.D., on behalf of themselves and their patients's claims alleging federal equal-protection violations, improper delegation of lawmaking authority, and arbitrary and unreasonable state action against Defendants David Lakey, M.D., Commissioner of the Texas Department of State Health Services, in his official capacity, and Mari Robinson, Executive Director of the Texas Medical Board, in her official capacity (together the "State"). On this date by Memorandum Opinion Incorporating Findings of Fact and Conclusions of Law, the court found and concluded that the ambulatory-surgical-center requirement of the Act of July 12, 2013, 83rd Leg., 2nd C.S., ch. 1, 2013 Tex. Gen. Laws 4795; ("House Bill 2") (codified at Tex. Health & Safety Code Ann. §§ 171.0031, 245.010(a) (West Supp. 2014) is unconstitutional, that the admitting-privileges and ambulatory-surgical-center requirements of House Bill 2 as applied to Plaintiffs Whole Woman's Health clinic in McAllen, Texas, and Nova Health Systems's clinic in El Paso, Texas, are unconstitutional, that the ambulatory-surgical-center requirement of House Bill 2, as applied to medication abortions, is unconstitutional, and that the provisions considered together create an impermissible obstacle as applied to all women seeking a previability abortion. As nothing remains for the court to resolve, the court renders the following final judgment pursuant to Federal Rule of Civil Procedure 58.

THE COURT DECLARES that the portion of the Texas Health and Safety Code, Section 245.010(a), "On and after September 1, 2014, the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under Section 243.010 for ambulatory surgical centers" is unconstitutional:

1. As to all abortion facilities in the State, with the exception of

   (a) abortion facilities currently licensed and meeting the minimum standards adopted under the Texas Health and Safety Code, Section 243.010 for ambulatory surgical centers, and

   (b) abortion facilities commencing operation after September 1, 2014, and which were not previously licensed abortion facilities under the Texas Health and Safety Code, Section 245.

2. As applied to the provision of medical abortion, as defined in Texas Health and Safety Code, Section 171.061.

THE COURT FURTHER DECLARES that the portion of Texas Health and Safety Code, Section 171.0031(a)(1) is unconstitutional as applied to Plaintiffs Whole Woman's Health and Sherwood Lynn with respect to the operation of an abortion facility in McAllen, Texas, and Plaintiffs Nova Health Systems and Pamela Richter with respect to the operation of an abortion facility in El Paso, Texas.

THE COURT FURTHER DECLARES that the two portions of Texas Health and Safety Code, Sections 245.010(a) and 171.0031(a)(1), create an impermissible obstacle as applied to all women seeking a previability abortion.

IT IS ORDERED that the State, its agents, employees, and any other persons or entities acting on its behalf are enjoined from enforcing the above-listed portions of sections of the Texas Health and Safety Code to the extent stated herein, including enforcing any criminal and administrative penalties against any person accused of violating any provision of the Texas Health and Safety Code declared unconstitutional by this final judgment.

Any claim for attorney's fees incurred in this action will be determined post judgment and pursuant to Rule CV-7(j), of the Local Rules of the United States District Court for the Western District of Texas.

IT IS FURTHER ORDERED that Plaintiffs recover their costs of court.

IT IS FURTHER ORDERED, except as expressly provided herein, all other relief requested by any party is **DENIED**.

SIGNED this 29th day of August, 2014

LEE YEAKEL
UNITED STATES DISTRICT JUDGE

C

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

WHOLE WOMAN'S HEALTH; ABORTION ADVANTAGE; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS d/b/a REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; LENDOL L. DAVIS, M.D.; and LAMAR ROBINSON, M.D., on behalf of themselves and their patients,

Plaintiffs,

v.

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; JAIME ESPARZA, District Attorney for El Paso County; RENÉ GUERRA, Criminal District Attorney for Hidalgo County; JAMES E. NICHOLS, County Attorney for Bell County; SUSAN D. REED, Criminal District Attorney for Bexar County; JOE SHANNON, JR., Criminal District Attorney for Tarrant County; CRAIG WATKINS, Criminal District Attorney for Dallas County, in their official capacities,

Defendants.

CIVIL ACTION

CASE NO. A14CV0284 LY

COMPLAINT

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. Pursuant to 42 U.S.C. § 1983, Plaintiffs, who are Texas health care providers, bring

this action on behalf of themselves and their patients. They seek declaratory and injunctive relief from certain unconstitutional requirements imposed by Texas House Bill No. 2 ("the Act"), Act of July 18, 2013, 83rd Leg., 2nd C.S., ch. 1, Tex. Gen. Laws, and its implementing regulations, *see* 38 Tex. Reg. 6536-46 (Sept. 27, 2013) (notice of proposed rules); 38 Tex. Reg. 9577-93 (adoption of proposed rules). [1]

2. The Act targets abortion providers for the imposition of unique regulatory burdens that are not imposed on any other health care providers in Texas, are inconsistent with accepted medical standards, impose costs that are far in excess of any potential benefits, and will dramatically reduce the number and geographic distribution of medical facilities in the State where women can access safe and legal abortion services.

3. These regulatory burdens include the "admitting privileges requirement," which provides, in relevant part, 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 located not further than 30 miles from the location at which the abortion is performed or induced." Act, § 2 (codified at Tex. Health & Safety Code Ann. § 171.0031); 25 Tex. Admin Code §§139.53(c), 139.56(a).

4. They also include the "ASC requirement," which provides, in relevant part, that "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

[1] A copy of the Act is attached hereto as Exhibit 1. The pages of the Texas Register providing notice of the proposed regulations and their adoption are attached hereto as Exhibit 2.

5. The Act was signed by Governor Rick Perry on July 18, 2013.

6. Initially scheduled to take effect on October 29, 2013, the admitting privileges requirement was the subject of a pre-enforcement, facial challenge by a coalition of abortion providers, including some of the Plaintiffs in this case. It was permanently enjoined by a judge of this Court on October 28, 2013, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891, 909 (W.D. Tex. 2013), but the U.S. Court of Appeals for the Fifth Circuit stayed that injunction on the evening of October 31, 2013, 734 F.3d 406, 419 (5th Cir. 2013), *motion to vacate denied*, 134 S. Ct. 506 (2013), and ultimately reversed the district court's judgment, ___ F.3d ___, 13-51008, 2014 WL 1257965 (5th Cir. Mar. 27, 2014). The Fifth Circuit expressly noted that "[l]ater as-applied challenges" could be brought to "deal with subsequent, concrete constitutional issues." *Id.* at * 2.

7. Here, Plaintiffs Whole Woman's Health and Dr. Lynn challenge the admitting privileges requirement as applied to the licensed abortion facility operated by Whole Woman's Health in McAllen (the "McAllen clinic"). The McAllen clinic is currently the only licensed abortion facility in the Rio Grande Valley. During the past ten years, over 14,000 abortions were performed at the McAllen clinic; only two of those patients needed to be transported from the clinic to a hospital. The McAllen clinic has not been able to provide abortion services since the admitting privileges requirement took effect.

8. Plaintiffs Nova Health Systems d/b/a Reproductive Services ("Reproductive Services") and Dr. Richter challenge the admitting privileges requirement as applied to the licensed abortion facility operated by Reproductive Services in El Paso (the "El Paso clinic"). The El Paso clinic is currently one of only two licensed abortion facilities located west of San Antonio. During the past ten years, over 17,000 abortions were performed at the El Paso clinic;

not one of those patients needed to be transported from the clinic to a hospital. Absent injunctive relief from the admitting privileges requirement, the El Paso clinic will be forced to cease providing abortion services after May 13, 2014, when Dr. Richter's temporary admitting privileges at an El Paso-area hospital are set to expire.

9. The ASC requirement is scheduled to take effect on September 1, 2014. *See* Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)).

10. All plaintiffs challenge the ASC requirement on its face.

11. In addition, Whole Woman's Health and Dr. Lynn challenge the ASC requirement as applied to the McAllen clinic, and Reproductive Services and Dr. Richter challenge the ASC requirement as applied to the El Paso clinic.

12. Prior to the passage of the Act, there were over three dozen licensed abortion clinics in Texas. Since the admitting privileges requirement has taken effect, that number has dropped significantly. If the ASC requirement is permitted to take effect, there will be fewer than ten abortion clinics in the State, all clustered in eastern metropolitan areas, with no clinics west or south of San Antonio.

II. JURISDICTION AND VENUE

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

14. 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.

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

III. PLAINTIFFS

16. Plaintiff Whole Woman's Health operates licensed abortion facilities in Austin, Fort

Worth, and San Antonio. In addition, it operates a licensed ASC in San Antonio. These medical facilities have provided high quality reproductive health care services, including abortion services, to Texas women for over a decade. Until the admitting privileges requirement took effect, Whole Woman's Health also operated licensed abortion facilities in Beaumont and McAllen. If the admitting privileges requirement were enjoined with respect to the McAllen clinic, Whole Woman's Health would immediately resume providing services at that location. Whole Woman's Health sues on behalf of itself and its patients.

17. Plaintiff Sherwood C. Lynn, Jr., M.D., is a board-certified obstetrician-gynecologist ("ob-gyn") licensed to practice medicine in the State of Texas. He has over 35 years of experience providing reproductive health care, including abortion care. He serves as the Medical Director of Whole Woman's Health's licensed abortion facility and ASC in San Antonio, and he seeks to provide abortion services at the McAllen clinic. Although he has admitting privileges at a hospital in San Antonio, no hospital within 30 miles of the McAllen clinic will grant him admitting privileges. Dr. Lynn sues on behalf of himself and his patients.

18. Plaintiff Abortion Advantage operates a licensed abortion facility in Dallas. It has provided high quality reproductive health care services, including abortion services, to Texas women for over 25 years. Abortion Advantage sues on behalf of itself and its patients.

19. Plaintiff Lamar Robinson, M.D., is an ob-gyn licensed to practice medicine in the State of Texas. He has over 28 years of experience providing reproductive health care, including abortion care. He currently serves as the Medical Director of Abortion Advantage. Dr. Robinson sues on behalf of himself and his patients.

20. Plaintiffs Austin Women's Health Center and Killeen Women's Health Center (collectively, the "Health Centers") operate licensed abortion facilities in Austin and Killeen,

respectively. These medical facilities have provided high quality reproductive health care services, including abortion services, to Texas women for over 35 years. The Health Centers sue on behalf of themselves and their patients.

21. Plaintiff Lendol L. "Tad" Davis, M.D., is a board-certified ob-gyn licensed to practice medicine in the State of Texas. He has over 35 years of experience providing reproductive health care, including abortion care. He serves as the Medical Director of Austin Women's Health Center and Killeen Women's Health Center. Dr. Davis sues on behalf of himself and his patients.

22. Plaintiff Nova Health Systems d/b/a Reproductive Services ("Reproductive Services") operates a licensed abortion facility in El Paso. The El Paso clinic has provided high-quality reproductive health care services, including abortion services, to Texas women for over 35 years. If the admitting privileges requirement is not enjoined prior to May 14, 2014, then the El Paso clinic will be forced to close on that date. Reproductive Services sues on behalf of itself and its patients.

23. Plaintiff Pamela J. Richter, D.O., is a board-eligible family medicine doctor licensed to practice medicine in the State of Texas. She has been providing reproductive health care, including abortion care, for over 20 years. She currently serves as Medical Director of the El Paso clinic. Dr. Richter has temporary admitting privileges at Foundation Surgical Hospital of El Paso, which will expire on May 13, 2014. No hospital within 30 miles of the El Paso clinic will grant Dr. Richter admitting privileges that are effective after May 13, 2014. She sues on behalf of herself and her patients.

IV. DEFENDANTS

24. 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 the Act challenged here. Commissioner Lakey is sued in his official capacity and may be served with process at 1100 West 49th Street, Austin, Texas 78756-3199.

25. 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. Ms. Robinson is sued in her official capacity and may be served with process at 333 Guadalupe, Tower 3, Suite 610, Austin, Texas 78701.

26. Defendant David Escamilla is the County Attorney for Travis County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, 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.

27. Defendant Jaime Esparza is the District Attorney for El Paso County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, 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.

28. Defendant René Guerra is the Criminal District Attorney for Hidalgo County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, 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.

29. Defendant James E. Nichols is the County Attorney for Bell County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, 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 Susan D. Reed is the Criminal District Attorney for Bexar County. She is responsible for prosecuting misdemeanors, including criminal violations of the Act, 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.

31. Defendant Joe Shannon, Jr. is the Criminal District Attorney for Tarrant County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, 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.

32. Defendant Craig Watkins is the Criminal District Attorney for Dallas County. He is responsible for prosecuting misdemeanors, including criminal violations of the Act, 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.

V. FACTUAL ALLEGATIONS

A. The Admitting Privileges Requirement

Overview

33. The admitting privileges requirement provides, *inter alia*, 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 located not further than 30 miles from the location at which the abortion is performed or induced." Act, § 2 (codified at Tex. Health & Safety Code Ann. § 171.0031); 25 Tex. Admin. Code §§ 139.53(c), 139.56(a).

34. Any physician who violates this requirement commits a Class A misdemeanor offense. The physician is also subject to license revocation, and the abortion facility at which the

abortion is performed is subject to license revocation. *See* Tex. Health & Safety Code § 171.0031; Tex. Occ. Code § 164.055(a); 25 Tex. Admin. Code § 139.32.

35. Prior to the enactment of the admitting privileges requirement, Texas law required that: "A licensed abortion facility shall have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital. The facility shall ensure that the physicians who practice at the facility have admitting privileges or have a working arrangement with a physician(s) who has admitting privileges at a local hospital in order to ensure the necessary back up for medical complications." 25 Tex. Admin. Code § 139.56(a) (2012).

36. This regulation had been in effect since 2009 and had never been challenged in litigation.

37. Both the McAllen clinic and the El Paso clinic were in compliance with this regulation when the admitting privileges requirement was enacted.

38. Both the McAllen clinic and the El Paso clinic continue to have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital.

39. Both the McAllen clinic and the El Paso clinic continue to ensure that the physicians who practice at the respective facilities have a working arrangement with at least one physician who has admitting privileges at a local hospital.

40. The admitting privileges requirement effectively gives local hospitals veto power over the McAllen clinic's ability to provide abortion care to women in the Rio Grande Valley and the El Paso clinic's ability to provide abortion care to women in West Texas. Hospitals in Texas have broad discretion to set the criteria for granting admitting privileges and can thereby

grant or refuse privileges on the basis of idiosyncratic rules and regulations. *See* Tex. Health & Safety Code § 241.101.

41. Hospitals within Texas have varying requirements for admitting 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 admitting privileges to physicians who are directly employed by or under contract with the hospital; while others require a physician to designate an alternate physician with admitting privileges at the hospital who is willing to co-sign the application. These criteria, unrelated to a physician's ability to provide high-quality abortion care, may preclude physicians from obtaining admitting privileges at a local hospital.

The McAllen Clinic's Inability to Comply with the Admitting Privileges Requirement

42. After the admitting privileges requirement was enacted, four physicians affiliated with Whole Woman's Health, including Dr. Lynn, sought to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic. Each physician is a board-certified ob-gyn and experienced abortion provider, and three of the four have admitting privileges at hospitals in other parts of the State.

43. None was able to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic.

44. There are eight hospitals located within 30 miles of the McAllen clinic. Each of them requires, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. The designated alternate physician must already have admitting privileges at the hospital. If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other requirements.

45. Only one eligible physician was willing to serve as a designated alternate physician for the physicians affiliated with the McAllen clinic, and this physician only has privileges at one area hospital: Doctors Hospital at Renaissance. The other physicians approached by the clinic expressed concern about retaliation from the hospitals at which they had admitting privileges and the possibility that their privileges would be revoked or discontinued if they facilitated the application of a known abortion provider.

46. Thus, the physicians affiliated with the McAllen clinic were only able to satisfy the application criteria for Doctors Hospital at Renaissance. At this hospital, the first step in applying for admitting privileges is to submit a written request for an application.

47. In September 2013, all four physicians submitted such requests.

48. In November or December 2013, each of the physicians received a letter in response stating that, based on the recommendation of the hospital's Credentials Committee, the Medical Executive Committee was denying the physician's request for an application for privileges. Each letter further stated that the Board of Governors had considered the request and determined not to extend an application "as authorized under the Bylaws and Rules and Regulations of the Medical Staff for the Hospital" and that the "decision of the Governing Body was not based on clinical competence consideration." The letters provided no other explanation as to why each of the four physicians was denied the opportunity to apply for admitting privileges at the hospital.

49. Whole Woman's Health has been unable to recruit a physician with admitting privileges at a hospital within 30 miles of the McAllen clinic to provide abortion services at the clinic.

Challenges Facing Women in the Rio Grande Valley Who Seek Abortion Care

50. In 2010, the latest year for which DSHS data is available, 2,845 women from the Rio Grande Valley had abortions in Texas. *See* Texas Dep't of State Health Servs., Table 35: Induced Terminations of Pregnancy by County of Residence and Race/Ethnicity, http://www.dshs.state.tx.us/chs/vstat/vs10/t35.shtm (last accessed April 1, 2014).

51. The McAllen clinic is currently the only licensed abortion facility in the Rio Grande Valley.

52. Absent as-applied relief from the Court, the McAllen clinic will be unable to resume its provision of medical services, leaving women in the Rio Grande Valley without an abortion provider in their region. The closest abortion provider would be in Corpus Christi, which is over 150 miles from McAllen.

53. For many women in the Rio Grande Valley, a 150-mile distance is a substantial obstacle to accessing abortion care.

54. The Rio Grande Valley is comprised of four counties along the eastern border of Texas and Mexico: Starr County, Hidalgo County, Willacy County, and Cameron County. It has a population of approximately 1.3 million.[2]

55. There are some urban centers in the Rio Grande Valley—for example, in McAllen, Harlingen, and Brownsville—but much of the region is rural. The rural areas include unincorporated towns known as *colonias*, which are more prevalent in the Rio Grande Valley than anywhere else in the United States. *Colonias* can be hard to reach because they often do not

[2] U.S. Census Bureau, Population Div., Annual Estimates of the Resident Population: Apr. 1, 2010 to July 1, 2012 (2010), http://factfinder2.census.gov/bkmk/table/1.0/en/PEP/2012/PEPANNRES/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed April 1, 2014).

appear on maps. In many *colonias*, residents have a difficult time accessing basic public services, including water, electricity, sewage and drainage systems and paved roads. *See* Federal Reserve Bank of Dallas, *Texas Colonias: A Thumbnail Sketch of the Conditions, Issues, Challenges and Opportunities* (2007), http://www.dallasfed.org/assets/documents/cd/pubs/colonias.pdf.

56. The vast majority of people living in the Rio Grande Valley are Latino.[3] Latinos in Texas are three times as likely to live in poverty as white people.[4] Overall, approximately one-third of the population in the Rio Grande Valley lives in poverty.[5]

57. Nearly half of the population has less than a ninth-grade education,[6] and the region has a high proportion of farmworkers and seasonal migrant workers. Employment outside of the agricultural field, especially for uneducated and unskilled workers, is scarce. As a result, unemployment in the Rio Grande Valley is higher than in the rest of the State.[7]

58. Most of the Rio Grande Valley is designated as a medically underserved area by

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[3] U.S. Census Bureau, Population Div., ACS Demographic and Housing Estimates, 2009-2011 (2007-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11_5YR/DP05/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed April 1, 2014).

[4] KFF, Poverty Rate by Race/Ethnicity (2010-2011), http://kff.org/other/state-indicator/poverty-rate-by-raceethnicity/ (last accessed April 1, 2014).

[5] U.S. Census Bureau, Poverty Status in the Past 12 Months (2009-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11_3YR/S1701/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed April 1, 2014).

[6] U.S. Census Bureau, Educational Attainment –2009-2011 American Community Survey 3-year Estimates, 2009 – 2011 (2009-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11_3YR/S1501/0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed April 1, 2014).

[7] U.S. Census Bureau, Employment Status – 2009-2011 American Community Survey 3-Year Estimates, 2009–2011 (2009-2011), http://factfinder2.census.gov/bkmk/table/1.0/en/ACS/11_5YR/S2301/0400000US48|0500000US48061|0500000US48215|0500000US48427|0500000US48489 (last accessed April 1, 2014).

the federal government because the population has a shortage of health services and faces numerous socioeconomic barriers to health care access. *See* Texas Dep't of State Health Servs., *MUA and MUP Designations*, http://www.dshs.state.tx.us/CHS/hprc/MUAlist.shtm (last updated April 10, 2012).

59. Women living in the Rio Grande Valley face many challenges in accessing reproductive health care services generally and abortion care specifically. These challenges include poverty, lack of service providers, lack of access to transportation, need for childcare, and inability to take time off from work.

60. Many women in the Rio Grande Valley rely on State-subsidized health clinics for preventative reproductive health care, such as pap smears and contraceptives. In 2011, the number of these clinics was dramatically reduced as a result of changes in State law. Few of them remain in the Rio Grande Valley, and demand for their services now exceeds their capacity. As a result, women must endure long waits for appointments, and some simply live too far from the nearest clinic to access services. The reduction in State-subsidized clinics has had a devastating impact on women's ability to access preventative reproductive health care.

61. As a result, it is now much harder for women in the Rio Grande Valley to avoid unwanted pregnancies. Many women do not want to have additional children, but they no longer have access to affordable contraceptives and cannot afford the cost of a sterilization procedure. *See* Center for Reproductive Rights & National Latina Institute for Reproductive Health, *Nuestra Voz, Nuestra Salud, Nuestro Texas: The Fight for Women's Reproductive Health in the Rio Grande Valley* (2013), *available at* http://www.nuestrotexas.org/ pdf/NT-spread.pdf (last accessed April 1, 2014).

62. The obstacles preventing women in the Rio Grande Valley from accessing

preventative services at non-local clinics will likewise prevent women from accessing abortion services at non-local clinics.

63. As a result, women in the Rio Grande Valley are left with few options for controlling the number and spacing of their children.

The El Paso Clinic's Inability to Comply with the Admitting Privileges Requirement after May 13, 2014

64. After the admitting privileges requirement was enacted, Dr. Richter sought to obtain admitting privileges at a hospital within 30 miles of the El Paso Clinic. She is the Medical Director of the clinic and the only physician who provides abortion services there.

65. In addition to her work at the El Paso clinic, Dr. Richter also works for the State of Texas. She serves as a staff physician at the state supported living center ("State Center") in El Paso operated by the Texas Department of Aging and Disability Services ("DADS"). The State Center provides 24-hour residential services, comprehensive behavioral treatment services, vocational and rehabilitation services, and general health care services to people with intellectual and developmental disabilities.

66. Previously, from 1990 to 2001, Dr. Richter maintained a family medicine practice in El Paso.

67. From January 1990 to May 2003, Dr. Richter had admitting privileges at Del Sol Medical Center, which is located within 30 miles of the El Paso clinic. One of the criteria for maintaining admitting privileges at that hospital is admitting a minimum number of patients to the hospital each year. After Dr. Richter closed her private practice in 2001, she was no longer able to admit the requisite number of patients to the hospital. As a result, when her privileges came up for renewal in 2003, they were not renewed.

68. Subsequent to the enactment of the admitting privileges requirement, one hospital

within 30 miles of the El Paso clinic granted Dr. Richter temporary admitting privileges, effective through May 13, 2014. To date, no hospital within 30 miles of the El Paso clinic has been willing to grant Dr. Richter admitting privileges that are effective after May 13, 2014.

69. Reproductive Services has been unable to recruit a physician with admitting privileges at a hospital within 30 miles of the El Paso clinic to provide abortion services at the clinic.

Challenges Facing Women in West Texas Who Seek Abortion Care

70. Currently, the El Paso clinic is one of only two licensed abortion facilities west of San Antonio.

71. Absent as-applied relief from the Court, the El Paso clinic will be forced to stop providing abortion services after May 13, 2014, leaving a huge region of the State with only a single abortion provider. Women unable to get an appointment with that provider would have to travel to San Antonio to obtain abortion services. San Antonio is over 550 miles from El Paso.

72. For many women in West Texas, a 550-mile distance is a substantial obstacle to accessing abortion care.

73. West Texas is a vast region with numerous, largely rural, counties.

74. The "Trans-Pecos" region of West Texas is comprised of nine counties: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Pecos, Presidio, Reeves, and Terrell. Approximately 877,000 people live in these counties, and over 80% of them are Latino. The region has high levels of poverty: 24% of the population as a whole, and 27% of the Latino population, live below the poverty line. Nearly one-third of the population has a household income less than $25,000 a year. *See* Institute for Demographic and Socioeconomic Research, TxDOT Data Analysis Tool, at http://idserportal.utsa.edu/txDoT/OneStop/Output.aspx?id=8137&tp

=single&l=11 (aggregate data for Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Pecos, Presidio, Reeves, and Terrell counties) (last accessed April 1, 2014).

75. Most of the Trans-Pecos region is designated as a medically underserved area by the federal government. *See* Texas Dep't of State Health Servs., *MUA and MUP Designations*, http://www.dshs.state.tx.us/CHS/hprc/MUAlist.shtm (last updated April 10, 2012).

76. In 2010, the latest year for which DSHS data is available, 2,278 women in the Trans-Pecos region had abortions in Texas; 2,216 of them were from El Paso County. *See* Texas Dep't of State Health Servs., Table 35: Induced Terminations of Pregnancy by County of Residence and Race/Ethnicity, http://www.dshs.state.tx.us/chs/vstat/vs10/t35.shtm (last accessed April 1, 2014).

77. If the El Paso clinic closes, the other licensed abortion facility in the region would not be able to meet patient demand for services. As a result, some women would have to endure long waits for an appointment, and other women would be turned away.

Safety of Abortion Care at the McAllen and El Paso Clinics

78. As applied to the McAllen and El Paso clinics, the admitting privileges requirement does not advance the State's interest in women's health.

79. There are generally two methods of performing abortions in the United States: surgical abortion, which involves the use of medical instruments to evacuate the contents of the uterus; and medical abortion, which involves the administration of medications that cause the termination of a pregnancy.

80. Both types of abortion are extremely safe. The mortality rate from use of penicillin is roughly three times higher than the mortality rate from abortion, and the mortality rate from childbirth is roughly 14 times higher. Serious complications from abortion are rare and hardly

ever require hospitalization.

81. The types of abortions performed at the McAllen and El Paso clinics are among the safest of all abortion procedures.

82. While abortion is extremely safe throughout pregnancy, a woman's risk of experiencing an abortion-related complication increases with the gestational age of her pregnancy. Therefore, earlier abortions have less risk of complications.

83. The McAllen clinic provided abortion services prior to 16 weeks of pregnancy. The highest level of sedation offered to patients at the McAllen clinic was moderate sedation/analgesia, also known as conscious sedation.

84. The El Paso clinic provides abortion services prior to 16 weeks of pregnancy. The highest level of sedation offered to patients at the El Paso clinic is minimal sedation/analgesia.

85. During the past ten years, the McAllen clinic only had to transfer two patients from the clinic to a hospital. Over 14,000 abortions were performed there during that period.

86. During the past ten years, the El Paso clinic has not had to transfer any patients from the clinic to the hospital. Over 17,000 abortions were performed there during that period.

Accepted Medical Standards for Outpatient Practice

87. The admitting privileges requirement is inconsistent with accepted medical standards.

88. In Texas, physicians and other licensed medical practitioners provide a variety of surgical and non-surgical procedures in outpatient settings, some of which are comparable in safety to abortion and some of which entail far greater risks than abortion. Yet only physicians providing abortion services are required to have admitting privileges at a local hospital.

89. Moreover, Texas law does not require any type of medical facility besides abortion

clinics to employ physicians with admitting privileges as a condition of licensure. The regulations governing freestanding emergency medical care facilities and end stage renal disease facilities require only that a facility have a transfer agreement with a hospital. *See* 25 Tex. Admin. Code §§ 131.52(s), 131.66, 131.67 (freestanding emergency medical care facilities); 25 Tex. Admin Code § 117.45(b)(4) (end stage renal disease facilities). The regulations governing ambulatory surgical centers ("ASCs") permit a facility to maintain a transfer agreement with a hospital as an alternative to employing physicians with admitting privileges. *See* 25 Tex. Admin. Code § 135.4(c)(11)(B). And, the regulations governing birthing centers and special care facilities for the treatment of terminally ill patients require only that a facility has a plan for managing patient emergencies. *See* 25 Tex. Admin. Code § 137.46 (birthing centers); 25 Tex. Admin. Code § 125.32(a)(3) (special care facilities).

90. Moreover, the nation's leading medical associations and accreditation bodies—including the American Medical Association ("AMA"), the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Surgeons ("ACS"), the American Society of Anesthesiologists ("ASA"), the Accreditation Association for Ambulatory Health Care ("AAAHC"), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF"), and the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations or "JCAHO")—recognize that admitting privileges at a local hospital are not required for the safe performance of outpatient procedures.

91. In connection with the facial challenge to the admitting privileges requirement, the AMA and ACOG filed a brief in the Fifth Circuit explaining that admitting privileges at a local hospital are not required for the safe performance of abortion procedures in outpatient settings and are not part of the standard of care. *See* Br. of *Amicus Curiae* Am. Coll. of Obstetricians &

Gynecologists and Am. Med. Ass'n, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, ___ F.3d ___ (5th Cir. Mar. 27, 2014) (No. 13-51008), 2013 WL 6837500.

92. ACOG, ACS, and ASA have all issued guidelines concerning outpatient surgery. None requires that physicians performing outpatient surgery have admitting privileges at a local hospital.

93. The National Abortion Federation ("NAF") Clinical Policy Guidelines do not require physicians performing or supervising abortions to have admitting privileges at a local hospital.

94. Of the three major national organizations that accredit healthcare facilities—AAAHC, AAAASH, and the Joint Commission—none requires an outpatient facility to employ physicians with admitting privileges as a condition of accreditation.

95. In the rare event that a patient who has had an abortion requires hospitalization, the quality of care that she receives at the hospital will not be affected by whether her abortion provider has admitting privileges there. Upon the patient's arrival at the hospital via ambulance, an emergency room physician will evaluate the patient and consult with other specialists at the hospital as needed. The patient may require admission to the hospital, or she may simply be treated in the emergency room and then released. Either way, continuity of care can be maintained by direct telephone communication between the abortion provider and the emergency room physician, regardless of whether the abortion provider has admitting privileges at the hospital.

96. Physicians practicing in outpatient settings often refer patients for treatment at hospitals at which they do not have admitting privileges. This is standard medical practice.

97. In fact, the trend in medicine is toward bifurcation of outpatient practice and

hospital-based practice, such that physicians are increasingly specializing in one type of practice setting or the other. Coordination and continuity of care of a patient that is transferred from an outpatient setting to a hospital are achieved through communication between the physician referring the patient to the hospital and the physician treating the patient at the hospital.

Futility of the Admitting Privileges Requirement As Applied to the McAllen and El Paso Clinics

98. Many complications from abortion arise only after a patient has left the clinic and returned home. This is almost always true of complications arising from medical abortions because the medications used to induce those abortions take time to exert their effects.

99. If a patient experiences a serious complication after she has left the clinic and returned home, the appropriate course of action would be for her to go to the nearest emergency room.

100. By forcing the McAllen and El Paso clinics to close, the admitting privileges requirement would require all women in the Rio Grande Valley and many women in West Texas to travel hundreds of miles from their homes to access abortion services, guaranteeing that each of those women would be hundreds of miles from the facility at which her abortion was performed if she experienced a serious complication after she returned home. Thus, the admitting privileges requirement does not make it more likely that women from the Rio Grande Valley or West Texas who experience abortion-related complications would be treated at a hospital where their abortion-provider has admitting privileges.

101. As applied to the McAllen and El Paso clinics, the admitting privileges requirement is therefore futile.

Harms to Women in the Rio Grande Valley and West Texas Caused by the Admitting Privileges Requirement

102. By sharply restricting their access to safe and legal abortion services, the

admitting privileges requirement puts the health of women in the Rio Grande Valley and West Texas at risk.

103. As a result of the admitting privileges requirement, some women will be delayed in accessing abortion care, some will be forced to carry an unwanted pregnancy to term, and some will attempt to self-induce abortion. Each of these courses of action is riskier than having an abortion at the McAllen or El Paso clinic without delay.

104. Although abortion is very safe throughout pregnancy, the risks of experiencing an abortion-related complication increase with gestational age. As a result, women who are delayed in accessing abortion services are subject to greater health risks than women who are not delayed.

105. Women who are unable to obtain abortion services must instead carry their pregnancies to term and give birth. These women are also subject to increased health risks because the risk of death from childbirth is 14 times higher than the risk of death from abortion.

106. Additionally, some women who cannot access legal abortion services will instead attempt self-induction of abortion. Prior to the enactment of the admitting privileges requirement, self-abortion was already practiced by women in the Rio Grande Valley and West Texas who were desperate to end a pregnancy but did not have the means to obtain abortion services at a licensed clinic.

107. During the four-month period of time when the McAllen clinic was open but not providing abortion services, clinic staff members encountered a larger number of prospective patients who had attempted self-abortion. These women utilized a variety of methods, including herbal teas, douches, physical trauma to the abdomen, and medications purchased on the black market.

108. Many women are aware that misoprostol can be used to induce an abortion. This medication is available over-the-counter in Mexico and is widely trafficked in the Rio Grande Valley and West Texas, which both border Mexico. It is also sold on the internet.

109. Like any medication obtained on the black market, misoprostol obtained in this way can be counterfeit, inappropriate for a particular woman's medical needs, or used incorrectly because a woman does not have adequate information.

110. Self-induction of abortion is less safe than abortion performed by a trained medical practitioner.

111. In addition to abortion services, the McAllen clinic provided other gynecological and family planning services, such as diagnosis and treatment of sexually transmitted infections, contraceptive counseling and provision, pregnancy testing, and diagnosis and treatment of abnormal pap smears. The McAllen clinic also provided assistance, including counseling and referrals, to pregnant women interested in adoption.

112. Without the revenue generated from providing abortion services, the McAllen clinic was unable to sustain the remainder of its practice after the admitting privileges requirement took effect. As a result, it is no longer able to provide these other services to women in the Rio Grande Valley.

113. In addition to abortion services, the El Paso clinic provides other gynecological and family planning services, such as annual well-woman examinations, which include pelvic examinations, pap smears, and breast examinations; testing and treatment for STIs; provision of contraceptives; and pregnancy testing. The El Paso clinic also works with an affiliated adoption agency to help interested women place their children for adoption.

114. If the El Paso clinic is forced by the admitting privileges requirement to stop

providing abortion services, it would have to close, and would therefore be unable to provide these other services to women in West Texas.

B. The ASC Requirement

115. The ASC requirement provides that "[o]n or after September 1, 2014, the minimum standards for an abortion facility must be equivalent to the minimum standards . . . for ambulatory surgical centers." Act, § 4 (codified at Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

116. Failure to comply with those standards may give rise to criminal, civil, and administrative penalties. Tex. Health & Safety Code Ann. §§ 245.014 (criminal penalties), 245.015 (civil penalties), 245.017 (administrative penalties). It may also result in the denial, suspension, probation, or revocation of an abortion facility license. Tex. Health & Safety Code Ann. § 245.012.

117. Independently of the Act, Texas law requires that "[a]n abortion of a fetus age 16 weeks or more may be performed only at an ambulatory surgical center or hospital licensed to perform the abortion." Tex. Health & Safety Code Ann. §171.004. Plaintiffs do not challenge this requirement, which would remain in effect if the Act and its implementing regulations were enjoined.

118. The ASC requirement will force all licensed abortion facilities to meet detailed physical plant requirements, which specify, among other things, hallway widths; ceiling heights; area of various rooms; floor, wall, and ceiling finishes; HVAC system requirements; and number and configuration of bathrooms, janitorial closets, and parking spaces. *See* 25 Tex. Admin. Code § 139.40 (incorporating by reference, *inter alia*, 25 Tex. Admin. Code § 135.52).

119. An ASC is far more expensive to acquire and operate than a health care facility that meets existing abortion facility standards.

120. The licensed abortion facilities operated by Whole Woman's Health in Austin, Fort Worth, and San Antonio do not meet the minimum standards for ASCs. Likewise, the McAllen clinic does not meet the minimum standards for ASCs.

121. The licensed abortion facility operated by Abortion Advantage does not meet the minimum standards for ASCs.

122. The licensed abortion facilities operated by the Health Centers do not meet the minimum standards for ASCs.

123. The El Paso clinic does not meet the minimum standards for ASCs.

124. If the ASC requirement is permitted to take effect, there would be fewer than ten facilities in the State that are permitted to provide abortion services ("abortion-care ASCs"). Those facilities would be clustered in eastern metropolitan areas. There would be no abortion-care ASCs west or south of San Antonio.

125. The closest abortion-care ASC to McAllen would be in San Antonio, over 235 miles away. The closest abortion-care ASC to El Paso would also be in San Antonio, over 550 miles away.

126. Requiring licensed abortion facilities to meet the minimum standards for ASCs will not enhance the safety of abortion procedures. It will only reduce the availability of abortion services, and thereby threaten the health of women seeking abortion services.

127. Apart from abortion procedures, Texas law does not require any other outpatient surgical or medical procedures to be performed in an ASC.

128. Many procedures commonly performed in outpatient settings are comparable to surgical abortion in terms of risks, invasiveness, instrumentation, and duration. These include gynecological procedures such as dilation and curettage ("D&C") and non-gynecological

procedures such as colonoscopy. Texas law does not require the facilities in which these procedures are performed to meet the minimum standards for ASCs.

129. Procedures that are more complex than abortion and entail greater risks of morbidity and mortality are also commonly performed in outpatient settings, including gynecological procedures such as laparoscopy and vaginal hysterectomy and non-gynecological procedures such as plastic surgery and bariatric surgery. These procedures are usually performed while the patient is under general anesthesia, which by itself is much riskier than abortion. Texas law does not require the facilities in which these procedures are performed to meet the minimum standards for ASCs.

130. Moreover, Texas law does not require outpatient birthing centers to meet the minimum standards for ASCs. *See* Tex. Health & Safety Code Ann. § 244.010; 25 Tex. Admin Code §§ 137.1-137.55. But childbirth entails far more medical risks than abortion. As stated above, the risk of death from childbirth is approximately 14 times higher than the risk of death from abortion.

131. Certain characteristics of surgical abortion procedures render many of the minimum standards for ASCs inappropriate. For example, like other surgical procedures involving entry into the respiratory, alimentary, genital, or urinary tracts, surgical abortion procedures involve a clean-contaminated surgical site. Further, surgical abortion procedures do not entail an incision into the body; instead, they entail insertion of instruments into a body cavity through a natural orifice. In this respect, surgical abortion is analogous to insertion of a catheter.

132. Medical abortion does not involve surgery of any kind. As practiced in Texas, it entails the oral administration of medications—*i.e.*, the patient merely swallows a series of

tablets.

133. The ASC requirement will not advance the State's interest in women's health.

134. The ASC requirement will not increase the safety of surgical abortion.

135. The ASC requirement will not increase the safety of medical abortion.

136. By reducing the number and geographic distribution of abortion providers in Texas, the ASC requirement will place substantial obstacles in the path of Texas women seeking abortion services and will expose those women to increased health risks.

137. These obstacles and risks will be greatest for women living in the Rio Grande Valley and West Texas.

CLAIMS FOR RELIEF

COUNT I
(Undue Burden/Admitting Privileges Requirement)

138. The allegations of paragraphs 1 through 137 are incorporated as though fully set forth herein.

139. As applied to the McAllen clinic, the admitting privileges requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in the Rio Grande Valley to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

140. As applied to the El Paso clinic, the admitting privileges requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in West Texas to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT II
(Equal Protection/Admitting Privileges Requirement)

141. The allegations of paragraphs 1 through 140 are incorporated as though fully set

forth herein.

142. As applied to the McAllen clinic, the admitting privileges requirement denies equal protection of the laws to Whole Woman's Health, Dr. Lynn, and their patients in the Rio Grande Valley in violation of the Equal Protection Clause of the Fourteenth Amendment.

143. As applied to the El Paso clinic, the admitting privileges requirement denies equal protection of the laws to Reproductive Services, Dr. Richter and their patients in West Texas in violation of the Equal Protection Clause of the Fourteenth Amendment.

COUNT III
(Unlawful Delegation/Admitting Privileges Requirement)

144. The allegations of paragraphs 1 through 143 are incorporated as though fully set forth herein.

145. The admitting privileges requirement improperly delegates lawmaking authority to hospitals located within 30 miles of the McAllen clinic in violation of the Due Process Clause of the Fourteenth Amendment.

146. The admitting privileges requirement improperly delegates lawmaking authority to hospitals located within 30 miles of the El Paso clinic in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT IV
(Arbitrary & Unreasonable State Action/Admitting Privileges Requirement)

147. The allegations of paragraphs 1 through 146 are incorporated as though fully set forth herein.

148. As applied to the McAllen clinic, the admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

149. As applied to the provision of medical abortion at the McAllen clinic, the

admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

150. As applied to the El Paso clinic, the admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

151. As applied to the provision of medical abortion at the El Paso clinic, the admitting privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT V
(Undue Burden/ASC Requirement)

152. The allegations of paragraphs 1 through 151 are incorporated as though fully set forth herein.

153. The ASC requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in Texas to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

154. As applied to the McAllen clinic, the ASC requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in the Rio Grande Valley to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

155. As applied to the El Paso clinic, the ASC requirement—standing alone and in conjunction with burdens imposed by other provisions of Texas law—imposes an undue burden on the right of women in West Texas to terminate a pregnancy prior to viability in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT VI
(Equal Protection/ASC Requirement)

156. The allegations of paragraphs 1 through 155 are incorporated as though fully set forth herein.

157. The ASC requirement denies equal protection of the laws to Plaintiffs and their patients in violation of the Equal Protection Clause of the Fourteenth Amendment.

COUNT IV
(Arbitrary & Unreasonable State Action/ASC Requirement)

158. The allegations of paragraphs 1 through 157 are incorporated as though fully set forth herein.

159. The ASC requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

160. As applied to the provision of medical abortion, the ASC requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

REQUEST FOR RELIEF

Plaintiffs respectfully request that this Court:

A. Issue a declaratory judgment that the admitting privileges requirement is unconstitutional and unenforceable:

a. as applied to the McAllen clinic; and/or

b. as applied to the provision of medical abortion at the McAllen clinic; and/or

c. as applied to the El Paso clinic; and/or

d. as applied to the provision of medical abortion at the El Paso clinic; and/or

B. Issue a declaratory judgment that the ASC requirement is unconstitutional and unenforceable:

a. on its face; and/or

b. as applied to the provision of medical abortion; and/or

c. as applied to the McAllen clinic; and/or

d. as applied to the El Paso clinic; and/or

C. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the admitting privileges requirement:

a. as applied to the McAllen clinic; and/or

b. as applied to the provision of medical abortion at the McAllen clinic; and/or

c. as applied to the El Paso Clinic; and/or

d. as applied to the provision of medical abortion at the El Paso clinic; and/or

D. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the ASC requirement:

a. on its face; and/or

b. as applied to the provision of medical abortion; and/or

c. as applied to the McAllen clinic; and/or

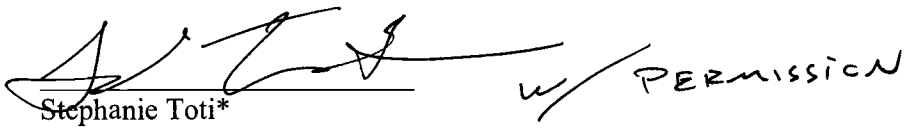
d. as applied to the El Paso clinic; and/or

E. Grant Plaintiffs attorney's fees and costs pursuant to 42 U.S.C. § 1988; and/or

F. Grant such other and further relief as the Court may deem just, proper, and equitable.

Dated: April 2, 2014

Respectfully submitted,



Stephanie Toti*
Esha Bhandari*
Natasha Lycia Ora Bannan*
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3600
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org

Attorneys for Plaintiffs

*Application for admission forthcoming

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

Whole Woman's Health, *et al*, Plaintiffs, v. **David Lakey, M.D., *et al*,** Defendants.	Civil Action No. 1:14-cv-284-LY

STATE DEFENDANTS' ORIGINAL ANSWER AND AFFIRMATIVE DEFENSES

TO THE HONORABLE LEE YEAKEL, U.S. DISTRICT JUDGE:

Now come Defendants, David Lakey, M.D., and Mari Robinson (the "State Defendants"), and hereby file their Answer and Affirmative Defenses to Plaintiffs' Complaint, and would respectfully show the Court the following:

ANSWER TO COMPLAINT

Pursuant to Federal Rule of Civil Procedure 8(b) and (c), the State Defendants deny each and every allegation contained in Plaintiffs' Complaint except for those expressly admitted herein. The numbered paragraphs and titles below correspond to the numbered paragraphs and titles within Plaintiffs' Complaint.

I. PRELIMINARY STATEMENT

1. As merely the plaintiffs' description of their claims, this paragraph does not require admission or denial, but to the extent a response is deemed to be required State Defendants deny.

2. Deny.

3. The State Defendants admit that Plaintiffs quote portions of language from the Texas Health and Safety Code, and the Texas Administrative Code. State Defendants deny that the quoted provisions cause or constitute "regulatory burdens."

4. The State Defendants admit that Plaintiffs quote portions of language from the Texas Health and Safety Code, and the Texas Administrative Code. State Defendants deny that the quoted provisions cause or constitute "regulatory burdens."

5. Admit.

6. State Defendants admit Plaintiffs in this case were parties or privities to parties that challenged the constitutionality of House Bill 2 in *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891, 909 (W.D. Tex. 2013). State Defendants admit that the earlier action proceeded to final judgment, and the Fifth Circuit stayed the trial court's injunction and ultimately reversed the district court's judgment. State Defendants admit Plaintiffs quoted portions of the decision in *Abbott*, but deny that Plaintiffs can properly bring as-applied challenges in this case because such claims are barred by res judicata.

7. As merely plaintiffs' description of its claims, the first sentence in this paragraph does not require admission or denial, but to the extent a response is deemed to be required State Defendants deny. State Defendants admit that at the time Plaintiffs filed their complaint there were no other licensed

abortion facilities in the Rio Grande Valley. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph, and therefore deny.

8. As merely plaintiffs' description of its claims, the first sentence in this paragraph does not require admission or denial, but to the extent a response is deemed to be required State Defendants deny. State Defendants admit that at the time Plaintiffs filed their complaint there was one other licensed abortion facility located west of San Antonio and in the State of Texas. The State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph, and therefore deny.

9. Admit.

10. As merely plaintiffs' description of its claims, this paragraph does not require admission or denial, but to the extent a response is deemed to be required State Defendants deny.

11. As merely plaintiffs' description of its claims, this paragraph does not require admission or denial, but to the extent a response is deemed to be required State Defendants deny.

12. State Defendants admit that the number of licensed abortion facilities in Texas has dropped since the admitting privileges requirement took effect. State Defendants deny that it has dropped "significantly" or that all closures have been due to the admitting privileges requirement. Currently there are at least seven abortion clinics in Texas that meet the minimum standards of the ASC requirement. By information and belief, Planned Parenthood plans

to open an abortion clinic ASC in San Antonio in the near future. Additionally, two other abortion providers associated with the Plaintiffs have recently purchased property with the intention of opening an ASC to provide abortion services. The State Defendants are without sufficient knowledge to admit or deny the remainder of the paragraph, and therefore deny.

II. JURISDICTION AND VENUE

13. State Defendants deny that Plaintiffs have standing to bring undue-burden challenges—both facial and as applied—on behalf of their patients. State Defendants admit that the district court has jurisdiction over the remainder of Plaintiffs' claims.

14. State Defendants deny that Plaintiffs have standing to bring undue-burden challenges—both facial and as applied—on behalf of their patients. State Defendants deny that 28 U.S.C. §§ 2201 and 2202 permit Plaintiffs to bring claims for declaratory relief on behalf of their patients. State Defendants admit that the court has jurisdiction over the remainder of Plaintiffs claims.

15. Admit.

III. PLAINTIFFS

16. State Defendants admit that Plaintiff Whole Woman's Health operates licensed abortion facilities in Fort Worth and San Antonio. State Defendants deny that Whole Woman's Health operates a currently licensed abortion facility in Austin. State Defendants admit that Whole Woman's Health operates a licensed ASC that provides abortion services in San Antonio. State Defendants admit that Whole Woman's Health previously operated

abortion facilities in Beaumont and McAllen. State Defendants deny that Whole Woman's Health's Beaumont facility closed due to or at the time of the admitting privileges requirement. Whole Woman's Health Beaumont continued to operate after the admitting privileges requirement took effect, and closed despite the fact that it was in full compliance with the admitting privileges requirement. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

17. State Defendants admit that Plaintiff Sherwood C. Lynn, M.D. is licensed to practice medicine in the State of Texas. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

18. State Defendants deny that Abortion Advantage is currently a Plaintiff in this case as its claims were dismissed on June 3, 2014. (Doc. No. 71). State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

19. State Defendants deny that Lamar Robinson, M.D. is currently a Plaintiff in this case as his claims were dismissed on June 3, 2014. (Doc. No. 71). State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

20. State Defendants admit that Plaintiff Health Centers operates a licensed abortion facility in Austin. State Defendants deny that Health Centers operates a licensed abortion clinic in Killeen. State Defendants are without

sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

21. State Defendants admit that Lendol L. Davis, M.D. is licensed to practice medicine in the State of Texas. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

22. State Defendants deny that Plaintiff Nova Health System d/b/a Reproductive Services currently operates a licensed abortion facility in El Paso. State Defendants admit that Nova Health Systems operated a licensed abortion facility at time this lawsuit was filed. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

23. State Defendants admit that Pamela J. Richter, D.O., is licensed to practice medicine in the State of Texas. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

IV. DEFENDANTS

24. Admit.

25. Admit.

26. Upon agreement of Plaintiffs and the Local Prosecutor Defendants, all named local prosecutors were dismissed from the case on May 12, 2014. (Doc. No. 54). State Defendants therefore deny.

27. Upon agreement of Plaintiffs and the Local Prosecutor Defendants, all named local prosecutors were dismissed from the case on May 12, 2014. (Doc. No. 54). State Defendants therefore deny.

28. Upon agreement of Plaintiffs and the Local Prosecutor Defendants, all named local prosecutors were dismissed from the case on May 12, 2014. (Doc. No. 54). State Defendants therefore deny.

29. Upon agreement of Plaintiffs and the Local Prosecutor Defendants, all named local prosecutors were dismissed from the case on May 12, 2014. (Doc. No. 54). State Defendants therefore deny.

30. Upon agreement of Plaintiffs and the Local Prosecutor Defendants, all named local prosecutors were dismissed from the case on May 12, 2014. (Doc. No. 54). State Defendants therefore deny.

31. Upon agreement of Plaintiffs and the Local Prosecutor Defendants, all named local prosecutors were dismissed from the case on May 12, 2014. (Doc. No. 54). State Defendants therefore deny.

32. Upon agreement of Plaintiffs and the Local Prosecutor Defendants, all named local prosecutors were dismissed from the case on May 12, 2014. (Doc. No. 54). State Defendants therefore deny.

V. FACTUAL ALLEGATIONS

33. Admit.

34. Admit

35. The State Defendants admit that Plaintiffs quote portions of language from the Texas Administrative Code (2012).

36. Admit.

37. The State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

38. The State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

39. The State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

40. State Defendants admit that hospitals have limited discretion to set criteria for granting admitting privileges, but hospitals may not discriminate against physicians because of their willingness to perform abortions. *See* 42 U.S.C. § 300a-7(c)(1) and TEX. OCC. CODE § 103.002(b). State Defendants deny the remainder of this paragraph.

41. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

42. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

43. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

44. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

45. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

46. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

47. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

48. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

49. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

50. Admit.

51. Admit.

52. The State Defendants are without sufficient knowledge to admit or deny this paragraph.

53. Deny.

54. Admit.

55. State Defendants admit that there are some urban centers in the Rio Grande Valley and that some of the region is rural. The State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

56. State Defendants admit that the majority of people living in the Rio Grande Valley are Latino and the citation in footnote 5 of the Complaint states approximately one-third of the region's population were at or below the federal poverty level for the relevant years. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

57. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny

58. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

59. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

60. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

61. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

62. State Defendants deny that obstacles will prevent patients in the Rio Grande Valley from accessing abortion services at non-local clinics. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

63. Deny.

64. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

65. State Defendants are without sufficient knowledge of admit or deny whether Dr. Ritcher currently works at the El Paso clinic and therefore deny. State Defendants admit the remainder of this paragraph.

66. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

67. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

68. State Defendants admit that Dr. Richter previously had temporary admitting privileges. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

69. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

70. State Defendants admit that Hilltop Reproductive Clinic of El Paso currently operates a licensed abortion clinic in El Paso, Texas. State Defendants deny the remainder of this paragraph.

71. State Defendants deny that the closure of Plaintiff El Paso Clinic would leave the region with only one abortion provider. In addition to Hilltop Reproductive Clinic of El Paso, the El Paso metropolitan area is served by the Hilltop Reproductive Clinic of New Mexico, which is located less than a mile from the New Mexico-El Paso border and provides abortion services to patients in El Paso. In addition, by information and belief, Plaintiff Nova Health System d/b/a Reproductive Services is currently contemplating opening an abortion facility on the New Mexico-El Paso border in order to provide abortion services to patients in the El Paso metropolitan area. Further, by information and belief, Plaintiff Whole Woman's Health is currently contemplating opening an abortion facility near the New Mexico-El Paso border that would also provide abortion services to patients in the El Paso metropolitan area. State Defendants, therefore, deny any El Paso

abortion-patient would have to travel to San Antonio to obtain abortion services. State Defendants admit San Antonio is approximately 549 miles from El Paso. The State Defendants deny the remainder of this paragraph.

72. Deny.

73. Admit.

74. State Defendants admit that Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Pecos, Presidio, Reeves, and Terrell counties are located in West Texas. State Defendants are without sufficient knowledge to admit or deny what the current socioeconomic makeup of these counties is and therefore deny this paragraph.

75. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

76. Admit.

77. Deny.

78. Deny.

79. Admit.

80. Deny.

81. State Defendants are without sufficient knowledge to admit or deny what types of abortions are performed at the McAllen and El Paso clinic and therefore deny this paragraph.

82. State Defendants deny that abortion is extremely safe through pregnancy. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

83. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

84. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

85. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

86. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

87. Deny.

88. State Defendants deny that any other medical procedure is comparable to abortion. State Defendants admit that some other surgical and non-surgical procedures are performed in outpatient setting. State Defendants admit that abortion providers are required to have admitting privileges at a local hospital. Additionally, hospitals in Texas can require physicians performing medical procedures at their hospital to have admitting privileges. State Defendants deny the remainder of this paragraph.

89. State Defendants admit that Plaintiffs quote portions of language from the Texas Administrative Code, otherwise State Defendants deny this paragraph.

90. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

91. Admit.

92. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

93. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

94. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

95. Deny.

96. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

97. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

98. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

99. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

100. Deny. After Plaintiff El Paso Clinic closed, abortion patients in El Paso could access abortion services within the El Paso metropolitan area at Hilltop Reproductive Services of El Paso or of New Mexico. On information and belief, Whole Woman's Health plans to open an abortion facility in Santa Teresa, New Mexico as well. The abortion providers at Hilltop Reproductive Services of El Paso and of New Mexico have admitting privileges at all El Paso area hospitals. Furthermore, should an abortion provider obtain admitting privileges in the Rio Grande Valley, nothing in House Bill 2 would "require all women in the Rio Grande Valley" to travel hundreds of miles to obtain an abortion.

101. Deny.

102. Deny

103. Deny.

104. State Defendants deny that abortion is extremely safe through pregnancy. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny

105. State Defendants admit the first sentence of this paragraph. State Defendants deny the second sentence of this paragraph.

106. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

107. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

108. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

109. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

110. Admit.

111. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

112. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

113. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

114. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

115. Admit

116. Admit

117. Admit.

118. Admit.

119. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

120. State Defendants admit the licensed abortion facilities operated by Whole Woman's Health in Fort Worth and McAllen did not meet the minimum standards for ASCs at the time Plaintiffs filed their complaint. State Defendants deny that the Whole Woman's Health ASC in San Antonio does not meet the minimum standards for ASCs.

121. Admit as of the time Plaintiffs filed their complaint.

122. Admit as of the time Plaintiffs filed their complaint.

123. Admit as of the time Plaintiffs filed their complaint.

124. State Defendants are without sufficient knowledge to admit or deny this paragraph and therefore deny.

125. State Defendants admit that currently the closest licensed abortion-care ASC to McAllen is approximately 235 miles away. State Defendants are without sufficient knowledge to admit or deny whether any closer abortion-care ASC to McAllen will open on or after September 1, 2014. State Defendants admit that currently the closest licensed abortion-care ASC to El Paso in Texas is

approximately 550 miles away. State Defendants are without sufficient knowledge to admit or deny whether there is a closer abortion-care ASC to El Paso located in another state or if a closer abortion-care ASC to El Paso will open on or after September 1, 2014.

126. Deny.

127. Admit.

128. State Defendants deny that any other medical procedure is comparable to abortion. State Defendants admit that dilation and curettage is a gynecological procedure and that colonoscopy is a non-gynecological procedure. State Defendants admit that Texas law does not require dilation and curettage and colonoscopies to be performed in facilities that meet the minimum standards for ASCs. State Defendants deny the remainder of this paragraph.

129. State Defendants deny that any other medical procedure is comparable to abortion. State Defendants admit that laparoscopy and vaginal hysterectomy are gynecological procedures and that plastic surgery and bariatric surgery are non-gynecological procedures. State Defendants admit laparoscopy, vaginal hysterectomy, plastic surgery, and bariatric surgery are not required to be performed in facilities that meet the minimum standards for ASCs. State Defendants are without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

130. State Defendants admit that Texas law does not require outpatient birthing centers to meet the minimum standards for ASCs. State Defendants are

without sufficient knowledge to admit or deny the remainder of this paragraph and therefore deny.

131. Deny.

132. State Defendants deny that medical abortion never involves surgery. State Defendants admit that medical abortion begins with the oral administration of medications.

133. Deny.

134. Deny.

135. Deny.

136. Deny.

137. Deny.

CLAIMS FOR RELIEF

Count 1
(Undue Burden/ Admitting Privileges Requirement)

138. State Defendants incorporate by reference their responses to paragraphs 1 through 137.

139. Deny.

140. Deny

Count II
(Equal Protection/ Admitting Privileges Requirement)

141. State Defendants incorporate by reference their responses to paragraphs 1 through 140.

142. Deny.

143. Deny.

Count III
(Unlawful Delegation/ Admitting Privileges Requirement)

144. State Defendants incorporate by reference their responses to paragraphs 1 through 143.

145. Deny.

146. Deny.

Count IV
(Arbitrary & Unreasonable State Action/Admitting Privileges Requirement)

147. State Defendants incorporate by reference their responses to paragraphs 1 through 146.

148. Deny.

149. Deny.

150. Deny.

151. Deny.

Count V
(Undue Burden/ ASC Requirement)

152. State Defendants incorporate by reference their responses to paragraphs 1 through 151.

153. Deny.

154. Deny.

155. Deny.

Count VI
(Equal Protection/ ASC Requirement)

156. State Defendants incorporate by reference their responses to paragraphs 1 through 155.

157. Deny.

Count IV (sic)
(Arbitrary & Unreasonable State Action/ ASC Requirement)

158. State Defendants incorporate by reference their responses to paragraphs 1 through 157.

159. Deny.

160. Deny.

REQUEST FOR RELIEF

A-F: The State Defendants deny that the Plaintiffs are entitled to any of the requested relief.

AFFIRMATIVE DEFENSES

1. State Defendants assert that Plaintiffs' claims are barred by res judicata.

Respectfully submitted,

GREG ABBOTT
Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

JAMES D. BLACKLOCK
Deputy Attorney General for Legal Counsel

JONATHAN F. MITCHELL
Solicitor General

ANDREW S. OLDHAM
Deputy Solicitor General

ARTHUR C. D'ANDREA
BETH KLUSMANN
PHILIP A. LIONBERGER
MICHAEL P. MURPHY
Assistant Solicitors General

/s/ Andrew Stephens
ANDREW B. STEPHENS
Texas Bar No. 24079396
ESTEBAN S.M. SOTO
Texas Bar No. 24052284
ENRIQUE VARELA
Texas Bar No. 24043971
Assistant Attorneys General

300 West 15th Street
P.O. Box 12548
Austin, Texas 78711-2548
(512) 463-2120 (phone)
(512) 320-0667 (fax)

COUNSEL FOR DEFENDANTS DAVID LAKEY, M.D., AND MARI ROBINSON

CERTIFICATE OF SERVICE

I certify that on August 15, 2014, this document was served on counsel of record through the Court's CM/ECF Document Filing System or through e-mail.

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'CONNELL & SOIFER LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

John H. Bucy, II
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan
David P. Brown
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org
dbrown@reprorights.org

J. Alexander Lawrence
MORRISON & FOERSTER LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

Betre M. Gizaw
Marissa P. Harris
MORRISON & FOERSTER LLP
2000 Pennsylvania Ave., NW, Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com

Colin M. O'Brien
MORRISON & FOERSTER LLP
370 17th Street, Suite 5200
Denver, CO 80202
(303) 592-2252
(303) 592-1510
cobrien@mofo.com

COUNSEL FOR PLAINTIFFS

/s/ Andrew Stephens
ANDREW B. STEPHENS
Assistant Attorney General

E

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

Whole Woman's Health, et al, Plaintiffs, v. **David Lakey, M.D.,** Commissioner of the Texas Department of State Health Services, et al, Defendants.	Civil Action No. 1:14-cv-284-LY

STATE DEFENDANTS' MOTION TO DISMISS

Defendants David Lakey, M.D., and Mari Robinson respectfully move to dismiss the plaintiffs' complaint for failing to state a claim on which relief can be granted. *See* Fed. R. Civ. P. 12(b)(6).

The plaintiffs' as-applied challenges to HB2's admitting-privileges requirement should be dismissed for several independent reasons. First, these claims are barred by res judicata. Each of the plaintiffs seeking as-applied relief was a party to the previous constitutional challenge to HB2 and could have sought that relief in the earlier proceeding. Second, even if these claims were not barred by res judicata, the Fifth Circuit's ruling upholding HB2's admitting-privileges requirement forecloses the plaintiffs' undue-burden, equal-protection, unlawful delegation, and "arbitrary and unreasonable state action" claims. *See Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 13-51008, 2014 WL 1257965, at *11 (5th Cir. Mar. 27, 2014).

The plaintiffs' challenges to HB2's ambulatory-surgical-center requirement should also be dismissed under the doctrine of res judicata. And even if the plaintiffs could surmount the res judicata obstacle, they cannot maintain a facial undue-burden challenge in the face of HB2's severability clause and the plaintiffs' inability to assert the constitutional rights of other providers' patients.

Finally, *all* of the patients' undue-burden challenges—both facial and as-applied—should be dismissed because there is no cause of action under either 42 U.S.C. § 1983 or the Declaratory Judgment Act that allows a litigant to assert the rights of third parties. This is a separate question from whether the litigants have "standing"; even plaintiffs who can surmount the Supreme Court's doctrinal restrictions on third-party standing must still point to a provision of law that authorizes them to sue. The plaintiffs do not have any cause of action that would allow them to assert the constitutional rights of their patients.

I. THE PLAINTIFFS' CHALLENGES TO THE ADMITTING-PRIVILEGES REQUIREMENT SHOULD BE DISMISSED.

A. Each Of The Plaintiffs' Challenges To The Admitting-Privileges Requirements Are Barred By Res Judicata.

The plaintiffs' "as applied" challenges to HB2's admitting-privileges requirement could have been brought in the previous action challenging HB2. They are now barred by res judicata because the earlier action has proceeded to final judgment, the plaintiffs were all parties (or privities to parties[1]) in the previous case, and their claims arise from the same transaction litigated in the earlier proceeding. *See* Restatement (Second) of Judgments §§ 19, 24 (1982). Although res judicata is

[1] Doctors Lynn and Davis were not parties to the earlier proceeding, but they were in privity with Whole Women's Health, which sued on their behalf. Compl. ¶ 13, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 1:13-CV-862-LY (W.D. Tex., filed Sept. 27, 2013) (stating that Whole Woman's Health sues "on behalf of . . . its physicians"). And Reproductive Services is in privity with Dr. Richter, who sued in the initial lawsuit challenging HB2.

an affirmative defense that must normally be raised in an answer, a defendant may properly assert res judicata in a Rule 12(b)(6) motion if the defense is disclosed in the complaint. *See Jones v. Bock*, 549 U.S. 199, 215 (2007). Here, the complaint acknowledges the previous lawsuit challenging HB2's requirements. *See* Compl. ¶ 6.

Res judicata extinguishes not only the claims that were actually litigated and resolved, but also claims that *could* have been brought—and any remedies that *could* have been sought. *See Allen v. McCurry*, 449 U.S. 90, 94 (1980) ("Under res judicata, a final judgment on the merits of an action precludes the parties or their privies from relitigating issues that were or could have been raised in that action."); *Brown v. Felsen*, 442 U.S. 127, 131 (1979) ("Res judicata prevents litigation of all grounds for, or defenses to, recovery that were previously available to the parties, regardless of whether they were asserted or determined in the prior proceeding."); *In re Howe*, 913 F.2d 1138, 1144 n.10 (5th Cir. 1990) ("A party may not avoid the preclusive affect of res judicata by asserting a new theory or a different remedy. The nucleus of facts defines the claim rather than the legal theory posed or recovery sought."); *Nilsen v. City of Moss Point*, 701 F.2d 556, 560 (5th Cir. 1983) ("*[R]es judicata* … bars all claims that were or *could have been* advanced in support of the cause of action on the occasion of its former adjudication, not merely those that were adjudicated. And it is equally settled that one who has a choice of more than one remedy for a given wrong … may not assert them serially, in successive actions, but must advance all at once on pain of bar." (citation and footnotes omitted)); David P. Currie, *Res Judicata: The Neglected Defense*, 45 U. Chi. L. Rev. 317, 325 (1978) ("[T]o allow a party to advance arguments in a second proceeding that he could have made in a prior proceeding … imposes unnecessary costs on both opposing parties and the judicial system.").

The plaintiffs do not allege—and could not plausibly allege—that they were unable to seek as-applied relief for the El Paso and McAllen clinics in the earlier proceeding.[2] Indeed, they specifically alleged that Dr. Richter and the physicians at the McAllen clinic lacked hospital admitting privileges, and that the El Paso and McAllen clinics would be forced to stop performing abortions if HB2 were to take effect. Compl. ¶¶ 13, 21, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 1:13-CV-862-LY (W.D. Tex., filed Sept. 27, 2013). Instead, the plaintiffs made a strategic decision to eschew any request for as-applied relief and force the courts into an all-or-nothing choice: total invalidation of HB2's admitting-privileges requirement, or nothing. *Id.* ¶¶ 5, 90. The plaintiffs made that tactical decision even after the State pointed out that HB2's severability clause required them to seek more narrowly tailored relief. *See* State Defs.' Trial Br. at 15, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 1:13-CV-862-LY (W.D. Tex., filed Oct. 15, 2013); *see also Planned Parenthood of Greater Tex.*, 2014 WL 1257965, at *2 ("Federal courts are bound to apply state law severability provisions. Even when considering facial invalidation of a state statute, the court must preserve the valid scope of the provision to the greatest extent possible." (citation omitted)). Yet the plaintiffs demanded facial invalidation, and refused to seek as-applied relief as a fallback option in the event that the courts rejected their demand for across-the-board nullification. It is too late for them to seek as-applied relief now.

The plaintiffs suggest that this Court can ignore res judicata because the Fifth Circuit wrote that "[l]ater as-applied challenges can always deal with subsequent,

[2] The plaintiffs' complaint in this case demonstrates that claims seeking total, facial invalidation can be brought simultaneously with claims requesting more limited, as-applied relief. *See* Compl. ¶ 10 ("All plaintiffs challenge the ASC requirement on its face."); *id.* ¶ 11 ("In addition, Whole Woman's Health and Dr. Lynn challenge the ASC requirement as applied to the McAllen clinic, and Reproductive Services and Dr. Richter challenge the ASC requirement as applied to the El Paso clinic.").

concrete constitutional issues." *Planned Parenthood of Greater Tex.*, 2014 WL 1257965, at *2; *see also* Compl. ¶ 6. That contention is meritless for numerous reasons. First, the Fifth Circuit's opinion does not purport to alter the law of claim preclusion or exempt the plaintiffs from the requirements of that doctrine. Second, the Fifth Circuit panel has no power to change the law of claim preclusion, which is grounded in pronouncements from the Supreme Court of the United States and must be obeyed by every inferior tribunal. *See, e.g,. Allen*, 449 U.S. at 94; *Brown*, 442 U.S. at 131. Third, the Fifth Circuit was not opining on the plaintiffs' constitutional challenges to HB2, but on the general duty of federal courts to respect severability clauses in state legislation. Here is the relevant context of the Fifth Circuit's discussion:

> Federal courts are bound to apply state law severability provisions. *Leavitt v. Jane L.*, 518 U.S. 137, 138–39, 116 S. Ct. 2068, 135 L. Ed. 2d 443 (1996). Even when considering facial invalidation *of a state statute*, the court must preserve the valid scope of the provision to the greatest extent possible. Later as-applied challenges can always deal with subsequent, concrete constitutional issues.

Planned Parenthood of Greater Tex., 2014 WL 1257965, at *2 (emphasis added). Finally, even if the Fifth Circuit were purporting to opine on the plaintiffs' ability to bring subsequent lawsuits against HB2's admitting-privileges requirement, its discussion would be dictum because the parties did not litigate that question and it had nothing to do with the issues resolved on appeal. *See, e.g.*, Pierre N. Leval, *Judging Under the Constitution: Dicta About Dicta*, 81 N.Y.U. L. Rev. 1249 (2006); Michael Abramowicz & Maxwell Stearns, *Defining Dicta*, 57 Stan. L. Rev. 953 (2005). The Fifth Circuit's ruling did not exempt abortion clinics from the law of res judicata, as the plaintiffs appear to believe.

B. The Plaintiffs' Undue-Burden Challenges To The Admitting-Privileges Requirements Fail To State A Claim On Which Relief May Be Granted.

Even if the plaintiffs could somehow overcome the res judicata barrier, they have failed to state a claim against the admitting-privileges requirement after the Fifth Circuit's ruling in *Planned Parenthood of Greater Texas*.

1. The McAllen Clinic's As-Applied Undue-Burden Challenge Fails To State A Claim On Which Relief May Be Granted.

The Fifth Circuit considered and rejected the plaintiffs' argument that the closure of the McAllen clinic would impose an "undue burden" on abortion patients in the Rio Grande Valley. *See Planned Parenthood of Greater Tex.*, 2014 WL 1257965, at *11 ("Even if we were to accept that both clinics in the Rio Grande Valley were about to close as a result of the admitting privileges provision, however, this finding does not show an undue burden. … [A]n increase of travel of less than 150 miles for some women is not an undue burden under *Casey*."). The undue-burden claims surrounding the closure of the McAllen clinic are therefore barred by collateral estoppel as well as res judicata. *See Allen*, 449 U.S. at 94 ("Under collateral estoppel, once a court has decided an issue of fact or law necessary to its judgment, that decision may preclude relitigation of the issue in a suit on a different cause of action involving a party to the first case."). They are also foreclosed by stare decisis. *See Hutto v. Davis*, 454 U.S. 370, 375 (1982) (per curiam) ("[U]nless we wish anarchy to prevail within the federal judicial system, a precedent of this Court must be followed by the lower federal courts no matter how misguided the judges of those courts may think it to be.").

The plaintiffs try to get around this problem by asserting that "women living in the Rio Grande Valley are extremely poor and lack access to transportation" and that "[m]aking a 300-mile round trip is therefore far more burdensome for them

than for women living in other regions of Texas." Mem. of Law in Sup. of Pls.' Am. Mot. for a Prelim. Inj. at 8. That is not a basis on which the plaintiffs can relitigate the Fifth Circuit's finding that the closure of the McAllen clinic will not impose an "undue burden." Arguments and evidence regarding poverty in the Rio Grande Valley were presented at trial and on appeal in the first proceeding. *See* Trial Tr., Vol. 2 at 39–41, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 1:13-CV-862-LY (W.D. Tex., Oct. 22, 2013); Appellees' Br. at 24, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, No. 13-51008 (5th Cir., filed Dec. 13, 2013) ("Appellants similarly focus their argument on travel distances. In doing so, they ignore evidence before the court showing not just that the additional travel would be 'particularly burdensome,' Br. at 17, but that the additional travel would be an absolute obstacle for many women. ROA.1934."). Yet the Fifth Circuit nevertheless held that the record was insufficient to establish an undue burden on patients in the Rio Grande Valley. *See Planned Parenthood of Greater Tex.*, 2014 WL 1257965, at *11 ("The record before us does not indicate that the admitting–privileges requirement imposes an undue burden by virtue of the potential increase in travel distance in the Rio Grande Valley."). And even if the plaintiffs were purporting to offer new evidence regarding the burdens of a 150-mile trip, they cannot relitigate the Fifth Circuit's conclusion. *See Jones v. Tex. Tech Univ.*, 656 F.2d 1137, 1141 (5th Cir. Unit A Sept. 1981) ("[J]udgment or decree upon the merits in the first case is an absolute bar to the subsequent action or suit, not only in respect of every matter which was actually offered and received to sustain the demand, but also as to every ground of recovery which might have been presented."); *see also Nilsen*, 701 F.2d at 560 n.6 ("That a number of different legal theories casting liability on an actor may apply to a given episode does not create multiple transactions and hence multiple claims. This remains true although the several le-

gal theories depend on different shadings of the facts, or would emphasize different elements of the facts, or would call for different measures of liability or different kinds of relief." (quoting Restatement (Second) of Judgments § 24 cmt. c (1982)).

Even apart from the obstacles imposed by preclusion and stare decisis, the plaintiffs' argument is untenable. In *every* region of the State there will be abortion patients who have limited resources or lack access to a vehicle. That cannot be sufficient to exempt an abortion clinic from a generally applicable regulation; otherwise every abortion clinic can exempt itself from 24-hour waiting requirements or laws that require abortions to be performed by licensed physicians simply by showing that some of its patients are poor or do not own cars. The sounder approach is to follow the Eighth Circuit and hold that a single trip to an abortion clinic does not impose an undue burden as a matter of law. *See Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 533 (8th Cir. 1994) (upholding 24-hour waiting period and holding that "[w]e do not believe a … single trip, *whatever the distance to the medical facility*, create[s] an undue burden") (emphasis added); *see also Karlin v. Foust*, 188 F.3d 446, 481 (7th Cir. 1999) ("[I]nconvenience, even severe inconvenience, is not an undue burden.").

2. The El Paso Clinic's As-Applied Undue-Burden Challenge Fails To State A Claim On Which Relief May Be Granted.

The plaintiffs' claims regarding the El Paso clinic are even more untenable. Even if Reproductive Services closes, the plaintiffs' complaint acknowledges that another licensed abortion clinic in El Paso will remain open. *See* Compl. ¶¶ 8, 70. Although the plaintiffs assert in conclusory fashion that this clinic "would not be able to meet patient demand for services," that allegation is not plausible given the plaintiffs' allegation that only 2,278 women in the Trans-Pecos region had abortions in 2010. *See* Compl. ¶¶ 76, 77; *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) ("To survive a motion to dismiss, a complaint must contain sufficient factual matter, accept-

ed as true, to state a claim to relief that is plausible on its face.") (citation and internal quotation marks omitted). It is not plausible to assert that a single abortion clinic is incapable of performing 45 abortions per week. What's more, El Paso is close to the Texas–New Mexico border, and the plaintiffs do not allege that the patients of Reproductive Services are unable to obtain abortions in New Mexico, or will encounter "undue burdens" in doing so.

C. The Plaintiffs' Equal-Protection Challenges Fail To State A Claim On Which Relief May Be Granted.

The plaintiffs' equal-protection challenges fail to state a claim, as it has long been settled that States may impose abortion-specific regulations without extending those requirements to other medical procedures. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 66–67 (1976) (upholding requirement of written consent for abortion even though not imposed on other surgical procedures); *see also Harris v. McRae*, 448 U.S. 297, 325 (1980) ("Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of [unborn] life.").

In all events, neither HB2's admitting-privileges requirement nor its ambulatory-surgical-center requirement draws any classification that triggers heightened scrutiny, and the Fifth Circuit has already held that HB2's admitting-privileges requirement survives rational-basis review. *See Planned Parenthood of Greater Tex.*, 2014 WL 1257965, at *8 ("[T]he State's articulation of rational legislative objectives, which was backed by evidence placed before the state legislature, easily supplied a connection between the admitting–privileges rule and the desirable protection of abortion patients' health.").

D. The Plaintiffs' "Unlawful Delegation" Challenge To HB2's Admitting-Privileges Requirement Fails To State A Claim On Which Relief May Be Granted.

The plaintiffs' unlawful-delegation claim is foreclosed by *Planned Parenthood of Greater Texas*, where the court wrote:

> The requirement that physicians performing abortions obtain surgical privileges, which involves the independent action of a public or private hospital, poses no more significant threat to plaintiffs' due process rights than the requirement that those performing abortions be licensed physicians, which involves the independent action of a medical licensing board.

2014 WL 1257965, at *13 (quoting *Women's Health Ctr. of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989)). The plaintiffs cannot maintain this claim in the face of this binding Fifth Circuit pronouncement.

E. The Plaintiffs "Arbitrary and Unreasonable State Action" Challenges Fail To State A Claim On Which Relief May Be Granted.

There is no such thing as a constitutional right to be free from "arbitrary and unreasonable state action." If the plaintiffs are using "arbitrary and unreasonable" as shorthand for saying that HB2's requirements fail rational-basis review, the Fifth Circuit has held that the admitting-privileges law survives rational-basis review. *Id.*, at *8 ("[T]he State's articulation of rational legislative objectives, which was backed by evidence placed before the state legislature, easily supplied a connection between the admitting-privileges rule and the desirable protection of abortion patients' health"). And its holding is equally applicable to the ambulatory-surgical-center requirement. Rational-basis review asks only whether it is *possible to imagine* that HB2's requirements could improve patient care, and the ambulatory-surgical-center requirement easily satisfies that standard. *See FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993) (holding that a legislative decision "is not

subject to courtroom fact-finding and may be based on rational speculation unsupported by evidence or empirical data.").

II. THE PLAINTIFFS' CHALLENGES TO THE AMBULATORY-SURGICAL-CENTER REQUIREMENT SHOULD BE DISMISSED.

A. Each Of The Plaintiffs' Challenges To The Ambulatory-Surgical-Center Requirement Is Barred By Res Judicata.

The plaintiffs could have challenged the ambulatory-surgical-center requirement in the previous action challenging HB2. The doctrine of res judicata precludes them from doing so now. The earlier action has proceeded to final judgment, the plaintiffs were all parties (or privities to parties) in the previous case, and their claims arise from the same transaction litigated in the earlier proceeding. *See* Restatement (Second) of Judgments §§ 19, 24 (1982); *see also* Section I.A. The plaintiffs do not (and could not plausibly) allege that they were unable to challenge the ambulatory-surgical-center requirement in the earlier proceeding. They are simply trying to get two bites at the apple, and the doctrine of res judicata does not permit these piecemeal litigation tactics.

B. The Plaintiffs' Facial Undue-Burden Challenge To HB2's Ambulatory-Surgical-Center Requirement Cannot Be Maintained In Light Of HB2's Severability Clause.

The plaintiffs have brought a facial challenge to the ambulatory-surgical-center requirement, demanding that this Court enjoin its enforcement in all circumstances, as applied to every abortion provider in the State. Their facial challenge must be rejected out of hand, because the plaintiffs do not allege (and cannot plausibly allege) that HB2's ambulatory-surgical-center requirement will impose an "undue burden" when applied to every abortion patient and provider in the State.

Sections 1(b) and 10(b) of HB2 require reviewing courts to sever not only the discrete statutory provisions of HB2, but also the statute's applications to every individual patient and abortion provider. *See* HB2 § 1(b) ("The legislature intends

that *every application of this statute to every individual woman* shall be severable from each other.") (emphasis added); *id.* § 10(b) ("[E]very application of the provisions in this Act[ ] [is] severable from each other."). That means that the plaintiffs cannot maintain a facial challenge unless they allege and prove that HB2's hospital-admitting privileges requirement will unduly burden *every* abortion patient and provider in the State. The severability provisions specifically provide that applications of HB2 that do not present an undue burden as applied to any particular patients or providers or groups of patients or providers must be severed and allowed to remain in force. *See* HB2 § 1(b) ("In the unexpected event that the application of this statute is found to impose an impermissible undue burden on any pregnant woman or group of pregnant women, the application of the statute to those women shall be severed from the remaining applications of the statute that do not impose an undue burden, and those remaining applications shall remain in force and unaffected, consistent with Section 10 of this Act."); *id.* § 10(b).

The plaintiffs cannot maintain their facial challenge to the ambulatory-surgical-center requirement in the face of this severability language. Federal courts are bound to follow state severability law. *See Leavitt*, 518 U.S. at 138; *Dorchy v. Kansas*, 264 U.S. 286, 290 (1924); *Voting for Am., Inc. v. Steen*, 732 F.3d 382, 398 (5th Cir. 2013); *see also Planned Parenthood of Greater Tex.*, 2014 WL 1257965, at *2 (noting HB2's "comprehensive and careful severability provision" and holding that "[f]ederal courts are bound to apply state law severability provisions."); *id.* ("Even when considering facial invalidation of a state statute, the court must preserve the valid scope of the provision to the greatest extent possible."). And sections 1(b) and 10(b) are as clear a statement of legislative intent as one can possibly imagine. *See Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330–31 (2006) (holding that "the touchstone for any decision about remedy is legislative intent"

and remanding to determine "whether New Hampshire's legislature intended" courts to sever the unconstitutional applications of an abortion statute). This alone compels dismissal of the plaintiffs' facial challenge to HB2's ambulatory-surgical-center requirement.

C. The Plaintiffs' Facial Undue-Burden Challenge To The Ambulatory-Surgical-Center Requirement Should Be Dismissed Because The Plaintiffs' Lack Third-Party Standing To Assert The Rights Of Other Providers' Patients.

The plaintiffs' facial undue-burden challenge to HB2's ambulatory-surgical-center requirement asserts the constitutional rights of not only their own patients but also the patients of every other abortion provider in Texas. Litigants, however, may assert the rights of third parties only when: (1) the litigant has a "close relation[ ]" to the third party; and (2) there is some "hindrance" to the third party's ability to protect his or her own interests. *See Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004). In addition, the litigant's complaint must clearly allege facts demonstrating that these criteria for third-party standing are met. *See Warth v. Seldin*, 422 U.S. 490, 518 (1975) ("It is the responsibility of the complainant *clearly to allege facts* demonstrating that he is a proper party to invoke judicial resolution of the dispute and the exercise of the court's remedial powers.") (emphasis added). The plaintiffs have failed to allege facts demonstrating their standing to assert the rights of other providers' patients, and in all events they cannot show that third-party standing is proper.

The plaintiffs in this case represent only a small subset of the abortion providers in Texas. There is no conceivable basis on which these plaintiffs can claim a "close relation" with the patients of *other* abortion providers who have not joined this lawsuit. The Fifth Circuit's ruling upholding the hospital-admitting-privileges requirement ruled only that "doctors who perform abortions share a sufficiently close relationship with *their* patients." *See Planned Parenthood of Greater Tex.*,

2014 WL 1257965, at *2 (emphasis added).[3] It did not hold or intimate that a "close relationship" existed between plaintiffs and the patients of other abortion providers. Allowing the plaintiffs to assert those constitutional rights would essentially confer universal standing on abortion providers to assert third-party "undue burden" rights.

III. THE PLAINTIFFS' UNDUE-BURDEN CLAIMS (BOTH FACIAL AND AS-APPLIED) SHOULD BE DISMISSED FOR LACK OF A CAUSE OF ACTION.

Even if the plaintiffs could somehow avoid the Supreme Court's limits on third-party litigation, they still cannot assert third-party rights under 42 U.S.C. § 1983 or the Declaratory Judgment Act. Each of these statutes establishes a limited cause of action—one that extends only to litigants who assert their *own* rights. *See* 42 U.S.C. § 1983 (providing that every "person" who acts under color of state law and deprives another person of his constitutional or federal rights "shall be liable *to the party injured*") (emphasis added); 28 U.S.C. § 2201(a) (authorizing federal court to "declare the rights and other legal relations of *any interested party seeking such dec-*

[3] The State also respectfully submits that the plaintiffs lack third-party standing to assert even the rights of their own patients, because challenges to health-and-safety regulations present an irreconcilable conflict of interest between the providers and consumers of abortion, and third-party standing is forbidden if the interests of the litigant and the third-party rights-holder are even "potentially in conflict." *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 15 (2004); *see also Kowalski*, 543 U.S. at 135 (Thomas, J., concurring) (noting that third-party standing is disallowed when the litigants "may have very different interests from the individuals whose rights they are raising"). The Fifth Circuit, however, held in *Planned Parenthood of Greater Tex.* that abortion providers had third-party standing to raise an "undue burden" challenge to the hospital admitting-privileges requirement, and although it acknowledged the possibility that a conflict of interest between providers and patients could defeat third-party standing, it was "convinced that such no such conflict exists here, however." 2014 WL 1257965, at *2 n.9. The State recognizes that this particular argument against third-party standing is an uphill climb in light of the Fifth Circuit's ruling, but it wishes to preserve the argument for appeal.

laration . . .") (emphasis added). The third-party claims therefore cannot proceed under either section 1983 or the Declaratory Judgment Act; the plaintiffs must either assert a different cause of action or else face the dismissal of these third-party claims for failing to state a claim on which relief can be granted.

The cause-of-action inquiry is distinct from the question of "standing." As the Supreme Court has explained, "*standing* is a question of whether a plaintiff is sufficiently adversary to a defendant to create an Art. III case or controversy, or at least to overcome prudential limitations on federal-court jurisdiction," while "*cause of action* is a question of whether a particular plaintiff is a member of the class of litigants that may, as a matter of law, appropriately invoke the power of the court." *Davis v. Passman*, 442 U.S. 228, 239 n.18 (1979). Even plaintiffs who can surmount the Supreme Court's doctrinal restrictions on third-party standing must still point to a provision of law that authorizes them to sue. The plaintiffs' complaint invokes both 42 U.S.C. § 1983 and the Declaratory Judgment Act, but neither of those statutes provides a cause of action that allows plaintiffs to assert the rights of non-litigant third parties.

Section 1983 provides that when a person acting under color of state law deprives "any citizen of the United States or other person within the jurisdiction thereof" of constitutional rights, the state officer "shall be liable *to the party injured*." (emphasis added). That section 1983 deploys a definite article ("*the* party injured," not "*a* party injured") indicates that its description of the permissible plaintiffs refers back to its earlier description of the "citizen" or "person" who has suffered the deprivation of his rights. In the words of Professor Currie, section 1983:

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

David P. Currie, *Misunderstanding Standing*, 1981 Sup. Ct. Rev. 41, 45 (emphasis added). Only the rights-holder may sue as a plaintiff under section 1983; the statutory language does not accommodate lawsuits brought by plaintiffs who seek to vindicate the constitutional rights of third parties.

Rizzo v. Goode, 423 U.S. 362 (1976), recognizes that liability under section 1983 can attach only to conduct that violates *the complainant's* federally protected rights—and not the rights of non-litigant third parties. The *Rizzo* Court explained that "[t]he plain words of the statute impose liability whether in the form of payment of redressive damages or being placed under an injunction *only for* conduct which 'subjects, or causes to be subjected' *the complainant* to a deprivation of a right secured by the Constitution and laws." *Id.* at 370–71 (emphasis added) (citation omitted). The Fifth Circuit follows *Rizzo*'s construction of section 1983, holding in *Coon v. Ledbetter*, 780 F.2d 1158 (5th Cir. 1986), that plaintiffs who invoke section 1983 are "required to prove some violation of their *personal* rights." *Id.* at 1160 (emphasis added); *see also id.* (citing with approval rulings from other federal courts that prohibit third-party litigation under section 1983). And in *Shaw v. Garrison*, 545 F.2d 980 (5th Cir. 1977) *rev'd on other grounds sub nom. Robertson v. Wegmann*, 436 U.S. 584 (1978), the Fifth Circuit allowed a section 1983 lawsuit to proceed only after concluding that it was "not an attempt to sue under the civil rights statutes for deprivation of another's constitutional rights" and noting that "[s]uch suits are impermissible." *Id.* at 983 n.4. This Court cannot allow the plaintiffs' third-party claims to proceed under section 1983 without contradicting the binding pronouncements in *Rizzo*, *Coon*, and *Shaw*—not to mention the unambiguous language of section 1983.[4]

[4] Other courts of appeals follow the text of 42 U.S.C. § 1983 by categorically excluding plaintiffs who try to invoke the rights of third parties—regardless of whether those plaintiffs might satisfy the Supreme Court's doctrinal tests for third-party

Doubtless the plaintiffs will respond by citing cases in which abortion providers successfully asserted third-party claims under section 1983 because the State's lawyers failed to object to this maneuver. *See, e.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 744 F. Supp. 1323, 1325 (E.D. Pa. 1990) (noting that the plaintiff abortion providers challenged Pennsylvania's Abortion Control Act under 42 U.S.C. § 1983, while asserting the third-party rights of women). But when a State's lawyers forfeit this defense by failing to raise it—an all-too-common occurrence in abortion litigation—the case has no precedential value on whether plaintiffs may use section 1983 to assert the rights of non-litigant third parties. Cases such as *Casey* never discuss this issue because the parties didn't raise it; these types of cases cannot relieve future courts of their obligation to enforce the language of section 1983 when the State's lawyers preserve the issue. That other States have forfeited this contention

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standing. *See, e.g.*, *Advantage Media, L.L.C. v. City of Eden Prairie*, 456 F.3d 793, 801 (8th Cir. 2006) ("On an overbreadth challenge [plaintiff] would also be barred from collecting § 1983 damages which are available only for violations of a party's own constitutional rights."); *Bates v. Sponberg*, 547 F.2d 325, 331 (6th Cir. 1976) ("42 U.S.C. § 1983 offers relief only to those persons whose federal statutory or federal constitutional rights have been violated."); *see Hunt v. City of Los Angeles*, 638 F.3d 703, 710 (9th Cir. 2011) ("Where a plaintiff challenges an ordinance based on the violation of third parties' rights, however, § 1983 damages are not available because there has been no violation of the plaintiff's own constitutional rights."); *Archuleta v. McShan*, 897 F.2d 495, 497 (10th Cir. 1990) ("We must also keep firmly in mind the well-settled principle that a section 1983 claim must be based upon the violation of plaintiff's personal rights, and not the rights of someone else."). *See also Estate of Gilliam ex rel. Waldroup v. City of Prattville*, 639 F.3d 1041, 1047 (11th Cir. 2011) ("[B]y its own terms, § 1983 grants the cause of action 'to the party injured.'"); *Andrews v. Neer*, 253 F.3d 1052, 1056 (8th Cir. 2001) ("Under § 1983, state actors who infringe the constitutional rights of an individual are liable 'to the party injured.'"); *Claybrook v. Birchwell*, 199 F.3d 350, 357 (6th Cir. 2000) ("[A] section 1983 cause of action is entirely personal to the direct victim of the alleged constitutional tort."); *Garrett v. Clarke*, 147 F.3d 745, 746 (8th Cir. 1998) ("Garrett may not base his Section 1983 action on a violation of the rights of third parties.").

in past abortion cases does not in any way preclude the State of Texas from relying on it here. *See, e.g.*, *Lewis v. Casey*, 518 U.S. 343, 352 n.2 (1996).

The Declaratory Judgment Act imposes the same obstacle to the third-party claims in this case. The text of the statute provides, in relevant part:

> In a case of actual controversy within its jurisdiction, . . . any court of the United States . . . may declare the rights and other legal relations *of any interested party seeking such declaration*.

28 U.S.C. § 2201 (emphasis added). Like section 1983, the federal Declaratory Judgment Act establishes a limited cause of action, one that allows litigants to seek a declaration only of their *own* rights and legal relations. By authorizing the federal courts to declare the rights and legal relations "of *any interested party seeking such declaration*," the Declaratory Judgment Act necessarily excludes actions brought to declare the rights or legal relations of non-parties—or anyone other than the party "seeking such declaration" under the Act. *See* Currie, *Misunderstanding Standing*, 1981 Sup. Ct. Rev. 41. It provides no authority for a federal court to declare the rights of those who are not "seeking" a declaration under the statute.

CONCLUSION

The complaint should be dismissed for failure to state a claim on which relief may be granted.

Respectfully submitted.

GREG ABBOTT
Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

JAMES D. BLACKLOCK
Deputy Attorney General for Legal Counsel

/s/ Jonathan F. Mitchell
JONATHAN F. MITCHELL
Solicitor General
State Bar No. 24075463

ANDREW S. OLDHAM
Deputy Solicitor General

ARTHUR C. D'ANDREA
BETH KLUSMANN
PHILIP A. LIONBERGER
MICHAEL P. MURPHY
Assistant Solicitors General

209 West 14th Street
P.O. Box 12548 (MC-059)
Austin, Texas 78711-2548
(512) 936-1700 (phone)
(512) 474-2697 (fax)
jonathan.mitchell@texasattorneygeneral.gov

COUNSEL FOR DEFENDANTS
DAVID LAKEY, M.D., AND
MARI ROBINSON

Dated: May 2, 2014

CERTIFICATE OF SERVICE

I certify that on May 2, 2014, this document was served on counsel of record through the Court's CM/ECF Document Filing System or through e-mail.

Jan Soifer
Patrick J. O'Connell
98 San Jacinto Blvd., Ste. 540
Austin, TX 78701
(512) 583-0451
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

John H. Bucy, II
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3600
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org

COUNSEL FOR PLAINTIFFS

/s/ Jonathan F. Mitchell
JONATHAN F. MITCHELL
Solicitor General

F

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

WHOLE WOMAN'S HEALTH; *et al.*,	)	
	)	
Plaintiffs,	)	
	)	CIVIL ACTION
v.	)	
	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
	)	
Defendants.	)	

PLAINTIFFS' MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

CASES **PAGE(S)**

TABLE OF AUTHORITIES
(continued)

CASES **PAGE(S)**

TABLE OF AUTHORITIES
(continued)

CASES **PAGE(S)**

STATUTES

OTHER AUTHORITIES

Plaintiffs respectfully submit this opposition to Defendants' motion to dismiss. The motion should be denied in its entirety because determination of the claims and issues presented in this case is not precluded by res judicata or collateral estoppel; Plaintiffs' standing is confirmed by well-settled precedent; and this Court has already implicitly rejected Defendants' arguments concerning 42 U.S.C. § 1983 and the Declaratory Judgment Act

STATEMENT OF FACTS

Plaintiffs are Texas abortion providers. Plaintiffs bring this action on behalf of themselves and their patients. They seek declaratory and injunctive relief from certain unconstitutional requirements imposed by Texas House Bill No. 2 ("the Act"), H.B. 2, 83rd Leg., 2nd Called Sess. (Tex. 2013), which was signed into law on July 18, 2013. The challenged provisions are: (i) the "admitting privileges requirement," which provides in relevant part, 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 located not further than 30 miles from the location at which the abortion is performed or induced," Tex. Health & Safety Code Ann. § 171.0031, and (ii) the "ASC requirement," which provides in relevant part, that "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Tex. Health & Safety Code Ann. § 245.010(a).

Initially scheduled to take effect on October 29, 2013, the admitting privileges requirement was the subject of a pre-enforcement, facial challenge by a coalition of abortion providers, including some of the Plaintiffs in this case. This Court permanently enjoined the requirement on October 28, 2013, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891, 909 (W.D. Tex. 2013), but the Fifth Circuit stayed that injunction on the evening of October 31, 2013, 734 F.3d 406, 419 (5th Cir. 2013), *motion to vacate denied*,

134 S. Ct. 506 (2013), and ultimately reversed the district court's judgment, 2014 WL 1257965 (5th Cir. Mar. 27, 2014).

Subsequent to this Court's entry of judgment in *Abbott*, both the "McAllen clinic" operated by Whole Woman's Health and the "El Paso clinic" operated by Reproductive Services were forced to stop providing abortion services because the physicians affiliated with those clinics were unable to obtain the required admitting privileges. *See* Complaint ¶¶ 7-8. Accordingly, Whole Woman's Health and Dr. Lynn are challenging the admitting privileges requirement as applied to the McAllen clinic, and Reproductive Services and Dr. Richter are challenging the admitting privileges requirement as applied to the El Paso clinic. The McAllen clinic is the last remaining licensed abortion facility in the Rio Grande Valley, but it has not been able to provide abortion services since the admitting privileges requirement took effect. *Id.* ¶ 6. The El Paso clinic is currently one of only two licensed abortion facilities located west of San Antonio, and the only facility west of San Antonio that provides medical abortions, but, as a result of the admitting privileges requirement, it has not been able to provide any abortion services since April 11, 2014. *Id.* ¶ 7; Toti Decl. ¶ 3 (ECF No. 22-2).

All Plaintiffs challenge the ASC requirement, which is scheduled to take effect on September 1, 2014, on its face and as applied to the provision of medical abortions. In addition, Whole Woman's Health and Dr. Lynn challenge the ASC requirement as applied to the McAllen clinic, and Reproductive Services and Dr. Richter challenge the ASC requirement as applied to the El Paso clinic. The facilities operated by Plaintiffs do not meet the minimum standards for ASCs, Complaint ¶¶ 120-123, and none will be in compliance on September 1, 2014.

Prior to the passage of the Act, there were over three dozen licensed abortion clinics in Texas. *Id.* ¶ 12. Since the admitting privileges requirement has taken effect, that number has

dropped significantly. *Id*. If the ASC requirement is permitted to take effect, there will be fewer than ten abortion clinics in the State, all clustered in eastern metropolitan areas, with no clinics west or south of San Antonio. *Id.*

ARGUMENT

I. Standard of Review

To survive a motion to dismiss under Rule 12(b)(6), a complaint must contain sufficient factual matter, accepted as true, to "'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged. *Id.* When standing is challenged on a motion to dismiss under Rule 12(b)(1), a court must "'accept as true all material allegations of the complaint'" and "'construe the complaint in favor of the complaining party.'" *Ass'n of Am. Physicians & Surgeons, Inc. v. Texas Med. Bd.*, 627 F.3d 547, 553 (5th Cir. 2010) (quoting *Pennell v. City of San Jose*, 485 U.S. 1, 7 (1988)).

II. Plaintiffs' Claims Are Not Precluded by Res Judicata Because They Depend on Facts that Occurred Subsequent to this Court's Entry of Judgment in *Abbott.*

Contrary to Defendants' assertions, res judicata precludes none of Plaintiffs' claims. The test for res judicata has four elements: (1) the parties are identical or in privity; (2) the judgment in the prior action was rendered by a court of competent jurisdiction; (3) the prior action was concluded by a final judgment on the merits; and (4) the same claim or cause of action was involved in both actions. *Petro-Hunt, L.L.C. v. United States*, 365 F.3d 385, 395 (5th Cir. 2004). Here, the fourth element of res judicata is not satisfied because Plaintiffs' claims depend on facts that occurred subsequent to this Court's entry of judgment in *Abbott*.

To determine whether two lawsuits involve the same claim or cause of action, the Fifth Circuit has adopted the transactional test of the Restatement (Second) of Judgments, § 24. *Petro Hunt, L.L.C.*, 365 F.3d at 395. Under that test, "[m]aterial operative facts occurring after the decision of an action with respect to the same subject matter may in themselves, or taken in conjunction with the antecedent facts, comprise a transaction which may be made the basis of a second action not precluded by the first." Restatement (Second) of Judgments, § 24 cmt. (f). The Restatement provides that, "[w]here important human values—such as the lawfulness of a continuing personal disability or restraint—are at stake, even a slight change of circumstances may afford a sufficient basis for concluding that a second action may be brought." *Id.* Accordingly, the Fifth Circuit has consistently held that res judicata does not serve to bar claims that depend on facts occurring after the entry of a prior judgment. *See, e.g., Blair v. City of Greenville*, 649 F.2d 365, 368 (5th Cir. Unit A 1981); *Kilgoar v. Colbert Cnty. Bd. of Educ.*, 578 F.2d 1033, 1035 (5th Cir. 1978) ("The district court erred in dismissing the case because of res judicata. Claims based on conduct subsequent to prior litigation are not precluded."); *Dawkins v. Nabisco, Inc.*, 549 F.2d 396, 396 (5th Cir. 1977); *Exhibitors Poster Exch., Inc. v. Nat. Screen Serv. Corp.*, 421 F.2d 1313, 1318 (5th Cir. 1970).

The rule typically prevents a pre-enforcement, facial challenge to a statute from precluding parties from bringing subsequent, as-applied challenges after the statute takes effect. *See Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l Planning Agency*, 322 F.3d 1064, 1080 (9th Cir. 2003) ("Often, an as-applied challenge will not be precluded by an earlier facial challenge because the 'transactional nucleus of facts' surrounding the enactment of a regulation will be different from the nucleus of facts involved when that regulation is applied to a particular property."); *cf. Stanton v. D.C. Ct. of Appeals*, 127 F.3d 72, 78-79 (D.C. Cir. 1997) (permitting

successive as-applied challenges to rules of attorney conduct). Only in cases where the subsequent post-enforcement challenge involves no new facts will it be precluded by an earlier denial of pre-enforcement relief. *See Tahoe-Sierra Pres. Council, Inc.*, 322 F.3d at 1080. For example, the Supreme Court's decision upholding Section 203 of the Bipartisan Campaign Reform Act of 2002, *McConnell v. Fed. Election Comm'n*, 540 U.S. 93, 203 (2003), following a facial challenge by the National Right to Life Committee, did not preclude its privy, Wisconsin Right to Life, from bringing a subsequent as-applied challenge to that provision, *see Wis. Right to Life, Inc. v. Fed. Election Comm'n*, 546 U.S. 410, 411-12 (2006) (*per curiam*) ("In upholding § 203 against a facial challenge, we did not purport to resolve future as-applied challenges."). Thus, the *Abbott* panel was not "chang[ing] the law of claim preclusion," as Defendants contend, when it explained that: "[W]hen considering facial invalidation of a state statute, the court must preserve the valid scope of the provision to the greatest extent possible. Later as-applied challenges can always deal with subsequent, concrete constitutional issues." *Abbott*, 2014 WL 1257965 at *2.

Here, the claims concerning application of the admitting privileges requirement to the McAllen and El Paso clinics depend on facts that occurred after judgment was entered in *Abbott*'s pre-enforcement challenge. This Court entered judgment in that case in October 2013, before the admitting privileges requirement took effect. The appellate panel declined to consider any facts that occurred subsequently. *See Abbott*, 2014 WL 1257965 at *13 n.14 ("To the extent that the State and Planned Parenthood rely on developments since the conclusion of the bench trial and during this appeal, we do not consider any arguments based on those facts, nor do we rely on any facts asserted in amicus briefs. This opinion[] is confined to the record before the

trial court."). But material operative facts giving rise to the claims in this case did not occur until after the district court entered its judgment.

In particular, it was not known at the time of the judgment how many abortion providers would be unable to obtain admitting privileges or how enforcement of the admitting privileges requirement would ultimately impact women's access to abortion services in Texas. *See id.* at *6 ("The State . . . attacked Planned Parenthood's evidence as to the effects of the admitting-privileges requirement."); *id.* at *11 ("[T]he statement that *both* clinics in the Rio Grande Valley will close may be disregarded as clearly erroneous based on the trial court record.") (emphasis in original); *id.* at *12 ("[T]he record does not show that abortion practitioners will likely be unable to comply with the privileges requirement."). At that time, "[a]ll of the major Texas cities, including Austin, Corpus Christi, Dallas, El Paso, Houston, and San Antonio, continue[d] to have multiple clinics where[, the panel found,] many physicians will have or obtain hospital admitting privileges." *Id*.

Subsequently, both the McAllen and the El Paso clinics were forced to stop providing abortion services because the physicians affiliated with those clinics were unable to obtain the required admitting privileges. *See* Complaint ¶¶ 7-8. This is the critical fact that forms the basis of the claims concerning the admitting privileges requirement in this case, and it did not occur until after judgment was entered in *Abbott*. The McAllen physicians, including Dr. Lynn, did not receive notices from Doctors Hospital at Renaissance, the only McAllen-area hospital at which they were eligible to apply for admitting privileges, that the hospital's Governing Body had declined to extend them applications for reasons unrelated to their "clinical competence" until November-December 2013. *Id.* ¶¶ 46-48. And Dr. Richter, the only physician providing abortion services at the El Paso clinic, did not receive notice until February 2014 that her

temporary admitting privileges at Foundation Hospital would not be extended beyond May 13, 2014.[1] *See* Complaint ¶ 68; Laster Decl. ¶ 21 (ECF No. 12-4). As a result, there are no longer any licensed abortion facilities operating in the Rio Grande Valley, Complaint, ¶ 7, and there is only one licensed abortion clinic operating in the entire region west of San Antonio, *id.* ¶ 70. Furthermore, because of the combined impact of the admitting privileges requirement and the ASC requirement, in the absence of relief from the Court, after September 1, 2014, there will be no licensed abortion clinics operating in Corpus Christi or El Paso.[2] *Id.* ¶ 12.

Since the admitting privileges requirement caused the closure of numerous licensed abortion facilities in Texas, there has been an increase in women attempting self-abortion, which is less safe than abortion performed in a medical setting. *See* Complaint ¶¶ 109-110. For example, after the McAllen clinic stopped providing abortion services, Whole Woman's Health staff members encountered an increased number of prospective patients who had attempted self-abortion using a variety of methods, including herbal teas, douches, physical trauma to the abdomen, and medications purchased on the black market. *See id.* ¶ 107. This impact was not known at the time of the *Abbott* litigation and constitutes important evidence supporting Plaintiffs' claim that, as applied to the McAllen and El Paso clinics, the admitting privileges requirement imposes an undue burden on women seeking access to abortion services in the Rio Grande Valley and West Texas. Given that the McAllen and El Paso clinics have now both stopped providing abortion services as a result of the admitting privileges requirement, discovery

[1] On April 11, 2014, the hospital notified Dr. Richter's attorney that it would no longer honor her temporary admitting privileges. Toti Decl. ¶ 3 (ECF No. 22-2). On that date, the El Paso clinic stopped providing abortions.

[2] "When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered." *Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 796 (7th Cir. 2013).

is likely to yield additional information about the impact of that requirement on women's ability to access abortion services that was unknown at the time of the *Abbott* decision, before those clinics stopped providing abortions. Because material operative facts giving rise to the claims in this case have occurred and are continuing to occur since this Court entered judgment in *Abbott*, the decision in *Abbott* does not preclude Plaintiffs from challenging application of the admitting privileges requirement to the McAllen and El Paso clinics.

Likewise, res judicata does not preclude Plaintiffs' claims concerning the ASC requirement. The regulations implementing that requirement were not adopted until December 27, 2013, *see* 38 Tex. Reg. 9577-93 (Dec. 27, 2013), well after this Court entered judgment in *Abbott*. Prior to adoption of the final regulations, Plaintiffs' claims against the ASC requirement were not ripe. Many of the 19,799 comments submitted in response to the proposed regulations promulgated by DSHS asked the Department to provide a mechanism for grandfathering existing facilities, as it does for ASCs that do not provide abortion services, *see* 25 Tex. Admin. Code § 135.51, and/or to exempt providers of medical abortions from surgery center requirements. *See* 38 Tex. Reg. 9588 (Dec. 27, 2013). Thus, prior to the adoption of the final regulations, Plaintiffs could not know the nature and extent of the burdens imposed by the ASC requirement or the constitutional violations caused by them. Adoption of the final regulations is, therefore, a material operative fact that occurred subsequent to this Court's entry of judgment in *Abbott*. *See Aspex Eyewear, Inc. v. Marchon Eyewear, Inc.*, 672 F.3d 1335, 1342 (Fed. Cir. 2012) ("[R]es judicata requires that in order for a particular claim to be barred, it is necessary that the claim either was asserted, or could have been asserted, in the prior action. If the claim did not exist at the time of the earlier action, it could not have been asserted in that action and is not barred by res judicata."); *In re Piper Aircraft Corp.*, 244 F.3d 1289, 1289 (11th Cir. 2001).

Further, enforcement of the ASC requirement is not part of the same "transaction, or series of connected transactions" as enforcement of any other provisions of the omnibus Act, as the Restatement (Second) of Judgments requires for res judicata to apply. *Petro-Hunt, L.L.C.*, 365 F.3d at 395-96 (quoting Restatement (Second) of Judgments, § 24(1)). Under the Restatement, the transactional test is "pragmatic[]," not formal, and turns on whether the two actions under consideration are based on "the *same nucleus of operative facts*." *Id.* (emphasis in original); *accord* Restatement (Second) of Judgments, § 24(2) & cmt. (b). Here, this test is not satisfied merely because the ASC requirement was enacted as part of the an omnibus statute containing other requirements. The ASC requirement operates independently from the other requirements in the Act, as evidenced by its separate effective date and the need for implementing regulations to give it effect. And Plaintiffs' claims concerning the ASC requirement will require different proof than the claims in *Abbott*. Accordingly, for res judicata purposes, enforcement of the ASC requirement is not part of the same transaction or series of transactions as enforcement of any other provisions of the Act.

III. Plaintiffs Are Not Precluded by Collateral Estoppel from Litigating Any of the Issues Raised in This Case Because the Facts and Legal Standard at Issue Here Are Not the Same as Those in *Abbott.*

Plaintiffs are not collaterally estopped, as Defendants contend, from litigating the issue of whether the admitting privileges requirement, as-applied to the McAllen clinic, imposes an undue burden on women seeking abortions in the Rio Grande Valley because that issue was not litigated in *Abbott*.[3] Collateral estoppel precludes a party from litigating an issue raised in an earlier action only if: (1) the issue at stake is identical to the one involved in the earlier action;

[3] Defendants assert collateral estoppel only in connection with the issue of whether the admitting privileges requirement imposes an undue burden as applied to the McAllen clinic. *See* Defs.' Mot. to Dismiss at 6-8 (ECF No. 48). The term "collateral estoppel" and citations to legal authorities concerning collateral estoppel appear nowhere else in the motion.

(2) the issue was actually litigated in the earlier action; and (3) the determination of the issue in the earlier action was a necessary part of the judgment in that action. *Petro-Hunt, L.L.C.*, 365 F.3d at 397. Notably, "[c]ollateral estoppel does not preclude litigation of an issue unless both the facts and the legal standard used to assess them are the same in both proceedings." *Copeland v. Merrill Lynch & Co., Inc.*, 47 F.3d 1415, 1422 (5th Cir. 1995) (citing *Recoveredge L.P. v. Pentecost*, 44 F.3d 1284, 1291 (5th Cir. 1995); *Brister v. A.W.I., Inc.*, 946 F.2d 350, 354 & n.1 (5th Cir. 1991)). Furthermore, collateral estoppel "is an equitable doctrine which should be 'applied only when the alignment of the parties and the legal and factual issues raised warrant it.'" *Copeland, 47 F.3d* at 1423 (quoting *Nations v. Sun Oil Co. (Del.)*, 705 F.2d 742, 744-45 (5th Cir. 1983) (en banc)). "The district court has broad discretion to determine when collateral estoppel . . . should be applied to preclude litigation of an issue." *Id.*[4]

Both the legal standard and the facts relevant to the issue of whether the admitting privileges requirement, as applied to the McAllen clinic, imposes an undue burden on women in the Rio Grande Valley are different from those relevant to the issue of whether the admitting privileges requirement imposes an undue burden on its face. In *Abbott*, the plaintiffs sought only facial invalidation of the admitting privileges requirement; the plaintiffs' entitlement to a narrower remedy was neither litigated nor considered *sua sponte* by the panel. *Abbott*, 2014 WL

[4] Additionally, Plaintiffs cannot be collaterally estopped by the panel's decision in *Abbott* because that decision is not yet final. No mandate has issued; the plaintiffs have filed a petition for rehearing en banc, Pet. for Reh'g En Banc, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbot*, No. 13-51008 (5th Cir. Apr. 10, 2014); and the court has called for a response from the defendants, Ct. Directive, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbot*, No. 13-51008 (5th Cir. Apr. 25, 2014). Although a pending appeal does not typically prevent application of collateral estoppel, *see Prager v. El Paso Nat. Bank*, 417 F.2d 1111, 1112 (5th Cir. 1969), to have a preclusive effect, the decision relied upon "must ordinarily be a firm and stable one, the 'last word' of the rendering court—a 'final' judgment." Restatement (Second) of Judgments, § 13 cmt. (a). The decision of the panel in *Abbott* will not be final unless and until a mandate issues.

1257965, at *2, *13. To prevail on their facial challenge, the *Abbott* plaintiffs were required to show that the admitting privileges requirement would place a substantial obstacle in the path of women seeking previability abortion services "in a large fraction of the cases in which [it] is relevant." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 895 (1992); *accord Abbott*, 2014 WL 1257965, at *2. The *Abbott* panel held that they failed to meet this exacting standard. *Id.* at *13 ("The evidence presented to the district court demonstrates that if the admitting-privileges regulation burdens abortion access by diminishing the number of doctors who will perform abortions and requiring women to travel farther, the burden does not fall on the vast majority of Texas women seeking abortions. Put otherwise, the regulation will not affect a significant (much less 'large') fraction of such women . . ."). Here, Plaintiffs seek narrower relief on their admitting privileges claim and, therefore, do not have to satisfy this standard.

Notably, the Fifth Circuit did not conclude as a *matter of law*, as Defendants contend, that the admitting privileges requirement would not impose a substantial obstacle in the path of women in the Rio Grande Valley who had to travel long distances to obtain abortions services as a result of its enforcement. Its conclusions concerning that issue were based on application of the law to the facts in the record. *See id.* at *11 ("*The record before us* does not indicate that the admitting-privileges requirement imposes an undue burden by virtue of the potential increase in travel distance in the Rio Grande Valley.") (emphasis added). In that respect, its approach was consistent with that taken in *Casey*. *See Casey*, 505 U.S. at 887 ("Hence, *on the record before us, and in the context of this facial challenge*, we are not convinced that the 24-hour waiting period constitutes an undue burden.") (emphasis added). Both *Abbott* and *Casey* leave open the

possibility that a different factual showing on the same issue may yield a different result.[5] Thus, Plaintiffs are not collaterally estopped from litigating the issue in this case.

IV. Each of Plaintiffs' Claims for Relief is Plausible on Its Face.

A. Defendants Have Failed to Demonstrate That Plaintiffs' Undue Burden Claim Concerning Application of the Admitting Privileges Requirement to the El Paso Clinic Should Be Dismissed.

Defendants erroneously contend that Plaintiffs' undue burden claim concerning application of the admitting privileges requirement to the El Paso clinic is implausible given that, in 2010, the total number of women seeking abortions was approximately 2,278. But Defendants ignore the fact that there is currently not a single abortion provider operating between El Paso and San Antonio. *See* Complaint ¶ 8. Thus, those 2,278 women from the Trans-Pecos region will be forced to compete with thousands of other women from the western part of Texas, including those from Odessa-Midland and Lubbock, for appointments at the lone abortion provider in El Paso. For women in those areas who can overcome the obstacles to travel, that clinic is now their only option. Moreover, it does not provide medical abortions, and it will close on or before September 1, 2014, absent relief from this Court. *See id*. ¶ 12. Additionally, Defendants' speculation that women in West Texas will be able to access abortion services in New Mexico is irrelevant to the constitutional analysis. Taking into consideration the

[5] Defendants mistakenly rely on *Jones v. Tex. Tech Univ.*, 656 F.2d 1137, 1141 (5th Cir. Unit A 1981), and *Nilsen v. City of Moss Point*, 701 F.2d 556, 560 n.6 (5th Cir. 1983), for the proposition that Plaintiffs may not introduce new facts in support of their admitting privileges claims in this case. But those cases deal with res judicata, not collateral estoppel. Collateral estoppel, which is a "narrower doctrine[]" than res judicata, *Nilsen*, 701 F.2d at 560, is defeated by the introduction of new facts. *See Copeland*, 47 F.3d at 1422 ("Collateral estoppel does not preclude litigation of an issue unless both the facts and the legal standard used to assess them are the same in both proceedings."). Analysis of the two should not be conflated. *See Petro-Hunt, L.L.C.*, 365 F.3d at 396-97. If the Court concludes that res judicata does not bar Plaintiffs' admitting privileges claims, then res judicata considerations should not factor into its collateral estoppel analysis.

availability of abortion care in other states would violate Supreme Court precedent that the Constitution imposes obligations on *each* state and that "no state can be excused from performance by what another State may do," *Missouri ex rel. Gaines v. Canada*, 305 U.S. 337, 350 (1938).

In light of these considerations, Plaintiffs have stated a plausible claim for relief. All parties are currently seeking discovery about the capacity of El Paso's remaining clinic to provide services going forward, and that discovery is likely to yield additional evidence to support Plaintiffs' undue burden claim.

B. Defendants' Have Failed to Demonstrate That Plaintiffs' Equal Protection Claims Should Be Dismissed.

Defendants' arguments concerning Plaintiffs' equal protection claims are unavailing. First, those claims are not foreclosed by the Supreme Court's decision in *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 66-67 (1976) or *Harris v. McRae*, 448 U.S. 297, 325 (1980). The statutory provision upheld in *Danforth*, which was evaluated in the context of a substantive due process claim, not an equal protection claim, merely required a woman to sign a consent form prior to an abortion procedure. *Danforth*, 428 U.S. at 66-67. The burdens imposed by that requirement are in no way comparable to the burdens imposed by the ASC and admitting privileges requirements, which will result in the closure of dozens of licensed abortion facilities. *See* Complaint ¶ 12. The contention that, in upholding a *de minimis* abortion restriction against one type of claim, the Supreme Court intended to foreclose challenges to all abortion restrictions based on all claims, is unsound.

Harris is likewise distinguishable. The mere fact that abortion is different from other medical procedures in some respects does not serve to defeat Plaintiffs' equal protection claims. For purposes of equal protection review—even under the rational basis standard—the difference

must be directly related to the interest advanced by the statute. Thus, in *City of Cleburne*, the Supreme Court held that, although people with mental disabilities are different from other people in some respects, those differences had nothing to do with the interests purportedly underlying a zoning ordinance that excluded housing for people with mental disabilities from certain zones. *See City of Cleburne v. Cleburne Living Ctr.* 473 U.S. 432, 448 (1985). Applying rational basis scrutiny, the Court struck down the ordinance as applied to the proposed operator of a group home on the ground that it violated equal protection. *Id.* ("It is true . . . that the mentally retarded as a group are indeed different from others not sharing their misfortune . . . . But this difference is largely irrelevant unless the [group] home and those who would occupy it would threaten legitimate interests of the city in a way that other permitted uses such as boarding houses and hospitals would not."). Here, Defendants rely on *Harris* for the proposition that "[a]bortion is inherently different from other medical procedures[] because no other procedure involves the purposeful termination of a potential life." *Harris*, 448 U.S. at 325. But that difference has nothing to do with the interests advanced by the ASC and admitting privileges requirements, which are purportedly the health and safety of women seeking abortion services. Thus, *Harris* provides no basis for attacking Plaintiffs' equal protection claims.

Second, Defendants' contention that the panel decision in *Abbott* forecloses Plaintiffs' equal protection claims is also wrong. The *Abbott* plaintiffs challenged the admitting privileges requirement on its face; whereas, the Plaintiffs here challenge the admitting privileges requirement as applied to specific facilities; thus, different standards apply in each case. *See infra* at 16-17. Moreover, in *Abbott*, the panel's rational basis review occurred in the context of a substantive due process challenge, not an equal protection challenge. As a result, the panel focused on the requirement itself and not the classification drawn by the requirement. *See*

Abbott, 2014 WL 1257965, at *7-8. It is plausible that a court could conclude that, although rational in general, a requirement that physicians have admitting privileges at a local hospital is irrational when applied only to abortion providers and not to the providers of procedures that entail more risk or have higher hospitalization rates. *See Van Hollen*, 738 F.3d at 790 ("An issue of equal protection . . . is lurking in this case. For the state seems indifferent to complications from non-hospital procedures other than surgical abortion . . ., even when they are more likely to produce complications.")

Thus, Defendants have failed to demonstrate that Plaintiffs' equal protection claims should be dismissed.

C. Defendants Have Failed to Demonstrate That Plaintiffs' Unlawful Delegation and Arbitrary State Action Claims Should Be Dismissed.

Longstanding principles of due process hold that: (1) states may not authorize private parties to act against third-party liberty or property interests in ways that the state itself could not act; and (2) in order for a delegation of governmental authority to be constitutional, states must retain the ability to review private parties' exercise of governmental discretion. *See, e.g., State of Wash. ex. rel. Seattle Title Trust Co. v. Roberge*, 278 U.S. 116 (1928) (striking down law preventing certain uses of land unless consented to in writing by two-thirds of the property owners in the immediate vicinity); *Birth Control Ctrs., Inc. v. Reizen*, 508 F. Supp. 1366, 1374 (E.D. Mich. 1981), *aff'd on other grounds*, 743 F.2d 352 (6th Cir. 1984) (law requiring abortion clinics to have a backup agreement with a physician who had staff privileges at a local hospital "violate[d] due process concepts because [it] delegate[d] a licensing function to private entities without standards to guide their discretion"); *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153, 1158 (E.D.N.C. 1974), *aff'd*, 519 F.2d 1315 (4th Cir. 1975) (striking down written transfer agreement or admitting privileges requirement for abortion providers because

"the state . . . placed no limits on the hospital's decision to grant or withhold a transfer agreement"). The Due Process Clause also requires that states act only through means appropriately related to legitimate ends. *See Brennan v. Stewart*, 834 F.2d 1248, 1256 (5th Cir. 1988). Every governmental action must be rationally related to its end, and ends that "'shock the conscience'" or otherwise violate norms "'implicit in the concept of ordered liberty'" are illegitimate. *Id.*

Defendants are incorrect in arguing that the panel's decision in *Abbott* is dispositive of Plaintiffs' claims that the admitting privileges requirement, as applied to the McAllen and El Paso clinics, violates these fundamental tenets of due process. Because the *Abbott* plaintiffs sought only facial invalidation of the admitting privileges requirement, the panel evaluated these claims under the standard for facial invalidation of a statute (outside the undue burden context)—*i.e.*, whether "no possible application of the challenged law would be constitutional," *Abbott*, 2014 WL 1257965, at *2, and concluded that the standard was not satisfied, *id.* at *13. But, from the panel's conclusion that *all* applications of the admitting privileges requirement do not amount to an unlawful delegation or arbitrary state action, it does not follow that *none* of them do. In *City of Cleburne*, for example, the Supreme Court explained that a zoning ordinance could be invalid, under rational basis scrutiny, as applied to a particular set of plaintiffs even if it was rational on its face. *See City of Cleburne*, 473 U.S. at 447.

Here, it is plausible that the admitting privileges requirement could be a proper delegation in some circumstances but not others, such as when a hospital denies an abortion provider's request for admitting privileges for reasons unrelated to the provider's clinical competence. *See* Complaint ¶ 48. Likewise, it is plausible that the admitting privileges requirement could be rational as applied to certain licensed abortion facilities but not others, such as a facility that has

performed over 17,000 abortions during the past ten years without needing to transfer a single patient to the hospital. *See* Complaint ¶ 8. Accordingly, Plaintiffs should be entitled to gather and present evidence in support of these claims.

V. Plaintiffs' Entitlement to Facial Relief from the ASC Requirement May Only Be Assessed at the Conclusion of the Lawsuit, Not at the Outset.

Whether a plaintiff can prevail in a facial challenge is not a question of justiciability to be assessed at the outset of a lawsuit, but a question of remedy to be assessed at the conclusion. *See Citizens United v. Fed. Election Comm'n*, 558 U.S. 310, 330-31 (2010). The Supreme Court has explained that the distinction between facial and as-applied challenges "goes to the breadth of the remedy employed by the Court, not what must be pleaded in a complaint." *Id.* Further, when a plaintiff requests facial invalidation of a statute but fails to meet the standard for obtaining it, the plaintiff may nevertheless be entitled to partial invalidation of the statute. *See Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 328-31 (2006) (remanding case for reconsideration of remedy); Richard H. Fallon, *As-Applied and Facial Challenges and Third-Party Standing*, 113 Harv. L. Rev. 1321, 1324 (2000).

Here, neither the nature of Plaintiffs' standing nor the Act's severability clause forecloses facial relief from the ASC requirement as a matter of law. And even if they did, it would be inappropriate to dismiss Plaintiffs' claims against the ASC requirement on that basis because Plaintiffs would still be entitled to seek partial invalidation of the requirement.[6] The appropriate time to determine the scope of the remedy to which Plaintiffs are entitled is after the trial.

[6] As an alternative to facial invalidation of the ASC requirement, Plaintiffs seek, *inter alia*, invalidation of the requirement as applied to the provision of medical abortion; and/or as applied to the McAllen clinic; and/or as applied to the El Paso clinic, Complaint, Request for Relief ¶¶ B(b)-(d), D(b)-(d); as well as such other and further relief as the Court may deem just, proper, and equitable, *Id.* ¶ F.

A. Plaintiffs' Standing to Challenge the ASC Requirement Does Not Depend on the Scope of the Remedy Plaintiffs Seek.

It is well settled law that abortion providers have third-party standing to assert the constitutional rights of their patients. *See, e.g., Bellotti v. Baird*, 443 U.S 622, 627 & n.5 (1979); *Singleton v. Wulff*, 428 U.S. 106, 117 (1976).[7] The *Abbott* panel acknowledged and applied this controlling rule of law. *See Abbott*, 2014 WL 1257965 at *2.[8]

Defendants' contention that this rule does not apply when a plaintiff seeks facial invalidation of a statute ignores the nature and purpose of facial remedies. It is true that, if Plaintiffs' request for facial invalidation of the ASC requirement is granted, all women seeking abortion services in Texas would benefit. But in all cases in which a facial remedy is granted, parties beyond the plaintiffs (and third-parties represented by the plaintiffs) benefit. That is the purpose of a facial remedy: it serves to invalidate all applications of a statute, not merely applications directed at the plaintiff. *See* Fallon, 113 Harv. L. Rev. at 1326.

In general, a plaintiff need not have standing to assert the rights of *all persons* who will benefit from a facial remedy. Rather, the plaintiff must have standing to assert *someone's* rights (the plaintiff's own or a third party's) and then demonstrate that the legal standard for obtaining a facial remedy for the plaintiff's claim is satisfied. If the rule urged by Defendants were adopted, it would prevent a court from granting a facial remedy without first inquiring whether the

[7] Here, Plaintiffs assert three claims for relief against the ASC requirement: undue burden, equal protection, and arbitrary and unreasonable state action. Complaint ¶¶ 152-160. Plaintiffs rely on third-party standing only for the undue burden claim. With respect to the other claims, Plaintiffs assert violations of their own constitutional rights.

[8] Defendants erroneously contend that Plaintiffs lack third-party standing to assert the rights of their patients because they have a conflict of interests concerning the ASC requirement. The interests of Plaintiffs and their patients are aligned; all benefit from ensuring that women are not unduly burdened by restrictions on access to abortion. As Defendants correctly note, the *Abbott* panel considered and rejected the argument that a conflict of interests exists among abortion providers and patients when the restrictions at issue purport to serve a health and safety rationale.

plaintiff had third-party standing to assert the rights of *all* beneficiaries of that remedy. This would be a radical departure from existing precedent. *See, e.g., Citizens United*, 558 U.S. at 330-31 (facially invalidating a campaign finance reform law affecting a multitude of people even though the plaintiff sought only as-applied relief).

B. The Act's Severability Provision Does Not Bar Plaintiffs from Seeking Facial Invalidation of the ASC Requirement.

Defendants' contention that the Texas Legislature can modify rights guaranteed by the U.S. Constitution through the enactment of a severability statute is wrong. The U.S. Supreme Court is the arbiter of federal constitutional rights, not the Texas legislature. In *Casey*, the Court held that a plaintiff is entitled to facial invalidation of a restriction on abortion if the plaintiff can demonstrate that it imposes an undue burden "in a large fraction of the cases in which [the restriction] is relevant." *Casey*, 505 U.S. at 895; *accord Abbott*, 2014 WL 1257965, *2. The Texas legislature does not have the power to alter this standard, and to the extent that the Act's severability provision is inconsistent with it, the severability provision is invalid. *See* U.S. Const. Art. VI, Cl. 2 ("This Constitution . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."). Accordingly, the Act's severability provision does not bar Plaintiffs from seeking facial invalidation of the ASC requirement.

VI. Plaintiffs May Assert Their Patients' Claims Under Section 1983 and the Declaratory Judgment Act.

Defendants previously raised the argument that Plaintiffs cannot bring third-party claims under Section 1983 and the Declaratory Judgment Act before this Court and the Fifth Circuit in *Abbott*.[9] Both courts rejected the argument *sub silentio*, and it remains unpersuasive.

[9] *See* State Defs.' Trial Br. at 10-13, No. 1:13-CV-00862-LY (W.D. Tex. Oct. 15, 2013), ECF No. 59; Appellant's Br. at 48-52, No. 13-51008 (5th Cir. Nov. 22, 2013).

None of the cases Defendants rely upon stand for the proposition that a plaintiff with third-party standing may not seek prospective relief under Section 1983 on behalf of the third party. Further, Defendants' argument is contradicted by the plain language of Section 1983, numerous cases, and principles of equity. Section 1983 states in relevant part: "Every person who . . . subjects . . . any . . . person . . . to the deprivation of any rights . . . secured by the Constitution and laws, shall be liable to the party injured . . . ." 42 U.S.C. § 1983. The statute does not limit who may bring suit, but only describes to whom defendants may be liable. Here, Plaintiffs may bring a claim under Section 1983 on behalf of their patients, who are the "injured" parties to whom defendants "shall be liable." *See generally Van Hollen*, 738 F.3d at 795 ("the justiciability of such cases [under Section 1983] is not in question").[10]

Defendants are also mistaken that Plaintiffs cannot vindicate their patients' rights under the Declaratory Judgment Act, a proposition for which they cite no cases at all. That Act states that "any court of the United States . . . may declare the rights and other legal relations of any interested party seeking such declaration." 28 U.S.C. § 2201(a). Because a declaration of the Act's unconstitutionality would affect their ability to provide constitutionally protected medical services, Plaintiffs are interested parties whose "rights and other legal relations" will be affected by the court's ruling.

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[10] For decades, courts have allowed plaintiffs to assert the rights of third parties in actions brought pursuant to Section 1983, including cases brought by abortion providers on behalf of their patients. *See, e.g.*, *Casey*, 505 U.S. at 845 (allowing abortion providers to challenge on behalf of their patients various restrictions on access to abortion services); *Craig v. Boren*, 429 U.S. 190 (1976) (allowing vendors on behalf of male customers to challenge the constitutionality of a prohibition on sale of beer to males under age of twenty one); *Ass'n of Am. Physicians & Surgeons, Inc.*, 627 F.3d at 547 (allowing medical association to challenge on behalf of its members the constitutionality of actions by Texas Medical Board). If Congress had intended otherwise, presumably it would have amended the statute to make its intentions clear. *Cf. Newport News Shipbuilding & Dry Dock Co. v. E.E.O.C.*, 462 U.S. 669, 670, 678-79 (1983) (explaining that Congress enacted the Pregnancy Discrimination Act of 1978 "to overrule" the Supreme Court's interpretation of Title VII of the Civil Rights Act of 1964).

Dated: May 19, 2014

/S/ Stephanie Toti

Stephanie Toti*
Esha Bhandari*
Natasha Lycia Ora Bannan*
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'CONNELL & SOIFER LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

J. Alexander Lawrence*
MORRISON & FOERSTER LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

John H. Bucy, II*
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Betre M. Gizaw*
MORRISON & FOERSTER LLP
2000 Pennsylvania Avenue, NW
Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com

*Admitted pro hac vice

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on May 19, 2014, the foregoing was served on all counsel of record via the CM/ECF system.

/S/ Stephanie Toti
Stephanie Toti

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

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.,** Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:14-cv-284-LY

REPLY BRIEF SUPPORTING DEFENDANTS' MOTION TO DISMISS

I. THE PLAINTIFFS' CHALLENGES TO THE ADMITTING-PRIVILEGES REQUIREMENT SHOULD BE DISMISSED.

The challenges to the admitting-privileges requirement are foreclosed by res judicata and the Fifth Circuit's ruling in *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, No. 13-51008, 2014 WL 1257965 (5th Cir. Mar. 27, 2014). The plaintiffs' arguments do not overcome either of these obstacles.

A. Each Of The Plaintiffs' Challenges To The Admitting-Privileges Requirements Is Barred By Res Judicata.

If the plaintiffs' as-applied challenges could have been brought in the earlier HB2 proceeding, then the claims are foreclosed by res judicata. *See Allen v. McCurry*, 449 U.S. 90, 94 (1980) ("Under res judicata, a final judgment on the merits of an action precludes the parties or their privies from relitigating issues that were or could have been raised in that action."); *Laurel Sand & Gravel, Inc. v. Wilson*, 519 F.3d 156, 163 (4th Cir. 2008) (holding that res judicata barred plaintiff's as-applied challenge that the plaintiff "could have raised" in an earlier facial challenge to the

law). The plaintiffs do not contend that they were unable to bring their as-applied challenges in the previous lawsuit, and they could have sought as-applied relief that would have kept the El Paso and McAllen clinics open. They chose to spurn that opportunity and cannot take a second bite at the apple.[1]

It was uncontested at the time of the first lawsuit that Dr. Richter and the doctors at the McAllen clinic lacked hospital admitting privileges and would cease providing abortions once HB2 took effect on October 29, 2013. *See* Complaint at ¶ 21, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F. Supp. 2d 891 (W.D. Tex. 2013) (1:13-CV-862-LY) ("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."); *id.* at ¶ 13 ("If the admitting privileges requirement of the Act is allowed to take effect, WWH will stop providing abortions altogether at … McAllen"); *id.* at ¶ 50 ("If allowed to take effect on October 29, the admitting privileges requirement … will cause the sole abortion facilities in Lubbock, Waco, Killeen, Harlingen, and McAllen to cease providing abortions"). The plaintiffs could have used those uncontested facts—if combined with proof that closure of the El Paso or McAllen clinics would impose an "undue burden" on abortion patients—to seek as-applied relief that would keep

[1] *Wisconsin Right to Life, Inc. v. FEC*, 546 U.S. 410 (2006) (per curiam), is no help to the plaintiffs on the res judicata question. *Wisconsin Right to Life* held only that as-applied challenges to BCRA were not barred by stare decisis; it said nothing about the res judicata question, which was not litigated. *See United States v. L.A. Tucker Truck Lines, Inc.*, 344 U.S. 33, 38 (1952) ("The [issue] was not there raised in briefs or argument nor discussed in the opinion of the Court. Therefore, the case is not a binding precedent on this point."); *Webster v. Fall*, 266 U.S. 507, 511 (1925) ("Questions which merely lurk in the record, neither brought to the attention of the court nor ruled upon, are not to be considered as having been so decided as to constitute precedents.").

those clinics open. If, for example, the plaintiffs had proven that an "undue burden" would befall their patients if either of those clinics were to close, and that Dr. Richter and the McAllen doctors had been diligently pursuing hospital admitting privileges since the moment HB2 was signed into law, then this Court could have awarded the plaintiffs as-applied relief.

The plaintiffs suggest that they could not have brought their as-applied challenges until the admitting-privileges applications submitted by Dr. Richter and the McAllen doctors were formally rejected. *See* Response at 6–7. The plaintiffs are wrong. To bring an as-applied claim, the plaintiffs needed only to prove that Dr. Richter and the McAllen doctors were unable to get admitting privileges before October 29, 2013, notwithstanding their best efforts to obtain them, that the El Paso and McAllen clinics would therefore close at least temporarily, and that this situation would unconstitutionally burden the rights of abortion patients. If the plaintiffs had proven that case, then this Court could have awarded as-applied relief by declaring that HB2 may not be applied in a manner that leaves the Rio Grande Valley without any abortion provider or that leaves El Paso with only one abortion clinic. And it could have enjoined the State from enforcing HB2 against those clinics while the doctors pursued their applications for hospital admitting privileges, conditioned on regular reports from the plaintiffs showing that their doctors were exhausting all possible opportunities to obtain admitting privileges, and providing that the injunction would dissolve once any abortion provider in the area secured admitting privileges in compliance with HB2.

The plaintiffs would not have been able to obtain a permanent, unconditional injunction blocking the State from enforcing HB2 against the El Paso and McAllen clinics in the initial HB2 proceeding. But the plaintiffs' claims remain ineligible for that type of "as-applied" relief even in this lawsuit. It is impossible for the plaintiffs

to prove that Dr. Richter and the McAllen doctors will *never* be able to secure admitting privileges at hospitals near their clinics. Hospitals can change their requirements, new hospitals can emerge, and doctors whose initial applications are rejected can sometimes remedy those deficiencies. And it is impossible to prove that no future abortion providers will open up business in the El Paso or McAllen regions. The most that the plaintiffs can hope to obtain—even under the best-case assumptions surrounding the plaintiffs' evidence and proof—is a qualified injunction conditioned on the plaintiffs' continued best efforts to secure hospital admitting privileges, and further conditioned on no new abortion providers emerging near El Paso or McAllen.

Even if the plaintiffs could obtain a broader or more rigid injunction by waiting until now to bring their as-applied challenges, res judicata asks only whether the plaintiffs' *claims* could have been brought in the earlier proceeding. The plaintiffs' undue-burden, unlawful-delegation, and procedural-due-process claims not only could have been brought, they in fact were brought in the initial HB2 litigation. *See* Complaint at ¶¶ 89–91, 95–100, *Abbott*, 951 F. Supp. 2d 891 (No. 1:13-CV-862-LY). The "facial" and "as-applied" variants on these challenges are still the *same claim*. The only distinction is in the remedy sought: a "facial" challenge calls for total, across-the-board invalidation of a statutory provision, while an "as-applied" challenge seeks to enjoin only a subset of the statute's applications. *See* Response at 17 ("[W]hen a plaintiff requests facial invalidation of a statute but fails to meet the standard for obtaining it, the plaintiff may nevertheless be entitled to partial invalidation of the statute.").

The plaintiffs also contend that they should escape a res judicata dismissal because their as-applied claims "depend on facts that occurred after judgment"—namely, the rejection of Dr. Richter and the McAllen doctors' applications for hospi-

tal admitting privileges. But the plaintiffs' as-applied challenge to HB2 does not "depend" on those new facts. The State did not contest the plaintiffs' claims in the previous lawsuit that Dr. Richter and the McAllen doctors lacked hospital admitting privileges and would have to cease offering abortions once HB2 took effect on October 29, 2013. Later developments that merely confirm facts that were assumed and uncontested in the earlier proceeding do not establish a different "nucleus of operative facts." If Dr. Richter or Dr. Lynn held hospital admitting privileges at the time the first lawsuit was filed, but the hospital unexpectedly pulled their privileges after the entry of final judgment, then the plaintiffs could plausibly maintain that their as-applied challenge in this case rests on a different nucleus of operative facts. But that is not what happened, and the as-applied challenges presented in this case were ripe at the time of the first lawsuit. All the plaintiffs had to do was ask the Court for an injunction limited to the El Paso and McAllen clinics and present evidence proving that HB2 would impose an "undue burden" on the patients of those clinics. Instead, the plaintiffs refused to request as-applied relief as a fallback option and forced the courts into an all-or-nothing choice. Having lost that gamble, the plaintiffs cannot turn around and file a second lawsuit seeking the more limited injunctive relief that they could and should have sought in the initial proceeding.

Finally, the plaintiffs' allegation of an increase in women attempting self-abortion is not sufficient to establish a different "nucleus" of facts. *See In re Howe*, 913 F.2d 1138, 1144 n.10 (5th Cir. 1990). Indeed, the plaintiffs' contention that they can re-litigate their undue-burden claims on account of this evidence would mean that no ruling in an abortion case could ever have preclusive effect. *See* Response at 7. There will always be evidence of the effects of abortion regulations that emerges after a court upholds the constitutionality of a law, and there will always be ebbs and flows in the supply of and demand for abortion services in any given region of

the State. If evidence such as this enables litigants to revive "undue burden" challenges that courts have previously rejected, then there will never be finality in abortion litigation, and abortion providers can keep suing and suing until they finally get a judge to rule their way. *See Monahan v. New York City Dep't of Corr.*, 214 F.3d 275, 289 (2d Cir. 2000) ("Plaintiffs' assertion of new incidents arising from the application of the challenged policy is … insufficient to bar the application of *res judicata*."); *Brooks v. Giuliani*, 84 F.3d 1454, 1463 (2d Cir. 1996) (applying New York law) (rejecting argument that state conduct post-dating earlier action was not part of same transaction or series of transactions). Res judicata turns on whether the claims arise from the same *nucleus* of operative fact, and the nucleus of the plaintiffs' claims remains the same even if some new electrons have entered into orbit.

B. The Plaintiffs' Undue-Burden Challenges To The Admitting-Privileges Requirements Fail To State A Claim On Which Relief May Be Granted.

Even apart from res judicata, the plaintiffs' undue-burden claims are squarely foreclosed by the Fifth Circuit decision in *Planned Parenthood of Greater Texas v. Abbott*.

1. The McAllen Clinic's As-Applied Undue-Burden Challenge Fails To State A Claim On Which Relief May Be Granted.

The plaintiffs contend that the Fifth Circuit did not hold "as a matter of law" that HB2's admitting-privileges requirement would not impose an undue burden as applied to the McAllen clinic. But the Fifth Circuit did hold as a matter of law that "an increase of travel of less than 150 miles for some women is not an undue burden under *Casey*"—and that proposition of law remains binding on this court.

The plaintiffs seize on the Fifth Circuit's statement that "*[t]he record before us* does not indicate that the admitting-privileges requirement imposes an undue burden by virtue of the potential increase in travel distance in the Rio Grande Valley."

Abbott, 2014 WL 1257965, at *11 (emphasis added). But the record in that earlier proceeding failed to show an undue burden because it was undisputed that abortions would remain available within 150 miles of the Rio Grande Valley if the McAllen clinic were to close, and nothing the plaintiffs can show in their as-applied challenge to HB2's admitting-privileges requirement will change that fact. The plaintiffs have not alleged that enforcing the admitting-privileges requirement against the McAllen clinic will cause patients to travel distances greater than 150 miles. Even if all of the plaintiffs' allegations prove true, any travel distances beyond the 150-mile safe harbor established in *Abbott* will be caused by the ambulatory-surgical-center requirement, not the admitting-privileges law.

Collateral estoppel also forecloses the plaintiffs from relitigating the Fifth Circuit's holding that "an increase of travel of less than 150 miles for some women is not an undue burden under *Casey*." That holding meets all the requirements for collateral estoppel, as it was "actually litigated" and a "necessary part of the judgment." *Petro-Hunt, L.L.C. v. United States*, 365 F.3d 385, 397 (5th Cir. 2004). The plaintiffs do not explain how they can prove that a "large fraction" of patients in the Rio Grande Valley will encounter "substantial obstacles" when *none* of those patients will need to travel more than 150 miles on account of the admitting-privileges law. And the plaintiffs' vague and unsubstantiated allegations of an "increase" in attempts at self-abortion do not suffice, as they have not even alleged that a "large fraction" of patients in McAllen would choose this option rather than travel 150 miles, and in all events they cannot prove that these decisions are caused by the admitting-privileges law as opposed to other factors. *Casey* forbids a court to issue *any* type of relief under the undue-burden test unless the plaintiffs prove that an abortion regulation imposes a substantial obstacle to previability abortion "in a

large fraction of the case in which [it] is relevant." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 895 (1992).

2. The El Paso Clinic's As-Applied Undue-Burden Challenge Fails To State A Claim On Which Relief May Be Granted.

The plaintiffs are wrong to assert that the availability of abortions in Santa Teresa, New Mexico is irrelevant to the "undue burden" inquiry. Texas law does not prohibit Texans from traveling out of state to obtain abortions, and there are no obstacles involved with traveling across state lines, particularly when the clinic in question is less than a mile from the state line. The States are not under any affirmative obligation to make abortion services available in-state to their residents. *Cf. Harris v. McRae*, 448 U.S. 297 (1980). Their only duty is to refrain from imposing "undue burdens" on patients who seek abortions on their own initiative. No one can plausibly claim that Texas has imposed an "undue burden" on patients who remain capable of obtaining abortions less than a mile from the state line in the same metropolitan area in which Dr. Richter's clinic is located. And the plaintiffs do not cite any authority holding that the availability of out-of-state abortions is irrelevant to the undue-burden inquiry. *See Planned Parenthood of Wis., Inc. v. Van Hollen*, 738 F.3d 786, 805 n.9 (7th Cir. 2013) (Manion, J., concurring in part and in the judgment) (concluding that "state lines are unlikely to affect a woman's decision about where to get an abortion and the availability of abortion at out-of-state clinics should be considered in the undue burden analysis," because "the availability of near-but-out-of-state abortions at least speaks to whether the admitting-privileges requirement has the 'practical effect' of preventing a 'significant number' of women from obtaining abortions").

And of course there will *still* be an abortion clinic in El Paso even if Dr. Richter remains unable to secure hospital admitting privileges. The plaintiffs complain that patients from Odessa-Midland and Lubbock must travel to El Paso, but that was

true before HB2 took effect; the lack of abortion providers in Odessa-Midland and Lubbock has nothing to do with HB2's admitting-privileges law. *See Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 415 (5th Cir. 2013) (holding that "obstacle[s]" that are "unrelated to the hospital-admitting-privileges requirement" are irrelevant to the undue-burden inquiry). And although the plaintiffs allege that the remaining El Paso clinic will eventually close on account of the *ASC requirement*, that is not a reason to enjoin the State from enforcing the *admitting-privileges requirement* against Dr. Richter.

C. The Plaintiffs' Equal-Protection Challenges Fail To State A Claim On Which Relief May Be Granted.

The plaintiffs mischaracterize rational-basis review in numerous respects. First, rational-basis review is the same regardless of whether a claim is brought under the equal-protection clause or "substantive due process" doctrine. The test is whether it is *possible to imagine* a rational purpose for the State's law—regardless of whether any empirical evidence exists to support the State's decision, and regardless of whether empirical evidence *contradicts* the State's decision. *See, e.g.*, *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993) (holding that under rational-basis review, a legislative decision "is not subject to courtroom fact-finding and may be based on rational speculation unsupported by evidence or empirical data"); *Abbott*, 2014 WL 1257965, at *7 ("As the Supreme Court has often stressed, the rational basis test seeks only to determine whether any conceivable rationale exists for an enactment. … The court may not replace legislative predictions or calculations of probabilities with its own, else it usurps the legislative power."); *id.* ("The fact that reasonable minds can disagree on legislation, moreover, suffices to prove that the law has a rational basis.").

Second, a statutory distinction need not be "directly related" to the State's interest. *See* Response at 14. It is enough if a distinction is only marginally or tangen-

tially related to a legitimate state goal, or even if it is only *possible to imagine* that the distinction is so related. *See Heller v. Doe*, 509 U.S. 312, 321 (1993) ("[C]ourts are compelled under rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends."); *id.* ("The problems of government are practical ones and may justify, if they do not require, rough accommodations—illogical, it may be, and unscientific." (quoting *Metropolis Theatre Co. v. Chicago*, 228 U.S. 61, 69–70 (1913))); *Hayden v. Paterson*, 594 F.3d 150, 171 (2d Cir. 2010) ("[R]ational basis review allows legislatures to act incrementally and to pass laws that are over (and under) inclusive without violating the Fourteenth Amendment.").

Third, the plaintiffs are wrong to assert that the *only* state interest advanced by the ASC and admitting privileges requirements is promoting women's health and safety. *See* Response at 14. These requirements also serve to protect the life of the unborn—as the State has maintained from the outset of the previous litigation. *See Casey*, 505 U.S. at 873 (recognizing the State's "interest in protecting the life of the unborn"). The Constitution allows the State to protect unborn human life by enacting regulations that do not rise to the level of "undue" burdens or "substantial" obstacles.

And it is assuredly rational for a State to single out abortion practitioners for special regulations. The abortion profession has been known to attract disreputable practitioners who have inflicted grievous harms on their patients. *See* Jon Hurdle, *Doctor Starts His Life Term in Grisly Abortion Clinic Case*, N.Y. TIMES, May 15, 2013 (reporting Kermit Gosnell's 30-year sentence for murdering a baby born alive during a botched abortion); Denise Lavoie, *Doctor Gets 6 Months in Abortion Patient Death*, ASSOCIATED PRESS, Sept. 14, 2010 (reporting Rapin Osathanondh's guilty plea to involuntary manslaughter of a patient who died after her abortion); Lynette

Holloway, *Abortion Doctor Guilty of Murder*, N.Y. TIMES, Aug. 9, 1995 (reporting Dr. David Benjamin's conviction of second-degree murder resulting from a botched abortion). No other field of medicine has had a Gosnell-like episode that would warrant special attention or treatment from state regulators. And abortion regulations (unlike regulations of other medical procedures) advance the State's interest in protecting unborn life. States may enact abortion-specific regulations without extending those requirements to other surgical procedures. *See Women's Health Ctr. of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989) (rejecting challenge to law that "places more stringent requirements on abortions than on other surgical procedures."); *Stenberg v. Carhart*, 530 U.S. 914, 968 (2000) (Kennedy, J., dissenting) ("Courts are ill-equipped to evaluate the relative worth of particular surgical procedures. The legislatures of the several States have superior factfinding capabilities in this regard.").

II. THE PLAINTIFFS' CHALLENGES TO THE AMBULATORY-SURGICAL-CENTER REQUIREMENT ARE BARRED BY RES JUDICATA.

The plaintiffs are wrong to contend that their challenge to HB2's ambulatory-surgical center requirement was "not ripe" until the State adopted regulations making clear that it would not exempt existing clinics from the law's requirements. HB2's ambulatory-surgical center requirement unambiguously applied to *all* abortion clinics in the State. Even if the plaintiffs held out hope that the Department of State Health Services would violate the statute and "grandfather" in existing abortion clinics, that does not mean their challenge to the ASC requirement was not "ripe" after HB2 was enacted. The statute imposed a clear legal obligation on abortion clinics to upgrade their facilities by September 1, 2014, and the plaintiffs could have sued immediately and asked a court to block the requirement so they could avoid the need to begin making those statutorily required upgrades. The plaintiffs

have no excuse for their failure to challenge the ASC requirement in the earlier proceeding, which can be explained only by a strategic desire to get two bites at the apple and enhance their odds of drawing at least one favorable appellate panel. The doctrine of res judicata does not permit these piecemeal litigation tactics.

The plaintiffs are also mistaken to deny that their challenges to the ASC and admitting-privileges requirements involve a "series of connected transactions." Response at 9 (quoting Restatement (Second) of Judgments, § 24(1)). These statutory requirements are undoubtedly "connected" to each other. They are part of the same law, they were enacted at the same time, they were enacted for the same purposes (protecting the health and safety of abortion patients as well as the lives of the unborn), they are administered by the same state agency (DSHS), and they are governed by the same legal standards (the *Casey* "undue burden" standard and the rational-basis test). That the plaintiffs' challenges may require "different proof" is not sufficient to avoid a res judicata dismissal. These transactions are undoubtedly "connected" to each other. *See Monahan*, 214 F.3d at 289 ("We look to see whether the same transaction or *connected series of transactions* is at issue." (citation and internal quotation marks omitted)).

CONCLUSION

The complaint should be dismissed for failure to state a claim on which relief may be granted.

Respectfully submitted.

GREG ABBOTT
Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

JAMES D. BLACKLOCK
Deputy Attorney General for Legal Counsel

/s/ Jonathan F. Mitchell
JONATHAN F. MITCHELL
Solicitor General
State Bar No. 24075463

ANDREW S. OLDHAM
Deputy Solicitor General

ARTHUR C. D'ANDREA
BETH KLUSMANN
PHILIP A. LIONBERGER
MICHAEL P. MURPHY
Assistant Solicitors General

209 West 14th Street
P.O. Box 12548 (MC-059)
Austin, Texas 78711-2548
(512) 936-1700 (phone)
(512) 474-2697 (fax)
jonathan.mitchell@texasattorneygeneral.gov

COUNSEL FOR DEFENDANTS
DAVID LAKEY, M.D., AND
MARI ROBINSON

Dated: May 27, 2014

CERTIFICATE OF SERVICE

I certify that on May 27, 2014, this document was served on counsel of record through the Court's CM/ECF Document Filing System or through e-mail.

Jan Soifer
Patrick J. O'Connell
98 San Jacinto Blvd., Ste. 540
Austin, TX 78701
(512) 583-0451
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

John H. Bucy, II
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3600
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org

COUNSEL FOR PLAINTIFFS

/s/ Jonathan F. Mitchell
JONATHAN F. MITCHELL
Solicitor General

H

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

WHOLE WOMAN'S HEALTH, AUSTIN WOMAN'S HEALTH CENTER, KILLEEN WOMAN'S HEALTH CENTER, NOVA HEALTH SYSTEMS D/B/A REPRODUCTIVE SERVICES, AND SHERWOOD C. LYNN, JR., M.D., PAMELA J. RICHTER, D.O., AND LENDOL L. DAVIS, M.D. (ON BEHALF OF THEMSELVES AND THEIR PATIENTS), PLAINTIFFS,	§	
V.	§	CAUSE NO. 1:14-CV-284-LY
DAVID LAKEY, M.D. AND MARI ROBINSON (IN THEIR OFFICIAL CAPACITIES), DEFENDANTS.	§	

ORDER

Before the court in the above-styled and numbered cause are Defendants' Motion to Dismiss filed May 2, 2014 (Clerk's Doc. No. 48), Plaintiffs' Memorandum of Law in Opposition to Defendants' Motion to Dismiss filed May 19, 2014 (Clerk's Doc. No. 57), and Defendants' Reply Brief Supporting Defendants' Motion to Dismiss filed May 29, 2014 (Clerk's Doc. No. 63). Defendants (hereafter "the State") move to dismiss Plaintiffs' complaint for failure to state a claim upon which relief may be granted. *See* Fed. R. Civ. P. 12(b)(6). Having reviewed the motion, response, reply, pleadings, and applicable law, the court will grant in part and deny in part the State's motion.

I. Background

Plaintiffs Whole Woman's Health, Austin Woman's Health Center, Killeen Woman's Health Center, Nova Health Systems d/b/a Reproductive Services, Dr. Sherwood Lynn, Jr., Dr. Pamela Richter, and Dr. Lendol Davis (collectively "Plaintiffs") bring this action on behalf of themselves and their patients. Plaintiffs seek declaratory and injunctive relief relating to two requirements of Texas law imposed by Texas House Bill No. 2 ("House Bill 2" or "the Act") and the Act's implementing regulations. Act of July 12, 2013, 83rd Leg., 2nd C.S., ch. 1, Tex. Gen. Laws; 38 Tex. Reg. 9577-93 (adoption of proposed rules). The Act's "admitting-privileges requirement" provides 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 located not further than 30 miles from the location at which the abortion is performed or induced." Act, § 2 (codified at Tex. Health & Safety Code § 171.0031); 25 Tex. Admin Code §§ 139.539(c), 139.56(a). The "ambulatory-surgical-center requirement" provides, in relevant part, that by September 1, 2014, "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Act, § 4 (codified at Tex. Health & Safety Code § 245.010(a)); 25 Tex. Admin Code § 139.40.

The admitting-privileges requirement was the subject of a pre-enforcement facial challenge brought by several abortion providers, including some of the plaintiffs in this case. This court permanently enjoined the requirement on October 28, 2013. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F.Supp.2d 891 (W.D. Tex. 2013). The United States Court of Appeals for the Fifth Circuit stayed the injunction and ultimately reversed, in part, this court's judgment, finding that the admitting-privileges requirement is constitutional on its face. *Planned*

Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583 (5th Cir. 2014).

In the present case, Whole Woman's Health and Dr. Lynn challenge the admitting-privileges requirement as applied to the abortion facility operated by Whole Woman's Health in McAllen, Texas (the "McAllen clinic"). Nova Health Systems and Dr. Richter challenge the admitting-privileges requirement as applied to the abortion facility operated by Nova Health Systems in El Paso, Texas (the "El Paso clinic"). All plaintiffs challenge the ambulatory-surgical-center requirement on its face, Whole Woman's Health and Dr. Lynn challenge the ambulatory-surgical-center requirement as applied to the McAllen Clinic, and Nova Health Systems and Dr. Richter challenge the ambulatory-surgical-center requirement as applied to the El Paso Clinic.

Specifically, Plaintiffs allege that: (1) as applied to the McAllen and El Paso clinics, the admitting-privileges requirement violates the Due Process Clause of the Fourteenth Amendment with regard to women in the Rio Grande Valley and West Texas; (2) as applied to the McAllen and El Paso clinics, the admitting-privileges requirement violates the Equal Protection Clause of the Fourteenth Amendment with regard to the Plaintiffs and their patients in the Rio Grande Valley and West Texas; (3) as applied to the McAllen and El Paso Clinics the admitting-privileges requirement improperly delegates lawmaking authority in violation of the Due Process Clause of the Fourteenth Amendment; (4) as applied to the McAllen and El Paso clinics and the provision of medical abortion at those clinics, the admitting-privileges requirement constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment; (5) the ambulatory-surgical-center requirement with regard to all women in Texas and, as applied to the McAllen and El Paso clinics specifically, with regard to women in the Rio Grande Valley and West Texas, violates the Due Process Clause of the Fourteenth Amendment; (6) the ambulatory-surgical-center

requirement violates the Equal Protection Clause of the Fourteenth Amendment with regard to the Plaintiffs and their patients; and (7) the ambulatory-surgical-center requirement, on its face and as applied to the provision of medical abortion, constitutes arbitrary and unreasonable State action in violation of the Due Process Clause of the Fourteenth Amendment.

The State argues that Plaintiffs' complaint fails and should be dismissed. Specifically, the State argues that each of the Plaintiffs' challenges to the admitting-privileges requirement and the ambulatory-surgical-center requirement are barred by *res judicata*. The State also argues that the Fifth Circuit's ruling in *Planned Parenthood of Greater Texas* forecloses the McAllen and El Paso clinics' as-applied Due Process challenges to the admitting-privilege requirement. 748 F.3d 583 (5th Cir. 2014). The State further asserts that the Plaintiffs' Equal Protection and Unlawful Delegation claims fail due to binding precedent. The State also argues that the "arbitrary and unreasonable state action" challenges in Plaintiffs' complaint fail because there is no constitutional right to be free from "arbitrary and unreasonable state action." Instead, the State asserts, *Planned Parenthood of Greater Texas* establishes that the admitting-privileges and ambulatory-surgical-center requirements withstand rational basis review. Additionally, the State argues that the Plaintiffs' facial challenge to the ambulatory-surgical-center requirement must be dismissed both because the Plaintiffs lack third-party standing to assert other providers' patients' rights and in light of the Act's severability clause. Finally, the State argues that the Plaintiffs cannot assert third-party rights under Title 42, United States Code Section 1983 or the Declaratory Judgment Act.

II. Legal Standard

The Federal Rules of Civil Procedure allow for dismissal of an action "for failure to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). When evaluating a motion to dismiss, the court must liberally construe the complaint in favor of the plaintiff, and all facts pleaded must be taken as true. *Leatherman v. Tarrant Cnty. Narcotics Intelligence & Coordination Unit*, 507 U.S. 163, 164 (1993); *Baker v. Putnal*, 75 F.3d 190, 196 (5th Cir. 1996). A pleading need only contain a "short and plain statement of the claim showing that the pleader is entitled to relief," Fed. R. Civ. P. 8, but the standard demands more than "a formulaic recitation of the elements of a cause of action," or "naked assertion[s]" devoid of "further factual enhancement." *Bell Atl. v. Twombly*, 550 U.S. 544, 555–57 (2007). Rather, a complaint must contain sufficient factual matter, accepted as true, to "state a claim to relief that is plausible on its face." *Id.* at 570. The court considers the complaint in its entirety, together with "documents incorporated into the complaint by reference, and matters of which a court may take judicial notice." *Funk v. Stryker Corp.*, 631 F.3d 777, 783 (5th Cir. 2011) (quoting *Tellabs Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007)).

The plausibility standard is not a "probability requirement," but does impose a standard higher than "a sheer possibility that a defendant has acted unlawfully." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). Although "a court must accept as true all of the allegations contained in a complaint," that tenet is inapplicable to legal conclusions, and "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Id.* "Determining whether a complaint states a plausible claim for relief will . . . be a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." *Id.* at 679. Thus, in considering a motion to dismiss, the court must initially identify pleadings that are no more than

legal conclusions not entitled to the assumption of truth, then assume the veracity of well-pleaded factual allegations and determine whether those allegations plausibly give rise to an entitlement to relief. If not, "the complaint has alleged—but it has not 'show[n]'—'that the pleader is entitled to relief.'" *Id.* (quoting Fed. R. Civ. P. 8(a)(2)).

III. Discussion

A. Claim Preclusion

"Claim preclusion, or *res judicata*, bars the litigation of claims that either have been litigated or should have been raised in an earlier suit." *In re Southmark Corp.*, 163 F.3d 925, 935 (5th Cir. 1999). The doctrine "prevents litigation of all grounds for, or defenses to, recovery that were previously available to the parties, regardless of whether they were asserted or determined in the prior proceeding." *Brown v. Felsen*, 442 U.S. 127, 131 (1979). In the Fifth Circuit, the test for *res judicata* has four elements: (1) the parties are identical or in privity; (2) the judgment in the prior action was rendered by a court of competent jurisdiction; (3) the prior action was concluded by a final judgment on the merits; and (4) the same claim or cause of action was involved in both actions. *Petro-Hunt, L.L.C. v. United States*, 365 F.3d 385, 395 (5th Cir. 2004). The only point of contention applicable to this case concerns the final element.

The Fifth Circuit has adopted the transactional test of Section 24 of the Restatement (Second) of Judgments to determine whether two suits involve the same claim or cause of action. *Id*; *see also Southmark Properties v. Charles House Corp.*, 742 F.2d 862 (5th Cir. 1984). Under the Restatement, what constitutes a "transaction" is "to be determined pragmatically, giving weight to such considerations as whether the facts are related in time, space, origin, or motivation, whether

they form a convenient trial unit, and whether their treatment as a unit conforms to the parties' expectations or business understanding or usage." Restatement (Second) of Judgments § 24. The Restatement also provides that

> [m]aterial operative facts occurring after the decision of an action with respect to the same subject matter may in themselves, or taken in conjunction with the antecedent facts, comprise a transaction which may be made the basis of a second action not precluded by the first. . . . Where important human values—such as the lawfulness of a continuing personal disability or restraint—are at stake, even a slight change of circumstances may afford a sufficient basis for concluding that a second action may be brought.

Id. at comment (f). Underlying the pragmatic standard "is the need to strike a delicate balance between, on the one hand, the interests of the defendant and of the courts in bringing litigation to a close and, on the other, the interest of the plaintiff in the vindication of a just claim." *Id.* at comment (b).

The State alleges that the Plaintiffs are barred from all of their claims by *Planned Parenthood of Greater Texas*, because the claims "arise from the same transaction litigated in the earlier proceeding." The State also argues that all claims asserted in this lawsuit could have been brought in that proceeding. The court disagrees. The doctrine of *res judicata* "is to be invoked only after careful inquiry." *Felsen*, 442 U.S. at 132. Giving appropriate weight to the factors outlined in the Restatement and the Restatement's comments, the court strikes the balance in favor of Plaintiffs.

Construing the pleaded facts in the light most favorable to Plaintiffs, Plaintiffs' as-applied challenge to the admitting-privileges requirement relies on facts that occurred after judgment was rendered in the previous lawsuit and that were not considered by either this court or the appellate court. *Planned Parenthood of Greater Texas*, 748 F.3d at 599 n.14 ("To the extent that the State and [Plaintiffs] rely on developments since the conclusion of the bench trial . . . [the court did] not

consider any arguments based on those facts, nor [did the court] rely on any facts asserted in amicus briefs."). In particular, it was not known in late October 2013 that the McAllen and El Paso clinics' physicians would ultimately be unable to obtain admitting privileges despite efforts to secure them. Neither was known the impact of that reality on the clinics' patients' access to previability abortions. The McAllen clinic physicians did not receive notice that they had been denied admitting-privileges until November or December 2013, after the final judgment in *Planned Parenthood of Greater Texas*. The El Paso clinic physician received notice that her temporary privileges would not be extended in February 2014. Plaintiffs plead additional facts that could not have been known at the time of the prior judgment which, if assumed to be true, tend to demonstrate the effect of the admitting-privileges requirement as applied to patients of the clinics. For example, Plaintiffs state that after abortion services ceased in McAllen, health professionals observed an increase in patients from the Rio Grande Valley who had attempted self-abortion without the assistance of a physician.

Plaintiffs' claims regarding the ambulatory-surgical-center requirement are likewise not precluded by *res judiciata*. Regulations implementing the ambulatory-surgical-center requirement were not finalized until late December 2013. 38 Tex. Reg. 9577-93 (Dec. 27, 2013). The Plaintiffs could not have known the extent of the enforcement nor the nature of the regulations governing the ambulatory-surgical-center requirement until after judgment in *Planned Parenthood of Greater Texas*. Moreover, despite being passed as part of an omnibus act, enforcement of the ambulatory-surgical-center requirement is distinct from the admitting-privileges requirement and is not part of the same "transaction, or series of connected transactions." *Petro-Hunt, L.L.C.*, 365 F.3d at 395. As the Plaintiffs' argue, "the [ambulatory-surgical-center] requirement operates independently from the other requirements in the Act, as evidenced by [the requirement's] separate effective date and

the need for implementing regulations to give it effect."

In sum, Plaintiffs' claims in this case are not precluded by *res judicata* because those claims are not "the same claim or cause of action" that was brought in the earlier lawsuit. *Id.* In a case such as this, "where important human values . . . are at stake," the pleaded facts afford the court "a sufficient basis for concluding that a second action may be brought." Restatement (Second) of Judgments § 24, comment (f).

B. Undue-Burden Challenges to the Admitting-Privileges Requirement

The State argues that *Planned Parenthood of Greater Texas* also forecloses the Plaintiffs' undue-burden challenges to the admitting-privileges requirement. Specifically, the State claims that the court's conclusion that "an increase of travel of less than 150 miles for some women is not an undue burden under *Casey*" settles the question with regard to the McAllen clinic as a matter of law. 748 F.3d at 598. The State argues that Plaintiffs' claims are thus collaterally estopped. The State further asserts that the facts alleged in Plaintiffs' undue-burden challenge with regard to the El Paso clinic are "not plausible" and cannot sustain a claim for relief.

Collateral estoppel prevents a party from relitigating an issue raised in an earlier action if (1) the issue at stake is identical to the one involved in the earlier action; (2) the issue was actually litigated in the prior action; and (3) the determination of the issue in the prior action was a necessary part of the judgment in that action. *Petro-Hunt, L.L.C.*, 365 F.3d at 397. "Collateral estoppel does not preclude litigation of an issue unless both the facts and the legal standard used to assess them are the same in both proceedings." *Copeland v. Merrill Lynch & Co., Inc.*, 47 F.3d 1415, 1422 (5th Cir. 1995).

In *Planned Parenthood of Greater Texas*, this court and the Fifth Circuit considered, in part, the merits of a total facial invalidation of the Act's admitting-privileges requirement. The Fifth Circuit, in examining the effect of presumed clinic closures resulting from the admitting-privileges requirement, considered the statute in context of women throughout Texas. *Planned Parenthood of Greater Texas*, 748 F.3d at 600 ("[The record] demonstrates that if the admitting-privileges regulation burdens abortion access by diminishing the number of doctors who will perform abortions and requiring women to travel farther, the burden does not fall on the vast majority of Texas women seeking abortions. Put otherwise, the regulation will not affect a significant (much less "large") fraction of such women, and it imposes on other women in Texas less of a burden than the waiting-period provision upheld in *Casey*."). In other words, women in the Rio Grande Valley who may have to travel distances up to 150 miles do not constitute a large enough fraction of potential previability abortion patients in Texas to justify invalidating the statute under *Casey*. *Planned Parenthood of Southeast Pa. v. Casey,* 505 U.S. 833, 895 (1992). However, neither court considered the question of an allegedly undue burden resulting from the application of the admitting-privileges requirement to a specific clinic or patient population. The Plaintiffs' undue-burden claims as applied to the McAllen clinic survive the State's motion to dismiss.

Similarly, the El Paso clinic's as-applied challenge was not previously considered by this court and is not precluded by *Planned Parenthood of Greater Texas*. The court does not find that Plaintiffs' alleged claims are implausible, nor does the court find merit in the State's argument that women in West Texas can travel to New Mexico to obtain abortion services. *See Jackson Women's Health Organization v. Currier*, 13-60599, – F.3d –, 2014 WL 3730467, *10 (5th Cir. July 29, 2014) (holding that availability of abortion services in neighboring state is not proper consideration for

purposes of undue-burden analysis). The court concludes that Plaintiffs' undue-burden claims as applied to the El Paso clinic are plausible and survive the State's motion to dismiss.

C. Equal Protection Claims

The State argues that Plaintiffs' Equal Protection challenges to the ambulatory-surgical-center requirement and the admitting-privileges requirement fail because "it has long been settled that States may impose abortion-specific regulations without extending those requirements to other medical procedures." Further, the State asserts, the requirements do not draw any classification that triggers heightened scrutiny. The State also argues that the Fifth Circuit held that the admitting-privileges requirement survives rational-basis review. *Planned Parenthood of Greater Texas*, 748 F.3d at 596; *see also Jackson Women's Health Organization*, 2014 WL 3730467 at *5.

Plaintiffs' arguments to the contrary are unavailing. There is no constitutional requirement that a statutory distinction be "directly related" to the State's interest. *See Heller v. Doe*, 509 U.S. 312, 321 (1993) ("[C]ourts are compelled under rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends."). Specifically, when analyzing the rational basis of the Act, the Fifth Circuit noted that "[t]he fact that reasonable minds can disagree on legislation, moreover, suffices to prove that the law has a rational basis." *Planned Parenthood of Greater Texas*, 748 F.3d at 594. Despite Plaintiffs' attempts to distinguish it, the Supreme Court's approval of regulations that apply only to abortion procedures and that are not equally applied to other medical procedures informs this court's decision. *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 67 (1976). For these reasons, Plaintiffs' Equal Protection claims with regard to both requirements cannot succeed and will be dismissed.

D. Unlawful-Delegation Claims

The State asserts that the Fifth Circuit addressed the question of unlawful delegation with regard to the admitting-privileges requirement when it stated:

> The requirement that physicians performing abortions obtain surgical privileges, which involves the independent action of a public or private hospital, poses no more significant threat to plaintiffs' due process rights than the requirement that those performing abortions be licensed physicians, which involves the independent action of a medical licensing board.

Planned Parenthood of Greater Texas, 748 F.3d at 600. Plaintiffs' arguments that the requirement could be proper in some circumstances but not all circumstances does not persuade the court or surmount the plausibility standard. Plaintiffs cannot succeed on this claim in the face of the Fifth Circuit's *Planned Parenthood of Greater Texas* holding. Plaintiffs' unlawful-delegation claims will be dismissed.

E. "Arbitrary and Unreasonable State Action" Claims

Although not clear from the pleadings, the court construes Plaintiffs' claims involving "arbitrary and unreasonable state action" to be claims relating to the rationality of both requirements–the admitting-privileges requirement as applied to the McAllen and El Paso Clinics and the ambulatory-surgical-center requirement on its face and as applied to the two clinics. The claims also encompass the rationality of both requirements on the provision of medical abortions. Plaintiffs do not direct the court to any precedent that guarantees a specific constitutional right to be free from arbitrary and unreasonable state action, nor do they respond directly to the State's arguments that there is no such right. The court concludes that the Plaintiffs' claims contest the rational basis of the requirements contained in the Act.

There is a rational connection between the admitting-privileges requirement and the State's goals. *Planned Parenthood of Greater Texas*, 748 F.3d at 594 ("[T]he State's articulation of rational legislative objectives . . . easily supplied a connection between the admitting-privileges rule and the desirable protection of abortion patients' health."). The same analysis applies to legislative objectives with regard to the ambulatory-surgical-center requirement and the State's purported interests in enacting the requirement. In light of *Planned Parenthood of Greater Texas*, it is not plausible that any facts, construed in the light most favorable to Plaintiffs, would result in a finding that either requirement fails rational-basis review, either as-applied or on its face. For this reason, Plaintiffs' claims involving "arbitrary and unreasonable state action" will be dismissed.

F. Ambulatory-Surgical-Center Requirement Claims

The State maintains that the Act's severability clause requires Plaintiffs' facial challenge to the ambulatory-surgical-center requirement to be "rejected out of hand." It is well settled that "[f]ederal courts are bound to apply state law severability provisions." *Planned Parenthood of Greater Texas*, 748 F.3d at 589. However, the existence of such a provision does not preclude a plaintiff from challenging a state law's constitutionality on its face. *Id.* ("Even *when considering facial invalidation of a state statute*, the court must preserve the valid scope of the provision to the greatest extent possible.") (emphasis added). To conclude otherwise would strike at the heart of this nation's principles of constitutional federalism. The question of appropriate remedy comes at the conclusion of the trial on the merits. The court will not reject "out of hand" Plaintiffs' facial challenge.

The State also asserts that Plaintiffs lack third-party standing to assert the rights of other providers' patients. In light of long-standing precedent tacitly acknowledging third-party standing for abortion providers who challenge the validity of abortion regulations, and the Fifth Circuit's finding third-party standing in *Planned Parenthood of Greater Texas*, this court concludes that Plaintiffs here have third-party standing to bring a facial challenge to the ambulatory-surgical-center requirement. *Id.*

Finally, the State argues that Plaintiffs' undue-burden claims, both facial and as-applied, cannot be sustained because Title 42 United States Code, Section 1983 and the Declaratory Judgment Act only extend to litigants who assert their own rights. That many challenges to abortion regulations have been successfully pursued under Section 1983 does not deter the State's position. *See, e.g. Planned Parenthood of Se. Pa. v. Casey*, 744 F. Supp. 1323 (E.D. Pa. 1990); *Planned Parenthood of Greater Texas*, 951 F. Supp. 2d 891 (W.D. Tex. 2013). This court finds the State's argument unpersuasive and will not adopt its reading of Section 1983 or the Declaratory Judgment Act.

III. Conclusion

For the reasons discussed above, several of Plaintiffs' claims survive the State's motion to dismiss and several do not. Accordingly,

IT IS HEREBY ORDERED that the State Defendants' Motion to Dismiss (Clerk's Doc. No. 48) is **GRANTED IN PART** to the following extent: (1) Plaintiffs' challenges to the admitting-privileges requirement and the ambulatory-surgical-center requirement under the Equal Protection Clause of the Fourteenth Amendment are **DISMISSED**; (2) Plaintiffs' improper delegation of

lawmaking authority claims are **DISMISSED**; (3) Plaintiffs' claims that both requirements constitute arbitrary and unreasonable state action are **DISMISSED**. In all other respects, the State's motion is **DENIED**.

Remaining for trial are the Plaintiffs' claims that (1) the admitting-privileges requirement, as-applied to the McAllen and El Paso clinics, violates the Due Process Clause of the Fourteenth Amendment with regard to women in the Rio Grande Valley and West Texas, and (2) the ambulatory-surgical-center requirement, facially in regard to all Texas women and, as applied to the McAllen and El Paso clinics specifically, in regard to women in the Rio Grande Valley and West Texas, violates the Due Process Clause of the Fourteenth Amendment.

SIGNED this 1st day of August, 2014

LEE YEAKEL
UNITED STATES DISTRICT JUDGE

I

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

WHOLE WOMAN'S HEALTH; *et al.*,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
Defendants.	)	

PLAINTIFFS' PROPOSED FINDINGS OF FACTS AND CONCLUSIONS OF LAW

FINDINGS OF FACT

The Act

1. Texas House Bill No. 2 ("the Act"), H.B. 2, 83rd Leg., 2nd Called Sess. (Tex. 2013), was signed into law on July 18, 2013.

2. The Act targets abortion providers for the imposition of unique regulatory burdens that are not imposed on any other health care providers in Texas, are inconsistent with accepted medical standards, impose costs that are far in excess of any potential benefits, and will dramatically reduce the number and geographic distribution of medical facilities in the State where women can access safe and legal abortion services.

3. These regulatory burdens include the "admitting privileges requirement," which provides, in relevant part, 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 located not further than 30 miles from the location at which the abortion is performed or induced," Act, § 2 (codified at Tex. Health & Safety Code Ann. § 171.0031); 25 Tex. Admin Code §§139.53(c), 139.56(a), and the "ASC requirement," which provides, in relevant part, that "the minimum

standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Act, § 4 (Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40.

4. The admitting privileges requirement is currently in effect.

5. The ASC requirement is scheduled to take effect on September 1, 2014.

6. Prior to the passage of the Act, there were over three dozen licensed abortion clinics in Texas. Since the admitting privileges requirement has taken effect, that number has dropped significantly. If the ASC requirement is permitted to take effect, there will be fewer than ten abortion clinics in the State, clustered in four metropolitan areas in the eastern part of the State, with no clinics west or south of San Antonio.

The Parties

7. Plaintiff Whole Woman's Health has been providing high quality reproductive health care services, including abortion services, to Texas women for over a decade. It currently operates licensed abortion facilities in Fort Worth and San Antonio. In addition, it operates a licensed ASC in San Antonio. Until recently, Whole Woman's Health also operated licensed abortion facilities in Austin, Beaumont, and McAllen (the "McAllen clinic"). These facilities closed as a result of the admitting privileges and ASC requirements. If those provisions were enjoined, Whole Women's Health would reestablish licensed abortion facilities in Austin and McAllen.

8. Plaintiff Sherwood C. Lynn, Jr., M.D., is a board-certified obstetrician-gynecologist ("ob-gyn") licensed to practice medicine in the State of Texas. He has over 35 years of experience providing reproductive health care, including abortion care. He serves as the Medical Director of Whole Woman's Health's licensed abortion facility and ASC in San Antonio,

and he seeks to provide abortion services at the McAllen clinic.

9. Plaintiff Austin Women's Health Center operates a licensed abortion facility in Austin. Until recently, its sister clinic, Plaintiff Killeen Women's Health Center operated a licensed abortion facility in Killeen. That facility closed because it could not meet the ASC requirement. If that provision were enjoined, Killeen Women's Health Center would reopen. Together, Austin Women's Health Center and Killeen Women's Health Center (collectively, the "Health Centers") have provided high quality reproductive health care services, including abortion services, to Texas women for over 35 years.

10. Plaintiff Lendol L. "Tad" Davis, M.D., is a board-certified ob-gyn licensed to practice medicine in the State of Texas. He has over 35 years of experience providing reproductive health care, including abortion care. He serves as the Medical Director of Austin Women's Health Center and served as the Medical Director of the Killeen Women's Health Center before it closed.

11. Until recently, Plaintiff Nova Health Systems d/b/a Reproductive Services ("Reproductive Services") operated a licensed abortion facility in El Paso (the "El Paso clinic"). That facility closed because it could not meet the admitting privileges requirement or the ASC requirement. The El Paso clinic provided high-quality reproductive health care services, including abortion services, to Texas women for over 35 years. If the admitting privileges and ASC requirements were enjoined, Reproductive Services would reestablish a licensed abortion facility in El Paso.

12. Plaintiff Pamela J. Richter, D.O., is a board-eligible family medicine doctor licensed to practice medicine in the State of Texas. She has been providing reproductive health care, including abortion care, for over 20 years. She served as Medical Director of the El Paso clinic and would like to resume that role.

13. 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 the Act challenged here. Commissioner Lakey is sued in his official capacity.

14. 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. Ms. Robinson is sued in her official capacity.

Safety of Legal Induced Abortion in the United States

15. There are generally two methods of performing abortions in the United States: surgical abortion, which involves the use of medical instruments to evacuate the contents of the uterus; and medical abortion, which involves the administration of medications that cause the termination of a pregnancy. Both types of abortion are extremely safe.

16. The mortality rate for legal induced abortion in the United States is quite low and has declined over time. In 1973-1979, following the Supreme Court's decision in *Roe v. Wade*, the U.S. Centers for Disease Control and Prevention ("CDC") estimated this rate as 2.09 deaths per 100,000 procedures. The risk subsequently dropped and has been stable at the current rate, of approximately 0.69 deaths per 100,000 legal abortions, for the past 30 years.

17. To put this risk in context, it is important to consider that, nationwide, the mortality rate from childbirth is roughly 14 times higher than the mortality rate from abortion. Texas' maternal mortality rate is significantly higher than the national average.

18. Serious complications from abortion are rare and seldom require hospitalization.

19. Many procedures commonly performed in office-based settings are comparable in safety to abortion or entail greater risks. Such procedures include dilation and curettage,

colonoscopy, cystoscopy, and plastic surgery.

20. Although legal induced abortion is extremely safe throughout pregnancy, the medical risks of abortion increase with gestational age. Thus, women who are delayed in accessing abortion care are exposed to increased risks.

Management of Abortion-Related Complications

21. Some complications of abortion may occur during or shortly after a surgical abortion procedure, or they may be recognized at a follow-up appointment at the abortion facility. Such complications can almost always be managed at the abortion facility itself. Complications requiring that a patient be sent from an abortion facility to a hospital are very rare.

22. Abortion complications may also present when the patient is at home. This is almost universally true of acute complications of medical abortion because the medications used to induce the abortion take time to exert their effects. Complications occurring out of the office are rarely emergencies and can almost always be managed on an outpatient basis, either at the abortion facility or at another outpatient point of care.

The Admitting Privileges Requirement is Inconsistent with Accepted Medical Practice

23. It is common and acceptable medical practice for a physician practicing in an outpatient setting to refer patients to a hospital at which the physician does not have admitting privileges. It does not enhance patient safety when physicians practicing in outpatient settings maintain admitting privileges. In fact, the trend in medicine is toward bifurcation of outpatient practice and hospital-based practice, such that physicians are increasingly specializing in one type of practice setting or the other. Coordination and continuity of care of a patient that is transferred from an outpatient setting to a hospital are achieved through communication between the physician referring the patient to the hospital and the physician treating the patient at the hospital. This is

standard medical practice.

24. Accordingly, the nation's leading accreditation bodies and medical associations—including the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Surgeons, the American Society of Anesthesiologists, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, and the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations or "JCAHO")—recognize that admitting privileges at a local hospital are not required for the safe performance of outpatient procedures. In addition, the Clinical Policy Guidelines of the National Abortion Federation do not require abortion providers to maintain admitting privileges at a local hospital.

25. On those rare occasions when a patient who has had an abortion requires hospitalization, the quality of care that she receives at the hospital would not be affected by whether her abortion provider has admitting privileges there. Upon the patient's arrival at the hospital via ambulance, an emergency room physician will evaluate the patient and consult with other specialists at the hospital as necessary. The patient may require admission to the hospital, or she may simply be treated in the emergency room and then released. Either way, continuity of care can be maintained by direct communication between the abortion provider and the emergency room physician, regardless of whether the abortion provider has admitting privileges at the hospital.

26. Moreover, in many of the cases in which a patient experiences a complication following an abortion procedure, the complication does not arise until after the abortion patient has been discharged from the clinic and returned home. If a woman experiences a complication that requires hospital treatment after she has returned home following an abortion procedure, it

would be safest for her to seek treatment at the hospital nearest to her home. Thus, a woman who lives more than 30 miles away from an abortion clinic should not travel back to the vicinity of the clinic in the event of an emergency to obtain hospital treatment; she should, instead, seek treatment at the emergency room nearest to her present location.

After Providing Safe Abortion Care for Decades, the McAllen and El Paso Clinics Were Forced to Close as a Result of the Admitting Privileges Requirement

27. Prior to its recent closure, the McAllen clinic had operated continuously since January 2004. The McAllen clinic provided abortion services up to 16 weeks of pregnancy. The highest level of sedation offered to patients was moderate sedation/analgesia, also known as conscious sedation. In addition to abortion services, the McAllen clinic provided a variety of gynecological and family planning services to women in the Rio Grande Valley, including diagnosis and treatment of sexually transmitted infections, provision of contraceptives, pregnancy testing, and diagnosis and treatment of abnormal pap smears. The McAllen clinic also provided referrals to help interested women place their children for adoption.

28. Prior to its closure, the McAllen clinic had an emergency protocol in place to protect the health of a patient in the rare event that she required transfer to a hospital. The protocol ensured continuity of the patient's care by requiring the physician who performed the patient's abortion to speak directly to the staff at the hospital emergency room and requiring clinic staff members to provide the patient's medical records to the emergency medical services team responsible for transporting the patient to the hospital. In addition, the McAllen clinic ensured that all of its physicians maintained agreements with back-up physicians who had admitting privileges at a local hospital. This was a requirement of Texas law before the admitting privileges requirement was enacted. *See* 25 Tex. Admin. Code § 139.56(a) (2012).

29. During the past ten years, the McAllen clinic provided abortion services to over

14,000 patients. Only two of these patients required transfer from the clinic to a hospital. In both cases, the patients were successfully treated at the hospital.

30. After the admitting privileges requirement was enacted, four physicians affiliated with Whole Woman's Health, including Dr. Lynn, sought to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic. All four physicians are board-certified ob-gyns with years of experience performing abortion procedures, and three of them maintain admitting privileges at hospitals in other parts of the State. One of the four physicians who sought admitting privileges in McAllen is Dr. Lynn, who currently serves as the Medical Director of Whole Woman's Health's licensed abortion facility and ambulatory surgical center in San Antonio. Dr. Lynn has admitting privileges at hospitals in San Antonio and Austin.

31. There are eight hospitals located within 30 miles of the McAllen clinic. Each of them requires, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. The designated alternate physician must already have admitting privileges at the hospital. If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other requirements. Only one eligible physician was willing to serve as a designated alternate physician for the doctors affiliated with the McAllen clinic, and this physician only has privileges at one area hospital: Doctors Hospital at Renaissance. The other eligible physicians approached by the clinic expressed concern about retaliation from the hospitals at which they had admitting privileges and the possibility that their privileges would be revoked or discontinued if they facilitated the application of a known abortion provider.

32. Thus, the physicians affiliated with the McAllen clinic were only able to satisfy the

application criteria for Doctors Hospital at Renaissance. At this hospital, the first step in applying for admitting privileges is to submit a written request for an application for admitting privileges. In September 2013, all four physicians submitted such requests. Two months later, each of the physicians received a letter in response stating that, based on the recommendation of the hospital's Credentials Committee, the Medical Executive Committee was denying the physician's request for an application for privileges. Each letter further stated that the Board of Governors had considered the request and decided not to extend an application "as authorized under the Bylaws and Rules and Regulations of the Medical Staff for the Hospital." The letters noted that the "decision of the Governing Board was not based on clinical competence consideration." The letters provided no other explanation as to why each of the four physicians was denied the opportunity even to apply for admitting privileges at the hospital.

33. Despite extensive efforts, Whole Woman's Health has also been unsuccessful in recruiting physicians who already possess admitting privileges at a hospital within 30 miles of the McAllen clinic to provide abortion services at the clinic. Physicians have cited several reasons for declining recruitment offers from Whole Woman's Health: Many are worried about their personal safety and the safety of their families. Harassment and threats of violence have been a particular problem at the McAllen clinic, leading to a recent investigation by the Federal Anti-Terrorism Task Force and Department of Justice. In addition, some physicians are concerned about the hostile regulatory environment in Texas and potential exposure to criminal liability. Some also express concern about retaliation by hospital administrators and other medical professionals who are opposed to abortion.

34. In light of the foregoing, the McAllen clinic has been unable to comply with the admitting privileges requirement. It was forced to stop providing abortion services after the

requirement took effect on October 31, 2013. For four months, the McAllen clinic continued to provide non-abortion services, but the revenue from these services was not sufficient to offset the clinic's expenses, including its mortgage, utilities, and personnel expenses. By March 2014, continued operation of the McAllen clinic had become financially unsustainable, and it closed its doors on March 6, 2014.

35. Currently, there are no licensed abortion facilities in the Rio Grande Valley.

36. Prior to its recent closure, the El Paso clinic had operated continuously since 1977. It provided abortion services up to 16 weeks of pregnancy, as well as a variety of other gynecological and family planning services including well-woman examinations; diagnosis and treatment of sexually transmitted infections, provision of contraceptives, and pregnancy testing. It also worked with Adoption Affiliates, an organization formed by the principals of Reproductive Services, to help interested women place their children for adoption. The highest level of sedation used at the El Paso clinic was minimal sedation.

37. The El Paso clinic had a protocol in place for responding to a medical emergency requiring patient transport to a nearby hospital, and ensured that Dr. Richter maintained an agreement with a backup physician with admitting privileges at a local hospital. During the past ten years, the El Paso clinic has not experienced a single medical emergency requiring a hospital transfer; over 17,000 abortions have been performed there during that time.

38. The only physician who provides abortion services at the El Paso clinic is Dr. Richter. She is a board-eligible family medicine physician licensed to practice medicine by the State of Texas. She has over two decades of experience providing abortion care in Texas. In addition to her work at the El Paso clinic, Dr. Richter also works for the State of Texas. She serves as a staff physician for the state supported living center ("State Center") in El Paso operated by

the Texas Department of Aging and Disability Services ("DADS"). There, she provides general medical care and gynecological services to people with intellectual and developmental disabilities who are medically fragile or have behavioral problems. Previously, from 1990 to 2001, Dr. Richter maintained a private family medicine practice in El Paso.

39. From 1990 to 2009, Dr. Richter was board certified in family medicine. She did not seek recertification after 2009 because the nature of her practice did not require board certification. Dr. Richter maintained admitting privileges at Del Sol Medical Center in El Paso from January 1990 to May 2003. One of the criteria for maintaining admitting privileges at that hospital is admitting a minimum number of patients to the hospital each year. After Dr. Richter closed her private practice in 2001, she was no longer able to admit the requisite number of patients to the hospital. As a result, she was forced to relinquish her privileges in 2003.

40. After passage of the admitting privileges requirement, Dr. Richter sought to obtain admitting privileges at a hospital within 30 miles of the El Paso clinic. There are seven such hospitals, belonging to four different hospital groups. Dr. Richter was granted temporary admitting privileges by one hospital, Foundation Surgical Hospital of El Paso, but to date has been unable to obtain permanent admitting privileges at any hospital.

41. Dr. Richter has begun taking the steps necessary to become board certified again. To do so, she must take the board exam in family medicine. She has registered to take the exam during the next available testing period, which is November 2014. But even if Dr. Richter became board certified again, she would likely be unable to maintain active admitting privileges at an El Paso-area hospital because she would not be able to admit the requisite number of patients per year.

42. Reproductive Services has been unable to recruit a physician who has admitting

privileges at a hospital within 30 miles of the El Paso clinic to provide abortion services at the clinic.

43. As a result of the admitting privileges requirement, Reproductive Services was forced to close earlier this year.

44. Currently, there is only one licensed abortion facility west of San Antonio, and it will close before September because it cannot satisfy the ASC requirement.

The ASC Requirement is Inconsistent with Accepted Medical Practice

45. It is accepted medical practice for abortion procedures to be performed in office-based settings such as doctor's offices and clinics. Indeed, the vast majority of abortions in Texas and nationwide have been safely performed in such settings for decades.

46. No evidence exists to suggest that abortion is safer when performed in ASCs than when performed in other outpatient settings. In fact, a comparison of complication rates at the clinics and ASC operated by Whole Woman's Health demonstrates that abortion is not safer when performed in an ASC.

47. ACOG's "Guidelines for Women's Health Care" (3d edition) recognize that abortion procedures may appropriately be performed in office-based settings. Indeed, the Guidelines specifically denounce the imposition of "obstacles [to abortion access] such as… facility regulations that are more stringent than for other surgical procedures of similar risk."

48. Many of the minimum ASC standards imposed by Texas law—such as those related to maintenance of a one-way traffic pattern in the facility, segregation of the surgical suite, scrub facilities, detail and finish requirements, air flow and filtration, and humidity control—are geared toward creating and preserving a sterile operating environment. But, like other surgical procedures involving entry into the respiratory, alimentary, genital, or urinary tracts, which are naturally

colonized by bacteria, surgical abortion does not entail an aseptic operating site. Accordingly, precautions aimed at maintaining a sterile environment, beyond basic handwashing and use of sterile instruments, provide no health or safety benefit to abortion patients.

49. The square footage requirement for operating rooms is also unnecessary for the safe provision of abortion care. Unlike more complex surgeries, abortion requires only a small number of medical personnel and small amount of equipment. A procedure room much smaller than 240 square feet can accommodate all of the personnel and equipment needed to perform surgical abortion, including any personnel and equipment that may be needed in the rare event of a medical emergency. The excess space mandated by the ASC standards provides no health or safety benefit.

50. Similarly, heightened staffing requirements for ASCs are geared toward surgeries that are more complex that abortion. Many of the personnel typically needed for those types of surgeries, such as scrub nurses or technicians and circulating nurses, are not needed for abortion procedures.

51. Medical abortion does not involve surgery of any kind. As practiced in Texas, it entails the oral administration of medications—*i.e.*, the patient merely swallows a series of tablets. There is no medical basis for requiring the administration of those medications to take place in a facility designed to ensure sterile surgical conditions.

52. Aside from abortion procedures, Texas law does not limit the type of facility in which any other surgical or medical procedure may be performed. In fact, Texas law expressly permits surgeries involving deep sedation and general anesthesia, which entail much greater risks than abortion procedures, to be performed in office-based settings. *See* 22 Tex. Admin. Code §§ 192.1-192.6.

The ASC Requirement is Inconsistent with Accepted Standards for the Design and Construction of Healthcare Facilities

53. Prevailing standards for the design and construction of various types of buildings, including healthcare facilities, are set forth in model building codes such as the International Building Code ("IBC"), the National Fire Protection Association Life Safety Code ("NFPA 101"), and the Guidelines for Design and Construction of Hospitals and Outpatient Facilities published by the Facility Guidelines Institute ("FGI Guidelines"). These codes are generated by councils composed of individuals with diverse expertise, including fire marshals, code enforcers, engineers, architects, business owners, healthcare professional, developers and other interested and knowledgeable experts.

54. Model building codes are evidence-based; that is, they are based on a continuous and exhaustive process of research that entails gathering data from throughout the nation and around the world. This research is reflected in the publication of revised versions of these codes, typically every three years. Based on evidence concerning a given edition's performance, subsequent editions may make some code provisions stricter, while relaxing or eliminating others that created unnecessary expense while providing no safety benefit.

55. The ASC requirement is inconsistent with the prevailing standards set forth in model building codes in several respects.

56. First, model building codes embody the principle that regulations must balance the protection of life safety with the realities of cost and disruption to services and businesses. Accordingly, as new code editions are published or adopted, it is virtually unheard of that new regulations would be retroactively required of existing businesses or real estate. Rather, existing buildings are typically grandfathered under existing regulations. Similarly, prevailing standards recognize that waivers from specific code requirements should be granted when an alternative

would not pose a threat to public health or safety. But the ASC requirement does not permit licensed abortion facilities to be grandfathered or seek waivers.

57. Second, prevailing standards for healthcare facility construction distinguish between procedures that are performed in an aseptic surgical field and those that are not. Facilities in which the former types of procedures are performed are subject to more rigorous standards because patients undergoing such procedures are at much greater risk of infection. But the ASC requirement fails to make this distinction.

58. Third, under NFPA 101, an outpatient healthcare facility should be treated as a business occupancy if, at any given time, fewer than four patients present in the facility would be incapable of taking action for self-preservation without the assistance of others in the event of an emergency. But the ASC requirement treats all licensed abortion facilities as ambulatory healthcare occupancies regardless of the number of patients who would be incapable of self-preservation in an emergency.

59. Thus, the ASC requirement represents a clear departure from prevailing standards for the design and construction of healthcare facilities.

Although the ASC Requirement Provides No Medical Benefit to Abortion Patients, It Imposes Substantial Costs on Both Patients and Abortion Providers

60. An ASC is far more expensive to acquire and operate than a health care facility that meets existing abortion facility standards.

61. To meet new construction standards, an ASC needs to be at least 7,000 square feet in area.

62. None of the clinics operated by Plaintiffs currently meet the minimum standards for ASCs. None have the wide hallways and large surgical suites required by the ASC minimum standards; none have the HVAC systems. Further, none operate in buildings that are large enough

to be retrofitted to meet ASC standards; most have only half the required square footage.

63. Building a new ASC that is 7,000 square feet in area would cost roughly 2 - 3 million dollars, exclusive of the cost of the property on which the ASC is built.

64. Purchasing an ASC is similarly expensive.

65. As a result of the ASC requirement, the number and geographic distribution of abortion providers in Texas will be greatly diminished.

66. This will increase the cost of abortion services as well as the distances that women must travel to access abortion services. Defendants concede that, after the ASC requirement takes effect, at least 800,000 Texas women of reproductive age will live farther than 150 miles from the nearest abortion provider.

67. The increased costs and travel distances will cause some women to delay accessing abortion care and others to forgo abortion altogether. Both of these outcomes impose health risks on women.

68. Additionally, some women who cannot access legal abortion services will instead attempt self-induction of abortion. During the four month period of time when the McAllen clinic was open but not providing abortion services, clinic staff members encountered a significant increase in the number of women seeking assistance after attempting self-abortion. These women used a variety of methods, including herbal teas, douches, physical trauma to the abdomen, and medications purchased on the black market.

69. Many women in Texas are aware that misoprostol can be used to induce an abortion. This medication is available over-the-counter in Mexico and is widely trafficked in the Rio Grande Valley and West Texas, which both border Mexico. Like any medication obtained on the black market, misoprostol obtained in this way can be counterfeit, inappropriate for a particular

woman's medical needs, or used incorrectly because a woman does not have adequate information.

The Burdens Imposed by the Admitting Privileges and ASC Requirements Will Have the Greatest Impact on Women in the Rio Grande Valley and West Texas

70. Women in the Rio Grande Valley and West Texas are far more likely to be impeded by the need to travel long distances to obtain an abortion than women in other areas of the State because many of them are poor and lack access to reliable transportation and childcare

71. The Rio Grande Valley, comprised of Starr, Hidalgo, Willacy, and Cameron counties along the eastern border of Texas and Mexico, has a population of approximately 1.3 million people. The region is largely rural and a substantial percentage of its residents are poor. The vast majority of people living in the Rio Grande Valley are Latino. Latinos in Texas are three times as likely to live in poverty as white people.

72. Similarly, West Texas is a predominantly rural area with a high level of poverty. Nearly a quarter of the people living in this region are poor, and a third live in households with an annual income of less than $25,000. Much of the Rio Grande Valley and West Texas are designated as medically underserved areas by the federal government because the population has a shortage of health services and faces numerous socioeconomic barriers to health care access. Traveling outside of these regions for health care services is difficult—and for some, impossible—because many residents lack cars or the money to pay for gasoline.

CONCLUSIONS OF LAW

The Admitting Privileges Requirement is Unconstitutional.

A. The Admitting Privileges Requirement Imposes an Undue Burden on Women Seeking Abortion Services at the McAllen and El Paso Clinics.

1. Since its landmark decision in *Roe v. Wade*, 410 U.S. 113 (1973), the Supreme Court has consistently held that the Due Process Clause of the Fourteenth Amendment protects a woman's right to terminate her pregnancy as an exercise of her liberty. *See, e.g., Lawrence v.*

Texas, 539 U.S. 558, 565 (2003); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (opinion of the Court); *Jackson Women's Health Org. v. Currier*, No. 13-60599, slip op. at 8 (5th Cir. July 29, 2014) ("[F]or more than forty years, it has been settled constitutional law that the Fourteenth Amendment protects a woman's basic right to choose an abortion.").

2. In *Casey*, the Court reaffirmed the essential holding of *Roe*, *see Casey*, 505 U.S. at 846, but held that *Roe*'s trimester framework failed to afford sufficient weight to the State's substantial interest in potential life, *id.* at 876 (joint opinion of O'Connor, Kennedy & Souter, JJ.). As a result, the Court replaced the trimester framework with the undue burden standard, which governs this case. *See id.* at 876-77.

3. Pursuant to that standard, states may not impose an undue burden on the right to terminate a pregnancy prior to viability. *See id.* at 876 (joint opinion of O'Connor, Kennedy & Souter, JJ); *Jackson Women's Health Org.*, slip op. at 8. "A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877. "A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Id.* "And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Id.*

4. In addition, an abortion regulation violates due process if it subjects women to "significant health risks." *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006)); *accord Casey*, 505 U.S. at 880.

5. Thus, to satisfy these controlling standards, a law regulating abortion must (1) have a valid purpose; (2) further a valid state interest; (3) avoid imposing substantial obstacles in the path of women seeking previability abortion services; and (4) avoid subjecting women to significant health risks. Further, the Fifth Circuit recently clarified that, with respect to the substantial obstacle element of the test, "the proper formulation of the undue burden analysis focuses solely on the effects within the regulating state." *Jackson Women's Health Org.*, slip. op. at 16.

6. As applied to the McAllen and El Paso clinics, the admitting privileges requirement fails this test. Under the undue burden standard, the Supreme Court has never upheld an abortion regulation that required a clinic to close or a woman to travel to a different location to obtain an abortion than she would have had the regulation not been enacted. *See, e.g., Mazurek v. Armstrong*, 520 U.S. 968, 974 (1997) ("[N]o woman seeking an abortion would be required by the new law to travel to a different facility than was previously available."); *see also* Casey, 505 U.S. at 879-887, 899-901.

7. The purpose of the admitting privileges requirement is to place substantial obstacles in the paths of women seeking previability abortion care.

8. As applied to the McAllen and El Paso clinics, the admitting privileges requirement fails to further a valid state interest.

9. With respect to the State's legitimate interest in potential life, "the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion." *Casey*, 505 U.S. at 878. The State may not, however, further this interest simply by making abortion services more difficult to obtain. *Id.* at 877 ("[T]he means chosen by

the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it."). Here, the admitting privileges requirement does not serve in any way to inform or persuade a woman seeking an abortion. Accordingly, it does not advance the State's interest in potential life in a permissible way.

10. With respect to the State's interest in women's health, the State may enact health regulations that are consistent with accepted medical practice, *see Simopoulos v. Virginia*, 462 U.S. 506, 516-17 (1983), and further women's health in a demonstrable way, *see City of Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 430 (1983).[1] But health regulations that are inconsistent with accepted medical practice or fail to advance women's health in a demonstrable way cannot be sustained. *Id.* at 434. Thus in *Danforth*, the Court struck down a statutory provision banning the use of saline amniocentesis as a method of second-trimester abortion because the State failed to demonstrate that it was "a reasonable regulation for the protection of maternal health." *Danforth*, 428 U.S. at 79; *see Carhart*, 550 U.S. at 164-65 (treating *Danforth*'s invalidation of the ban on saline amniocentesis as vital and relevant precedent). As applied to the McAllen and El Paso clinics, the admitting privileges requirement is inconsistent with accepted medical practice and fails to advance women's health in a demonstrable way.

11. As applied to the McAllen clinic, the admitting privileges requirement places substantial obstacles in the paths of women seeking previability abortion care in the Rio Grande Valley. As a result of the law, women who would have been able to obtain abortion services in McAllen must now travel to San Antonio or farther. This constitutes a substantial obstacle for

[1] In *Danforth*, for example, the Court upheld certain documentation and recordkeeping requirements in the wake of a challenge by abortion providers. *Danforth*, 428 U.S. at 80-81. Subsequently, the Court explained that the "decisive factor" in its decision "was that the State met its burden of demonstrating that these regulations furthered important health-related State concerns." *City of Akron*, 462 U.S. at 430.

many of those women such that they have to delay seeking abortion services while they arrange for transportation, childcare, and/or time off from work or forgo seeking legal abortion services altogether. As a population, women living in the Rio Grande Valley are extremely poor and lack access to transportation. Making a round trip of nearly 500 miles is far more burdensome for women living there than for women living in other regions of Texas.

12. Likewise, as applied to the El Paso clinic, the admitting privileges requirement places substantial obstacles in the paths of women seeking previability abortion care in West Texas. As a result of the law, there is currently only one abortion clinic serving the entire portion of the State west of San Antonio, and that clinic is planning to close before September. As a result, many women will experience substantial delays in accessing abortion care, and others will be forced to travel to San Antonio, which is over a 1,000-mile round trip. Like women in the Rio Grande Valley, women in the El Paso-area are poorer and have less access to transportation than Texas women overall.

13. In addition, as applied to the McAllen and El Paso clinics, the admitting privileges requirement subjects women in the Rio Grande Valley and West Texas to significant health risks. As a result of the clinic closures, many women in the Rio Grande Valley and West Texas now have to delay accessing abortion care, others have to forgo desired abortion care and carry unwanted pregnancies to term, and still others are resorting to self-induction of abortion using illegally obtained drugs or other methods. All of these outcomes carry greater health risks than legal induced abortion without delay.

B. The Admitting Privileges Requirement Denies Equal Protection of the Laws to the McAllen and El Paso Clinics and Their Patients.

14. As applied to the McAllen clinic, the admitting privileges requirement denies equal protection of the laws to Whole Woman's Health, Dr. Lynn, and women seeking abortion care in

the Rio Grande Valley in violation of the Equal Protection Clause of the Fourteenth Amendment. Likewise, as applied to the El Paso clinic, the admitting privileges requirement denies equal protection of the laws to Reproductive Services, Dr. Richter, and women seeking abortion care in West Texas in violation of the Equal Protection Clause of the Fourteenth Amendment.

15. "The framers of the Constitution knew, and we should not forget today, that there is no more effective practical guarantee against arbitrary and unreasonable government than to require that the principles of law which officials would impose upon a minority be imposed generally." *Railway Express Agency, Inc. v. New York*, 336 U.S. 106, 112 (1949) (Jackson, J., concurring) (quoted in *Lawrence v. Texas*, 539 U.S. 558, 585 (2003) (O'Connor, J., concurring)). The admitting privileges requirement violates the Equal Protection Clause of the Fourteenth Amendment because it singles out physicians who perform abortions from all other physicians performing outpatient procedures for imposition of an onerous burden.

16. The admitting privileges requirement treats abortion providers differently than other healthcare providers who are similarly situated. *See Planned Parenthood of Wisc., Inc. v. Van Hollen*, 738 F.3d 786, 790 (7th Cir. 2013) ("An issue of equal protection . . . is lurking in this case. For the state seems indifferent to complications from non-hospital procedures other than surgical abortion . . ., even when they are more likely to produce complications.").

17. Given that this classification burdens the fundamental right to terminate a pregnancy, it should be subject to heightened scrutiny. *See Casey*, 505 U.S. at 851 (opinion of the Court) (explaining that the principles of rational basis scrutiny set forth in *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483 (1955) and similar cases do not apply in cases involving "a protected liberty"). But even under rational basis scrutiny, the classification fails.

18. As applied to the McAllen and El Paso clinics, the classification drawn by the admitting privileges requirement is not rationally related to a legitimate state interest. For purposes of equal protection review—even under the rational basis standard—the classification drawn by a law must be directly related to the interest it purports to advance. *See City of Cleburne v. Cleburne Living Ctr.* 473 U.S. 432, 448 (1985) (holding that a municipal zoning ordinance violated equal protection as applied to the proposed operator of a group home for people with mental disabilities because there was no rational basis on which to conclude that such a home would threaten legitimate interests of the city in a way that other permitted uses such as boarding houses and hospitals would not).

19. The objective of the admitting privileges requirement is a bare desire to harm abortion providers, which is not constitutionally permissible. *United States v. Windsor*, 133 S. Ct. 2675, 2693 (2013); *Romer v. Evans*, 517 U.S. 620, 632-35 (1995); *City of Cleburne*, 473 U.S. at 446-47; *U.S. Dept. of Agric. v. Moreno*, 413 U.S. 528, 534 (1973).

C. The Admitting Privileges Requirement Improperly Delegates Lawmaking Authority to Hospitals Located within Thirty Miles of the McAllen and El Paso Clinics in Violation of the Due Process Clause of the Fourteenth Amendment.

20. Longstanding principles of due process hold that: (1) states may not authorize private parties to act against third-party liberty or property interests in ways that the state itself could not act; and (2) in order for a delegation of governmental authority to be constitutional, states must retain the ability to review private parties' exercise of governmental discretion. *See, e.g., State of Wash. ex. rel. Seattle Title Trust Co. v. Roberge*, 278 U.S. 116 (1928) (striking down law preventing certain uses of land unless consented to in writing by two-thirds of the property owners in the immediate vicinity); *Birth Control Ctrs., Inc. v. Reizen*, 508 F. Supp. 1366, 1374 (E.D. Mich. 1981), *aff'd on other grounds*, 743 F.2d 352 (6th Cir. 1984) (law requiring abortion clinics to have a backup agreement with a physician who had staff privileges at a local hospital "violate[d] due

process concepts because [it] delegate[d] a licensing function to private entities without standards to guide their discretion"); *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153, 1158 (E.D.N.C. 1974) (striking down written transfer agreement or admitting privileges requirement for abortion providers because "the state . . . placed no limits on the hospital's decision to grant or withhold a transfer agreement").

21. As applied to the McAllen and El Paso clinics, the admitting privileges requirement authorizes hospitals located within 30 miles of each clinic to act against Plaintiffs' liberty and property interests in ways that the State of Texas itself could not act.

22. Furthermore, Texas does not retain the ability to review the exercise of discretion by hospitals within 30 miles of the McAllen and El Paso clinics concerning the denial of admitting privileges to physicians seeking to provide abortion services.

23. As a result, the admitting privileges requirement improperly delegates lawmaking authority to hospitals located within 30 miles of the McAllen and El Paso clinics in violation of the Due Process Clause of the Fourteenth Amendment. *See Roberge*, 278 U.S. at 116; *Reizen*, 508 F. Supp. at 1374 *Hallmark Clinic*, 380 F. Supp. at 1158.

D. As Applied to the McAllen and El Paso Clinics, the Admitting Privileges Requirement is Arbitrary and Irrational.

24. The Due Process Clause requires that states act only through means appropriately related to legitimate ends. *See Brennan v. Stewart*, 834 F.2d 1248, 1256 (5th Cir. 1988). Every governmental action must be rationally related to its end, and ends that 'shock the conscience' or otherwise violate norms 'implicit in the concept of ordered liberty' are illegitimate. *Id.*

25. As applied to the McAllen and El Paso clinics, the admitting privileges requirement violates the Due Process Clause of the Fourteenth Amendment because it is arbitrary and not reasonably related to a legitimate state interest.

26. Further, as applied to the provision of medical abortion at the two clinics, the admitting privileges requirement is not reasonably related to any legitimate state interest.

The ASC Requirement is Unconstitutional.

A. The ASC Requirement Imposes an Undue Burden on Women Seeking Abortion Services in Texas.

27. The ASC requirement—both on its face and as applied to the McAllen and El Paso clinics—violates the Due Process Clause of the Fourteenth Amendment by imposing an undue burden on the right to access previability abortion care. *See Casey*, 505 U.S. at 876; *Jackson Women's Health Org.*, slip op. at 8.

28. The purpose of the ASC requirement is to place substantial obstacles in the paths of women seeking previability abortion care in Texas.

29. The ASC requirement will force all licensed abortion facilities to meet detailed construction requirements, which specify, among other things, hallway widths; ceiling heights; area of various rooms; floor, wall, and ceiling finishes; HVAC system requirements; and number and configuration of bathrooms, janitorial closets, and parking spaces. *See* 25 Tex. Admin. Code § 139.40 (incorporating by reference, *inter alia*, 25 Tex. Admin. Code § 135.52). The vast majority of licensed ASCs in Texas are exempt from these requirements because they have been grandfathered pursuant to 25 Tex. Admin. Code § 135.51(a)(1) and/or granted waivers pursuant to 25 Tex. Admin. Code § 135.51(b). Licensed abortion facilities, however, are expressly made ineligible for grandfathering and waivers. *See* 25 Tex. Admin. Code § 139.40(d)(3).

30. The ASC requirement fails to further a valid state interest.

31. Like the admitting privileges requirement, the ASC requirement fails to advance the State's interest in potential life in any permissible way because it does not serve to inform or

persuade women seeking abortion services; it merely makes abortion services more difficult—and, for some women, impossible—to obtain. *Casey*, 505 U.S. at 877.

32. Similarly, the ASC requirement fails to advance the State's interest in health because it is inconsistent with accepted medical practice and fails to advance the health of women seeking abortion care in a demonstrable way. *See Danforth*, 428 U.S. at 79.

33. The ASC requirement places substantial obstacles in the paths of women seeking previability abortion care in Texas. If it were permitted to take effect, there would be fewer than ten facilities in Texas providing abortion services, and they would all be clustered in four metropolitan areas in the eastern part of the State (Dallas-Ft. Worth, Houston, Austin, and San Antonio). There would be no abortion providers west or south of San Antonio, which is a huge geographic area. For women living in the Rio Grande Valley, the nearest Texas abortion provider would be nearly 250 miles away. And for women living in El Paso, the nearest Texas abortion provider would be over 500 miles away.

34. Like the admitting privileges requirement, the ASC requirement subjects women in Texas to significant health risks. By dramatically reducing the number and geographic distribution of abortion providers in Texas, the ASC requirement will cause some women to delay or forgo abortion care and others to attempt self-induction.

35. As a result of the ASC requirement, the cumulative burdens imposed by Texas law place substantial obstacles in the paths of women seeking previability abortion. *See Van Hollen*, 738 F.3d at 796 ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered."). Even Defendants concede that, after the ASC requirement takes effect, over 800,000 Texas women of reproductive age will have to travel more than 150 miles to access legal abortion services.

B. **The ASC Requirement Denies Equal Protection of the Laws to Abortion Providers and Women Seeking Abortion Care in Texas.**

36. The ASC requirement denies equal protection of the laws to abortion providers and women seeking abortion care in Texas in violation of the Equal Protection Clause of the Fourteenth Amendment.

37. The ASC requirement treats abortion providers differently than other healthcare providers who are similarly situated. *See Van Hollen*, 738 F.3d at 790. Aside from abortion procedures, Texas law does not impose restrictions on the type of facility in which any outpatient surgery may be performed.

38. The classification drawn by the ASC requirement is not rationally related to a legitimate state interest. *See City of Cleburne*, 473 U.S. at 448. Many outpatient surgical procedures that are comparable to abortion or less safe than abortion are routinely performed in office-based settings.

39. The objective of the ASC requirement is a bare desire to harm abortion providers, which is constitutionally impermissible. *Windsor*, 133 S. Ct. at 2693 (2013); *Romer*, 517 U.S. at 632-35 (1995); *City of Cleburne*, 473 U.S. at 446-47; *Moreno*, 413 U.S. at 534 (1973).

C. The ASC Requirement is Arbitrary and Irrational.

40. The ASC requirement violates the Due Process Clause of the Fourteenth Amendment because it is arbitrary and not reasonably related to a legitimate state interest. *See Brennan*, 834 F.2d at 1256.

41. The ASC requirement is not reasonably related to any legitimate state interest. Certain characteristics of surgical abortion procedures render many of the minimum standards for ASCs inappropriate. Notably, surgical abortion does not require an aseptic surgical field because it is performed through the vagina, an orifice that is naturally colonized with bacteria.

Accordingly, the type of sterile precautions that are appropriate for surgery performed on a sterile operating site provide no medical benefit to an abortion patient.

42. As applied to the provision of medical abortion, the ASC requirement is not reasonably related to any legitimate state interest. Medical abortion does not involve surgery of any kind. As practiced in Texas, it entails the oral administration of medications—*i.e.*, the patient merely swallows a series of tablets.

Dated: July 31, 2014

/S/ Stephanie Toti

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan*
David P. Brown*
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org
dbrown@reprorights.org

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'CONNELL & SOIFER LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

J. Alexander Lawrence*
Kiersten Fletcher*
MORRISON & FOERSTER LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

John H. Bucy, II*
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Betre M. Gizaw*
Marissa P. Harris*
MORRISON & FOERSTER LLP
2000 Pennsylvania Avenue, NW
Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com
mharris@mofo.com

Colin M. O'Brien*
MORRISON & FOERSTER LLP
370 17th Street, Suite 5200
Denver, CO 80202
(303) 592-2252
(303) 592-1510
cobrien@mofo.com

*Admitted pro hac vice

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on July 31, 2014, the foregoing was served on all counsel of record via the CM/ECF system.

/S/ Stephanie Toti
Stephanie Toti

J

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

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.,** Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:14-cv-284-LY

STATE DEFENDANTS' PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW

Table of Contents

Defendants David Lakey, Commissioner of the Texas Department of State Health Services, and Mari Robinson, Executive Director of the Texas Medical Board (collectively, "Defendants") submit their proposed findings of fact and conclusions of law. The plaintiffs' complaint should be dismissed or, in the alternative, judgment should be entered in Defendants' favor.

FINDINGS OF FACT

I. HOUSE BILL 2

1. On July 18, 2013, Texas Governor Rick Perry signed House Bill 2, relating to the regulation of abortion procedures, providers, and facilities. Of relevance to this suit, HB2 requires that physicians performing abortions have active admitting privileges at a hospital within thirty miles of where the abortion is performed (the "admitting-privileges requirement"), and that abortion clinics meet the same standards as ambulatory surgical centers (the "ASC requirement").

2. On April 2, 2014, the plaintiffs, a group of abortion clinics and physicians, filed suit, asking the Court to enjoin the admitting-privileges requirement as it applies to the plaintiff clinics and physicians in El Paso and McAllen and to enjoin the ASC requirement, both as applied to those clinics and on its face.

II. ABORTION PROCEDURE AND COMPLICATIONS

3. Abortion is a unique procedure in that it terminates a potential human life. Therefore, the standards of care for patients undergoing this procedure should be higher, not lower.

A. The Abortion Procedure and Its Risks

4. Abortion is an invasive procedure. The physician must forcibly open a patient's cervix with a dilator in order to remove the fetus. Entering the cervix carries the risk of perforation of the uterus, which can lead to infection, hemorrhage, or damage to other organs. Dilation can be extremely painful and require more than local anesthesia.

5. Abortion is comparable to a dilation and curettage (D&C), a procedure in which the contents of the uterus are removed following a miscarriage. When performed on a non-pregnant patient, a D&C is typically done in an ASC or hospital setting, due to the need for patient safety.

6. A pregnant uterus has an increased risk of complications when compared to a D&C performed on a non-pregnant uterus, as the walls of a pregnant uterus are thinner and easier to damage. A pregnant uterus also receives 10-15% of the total cardiac output of the heart and is more prone to bleeding as a complication.

7. The other risks from surgical abortion include bleeding, infection, and damage to the bowel, bladder, or upper genital tract. These risks can be

life-threatening. The risks from medical abortion include failed abortion, incomplete abortion, bleeding, and infection. The complications from medical abortion occur more frequently than those from surgical abortion.

8. The estimated frequency of short-term complications from abortions is .2-10%. Thus, follow up medical care is often needed on an urgent basis to treat infection, bleeding, or organ damage. Many patients must visit emergency rooms for treatment of post-abortion complications. Time delays, as little as one hour, can mean the difference between life and death.

9. Even the plaintiffs' expert agrees that some patients who receive abortions experience serious and even life-threatening complications. These patients deserve the highest standard of care.

10. Abortions should be performed in a sterile environment. Dr. Fine and Dr. Raymond's opinions that surgical abortion need not be performed in an aseptic surgical field are without merit. The uterus is sterile and the introduction of bacteria from unclean instruments or vaginal contamination is a major cause of abortion-related complications. A sterile operating environment reduces the risk of infection. Basic gynecological principles mandate that abortion procedures be performed in an ASC or hospital.

11. Dr. Fine's and Dr. Grossman's comparisons of the risk of abortion to those involved with endometrial biopsies or miscarriages are unfounded.

Endometrial biopsies do not require cervical dilation, and the cervix is already partially dilated when a miscarriage occurs.

B. Underreporting of Post-Abortion Complications

12. The plaintiffs' evidence concerning the relative safety of abortion is based on unreliable and incomplete data. Because the complications following abortions have not been empirically validated, it is reasonable to put more protections and safeguards into place, not less.

13. Complications from abortion procedures are often underreported, and the precise number of patients who have complications following abortions is largely unknown. There is no federal law requiring reporting of post-abortion complications, and many of the States do not have laws that require such reporting. Therefore, any statistical reporting of abortion complications must rely on estimates. Moreover, deaths due to abortion procedures are often reported under the complication (e.g., infection) rather than the procedure itself. Finally, many patients are reluctant to report that they have had an abortion. All of these factors contribute to the underreporting of abortion complications.

14. Data from the CDC, which is used by the plaintiffs' experts, is unreliable because the CDC must depend, in part, on reports from state health departments. Many state health departments, in turn, depend on voluntary reporting from abortion providers, which leads to underreporting. It

is estimated that only one-third to one-half of abortion patients return to the clinic for their follow-up appointment, meaning that clinics may never become aware of complications.

15. Data from the Guttmacher Institute, which is also used by the plaintiffs' experts, is unreliable because, up until recently, it was affiliated and/or funded by Planned Parenthood Federation of America, creating a conflict of interest and systematic information bias.

16. The previous trial regarding the admitting-privileges requirement demonstrated the ways in which complications are underreported in Texas. There, witnesses for the plaintiff, including Dr. Fine, testified under oath that the state-mandated Induced Abortion Report Form is completed on the same day of a medical abortion, that no complications are typically identified, and that the complication of "incomplete abortion" is not even listed on the form. Dr. Raymond states that it is almost universally true that complications of medical abortion will present after the plaintiff has left the abortion facility. Therefore, it is reasonable to conclude that complications from medical abortions are underreported in Texas and do not include complications that occur after the patient leaves the abortion facility.

17. Regardless, the available data demonstrates that many patients suffer post-abortion complications. In 2012, there were 66,098 abortions performed on Texas residents. Using Dr. Grossman's number of 0.3% of abortion

patients requiring hospitalization from serious complications, approximately 4 patients every week will need hospitalization as a result of an abortion.

18. Dr. Fine's assertion that the risk of death associated with childbirth is approximately fourteen times higher than that associated with abortion is unfounded and lacks scientific rigor and reality. Dr. Raymond's study, on which Dr. Fine based his opinion, contains multiple methodological weaknesses: reliance on voluntary and incomplete state reporting of abortions, data misclassification, failing to include abortion-related deaths beyond the first trimester (when abortion mortality risks equal and exceed childbirth), failure to account for evidence that childbirth is protective in the immediate and long-term against death from non-obstetrical causes, failure to cite contrary and methodologically superior evidence, failure to address concerns raised in reviews which resulted in conclusions different than her own, and the failure to take into account that the methods used to collect data on deaths with abortion and childbirth in the United States are inconsistent and incomparable.

III. BENEFITS OF ADMITTING PRIVILEGES

19. Receiving care from a surgeon with admitting privileges benefits the patient by maintaining continuity of care, enhancing inter-physician communication, and reducing medication errors and misdiagnosis, all of which improve patient safety. The admitting-privileges requirement also

protects patients from less-qualified providers by ensuring that physicians are credentialed and reviewed by their peers. The requirement also supports the ethical duty of care owed by the operating physician and prevents patient abandonment.

20. Hospitals credential and privilege physicians to protect patients, manage risks, and comply with accreditation and regulatory requirements. Credentialing involves identifying, confirming, and evaluating information concerning the physician's professional and technical competence. The credentialing process exposes physicians whose patient-care track record is suspect and may need remediation. Privileging involves the hospital's medical staff's determination that an individual practitioner be allowed to provide patient care in that institution.

21. Hospital privileging assures that the physician is qualified to perform the surgeries in another setting, is subject to peer and administrative review, and can maintain continuity of care for surgical complications.

22. At least fifteen States have enacted laws requiring abortion providers to have some affiliation with a local hospital.

A. Continuity of Care and Patient Safety

23. Continuity of care improves the quality of care and patient outcomes. The critical focus of continuity of care is the patient's health and safety. Continuity of care is increased when the physician who performed the

abortion is able to treat his or her patient's serious complications at a nearby hospital.

24. There are three major components of continuity of care: (1) informational continuity, i.e., formally recorded information is complemented by tacit knowledge of patient preferences, values, and context that is usually held in the memory of clinicians with whom the patient has an established relationship; (2) management continuity, i.e., shared management plans or care protocols, and explicit responsibility for follow-up and coordination, provide a sense of predictability and security in future care for both patients and providers; and (3) relationship continuity, i.e., built on accumulated knowledge of patient preferences and circumstances that is rarely recorded in formal records and interpersonal trust based on experience of past care and positive expectations of future competence and care. The admitting privileges requirements promote all three components of continuity of care.

25. The admitting-privileges requirement ensures continuity of care, which decreases the likelihood of medical errors. Medication errors can result from incomplete medical histories, inadequate communication, and a reluctance to disclose a recent abortion. The Joint Commission estimates that 80% of serious medical errors involve miscommunication between caregivers when patients are transferred or handed off.

26. Good communication is critical to patient safety. Research shows that ineffective team communication is the root cause for nearly 66% of all medical errors. Hospital admitting privileges help improve the communication between physicians in the case of post-abortion complications and help reduce poor outcomes attributable to communication errors. The physician who performed the abortion is the most knowledgeable about the patient and the procedure. He or she is also the most familiar with the patient's future reproductive plans, which may be crucial if serious complications arise.

27. Good clinician-patient communication is linked to patient satisfaction, adherence, and better health outcomes. According to the Joint Commission, communication failures are the leading root cause for medication errors, delays in treatment, and wrong-site surgeries, as well as the second most frequently cited root cause for operative and postoperative events and fatal falls. Furthermore, according to the Joint Commission, hospital emergency departments are the source of just over one-half of all reported sentinel event cases of patient death or permanent injury due to delays in treatment with breakdown in communication being cited in 84% of cases, most often with or between physicians (67%). The admitting privileges requirement helps ensure the availability of the physician who performs the abortion to be involved in the care of his/her patient in a medical emergency, thereby reducing the possibility for communication failures or medical errors.

28. The National Abortion Federation has recommended that "[i]n the case of an emergency, the doctor should be able to admit patients to a nearby hospital (no more than 20 minutes away)."

29. Reliance on emergency-room personnel to treat post-abortion complications is not acceptable medical care. Communication problems can arise and delay treatment. Abortion doctors rarely call emergency room physicians to convey information about a patient's abortion, the patient's condition, or the potential complications when his or her patient visits the emergency room for treatment from post-abortion complications.

30. There is no reliable evidence to support Dr. Fine's opinion that patient care improves and patient satisfaction increases when post-abortion complications are treated by a hospital "laborist" who has no prior relationship with the patient. Rather, the evidence suggests that using the "hospitalist" model increases medication and communication errors.

31. The requirement that abortion providers have admitting privileges at a local hospital is safer for patients than simply requiring transfer agreements with a hospital or another physician with admitting privileges. In the instance when a patient with post-abortion complications arrives at the hospital for treatment, if not transported directly from the abortion facility, it is unlikely that her medical records are available to the emergency room

physician. After-hours communication and long-distance providers make conveyance of this information less prompt, when time may be of the essence.

32. Moreover, some abortion providers do not live in the community in which they perform abortions, but travel around the State to provide their services. To the extent the abortion provider travels from city to city, he or she may not be readily available to consult with an emergency room physician over the phone.

33. Dr. Fine's belief that emergency room physicians may immediately consult with the OB/GYN on-call is misplaced. It is not reasonable to assume that OB/GYNs are readily available in areas other than urban metropolitan centers. Nationally, 73% of emergency departments report inadequate on-call coverage by specialist physicians, including OB/GYNs, who are particularly difficult to secure.

34. The duty of a surgeon to his patient is non-transferable to an ASC or hospital. To perform a surgical procedure and then become unavailable to the patient to treat any complications constitutes patient abandonment and is not an acceptable standard of care. In other settings, the failure to provide continuity of care can trigger an accountability review before hospital peers and disciplinary action.

35. Surgeons have an ethical duty to give his or her patients personal attention and to treat them postoperatively. The admitting-privileges re-

quirement helps prevent itinerant surgeons from being allowed to abandon their patients if complications arise. Physicians who perform abortions need to be available if complications arise to help orchestrate the patient care and/or the consultative process that would be most beneficial for the patient and their family.

B. Ensuring Physicians are Qualified

36. Obtaining hospital admitting privileges is a careful and considered process, and requiring abortion providers to undergo peer review through a local hospital's credentialing process is a standard which is reasonable and appropriate given the gravity and uniqueness of the nature of abortion, and the potentially life-threatening complications that can result for the patient. The peer-review process promotes the all-around competence of physicians, who must be able to perform not only abortions but must be trained to respond to various complications that could arise.

37. A physician should not engage in surgery outside of his practice or training. According to the Joint Commission, privileging is intended to assure patient safety by permitting only qualified physicians to provide such care.

38. Prior to the admitting-privileges requirement, abortion-performing physicians simply had to meet the physician licensing requirements of the Texas Medical Board. The higher scrutiny of the hospital cre-

dentialing and privileging processes provides better protection for abortion patients in the event that they experience complications than merely relying upon physicians who have no hospital privileges and have not undergone the independent evaluation of qualifications and skill provided by hospital privileging process.

39. The admitting-privileges requirement provides for a rigorous, non-biased evaluation of the abortion provider. There is a risk of bias and conflict of interest when the evaluation of abortion providers' qualifications and technical skills are conducted only by the abortion clinics that employ them.

40. Hospital credentialing is generally a more rigorous screening and evaluation of a physician than the process of obtaining a state medical license. Only the hospital-privileging process requires reporting the number of past procedures performed to verify the experience and training necessary for these specific procedures. By reviewing and evaluating this information the hospital is able to verify that the physician has sufficient training and experience to perform the requested procedures.

41. Most hospitals require credential and licensing review every two years, which helps maintain a quality medical staff and quality patient care. It provides another layer of protection to ensure physician qualifications for patient safety.

42. Admitting privileges may typically be granted if a physician is a graduate from an accredited medical school and residency, is board eligible or certified, competently trained and experienced, has no history of violations of practice standards, and holds state licensure in medicine. A competent and well-trained abortion provider should not have difficulty obtaining privileges.

43. Given that the majority of physicians in Texas that perform abortions have admitting privileges, the plaintiffs' concerns that they will be unable to obtain privileges are exaggerated.

44. Hospitals may address the issue of low or no volume providers in a number of ways that enable the provider to receive privileges. Many hospitals have different categories of admitting privileges, i.e., courtesy and temporary, to accommodate those physicians who have infrequent admissions. Many hospitals accommodate physician staff privilege requests once the physician has demonstrated training/experience and clinical competency, even if the physician has infrequent admissions. In special circumstances many hospitals have different medical staff classifications that allow for patient care without certain other staff requirements, i.e., committee assignments, minimum number of admissions, residence, or taking un-referred call.

IV. BENEFITS OF AMBULATORY SURGICAL CENTERS

45. The ASC requirement is reasonable and medically necessary to ensure the health and safety of patients in Texas who receive abortion ser-

vices. The regulation of outpatient surgery centers is not about the convenience of the physician, but rather what is best for the patient. The higher standard of care provided by ASCs justifies any burden placed on patients who must travel to receive that care.

46. ASCs provide heightened care for patients because they are monitored for quality assurance and patient safety by outside entities: the State, the federal Center for Medicare Services, and professional ASC associations or regulatory bodies.

47. Meeting ASC minimum standards will ensure: quality of care and quality assurance; professional staffing, including nursing care; anesthesia services; emergency (internal and external) training, and equipment; the development, implementation, and maintenance of an effective, ongoing, organization-wide, data-driven patient safety program (PSP); infection surveillance, sterilization equipment, and proper hazardous waste management; facility size and layout that maximize high quality care and patient safety in an emergency; medical record management and conveyance for continuity of care.

48. ASCs are better prepared to handle and triage serious abortion complications, including uterine perforations, and have anesthesia staff in place to stabilize patients with bleeding. It is also reasonable to require medication abortions to be performed at an ASC. Abortion providers will want to

make sure that the medication regimen is strictly followed. And in the 6.7% of patients whose medication abortion is incomplete, requiring a surgical abortion, it is medically prudent to have them return to the same provider at the same facility for follow-up care.

49. ASC minimum standards are created by fire marshals, code enforcers, engineers, architects, business owners, healthcare professional, developers and other interested and knowledgeable experts. ASC accrediting and regulatory bodies consider these standards to be consistent with safe, high-quality health care. Outpatient surgery facilities that are licensed or accredited are better equipped with staff and equipment to handle patient emergencies than doctor's offices.

50. There is a trend towards the use of ASCs generally. In 2005, only 6.9% of abortions in Texas were performed in ASCs. In 2011, that number had risen to 22.4%.

51. At least twenty-seven States require abortion clinics to meet the standards of ambulatory surgical centers.

52. Multiple studies confirm that performing surgeries in ASCs, rather than in physician offices, results in lower rates of death, injury, and adverse incidents.

53. Dr. Grossman's comparison of complications from a single ASC to complications from abortion clinics is flawed because (1) the patient charac-

teristics were not equivalent, (2) the comparison relied on speculation and estimates from clinic personnel, (3) the clinic logs may not be accurate because patients do not always follow up with their provider, (4) no attempt to independently verify the numbers was made, and (5) his work has not been peer-reviewed.

54. There are multiple approaches that a clinic may take to establish an ASC: renovating the existing clinic, purchasing a new location, entering into a time-share with an existing ASC, or leasing a dormant or soon-to-close ASC.

55. The Whole Women's Health facility in McAllen would need only one operating room to meet its previous demand. An ASC with only one operating room requires only 2500-3000 square feet. The Whole Women's Health clinic in McAllen already has over 3000 square feet of space. There are multiple options available to Whole Woman's Health to either turn its existing facility in McAllen into an ASC or to pursue a time-share or lease.

56. Johannes overestimates the costs of building an ASC. Renovating a shell can cost $195 a square foot, while building a new ASC can cost $302 a square foot. Johannes' estimate also unnecessarily inflates the costs of an ASC by including a number of rooms that are not required under the regulations.

V. FINDINGS REGARDING BURDENS ON WOMEN IN TEXAS

57. Receiving optimal care is not an undue burden. It would be safer for patients to drive further to receive an abortion at a surgical facility with a credentialed and privileged physician than to seek an abortion at a nearby, substandard clinic.

58. The plaintiffs' evidence regarding the burden of the ASC requirement on women in Texas is based on unreliable data and unwarranted assumptions. The better evidence is that the vast majority of women in the State will not be unduly burdened by the ASC requirement.

59. When the ASC requirement goes into effect on September 1, 2014, there will be eight abortion-providing ASCs in Texas, located in Dallas, Fort Worth, Austin, San Antonio, and Houston. The plaintiffs offer no evidence to suggest that these facilities lack the capacity to meet the demand for abortion in Texas. Instead, the plaintiffs rest their case on the alleged burdens of travel and cost.

60. The data supporting Dr. Grossman's opinion on the impact of facility closures is unreliable. Dr. Grossman relies entirely on TexPEP data, which has proven to be grossly inaccurate. In the initial lawsuit challenging the admitting-privileges requirement, TexPEP data was relied on by Dr. Joseph Potter to predict that over 22,000 women in Texas would be unable to receive abortion services. Dr. Grossman's own report in this lawsuit, even

assuming it is completely accurate, suggests that the decline in abortions is closer to 3600, only 16% of what was originally predicted. TexPEP's data collections are not reliable.

61. TexPEP data is also unreliable because it is not based on the official data collected and reported by the Texas Department of State Health Services. Instead, TexPEP surveyed clinics, questioned unknown individuals, and created its own estimates regarding the number and residence of women seeking abortions. For the clinics that had already closed, TexPEP used unidentified "knowledgeable sources" to estimate how many abortions the clinic had performed on a monthly basis. For the clinics that did not respond, TexPEP asked unidentified individuals in the community to estimate how many abortions the clinic performed on a monthly basis. And if no unidentified individuals could be found to provide an estimate, TexPEP simply came up with an "internal estimate" itself.

62. Moreover, because the plaintiffs did not provide a large portion of the TexPEP data, the estimates, and the underlying information relied on by Dr. Grossman, they have not demonstrated that Dr. Grossman's opinion is worthy of credence.

63. Dr. Grossman's opinion that an alleged decline in the number of abortions performed in Texas is caused by clinic closures is speculative. Recent research from the Guttmacher Institute found a national decline in abor-

tions between 2008 and 2011, but found no evidence to link it to a decrease in providers. Indeed, even using a decline of 3622 (which is suggested by Dr. Grossman's data), it is still smaller than the declines experienced in Texas between 2010-2011 and 2011-2012, prior to the passage of HB 2.

64. Dr. Grossman's conclusions regarding the distance women in Texas will live from an abortion clinic if the ASC requirement goes into effect are not reliable. For many patients, the nearest abortion clinic may be located out of state. And the evidence shows that patients around the country frequently travel out of state to receive abortion services. Dr. Grossman also does not explain how he calculated distances between "counties" and "clinics" which will vary depending on where in each county the women and the clinic are located. As calculated by the State's expert, 83.3% of women ages 15-44 in Texas live within 150 miles of an existing abortion-performing ASC. Another 7.2% live outside the 150 mile radius for reasons not alleged to be related to HB 2. Thus, 90.5% of Texas women ages 15-44 either live within 150 miles of an existing abortion-performing ASC or live outside that distance for reasons not alleged to be related to HB 2. When the calculation is amended to include the Hilltop Women's Clinic in Santa Theresa, New Mexico, that number rises to 93.8%.

65. Dr. Grossman's comparison of the distances women must travel in Texas to receive abortion services to national averages is flawed. It does

not account for the fact that women living in the South and in rural areas must generally travel farther to receive abortion services. In fact, many women in Texas who must travel more than 100 miles to receive abortion services must do so regardless of the ASC requirement.

66. The evidence also does not support Dr. Layne-Farrar's conclusion that it is unlikely that any new ASCs will be built. In 2004, Texas enacted a law requiring that all abortions past 15 weeks gestation be performed in ASCs. Despite a demand for only 3642 abortions on or after 16 weeks gestation in 2003, four new ASCs were built. It is conceivable that ASCs could be built in El Paso and McAllen to meet their annual demand of 2000 abortions.

67. Further, historical trends in Texas suggest that when the demand for abortions exceeds the supply, clinics expand their capacity and new clinics open. For example, between 2003 and 2006, twenty-five abortion clinics in Texas closed. But the number of abortions performed in Texas in 2007 was higher than in 2002. Moreover, eleven new clinics opened during that same time period.

68. Following the enactment of HB2, Planned Parenthood has announced plans to build new ASCs in Dallas and San Antonio. Austin Women's Health Center has also purchased land in Austin with the intent of opening an ASC there. Whole Woman's Health is seeking to open an ASC in Fort Worth. Doctors affiliated with Reproductive Services are seeking to open an

ASC in San Antonio. And Reproductive Services is seeking to open an abortion clinic in New Mexico, near the Texas border, to serve the El Paso area. There are also multiple organizations dedicated to raising funds to assist low-income women seeking abortion services by paying for the procedure, travel, and other associated costs.

VI. FINDINGS REGARDING BURDENS ON WOMEN NEAR THE EL PASO AND MCALLEN CLINICS

69. The plaintiffs have not presented evidence that any women in El Paso or the Rio Grande Valley, much less a large fraction of women in El Paso or the Rio Grande Valley will encounter an undue burden when seeking abortion care as a result of the admitting-privileges or ASC requirements. The burdens posed by travel are not undue, and the plaintiffs have offered no evidence of the costs involved in traveling from El Paso or the Rio Grande Valley to receive an abortion.

70. It is not reasonable to assume that all of the plaintiffs' predicted permanent clinic closures will come to pass. In the previous lawsuit challenging the admitting-privileges requirement, the plaintiffs provided sworn testimony that certain clinics in Austin and Dallas would shut down; yet those clinics reopened after their doctors received privileges.

71. Kristine Hopkins' testimony on poverty and teen pregnancy does not support the plaintiffs' claim of undue burden. Less than 7% of abortions

in Texas were performed on patients from the Rio Grande Valley and El Paso. Hopkins further acknowledges that a smaller percentage of women in El Paso and the Rio Grande Valley choose to have abortions than compared to the State as a whole. To the extent Hopkins opines that disadvantaged women in the Rio Grande Valley will face substantial obstacles to receiving abortions, her testimony is unreliable under Federal Rule of Evidence 702. The impact, if any, of the clinic closure in McAllen will be small.

72. Dr. Grossman's belief that more women will self-induce abortions if clinics close is speculative and lacks foundation. Dr. Grossman interviewed only five women in Texas. His own study found that a majority of women who self-induce wanted to avoid a clinic abortion and found that a number of women preferred self-induction.

A. El Paso Clinic

73. It is possible for doctors who perform abortions in El Paso to receive hospital admitting privileges. Dr. Theard, who owns an abortion clinic in El Paso, has admitting privileges at five hospitals in the area.

74. The plaintiffs greatly exaggerate the travel burdens facing women in El Paso. Dr. Grossman's assumption that women in El Paso will travel to San Antonio to receive abortion services is not credible. There is an abortion clinic in New Mexico that is only 13 miles away to which patients may easily travel. Dr. Theard has testified that he will keep that clinic open, and

patients in El Paso may travel there to receive abortion care. Further, Dr. Theard testified that the majority of abortion patients that he sees in his New Mexico clinic are from El Paso.

75. The plaintiffs have not proven that a large fraction of women in El Paso lack the ability to travel to San Antonio to receive abortion services. The evidence does show that many women in El Paso already choose to travel to New Mexico to receive abortion services, despite the presence of an abortion clinic in El Paso. Those patients should not be included in any undue-burden analysis, because they do not seek abortions in Texas.

76. The lack of an abortion clinic in El Paso is due to the actions of third parties, not the State. Hospitals in El Paso chose to deny Dr. Richter admitting privileges because of her lack of qualifications, not because sheperforms abortions. And Dr. Thread has made the business decision to locate his practice in Santa Theresa, New Mexico, rather than turn his El Paso clinic into an ASC.

B. McAllen Clinic

77. The plaintiffs have offered no evidence of any additional burden caused by traveling the extra distance from the Rio Grande Valley to San Antonio, instead of to Corpus Christi. One of the plaintiffs' experts testified that there is public transportation available from McAllen to San Antonio. After Whole Woman's Health ceased providing abortions at its McAllen clinic, it

encouraged Rio Grande Valley patients to travel to its San Antonio ASC, not to Corpus Christi, to obtain an abortion.

78. Lucy Felix's testimony regarding her belief that a large number of women in the Rio Grande Valley will be unable to receive abortion services is not credible. Felix provides no evidence other than her own speculation regarding what women in the Rio Grande Valley will do. Felix does not account for the fact that it is much more expensive to raise a child than to receive an abortion.

79. Felix also testified that, even before the clinic closures, women in the Rio Grande Valley had transportation and child-care challenges. She also testified that some women in the Rio Grande Valley will continue to self-induce abortions regardless of the proximity of clinics.

80. The plaintiffs' experts' opinions on the number of women impacted in the Rio Grande Valley is based on unreliable data. Specifically, the plaintiffs' experts relied on estimates provided by unidentified individuals as to how many patients from the Rio Grande Valley had received abortions in a particular clinic. Regardless, the TexPEP estimates show that the monthly average of abortions provided to patients in the Rio Grande Valley was higher in the six months following the clinic closures in November 2013 than it was in 2012, when two clinics were open.

81. The lack of an abortion clinic in the Rio Grande Valley is due to the actions of third parties, not the State. Various hospitals in the Rio Grande Valley chose to deny Whole Woman's Health physicians admitting privileges. And Whole Woman's Health has made the business decision not to invest in building an ASC in McAllen.

VII. FINDINGS REGARDING THE PLAINTIFFS

82. Plaintiff Whole Woman's Health operates licensed abortion facilities in Austin, Fort Worth, and San Antonio. Its San Antonio facility is an ASC. Its Austin, Fort Worth, and San Antonio facilities have physicians with admitting privileges at local hospitals. It is pursuing the establishment of an ASC in Fort Worth.

83. Plaintiff Sherwood C. Lynn is a board-certified OB/GYN, licensed to practice in Texas. He is the Medical Director for the Whole Woman's Health ASC in San Antonio. He performs abortions there and has admitting privileges there.

84. Plaintiffs Whole Woman's Health and Dr. Lynn assert that Dr. Lynn is unable to obtain privileges near McAllen, but refuse to disclose the individuals with whom they spoke.

85. Plaintiffs Austin Women's Health Center and Killeen Women's Health Center operate licensed abortion facilities in Austin and Killeen.

86. Plaintiff Lendol L. Davis is a board-certified OB/GYN licensed to practice in Texas. Dr. Davis is the Medical Director for the Austin Women's Health Center and the Killeen Women's Health Center.

87. The executive director of the Austin Women's Health Center and the Killeen Women's Health Center testified that they have purchased a building in Austin for the purpose of opening an ASC.

88. Plaintiff Nova Health Systems d/b/a Reproductive Services operates a licensed abortion clinic in El Paso. It ceased providing abortions when its provider, Dr. Richter, was unable to obtain admitting privileges.

89. Plaintiff Pamela J. Richter is a family medicine doctor licensed to practice in Texas. She previously performed abortions at Reproductive Services in El Paso. She has been unable to obtain admitting privileges in El Paso for reasons unrelated to her performance of abortions.

90. Reproductive Services is considering building an abortion clinic in New Mexico in order to provide services to the women of El Paso.

91. Dr. Alan Braid, a board member of Reproductive Services, has purchased land in San Antonio in order to open an ASC there.

CONCLUSIONS OF LAW

I. PLAINTIFFS' CLAIMS BARRED BY RES JUDICATA

1. Plaintiffs' "as applied" challenges to HB2's admitting-privileges requirement could have been brought in the previous action challenging HB2.

They are now barred by res judicata because the earlier action has proceeded to final judgment, Plaintiffs were all parties (or privities to parties) in the previous case, and their claims arise from the same transaction litigated in the earlier proceeding are barred by res judicata. *See Allen v. McCurry*, 449 U.S. 90, 94 (1980); *Brown v. Felsen*, 442 U.S. 127, 131 (1979); *In re Howe*, 913 F.2d 1138, 1144 n.10 (5th Cir. 1990).

2. The plaintiffs also could have challenged the ASC requirement in the previous action challenging HB2. The doctrine of res judicata precludes them from doing so now. The earlier action has proceeded to final judgment, the plaintiffs were all parties (or privities to parties) in the previous case, and their claims arise from the same transaction litigated in the earlier proceeding. *See* Restatement (Second) of Judgments §§ 19, 24 (1982); *Allen*, 449 U.S. at 94; *Brown*, 442 U.S. at 131; *In re Howe*, 913 F.2d at 1144 n.10.

II. LEGAL STANDARDS GOVERNING ABORTION CLAIMS

3. Courts must uphold state abortion regulations unless the law either: (1) lacks a rational basis, or (2) imposes an "undue burden" on patients seeking to abort a fetus prior to viability. See *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 590 (5th Cir. 2014).

4. The State has a legitimate interest in regulating the medical profession and promoting the health and safety of abortion patients. *See Gonzales*, 550 U.S. at 158 (2007) ("Where it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn."); *Casey*, 505 U.S. at 878 ("As with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion."). The State may regulate abortion to advance these interests, so long as its regulations do not rise to the level of "undue burdens."

5. The State also has a legitimate and substantial interest in protecting fetal life, and this interest is present throughout pregnancy. *See Casey*, 505 U.S. at 873 (recognizing the State's "interest in protecting the life of the unborn."); *id.* at 876 ("[T]here is a substantial state interest in potential life throughout pregnancy."); *Gonzales*, 550 U.S. at 145 ("[T]he government has a legitimate and substantial interest in preserving and promoting fetal life."). The State may regulate abortion to promote its interest in protecting fetal life, so long as its regulations do not rise to the level of "undue burdens."

6. The plaintiffs bear the burden of proving that a challenged abortion regulation is unconstitutional. *See Mazurek v. Armstrong*, 520 U.S. 968,

971 (1997) (per curiam) (rejecting a constitutional challenge to a Montana law requiring abortions be performed only by licensed doctors because the plaintiffs failed to establish that the law imposed a substantial obstacle to abortion); *Casey*, 505 U.S. at 884 (upholding Pennsylvania's requirement that a physician, rather than a qualified assistant, provide informed-consent information, because "there is no evidence on this record that requiring a doctor to give the information as provided by the statute would amount in practical terms to a substantial obstacle to a woman seeking an abortion"); *Planned Parenthood of Greater Tex.*, 748 F.3d at 597 ("As in litigation generally, the burden of proving the unconstitutionality of abortion regulations falls squarely on the plaintiffs.").

7. Courts are not to issue a pre-enforcement injunction against an abortion regulation if the effects of the law (and the reasons for those effects) are open to debate. *See A Woman's Choice—East Side Women's Clinic v. Newman*, 305 F.3d 684, 693 (7th Cir. 2002) ("[I]t is an abuse of discretion for a district judge to issue a pre-enforcement injunction while the effects of the law (and reasons for those effects) are open to debate.").

8. The independent actions of third parties, such as the decisions of the hospitals in El Paso and McAllen to deny admitting privileges, as well as the decisions of abortion providers who choose not to build ASCs, are not attributable to the State. *Cf. Lugar v. Edmondson Oil Co., Inc.*, 457 U.S. 922,

937 (1982) (articulating state-action requirement for § 1983 suits). Thus, the State is not liable under § 1983 for any alleged deprivation of rights caused by the decisions of those third parties.

A. Rational Basis

9. Rational-basis review does not require a State to produce evidence that a law will achieve its objectives. *See Heller v. Doe*, 509 U.S. 312, 320 (1993) ("A State . . . has no obligation to produce evidence to sustain the rationality of a statutory classification."); *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 315 (1993) (holding that a legislative decision "is not subject to courtroom fact-finding and may be based on rational speculation unsupported by evidence or empirical data.").

10. Courts may not weigh evidence or resolve disputed questions of fact when conducting rational-basis review. The mere *existence* of disagreement on an empirical question is enough to establish a "reasonably conceivable state of facts that could provide a rational basis." *Beach Commc'ns*, 508 U.S. at 313; *see also Planned Parenthood of Greater Tex.*, 748 F.3d at 594 ("The fact that reasonable minds can disagree on legislation … suffices to prove that the law has a rational basis."); *Nat'l Paint & Coatings Ass'n v. City of Chicago*, 45 F.3d 1124, 1127 (7th Cir. 1995) ("[T]o say that such a dispute exists—indeed, to say that one may be *imagined*—is to require a decision for

the state."); *Steffan v. Perry*, 41 F.3d 677, 685 (D.C. Cir. 1994) ("It is hard to imagine a more deferential standard than rational basis.").

11. Rational-basis review asks only whether there is any *conceivable* rationale that might support the statute. *See Beach Commc'ns*, 508 U.S. at 313 ("In areas of social and economic policy, a statutory classification that neither proceeds along suspect lines nor infringes fundamental constitutional rights must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification."); *Planned Parenthood of Greater Tex.*, 748 F.3d at 594 ("[T]he rational basis test seeks only to determine whether any conceivable rationale exists for an enactment."). So long as some conceivable rationale exists, the statute survives rational-basis review. The plaintiffs bear "the burden to negative every conceivable basis which might support" the challenged law. *Beach Commc'ns*, 508 U.S. at 315 (1993) (internal quotation marks omitted).

12. Rational-basis review allows States to enact over-inclusive and under-inclusive laws. A law cannot be invalidated under rational-basis review simply because there is an imperfect fit between ends and means. *See Heller*, 509 U.S. at 321 ("[C]ourts are compelled under rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends. A classification does not fail rational-basis review because it is not made with mathematical nicety or because in practice it re-

sults in some inequality.") (citation and internal quotation marks omitted); *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 316 (1976) (per curiam) ("[W]here rationality is the test, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect." (internal quotation marks and citation omitted)); *Hayden v. Paterson*, 594 F.3d 150, 171 (2d Cir. 2010) ("[R]ational basis review allows legislatures to act incrementally and to pass laws that are over (and under) inclusive.").

13. Rational-basis review does not require a State to employ the least restrictive means of advancing the State's interests. *See Planned Parenthood of Greater Tex.*, 748 F.3d at 595 ("[T]he State is not required under rational basis review to choose the least restrictive means to achieve a legitimate goal."); *Ileto v. Glock, Inc.*, 565 F.3d 1126, 1152 (9th Cir. 2009) ("[R]ational basis review does not require that legislation be the least restrictive means of achieving [the legislature's] ends."); *Tolchin v. Supreme Court of the State of N.J.*, 111 F.3d 1099, 1114 (3d Cir. 1997) ("For the purposes of rational basis review, we have held that a rule need not be the least restrictive means of achieving a permissible end.").

14. Rational-basis review does not require the State to prove that an abortion regulation is medically necessary. *See Gonzales*, 550 U.S. at 166 ("Considerations of marginal safety, including the balance of risks, are within

the legislative competence when the regulation is rational and in pursuit of legitimate ends."); *Planned Parenthood of Greater Tex.*, 748 F.3d at 594.

15. Rational-basis review does not require a State's abortion regulations to conform to "standard medical practice." *See Casey*, 505 U.S. at 881-87 (upholding Pennsylvania's informed-consent law, even though the district court in that case had entered findings that Pennsylvania's law conflicted with "standard medical practice"); *see also Planned Parenthood of Se. Pa. v. Casey*, 744 F. Supp. 1323, 1353 (E.D. Pa. 1990).

16. The Fifth Circuit has already held that HB2's admitting-privileges requirement is rationally related to patient safety. *See Planned Parenthood of Greater Tex.*, 748 F.3d at 595; *see also Jackson Women's Health Org. v. Currier*, 13-60599, 2014 WL 3730467, at *5 (5th Cir. July 29, 2014). This precludes any as-applied rational-basis challenge that the plaintiffs might seek to bring against the admitting-privileges law. *See Kimel v. Florida Bd. of Regents*, 528 U.S. 62, 85–86 (2000) (when the test is rational basis, "the constitutionality of state classifications . . . cannot be determined on a person-by-person basis."); *Murgia*, 427 U.S. at 316 ("[W]here rationality is the test, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect." (internal quotation marks and citation omitted)); *Costner v. United States*, 720 F.2d 539, 543 (8th Cir. 1983) ("If a challenged statutory or regulatory classification is rational, it may be

enforced without exception."); *id.* (rejecting plaintiff's challenge to age-based restrictions on truck drivers, even though court assumed plaintiff could safely drive trucks); *see also Lindsey Coal Min. Co. v. Chater*, 90 F.3d 688, 694-95 (3d Cir. 1996) ("Just because a measure is over- or under-inclusive will not render it irrational. . . . A fifteen-year-old cannot successfully challenge a minimum age requirement of sixteen for driving on the basis that *she* would be a great driver even though most individuals of that age would not.").

B. Undue Burden

17. A statute imposes an undue burden only when it "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877.

18. State abortion regulations may impose obstacles and burdens on abortion patients, so long as the obstacles do not rise to the level of "substantial" and the burdens do not rise to the level of "undue." *See Casey*, 505 U.S. at 876 ("Not all burdens on the right to decide whether to terminate a pregnancy will be undue."); *id.* at 875 ("[I]t is an overstatement to describe [the right to abortion] as a right to decide whether to have an abortion 'without interference from the State.' All abortion regulations interfere to some degree with a woman's ability to decide whether to terminate her pregnancy.") (citation omitted); *Karlin v. Foust*, 188 F.3d 446, 481 (7th Cir. 1999) ("[I]nconvenience, even severe inconvenience, is not an undue burden.").

19. The Fifth Circuit has held that an increase of travel of less than 150 miles is not an undue burden under the *Casey* standard. *See Planned Parenthood of Greater Tex.*, 748 F.3d at 598 ("[A]n increase of travel of less than 150 miles for some women is not an undue burden under *Casey*.").

20. *Casey* establishes that long travel distances do not qualify as an "undue burden," because it upheld Pennsylvania's 24-hour waiting period even though the district court specifically found that it would be "particularly burdensome" for patients who must travel long distances, 505 U.S. at 885–86, and even though the Pennsylvania law would double the travel distances for "the thousands of Pennsylvania women who travel *hundreds of miles* to obtain an abortion," Brief for Petitioners, at *10, 1992 WL 551419, *Casey*, 505 U.S. 833, Nos. 91-744 & 91-902 (1992) (citations omitted and emphasis added). *Casey* held that these travel distances were neither "undue" burdens nor "substantial" obstacles—even as it accepted the district court's finding that "the waiting period has the effect of 'increasing the cost and risk of delay of abortions.'" 505 U.S. at 886.

21. Long driving distances to an abortion clinic are not sufficient to establish an "undue burden." *See Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 533 (8th Cir. 1994) ("We do not believe . . . a single trip, whatever the distance to the medical facility, create[s] an undue burden."); *see also Jackson Women's Health Org.*, 2014 WL 3730467, at *6 ("JWHO does not ar-

gue that the distances involved alone impose an undue burden. Nor could it in the light of [*Planned Parenthood of Greater Texas*].”). Courts cannot pick an arbitrary number of miles and declare any driving distance above that court-chosen number to be “undue.” *See Vieth v. Jubelirer*, 541 U.S. 267, 278 (2004) (plurality opinion) (“[L]aw pronounced by the courts must be principled, rational, and based upon reasoned distinctions.”).

22. The undue-burden standard does not require state abortion regulations to be consistent with “standard medical practice.” *See, e.g.*, *Casey*, 505 U.S. at 883 (upholding State’s informed-consent law notwithstanding district-court finding that the law was “contrary to the standard medical practice”); *see also Casey*, 744 F. Supp. at 1353.

23. The undue-burden standard does not prohibit the States from regulating abortion providers until after a public-health problem occurs. *See Greenville Women’s Clinic v. Bryant*, 222 F.3d 157, 169 (4th Cir. 2000) (“[T]here is no requirement that a state refrain from regulating abortion facilities until a public-health problem manifests itself.”).

C. Facial Challenges

24. The law of the Fifth Circuit prohibits courts from facially invalidating a statute across the board unless the plaintiff shows that the law is invalid in all its applications. *See Voting for Am., Inc. v. Steen*, 732 F.3d 382, 387 (5th Cir. 2013) (“With the exception of First Amendment cases, a facial

challenge will succeed only if the plaintiff establishes that the act is invalid under all of its applications."); *Barnes v. Miss.*, 992 F.2d 1335, 1342 (5th Cir. 1993) (holding that in an abortion case, "[a] facial challenge will succeed only where the plaintiff shows that there is *no* set of circumstances under which the statute would be constitutional").

D. Severability Clause

25. Any challenge to HB 2 is subject to its severability provision. The Texas Legislature expressed its intent that "every application of this statute to every individual woman shall be severable from each other." HB 2 § 1(b). The Legislature further explained:

> All constitutionally valid applications of this Act shall be severed from any applications that a court finds to be invalid, leaving the valid applications in force, because it is the legislature's intent and priority that the valid applications be allowed to stand alone. Even if a reviewing court finds a provision of this Act to impose an undue burden in a large or substantial fraction of relevant cases, the applications that do not present an undue burden shall be severed from the remaining provisions and shall remain in force, and shall be treated as if the legislature had enacted a statute limited to the persons, group of persons, or circumstances for which the statute's application does not present an undue burden.

HB 2 § 10(b).

26. Federal courts must enforce HB2's severability clause because state severability law is mandatory and binding on federal courts. See *Leavitt v. Jane L.*, 518 U.S. 137, 138–39 (1996) (per curiam) (holding that

"[s]everability is of course a matter of state law" and rebuking the Tenth Circuit for refusing to treat as dispositive a state abortion statute's "explicit[] stat[ement]" of severability); *Dorchy v. Kansas*, 264 U.S. 286, 290 (1924) (holding that a state court's "decision as to the severability of a provision is conclusive upon this Court."); *Planned Parenthood of Greater Tex.*, 748 F.3d at 589 ("Federal courts are bound to apply state law severability provisions."); s*ee Voting for Am.,* 732 F.3d at 398 ("Severability is a state law issue that binds federal courts."). The Supreme Court enforces severability provisions that require reviewing courts to sever unconstitutional applications of state statutes, while leaving valid applications in force. *See, e.g., Wyoming v. Oklahoma*, 502 U.S. 437, 460–61 (1992); *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 501 & 506 n.14 (1985).

27. Because HB2's severability clause requires reviewing courts to sever not only the statutory provisions, but also the applications of those provisions to each individual and circumstance, a court cannot invalidate a statutory provision across the board unless it is unconstitutional in every single one of its applications. Any constitutional applications of HB2 to any person, group of persons, or circumstances must be severed and allowed to remain in force.

E. Scope of Injunctive Relief

28. The plaintiffs in this case are only a subset of the abortion providers in Texas, and this case has not been brought as a class action. This court lacks authority to enjoin the enforcement of HB2 against anyone other than the named plaintiffs in this case. *See Doran v. Salem Inn, Inc.*, 422 U.S. 922, 931 (1975) ("[N]either declaratory nor injunctive relief can directly interfere with enforcement of contested statutes or ordinances except with respect to the particular federal plaintiffs, and the State is free to prosecute others who may violate the statute."); *McKenzie v. City of Chicago*, 118 F.3d 552, 555 (7th Cir. 1997) ("[T]he question at issue [is] whether a court may grant relief to non-parties. The right answer is no.").

29. This court cannot enjoin the State from enforcing HB2 against Planned Parenthood or other abortion providers who are not parties to this lawsuit—even if this Court concludes that provisions of HB2 are facially unconstitutional. *See Doran*, 422 U.S. at 931; *McKenzie*, 118 F.3d at 555. The scope of the injunction may extend no further than the named plaintiffs.

30. As-applied relief may not extend beyond the named parties to a case. *See Jackson Women's Health Org.*, 2014 WL 3730467, at *9.

31. If the court decides to enjoin the admitting-privileges requirement as an "undue burden" as applied to the McAllen clinic, its injunction may award relief only to the McAllen providers that are named parties to this

case (Whole Woman's Health's clinic in McAllen and Dr. Lynn). The injunction may not extend to present or future Rio Grande Valley providers who are not named parties to this case. *See Jackson Women's Health Org.*, 2014 WL 3730467, at *9.

32. If the court decides to enjoin the ASC requirement as an "undue burden" as applied to the McAllen clinic, its injunction may award relief only to the McAllen providers that are named parties to this case (Whole Woman's Health's clinic in McAllen and Dr. Lynn). The injunction may not extend to present or future Rio Grande Valley providers who are not named parties to this case. *See Jackson Women's Health Org.*, 2014 WL 3730467, at *9.

33. If the court decides to enjoin the admitting-privileges requirement as an "undue burden" as applied to the El Paso clinic, its injunction may award relief only to the El Paso providers that are named parties to this case (the Reproductive Services clinic and Dr. Richter). The injunction may not extend to present or future El Paso providers who are not named parties to this case. *See Jackson Women's Health Org.*, 2014 WL 3730467, at *9.

34. If the court decides to enjoin the ASC requirement as an "undue burden" as applied to the El Paso clinic, its injunction may award relief only to the El Paso providers that are named parties to this case (the Reproductive Services clinic and Dr. Richter). The injunction may not extend to present or

future El Paso providers who are not named parties to this case. *See Jackson Women's Health Org.*, 2014 WL 3730467, at *9.

35. If the court decides to enjoin the admitting-privileges requirement as an "undue burden" as applied to the El Paso clinic, its injunction should state that it will expire as soon as an abortion provider with hospital-admitting privileges begins performing abortions in El Paso. If the court decides to enjoin the admitting-privileges requirement as an "undue burden" as applied to the McAllen clinic, its injunction should state that it will expire as soon as an abortion provider with hospital-admitting privileges begins performing abortions in the Rio Grande Valley .

36. If the court decides to enjoin the ASC requirement as an "undue burden" as applied to the El Paso clinic, its injunction should state that it will expire as soon as an ASC that performs abortions opens in El Paso. If the court decides to enjoin the ASC requirement as an "undue burden" as applied to the McAllen clinic, its injunction should state that it will expire as soon as an ASC that performs abortions opens in the Rio Grande Valley.

III. ADMITTING PRIVILEGES

37. Texas Health and Safety Code § 171.0031 provides, in part, that a physician performing or inducing an abortion must have admitting privileges at a hospital no more than thirty miles from the location at which the abortion is performed or induced.

38. Plaintiffs have brought only as-applied challenges to the admitting-privileges requirement, specifically to the requirement as it applies to the plaintiff clinics and physicians in El Paso and McAllen.

A. Count I – Undue Burden

39. Plaintiffs cannot bring an as-applied rational-basis challenge. *Kimel*, 528 U.S. at 85-86; *Heller*, 509 U.S. at 321; *see also Murgia*, 427 U.S. at 316. Regardless, the admitting-privileges requirement has a rational basis of protecting the health and safety of women in El Paso and the Rio Grande Valley, as well as protecting fetal life in those locations. *Planned Parenthood of Greater Tex.*, 748 F.3d at 594-95; *see also id.* at 590 ("[E]very limit on abortion that furthers a mother's health also protects any existing children and her future ability to bear children."). Plaintiffs have failed to prove the absence of any conceivable rationale for the admitting-privileges requirement.

40. Plaintiffs have not alleged or proven that the purpose of the admitting-privileges requirement was to place a substantial obstacle in the path of women seeking an abortion in El Paso or the Rio Grande Valley. Compl. ¶¶ 138-40; s*ee, e.g.*, *Women's Med. Ctr. of Nw. Houston v. Bell*, 248 F.3d 411, 419 (5th Cir. 2001) ("The record contains no evidence of anti-abortion animus, and no evidence that the 1999 amendments were passed in an attempt to limit abortion access or for any other improper purpose.").

41. Plaintiffs have not proven that the effect of the admitting-privileges requirement is to place a substantial obstacle in the path of women in El Paso or the Rio Grande Valley who may seek an abortion.

a. The admitting-privileges requirement creates burdens similar to those imposed by 24-hour waiting periods and laws that permit only licensed physicians to perform abortions—both of which the Supreme Court has held do not impose undue burdens. *Casey*, 505 U.S. at 885-87; *Mazurek*, 520 U.S. at 973-74. Licensing and certification requirements on abortion providers do not impose an undue burden as a matter of law. *See Mazurek*, 520 U.S. at 974 (noting the Court's "repeated statements . . . that the performance of abortions may be restricted to physicians," including "'only a physician currently licensed by the State'" (quoting *Roe v. Wade*, 410 U.S. 113, 165 (1973)); *id.* at 973 (noting that "the only extant study comparing the complication rates for first-trimester abortions performed by [physician-assistants] with those for first-trimester abortions performed by physicians found no significant difference" but holding that "the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others*") (citations and internal quotation marks omitted); s*ee also A Woman's Choice—E. Side Women's Clinic*, 305 F.3d at 688 ("The Court has held it constitutional to prevent non-

physicians from performing abortions, without factual inquiries into whether other medical professionals could do the job as safely, and how much prices may be elevated by a physician-only rule.") (citation omitted).

b. Added travel costs and the associated inconveniences do not constitute an undue burden as a matter of law. *See Karlin*, 188 F.3d at 481; *Greenville Women's Clinic*, 222 F.3d at 170 (rejecting an "undue burden" challenge to a South Carolina abortion regulation that might cause a Beaufort clinic to close, because "no evidence suggests that women in Beaufort could not go to the clinic in Charleston, some 70 miles away"); *Fargo Women's Health Org.*, 18 F.3d at 533 (upholding a 24-hour waiting period and holding that "[w]e do not believe a . . . single trip, whatever the distance to the medical facility, create[s] an undue burden").

c. The Fifth Circuit has held that an increase of 150 miles for patients living in the Rio Grande Valley (which includes McAllen) is not an undue burden. *Planned Parenthood of Greater Tex.*, 748 F.3d at 598. Further, the burden is lessened because patients who live 100 miles or more from the nearest licensed abortion facility are not required to wait 24 hours after their sonogram before obtaining an abortion. TEX. HEALTH & SAFETY CODE § 171.012(a)(4).

d. Plaintiffs have not proven an undue burden on a large fraction of women in El Paso. Plaintiffs' position that women in El Paso will

travel over 500 miles to San Antonio, rather than 10 miles across the border in New Mexico to receive abortion services is without merit.

e. The Fifth Circuit's recent decision in *Jackson Women's Health Organization* is distinguishable from this lawsuit. Unlike Mississippi, no patient in Texas will be "forced" to travel outside of the State in order to receive abortion services. *Jackson Women's Health Org.*, 2014 WL 3730467, at *6. There will still be at least eight ASCs, and perhaps more in the future, that will be sufficient to meet the demand for abortion. At most, some patients may choose to travel out of state for convenience. Texas has not "effectively extinguishe[d]" the right to an abortion within its borders. *Id.*, at *8. For that reason, the Court may consider the impact of the New Mexico clinic in its undue-burden analysis.

f. Plaintiffs have not proven an undue burden on a large fraction of women in the Rio Grande Valley. The increased travel from Corpus Christi to San Antonio is less than 100 miles for most points in the Rio Grande Valley, and there is no evidence that the cost of such a trip to receive an abortion is different in San Antonio than in Corpus Christi.

g. Regardless, the severability provisions of HB 2 require that any individual unconstitutional application of the admitting-privileges requirement be severed from the rest of the law. The Court cannot generally

hold that the law is unconstitutional in El Paso and the Rio Grande Valley absent proof that every patient in those cities will be unduly burdened.

B. Count II – Equal Protection

42. Plaintiffs have not proven an equal-protection violation as applied to the plaintiffs clinics and physicians in El Paso and McAllen. That the statutory classification may be imperfect does not render it unconstitutional under the Equal Protection Clause. *Murgia*, 427 U.S. at 316. To survive an equal-protection challenge, the admitting-privileges requirement must bear only a rational relationship to a legitimate state interest. *Kimel*, 528 U.S. at 84 ("[W]e will not overturn such [government action] unless the varying treatment of different groups or persons is so unrelated to the achievement of any combination of legitimate purposes that we can only conclude that the [government's] actions were irrational." (internal quotation marks and citation omitted)). For the reasons stated above regarding the rational basis for the admitting-privileges requirement, there is a rational relationship between the requirement and the State's legitimate interests in the health and safety of abortion patients in El Paso and the Rio Grande Valley and the protection of fetal life.

43. Moreover, Texas may distinguish between abortion and other medical procedures. "Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of

[fetal] life." *Harris v. McRae*, 448 U.S. 297, 325 (1980). Therefore, States can impose abortion-specific regulations without extending those requirements to other medical procedures. *See Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 67 (1976) (upholding requirement of written consent for abortion even though not imposed on other surgical procedures); *Women's Health Center of W. Cnty., Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989) (rejecting constitutional challenge to law that "places more stringent requirements on abortions than on other surgical procedures."). Plaintiffs have not proven that classifications that bear a rational relationship to the State's interest in Texas as a whole become irrational when considered in El Paso and the Rio Grande Valley.

44. To the extent Plaintiffs' as-applied challenge is based on the geographical distinction between El Paso, the Rio Grande Valley, and the rest of the State, the admitting-privileges requirement imposes no such classifications on its face. TEX. HEALTH & SAFETY CODE § 171.0031. The Equal Protection Clause prohibits only intentional discrimination. *See Washington v. Davis*, 426 U.S. 229, 242 (1976). There is no evidence that the Legislature intended to discriminate against women in El Paso and the Rio Grande Valley. Regardless, "[t]he Equal Protection Clause relates to equality between persons as such rather than between areas." *Salsburg v. State of Md.*, 346 U.S. 545, 551 (1954).

C. Count III – Unlawful Delegation

45. Plaintiffs have not proven that the admitting-privileges requirement is an unlawful delegation of lawmaking authority as applied to the plaintiff clinics and physicians in El Paso and the Rio Grande Valley. Government delegation to private entities is a time-honored and judicially sanctioned practice. *See Currin v. Wallace*, 306 U.S. 1, 15 (1939); *United States v. Rock Royal Co-operative*, 307 U.S. 533, 577 (1939); *see also* 42 U.S.C. § 3796ii-1(1)(A) (defining "mental illness" according to "the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association."); *Webster*, 871 F.2d at 1382 (rejecting nondelegation challenge to a requirement that abortion providers have surgical privileges at a hospital).

46. "The requirement that physicians performing abortions obtain surgical privileges, which involves the independent action of a public or private hospital, poses no more significant threat to plaintiffs' due process rights than the requirement that those performing abortions be licensed physicians, which involves the independent action of a medical licensing board." *Planned Parenthood of Greater Tex.*, 748 F.3d at 600 (internal quotation marks and citation omitted). If it is constitutional to rely on hospitals for determining admitting privileges in the Texas generally, it is constitutional to rely on hospitals in El Paso and the Rio Grande Valley.

47. That doctors in El Paso and McAllen were unable to obtain admitting privileges does not make the delegation unlawful. Hospitals are prohibited by federal and Texas law from discriminating against doctors who perform abortions. 42 U.S.C. § 300a-7(c)(1); TEX. OCC. CODE § 103.002(b). If those doctors believe they were illegally denied admitting privileges, there is a remedy available to them.

D. Count IV – Arbitrary & Unreasonable State Action

48. The admitting-privileges requirement is not an arbitrary and unreasonable state action in violation of the Due Process Clause as applied to the plaintiff clinics and physicians in El Paso and McAllen. There is no cause of action for "arbitrary and unreasonable state action." To the extent Plaintiffs intend this as some type of rational-basis challenge, it fails for all of the reasons noted above.

IV. ASC REQUIREMENTS

49. Texas Health and Safety Code § 245.010 provides that, on and after September 1, 2014, the minimum standards for an abortion facility must be equivalent to those for an ambulatory surgical center.

A. Count V – Undue Burden

50. The ASC requirement has the rational basis of protecting the health and safety of patients as well as protecting fetal life, with respect to both medical and surgical abortions. *See Planned Parenthood of Greater Tex.*,

748 F.3d at 594-95; *see also id.* at 590. Plaintiffs have failed to prove the absence of any conceivable rationale for the ASC requirement.

51. Plaintiffs have not alleged or proven that purpose of the ASC requirement was to place a substantial obstacle in the path of patients seeking an abortion. Compl. ¶¶ 152-55.

52. Plaintiffs have not proven that the effect of the ASC requirement is to place a substantial obstacle in the path of patients in Texas, El Paso, or the Rio Grande Valley who may seek an abortion.

53. As with the admitting-privilege requirement, the burdens, if any, imposed by the ASC requirement are not unconstitutional. *See, e.g.*, *Greenville Women's Clinic*, 222 F.3d at 170; *see also Women's Med. Professional Corp. v. Baird*, 438 F.3d 595, 604-06 (6th Cir. 2006) (finding no undue burden even though regulation would shut down clinic that served 3000 women a year). Increased travel, in order to receive better health care, is not an undue burden. *Karlin*, 188 F.3d at 481; *Fargo Women's Health Org.*, 18 F.3d at 533. And Plaintiffs have not proven that the costs will be prohibitive, especially in light of the fact that over 20% of abortion patients in Texas already go to ASCs for their abortions. Given that over 90% of women of child-bearing age in Texas will live within 150 miles of an abortion-providing ASC or live outside that distance for reasons not alleged to be related to HB 2, Plaintiffs have failed to prove that a "large fraction" of women will be unduly burdened.

54. Moreover, abortion facilities are able to meet the ASC requirements, as evidenced by the fact that multiple abortion-providing ASCs are open and will open in Texas. That a particular abortion clinic does not wish to update its facilities to meet ASC requirements does not mean that the State is burdening patients who seek abortions.

55. Further, as demonstrated above, if the burdens of travel and cost do not render the admitting-privileges requirement unduly burdensome as applied to El Paso and the Rio Grande Valley, then the ASC requirement also is not an undue burden as applied to El Paso and the Rio Grande Valley, as the travel and costs will be the same.

56. In any event, the severability provision requires that all unconstitutional applications be severed from the statute. Because the ASC requirement is not an undue burden on some women in Texas, it cannot be enjoined across the board.

57. Even if this Court were to determine that the ASC requirement is facially unconstitutional, it cannot issue relief extending beyond the named plaintiffs in this case.

B. Count VI – Equal Protection

58. For the reasons stated above with respect to the admitting-privileges requirement, Plaintiffs have not proven that the ASC requirement violates their equal protection rights. To survive an equal-protection chal-

lenge, the ASC requirement must bear only a rational relationship to a legitimate state interest. *Kimel*, 528 U.S. at 84 ("[W]e will not overturn such [government action] unless the varying treatment of different groups or persons is so unrelated to the achievement of any combination of legitimate purposes that we can only conclude that the [government's] actions were irrational." (internal quotation marks and citation omitted)).

59. Again, "[a]bortion is inherently different from other medical procedures," *Harris*, 448 U.S. at 325, and States can impose abortion-specific regulations. *See Danforth*, 428 U.S. at 66-67; *Webster*, 871 F.2d at 1381. That Texas has chosen to address the health and safety concerns raised by the abortion procedure, but not other procedures, is of no moment, as Texas does not have to address all health and safety concerns at once. *See Danforth*, 428 U.S. at 66-67.

C. Count VII – Arbitrary & Unreasonable State Action

60. Plaintiffs have not proven that the ASC requirement is an arbitrary and unreasonable state action. There is no cause of action for "arbitrary and unreasonable state action." To the extent Plaintiffs intend this as some type of rational-basis challenge, it fails for all of the reasons noted above.

61. Plaintiffs have also not proven that the ASC requirement is "arbitrary and unreasonable" as applied to medical abortion. Medical abortion

presents equal or greater risks for complications, and it is rational to require providers to be able to treat those complications at the place the abortion was induced.

V. ALTERNATIVE GROUNDS FOR JUDGMENT

A. Third-Party Standing

62. The physician plaintiffs (asserting the rights of their patients) and the abortion-clinic plaintiffs (asserting the rights of their patients and suing on behalf of their physician-employees) lack standing to assert the third-party claims raised in the complaint. *Kowalski v. Tesmer*, 543 U.S. 125, 129 (2004) (A litigant "generally must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." (internal citation and quotation marks omitted)). They have not alleged facts that clearly show both (1) that they have a "close relation" to the third parties and (2) there is some "hindrance" to the third parties' ability to protect their own interests, *id.* at 130; *see Warth v. Seldin*, 422 U.S. 490, 518 (1975); *but see Planned Parenthood of Greater Tex.*, 748 F.3d at 589 (finding physicians had standing to challenge admitting privileges requirement).

63. Abortion providers may bring suit on behalf of patients only when the rights holders are "*unable* to assert" their rights. *Diamond v. Charles*, 476 U.S. 54, 65-66 (1986) (emphasis added); *see also McCormack v. Nat'l Collegiate Athletic Ass'n*, 845 F.2d 1338, 1341 (5th Cir. 1988) (The Fifth

Circuit permits third-party standing only when the rights-holder is "disabled from pressing its rights."). The physician plaintiffs failed to clearly demonstrate that patients seeking abortions will face a "hindrance" to protecting their own rights. *Kowalski*, 543 U.S. at 130; *Warth*, 422 U.S. at 518.

64. Numerous plaintiffs have brought cases asserting their own rights post-*Roe*, thus precluding a finding of hindrance. *See, e.g.*, *Williams v. Zbaraz*, 448 U.S. 358 (1980); *Poelker v. Doe*, 432 U.S. 519 (1977) (per curiam); *Roe v. Crawford*, 514 F.3d 789 (8th Cir. 2008); *Doe v. United States*, 372 F.3d 1308 (Fed. Cir. 2004), *sub nom.* 419 F.3d 1058 (9th Cir. 2005); *Coe v. Melahn*, 958 F.2d 223 (8th Cir. 1992); *Rodos v. Michaelson*, 527 F.2d 582 (1st Cir. 1975).

65. Because Plaintiffs challenge regulations designed to protect the health and safety of their patients, which presents an impermissible conflict of interest between the providers and consumers of abortion, they do not have the required "close relation" with their patients. *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 15 (2004) (Mere potential conflicts preclude third-party standing.); *see also Kowalski*, 543 U.S. at 135 (Thomas, J., concurring) (noting that third-party standing is disallowed when the litigants "may have very different interests from the individuals whose rights they are raising."). Abortion providers cannot claim to act on behalf of their patients when they sue to invalidate a law designed to protect patients at the provider's expense.

66. Justice Blackmun's plurality opinion in *Singleton v. Wulff*, 428 U.S. 106 (1976), and the vacated panel opinion in *Okpalobi v. Foster*, 190 F.3d 337 (5th Cir. 1999), are not law. Permitting abortion providers to assert the rights of patients seeking an abortion would overrule *Roe v. Wade*'s holding that Jane Roe's claims were not moot because they were "capable of repetition, *yet evading review*." 410 U.S. at 125 (emphasis added).

B. Third-Party Cause of Action

67. Neither 42 U.S.C. § 1983 nor the Declaratory Judgment Act provides a cause of action for third-party plaintiffs.

68. Section 1983 provides that every "person" acting under color of state law and deprives another person of his rights "shall be liable to the party injured." 42 U.S.C. § 1983. This provision contemplates that only the party whose rights have been deprived may bring a claim under section 1983. *See Rizzo v. Goode*, 423 U.S. 362, 370-71 (1976); *Coon v. Ledbetter*, 780 F.2d 1158, 1160 (5th Cir. 1986); David P. Currie, *Misunderstanding Standing*, 1981 SUP. CT. REV. 41, 45-46. Doctors and abortions facilities may not assert a patient's third-party rights under 42 U.S.C. § 1983.

69. The Declaratory Judgment Act provides that "[i]n a case of actual controversy within its jurisdiction, . . . any court of the United States . . . may declare the rights and other legal relations *of any interested party seeking such declaration*." 28 U.S.C. § 2201 (emphasis added). By authorizing the

federal courts only to declare the rights "of any interested party seeking such declaration," *id*., the Declaratory Judgment Act necessarily excludes actions brought to declare the rights of non-parties, Currie, *Misunderstanding Standing*, 1981 SUP. CT. REV. 41. Doctors and abortions facilities may not assert a patient's third-party rights under the Declaratory Judgment Act.

Respectfully submitted,

GREG ABBOTT
Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

JAMES D. BLACKLOCK
Deputy Attorney General for Legal Counsel

JONATHAN F. MITCHELL
Solicitor General

ANDREW S. OLDHAM
Deputy Solicitor General

ARTHUR C. D'ANDREA
BETH KLUSMANN
PHILIP A. LIONBERGER
MICHAEL P. MURPHY
Assistant Solicitors General

/s/ Andrew B. Stephens
ANDREW B. STEPHENS
Texas Bar No. 24079396
ESTEBAN S.M. SOTO
ENRIQUE VARELA
Assistant Attorneys General

300 West 15th Street
P.O. Box 12548
Austin, Texas 78711-2548
(512) 463-2120 (phone)
(512) 320-0667 (fax)

COUNSEL FOR DEFENDANTS DAVID LAKEY, M.D., AND MARI ROBINSON

Dated: July 30, 2014

CERTIFICATE OF SERVICE

I certify that on July 30, 2014, this document was served on counsel of record through the Court's CM/ECF Document Filing System or through e-mail.

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'CONNELL & SOIFER LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

John H. Bucy, II
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan
David P. Brown
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org
dbrown@reprorights.org

J. Alexander Lawrence
MORRISON & FOERSTER LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

Betre M. Gizaw
Marissa P. Harris
MORRISON & FOERSTER LLP
2000 Pennsylvania Ave., NW, Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com

Colin M. O'Brien
MORRISON & FOERSTER LLP
370 17th Street, Suite 5200
Denver, CO 80202
(303) 592-2252
(303) 592-1510
cobrien@mofo.com

COUNSEL FOR PLAINTIFFS

/s/ Andrew B. Stephens
ANDREW B. STEPHENS
Assistant Attorney General

K

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

WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS d/b/a REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; and LENDOL L. DAVIS, M.D., on behalf of themselves and their patients,	)	
Plaintiffs,	)	CIVIL ACTION
v.	)	CASE NO. 1:14-CV-284-LY
DAVID LAKEY, M.D., Commissioner of the Texas Department of State Health Services; and MARI ROBINSON, Executive Director of the Texas Medical Board, in their official capacities,	)	
Defendants.	)	

PLAINTIFFS' TRIAL BRIEF

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

In 1973, the U.S. Supreme Court held that the State of Texas could not ban abortion within its borders. Texas now seeks to do indirectly what, for forty years, it has been unable to do directly: eliminate access to safe and legal abortion services from most of the State. With the pretext of advancing women's health, Texas has enacted a pair of restrictions that single out abortion from all other medical procedures for the imposition of unreasonable requirements that will do nothing to enhance the health or safety of abortion patients and are impossible for most abortion providers to meet. Prior to the enactment of these requirements, there were 41 licensed facilities providing abortion services in Texas. As of September 1, 2014, there will be at most seven, clustered in four metropolitan areas in the eastern part of the State. There will not be a single licensed facility providing abortion services west or south of San Antonio.

The public health impact of the elimination of licensed abortion providers from the vast majority of the State will be nothing short of catastrophic. Texas has already seen a surge in illegal abortion in areas where licensed abortion facilities have closed. With the closure of the remaining facilities on September 1, 2014, the incidence of illegal abortion will increase substantially, leading to devastating consequences for women who cannot afford to travel long distances to access abortion care.

The evidence presented at trial has demonstrated, unequivocally, that the challenged restrictions on abortion impose an undue burden on women's ability to access safe and legal abortion services in Texas. Accordingly, Plaintiffs respectfully request that the Court declare these requirements to be unconstitutional and permanently enjoin their enforcement.

STATEMENT OF FACTS

I. The Testimony Given by Plaintiffs' Expert Witnesses Is Based on the Witnesses' Own Specialized Knowledge and Experience While the Testimony Given by Defendants' Expert Witnesses Is Based on Facts and Opinions Supplied by a Litigation Consultant with No Relevant Expertise.

Plaintiffs are challenging two provisions of Texas House Bill No. 2 ("the Act"), H.B. 2, 83rd Leg., 2nd Called Sess. (Tex. 2013): the "**admitting privileges requirement**," which provides, in relevant part, 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 located not further than 30 miles from the location at which the abortion is performed or induced," Act, § 2 (codified at Tex. Health & Safety Code Ann. § 171.0031); 25 Tex. Admin Code §§139.53(c), 139.56(a), and the "**ASC requirement**," which provides, in relevant part, that "the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers." Act, § 4 (Tex. Health & Safety Code Ann. § 245.010(a)); 25 Tex. Admin. Code § 139.40. The admitting privileges requirement is currently in effect. Any physician who violates this requirement commits a Class A misdemeanor offense. The physician is also subject to license revocation, and the abortion facility at which the physician provides abortion services is subject to license revocation. *See* Tex. Health & Safety Code § 171.0031; Tex. Occ. Code § 164.055(a); 25 Tex. Admin. Code § 139.32. The ASC requirement is scheduled to take effect on September 1, 2014. Failure to comply with it will give rise to criminal, civil, and administrative penalties, Tex. Health & Safety Code Ann. §§ 245.014 (criminal penalties), 245.015 (civil penalties), 245.017 (administrative penalties), and can result in the denial, suspension, probation, or revocation of an abortion facility license. Tex. Health & Safety Code Ann. § 245.012.

The evidence presented at trial demonstrates that these requirements target abortion providers for the imposition of unique regulatory burdens that are not imposed on any other health care providers in Texas, are inconsistent with accepted medical standards, impose costs that are far in excess of any potential benefits, and will dramatically reduce the number and geographic distribution of medical facilities in the State where women can access safe and legal abortion services.

This evidence includes the testimony of seven expert witnesses called by the Plaintiffs:

- **Anne Layne-Farrar, Ph.D.**, an economist who holds a Ph.D. from the University of Chicago and serves as a Vice President of Charles River Associates, a top economic consulting firm, with extensive experience conducting cost-benefit analysis of proposed regulations, Layne-Farrar Direct at ¶¶ 1-5; Tr. Vol. 1 (Rough) at 188:6-189:8; Ex. P-001;
- **Elizabeth Gray Raymond, M.D., M.P.H.**, a leading medical researcher in the field of reproductive health with over 25 years of experience designing, managing, and evaluating clinical trials and other scientific studies, Raymond Direct at ¶¶ 1-6; Tr. Vol. 1 (Rough) at 141:6-22; Ex. P-003;
- **Daniel Grossman, M.D.**, a board-certified obstetrician-gynecologist ("ob-gyn") who serves as Vice President for Research at Ibis Reproductive Health, Grossman Direct at ¶¶ 1-6; Ex. P-002;
- **Paul M. Fine, M.D.**, a board-certified ob-gyn who serves as Medical Director of Planned Parenthood Gulf Coast and several municipal police, fire, and Emergency Medical Services ("EMS") departments in Galveston County, Fine Direct at ¶¶ 1-3; Ex. P-006;

- **George W. Johannes, A.I.A.**, a licensed architect with extensive experience designing healthcare facilities, including ambulatory surgical centers ("ASCs"), Johannes Direct at ¶¶ 1-4; Tr. Vol. 1 (Rough) at 85:14-86:12; P-004;
- **Kristine Hopkins, Ph.D.**, a sociologist specializing in demography at the University of Texas at Austin, whose research focuses on women's reproductive health, Hopkins Direct at ¶¶ 1-4; Ex. P-005;
- **Lucila ("Lucy") Ceballos Felix**, a State-certified *promotora* with over 17 years of experience working as a community health educator in the Rio Grande Valley, Felix Direct at ¶¶ 1-5; Tr. Vol. 1 (Rough) at 118:2-23.

The testimony given by these witnesses is based on their own specialized knowledge and experience in their respective fields. It is credible and reliable in all respects.

The evidence at trial also included testimony by five expert witnesses called by Defendants: Mayra Jimenez Thompson, M.D., an ob-gyn; James Anderson, M.D., a physician specializing in family practice and emergency medicine; Deborah Kitz, Ph.D., a healthcare consultant; Peter Uhlenberg, Ph.D., a retired sociologist and demographer; and Todd Giberson, an IT professional employed by the State Attorney General's Office ("OAG"). The testimony of four of these five witnesses (Drs. Thompson, Anderson, Kitz, and Uhlenberg) was drafted by Vincent Rue, Ph.D., a litigation consultant with no medical background engaged by OAG. Each of the four witnesses initially denied the scope of Mr. Rue's involvement, *see, e.g.* Tr. Vol. 4 (Rough) at 95:20-21 ("As far as I know, I have not discussed with Dr. Rue the substance of the case or the opinions."), but ultimately conceded that Rue drafted substantive portions of their testimony after being confronted by their email correspondence with him.

For example, Dr. Thompson initially denied that Dr. Rue contributed substantively to her testimony. Tr. Vol. 3 (Rough) at 7:13-9 ("Q: Dr. Thompson, isn't it true that Vincent Rue took the lead in drafting your expert report in this case? A. No. Q. Isn't it true that you sent Dr. Rue certain materials that you wanted him to include in the expert report, and he declined to include those materials? A. No."); *see also* Tr. Vol. 3 (Rough) at 18:1-14, 19:17-23. However, an email sent from Dr. Rue to Dr. Thompson on the day before Defendants' rebuttal expert reports were due shows that Dr. Rue drafted Dr. Thompson's rebuttal to Dr. Grossman's expert report before Dr. Thompson had ever seen Dr. Grossman's expert report. Tr. Vol. 3 (Rough) at 16:4-17:19; Exs. P-211-212. Further, an email from Dr. Rue to Dr. Thompson at 4:21 a.m. on the day that Defendants' rebuttal expert reports were due attached a copy of Dr. Thompson's rebuttal expert report and stated: "I tried to use as much of your material as I could, but time ran out." Tr. Vol. 3 (Rough) at 19:17-22; Ex. P-213. Dr. Thompson admitted that the opinions she offered in her written direct testimony were the same as the ones contained in her rebuttal expert report. Tr. Vol. 3 (Rough) at 5:9-12.

Dr. Anderson was more candid: he testified that he wrote his direct testimony as a "team" with Dr. Rue, Tr. Vol. 3 (Rough) at 48:10-17, 52:19-53:5, 59:22-60:11, 62:8-63:4, and that Dr. Rue was allowed to "overrule" Dr. Anderson's own judgment about whether to offer an opinion, Tr. Vol. 3 (Rough) at 52:3-18, Ex. P-216.[1]

[1] Also, an "exhibit" to Dr. Anderson's written direct testimony that had been created by Dr. Rue was not included as part of Dr. Anderson's submission to the Court; its removal was apparently done without the knowledge of Dr. Anderson, who said "[i]t's supposed to be attached" and "the fact that it's not there is a surprise to me." Tr. Vol. 3 (Rough) at 59:11-59:21, 60:22-25; 61:23-62:7. This raises serious questions about how else Dr. Anderson's testimony may have been altered after he signed off on it and whether the direct testimony submitted to the Court is a complete and accurate reflection of his views, as he testified it was. *See, e.g.*, Tr. Vol. 3 (Rough) at 45:9-11 (Q. The statements that you're making here on direct testimony are yours and yours alone, correct? A. Correct.").

During her deposition, Dr. Kitz denied that anyone contributed to the writing of her expert report. Tr. Vol. 4 (Rough) at 22:22-23:2 ("Q: And at your deposition you were asked: Did anyone else contribute to writing your report? Do you recall that? A. Yes. Q. And you responded no? A. Correct."); *see* Kitz Dep. Tr. 28:14-25. But after being confronted with the relevant documents, Dr. Kitz admitted that Dr. Rue developed her testimony based on a series of bullet points she had written, Tr. Vol. 4 (Rough) at 23:25-24:5, Ex. P-218, and that he added information to subsequent drafts that Dr. Kitz had not written, including a rebuttal of an expert report which, at that point, Dr. Kitz had not read, Tr. Vol. 4 (Rough) at 24:19-25:16; 26:23-29:2, Exs. P-219-220, P-222-223.

Likewise, Dr. Uhlenberg testified at his deposition that he had not discussed his opinions with Dr. Rue and never spoke with Dr. Rue about the substance of his report. Tr. Vol. 4 (Rough) at 94:8-95:21, 105:22-106:12. But on cross-examination at trial, Dr. Uhlenberg admitted that he had received "critical suggestions" from Dr. Rue about how to present an opinion, Tr. Vol. 4 (Rough) at 100:18-101:13, Ex. P-229, and that he included an opinion in his testimony at the behest of Dr. Rue that he himself had wished to omit, Tr. Vol. 4 (Rough) at 104:16-105:16, Ex. P-230.

Drs. Thompson, Anderson, and Uhlenberg also testified that they relied on various sources provided to them by Dr. Rue, some of which they did not review independently. Tr. Vol. 3 (Rough) at 20:5-20, 48:1-9, 54:4-24; 55:9-12; Tr. Vol. 4 (Rough) at 106:17-107:16; Exs. P-214, P-231.

Dr. Rue's involvement in developing substantive components of the direct testimony of these witnesses, and the witnesses' lack of veracity about Dr. Rue's involvement until confronted by documentary evidence, cast serious doubt on the testimony's credibility and reliability.

Accordingly, the Court should give little weight to the testimony of Drs. Thompson, Anderson, Kitz, and Uhlenberg in resolving disputed factual issues.

II. At the Time the ASC and Admitting Privileges Requirements Were Enacted, Existing Regulations Were Sufficient to Ensure the Health and Safety of Abortion Patients.

The ASC and admitting privileges requirements were not written on a blank slate. Prior to their enactment, Texas had in place numerous laws regulating the medical profession generally and abortion providers specifically. For example, under Texas law, all healthcare providers are required to meet accepted standards of medical care and are liable in tort if their failure to do so causes injury. *See generally* Tex. Civ. Prac. & Rem. Code Ann. §§ 74.001 – 74.507. Similarly, all physicians are required to practice medicine in an "acceptable professional manner consistent with public health and welfare" and are subject to disciplinary action by the Texas Medical Board for failure to do so. 22 Tex. Admin. Code § 190.8(1). Failure to practice in an acceptable professional manner consistent with public health and welfare expressly includes "failure to timely respond in person . . . when requested by emergency room or hospital staff." 22 Tex. Admin. Code § 190.8(1)(F).

Further, all healthcare facilities, other than hospitals and ASCs, that provide 50 or more abortion procedures on an annual basis must be licensed by the Texas Department of State Health Services ("DSHS" or the "Department") under chapter 139 of the Texas Administrative Code and meet the detailed standards set forth in that chapter. *See* 25 Tex. Admin. Code §§ 139.1 – 139.60. These standards include, *inter alia*, requirements concerning quality assurance ("QA"), 25 Tex. Admin. Code § 139.8; unannounced inspections, 25 Tex. Admin. Code § 139.31; policy development and review, 25 Tex. Admin. Code § 139.41; organizational structure, 25 Tex. Admin. Code § 139.42; orientation, training, and review of personnel, 25 Tex. Admin. Code § 139.44; qualifications of clinical and non-clinical staff, 25 Tex. Admin. Code §

139.46; physical environment, 25 Tex. Admin. Code § 139.48; infection control, 25 Tex. Admin. Code § 139.49; patient rights, 25 Tex. Admin. Code § 139.51; medical and clinical services, 25 Tex. Admin. Code § 139.53; health care services, 25 Tex. Admin. Code § 139.54; clinical records, 25 Tex. Admin. Code § 139.55; emergency services, 25 Tex. Admin. Code § 139.56; discharge and follow-up, 25 Tex. Admin. Code § 139.57; and anesthesia services, 25 Tex. Admin. Code § 139.59. In most respects, these standards are comparable to, or more stringent than, than minimum standards for ambulatory surgical centers ("ASCs") set forth in chapter 135 of the Texas Administrative Code. For example, whereas licensed abortion facilities must be inspected at least once annually,[2] 25 Tex. Admin. Code § 139.31(b)(1), ASCs need only be inspected once every three years, 25 Tex. Admin. Code § 135.21(a)(2). But the minimum standards for ASCs are more stringent in two respects: (1) they impose detailed requirements for new construction that abortion facilities are not currently required to meet, *see* 25 Tex. Admin. Code § 135.52; and they require the nursing staff to be much larger than at licensed abortion facilities, *compare* 25 Tex. Admin. Code § 135.15(a) *with* 25 Tex. Admin. Code § 139.46(3)(B). It is the construction and nursing requirements that form the basis of Plaintiffs' challenge.

Two requirements of Texas law that were in effect at the time of the Act's enactment are especially noteworthy. First, Texas law required that: "A licensed abortion facility shall have a readily accessible written protocol for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital. The facility shall ensure that the physicians who practice at the facility have admitting privileges or have a working arrangement with a

[2] A licensed abortion facility must also be inspected any time a complaint is made against it for violation of any applicable regulation, even if the complaint is made by an anti-abortion advocacy group. *See* 25 Tex. Admin. Code § 139.31(c). From January 2008 to June 2013, sixty-one complaint inspections were conducted at licensed abortion facilities in Texas, in addition to the annual licensure inspection of each facility. *See* Ex. P-014 at 5.

physician(s) who has admitting privileges at a local hospital in order to ensure the necessary back up for medical complications." 25 Tex. Admin. Code § 139.56(a) (2012). This requirement was superseded by the admitting privileges requirement challenged here. Second, Texas law required that "[a]n abortion of a fetus age 16 weeks or more may be performed only at an ambulatory surgical center or hospital licensed to perform the abortion." Tex. Health & Safety Code Ann. §171.004. This requirement remains in effect and is not challenged by Plaintiffs.

The record demonstrates that, at the time the ASC and admitting privileges requirements were enacted, existing regulations were sufficient to ensure the health and safety of abortion patients. In the five years leading up to the enactment of these requirements, only sixteen enforcement actions were taken against the State's more than three-dozen licensed abortion facilities, and these were primarily for alleged violations of recordkeeping and other administrative requirements. Layne-Farrar Direct at ¶ 26; Ex. P-014. None of these enforcement actions related to any serious health or safety risk. Layne-Farrar Direct at ¶ 26; Ex. P-014. Further, the Executive Director of the Texas Medical Board testified that, from her thirteen-year tenure at the Medical Board, which included service as Manger of Investigations and Enforcement Director, she could not identify a single instance in which a physician practicing at a licensed abortion facility engaged in conduct that posed a threat to public health or welfare that could not be adequately addressed through existing regulation. Tr. Vol. 4 (Rough) at 83:2-84:2. She further testified that she could not identify a single instance of an abortion provider failing to respond to a request by emergency room or hospital staff. Tr. Vol. 4 (Rough) at 81:2-82:18. In contrast, the Executive Director recalled vividly "a very high-profile case of a young child who died, I believe it was in a dental office, when anesthetic was used but the proper training and

equipment was not available." Tr. Vol. 4 (Rough) at 86:17-20. Dentists are not subject to an ASC or admitting privileges requirement under Texas law.

III. Abortion as Currently Practiced in the United States Is an Extremely Safe Procedure.

There are generally two methods of performing abortions in the United States: surgical abortion, which involves the use of medical instruments to evacuate the contents of the uterus; and medical abortion, which involves the administration of medications that cause the termination of a pregnancy. Raymond Direct at ¶ 11; Fine Direct at ¶¶ 7-15. Both types of abortion are extremely safe. Raymond Direct at ¶¶ 12-22; Fine Direct at ¶ 16; Grossman Direct at ¶¶ 36-39.

The mortality rate for legal induced abortion in the United States is quite low and has declined over time. Raymond Direct at ¶¶ 12-15. In 1973-1979, following the Supreme Court's decision in *Roe v. Wade*, the U.S. Centers for Disease Control and Prevention ("CDC") estimated this rate as 2.09 deaths per 100,000 procedures. *Id.* at ¶ 15. The risk subsequently dropped and has been stable at the current rate, of approximately 0.69 deaths per 100,000 legal abortions, for the past 30 years. *Id.* at ¶¶ 12-15.

To put this risk in context, it is important to consider that, nationwide, the risk of death from childbirth is roughly 14 times higher than the risk of death from abortion. *Id.* at 23; Tr. Vol. 1 (Rough) at 146:5-148:1. Texas' maternal mortality ratio is significantly higher than the national average, and in Texas, the risk of death from childbirth is roughly 100 times higher than the risk of death from abortion. Raymond Direct at ¶ 24 & Table 2; Tr. Vol. 1 (Rough) at 148:2-149:15.

Serious nonfatal complications from abortion are also rare and seldom require hospitalization. Dr. Raymond testified about nine different studies concerning abortion-related

morbidity. Raymond Direct at ¶¶ 17-22 & Table 1; Tr. Vol. 1 (Rough) at 141:23-145:6. Each of these studies was conducted independently of the others by different researchers at different times using patient data from different sources. Raymond Direct at ¶ 17. At least one of the studies had essentially complete follow up. *Id.* at ¶ 20; Tr. Vol. 1 (Rough) at 144:7-10. All of the studies reported a total complication rate of less than 4% and a rate of major complications requiring hospitalization of less than 0.5%. Raymond Direct at ¶¶ 17-22 & Table 1. Additional studies referenced in Dr. Grossman's testimony are also consistent with these findings. Grossman Direct at ¶ 39.

Many procedures commonly performed in office-based settings are comparable in safety to abortion or entail greater risks. Such procedures include dilation and curettage, endometrial ablation; colonoscopy, cystoscopy, vasectomy, and plastic surgery. Raymond Direct at ¶¶ 28-30; Fine Direct at ¶¶ 11, 18; Grossman Direct at ¶ 38. Colonoscopy, for example, has a mortality rate that is roughly ten times higher than the mortality rate for abortion. Raymond Direct at ¶ 30; Layne-Farrar Direct at ¶¶ 63-64.

While, abortion is extremely safe throughout pregnancy, the medical risks of abortion increase with gestational age. Raymond Direct at ¶¶ 16, 55; Fine Direct at ¶ 43. As a result, women who are delayed in accessing abortion care are exposed to increased risks. Raymond Direct at ¶¶ 16, 55; Fine Direct at ¶ 43.

Although Drs. Thompson and Anderson contend that abortion-related complications are underreported, neither has a credible basis for doing so. Dr. Thompson admitted during cross-examination that she had not reviewed the sources concerning abortion-related mortality on which Dr. Raymond relies, which include data published by the CDC; that she was unfamiliar with the methodology used by the CDC to collect data about abortion-related mortality; and that

she reviewed only one of the nine studies cited by Dr. Raymond concerning abortion-related morbidity. Tr. Vol. 3 (Rough) at 31:5-34:3. And Dr. Anderson admitted that his opinions about abortion-related complications are based on anecdotal experience rather than data. Tr. Vol. 3 (Rough) at 75:23-25 ("It just seems, from my anecdotal experience, that it's more frequent than the numbers I read. But I don't have any data to validate that."). He also testified that his anecdotal experience is from more than a decade ago, prior to when he ended his emergency room practice in 2005. Tr. Vol. 3 (Rough) at 83:14-85:17.

IV. Plaintiffs Have Been Providing High-Quality Reproductive Health Care Services to Texas Women for Decades.

Plaintiff Nova Health Systems d/b/a Reproductive Services ("Reproductive Services") is a nonprofit organization founded by Marilyn Eldridge and her late husband, Myron Chrisman, who was a Christian minister. Tr. Vol. 2 (Rough) at 19:25-20:22. Its mission is to provide high-quality and affordable reproductive healthcare services, including abortion services, to women in underserved communities.[3] Eldridge Direct at ¶ 1; Tr. Vol. 2 (Rough) at 20:19-22. Ms. Eldridge graduated from the University of Texas Law School in 1963, one of only five women in her graduating class. Tr. Vol. 2 (Rough) at 18:25-19:8. Due to sex discrimination, which was prevalent at that time, she could not get a job as a lawyer in Texas. Tr. Vol. 2 (Rough) at 19:9-15. Instead, she began to volunteer at Planned Parenthood, and eventually founded Reproductive Services with Rev. Chrisman. Tr. Vol. 2 (Rough) at 19:16-20:16. In March 1973, following the Supreme Court's decision in *Roe v. Wade*, Reproductive Services opened the first nonprofit

[3] In 1987, the principals of Reproductive Services founded a nonprofit organization called Adoption Affiliates, whose mission is to make professional, nonjudgmental adoption services available to women with unintended pregnancies. *Id.* at ¶ 3. Adoption Affiliates personnel worked on-site at the El Paso clinic to assist women who wished to place their children for adoption. *Id.*; Tr. Vol. 2 (Rough) at 21:8-22:12. Over the years, it facilitated the placement of more than 800 children. Tr. Vol. 2 (Rough) at 21:14-23.

abortion clinic in the State of Texas. Tr. Vol. 2 (Rough) at 20:14-16. It operated continuously in the State until its El Paso facility (the "El Paso clinic") was forced to close earlier this year because it could not meet the admitting privileges requirement. Eldridge Direct at ¶ 2. Plaintiff Pamela J. Richter, D.O., served as Medical Director of the El Paso clinic for the past 20 years and would like to resume that role. Eldridge Direct at ¶¶ 13, 27. If the admitting privileges and ASC requirements were enjoined, Reproductive Services would reestablish a licensed abortion facility in El Paso. Eldridge Direct at ¶ 27.

Plaintiff Whole Woman's Health has been providing high quality reproductive health care services, including abortion services, to Texas women for over a decade. Hagstrom Miller Direct at ¶ 1; Tr. Vol. 2 (Rough) at 89:25-90:8. It offers a safe and supportive environment to women seeking abortion services and prides itself on providing a holistic approach to abortion care that includes counseling services and emotional support for patients. Tr. Vol. 2 (Rough) at 68:3-6; 89:22-90:8. It currently operates licensed abortion facilities in Fort Worth and San Antonio. Hagstrom Miller Direct at ¶ 1. In addition, it operates a licensed ASC in San Antonio. *Id.* Until recently, Whole Woman's Health also operated licensed abortion facilities in Austin, Beaumont, and McAllen (the "McAllen clinic"). *Id.* These facilities closed as a result of the admitting privileges and ASC requirements. *Id.* If those provisions were enjoined, Whole Women's Health would reestablish licensed abortion facilities in Austin and McAllen. *Id.* at ¶¶ 3, 20.

Plaintiff Sherwood C. Lynn, Jr., M.D., is a board-certified ob-gyn with over 38 years of experience practicing medicine. Lynn Direct at ¶ 1. He currently serves as the Medical Director of the Whole Woman's Health facilities in San Antonio, and he seeks to provide abortion services at the McAllen clinic. *Id.* at ¶¶ 3, 7. Although Dr. Lynn retired from most facets of his

medical practice in 2006, he continues to provide abortion services because he believes that there is a critical need for those services but not enough physicians in Texas willing to provide them. *Id.* at ¶ 1.

Plaintiff Austin Women's Health Center operates a licensed abortion facility in Austin. Until recently, its sister clinic, Plaintiff Killeen Women's Health Center, operated a licensed abortion facility in Killeen. That facility closed in anticipation of the ASC requirement's implementation. Davis Direct at ¶ 6; Tr. Vol. 1 (Rough) at 27:10-28:6. Together, Austin Women's Health Center and Killeen Women's Health Center (collectively, the "Health Centers") have provided high quality reproductive health care services, including abortion services, to Texas women for over 35 years. Davis Direct at ¶ 3. Throughout that time, Plaintiff Lendol L. "Tad" Davis, M.D., board-certified ob-gyn, has served as the Medical Director of those facilities. *Id.* at ¶¶ 1, 3.

Each of the clinic Plaintiffs is a member of the National Abortion Federation ("NAF") and is therefore required to comply with NAF's Clinical Policy Guidelines. Eldridge Direct at ¶ 5; Hagstrom Miller Direct at ¶ 2; Davis Direct at ¶ 3.

V. After Providing Safe Abortion Care for Decades, the McAllen and El Paso Clinics Were Forced to Close as a Result of the Admitting Privileges Requirement.

A. The McAllen Clinic.

Prior to its recent closure, the McAllen clinic had operated continuously since January 2004. Hagstrom Miller Direct at ¶ 4. The McAllen clinic provided abortion services up to 16 weeks of pregnancy. *Id.* at ¶ 5. The highest level of sedation offered to patients was moderate sedation/analgesia, also known as conscious sedation. *Id.* at ¶ 6. In addition to abortion services, the McAllen clinic provided a variety of gynecological and family planning services to women in the Rio Grande Valley. *Id.* at ¶ 3. During its ten years of operation, the McAllen clinic provided

abortion services to over 14,000 patients. *Id.* at ¶ 7. Only two of these patients required transfer from the clinic to a hospital. *Id.* In both cases, the patients were successfully treated at the hospital. *Id.*

After the admitting privileges requirement was enacted, four physicians affiliated with Whole Woman's Health, including Dr. Lynn, sought to obtain admitting privileges at a hospital within 30 miles of the McAllen clinic. Hagstrom Miller Direct at ¶ 8; Lynn Direct at ¶ 7. All four physicians are board-certified ob-gyns with years of experience performing abortion procedures, and three of them maintain admitting privileges at hospitals in other parts of the State. Hagstrom Miller Direct at ¶ 8; Lynn Direct at ¶¶ 1, 6. Dr. Lynn, for instance, has admitting privileges at hospitals in San Antonio and Austin. Lynn Direct at ¶ 6.

There are eight hospitals located within 30 miles of the McAllen clinic. Each of them requires, as a condition of granting admitting privileges, that an application be signed by a "designated alternate" physician willing to attend to the applicant's patients when the applicant is unavailable. Lynn Direct at ¶¶ 8-10; Hagstrom Miller Direct at ¶¶ 9-10; Tr. Vol. 2 (Rough) at 82:1-21. The designated alternate physician must already have admitting privileges at the hospital. If an application is not signed by a designated alternate physician, it will not be considered, regardless of whether the applicant meets the hospital's other requirements. Lynn Direct at ¶¶ 8-10; Hagstrom Miller Direct at ¶¶ 9-10; Tr. Vol. 2 (Rough) at 82:1-21. Although Whole Woman's Health and Dr. Lynn reached out to numerous physicians with hospital admitting privileges in the McAllen area, only one was willing to serve as a designated alternate physician for the doctors affiliated with the McAllen clinic, and that physician had privileges at only one area hospital: Doctors Hospital at Renaissance. Hagstrom Miller Direct at ¶ 11; Lynn Direct at ¶ 11; Tr. Vol. 1 (Rough) at 162:22-164:4.

Thus, the physicians affiliated with the McAllen clinic were only able to satisfy the application criteria for Doctors Hospital at Renaissance. Hagstrom Miller Direct at ¶ 12; Lynn Direct at ¶ 12. At this hospital, the first step in applying for admitting privileges is to submit a written request for an application for admitting privileges. Hagstrom Miller Direct at ¶ 13; Lynn Direct at ¶ 13. In September 2013, all four physicians submitted such requests. Hagstrom Miller Direct at ¶ 13; Lynn Direct at ¶ 13; Ex. P-069. Two months later, each of the physicians received a letter in response stating that, based on the recommendation of the hospital's Credentials Committee, the Medical Executive Committee was denying the physician's request for an application for privileges. Hagstrom Miller Direct at ¶ 14; Lynn Direct at ¶ 14; Exs. P-068, P-071. The letters noted that the "decision of the Governing Board was **not** based on clinical competence consideration." Exs. P-068, P-071 (emphasis in original).

Despite extensive efforts, Whole Woman's Health was also unsuccessful in recruiting physicians who already possessed admitting privileges at a hospital within 30 miles of the McAllen clinic to provide abortion services at the clinic. Hagstrom Miller Direct at ¶ 15. As a result, the McAllen clinic has been unable to comply with the admitting privileges requirement. It was forced to stop providing abortion services when the requirement took effect on October 31, 2013. *Id.* at ¶ 3. For four months, it remained open providing non-abortion services. *Id.* But it ceased operations altogether on March 6, 2014, after ten years of providing safe abortion care to women in the Rio Grande Valley. *Id.*

B. The El Paso Clinic.

Prior to its recent closure, the El Paso clinic had operated continuously since 1977. Eldridge Direct at ¶ 5. It was legally permitted to provide abortion services up to 16 weeks of pregnancy, Tex. Health & Safety Code Ann. §171.004, and it also offered a variety of other

gynecological and family planning services, Eldridge Direct at ¶ at ¶¶ 6-7. The highest level of sedation used at the El Paso clinic was minimal sedation. *Id*. at ¶ 7. During the ten years prior to its closure, the El Paso clinic did not experience a single medical emergency requiring transfer of a patient to the hospital; over 17,000 abortions were performed there during that time. *Id*. at ¶¶ 24, 29; Tr. Vol. 2 (Rough) at 7:16-20.

The Medical Director of the El Paso Clinic was Dr. Pamela Richter, who served in that role for over twenty years. Eldridge Direct at ¶ 8; Tr. Vol. 2 (Rough) at 11:8-10. Dr. Richter is a board-eligible family medicine physician licensed to practice medicine by the State of Texas. Eldridge Direct at ¶ 8. She graduated from the Texas College of Osteopathic Medicine in 1983, then completed an internship at the Corpus Christi Osteopathic Hospital. *Id*. Dr. Richter is a warm and caring physician with an excellent bedside manner. *Id*. at ¶ 9; Tr. Vol. 2 (Rough) at 11:11-12. For more than two decades, she provided outstanding care to the patients at the El Paso clinic. Eldridge Direct at ¶ 8. In addition, Dr. Richter works for the State of Texas. *Id*. at ¶ 10. She serves as a staff physician for the state supported living center ("State Center") in El Paso operated by the Texas Department of Aging and Disability Services ("DADS"). *Id*. There, she provides general medical care and gynecological services to people with intellectual and developmental disabilities who are medically fragile or have behavioral problems. *Id*.

From 1990 to 2009, Dr. Richter was board certified in family medicine. *Id*. at ¶ 12. She did not seek recertification after 2009 because the nature of her practice did not require board certification. *Id*. Dr. Richter maintained admitting privileges at a hospital in El Paso from 1990 to 2000. *Id*. at ¶ 13; Tr. Vol. 2 (Rough) at 5:23-6:5. She resigned from the hospital staff in June 2000 because, at that point, the nature of her practice did not require her to admit patients to the hospital and she was having difficulty satisfying the hospital's minimum patient contact

requirement and holding emergency room call as frequently as the hospital required. Eldridge Direct at ¶ 13; Tr. Vol. 2 (Rough) at 6:6-10.

After passage of the admitting privileges requirement, Dr. Richter sought to obtain admitting privileges at a hospital within 30 miles of the El Paso clinic. Eldridge Direct at ¶ 15. The administrator of the El Paso clinic assisted her with this process. Tr. Vol. 2 (Rough) at 14:11-15. They identified four hospital groups within a 30-mile radius of the clinic: Las Palmas del Sol ("Las Palmas"), which includes two qualifying hospitals, Las Palmas Medical Center and Del Sol Medical Center; University Medical Center of El Paso ("UMC"); Sierra Providence Health Network ("Sierra Providence"), which includes three qualifying hospitals, Providence Memorial Hospital, Sierra Medical Center, and Sierra Providence East Medical Center; and Foundation Surgical Hospital of El Paso ("Foundation"). Eldridge Direct at ¶ 16. To date, Dr. Richter has been unable to secure permanent admitting privileges at any of these hospitals. *Id*. at ¶ 17.

At Foundation, Dr. Richter was granted temporary privileges for 120 days beginning on January 13, 2014. Eldridge Direct at ¶ 20; Ex. P-030. Subsequently, Foundation sent a letter dated February 12, 2014, stating that Dr. Richter's application for permanent privileges was being denied. The letter stated that "it is the decision of the Governing Body to deny your application for the reason that you do not meet requirement [sic] for successfully completing a residency in the field of specialty for which clinical privileges are required." Eldridge Direct at ¶ 21; Ex. P-060. This was curious because the application form for family medicine privileges at this hospital indicates that completion of a family medicine residency is not required if the physician can demonstrate "active participation in the examination process leading to certification in family practice . . . ." Ex. P-062. In fact, Dr. Richter had registered to take the

board examination for family medicine in November 2014, which is the next available testing period. Eldridge Direct at ¶ 21. The hospital's C.E.O. candidly told a DSHS investigator that, after learning that Dr. Richter was an abortion provider, the hospital combed through its own bylaws looking for a reason to deny her privileges. Ex. P-046 ("He stated the facility was not aware that Dr. Richter provided abortion services. He stated after finding out she provided these services that the facility looked at the bylaws and application to see if there was a reason to deny privileges to Dr. Richter."). Subsequently, Reproductive Services was informed through its attorney that Foundation Hospital would no longer honor Dr. Richter's temporary privileges. Eldridge Direct at ¶ 22.

Reproductive Services has sought to recruit additional physicians to provide abortion services at the El Paso clinic, but has not succeeded in doing so. *Id*. at ¶ 25. As a result, upon learning that Foundation Hospital would no longer honor Dr. Richter's temporary admitting privileges, the El Paso clinic was forced to cease providing abortion services. *Id*. at ¶ 25. It closed completely on June 1, 2014, after 37 years of continuous service to the women of West Texas. *Id*.

VI. Absent Relief from the Court, Plaintiffs' Remaining Clinics Will be Forced to Close as a Result of the ASC Requirement.

None of the licensed abortion facilities currently operated by the Plaintiffs meet the new construction standards for ASCs set forth in 25 Tex. Admin. Code § 135.52. *See* Joint Stipulation of Facts ("Stipulation") at ¶ 4 (Dkt. No. 154); Johannes Direct at ¶¶ 7, 31. Further, it would not be possible to renovate any of those facilities to meet the new construction standards because their footprints are too small. *Id.* at ¶¶ 7, 32.

Of the licensed abortion facilities currently operated by Plaintiffs, only the one operated by Whole Woman's Health in Fort Worth could be expanded to meet the new construction

standards for ASCs. *Id.* at ¶¶ 7, 35. Doing so would cost approximately $2.6 million. *Id.* at ¶ 36. Whole Woman's Health sought to purchase an existing ASC in Fort Worth, which would allow it to avoid downtime during construction. It identified a facility that would meet its needs, which was appraised at $2.3 million. Tr. Vol. 2 (Rough) at 72:12-21. It was unable to obtain financing for the purchase, however, despite engaging a broker who approached more than fifteen banks. Tr. Vol. 2 (Rough) at 72:22-74:19.

Whole Woman's Health also attempted to lease one or more ASCs. Tr. Vol. 2 (Rough) at 69:11-21. The owners of the Fort Worth ASC discussed above were unwilling to enter into a lease agreement with Whole Woman's Health. Tr. Vol. 2 (Rough) at 75:15-17. Whole Woman's Health had a promising lead on an ASC in Austin that was available for lease, but it turned out that a restrictive covenant ran with the property prohibiting the performance of abortions on the premises. Tr. Vol. 2 (Rough) at 69:23-71:22; Ex. P-066. Whole Woman's Health also sought to lease an ASC in McAllen, but the owners had religious objections to abortion and would not move forward with the transaction. Tr. Vol. 2 (Rough) at 80:20-81:9. In addition, Whole Woman's Health investigated the possibility of purchasing one or more mobile ASC units. Tr. Vol. 2 (Rough) at 78:11-79:25; Ex. P-067. Amy Hagstrom Miller, the President of Whole Woman's Health, contacted DSHS in April 2014 to ask if the mobile unit would satisfy the new construction standards for ASCs. Tr. Vol. 2 (Rough) at 77:24-78:25; Ex. P-019. To date, she has not received a substantive response. Tr. Vol. 2 (Rough) at 79:1-10.

Dr. Davis and his wife, who are respectively the Medical Director and Executive Director of the Health Centers, would like to build an ASC in Austin so they can continue to serve their patients there. Davis Direct at ¶ 8 ("Given the high level of need for abortion services in Texas, and the devastating consequences that can result when women do not have access to safe

abortion care, I am doing everything in my power to be able to continue providing abortion services at the one remaining Health Center."). They used their retirement savings to purchase a piece of property for $1.125 million with the aim of constructing a facility on it that meets ASC standards. *Id.* at 9. But after retaining an architectural firm that specializes in healthcare facility design to conduct a feasibility study, they learned that the ASC would have to be over 7,000 square feet in area to satisfy all of the new construction standards for ASCs, and construction would cost roughly $3.116 million, exclusive of site development costs. *Id.* at ¶ 11; Ex. P-073. They are now unsure whether they will move forward with the project. Davis Direct at ¶ 12. They are concerned that, even if they are able to obtain financing for the project, in order to make the loan payments when the building is complete, they would have to raise the price of an abortion considerably, which could make it prohibitively expensive for their patients to obtain abortion care. *Id.* If they do move forward with the project, the construction would take at least eighteen months to complete. *Id.* at ¶ 13.

Marilyn Eldridge, on behalf of Reproductive Services, also expressed concern that the cost of operating an ASC would make abortion care prohibitively expensive for Reproductive Services' patients, many of whom are living in poverty. Eldridge Direct at ¶ 33.

As things stand, absent relief from the Court, all of Plaintiffs' remaining clinics will be forced to close when the ASC requirement takes effect on September 1, 2014.

VII. The Admitting Privileges Requirement Departs from Accepted Medical Practice and Does Not Enhance the Safety of Abortion Care.

The evidence presented at trial shows that it is common and acceptable medical practice for a physician practicing in an outpatient setting to refer patients to a hospital at which the physician does not have admitting privileges. It does not enhance patient safety when physicians practicing in outpatient settings maintain admitting privileges. Raymond Direct at ¶¶ 9, 34-42;

Fine Direct at ¶ 26. In fact, the trend in medicine is toward bifurcation of outpatient practice and hospital-based practice, such that physicians are increasingly specializing in one type of practice setting or the other. *Id*. at ¶ 20. Coordination and continuity of care of a patient that is transferred from an outpatient setting to a hospital are achieved through communication between the physician referring the patient to the hospital and the physician treating the patient at the hospital. Tr. Vol. 3 (Rough) at 35:24-36:12; Thompson Dep. Tr. at 222:14-22; Keyes Dep. Tr. at 36:20-39:24. This is standard medical practice. Fine Direct ¶¶ 19-25; Raymond Direct ¶¶ 34-42.

Accordingly, the nation's leading accreditation bodies and medical associations—including the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Surgeons, the American Society of Anesthesiologists, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, and the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations or "JCAHO")—recognize that admitting privileges at a local hospital are not required for the safe performance of outpatient procedures. Raymond Direct at ¶¶ 35-40; Exs. P-029, P-189 – P-194; Keyes Dep. Tr. at 68:23-69:1, 69:16-71:2; Thompson Dep. Tr. at 154:4-11, 155:21-156:11. In addition, the Clinical Policy Guidelines of the National Abortion Federation do not require abortion providers to maintain admitting privileges at a local hospital. Raymond Direct at ¶ 41.

On those rare occasions when a patient who has had an abortion requires hospitalization, the quality of care that she receives at the hospital would not be affected by whether her abortion provider has admitting privileges there. *Id*. at ¶ 42; Fine Direct at ¶ 28. Upon the patient's arrival at the hospital via ambulance, an emergency room physician will evaluate the patient and consult with other specialists at the hospital as necessary. *Id*. The patient may require admission

to the hospital, or she may simply be treated in the emergency room and then released. *Id*. Either way, continuity of care can be maintained by direct communication between the abortion provider and the emergency room physician, regardless of whether the abortion provider has admitting privileges at the hospital. *Id*.; Raymond Direct at ¶ 42; Keyes Dep. Tr. at 36:20-39:24; Thompson Dep. Tr. at 222:14-22.

Moreover, in many of the cases in which a patient experiences a complication following an abortion procedure, the complication does not arise until after the abortion patient has been discharged from the clinic and returned home. Fine Direct at ¶ 30. If a woman experiences a complication that requires hospital treatment after she has returned home following an abortion procedure, it would be safest for her to seek treatment at the hospital nearest to her home. *Id*. at ¶ 31. Thus, a woman who lives more than 30 miles away from an abortion clinic should not travel back to the vicinity of the clinic in the event of an emergency to obtain hospital treatment; she should, instead, seek treatment at the emergency room nearest to her present location. *Id*.; *see also* Tr. Vol. 4 (Rough) at 6:24-7:3 ("Q: If she drove back home and she was 150 miles from the provider facility and that provider had privileges at a hospital within 30 miles, she would be 120 miles from that hospital; is that correct? A: I would assume that's right.").

VIII. The ASC Requirement Departs from Accepted Medical Practice and Does Not Enhance the Safety of Abortion Care.

The record demonstrates that the ASC requirement is a significant departure from accepted medical practice. The vast majority of abortion procedures in Texas and nationwide are performed in office-based settings, not ASCs or hospitals. Fine Direct at ¶¶ 36-37; Raymond Direct at ¶¶ 43-45. Indeed, in Texas, many kinds of surgeries are performed in doctor's offices, including surgeries performed under general anesthesia. Tr. Vol. 4 (Rough) at 84:10-86:12; *see* 22 Tex. Admin. Code §§ 192.1-192.6. Of those outpatient surgeries that are performed in ASCs,

few are performed in facilities that meet the standards to which abortion clinics will be subject if the ASC requirement takes effect. More than three-quarters of licensed ASCs are exempt from new construction requirements due to grandfathering, *see* Stipulation at ¶ 6, and waivers from them are "frequently" granted on an oral basis, Perkins Dep. Tr. at 44:6-44:19; 45:19-46:2. Notably, ACOG's Guidelines for Women's Health Care recognize that abortion procedures can be safely performed in doctor's offices and clinics, and they expressly denounce the imposition of "facility regulations that are more stringent [for abortion procedures] than for other surgical procedures of similar risk." Raymond Direct at ¶ 45; Ex. P-192.

The evidence further shows that the ASC requirement will not serve to enhance the health or safety of abortion patients. With respect to abortion procedures performed prior to 16 weeks post-fertilization, complications do not occur with greater frequency at clinics than at ASCs. Grossman Direct at ¶¶ 41, 43-48; Lynn Direct at ¶ 16. This is not surprising because the construction standards for ASCs are largely aimed at maintaining an ultra-sterile operating environment. Grossman Direct at ¶ 42; Fine Direct at ¶ 38. These standards enhance the safety of surgeries that involve cutting into sterile body tissue by reducing the likelihood of infection. Grossman Direct at ¶42; Fine Direct at ¶ 38. But surgical abortion is not performed in this manner. Rather, it entails insertion of instruments into the uterus through the vagina, which is naturally colonized by bacteria. Grossman Direct at ¶ 42; Fine Direct at ¶ 38; Raymond Direct at ¶ 48; Ex. P-037 at 191; Keyes Dep. Tr. at 86:12-87:2 Tr. Vol. 1 (Rough) at 26:25-27:3. Accordingly, precautions aimed at maintaining a sterile environment, beyond basic hand-washing and use of sterile instruments, provide no health or safety benefit to abortion patients. Grossman Direct at ¶ 42; Fine Direct at ¶ 38; P-037 at 784; Keyes Dep. Tr. 86:12-87:2. Similarly, the nursing requirements for ASCs are geared toward surgeries that are more complex

than abortion. Grossman Direct at ¶ 42; Fine Direct at 41. Many of the personnel typically needed for those types of surgeries, such as scrub nurses and circulating nurses, are not needed for abortion procedures. Grossman Direct at ¶ 42; Fine Direct at ¶ 41.

Indeed, Defendants' own expert Geoffrey Keyes, M.D., President of the American Association for Accreditation of Ambulatory Surgery Facilities ("AAAASF"), testified at his deposition that, in general, ASC standards related to construction are not relevant to the quality of care that is provided in a facility. Keyes Dep. Tr. at 60:12-63:16. He further testified that the accreditation standards enforced by his organization are sufficient to ensure patient health and safety, and they do not contain detailed construction standards such as specifications for a building's HVAC system or the square footage of its operating rooms. *Id.* at 78:6-84:1; Ex. P-012. He also testified that more onerous standards for healthcare facilities do not necessarily equate to better standards. *Id.* at 100:3-5 ("Some of it is more onerous than our process and onerous doesn't translate necessarily into being better, it is just onerous."). Not surprisingly, Defendants did not call Dr. Keyes to testify at trial.

Further, medical abortion does not involve surgery of any kind. As practiced in Texas, it entails the oral administration of medications—*i.e.*, the patient merely swallows a series of tablets. There is no medical basis for requiring the administration of those medications to take place in a facility designed to ensure sterile surgical conditions. Fine Direct at ¶ 42.

IX. Although the ASC Requirement Provides No Medical Benefit to Abortion Patients, It Imposes Substantial Costs on Both Patients and Abortion Providers.

Although the ASC requirement would provide no medical benefit to abortion patients, it would impose substantial costs on both abortion providers and women seeking abortion services in Texas. Layne-Farrar Direct at ¶¶ 36, 39, 40 & Table 3. To meet new construction standards,

an ASC would need to be at least 7,000 square feet in area.[4] Johannes Direct at ¶ 32; Davis Direct at ¶ 11; Exs. P-073-074. Construction of a 7,000 ASC in Texas would cost more than $3 million. Johannes Direct at ¶ 40; Davis Direct at ¶ 11; Ex. P-074. Remodeling an abortion clinic to meet ASC standards would generally cost about $2 million. Johannes Direct at ¶ 7 (providing estimates ranging from $1.7 to $2.6 million); Theard Dep. Tr. at 40:25-41:22 ($2 million estimate). Purchasing an existing ASC would be similarly expensive; the ASC that Whole Woman's Health sought to buy in Fort Worth was appraised at $2.3 million. Tr. Vol. 2 (Rough) at 71:24-72:21; Tr. Vol. 1 (Rough) at 101:17-102:17. In addition, the operating costs for an ASC exceed those for an abortion clinic by approximately $600,000 to $1 million per year. Layne-Farrar Direct at ¶ 40.

The reduction in the number and geographic distribution of abortion providers as a result of the ASC requirement will result in higher costs for abortion procedures and increased travel distances for women seeking abortion services. Layne-Farrar Direct at 42-44; Grossman Direct at ¶ 23 & Table 2. Defendants concede that, after the ASC requirement takes effect, at least 891,888 Texas women of reproductive age will live farther than 150 miles from a Texas abortion provider. Tr. Vol. 3 (Rough) at 116:17-117:4; Exs. D-040; D-041. That is more than the total population of reproductive-age women in 25 other states and the District of Columbia. Grossman Direct at Table 2.

[4] Dr. Kitz's testimony that an ASC need only be 3,000 square feet to meet the requirements imposed by Texas law lacks a reliable basis and should not be credited. In support of her opinions, she relied principally on printouts from the internet; she could not attest to the reliability of these sources and testified that she would not use them in her own consulting work. *See, e.g.*, Tr. Vol. 4 (Rough) at 49:19-82:9; Exs. D-225 – D-227. Further, Dr. Kitz did not take into account that more than three-quarters of all currently licensed ASCs are grandfathered, but abortion facilities will not be eligible for grandfathering when the ASC requirement takes effect. Tr. Vol. 4 (Rough) at 39:2-42:3.

The increased costs and travel distances will cause some women to delay accessing abortion care and others to forgo abortion altogether. Both of these outcomes impose significant health risks on women. Grossman Direct at ¶¶ 27, 28; Raymond Direct at ¶¶ 55-56; Fine Direct at ¶¶ 43-44; Layne-Farrar Direct at ¶¶ 49-52.

Additionally, some women who cannot access legal abortion services will instead attempt self-induction of abortion. Grossman Direct at ¶ 34; Hagstrom Miller at ¶ 19. Self-induction of abortion is already more prevalent among women in Texas, particularly along the Texas-Mexico border, than among women nationally. Grossman Direct at ¶ 32; *see* Eldridge Direct at ¶ 31; Hagstrom Miller Direct at ¶ 19. Many women in Texas are aware that misoprostol can be used to induce an abortion. Felix Direct at ¶ 30; Grossman Direct at ¶¶ 29, 30. This medication is available over-the-counter in Mexico and is widely trafficked in the Rio Grande Valley and West Texas, which both border Mexico. *Id.* Like any medication obtained on the black market, misoprostol obtained in this way can be counterfeit, inappropriate for a particular woman's medical needs, or used incorrectly because a woman does not have adequate information. Felix Direct at ¶ 31; Grossman Direct at ¶ 35.

During the four month period of time when the McAllen clinic was open but not providing abortion services, clinic staff members encountered a significant increase in the number of women seeking assistance after attempting self-abortion. Hagstrom Miller Direct at ¶¶ 18, 19. These women used a variety of methods in addition to misoprostol, including herbal teas, douches, and physical trauma to the abdomen. *Id.* During this period, Defendants also received reports about women attempting to self-induce abortions using misoprostol and about healthcare providers rendering treatment when such attempts were unsuccessful or resulted in complications, a process dubbed "miscarriage management." Exs. P-020, P-022, P-024.

Implementation of the ASC requirement will cause a further increase in the number of women attempting self-abortion, particularly in the Rio Grande Valley and El Paso, where there will be no abortion clinics and where there is easy access to misoprostol from across the border in Mexico. Grossman Direct at ¶ 35.

Self-induction of abortion carries significant health risks and the methods used may be quite dangerous. Grossman Direct at ¶ 33; *see McCormack v. Hiedman*, 694 F.3d 1004, 1008 (9th Cir. 2012) (concerning a pregnant woman who attempted abortion by ingesting drugs purchased over the internet because she could not access professional abortion services); *In re J.M.S.*, 280 P.3d 410, 411 (Utah 2011) (concerning a pregnant woman who attempted abortion by soliciting a stranger to punch her in the abdomen because she could not access professional abortion services); *Hillman v. State*, 503 S.E.2d 610, 611 (Ga. App. 1998) (concerning a pregnant woman who attempted abortion by shooting herself in the abdomen with a handgun because she could not access professional abortion services); *State v. Ashley*, 701 So.2d 338, 339 (Fla. 1997) (same). The ASC requirement will undoubtedly result in exposure to these risks by an increased number of women.

X. The Burdens Imposed by the Admitting Privileges and ASC Requirements Will Have the Greatest Impact on Women in the Rio Grande Valley and West Texas.

Women in the Rio Grande Valley and West Texas are far more likely to be impeded by the need to travel long distances to obtain an abortion than women in other areas of the state because many of them are poor and lack access to reliable transportation, childcare, and the ability to take time off work. Felix Direct at ¶¶ 9-11; Hopkins Direct at ¶¶ 5, 17; Layne-Farrar Direct at ¶ 13. A large number of women in these regions are disadvantaged and have fewer resources to overcome obstacles to accessing medical care than women in other parts of Texas. Hopkins Direct at ¶ 5.

The Rio Grande Valley is comprised of Starr, Hidalgo, Willacy, and Cameron counties along the eastern border of Texas and Mexico. Felix Direct at ¶ 1; Layne-Farrar Direct at Table 1. The vast majority of people living in the Rio Grande Valley are Latino. Felix Direct at ¶ 8; Layne-Farrar Direct at ¶ 13. The region is largely rural, and a substantial percentage of its residents are poor, with an average median income that is $19,000 less than the state average. Felix Direct at ¶¶ 6-8; Layne-Farrar Direct at ¶ 13. A majority of the women of reproductive age in the Rio Grande Valley do not have health insurance. Hopkins Direct at ¶ 10. Similarly, West Texas is a predominantly rural area with a high level of poverty, with an average median income that is $10,000 less than the state average, and with nearly 20% of residents living below the federal poverty line. Layne-Farrar Direct at ¶ 12. Over 40% of women of reproductive age in El Paso County lack health insurance. Hopkins Direct at ¶ 10.

Prior to the enactment of the ASC and admitting privileges requirements, there were two licensed abortion facilities in the Rio Grande Valley (the McAllen clinic and Reproductive Services of Harlingen), and two in El Paso County (the El Paso clinic and Hilltop Women's Reproductive Clinic). Grossman Direct at Table 1. Three of those four clinics are now closed. Hagstrom Miller Direct at ¶ 3 (McAllen clinic); Stipulation at ¶ 5 (Reproductive Services of Harlingen); Eldridge Direct at ¶ 26 (El Paso clinic). The fourth, Hilltop Women's Reproductive Clinic will close before September 2014 because it does not meet the ASC requirement. Stipulation at ¶ 4; Theard Dep. Tr. at 40:25-44:3. According to Defendants' own testimony, at least 332,637 women of reproductive age in the Rio Grande Valley now live father than 150 miles from the nearest Texas abortion provider. Giberson Direct at 6; Giberson Cross, Tr. Vol. 3 (Rough) at 16:54:49-16:55:39; Ex. D-040. It is undisputed that these women, along with those in West Texas, will have to travel greater distances to reach an abortion provider in Texas once the

ASC requirement takes effect, because there will only be abortion facilities available in Dallas-Fort Worth, Houston, Austin, and San Antonio. Grossman Direct at ¶ 23; Giberson Direct at 4; Tr. Vol. 3 (Rough) at 113:18-114:8.

The burden of travel on women in the Rio Grande Valley and West Texas is not alleviated even with the availability of financial assistance. For example, after the admitting privileges requirement took effect and the Rio Grande Valley was left without an abortion provider, Whole Woman's Health worked with a nonprofit organization to provide gas cards or bus tickets to women who presented at the McAllen clinic seeking abortion services, to enable them to travel to a licensed abortion facility in San Antonio. Hagstrom Miller Direct at ¶ 18. Even though every woman who presented at the McAllen clinic was offered assistance to travel to a licensed abortion facility, amounting to approximately 50-60 women per week over a four-month period, only about eight or nine women in total accepted a gas card or bus ticket from Whole Woman's Health. Tr. Vol. 2 (Rough) at 48:23-49:20, 66:3-15. Many of the women cited the inability to find childcare or take time off work as the reason they could not use the financial assistance. Hagstrom Miller Direct at ¶ 18. Many women also reported having a lawful immigration status that permitted them to be present in the region of the United States bordering Mexico, but did not permit them to travel north of Falfurrias, as required to reach the licensed abortion facility in San Antonio. *Id.*; Tr. Vol. 2 (Rough) at 48:23-49:20.

The evidence demonstrates that women in the Rio Grande Valley and West Texas will be particularly burdened by having to travel to access abortion services.

ARGUMENT

I. The ASC Requirement Is Unconstitutional on Its Face, As Applied to the McAllen and El Paso Clinics, and As Applied to Medical Abortion.

A. On its Face, the ASC Requirement Fails to Satisfy the Undue Burden Standard.

This case is governed by the undue burden standard set forth in *Planned Parenthood of Se. Pa. v. Casey*. *See* 505 U.S. 833, 876-77 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.). To understand the proper application of this standard, it is necessary to consider briefly its origin.

In *Roe v. Wade*, the Supreme Court held that the Due Process Clause of the Fourteenth Amendment protects a woman's right to terminate her pregnancy as an exercise of her liberty. *See* 410 U.S. 113, 153 (1973). Accordingly, the Court held that restrictions on abortion were permissible only if narrowly tailored to serve a compelling state interest. *See id.* at 155. It explained that a state's interest in the health of pregnant women became compelling at the point in pregnancy at which abortion-related mortality was greater than or equal to mortality from childbirth, which in 1973, was approximately the start of the second trimester. *See id.* at 163. It also explained that a state's interest in the potential life of the fetus became compelling at the point in pregnancy at which the fetus became viable, which in 1973 was approximately the start of the third trimester. *See id.* *Roe*'s regime for assessing the constitutionality of abortion restrictions became known as the "trimester framework." *See, e.g.*, *Casey*, 505 U.S. at 872.

In *Casey*, the Court reaffirmed the "essential holding" of *Roe*, that a woman has the fundamental right to terminate her pregnancy prior to viability, *see Casey*, 505 U.S. at 846, 871, but held that *Roe*'s trimester framework was too rigid to permit a proper balancing of the important interests at stake, *see id.* at 873 ("A logical reading of the central holding in *Roe* itself, and a necessary reconciliation of the liberty of the woman and the interest of the State in

promoting prenatal life, require, in our view, that we abandon the trimester framework as a rigid prohibition on all previability regulation aimed at the protection of fetal life."). As a result, the Court replaced the trimester framework with the undue burden standard, which governs this case. *See id.* at 876-77. This standard is intended to afford courts more flexibility in balancing women's right to access abortion services, which, for forty years, has facilitated "[t]he ability of women to participate equally in the economic and social life of the Nation," *Casey*, 505 U.S. at 856, with a state's interest in protecting potential life, *id.* at 873. It is not intended, however, to diminish the status of the abortion right or to permit states to restrict that right when doing so would not further a compelling state interest. *See, e.g., id.* at 851 (explaining that rational basis review is not sufficient for regulations that "intrude upon a protected liberty" like the abortion right).

Under the standard announced in *Casey*, states may not impose an undue burden on the right to terminate a pregnancy prior to viability. *See id.* at 876 (joint opinion of O'Connor, Kennedy & Souter, JJ); *Jackson Women's Health Org.*, slip op. at 8. "A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 877. "A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Id.* "And a statute which, *while furthering* the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." *Id.* (emphasis added). In addition, an abortion regulation violates due process if it subjects women to

"significant health risks," *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006)); *accord Casey*, 505 U.S. at 880.

Thus, to satisfy constitutional review, a law regulating abortion must (1) have a valid purpose; (2) further a compelling state interest; (3) avoid imposing substantial obstacles in the path of women seeking previability abortion services; and (4) avoid subjecting women to significant health risks. On its face, the ASC requirement fails this test.

1. The ASC Requirement Does Not Further a Compelling State Interest.

i. <u>The ASC requirement does not further the State's interest in potential life in a permissible way.</u>

With respect to the State's interest in potential life, "the State may take measures to ensure that the woman's choice is informed, and measures designed to advance this interest will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion." *Casey*, 505 U.S. at 878. The State may not, however, further this interest simply by making abortion services more difficult to obtain. *Id.* at 877 ("[T]he means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it."). Here, the ASC requirement does not serve in any way to inform or persuade a woman seeking an abortion. To the extent that the ASC requirement advances the State's interest in potential life, it does so only by reducing the availability of abortion services in Texas, and thereby forcing some women who seek abortions to carry their pregnancies to term. But this is not a permissible way of advancing the State's interest in potential life.

ii. <u>The ASC requirement does not further the State's interest in women's health.</u>

With respect to the State's interest in women's health, the State may enact abortion regulations that are consistent with accepted medical practice, *see Simopoulos v. Virginia*, 462 U.S. 506, 516-17 (1983), and further women's health in a demonstrable way, *see City of*

Akron v. Akron Ctr. for Reproductive Health, Inc., 462 U.S. 416, 430 (1983).[5] But health regulations that are inconsistent with accepted medical practice or fail to advance women's health in a demonstrable way cannot be sustained. *Id.* at 434. Thus in *Danforth*, the Court struck down a statutory provision banning the use of saline amniocentesis as a method of second-trimester abortion because the State failed to demonstrate that it was "a reasonable regulation for the protection of maternal health." *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 79 (1976); *see Carhart*, 550 U.S. at 164-65 (treating *Danforth*'s invalidation of the ban on saline amniocentesis as vital and relevant precedent).

Here, the overwhelming weight of the evidence shows that the ASC requirement is a departure from accepted medical practice. *See supra* at 21-23. And the evidence further shows that the ASC requirement will not serve to enhance the health or safety of abortion patients. *Id.* Accordingly, the ASC requirement does not further the State's interest in women's health.

2. The ASC Requirement Operates as a Substantial Obstacle for a Large Fraction of Women for Whom It Is Relevant.

In *Casey*, the Court struck down a provision of Pennsylvania law requiring that married women notify their husbands before obtaining abortion services on the ground that it imposed a substantial obstacle in the path of women seeking those services. *See Casey*, 505 U.S. at 893-94 ("The spousal notification requirement is . . . likely to prevent a significant number of women from obtaining an abortion. It does not merely make abortions a little more difficult or expensive to obtain; for many women, it will impose a substantial obstacle."). In so doing, the

[5] In *Danforth*, for example, the Court upheld certain documentation and recordkeeping requirements in the wake of a challenge by abortion providers. *Danforth*, 428 U.S. at 80-81. Subsequently, the Court explained that the "decisive factor" in its decision "was that the State met its burden of demonstrating that these regulations furthered important health-related State concerns." *City of Akron*, 462 U.S. at 430.

Court rejected the Commonwealth's argument that the provision should not be invalidated on its face because it would affect less than one percent of all women seeking abortions in Pennsylvania—namely, married women seeking abortions who would not notify their husbands absent the statutory mandate. *Id.* at 894. It explained that: "The analysis does not end with the one percent of women upon whom the statutes operates; it begins there. . . .The proper focus of constitutional inquiry is the group for whom the law is a restriction, not the group for whom the law is irrelevant." *Id.* Ultimately, the Court concluded that the provision must be invalidated on its face because, "in a large fraction of the cases in which [it] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." *Id.* at 895.

Here, the group for whom the law is relevant is comprised of those women who could have accessed abortion services in Texas prior to implementation of the ASC requirement, but will face increased obstacles as a result of the law. The dispositive issue is whether those obstacles are substantial for a large fraction of the women, and the evidence shows, unmistakably, that they are.

The record before the Court in this case stands in stark contrast to the record in *Abbott*. There, the record reflected that, after implementation of the admitting privileges requirement, women seeking abortion services would have to travel, at most, 150 miles to reach an abortion provider, *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583 597-98 (5th Cir. 2013), and "[a]ll of the major Texas cities, including Austin, Corpus Christi, Dallas, El Paso, Houston, and San Antonio, continue to have multiple clinics where many physicians will have or obtain hospital admitting privileges," *id.* at 598. Here, it is undisputed

that, upon implementation of the ASC requirement,[6] at least 891,888 Texas women of reproductive age would live more than 150 miles from the nearest Texas abortion provider, *see supra* at 26, and there would be at most seven licensed facilities providing abortion services, clustered in four metropolitan areas in the eastern part of the State. Grossman Direct at ¶ 23; Giberson Direct at 4; Tr. Vol. 3 (Rough) at 113:18-114:8; Ex. D-040. There would not be a single licensed facility providing abortion services west or south of San Antonio. *See id*.

Ample evidence demonstrates that this dramatic reduction in the number and geographic distribution of abortion providers will result make it impossible for some women to obtain desired abortions in Texas. First, Dr. Grossman's research shows that, during the period from November 1, 2012, to April 30, 2014, there was a 46% reduction in the number of licensed facilities providing abortion care (from 41 to 22), which corresponded to a 13% reduction in the Texas abortion rate, three times greater than the change in the national abortion rate. Grossman Direct at ¶¶ 10, 15. During the period from April 30, 2014, to September 1, 2014, there will be a further 68% reduction in the number of licensed facilities providing abortion care (from 22 to 7), which will lead to a further reduction in the abortion rate as more women are unable to access an abortion provider. Grossman Direct at Table 1.

Dr. Grossman's findings are consistent with other studies reported in the medical literature showing that lengthy travel distances prevent women from accessing legal abortion services. Grossman Direct at ¶ 27; Raymond Direct at ¶ 56; Tr. Vol. 3 (Rough) at 129:3-7. They

[6] It is important to note that many licensed abortion facilities have begun to close in anticipation of the implementation of the ASC requirement. As their licenses or building leases have come up for renewal in recent months, those facilities, knowing that they could not remain open beyond September 1, 2014, have been closing. *See, e.g.*, Davis Direct at ¶ 6; Tr. Vol. 1 (Rough) at 27:10-28:6; Hagstrom Miller Direct at ¶¶ 1, 20. Thus, the ASC requirement has already been exerting its effects, even though it will not be enforced until September.

are also consistent with Texas' experience following the 2003 enactment of a law limiting the performance of abortions at 16 weeks or later to ASCs and hospitals. A detailed study by economists found that, when the law took effect, there was an immediate and dramatic reduction in both the number of licensed facilities in Texas able to provide abortion services at 16 weeks and later and in the number of abortions performed in Texas at those gestational ages. Grossman Direct at ¶ 28. Two years later, the abortion rate for those gestational ages remained 50% below what it was prior to the law's enactment. *Id.*; Tr. Vol. 3 (Rough) at 127:11-21.

Even if the Court declines to hold that the ASC requirement, on its face, imposes a substantial obstacle on women seeking abortion services, it should hold that ASC requirement, as applied to the McAllen and El Paso clinics does so. First, women in those regions will face the greatest travel distances to obtain abortion care. It is a 235-mile trip from McAllen to San Antonio, and a 549-mile trip from El Paso to San Antonio.[7] Those staggering distances undoubtedly constitute substantial obstacles to accessing abortion services.

Second, a significant number of women in those regions are economically disadvantaged and have fewer resources to overcome obstacles to accessing abortion than women in other parts of the State. *See supra* at 28-30. Many do not have cars and cannot afford to ride the bus. Felix Direct at ¶¶ 18, 22, 27. And the record shows that other obstacles, including lack of reliable childcare or time off work, and immigration status, serve to prevent women from traveling the

[7] Although Defendants have argued throughout this case that women in El Paso would not be unduly burdened by the closure of all of the abortion clinics in West Texas because they could travel to New Mexico to obtain abortion services, the Fifth Circuit's recent decision in *Jackson Women's Health Org. v. Currier* flatly rejects that argument, holding that "the proper formulation of the undue burden analysis focuses solely on the effects within the regulating state." ___ F.3d ___, 2014 WL 3730467, at *9 (5th Cir. July 29, 2014).

required distances to access abortion care. Felix Direct at ¶¶ 9-11; Hopkins Direct at ¶¶ 5, 17; Layne-Farrar Direct at ¶ 13; Tr. Vol. 2 (Rough) at 48:23-49:20.

3. The ASC Requirement Subjects Women to Significant Health Risks.

In addition, the ASC requirement will subject a large fraction of women to significant health risks. By eliminating abortion providers from all parts of Texas except the State's four largest metropolitan areas, the ASC requirement will increase the costs of an abortion procedure as well as the distances that a woman must travel to obtain abortion services. *See supra* at 26-27. The undisputed evidence shows that such increases in cost and distance delay women in accessing abortion services. Grossman Direct at ¶¶ 22, 27, 28. Although abortion is safe throughout pregnancy, the risks of abortion increase with gestational age, *see supra* at 11. Thus, the ASC requirement will lead directly to an increased risk of abortion complications for many women. Moreover, for some women, the barriers to accessing abortion care raised by closing so many clinics will be insurmountable; these women will either carry an unwanted pregnancy to term, or turn to black market drugs or other methods to self-induce an abortion. *See supra* at 27-28. In Texas, carrying a pregnancy to term is roughly 100 more risky than having an abortion. *See supra* at 10. For a woman who wishes to have a child, that risk is surely worth it. But a woman who wishes to have an abortion is put at significantly increased risk when she is denied access to the procedure. The risks from black-market or illegal abortions are self-evident, including the potential for harm arising from ingesting counterfeit drugs, from misusing medication, or from self-caused physical trauma. *See supra* at 27-28. The health risks for women denied access to legal abortion by the ASC requirement are thus tangible and substantial.

4. The ASC Requirement Has an Improper Purpose.

When a statute's purpose is to place a substantial obstacle in the path of a woman seeking a previability abortion, the statute "is invalid because the means chosen by the State to further

the interest in potential life must be calculated to inform the woman's free choice, not hinder it." *Casey*, 505 U.S. at 877. In *Jane L.*, for example, the court held that a Utah statute banning abortion after twenty weeks' gestation, except in limited circumstances, had an unconstitutional purpose. *Jane L. v. Bangerter*, 102 F.3d 1112, 1116-17 (10th Cir. 1996), *cert. denied sub nom. Leavitt v. Jane L.*, 520 U.S. 1274 (1997) ("[W]e conclude that [the challenged statute] was enacted with the specific purpose of placing an insurmountable obstacle in the path of a woman seeking the nontherapeutic abortion of a nonviable fetus after twenty weeks, and it therefore imposes an unconstitutional undue burden on her right to choose under *Casey*.").

Similarly, in *Heineman*, the court granted a preliminary injunction against the operative provisions of a statute that imposed civil liability on abortion providers for failing to comply with certain disclosure requirements. *Planned Parenthood of the Heartland v. Heineman*, 724 F.Supp.2d 1025, 1031 (D. Neb. 2010). In relevant part, the statute required abortion providers, at least one hour prior to the performance of an abortion, to screen each woman seeking an abortion for "risk factors associated with abortion," to counsel the woman about the risk factors and associated complications, and to make certain written findings about the woman's risk of injury from abortion. *Id.* at 1033. The court held, *inter alia*, that the plaintiffs demonstrated a likelihood of success on the merits of their claim that the statute had an unconstitutional purpose. *Id.* at 1046. ("[T]his Court finds that Plaintiffs are likely to succeed on the merits of their Due Process liberty-and-privacy-interest claim, because the purpose of the bill appears to be the preservation of unborn human life through the creation of substantial, likely insurmountable, obstacles in the path of women seeking abortions in Nebraska.").

Many areas of constitutional law require courts, from time to time, to examine the purpose underlying legislative enactments or other state action. In determining whether the

purpose of a law restricting access to abortion is invalid, it is appropriate for a court to look to this jurisprudence for guidance. *See Okpalobi v. Foster*, 190 F.3d 337, 354 (5th Cir. 1999) ("We are not without guidance, however, as abortion law is not the only realm of jurisprudence in which courts are required to question whether a measure has been adopted for an impermissible purpose."), *vacated*, 201 F.3d 355 (5th Cir. 2000)[8]; *cf. Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 540 (1993) ("In determining if the object of a law is a neutral one under the Free Exercise Clause, we can also find guidance in our equal protection cases.").

The purpose of a law may be determined from both direct and circumstantial evidence. *See Church of the Lukumi*, 508 U.S. at 540; *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 266 (1977). Relevant considerations include the text of the law, *Church of the Lukumi*, 508 U.S. at 533, "the effect of [the] law in its real operation," *id.* at 535, whether the law restricts more conduct than is necessary to achieve the stated governmental interest, *id.* at 538, and its legislative history, *id.* at 540. In reviewing a preliminary injunction entered against a Wisconsin admitting privileges requirement, the Seventh Circuit recently noted that "[a] fuller enumeration of considerations based on purpose would include," *inter alia*, "the apparent absence of any medical benefit from requiring doctors who perform abortions to have such privileges at a nearby or even any hospital, [and] the differential treat of abortion vis-à-vis medical procedures that are at least as dangerous as abortions and probably more so." *Planned Parenthood of Wisc. v. Van Hollen*, 738 F.3d 786, 790-91 (7th Cir. 2013).

[8] Although the panel's decision in *Okpalobi* was vacated upon the grant of rehearing *en banc*, the subsequent *en banc* decision did not address the purpose issue. *See Okpalobi v. Foster*, 244 F.3d 405, 429 (5th Cir. 2001) (holding that the court lacked subject-matter jurisdiction over the case). Accordingly, the panel's discussion of purpose, while not controlling, remains persuasive authority.

Here, there are numerous indications that the ASC requirement has an improper purpose. First, it singles out facilities in which first and early second-trimester abortion procedures are performed for the imposition of construction requirements that are not imposed on facilities performing any other medical procedures. More than three-quarters of licensed ASCs are exempt from these construction requirements due to grandfathering, *see supra* at 24, and waivers from them are "frequently" granted on an oral basis, *id*. (Abortion facilities, of course, are prohibited by the Act's implementing regulations from seeking grandfathering or waivers. *See* 38 Tex. Reg. 6536, 6540 (declining to apply 25 Tex. Admin. Code § 135.51(a)).) And, apart from abortion providers, practice in an ASC setting is completely voluntary for physicians. Texas law expressly authorizes physicians to perform major outpatient surgeries—using forms of anesthesia, such as general anesthesia and deep sedation, that render the patient no longer ambulatory—in their offices, provided that they register with the Texas Medical Board and satisfy certain training and reporting requirements. *See* 22 Tex. Admin. Code §§ 192.1-192.6; Robinson Direct, Vol. 4 (Rough) at 84:3-85:5. The Executive Director of the Texas Medical Board testified that "several thousand" Texas physicians perform such surgeries in their offices. *Id.* at 85:6-9. Given that first and early second-trimester abortion is extremely safe overall and is as safe or safer than many other procedures performed in outpatient settings, *see supra* at 10-12, the targeting of abortion for heightened regulation indicates an improper purpose.

Second, the utter lack of evidence that the ASC requirement will enhance the health or safety of abortion patients, *see supra* at 23-25, supports an inference of improper purpose, as does the staggering costs of compliance, *see supra* at 25-28. The ASC requirement is essentially a multi-million dollar tax on the performance of abortion procedures, and it produces no offsetting benefit. *Id.*

Third, the record shows that the ASC requirement was a solution in search of a problem. Abortion was already extensively regulated prior to the enactment of the ASC requirement, and there is absolutely no evidence that suggests that existing regulations were insufficient to ensure the health and safety of abortion patients. *See supra* at 7-9. To the contrary, all evidence shows that legal abortion in Texas is extremely safe, and one-hundred times safer than the alternative. *See supra* at 10.

Fourth, Defendants' repeated contention that women unable to access abortion services in Texas can travel to New Mexico to obtain them is compelling evidence that the purpose of the ASC requirement is to reduce access to abortion services in Texas rather than to protect the health and safety of abortion patients. New Mexico does not have an ASC requirement in effect for abortion providers. It appears that the State of Texas has no health or safety concerns about women obtaining abortion services in facilities that do not meet ASC construction standards, provided that they are unable to obtain those services within the State's borders.

Finally, the most damning evidence of the ASC requirement's purpose is its effect. *Cf.*, *Church of the Lukumi*, 508 U.S. at 535; *Mazurek v. Armstrong*, 520 U.S. 968, 974 (1997) (holding that it was erroneous to conclude that a law had the purpose of imposing a substantial obstacle to abortion when there was no evidence that any "woman seeking an abortion would be required by the new law to travel to a different facility than was previously available."). Defendants admit that all existing licensed abortion facilities will be forced to close if the ASC requirement takes effect, leaving at most seven ASCs in four metropolitan areas to meet the demand for abortion services throughout the entire State. *See supra* at 30, 36. And some of those ASCs are currently unable to provide abortion services because of the admitting privileges

requirement. *Id.* This reduction in the availability legal abortion services is dramatic and unprecedented since the Supreme Court's decision in *Roe v. Wade*.

In sum, while any one of these factors in isolation may not be dispositive of the ASC requirement's purpose, considered together they can lead to only one conclusion: the purpose of the ASC requirement is to eliminate legal abortion services from the vast majority of Texas.[9]

II. The Admitting Privileges Requirement is Unconstitutional as Applied to the McAllen and El Paso Clinics.

The evidence clearly demonstrates that, as applied to the McAllen and El Paso clinics, the admitting privileges requirement fails the undue burden test. With respect to these two clinics in particular, the admitting privileges requirement does not advance the State's interest in women's health. Both Dr. Lynn and Dr. Richter are qualified and highly experienced abortion providers who have been providing safe abortion care for decades. *See supra* at 12-13, 17. Dr. Lynn currently holds admitting privileges at hospitals in Austin and San Antonio, Lynn Direct at ¶ 6, and Dr. Richter previously held admitting privileges at a hospital in El Paso, Eldridge Direct at ¶ 13; Tr. Vol. 2 (Rough) at 5:23-6:10. The record shows that Dr. Lynn and his colleagues at Whole Woman's Health were denied admitting privileges at Doctors Hospital at Renaissance for reasons unrelated to their clinical competence, *see supra* at 16, and Dr. Richter was denied

[9] At least some of the Act's sponsors were candid about its true aim. *See* H.B. 2 – 039 – Closing Arguments by Rep. Jason Villalba, https://www.youtube.com/watch?v=DM8mAcgB-KI at 3:40 ("So, regardless of what this debate may—where this debate may go, please understand that our intentions are honorable because we care for, and we fight for, human baby lives. When you ask about the inconvenience of driving a thousand miles, when you worry about a twenty-dollar ticket, when you talk about the issues that arise, we do so because we are protecting human baby lives."); H.B. 2 – 003 – Rep. Laubenberg Questioned by Rep. Farrar, https://www.youtube.com/watch?v=Be1EhiRmXM0 at 10:32 ("In response to your question on what other procedures would require the extra, higher standards, our answer to you is that the abortion—abortion is the only medical procedure where the result or the expected outcome is the taking of a life. This is a very unique procedure.").

admitting privileges at Foundation Surgical Hospital for pretextual reasons after the hospital's C.E.O. learned that she was an abortion provider, *see supra* at 18-19.

Further, for the reasons discussed above, the closure of the McAllen and El Paso clinics have imposed substantial obstacles on women in the Rio Grande Valley and West Texas who are seeking abortion services, leading to a disproportionate decline in the abortion rates in those regions and a surge in attempts at self-induced abortion. *See supra* at 27, 36. For these obstacles to be removed, the Court must strike down both the ASC requirement and the admitting privileges requirement as applied to the McAllen and El Paso clinics. *Cf. Van Hollen*, 738 F.3d at 796 ("When one abortion regulation compounds the effects of another, the aggregate effects on abortion rights must be considered.").

CONCLUSION

For the reasons set forth above, Plaintiffs respectfully request that the Court:

a. Issue a declaratory judgment that the ASC requirement is unconstitutional and unenforceable:
   i. on its face; and/or
   ii. as applied to the McAllen clinic; and/or
   iii. as applied to the El Paso clinic; and/or
   iv. as applied to the provision of medical abortion; and/or

b. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the ASC requirement:
   i. on its face; and/or
   ii. as applied to the McAllen clinic; and/or
   iii. as applied to the El Paso clinic; and/or
   iv. as applied to the provision of medical abortion; and/or

c. Issue a declaratory judgment that the admitting privileges requirement is unconstitutional and unenforceable:

   i. as applied to the McAllen clinic; and/or

   ii. as applied to the El Paso clinic; and/or

d. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the admitting privileges requirement:

   i. as applied to the McAllen clinic; and/or

   ii. as applied to the El Paso Clinic; and/or

e. Grant such other and further relief as the Court deems just, proper, and equitable.

Dated: August 12, 2014

/S/ Stephanie Toti

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan*
David P. Brown*
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org
dbrown@reprorights.org

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'CONNELL & SOIFER LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

J. Alexander Lawrence*
Kiersten Fletcher*
MORRISON & FOERSTER LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

John H. Bucy, II*
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Betre M. Gizaw*
Marissa P. Harris*
MORRISON & FOERSTER LLP
2000 Pennsylvania Avenue, NW
Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com
mharris@mofo.com

Colin M. O'Brien*
MORRISON & FOERSTER LLP
370 17th Street, Suite 5200
Denver, CO 80202
(303) 592-2252
(303) 592-1510
cobrien@mofo.com

*Admitted pro hac vice

Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that, on August 12, 2014, the foregoing was served on all counsel of record via the CM/ECF system.

/S/ *Stephanie Toti*
Stephanie Toti

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

Whole Woman's Health, et al., Plaintiffs, v. **David Lakey, M.D.,** Commissioner of the Texas Department of State Health Services, et al., Defendants.	Civil Action No. 1:14-cv-284-LY

STATE DEFENDANTS' POST-TRIAL BRIEF

The State defendants' brief will proceed in three parts. First, we will address the legal standards that apply to the plaintiffs' claims. Second, we will show that the plaintiffs' evidence is insufficient to carry their burden of proof. Finally, we will address the remedies that may be imposed if this Court were to find that the plaintiffs have proven their case.

I. THE PLAINTIFFS BEAR THE BURDEN OF PROOF, AND THEY MUST PROVE THAT HB2 IMPOSES A "SUBSTANTIAL OBSTACLE" IN THE PATH OF ABORTION PATIENTS.

The legal standards are clearly defined by *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), *Gonzales v. Carhart*, 550 U.S. 124 (2007), and *Planned Parenthood of Greater Texas Surgical Health Services v. Abbott*, 748 F.3d 583 (5th Cir. 2014). Under these rulings, courts are forbidden to invalidate abortion regulations unless the plaintiffs prove that the law (1) lacks a rational basis, or (2) imposes an "undue burden" on patients seeking pre-viability

abortions. *Gonzales*, 550 U.S. at 158 ("Where it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn."); *Casey*, 505 U.S. at 878 ("An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."); *Abbott*, 748 F.3d at 590. This Court has already held that HB2's provisions are rationally related to patient health and safety. *See* Order on Defs.' Mot. to Dismiss (doc. 148) at 12–13; *see also Abbott*, 748 F.3d at 594–96. The only question remaining is whether the plaintiffs have proven that HB2's admitting-privileges or ambulatory-surgical-center requirements will impose an "undue burden" on abortion patients.

A. The "Undue Burden" Test Is Concerned Solely With The Effects Of A Law On Abortion Patients.

The "undue burden" test asks one (and only one) question: does an abortion regulation have the purpose or effect of placing a "substantial obstacle" in the path of patients seeking pre-viability abortions? *See Casey*, 505 U.S. at 877. To satisfy this test, the plaintiffs must introduce evidence proving that the challenged law will create an "obstacle" for abortion patients—and they must prove that this obstacle is large enough to qualify as "substantial."

The undue-burden test is concerned solely with the effects of a law on abortion *patients*. It is not concerned with whether HB2 will impose burdens on abortion providers. Evidence of burdens imposed on providers is irrelevant absent proof that abortion patients will encounter "substantial obstacles" in their efforts to obtain pre-viability abortions. Nor does the "undue burden" test ask whether an abortion regulation is medically necessary or consistent with "accepted medical practice." *See*

Plfs.' Proposed Findings of Fact & Conclusions of Law (doc. 136, "FOF/COL"), COL ¶ 10. Once an abortion regulation passes rational-basis review, the *only* remaining question is whether it imposes a "substantial obstacle" in the path of abortion patients or was enacted for that purpose. *See Abbott*, 748 F.3d at 590 ("[T]he fundamental question is whether Planned Parenthood has met its burden to prove that the admitting privileges regulation imposes an undue burden on a woman's ability to choose an abortion; *only in that situation does* the state abridge 'the heart of the liberty protected by the Due Process Clause.'") (emphasis added).

The plaintiffs incorrectly assert that this Court may invalidate HB2's provisions if it finds them "inconsistent with accepted medical practice" or if they "fail to advance women's health in a demonstrable way." *See* Plfs.' FOF/COL, COL ¶ 10. That is a relic of the "strict scrutiny" that pre-*Casey* courts applied to abortion regulations. *See, e.g.*, *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 427 (1983) (requiring a compelling state interest to uphold regulation on abortion); *Roe v. Wade*, 410 U.S. 113, 155 (1973). *Casey* changed the law and requires courts to uphold any abortion regulation that survives rational-basis review and that does not impose an "undue burden" on abortion patients—regardless of whether the regulation comports with "accepted medical practice," and regardless of whether the State demonstrates in court that the regulation advances women's health.

Casey, for example, upheld Pennsylvania's informed-consent law even though the district court had entered factual findings that Pennsylvania's law conflicted with "standard medical practice." *See Planned Parenthood of Se. Pa. v. Casey*, 744 F. Supp. 1323, 1353 (E.D. Pa. 1990) ("214. . . . *Content-based informed consent is contrary to the standard medical practice* that informed consent be specifically tailored to the needs of the specific patient." (emphasis added)). And the petitioners' brief in *Casey* had argued that Pennsylvania's informed-consent law should be

struck down because it contradicted accepted medical practice. *See* Brief for Petitioners, at *9, 1992 WL 551419, *Casey*, 505 U.S. 833, Nos. 91-744 & 91-902 (1992) (arguing that Pennsylvania's informed-consent law "intrudes heavily on physicians' discretion by requiring them to supply a specified package of information to all patients. This conflicts with the accepted medical practice of giving patients information tailored to their individual needs and circumstances."). But the Supreme Court upheld Pennsylvania's informed-consent law notwithstanding its departure from standard medical practice. *Casey*, 505 U.S. at 883.

The plaintiffs' argument also contradicts *Gonzales v. Carhart*, which holds that States may regulate abortion providers without regard to whether the regulations comport with "accepted medical practice," and which forbids federal courts to act as "the country's *ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States." *Gonzales*, 550 U.S. at 164 (citation and internal quotation marks omitted). *See also id.* at 163 ("The law need not give abortion doctors unfettered choice in the course of their medical practice."); *id.* at 157 ("[T]he State has a significant role to play in regulating the medical profession."). The States may, for example, require that abortions be performed only by licensed physicians, even if evidence shows that physician-assistants can perform first-trimester abortions without any measurable risk to patient safety. *See Mazurek v. Armstrong*, 520 U.S. 968, 973 (1997) (noting that "the only extant study comparing the complication rates for first-trimester abortions performed by [physician-assistants] with those for first-trimester abortions performed by physicians found no significant difference" but holding that "the Constitution gives the States broad latitude to decide that particular functions may be performed only by licensed professionals, *even if an objective assessment might suggest that those same tasks could be performed by others*").

Finally, the Fifth Circuit explicitly rejected the plaintiffs' argument in *Abbott*, and held that courts may invalidate abortion regulations *only* when the plaintiffs prove that the law either lacks a rational basis or "imposes an undue burden on a woman's ability to choose an abortion." *Abbott*, 748 F.3d at 590. The plaintiffs had argued in *Abbott* that the State must show that its abortion-safety regulations comport with "accepted medical practice" and relied on *City of Akron*, but the Fifth Circuit considered and rejected this view. *See Abbott*, 748 F.3d at 590 ("*Akron*'s application of strict scrutiny was replaced by *Casey*'s undue burden balancing test"); *id.* ("[N]or do appellees cite a single Supreme Court or lower court opinion that has attempted to modify *Casey* in the way they propose."). The plaintiffs do not acknowledge *Abbott* in their proposed conclusions of law, and they make no effort to reconcile their argument with that binding Fifth Circuit pronouncement.

B. The Burden Of Proving An "Undue Burden" Rests Entirely With The Plaintiffs.

The burden of proving an "undue burden" rests entirely with the plaintiffs; any gap in the evidentiary record requires a judgment for the State. *See Abbott*, 748 F.3d at 597 ("As in litigation generally, the burden of proving the unconstitutionality of abortion regulations falls squarely on the plaintiffs."); *id.* at 590 ("[T]he fundamental question is whether Planned Parenthood has met its burden to prove that the admitting privileges regulation imposes an undue burden on a woman's ability to choose an abortion; only in that situation does the state abridge 'the heart of the liberty protected by the Due Process Clause.' *Casey*, 505 U.S. at 874."); *id.* at 597 ("The plaintiffs bore the burden of attacking the State's purpose here, yet the court imposed the burden on the State to disprove an improper purpose. This is plainly backwards.").

The plaintiffs suggest that the State bears a "burden of demonstrating that [its] regulations furthered important health-related State concerns." Plfs.' FOF/COL,

COL ¶ 10 n.1 (quoting *City of Akron*, 462 U.S. at 430). The State is under no such burden after *Casey* jettisoned the "strict scrutiny" standard and replaced it with a more lenient "undue burden" regime. After *Casey*, there is no requirement that abortion regulations "further[] important health-related State concerns," and there is assuredly no requirement that the State prove that its regulations further those interests. Once again, the plaintiffs do not attempt to reconcile their burden-of-proof argument with the Fifth Circuit's opinion in *Abbott*.

C. Driving Distances of 150 Miles Or Less Do Not Qualify As An "Undue Burden" Or A "Substantial Obstacle," And Courts May Not Base An "Undue Burden" Finding On Driving Distances Alone.

The law of the Fifth Circuit holds that abortion regulations that increase driving distances by 150 miles or fewer are *per se* lawful under *Casey*. *See Abbott*, 748 F.3d at 598 ("[A]n increase of travel of less than 150 miles for some women is not an undue burden under *Casey*."); *see also Jackson Women's Health Org. v. Currier*, No. 13-60599, 2014 WL 3730467, at *4, *6 (5th Cir. July 29, 2014). *Abbott* reached this conclusion by relying on *Casey*, which upheld Pennsylvania's 24-hour waiting period in spite of a district-court finding that abortion patients in 62 of Pennsylvania's 67 counties were already required to drive "for at least one hour, and sometimes longer than three hours" to their nearest abortion provider. *Casey*, 744 F. Supp. at 1352. Pennsylvania's 24-hour waiting period doubled those driving distances, yet the Supreme Court held that this did not impose an "undue burden" on abortion patients. These holdings from *Casey* and *Abbott* are binding and preclude the plaintiffs from establishing an "undue burden" based on increased driving distances of 150 miles or fewer (or increased travel times of three hours or fewer).

Abbott further holds that "*Casey* counsels against striking down a statute solely because women may have to travel long distances to obtain abortions." 748 F.3d at 598; *see also Jackson*, 2014 WL 3730467, at *6 ("JWHO does not argue that the dis-

tances involved alone impose an undue burden. Nor could it in the light of *Abbott*."); *Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 533 (8th Cir. 1994) (upholding 24-hour waiting period and holding that "[w]e do not believe a . . . single trip, *whatever the distance to the medical facility*, create[s] an undue burden") (emphasis added). Yet the plaintiffs' theory of "undue burden" relies solely on an increase in driving distances. The plaintiffs have not explained how this can establish an "undue burden" when the Fifth Circuit has instructed courts *not* to invalidate abortion laws based on increased driving distances. Nor have the plaintiffs explained why travelling from McAllen to San Antonio (between 220 and 270 miles) is an "undue burden" when the Fifth Circuit has held that travelling from McAllen to Corpus Christi (between 150 and 180 miles) is not. If the plaintiffs believe that driving distances that exceed 200 miles are "undue," then they must present an argument for why 200 miles should be the tipping point, rather than 300 miles, 400 miles, or 500 miles. They have not even attempted to do so.

Instead, the plaintiffs appear to contend that any regulation that causes *any* abortion clinic to close is an "undue burden." *See* Plfs.' FOF/COL, COL ¶ 6 ("[U]nder the undue burden standard, the Supreme Court has never upheld an abortion regulation that required a clinic to close or a woman to travel to a different location to obtain an abortion than she would have had the regulation not been enacted."). That view is untenable for many reasons, not least of which is that the Fifth Circuit upheld HB2's admitting-privileges requirement even though several abortion clinics claimed that they closed in response to that law. *See Abbott*, 748 F.3d at 598. The plaintiffs get nothing from their observation that "the Supreme Court has never upheld an abortion regulation that required a clinic to close," because the Fifth Circuit *has* upheld such an abortion regulation, and that holding is binding on this Court.

D. A Federal Court May Not Facially Invalidate An Abortion Regulation Unless The Plaintiffs Prove, At The Very Least, That It Will Impose An "Undue Burden" On A "Large Fraction" Of Abortion Patients In Texas.

Both *Gonzales* and *Abbott* forbid federal courts to facially invalidate an abortion regulation unless the plaintiffs prove, at an absolute minimum, that the law will impose an undue burden "in a large fraction of the cases in which [it] is relevant." *Gonzales*, 550 U.S. at 167 (quoting *Casey*, 505 U.S. at 895); *Abbott*, 748 F.3d at 599–600 (reversing the district court's decision to facially invalidate HB2's admitting-privileges requirement because "the district court opinion erroneously concluded that H.B. 2 imposed an undue burden in a large fraction of the cases."); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 414 (5th Cir. 2013) (staying the district court's decision to facially invalidate HB2's admitting-privileges requirement because "we are obligated by *Casey* to consider whether there is an undue burden 'in a large fraction of the cases in which' the admitting privilege is relevant"). The plaintiffs are demanding total, across-the-board invalidation of HB2's ambulatory-surgical-center requirement. Plfs. Compl. (doc. 1) at pp. 30–31. Yet their proposed findings of fact and conclusions of law do not even acknowledge the "large fraction" test, nor do they explain how their evidence could satisfy this test.

The plaintiffs appear to believe that they can win facial invalidation if they prove that HB2's ambulatory-surgical-center requirement will impose an "undue burden" on a mere *subset* of the State's abortion patients. *See* Plfs.' FOF/COL, COL ¶ 35 ("800,000 Texas women of reproductive age will have to travel more than 150 miles to access legal abortion services."). The Supreme Court rejected that view in *Gonzales*. *See Gonzales*, 550 U.S. at 167 ("[Facial] challenges of this type impose 'a heavy burden' upon the parties maintaining the suit."); *id.* at 167–68 ("[R]espondents have not demonstrated that the Act would be unconstitutional in a

large fraction of relevant cases."); id. at 168 ("[a]s-applied challenges are the basic building blocks of constitutional adjudication.") (citation omitted). The Fifth Circuit likewise rejected this view in *Abbott*, and specifically reversed the district court for failing to apply the "large fraction" test. *See Abbott*, 748 F.3d at 599–600; *see also Abbott*, 734 F.3d at 414–15.

E. HB2's Severability Clause Must Be Enforced.

Federal courts must enforce HB2's severability clause, which requires courts to sever not only the provisions of HB2, but also the statute's *applications* to individual abortion providers and patients. *See* HB2, § 10(b). That means that even if the plaintiffs prove that HB2's ambulatory-surgical-center requirement will impose an "undue burden" on abortion patients when applied to providers in El Paso or the Rio Grande Valley, those unconstitutional applications must be severed from the rest of the statute. This would allow the State to continue enforcing HB2's ambulatory-surgical-center requirement in regions of the State (such as Dallas, Houston, Austin, and San Antonio) where there is no evidence that its enforcement will impose an undue burden.

Federal courts are required to enforce state severability law, especially in abortion cases. *See Leavitt v. Jane L.*, 518 U.S. 137, 138–39 (1996) (holding that "[s]everability is of course a matter of state law" and rebuking the Tenth Circuit for refusing to enforce a state abortion statute's severability clause); *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 330–31 (2006) (holding that "the touchstone for any decision about remedy is legislative intent" and remanding to determine "whether New Hampshire's legislature intended" courts to sever unconstitutional applications of an abortion statute); *Dorchy v. Kansas*, 264 U.S. 286, 290 (1924) (holding that a state court's "decision as to the severability of a provision is

conclusive upon this Court."); *Voting for Am., Inc. v. Steen*, 732 F.3d 382, 398 (5th Cir. 2013) ("Severability is a state law issue that binds federal courts.").

Abbott reiterated that federal courts must enforce state severability law, and criticized the district court for failing to give effect to HB2's "comprehensive and careful severability provision." *Abbott*, 748 F.3d at 589; *see also id.* ("Federal courts are bound to apply state law severability provisions. . . . Even when considering facial invalidation of a state statute, the court must preserve the valid scope of the provision to the greatest extent possible." (citation omitted)). Yet the plaintiffs' proposed conclusions of law refuse to acknowledge HB2's severability clause and do not explain how this Court could facially invalidate the ambulatory-surgical-center requirement in light of the severability requirements.

F. The Fifth Circuit's Decision In *Jackson Women's Health Organization v. Currier* Does Not Preclude This Court From Considering The Availability Of Abortions In Santa Teresa, New Mexico.

The Fifth Circuit recently held that Mississippi could not enforce its admitting-privileges law against an abortion provider if doing so would close the only remaining abortion clinic in the State. *See Jackson*, 2014 WL 3730467, at *1. Mississippi had argued that this law would not impose an "undue burden" because its residents could still obtain abortion in Memphis, Tennessee, or Baton Rouge, Louisiana. But the Fifth Circuit rejected this argument, holding that the availability of abortions in other States cannot salvage a law that eliminates legal abortion in Mississippi. 2014 WL 3730467, at *6-*9. Had the Fifth Circuit upheld Mississippi's law by pointing to the availability of abortions in other States, it would follow that a State could prohibit all abortions performed within its borders—so long as it permits its residents to obtain abortions in other jurisdictions. It is hard to imagine that the current Supreme Court would accept that view of the *Casey* "undue burden" standard.

The plaintiffs believe that *Jackson* forbids this Court to consider the fact that El Paso residents can continue to obtain abortions in Santa Teresa, New Mexico—at a clinic less than one mile from the Texas–New Mexico border and only 12 miles from Reproductive Services in El Paso. Theard Depo 72:8-74:2, 74:5-13, 79:10-16. But *Jackson* made clear that its holding was limited to the facts of that case, including the fact that Mississippi's law would close the only remaining abortion clinic in the State. At the end of its opinion, the Court explained:

> Nothing in this opinion should be read to hold that any law or regulation that has the effect of closing all abortion clinics in a state would inevitably fail the undue burden analysis. . . . Here, we hold only that JWHO has demonstrated a substantial likelihood of proving that H.B. 1390, on this record and as applied to the plaintiffs in this case, imposes an undue burden on a woman's right to choose an abortion. *In reaching this determination, we look to the entire record and factual context in which the law operates*, including, but not limited to, the statutory provision in question, *the Clinic's status as the sole abortion clinic in Mississippi*, the ability of the Clinic to comply with H.B. 1390, Dr. Parker's and Dr. Doe's efforts to obtain admitting privileges, the reasons cited by the hospitals for denying admitting privileges to Dr. Parker and Dr. Doe, the absence of a Mississippi law prohibiting hospitals from discriminating against physicians who perform abortions when granting admitting privileges, and the nature and process of the admitting-privileges determination.

Id., at *9 (emphasis added).

If HB2 would close every remaining abortion clinic in Texas, then *Jackson* would preclude Texas from relying on the availability of abortions in Santa Teresa. A State cannot shut down every abortion clinic in the State and force all of its residents to obtain abortions from out-of-state practitioners. But when a State's regulations allow abortion to remain available within the State's borders, there is no reason to ignore the availability of abortions at a location only 15 minutes from El Paso. This is particularly true in an as-applied challenge that focuses solely on the availability of abortion in a particular city that is part of a cross-border metropoli-

tan area. Texas (unlike Mississippi) has not forced its residents to travel out of state to obtain abortions. El Paso residents will have a *choice* between obtaining abortions at an in-state ambulatory surgical center, or at an out-of-state clinic immediately across the Texas–New Mexico border. This choice does not impose an "undue burden" on El Paso residents, and *Jackson* does not hold otherwise.

II. THE PLAINTIFFS' EVIDENCE FAILS TO PROVE THAT HB2 WILL IMPOSE AN "UNDUE BURDEN" ON ABORTION PATIENTS.

The plaintiffs have four remaining claims. First, the plaintiffs contend that HB2's admitting-privileges and ambulatory-surgical-center requirements were enacted with the "purpose" of imposing a substantial obstacle in the path of abortion patients. Second, the plaintiffs seek facial invalidation of HB2's ambulatory-surgical-center requirement on the ground that it imposes a "substantial obstacle" in the path of a "large fraction" of the State's abortion patients. Third, the plaintiffs ask this Court to enjoin HB2's requirements as applied to the Whole Woman's Health's clinic in McAllen. Finally, the plaintiffs seek as-applied relief from HB2's requirements for the Reproductive Services' former clinic in El Paso. We will address each of these claims in turn.

A. The Plaintiffs Have Failed To Prove That HB2's Requirements Were Enacted With The "Purpose" Of Imposing A Substantial Obstacle In The Path Of Abortion Patients.

The plaintiffs have not introduced any evidence that the members of the Texas legislature enacted HB2 for the purpose of imposing "substantial obstacles" in the path of abortion patients. The legislature's stated purpose in enacting HB2 was to improve patient safety. *See, e.g.*, Senate Comm. on Health & Human Servs., Bill Analysis, Tex. H.B. 2, 83d Leg., 2d C.S. (2013) ("H.B. 2 seeks to increase the health and safety" of abortion patients and to provide them with "the highest standard of health care"). Courts do not second-guess a legislature's stated purposes absent

clear and compelling evidence to the contrary. *See Kansas v. Hendricks*, 521 U.S. 346, 361 (1997) ("[W]e ordinarily defer to the legislature's stated intent."); *Flemming v. Nestor*, 363 U.S. 603, 617 (1960) ("[O]nly the clearest proof could suffice to establish the unconstitutionality of a statute on [the] ground of [improper legislative motive].").

Here, the plaintiffs have produced zero evidence—let alone "clear[] proof"—that the purpose for enacting HB2 was anything other than the purpose stated by the Legislature. Not a single witness testified regarding the motivations of any member of the legislature. And the plaintiffs have not produced any statement from any legislator evincing a desire or hope that HB2 would impose "substantial obstacles" in the path of abortion patients. Even if the plaintiffs could uncover such a statement from a solitary member of the legislature, that would *still* be insufficient to prove a constitutional violation because a single legislator's views or motivations cannot be attributed to the legislative body as a whole. *See United States v. O'Brien*, 391 U.S. 367, 384 (1968) ("What motivates one legislator to make a speech about a statute is not necessarily what motivates scores of others to enact it."); *Rosenstiel v. Rodriguez*, 101 F.3d 1544, 1552 (8th Cir. 1996) ("[A]n isolated statement by an individual legislator is not a sufficient basis from which to infer the intent of that entire legislative body."). The plaintiffs simply have no way to prove that the dozens of legislators who voted for HB2 did so merely to impose roadblocks in the path of abortion patients, rather than out of a sincere desire to improve patient safety. *See Planned Parenthood of Wis. v. Van Hollen*, 738 F.3d 786, 791 (7th Cir. 2013) ("Discovering the intent behind a statute is difficult at best because of the collective character of a legislature, and may be impossible with regard to the admitting-privileges statutes. Some Wisconsin legislators doubtless voted for the statute in the hope that it would reduce the abortion rate, but others may have voted for it because they considered it

a first step toward making invasive outpatient procedures in general safer."). It is also not credible for the plaintiffs to attribute this purpose to the Texas legislature when HB2 gave abortion practitioners three months to secure hospital admitting privileges before the law took effect—and gave abortion clinics more than a year to comply with HB2's ambulatory-surgical-center requirement. HB2 § 10.

The plaintiffs also assert that HB2's requirements fail rational-basis review, but this Court has already held that HB2's requirements are rationally related to patient health and safety, and in all events Dr. Thompson's testimony is more than sufficient to supply a rational-basis for the law. Thompson Direct (doc. 175(1)), at ¶ 22 ("The pregnant uterus with higher risks should only be treated in an ASC or hospital setting where the necessary additional testing or surgery to assess and treat for complications can be safely accomplished."), *id.* at ¶ 24 ("By requiring all abortion providers to obtain admitting privileges at a local hospital and by requiring abortion facilities to conform to the minimum standards of ASCs, the Act addresses the specific needs of patients who may encounter serious abortion complications, not the best interests or convenience of the provider."). The mere existence of disagreement over the medical benefits of the law is enough to pass rational-basis review. *See Abbott*, 748 F.3d at 594 ("The fact that reasonable minds can disagree on legislation, moreover, suffices to prove that the law has a rational basis."); *see also Heller v. Doe*, 509 U.S. 312, 319 (1993) ("[R]ational-basis review … is not a license for courts to judge the wisdom, fairness, or logic of legislative choices.") (citations and internal quotation marks omitted). *id.* at 320 ("A State, moreover, has no obligation to produce evidence to sustain the rationality of a statutory classification."); *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 315 (1993) (under rational-basis review,

a legislative decision "is not subject to courtroom factfinding and may be based on rational speculation unsupported by evidence or empirical data.").[1]

Finally, the plaintiffs' "purpose" challenge to HB2's admitting-privileges requirement is barred by res judicata. This Court ruled that the plaintiffs' as-applied challenge to the "effects" of HB2's admitting-privileges requirement may go forward because that claim "relies on facts that occurred after judgment was rendered in the previous lawsuit." Order on Defs.' Mot. to Dismiss (doc. 148) at 7. Not so for the plaintiffs' claim regarding the "purpose" of the admitting-privileges law. The plaintiffs do not allege any facts regarding HB2's *purpose* that were not known or knowable at the time of the previous lawsuit. They cannot surmount the State's res judicata defense even under this Court's ruling.

B. The Plaintiffs' Evidence Is Insufficient To Justify Facial Invalidation of HB2's Ambulatory-Surgical-Center Requirement.

The plaintiffs have asked this Court to facially invalidate HB2's ambulatory-surgical-center requirement, and permanently enjoin its enforcement against *any* abortion clinic in the State. The plaintiffs undertake a "heavy burden" in bringing this facial challenge, as they must prove that HB2's ambulatory-surgical-center requirement will impose an "undue burden" on a "large fraction" of the State's abortion patients. *See Gonzales*, 550 U.S. at 167-68. The plaintiffs' evidence comes nowhere close to making this showing.

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[1] Even plaintiffs' expert, Dr. Elizabeth Raymond, admitted that there was at least a disagreement among health care providers regarding the benefits of the ASC requirement. Trial Tr., Vol. 1, 142:22-143:6 ("And you would also agree with me, wouldn't you, that there are at least some health care providers who believe requiring a clinic to be an ASC benefits the health and safety of a woman choosing to undergo an abortion? A. It's my understanding that's true, yes. Q. And also some physicians believe that because during an abortion a woman's cervix and uterus, which are -- are sterile, are penetrated during that procedure, that an abortion is considered an invasive -- an invasive procedure, correct? A. Yes."); *id.* at 143:10-11 ("Q. You disagree with those health care providers? A. Yes.").

The plaintiffs have stipulated that eight abortion clinics will remain open after HB2's ambulatory-surgical-center requirement takes effect. Joint Stipulation to Facts (doc. 154), at ¶¶ 1-3. They have not proven that a "large fraction" of the State's abortion patients will encounter "substantial obstacles" in obtaining abortions from these remaining clinics. Daniel Grossman opined that HB2 will increase driving distances for abortions, but he did not dispute the methodology or testimony of the defendant's expert, Todd Giberson, who demonstrated that even under the worst-case scenario envisioned by the plaintiffs, 83% of Texas women will still live within 150 miles of an ASC abortion clinic—and another 6–7% live outside that range for reasons not alleged to be caused by HB2. *Abbott* holds that driving distances of 150 miles or fewer are not an "undue burden," and that means that *at least* 83% of Texas women will not encounter an "undue burden" by travelling to these remaining ASC clinics.

Grossman's only response to Giberson is to say that 891,888 women of reproductive age will live outside that 150-mile boundary. Grossman Direct (doc. 161), at ¶ 24; *see also* Plfs.' FOF/COL, FOF ¶ 66. Of course, as Gibberson demonstrated, much of that number represents women who live in far-flung areas of the State (such as Lubbock, Amarillo, and Midland/Odessa) where the absence of an abortion clinic within 150 miles is not even alleged to be attributable to HB2. And in all events, a law cannot be *facially* invalidated unless the plaintiffs demonstrate an undue burden on a "large fraction" of the State's abortion patients—not a large raw number. The fraction of women outside the 150-mile safe harbor is no larger than 17%—and the fraction shrinks to less than 10% if one excludes the women living in areas whose driving distances will not be affected by the ASC requirement. A large fraction this is not. Grossman's testimony is essentially a confession that the ambu-

latory-surgical-center requirement cannot be facially invalidated under the "large fraction" test established in *Gonzales* and *Abbott*.

The plaintiffs are also wrong to insinuate that HB2 will impose an "undue burden" on the entire population residing outside the 150-mile border. Not every woman will seek an abortion. Even if some have to drive more than 150 miles, the plaintiffs have not proven that any of those patients will encounter substantial obstacle in doing so. *Abbott* did not hold that driving distances over 150 miles constitute an "undue burden"; to the contrary, *Abbott* said that long driving distances should *never* be deemed an undue burden for that reason alone. 748 F.3d at 598 ("*Casey* counsels against striking down a statute solely because women may have to travel long distances to obtain abortions."); *see also Jackson*, 2014 WL 3730467, at *6 ("JWHO does not argue that the distances involved alone impose an undue burden. Nor could it in the light of *Abbott*.").

Grossman also offers a bald assertion that the existing ASCs in Texas won't be able to handle the state-wide demand for abortion. Grossman Direct, at ¶ 20 ("My opinion is that these existing ASCs as a group will not be able to go from providing approximately 14,000 abortions annually, as they currently are, to providing the 60,000 to 70,000 abortions that are done each year in Texas once all of the non-ASC clinics are forced to close."). But he offers nothing to support that statement. No data, no research, no interviews, not even hearsay. That is not permissible expert testimony. Expert testimony must be reasoned, employ the methodology of a discipline, and be founded on data. Fed. R. Evid. 702; *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 592-93 (1993). Grossman's opinion on the "capacity" issue fails the *Daubert* standard and cannot be given any weight. Indeed, the plaintiffs have not even asked the court to make a lack-of-capacity finding in their proposed findings of fact.

The only other witness to testify about the state-wide effects of HB2's ambulatory-surgical-center requirement is Anne Layne-Farrar. Layne-Farrar testified that HB2 will increase the cost of abortion, but she never calculated or quantified how much those increased costs will be. She says only that "as a matter of economics, increasing the operational costs of providing a service will generally lead to an increase in the price of that service." Layne-Farrar Direct (doc. 160), at ¶ 44. But the undue-burden test allows States to enact laws that make abortions more expensive, so long as the increased cost does not rise to the level of a "substantial obstacle." *See Casey*, 505 U.S. at 878; *cf. Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012) (upholding Texas law requiring an ultrasound before an abortion). The plaintiffs must provide evidence of *how much* the price of an abortion will increase, not a bald assertion that increased regulations will (as a matter of economic theory) cause abortions to become more expensive than they otherwise would be. Layne-Farrar's testimony does not prove that *any* abortion patient in Texas will encounter a "substantial obstacle" on account of HB2, let alone that a "large fraction" of Texas abortion patients will encounter such obstacles.

C. The Plaintiffs Have Failed To Prove That HB2's Requirements Will Impose An "Undue Burden" On Patients In The Rio Grande Valley.

The plaintiffs have failed to prove that the closure of Whole Woman's Health's McAllen clinic will impose a "substantial obstacle" in the path of abortion patients in the Rio Grande Valley. First, the Fifth Circuit has already held that a trip from the Rio Grande Valley to Corpus Christi is not an "undue burden" under *Casey*. The plaintiffs have not introduced any evidence of the differences between a 250-mile trip to San Antonio and a 150-mile trip to Corpus Christi, nor have they explained how these differences can have constitutional significance. Indeed, the plaintiffs' own witnesses undermine any claim that traveling from the Rio Grande Valley to

San Antonio is materially more burdensome than traveling from the Rio Grande Valley to Corpus Christi. Lucia Felix testified that all of the travel burdens she alleged were equally applicable to Corpus Christi and San Antonio. Trial Tr., Vol. 1, 116:23-117:1 ("Q. So women who had to travel to Corpus already experienced some of the challenges that they would have going to San Antonio; isn't that right? A: Yes. It would be the same challenge."); *see also id.* at 117:2-22 (noting similar challenges in taking time off work, finding child care, and traveling). Amy Hagstrom Miller testified that many women in the Rio Grande Valley consider San Antonio to be part of the Rio Grande Valley and are more comfortable travelling there than to Corpus Christi. Trial Tr., Vol. 2, 52:3-7 ("A lot of times folks in the Rio Grande Valley are a little bit nervous about going to a city -- a big city. For some people in the Valley, San Antonio is kind of in the valley and Corpus feels really different unless they're from the Brownsville/Harlingen area."). This testimony directly undercuts the plaintiffs' case.

Once again, the plaintiffs are litigating their case as if *Abbott* had never been decided. But the Fifth Circuit held *twice* in *Abbott* that traveling from the Rio Grande Valley to Corpus Christi is not an undue burden under *Casey*. *See Abbott*, 748 F.3d at 598 ("[A]n increase of travel of less than 150 miles for some women is not an undue burden under *Casey*."); *Abbott*, 734 F.3d at 415 ("An increase in travel distance of less than 150 miles for some women is not an undue burden on abortion rights."); *see also Jackson*, 2014 WL 3730467, at *4, *6. If it's not an undue burden to travel to Corpus Christi—and the plaintiffs and this court are bound by the Fifth Circuit's holdings that it *isn't*—then travel burdens that are equally applicable to Corpus Christi and San Antonio are irrelevant in determining whether HB2's requirements impose an "undue burden" on abortion patients in the Rio Grande Valley. More importantly, the plaintiffs have already litigated and lost their claim that

generalized travel burdens for patients in the Rio Grande Valley amount to an "undue burden" under *Casey*, and they are precluded by collateral estoppel from relitigating that contention in this case—or by attempting to buttress it with new evidence or anecdotes. *See Allen v. McCurry*, 449 U.S. 90, 94 (1980); *Brown v. Felsen*, 442 U.S. 127, 131 (1979); *In re Howe*, 913 F.2d 1138, 1144 n.10 (5th Cir. 1990). The *only* remaining question is whether the *increased* burdens of travelling to San Antonio rather than Corpus Christi sufficiently onerous to tip the scale and become a "substantial obstacle." Generalized grievances regarding the travel burdens on patients in the Rio Grande Valley are not probative of that question. The plaintiffs' burden is to prove that the burden of traveling to San Antonio is significantly greater than the burden of traveling to Corpus—so much so that the need to travel to San Antonio can be deemed an "undue burden" even though a trip to Corpus Christi is not. The plaintiffs have offered no evidence whatsoever of these marginal costs, and the testimony from their witnesses only reinforces the notion that traveling to San Antonio is no more burdensome than traveling to Corpus Christi.

Second, the McAllen clinic ceased offering abortions on November 1, 2013. Yet the plaintiffs have not proven that *any* abortion patient in the Rio Grande Valley (or anywhere in Texas) was unable to obtain a legal abortion during that nine-month window. Amy Hagstrom Miller provides vague, hearsay anecdotes about patients who she claims declined referrals to Whole Woman's Health's San Antonio office. Hagstrom Miller Direct (doc. 171), at ¶ 18. But Hagstrom Miller does not know whether these unnamed patients obtained legal abortions in Corpus Christi or elsewhere, nor does she have any knowledge of whether they encountered substantial obstacles in doing so. Hagstrom Miller's claim that her McAllen staff observed a "significant increase" in attempted self-abortions after HB2 took effect is double hearsay and cannot supply a basis for an "undue burden" finding. (It is also far too

vague: How much of an increase? Over what time frames? How many patients were doing this before HB2?) Even if this claim were proven with admissible evidence, it still would not establish that HB2 caused these anonymous patients to take this action. Correlation is not proof of causation, and there could be countless other factors influencing these patients' decisions. One of the many problems with the plaintiffs' efforts to prove their case with hearsay is that second-hand anecdotes do not explain *why* these unidentified patients made the decisions that they made—which makes these anecdotes incapable of proving that any of these patients' decisions are attributable to HB2 rather than other factors.

Third, the plaintiffs have not proven that abortion patients in the Rio Grande Valley (or El Paso) will be unable to obtain financial assistance from outside sources. There are many entities who are ready to provide resources to abortion patients of limited means, including the Lilith Fund (http://www.lilithfund.org/), the National Network of Abortion Funds (http://www.fundabortionnow.org/), the Third Wave Foundation (http://thirdwavefund.org/index.html), and Planned Parenthood (http://www.plannedparenthood.org/planned-parenthood-greater-texas/newsroom/press-releases/building-our-future-fund). The plaintiffs want this Court to *assume* that there are no resources available to patients who might otherwise encounter "substantial obstacles" to obtaining abortions. But the plaintiffs produced no evidence whatsoever to support that assumption, and the plaintiffs bear the burden of proving that these third-party resources are unavailable to patients in the Rio Grande Valley.

Finally, the plaintiffs have not proven that no new HB2-compliant abortion providers will open in the Rio Grande Valley (or El Paso) after September 1. The plaintiffs have stipulated that there will be at least eight ASC abortion clinics in Texas, but they have not proven that those will be the *only* abortion clinics in the State.

Planned Parenthood, the State's leading abortion provider, is not a party to this lawsuit, and the plaintiffs have not produced any evidence that Planned Parenthood will not be opening a new ASC clinic in the Rio Grande Valley or in El Paso. For all we know, Planned Parenthood could be planning to open a new ASC clinic in the Rio Grande Valley on September 1. The State is not privy to Planned Parenthood's plans, and the plaintiffs have not subpoenaed Planned Parenthood's officials to come into court and prove otherwise. This is a major evidentiary failure that dooms the plaintiffs' case.

D. The Plaintiffs Have Failed To Prove That HB2's Requirements Will Impose An "Undue Burden" On Patients In El Paso.

The plaintiffs have likewise failed to prove that the closure of Reproductive Services will impose a "substantial obstacle" in the path of abortion patients in El Paso. It is undisputed that abortion patients in El Paso will have a choice after HB2 takes full effect: either travel to San Antonio (or another city hundreds of miles away) or travel less than one mile across the Texas–New Mexico border. Theard Depo 72:8-74:2, 74:5-13, 79:10-16. This choice does not "unduly burden" El Paso abortion patients. Even if this Court were to disregard the abortion clinic in Santa Teresa, *Abbott* holds that long driving distances alone should not constitute an "undue burden" under *Casey*, and the plaintiffs have not proven that abortion patients will be unable to travel to San Antonio, particularly given the availability of outside resources to assist them. *See* Part II.C. Marilyn Eldridge testified that she is "deeply concerned" that patients in El Paso will be "unable to access legal abortion care and will attempt self-abortion," but she does not acknowledge the availability of abortions in Santa Teresa, New Mexico, and in all events the plaintiffs cannot prove that patients in El Paso will forgo legal abortion simply by expressing deep concern that this might happen. The plaintiffs must provide evidence that patients in El

Paso will encounter "substantial obstacles" in their efforts to obtain abortions, and they have not provided anything in the way of evidence.

III. IF THE COURT FINDS THAT THE PLAINTIFFS HAVE CARRIED THEIR BURDEN OF PROOF, ITS REMEDY SHOULD BE LIMITED.

If the Court decides that the plaintiffs have carried their burden of proof, in whole or in part, there are three important limits on the Court's remedial authority.

First, the Court should limit its relief to the named parties to this lawsuit. The plaintiffs in this case are only a subset of the abortion providers in Texas, and this case has not been brought as a class action. The Court therefore lacks authority to enjoin the enforcement of HB2 against anyone other than the named plaintiffs. *See Doran v. Salem Inn, Inc.*, 422 U.S. 922, 931 (1975) ("[N]either declaratory nor injunctive relief can directly interfere with enforcement of contested statutes or ordinances except with respect to the particular federal plaintiffs, and the State is free to prosecute others who may violate the statute."); *McKenzie v. City of Chicago*, 118 F.3d 552, 555 (7th Cir. 1997) ("[T]he question at issue [is] whether a court may grant relief to non-parties. The right answer is no.").

A federal court may extend injunctive relief to non-parties only when "necessary to give prevailing parties the relief to which they are entitled." *Prof'l Ass'n of Coll. Educators v. El Paso Cnty. Cmty. Coll. Dist.*, 730 F.2d 258, 273–74 (5th Cir. 1984); *see also McKenzie*, 118 F.3d at 555 (acknowledging that injunctive relief may extend to non-parties "in reapportionment and school desegregation cases" because "it is not possible to award effective relief to the plaintiffs without altering the rights of third parties."). That allowance is not applicable here. The Article III injury suffered by the plaintiff abortion providers is the regulatory burden imposed by the challenged provision of HB2; that injury is fully redressed by a remedy that enjoins the State from enforcing HB2 against the plaintiff abortion providers.

Second, the Court should not facially invalidate HB2's ambulatory-surgical-center requirement unless it finds that the plaintiffs have satisfied the demanding "large fraction" test from *Gonzales* and *Abbott*. As we have explained, the plaintiffs have no chance of satisfying that test given Giberson's undisputed testimony that 83% of Texas women will live within 150 miles of an abortion clinic—the safe harbor established by the Fifth Circuit. And the relevant fraction of abortion patients adversely affected by HB2 is far lower than 17% because most of those patients were already living more than 150 miles from their nearest abortion clinic before HB2 took effect.

Finally, HB2's severability clause and the Fifth Circuit's ruling in *Abbott* require any as-applied relief to be narrowly tailored. *See Abbott*, 748 F.3d at 589 ("Even when considering facial invalidation of a state statute, the court must preserve the valid scope of the provision to the greatest extent possible."); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 418 (5th Cir. 2013) (staying district court's injunction against HB2 because its relief was "broader than necessary to remedy the undue burden found by the district court"). If this Court decides to enjoin the admitting-privileges or ambulatory-surgical-center requirement as an "undue burden" as applied to the El Paso clinic, its injunction should state that it will expire as soon as an HB2-compliant abortion provider begins performing abortions in El Paso. The same is true for the Rio Grande Valley. The plaintiffs are not entitled to a permanent injunction authorizing them to disregard HB2 forever even if a competitor clinic that complies with HB2 opens in those areas.

CONCLUSION

The court should enter judgment for the State on each of the plaintiffs' claims.

Respectfully submitted.

GREG ABBOTT
Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

JAMES D. BLACKLOCK
Deputy Attorney General for Legal Counsel

/s/ Jonathan F. Mitchell
JONATHAN F. MITCHELL
Solicitor General
State Bar No. 24075463

BETH KLUSMANN
PHILIP A. LIONBERGER
MICHAEL P. MURPHY
Assistant Solicitors General

ANDREW B. STEPHENS
ESTEBAN S.M. SOTO
ENRIQUE VARELA
Assistant Attorneys General

209 West 14th Street
P.O. Box 12548 (MC-059)
Austin, Texas 78711-2548
(512) 936-1700 (phone)
(512) 474-2697 (fax)
jonathan.mitchell@texasattorneygeneral.gov

COUNSEL FOR DEFENDANTS
DAVID LAKEY, M.D., AND
MARI ROBINSON

Dated: August 12, 2014

CERTIFICATE OF SERVICE

I certify that on August 12, 2014, this document was served on counsel of record through the Court's CM/ECF Document Filing System or through e-mail.

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'CONNELL & SOIFER LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

John H. Bucy, II
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan
David P. Brown
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org
dbrown@reprorights.org

J. Alexander Lawrence
MORRISON & FOERSTER LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

Betre M. Gizaw
Marissa P. Harris
MORRISON & FOERSTER LLP
2000 Pennsylvania Ave., NW, Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com

Colin M. O'Brien
MORRISON & FOERSTER LLP
370 17th Street, Suite 5200
Denver, CO 80202
(303) 592-2252
(303) 592-1510
cobrien@mofo.com

COUNSEL FOR PLAINTIFFS

/s/ Jonathan F. Mitchell
JONATHAN F. MITCHELL
Solicitor General

M

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

WHOLE WOMAN'S HEALTH; *et al.*,	)	
	)	
Plaintiffs,	)	
	)	CIVIL ACTION
v.	)	
	)	CASE NO. 14-CV-284-LY
DAVID LAKEY, M.D.; *et al.*,	)	
	)	
Defendants.	)	

JOINT STIPULATION TO FACTS

The parties hereby stipulate, solely for the purposes of the above-captioned action, to the truth of the following facts as of the date indicated below:

1. The following facilities are ambulatory surgical centers currently licensed by the State of Texas that perform abortions. These facilities will not be prevented by the ambulatory surgical center requirements of HB 2 from performing abortions after September 1, 2014.

Planned Parenthood South Austin Clinic
201 East Ben White Boulevard
Austin, Texas 78704

Southwestern Women's Surgery Center
8616 Greenville Avenue Suite 101
Dallas, Texas 75243

Planned Parenthood of Greater Texas Star Clinic
6464 John Ryan Drive
Fort Worth, Texas 76132

Planned Parenthood Center for Choice
4600 Gulf Freeway
Houston, Texas 77023

Whole Woman's Health San Antonio
4025 East Southcross
Building 3, Suite 15
San Antonio, Texas 78223

Texas Ambulatory Surgical Center
2505 North Shepherd
Houston, Texas 77008

2. Planned Parenthood of Greater Texas Surgical Health Services in Dallas, Texas has obtained a license from the State of Texas and has reported its intention to open an ambulatory surgical center that performs abortions in August 2014.

3. At an undisclosed date in the future, Planned Parenthood of South Texas plans to open a licensed ambulatory surgical center in San Antonio, Texas. Planned Parenthood has announced its intention to open its San Antonio ASC in September 2014, but it is unknown whether the facility will open in September 2014.

4. No facility licensed by the State of Texas as an abortion facility currently satisfies the ASC requirement of HB 2. As a result, each of these facilities will be prohibited from providing abortion services effective September 1, 2014.

5. Reproductive Services of Harlingen has not provided abortion services since the admitting privileges requirement of HB 2 took effect.

6. There are 433 licensed ambulatory surgical centers in Texas. Of these, 336 are "considered to be an existing licensed ASC" pursuant to 25 Tex. Admin. Code. § 135.51(a).

Dated: August 4, 2014

/S/ Stephanie Toti

Stephanie Toti
Esha Bhandari
Natasha Lycia Ora Bannan*
David P. Brown*
Center for Reproductive Rights
120 Wall Street, 14th Floor
New York, NY 10005
(917) 637-3684 (ST phone)
(917) 637-3659 (EB phone)
(917) 637-3784 (NLOB phone)
stoti@reprorights.org
ebhandari@reprorights.org
nbannan@reprorights.org
dbrown@reprorights.org

Jan Soifer
Texas Bar No. 18824530
Patrick J. O'Connell
Texas Bar No. 15179900
O'CONNELL & SOIFER LLP
98 San Jacinto Blvd., Ste. 540
Austin, Texas 78701
(512) 583-0451 (JS phone)
(512) 852-5918 (PJO phone)
jsoifer@oconnellsoifer.com
poconnell@oconnellsoifer.com

J. Alexander Lawrence*
Kiersten Fletcher*
MORRISON & FOERSTER LLP
250 W. 55th Street
New York, NY 10019
(212) 336-8638
(212) 468-7900 Fax
alawrence@mofo.com

John H. Bucy, II*
Texas Bar No. 03311500
6633 Highway 290 East, Suite 104
Austin, TX 78723-1157
(512) 291-6505
john@johnbucy.com

Betre M. Gizaw*
Marissa P. Harris*
MORRISON & FOERSTER LLP
2000 Pennsylvania Avenue, NW
Suite 6000
Washington, DC 20006-1888
(202) 887-8744
(202) 887-0763 Fax
bgizaw@mofo.com
mharris@mofo.com

Colin M. O'Brien*
MORRISON & FOERSTER LLP
370 17th Street, Suite 5200
Denver, CO 80202
(303) 592-2252
(303) 592-1510
cobrien@mofo.com

*Admitted pro hac vice

Attorneys for Plaintiffs

GREG ABBOTT
Attorney General of Texas

DANIEL T. HODGE
First Assistant Attorney General

JAMES D. BLACKLOCK
Deputy Attorney General for Legal Counsel

JONATHAN F. MITCHELL
Solicitor General

ANDREW S. OLDHAM
Deputy Solicitor General

ARTHUR C. D'ANDREA
BETH KLUSMANN
PHILIP A. LIONBERGER
MICHAEL P. MURPHY
Assistant Solicitors General

/s/ Andrew B. Stephens
ANDREW B. STEPHENS
Texas Bar No. 24079396
ESTEBAN S.M. SOTO
ENRIQUE VARELA
Assistant Attorneys General

300 West 15th Street
P.O. Box 12548
Austin, Texas 78711-2548
(512) 463-2120 (phone)
(512) 320-0667 (fax)

COUNSEL FOR DEFENDANTS
DAVID LAKEY, M.D., AND
MARI ROBINSON

N

AN ACT

relating to the regulation of abortion procedures, providers, and facilities; providing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. (a) The findings indicate that:

(1) substantial medical evidence recognizes that an unborn child is capable of experiencing pain by not later than 20 weeks after fertilization;

(2) the state has a compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that these children are capable of feeling pain;

(3) the compelling state interest in protecting the lives of unborn children from the stage at which substantial medical evidence indicates that an unborn child is capable of feeling pain is intended to be separate from and independent of the compelling state interest in protecting the lives of unborn children from the stage of viability, and neither state interest is intended to replace the other; and

(4) restricting elective abortions at or later than 20 weeks post-fertilization, as provided by this Act, does not impose an undue burden or a substantial obstacle on a woman's ability to have an abortion because:

(A) the woman has adequate time to decide whether

to have an abortion in the first 20 weeks after fertilization; and

(B) this Act does not apply to abortions that are necessary to avert the death or substantial and irreversible physical impairment of a major bodily function of the pregnant woman or abortions that are performed on unborn children with severe fetal abnormalities.

(b) The legislature intends that every application of this statute to every individual woman shall be severable from each other. In the unexpected event that the application of this statute is found to impose an impermissible undue burden on any pregnant woman or group of pregnant women, the application of the statute to those women shall be severed from the remaining applications of the statute that do not impose an undue burden, and those remaining applications shall remain in force and unaffected, consistent with Section 10 of this Act.

SECTION 2. Subchapter A, Chapter 171, Health and Safety Code, is amended by adding Section 171.0031 to read as follows:

Sec. 171.0031. REQUIREMENTS OF PHYSICIAN; OFFENSE. (a) A physician performing or inducing an abortion:

(1) must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that:

(A) is located not further than 30 miles from the location at which the abortion is performed or induced; and

(B) provides obstetrical or gynecological health care services; and

(2) shall provide the pregnant woman with:

(A) a telephone number by which the pregnant

woman may reach the physician, or other health care personnel employed by the physician or by the facility at which the abortion was performed or induced with access to the woman's relevant medical records, 24 hours a day to request assistance for any complications that arise from the performance or induction of the abortion or ask health-related questions regarding the abortion; and

(B) the name and telephone number of the nearest hospital to the home of the pregnant woman at which an emergency arising from the abortion would be treated.

(b) A physician who violates Subsection (a) commits an offense. An offense under this section is a Class A misdemeanor punishable by a fine only, not to exceed $4,000.

SECTION 3. Chapter 171, Health and Safety Code, is amended by adding Subchapters C and D to read as follows:

SUBCHAPTER C. ABORTION PROHIBITED AT OR AFTER 20 WEEKS POST-FERTILIZATION

Sec. 171.041. SHORT TITLE. This subchapter may be cited as the Preborn Pain Act.

Sec. 171.042. DEFINITIONS. In this subchapter:

(1) "Post-fertilization age" means the age of the unborn child as calculated from the fusion of a human spermatozoon with a human ovum.

(2) "Severe fetal abnormality" has the meaning assigned by Section 285.202.

Sec. 171.043. DETERMINATION OF POST-FERTILIZATION AGE REQUIRED. Except as otherwise provided by Section 171.046, a

physician may not perform or induce or attempt to perform or induce an abortion without, prior to the procedure:

(1) making a determination of the probable post-fertilization age of the unborn child; or

(2) possessing and relying on a determination of the probable post-fertilization age of the unborn child made by another physician.

Sec. 171.044. ABORTION OF UNBORN CHILD OF 20 OR MORE WEEKS POST-FERTILIZATION AGE PROHIBITED. Except as otherwise provided by Section 171.046, a person may not perform or induce or attempt to perform or induce an abortion on a woman if it has been determined, by the physician performing, inducing, or attempting to perform or induce the abortion or by another physician on whose determination that physician relies, that the probable post-fertilization age of the unborn child is 20 or more weeks.

Sec. 171.045. METHOD OF ABORTION. (a) This section applies only to an abortion authorized under Section 171.046(a)(1) or (2) in which:

(1) the probable post-fertilization age of the unborn child is 20 or more weeks; or

(2) the probable post-fertilization age of the unborn child has not been determined but could reasonably be 20 or more weeks.

(b) Except as otherwise provided by Section 171.046(a)(3), a physician performing an abortion under Subsection (a) shall terminate the pregnancy in the manner that, in the physician's reasonable medical judgment, provides the best opportunity for the

unborn child to survive.

Sec. 171.046. EXCEPTIONS. (a) The prohibitions and requirements under Sections 171.043, 171.044, and 171.045(b) do not apply to an abortion performed if there exists a condition that, in the physician's reasonable medical judgment, so complicates the medical condition of the woman that, to avert the woman's death or a serious risk of substantial and irreversible physical impairment of a major bodily function, other than a psychological condition, it necessitates, as applicable:

(1) the immediate abortion of her pregnancy without the delay necessary to determine the probable post-fertilization age of the unborn child;

(2) the abortion of her pregnancy even though the post-fertilization age of the unborn child is 20 or more weeks; or

(3) the use of a method of abortion other than a method described by Section 171.045(b).

(b) A physician may not take an action authorized under Subsection (a) if the risk of death or a substantial and irreversible physical impairment of a major bodily function arises from a claim or diagnosis that the woman will engage in conduct that may result in her death or in substantial and irreversible physical impairment of a major bodily function.

(c) The prohibitions and requirements under Sections 171.043, 171.044, and 171.045(b) do not apply to an abortion performed on an unborn child who has a severe fetal abnormality.

Sec. 171.047. PROTECTION OF PRIVACY IN COURT PROCEEDINGS. (a) Except as otherwise provided by this section, in a civil or

criminal proceeding or action involving an act prohibited under this subchapter, the identity of the woman on whom an abortion has been performed or induced or attempted to be performed or induced is not subject to public disclosure if the woman does not give consent to disclosure.

(b) Unless the court makes a ruling under Subsection (c) to allow disclosure of the woman's identity, the court shall issue orders to the parties, witnesses, and counsel and shall direct the sealing of the record and exclusion of individuals from courtrooms or hearing rooms to the extent necessary to protect the woman's identity from public disclosure.

(c) A court may order the disclosure of information that is confidential under this section if:

(1) a motion is filed with the court requesting release of the information and a hearing on that request;

(2) notice of the hearing is served on each interested party; and

(3) the court determines after the hearing and an in camera review that disclosure is essential to the administration of justice and there is no reasonable alternative to disclosure.

Sec. 171.048. CONSTRUCTION OF SUBCHAPTER. (a) This subchapter shall be construed, as a matter of state law, to be enforceable up to but no further than the maximum possible extent consistent with federal constitutional requirements, even if that construction is not readily apparent, as such constructions are authorized only to the extent necessary to save the subchapter from judicial invalidation. Judicial reformation of statutory language

is explicitly authorized only to the extent necessary to save the statutory provision from invalidity.

(b) If any court determines that a provision of this subchapter is unconstitutionally vague, the court shall interpret the provision, as a matter of state law, to avoid the vagueness problem and shall enforce the provision to the maximum possible extent. If a federal court finds any provision of this subchapter or its application to any person, group of persons, or circumstances to be unconstitutionally vague and declines to impose the saving construction described by this subsection, the Supreme Court of Texas shall provide an authoritative construction of the objectionable statutory provisions that avoids the constitutional problems while enforcing the statute's restrictions to the maximum possible extent, and shall agree to answer any question certified from a federal appellate court regarding the statute.

(c) A state executive or administrative official may not decline to enforce this subchapter, or adopt a construction of this subchapter in a way that narrows its applicability, based on the official's own beliefs about what the state or federal constitution requires, unless the official is enjoined by a state or federal court from enforcing this subchapter.

(d) This subchapter may not be construed to authorize the prosecution of or a cause of action to be brought against a woman on whom an abortion is performed or induced or attempted to be performed or induced in violation of this subchapter.

SUBCHAPTER D. ABORTION-INDUCING DRUGS

Sec. 171.061. DEFINITIONS. In this subchapter:

(1) "Abortion" means the act of using, administering, prescribing, or otherwise providing an instrument, a drug, a medicine, or any other substance, device, or means with the intent to terminate a clinically diagnosable pregnancy of a woman and with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the woman's unborn child. An act is not an abortion if the act is done with the intent to:

(A) save the life or preserve the health of an unborn child;

(B) remove a dead, unborn child whose death was caused by spontaneous abortion;

(C) remove an ectopic pregnancy; or

(D) treat a maternal disease or illness for which a prescribed drug, medicine, or other substance is indicated.

(2) "Abortion-inducing drug" means a drug, a medicine, or any other substance, including a regimen of two or more drugs, medicines, or substances, prescribed, dispensed, or administered with the intent of terminating a clinically diagnosable pregnancy of a woman and with knowledge that the termination will, with reasonable likelihood, cause the death of the woman's unborn child. The term includes off-label use of drugs, medicines, or other substances known to have abortion-inducing properties that are prescribed, dispensed, or administered with the intent of causing an abortion, including the Mifeprex regimen. The term does not include a drug, medicine, or other substance that may be known to cause an abortion but is prescribed, dispensed, or administered for other medical reasons.

(3) "Final printed label" or "FPL" means the informational document approved by the United States Food and Drug Administration for an abortion-inducing drug that:

(A) outlines the protocol authorized by that agency and agreed to by the drug company applying for authorization of the drug by that agency; and

(B) delineates how a drug is to be used according to approval by that agency.

(4) "Gestational age" means the amount of time that has elapsed since the first day of a woman's last menstrual period.

(5) "Medical abortion" means the administration or use of an abortion-inducing drug to induce an abortion.

(6) "Mifeprex regimen," "RU-486 regimen," or "RU-486" means the abortion-inducing drug regimen approved by the United States Food and Drug Administration that consists of administering mifepristone and misoprostol.

(7) "Physician" means an individual who is licensed to practice medicine in this state, including a medical doctor and a doctor of osteopathic medicine.

(8) "Pregnant" means the female reproductive condition of having an unborn child in a woman's uterus.

(9) "Unborn child" means an offspring of human beings from conception until birth.

Sec. 171.062. ENFORCEMENT BY TEXAS MEDICAL BOARD. Notwithstanding Section 171.005, the Texas Medical Board shall enforce this subchapter.

Sec. 171.063. DISTRIBUTION OF ABORTION-INDUCING DRUG.

(a) A person may not knowingly give, sell, dispense, administer, provide, or prescribe an abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion in the pregnant woman or enabling another person to induce an abortion in the pregnant woman unless:

(1) the person who gives, sells, dispenses, administers, provides, or prescribes the abortion-inducing drug is a physician; and

(2) except as otherwise provided by Subsection (b), the provision, prescription, or administration of the abortion-inducing drug 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.

(b) 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.

(c) Before the physician gives, sells, dispenses, administers, provides, or prescribes an abortion-inducing drug, the physician must examine the pregnant woman and document, in the woman's medical record, the gestational age and intrauterine location of the pregnancy.

(d) The physician who gives, sells, dispenses, administers, provides, or prescribes an abortion-inducing drug shall provide the pregnant woman with:

(1) a copy of the final printed label of that

abortion-inducing drug; and

(2) a telephone number by which the pregnant woman may reach the physician, or other health care personnel employed by the physician or by the facility at which the abortion was performed with access to the woman's relevant medical records, 24 hours a day to request assistance for any complications that arise from the administration or use of the drug or ask health-related questions regarding the administration or use of the drug.

(e) The physician who gives, sells, dispenses, administers, provides, or prescribes the abortion-inducing drug, or the physician's agent, must schedule a follow-up visit for the woman to occur not more than 14 days after the administration or use of the drug. At the follow-up visit, the physician must:

(1) confirm that the pregnancy is completely terminated; and

(2) assess the degree of bleeding.

(f) The physician who gives, sells, dispenses, administers, provides, or prescribes the abortion-inducing drug, or the physician's agent, shall make a reasonable effort to ensure that the woman returns for the scheduled follow-up visit under Subsection (e). The physician or the physician's agent shall document a brief description of any effort made to comply with this subsection, including the date, time, and name of the person making the effort, in the woman's medical record.

(g) If a physician gives, sells, dispenses, administers, provides, or prescribes an abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion as authorized by this

section and the physician knows that the woman experiences a serious adverse event, as defined by the MedWatch Reporting System, during or after the administration or use of the drug, the physician shall report the event to the United States Food and Drug Administration through the MedWatch Reporting System not later than the third day after the date the physician learns that the event occurred.

Sec. 171.064. ADMINISTRATIVE PENALTY. (a) The Texas Medical Board may take disciplinary action under Chapter 164, Occupations Code, or assess an administrative penalty under Subchapter A, Chapter 165, Occupations Code, against a person who violates Section 171.063.

(b) A penalty may not be assessed under this section against a pregnant woman who receives a medical abortion.

SECTION 4. Section 245.010(a), Health and Safety Code, is amended to read as follows:

(a) The rules must contain minimum standards to protect the health and safety of a patient of an abortion facility and must contain provisions requiring compliance with the requirements of Subchapter B, Chapter 171. On and after September 1, 2014, the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under Section 243.010 for ambulatory surgical centers.

SECTION 5. Section 245.011(c), Health and Safety Code, is amended to read as follows:

(c) The report must include:

(1) whether the abortion facility at which the

abortion is performed is licensed under this chapter;

(2) the patient's year of birth, race, marital status, and state and county of residence;

(3) the type of abortion procedure;

(4) the date the abortion was performed;

(5) whether the patient survived the abortion, and if the patient did not survive, the cause of death;

(6) the probable post-fertilization age of the unborn child [~~period of gestation~~] based on the best medical judgment of the attending physician at the time of the procedure;

(7) the date, if known, of the patient's last menstrual cycle;

(8) the number of previous live births of the patient; and

(9) the number of previous induced abortions of the patient.

SECTION 6. Section 164.052(a), Occupations Code, is amended to read as follows:

(a) A physician or an applicant for a license to practice medicine commits a prohibited practice if that person:

(1) submits to the board a false or misleading statement, document, or certificate in an application for a license;

(2) presents to the board a license, certificate, or diploma that was illegally or fraudulently obtained;

(3) commits fraud or deception in taking or passing an examination;

(4) uses alcohol or drugs in an intemperate manner that, in the board's opinion, could endanger a patient's life;

(5) commits unprofessional or dishonorable conduct that is likely to deceive or defraud the public, as provided by Section 164.053, or injure the public;

(6) uses an advertising statement that is false, misleading, or deceptive;

(7) advertises professional superiority or the performance of professional service in a superior manner if that advertising is not readily subject to verification;

(8) purchases, sells, barters, or uses, or offers to purchase, sell, barter, or use, a medical degree, license, certificate, or diploma, or a transcript of a license, certificate, or diploma in or incident to an application to the board for a license to practice medicine;

(9) alters, with fraudulent intent, a medical license, certificate, or diploma, or a transcript of a medical license, certificate, or diploma;

(10) uses a medical license, certificate, or diploma, or a transcript of a medical license, certificate, or diploma that has been:

(A) fraudulently purchased or issued;

(B) counterfeited; or

(C) materially altered;

(11) impersonates or acts as proxy for another person in an examination required by this subtitle for a medical license;

(12) engages in conduct that subverts or attempts to

subvert an examination process required by this subtitle for a medical license;

(13) impersonates a physician or permits another to use the person's license or certificate to practice medicine in this state;

(14) directly or indirectly employs a person whose license to practice medicine has been suspended, canceled, or revoked;

(15) associates in the practice of medicine with a person:

(A) whose license to practice medicine has been suspended, canceled, or revoked; or

(B) who has been convicted of the unlawful practice of medicine in this state or elsewhere;

(16) performs or procures a criminal abortion, aids or abets in the procuring of a criminal abortion, attempts to perform or procure a criminal abortion, or attempts to aid or abet the performance or procurement of a criminal abortion;

(17) directly or indirectly aids or abets the practice of medicine by a person, partnership, association, or corporation that is not licensed to practice medicine by the board;

(18) performs an abortion on a woman who is pregnant with a viable unborn child during the third trimester of the pregnancy unless:

(A) the abortion is necessary to prevent the death of the woman;

(B) the viable unborn child has a severe,

irreversible brain impairment; or

(C) the woman is diagnosed with a significant likelihood of suffering imminent severe, irreversible brain damage or imminent severe, irreversible paralysis; [~~or~~]

(19) performs an abortion on an unemancipated minor without the written consent of the child's parent, managing conservator, or legal guardian or without a court order, as provided by Section 33.003 or 33.004, Family Code, authorizing the minor to consent to the abortion, unless the physician concludes that on the basis of the physician's good faith clinical judgment, a condition exists that complicates the medical condition of the pregnant minor and necessitates the immediate abortion of her pregnancy to avert her death or to avoid a serious risk of substantial impairment of a major bodily function and that there is insufficient time to obtain the consent of the child's parent, managing conservator, or legal guardian; or

(20) performs or induces or attempts to perform or induce an abortion in violation of Subchapter C, Chapter 171, Health and Safety Code.

SECTION 7. Section 164.055(b), Occupations Code, is amended to read as follows:

(b) The sanctions provided by Subsection (a) are in addition to any other grounds for refusal to admit persons to examination under this subtitle or to issue a license or renew a license to practice medicine under this subtitle. The criminal penalties provided by Section 165.152 do not apply to a violation of Section 170.002 or Subchapter C, Chapter 171, Health and Safety Code.

SECTION 8. Effective September 1, 2014, Section 245.010(c), Health and Safety Code, is repealed.

SECTION 9. This Act may not be construed to repeal, by implication or otherwise, Section 164.052(a)(18), Occupations Code, Section 170.002, Health and Safety Code, or any other provision of Texas law regulating or restricting abortion not specifically addressed by this Act. An abortion that complies with this Act but violates any other law is unlawful. An abortion that complies with another state law but violates this Act is unlawful as provided in this Act.

SECTION 10. (a) If some or all of the provisions of this Act are ever temporarily or permanently restrained or enjoined by judicial order, all other provisions of Texas law regulating or restricting abortion shall be enforced as though the restrained or enjoined provisions had not been adopted; provided, however, that whenever the temporary or permanent restraining order or injunction is stayed or dissolved, or otherwise ceases to have effect, the provisions shall have full force and effect.

(b) Mindful of Leavitt v. Jane L., 518 U.S. 137 (1996), in which in the context of determining the severability of a state statute regulating abortion the United States Supreme Court held that an explicit statement of legislative intent is controlling, it is the intent of the legislature that every provision, section, subsection, sentence, clause, phrase, or word in this Act, and every application of the provisions in this Act, are severable from each other. If any application of any provision in this Act to any person, group of persons, or circumstances is found by a court to be

invalid, the remaining applications of that provision to all other persons and circumstances shall be severed and may not be affected. All constitutionally valid applications of this Act shall be severed from any applications that a court finds to be invalid, leaving the valid applications in force, because it is the legislature's intent and priority that the valid applications be allowed to stand alone. Even if a reviewing court finds a provision of this Act to impose an undue burden in a large or substantial fraction of relevant cases, the applications that do not present an undue burden shall be severed from the remaining provisions and shall remain in force, and shall be treated as if the legislature had enacted a statute limited to the persons, group of persons, or circumstances for which the statute's application does not present an undue burden. The legislature further declares that it would have passed this Act, and each provision, section, subsection, sentence, clause, phrase, or word, and all constitutional applications of this Act, irrespective of the fact that any provision, section, subsection, sentence, clause, phrase, or word, or applications of this Act, were to be declared unconstitutional or to represent an undue burden.

(c) If Subchapter C, Chapter 171, Health and Safety Code, as added by this Act, prohibiting abortions performed on an unborn child 20 or more weeks after fertilization is found by any court to be invalid or to impose an undue burden as applied to any person, group of persons, or circumstances, the prohibition shall apply to that person or group of persons or circumstances on the earliest date on which the subchapter can be constitutionally applied.

(d) If any provision of this Act is found by any court to be unconstitutionally vague, then the applications of that provision that do not present constitutional vagueness problems shall be severed and remain in force.

SECTION 11. (a) The executive commissioner of the Health and Human Services Commission shall adopt the standards required by Section 245.010, Health and Safety Code, as amended by this Act, not later than January 1, 2014.

(b) A facility licensed under Chapter 245, Health and Safety Code, is not required to comply with the standards adopted under Section 245.010, Health and Safety Code, as amended by this Act, before September 1, 2014.

SECTION 12. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect on the 91st day after the last day of the legislative session.

President of the Senate

Speaker of the House

I certify that H.B. No. 2 was passed by the House on July 10, 2013, by the following vote: Yeas 96, Nays 49, 1 present, not voting.

Chief Clerk of the House

I certify that H.B. No. 2 was passed by the Senate on July 12, 2013, by the following vote: Yeas 19, Nays 11.

Secretary of the Senate

APPROVED: _____

Date

_____

Governor

O

DEPARTMENT OF STATE
HEALTH SERVICES
REGULATORY LICENSING UNIT
FACILITY LICENSING GROUP

TITLE 25
TEXAS ADMINISTRATIVE CODE
CHAPTER 135
AMBULATORY SURGICAL CENTERS
LICENSING RULES

EFFECTIVE
NOVEMBER 25, 2010

TABLE OF CONTENTS

25 Texas Administrative Code

Chapter 135. AMBULATORY SURGICAL CENTERS

SUBCHAPTER C. PHYSICAL PLANT AND CONSTRUCTION REQUIREMENTS

Subchapter A. Operating Requirements for Ambulatory Surgical Centers.

§135.1. Scope and Purpose.

(a) The purpose of these sections is to implement Health and Safety Code, Chapter 243, which requires ambulatory surgical centers to be licensed by the Department of State Health Services.

(b) These sections provide minimum standards for ambulatory surgical center licenses and procedures for granting, denying, suspending, and revoking a license and licensure fees. The sections under this subchapter primarily cover the licensing procedures and standards for operation, and the remaining sections of this chapter primarily cover the requirements concerning construction design and the life safety code.

(c) The standards pertaining to the construction and design, the qualifications of the professional staff and other personnel, the equipment essential to the health and welfare of the patients, sanitary and hygienic conditions, and the quality assurance program may not exceed the minimum standards for certification under the Social Security Act, Title XVIII, 42 United States Code (USC), §§1395 et seq.

§135.2. Definitions.

The following words and terms, when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Act--Texas Ambulatory Surgical Center Licensing Act, Health and Safety Code, Chapter 243.

(2) Action plan--A written document that includes specific measures to correct identified problems or areas of concern; identifies strategies for implementing system improvements; and includes outcome measures to indicate the effectiveness of system improvements in reducing, controlling or eliminating identified problem areas.

(3) Administrator--A person who is a physician, is a registered nurse, has a baccalaureate or postgraduate degree in administration or a health-related field, or has one year of administrative experience in a health care setting.

(4) Advanced practice registered nurse (APRN)--A registered nurse approved by the Texas Board of Nursing to practice as an advanced practice registered nurse in Texas. The term includes a nurse practitioner, nurse midwife, nurse anesthetist, and clinical nurse specialist. The term is synonymous with "advanced nurse practitioner."

(5) Ambulatory Surgical Center (ASC)--A facility that primarily provides surgical services to patients who do not require overnight hospitalization or extensive recovery, convalescent time or observation. The planned total length of stay for an ASC patient shall not exceed 23 hours. Patient stays of greater than 23 hours shall be the result of an unanticipated

medical condition and shall occur infrequently. The 23-hour period begins with the induction of anesthesia.

(6) Autologous blood units--Units of blood or blood products derived from the recipient.

(7) Available--Able to be physically present in the facility to assume responsibility for the delivery of patient care services within five minutes.

(8) Certified registered nurse anesthetist (CRNA)--A registered nurse who has current certification from the Council on Certification of Nurse Anesthetists and who is currently authorized to practice as an advanced practice registered nurse by the Texas Board of Nursing.

(9) Change of ownership--

(A) a sole proprietor who transfers all or part of the ASC's ownership to another person or persons;

(B) the removal, addition, or substitution of a person or persons as a general, managing, or controlling partner in an ASC owned by a partnership and the tax identification number of that ownership changes; or

(C) a corporation that transfers all or part of the corporate stock which represents the ASC's ownership to another person or persons and the tax identification number of that ownership changes.

(10) Dentist--A person who is currently licensed under the laws of this state to practice dentistry.

(11) Department--The Department of State Health Services.

(12) Disposal--The discharge, deposit, injection, dumping, spilling, leaking, or placing of any solid waste or hazardous waste (whether containerized or uncontainerized) into or on any land or water so that such solid waste or hazardous waste or any constituent thereof may enter the environment or be emitted into the air or discharge into any waters, including ground waters.

(13) Extended observation--The period of time that a patient remains in the facility following recovery from anesthesia and discharge from the postanesthesia care unit, during which additional comfort measures or observation may be provided.

(14) Health care practitioners (qualified medical personnel)--Individuals currently licensed under the laws of this state who are authorized to provide services in an ASC.

(15) Licensed vocational nurse (LVN)--A person who is currently licensed by the Texas Board of Nursing as a licensed vocational nurse.

(16) Medicare-approved reference laboratory--A facility that has been certified and found eligible for Medicare reimbursement, and includes hospital laboratories which may be Joint Commission or American Osteopathic Association accredited or nonaccredited Medicare approved hospitals, and Medicare certified independent laboratories.

(17) Person--Any individual, firm, partnership, corporation, or association.

(18) Physician--An individual licensed by the Texas Medical Board and authorized to practice medicine in the State of Texas.

(19) Premises--A building where patients receive outpatient surgical services.

(20) Registered nurse (RN)--A person who is currently licensed by the Texas Board of Nursing as a registered nurse.

(21) Surgical technologist--A person who practices surgical technology as defined in Health and Safety Code, Chapter 259.

(22) Title XVIII--Title XVIII of the United States Social Security Act, 42 United States Code (USC), §§1395 et seq.

§135.3. Fees.

(a) Initial license fee. The fee for an initial license (includes change of ownership or relocation) is $5,200. The license term is two years.

(b) Renewal license fee. The fee for a renewal license is $5,200. The license term is two years.

(c) Official submission. The department shall not consider an application as officially submitted until the applicant pays the application fee and submits the application form.

(d) Nonrefundable. Fees paid to the department are not refundable.

(e) Payment of fees. All fees shall be paid to the Department of State Health Services.

(f) Fee schedule review. The department shall make periodic reviews of its fee schedule and make any adjustments necessary to provide funds to meet its expenses without creating an unnecessary surplus. Such adjustments shall be through section amendments.

(g) Other fees. The department is authorized to collect subscription and convenience fees, in amounts determined by the TexasOnline Authority, to recover costs associated with application and renewal application processing through TexasOnline, in accordance with Government Code, §2054.111.

§135.4. Ambulatory Surgical Center (ASC) Operation.

(a) The ASC shall have a governing body that sets policy and assumes full legal responsibility for the total operation of the ASC.

(b) The governing body shall be responsible for assuring that medical staff bylaws are current and on file.

(c) The governing body shall address and is fully responsible, either directly or by appropriate professional delegation, for the operation and performance of the ASC. Governing body responsibilities include, but are not limited to:

(1) determining the mission, goals, and objectives of the ASC;

(2) assuring that facilities and personnel are adequate and appropriate to carry out the mission;

(3) establishing an organizational structure and specifying functional relationships among the various components of the ASC;

(4) adopting bylaws or similar rules and regulations for the orderly development and management of the ASC;

(5) adopting policies or procedures necessary for the orderly conduct of the ASC;

(6) assuring that the quality of care is evaluated and that identified problems are addressed;

(7) reviewing all legal and ethical matters concerning the ASC and its staff and, when necessary, responding appropriately;

(8) maintaining effective communication throughout the ASC;

(9) establishing a system of financial management and accountability that includes an audit appropriate to the ASC;

(10) developing, implementing, and enforcing a policy on the rights of patients;

(11) approving all major contracts or arrangements affecting the medical care provided under its auspices, including, but not limited to, those concerning:

(A) the employment of health care practitioners;

(B) an effective procedure for the immediate transfer to a hospital of patients requiring emergency care beyond the capabilities of the ASC. The ASC shall have a

written transfer agreement with a hospital or all physicians performing surgery at the ASC shall have admitting privileges at a local hospital;

(C) the use of external laboratories;

(D) an effective procedure for obtaining emergency laboratory, radiology, and pharmaceutical services if laboratory, X-ray, and pharmacy services are not provided on site;

(E) the provision of education to students and postgraduate trainees if the ASC participates in such programs;

(12) formulating long-range plans in accordance with the mission, goals, and objectives of the ASC;

(13) operating the ASC without limitation because of race, creed, sex, or national origin;

(14) assuring that all marketing and advertising concerning the ASC does not imply that it provides care or services which it is not capable of providing; and

(15) developing a system of risk management appropriate to the ASC including, but not limited to:

(A) periodic review of all litigation involving the ASC, its staff, and health care practitioners regarding activities in the ASC;

(B) periodic review of all incidents reported by staff and patients;

(C) review of all deaths, trauma, or adverse reactions occurring on premises; and

(D) evaluation of patient complaints.

(d) The governing body shall provide for full disclosure of ownership to the department.

(e) The governing body shall meet at least annually and keep such minutes or other records as may be necessary for the orderly conduct of the ASC.

(f) If the governing body elects, appoints, or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions shall be defined.

(g) When a majority of its members are physicians, the governing body, either directly or by delegation, shall make (in a manner consistent with state law and based on evidence of the education, training, and current competence of the physician) initial appointments, reappointments, and assignment or curtailment of medical privileges. When a majority of the

members of the governing body are not physicians, the ASC's bylaws or similar rules and regulations shall specify a procedure for establishing medical review for the purpose of making (in a manner consistent with state law and based on evidence of the education, training, and current competence of the physician) initial appointments, reappointments, and assignment or curtailment of medical privileges.

(h) The governing body shall provide (in a manner consistent with state law and based on evidence of education, training, and current competence) for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for nonphysician health care personnel and practitioners.

(i) The governing body shall encourage personnel to participate in continuing education that is relevant to their responsibilities within the ASC.

(j) The governing body shall adopt, implement, and enforce written policies to ensure compliance with Health and Safety Code, Chapter 324, Consumer Access to Health Care Information.

(k) The governing body shall adopt, implement and enforce written policies to ensure compliance with applicable state laws.

(l) An ASC that performs abortions shall adopt, implement and enforce a policy to ensure compliance with Health and Safety Code, Chapters 245 and 171, Subchapters A and B (relating to Abortion and Informed Consent).

§135.5. Patient Rights.

(a) Patients shall be treated with respect, consideration, and dignity.

(b) Patients shall be provided appropriate privacy.

(c) Patient records shall be treated confidentially and, except when authorized by law, patients shall be given the opportunity to approve or refuse their release.

(d) Patients shall be provided, to the degree known, appropriate information concerning their diagnosis, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information shall be provided to a person designated by the patient or to a legally authorized person.

(e) Patients shall be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.

(f) Information shall be available to patients and staff concerning:

(1) patient rights, including those specified in subsections (a) - (e) of this section;

(2) patient conduct and responsibilities;

(3) services available at the ambulatory surgical center (ASC);

(4) provisions for after-hours and emergency care;

(5) fees for services;

(6) payment policies;

(7) patient's right to refuse to participate in experimental research; and

(8) methods for expressing complaints and suggestions to the ASC.

(g) Marketing or advertising regarding the competence and/or capabilities of the organization shall not be misleading to patients.

§135.6. Administration.

(a) Administrative policies, procedures, and controls shall be established and implemented to assure the orderly and efficient management of the ambulatory surgical center (ASC). Administrative responsibilities shall include, but are not limited to:

(1) enforcing policies delegated by the governing body;

(2) employing qualified management personnel;

(3) long-range and short-range planning for the needs of the ASC, as determined by the governing body;

(4) using methods of communicating and reporting, designed to assure the orderly flow of information within the ASC;

(5) controlling the purchase, maintenance, and distribution of the equipment, materials, and facilities of the ASC;

(6) establishing lines of authority, accountability, and supervision of personnel;

(7) establishing controls relating to the custody of the official documents of the ASC; and

(8) maintaining the confidentiality, security, and physical safety of data on patients and staff.

(b) Personnel policies shall be established and implemented to facilitate attainment of the mission, goals, and objectives of the ASC. Personnel policies shall:

(1) define and delineate functional responsibilities and authority;

(2) require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification;

(3) require periodic appraisal of each person's job performance;

(4) specify responsibilities and privileges of employment;

(5) be made known to employees at the time of employment; and

(6) provide adequate orientation and training to familiarize all personnel with the ASC's policies, procedures, and facilities.

(c) The ASC shall periodically assess patient satisfaction with services and facilities provided by the ASC. The findings shall be reviewed by the governing body.

(d) When students and postgraduate trainees are present, their status shall be defined in the ASC's personnel policies.

(e) All employee categories shall be included in personnel policies and appropriate job descriptions shall be developed.

§135.7. Quality of Care.

(a) All health care practitioners shall have the necessary and appropriate training and skills to deliver the services provided by the ambulatory surgical center (ASC).

(b) Health care practitioners shall practice in accordance with applicable state law and conform to the standards and ethics of their professions.

(c) Patient care responsibilities shall be delineated in accordance with recognized standards of practice.

(d) There shall be qualified medical personnel available for emergency treatment whenever there is a patient in the ASC who has received services.

(e) The provision of quality health care services shall be demonstrated by at least the following:

(1) accessible and available health services;

(2) appropriate and timely diagnostic procedures;

(3) treatment that is consistent with clinical impression or working diagnosis;

(4) appropriate and timely consultation;

(5) absence of clinically unnecessary diagnostic or therapeutic procedures;

(6) provision for services when the ASC is not open;

(7) appropriate, accurate, and complete medical record entries; and

(8) adequate transfer of information when patients are transferred to and from other health care providers.

(f) When clinically indicated, patients shall be contacted as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiologic findings that have been identified.

(g) When the need arises, patients shall be transferred from the care of one health care practitioner to another.

(1) Adequate specialty consultation services shall be made available by prior arrangement.

(2) Referral to another health care practitioner shall be clearly outlined to the patient and arranged with the accepting health care practitioner prior to transfer.

(h) Concern for the appropriateness of care shall be governed by the following:

(1) the relevance of health care services to the needs of the patients;

(2) the absence of duplicative diagnostic procedures;

(3) the appropriateness of treatment frequency; and

(4) the use of ancillary services that is consistent with patients' needs.

(i) Education activities shall relate, in part, to the findings as quality assurance activities and shall include cardiopulmonary resuscitation training.

§135.8. Quality Assurance.

(a) Quality assurance includes the selection of professional personnel prior to engagement for service, ongoing review of clinical responsibilities and authority, and peer review and supervision of all professional and technical activities of personnel.

(b) The professional and administrative staff shall understand, support, and participate in the quality assurance program.

(c) The quality assurance program shall address clinical, administrative, and cost effective issues. Exclusive concentration on administrative cost effective issues does not fulfill this requirement.

(d) Quality assurance activities shall be conducted by the quality assurance committee, which is composed of specific clinical disciplines within the ambulatory surgical center (ASC) (individual medical specialties, nursing, etc.), and shall be consistent with the characteristics of the overall quality assurance program and the services provided by the ASC.

(e) Problem identification and resolution activities shall be conducted as part of an ongoing, organized quality assurance program in which all practitioners in all clinical disciplines have an opportunity to participate. A variety of self-assessment methodologies may be used to implement the quality assurance program. Assessment techniques shall examine the structure, process, or outcome of care, and shall be assessed prospectively, concurrently, or retrospectively.

(f) Quality assurance activities shall address the following.

(1) Important problems or concerns in the care of patients shall be identified. Although the medical record is an important data source for identifying previously unrecognized problems, any sources may be used. Problems concerning accessibility, medical-legal issues, and wasteful practices shall be considered, as well as concerns previously recognized by patients and staff but inadequately addressed.

(2) The frequency, severity, and source of suspected problems or concerns shall be assessed.

(A) Health care practitioners shall participate in the development and application of the criteria used to evaluate the care they provide.

(B) Health care practitioners shall participate in the evaluation of the problems or concerns identified.

(C) A record shall be maintained of all fires, patient deaths, and all transfers from the ASC to the hospital.

(3) Measures shall be implemented to resolve important problems or concerns that have been identified. Health care practitioners as well as administrative staff shall participate in the resolution of the problems or concerns that are identified.

(4) The problems or concerns shall be reassessed to determine objectively whether or not the measures have achieved and sustained the desired result, and if not, why not.

(5) Through the ASC’s designated mechanisms, quality assurance activities shall be reported, as appropriate, to the proper personnel and the governing body.

(g) Quality assurance activities described in subsection (f) of this section shall encompass, but are not limited to:

(1) the clinical performance of health care practitioners;

(2) the standards for medical records;

(3) quality controls for and the use of radiology, pathology, and medical laboratory services;

(4) other professional and technical services provided; and

(5) studies of patient satisfaction.

(h) The quality assurance program shall be a well-defined organized program designed to enhance patient care through the ongoing objective assessment of important aspects of patient care and the associated or identified problems. The responsibilities for quality assurance activities shall be clearly delineated.

(1) Qualified medical staff shall participate in assessment of medical services by health care practitioners and shall be accomplished by a specified member(s) of the medical staff or by staff as a group.

(2) Nursing service shall be represented by one or more qualified registered nurses in quality assurance activities.

§135.9. Medical Records.

(a) The ambulatory surgical center (ASC) shall develop and maintain a system for the collection, processing, maintenance, storage, retrieval, and distribution of patient's medical records.

(b) An individual medical record shall be established for each person receiving care.

(c) All clinical information relevant to a patient shall be readily available to health care practitioners involved in the care of that patient.

(d) Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient shall be strictly confidential and shall be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.

(e) A person shall be designated to be in charge of medical records whose responsibilities include, but are not limited to:

(1) the confidentiality, security, and safe storage of medical records;

(2) the timely retrieval of individual medical records upon request;

(3) the specific identification of each patient's medical record;

(4) the supervision of the collection, processing, maintenance, storage, retrieval, and distribution of medical records; and

(5) the maintenance of a predetermined organized medical record format.

(f) Policies concerning medical records shall follow current statute in regard to retention of active records, retirement of inactive records, and the release of information contained in the record.

(g) Except when otherwise required by law, the content and format of medical records, including the sequence of information, shall be uniform.

(h) Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, X-ray readings, and consultation) shall be incorporated into the medical record in a timely manner.

(i) Medical records shall be available to authorized health care practitioners any time the ASC is open to patients.

(j) The ASC shall include the following in patients' medical records:

(1) patient identification;

(2) allergies and untoward reactions to drugs recorded in a prominent and uniform location;

(3) all preoperative, postoperative medications administered and drug/dose/route/frequency/quantity of all postoperative drugs dispensed to the patient by the ASC and entered on the patient's record;

(4) significant medical history and results of physical examination;

(5) a preanesthesia evaluation by an individual qualified to administer anesthesia;

(6) preoperative diagnostic studies entered before surgery, if required by policy or ordered by a physician, podiatrist, dentist, or advanced practice registered nurse;

(7) findings and techniques of the operation (operative report);

(8) pathology report on all tissues removed during surgery, except those exempted by the governing body;

(9) anesthesia administration record;

(10) documentation of a properly executed informed consent;

(11) evidence of evaluation of the patient by a physician or advanced practice registered nurse prior to dismissal;

(12) evidence that the patient left the facility in the company of a responsible adult, unless the operating surgeon or advanced practice registered nurse writes an order that the patient may leave the facility without the company of a responsible adult; and

(13) for patients with a length of stay greater than eight hours, an evaluation of nutritional needs and evidence of how identified needs were met.

(k) Appropriate medical advice given to a patient by telephone shall be entered in the patient's medical record and appropriately signed or initialed.

(l) Entries in patients' medical records shall be legible to clinical personnel, and shall be accurate and completed promptly.

(m) Any notation in a patient's medical record indicating diagnostic or therapeutic intervention as part of clinical research shall be clearly contrasted with entries regarding the provision of nonresearch-related care.

(n) When necessary for assuring continuity of care, summaries of records of a patient who was treated elsewhere (such as by another physician, hospital, ambulatory surgical center, nursing home, or consultant) shall be obtained.

(o) When necessary for assuring continuity of care, summaries or photocopies of the patient's record shall be transferred to the health care practitioner to whom the patient was referred and, if appropriate, to the facility where future care will be rendered.

(p) Certain repetitive procedures are suitable for pre-printed operative notes. These operative notes are suitable as long as they are approved by the governing body, are signed by the surgeon, and transmit to a knowledgeable reader the events of the surgical procedure.

(q) All final tissue and abnormal cytology reports from the Medicare-approved reference laboratory shall be signed by a pathologist.

§135.10. Facilities and Environment.

(a) The ambulatory surgical center (ASC) shall have the necessary personnel, equipment, and procedures to handle medical emergencies that may arise in connection with services sought or provided. At a minimum, the ASC shall provide:

(1) periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment;

(2) procedures, including adequate surveillance techniques, that minimize sources and transmission of infections;

(3) a comprehensive emergency plan to address internal and external emergencies, including:

(A) a provision for the safe evacuation of patients during an internal emergency, especially patients who have difficulty walking;

(B) a provision for the most efficient use of available facilities and services during an external emergency; and

(C) a requirement for at least four drills a year of the internal emergency plan.

(b) Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma shall be eliminated.

(c) Facilities shall be clean and properly maintained.

(d) An emergency call system shall be provided and readily accessible to staff and patients in all areas of the facility.

(e) All equipment, including emergency equipment, shall be properly maintained and periodically tested.

(f) There shall be a system for the proper identification, management, handling, transport, treatment, and disposition of hazardous materials and wastes whether solid, liquid, or gas.

(1) This system shall include, but is not limited to, infectious, radioactive, chemical, and physical hazards.

(2) The system shall provide for the protection of patients, staff, and the environment.

(g) An ambulatory surgical center shall meet the requirements set forth by the department in §§1.131 et seq. of this title (relating to Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities).

(h) Sufficient space, equipment, and supplies shall be provided to perform the volume of work with optimal accuracy, precision, efficiency, and safety in the laboratory and x-ray. The ASC shall furnish equipment for basic diagnostic purposes, depending on the extent of services

provided. Dressing area(s) shall be required, depending on services provided, with convenient access to toilets, and may be shared with patient changing/preoperative rooms.

§135.11. Anesthesia and Surgical Services.

(a) Anesthesia services.

(1) Anesthesia services provided in the ambulatory surgical center (ASC) shall be limited to those that are approved by the governing body, which may include the following.

(A) Topical anesthesia--An anesthetic agent applied directly or by spray to the skin or mucous membranes, intended to produce transient and reversible loss of sensation to the circumscribed area.

(B) Local anesthesia--Administration of an agent that produces a transient and reversible loss of sensation to a circumscribed portion of the body.

(C) Regional anesthesia--Anesthetic injected around a single nerve, a network of nerves, or vein that serves the area involved in a surgical procedure to block pain.

(D) Minimal sedation (anxiolysis)--A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

(E) Moderate sedation/analgesia ("conscious sedation")--A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. (Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.)

(F) Deep sedation/analgesia--A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. (Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.)

(G) General anesthesia--A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(2) The anesthesia department shall be under the medical direction of a physician approved by the governing body upon the recommendation of the ASC medical staff.

(3) The medical staff shall develop written policies and practice guidelines for the anesthesia service, which shall be approved, implemented and enforced by the governing body. The policies and guidelines shall include consideration of the applicable practice standards and guidelines of the American Society of Anesthesiologists, the American Association of Nurse Anesthetists, and the licensing rules and standards applicable to those categories of licensed professionals qualified to administer anesthesia.

(4) Only personnel who have been approved by the facility to provide anesthesia services shall administer anesthesia. All approvals or delegations of anesthesia services as authorized by law shall be documented and include the training, experience, and qualifications of the person who provided the service. A qualified registered nurse (RN) who is not a certified registered nurse anesthetist (CRNA), in accordance with the orders of the operating surgeon, anesthesiologist, or CRNA, may administer topical anesthesia, local anesthesia, minimal sedation and moderate sedation, in accordance with all applicable rules, polices, directives and guidelines issued by the Texas Board of Nursing. When an RN who is not a CRNA administers sedation, as permitted in this paragraph, the facility shall:

(A) verify that the registered nurse has the requisite training, education, and experience;

(B) maintain documentation to support that the registered nurse has demonstrated competency in the administration of sedation;

(C) with input from the facility's qualified anesthesia providers, develop, implement and enforce detailed, written policies and procedures to guide the registered nurse; and

(D) ensure that, when administering sedation during a procedure, the registered nurse has no other duties except to monitor the patient.

(5) Anesthesia shall not be administered unless the operating surgeon has evaluated the patient immediately prior to the procedure to assess the risk of the anesthesia and of the procedure to be performed.

(6) The advanced practice registered nurse, the anesthesiologist, or the operating surgeon shall be available until all of his or her patients operated on that day have been discharged from the postanesthesia care unit.

(7) Patients who have received anesthesia shall be evaluated for proper anesthesia recovery by the operating surgeon or the person administering the anesthesia prior to discharge from the postanesthesia care unit using criteria approved by the medical staff.

(8) Patients who remain in the facility for extended observation following discharge from the postanesthesia care unit shall be evaluated immediately prior to leaving the facility by a physician, the person administering the anesthesia, or a registered nurse acting in accordance with physician's orders and written policies, procedures, and criteria developed by the medical staff.

(9) A physician shall be on call and able to respond physically or by telephone within 30 minutes until all patients have been discharged from the ASC.

(10) Emergency equipment and supplies appropriate for the type of anesthesia services provided shall be maintained and accessible to staff at all times.

(A) Functioning equipment and supplies which are required for all facilities include:

(i) suctioning equipment, including a source of suction and suction catheters in appropriate sizes for the population being served;

(ii) source of compressed oxygen;

(iii) basic airway management equipment, including oral and nasal airways, face masks, and self-inflating breathing bag valve set;

(iv) blood pressure monitoring equipment; and

(v) emergency medications specified by the medical staff and appropriate to the type of surgical procedures and anesthesia services provided by the facility.

(B) In addition to the equipment and supplies required under subparagraph (A) of this paragraph, facilities which provide moderate sedation/analgesia, deep sedation/analgesia, regional analgesia and/or general anesthesia shall provide the following:

(i) intravenous equipment, including catheters, tubing, fluids, dressing supplies, and appropriately sized needles and syringes;

(ii) advanced airway management equipment, including laryngoscopes and an assortment of blades, endotracheal tubes and stylets in appropriate sizes for the population being served;

(iii) a mechanism for monitoring blood oxygenation, such as pulse oximetry;

(iv) electrocardiographic monitoring equipment;

(v) cardiovertor-defibrillator; and

(vi) pharmacologic antagonists as specified by the medical staff and appropriate to the type of anesthesia services provided.

(b) Surgical services.

(1) Surgical procedures performed in the ASC shall be limited to those procedures that are approved by the governing body upon the recommendation of qualified medical personnel.

(2) Adequate supervision of surgery conducted in the ASC shall be a responsibility of the governing body, shall be recommended by qualified medical personnel, and shall be provided by appropriate personnel.

(3) Surgical procedures shall be performed only by health care practitioners who are licensed to perform such procedures within Texas and who have been granted privileges to perform those procedures by the governing body of the ASC, upon the recommendation of qualified medical personnel and after medical review of the practitioner's documented education, training, experience, and current competence.

(4) Surgical procedures to be performed in the ASC shall be reviewed periodically as part of the peer review portion of the ASC's quality assurance program.

(5) An appropriate history, physical examination, and pertinent preoperative diagnostic studies shall be incorporated into the patient's medical record prior to surgery.

(6) The necessity or appropriateness of the proposed surgery, as well as any available alternative treatment techniques, shall be discussed with the patient prior to scheduling the patient for surgery.

(7) Licensed nurses and other personnel assisting in the provision of surgical services shall be appropriately trained and supervised and shall be available in sufficient numbers for the surgical care provided.

(8) Each operating room shall be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all persons in the area.

(A) If flammable agents are present in an operating room the room shall be constructed and equipped in compliance with standards established by the National Fire Protection Association (NFPA 99, Annex 2, Flammable Anesthetizing Locations, 1999) and with applicable state and local fire codes.

(B) If nonflammable agents are present in an operating room the room shall be constructed and equipped in compliance with standards established by the National Fire Protection Association (NFPA 99, Chapters 4 and 8, 1999) and with applicable state and local fire codes.

(9) With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery shall be examined by a pathologist, whose signed report of the examination shall be made a part of the patient's medical record.

(10) A description of the findings and techniques of an operation shall be accurately and completely written or dictated immediately after the procedure by the health care practitioner who performed the operation. If the description is dictated, an accurate written summary shall be immediately available to the health care practitioners providing patient care and shall become part of the patient's medical record. Refer to §135.9(p) of this title (relating to Medical Records).

(11) A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross infection, shall be assured through the provision of adequate space, equipment, and personnel.

(A) Provisions shall be made for the isolation or immediate transfer of patients with communicable diseases.

(B) All persons entering operating rooms shall be properly attired.

(C) Acceptable aseptic techniques shall be used by all persons in the surgical area.

(D) Only authorized persons shall be allowed in the surgical area.

(E) Suitable equipment for rapid and routine sterilization shall be available to assure that operating room materials are sterile.

(F) Environmental controls shall be implemented to assure a safe and sanitary environment.

(G) Operating rooms shall be appropriately cleaned before each operation.

(12) Written policies and procedures for decontamination, disinfection, sterilization, and storage of sterile supplies shall be developed, implemented and enforced. Policies shall include, but not be limited to, the receiving, cleaning, decontaminating, disinfecting, preparing, and sterilization of critical items (reusable items), as well as for the assembly, wrapping, storage, distribution, and the monitoring and control of sterile items and equipment.

(A) Policies and procedures shall be developed following standards, guidelines, and recommendations issued by the Association of periOperative Registered Nurses (AORN), the Association for Professionals in Infection Control and Epidemiology (APIC), the Centers for Disease Control and Prevention (CDC) and, if applicable, the Society of Gastroenterology Nurses and Associates (SGNA). Standards, guidelines, and recommendations

of these organizations are available for review at the Department of State Health Services, Exchange Building, 8407 Wall Street, Austin, Texas. Copies may also be obtained directly from each organization, as follows: AORN, 2170 South Parker Road, Suite 300, Denver Colorado, 80231, (800) 755-2676; APIC, 1275 K Street, Northwest, Suite 1000, Washington, District of Columbia, 20005-4006, (202) 789-1890; CDC, 1600 Clifton Road, Atlanta, Georgia, 30333, (800) 311-3435; SGNA, 401 North Michigan Avenue, Chicago, Illinois, 60611-4267, (312) 321-5165.

(B) Policies and procedures shall also address proper use of external chemical indicators and biological indicators.

(C) Performance records for all sterilizers shall be maintained for a period of six months.

(D) Preventive maintenance of all sterilizers shall be completed according to manufacturer's recommendations on a scheduled basis. A preventive maintenance record shall be maintained for each sterilizer. These records shall be retained at least one year and shall be available for review to the facility within two hours of request by the department.

(13) Emergency power adequate for the type of surgery performed shall be available in the operative and postoperative recovery areas.

(14) Periodic calibration and/or preventive maintenance of all equipment shall be provided in accordance with manufacturer's guidelines.

(15) The informed consent of the patient or, if applicable, of the patient's legal representative shall be obtained before an operation is performed.

(16) A written procedure shall be established for observation and care of the patient during the preoperative preparation and postoperative recovery period.

(17) Written protocols shall be established for instructing patients in self-care after surgery, including written instructions to be given to patients who receive conscious sedation, regional, and general anesthesia.

(18) Patients who have received anesthesia shall only be allowed to leave the facility in the company of a responsible adult, unless the operating surgeon or an advanced practice registered nurse writes an order that the patient may leave without the company of a responsible adult.

(19) An effective written procedure for the immediate transfer to a hospital of patients requiring emergency care beyond the capabilities of the ASC shall be developed. The ASC shall have a written transfer agreement with a hospital, or all physicians on staff at the ASC shall have admitting privileges at a local hospital.

§135.12. Pharmaceutical Services.

(a) The ambulatory surgical center (ASC) shall provide drugs and biologicals in a safe and effective manner in accordance with professional practices and shall be in compliance with all state and federal laws and regulations. The ASC shall be licensed as required by the Texas State Board of Pharmacy and comply with 22 Texas Administrative Code, §291.76 (relating to Class C Pharmacies Located in a Freestanding Ambulatory Surgical Center).

(b) Pharmaceutical services may be made available by the ASC through a contractual agreement and shall be provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the ASC.

§135.13. Pathology and Medical Laboratory Services.

Pathological and clinical services shall be provided or made available when appropriate to meet the needs of the patients and adequately support the ambulatory surgical center's (ASC's) clinical capabilities.

(1) Pathology and clinical laboratory services shall include, but are not limited to:

(A) conducting laboratory procedures that are appropriate to the needs of the patients;

(B) performing tests in a timely manner;

(C) distributing test results within 24 hours after completion of a test and maintaining a copy of the results in the laboratory; and

(D) performing and documenting appropriate quality assurance procedures, including, but not limited to, calibrating equipment periodically and validating test results through use of standardized control specimens or laboratories.

(2) Preoperative laboratory procedures may be required as follows.

(A) It shall be at the discretion of the governing body upon the recommendation of the medical staff to require preoperative laboratory orders.

(B) If specific preoperative laboratory work is required, the medical staff shall approve them in accordance with the medical staff bylaws. Other laboratory work shall be performed only on the order of a physician, podiatrist, dentist, or advanced practice registered nurse and written on the patient's chart.

(C) These services shall be provided either directly within or through an effective contract arrangement with a Medicare-approved reference laboratory.

(D) The contractual agreement with the Medicare-approved reference laboratory shall provide for routine and stat work to include pathology, clinical, and blood bank services, if blood is authorized by the ASC, and shall be available for review.

(3) The patient may be instructed to go directly to the Medicare-approved reference laboratory, or the specimen may be collected on the ambulatory surgical center's premises and then referred to the Medicare-approved reference laboratory.

(4) If the specimens are collected on the premises only, the following shall be maintained:

(A) procedures and policies governing the Medicare-approved reference laboratory specimen requirements; identification, collection, labeling, storage, and transportation of the specimen, and preventive maintenance of equipment used in processing and storage of specimen;

(B) a log book which shall include patient name and identification number, doctor's name, date the specimen was drawn and sent to the Medicare-approved reference laboratory, laboratory tests ordered, date the final report came back from the reference laboratory, and condition of the specimen. The final report shall be on the patient's chart, with copies kept in the ASC's laboratory.

(5) If laboratory tests are performed on the premises, the following shall be maintained:

(A) procedures governing identification, collection, labeling, and storage of specimens;

(B) a log book, which shall include patient name and identification number, practitioner's name, date the specimen was drawn, test ordered, and results;

(C) procedures for each test procedure performed by the laboratory, including source of reagents, standards, and calibration procedures, and information concerning the basis for the tested normal ranges;

(D) procedures and documentation of performed maintenance on equipment used to process laboratory work;

(E) dated reports of all examinations performed and made a part of the patient's medical record; and

(F) proficiency testing.

(6) Quality control of the laboratory shall be monitored through the quality assurance committee.

(7) If the ASC designates its laboratory to perform as an independent laboratory, it shall be surveyed according to 42 Code of Federal Regulations, §§493.1 - 493.1780.

(8) The ASC can allow laboratory work to be performed and brought in from other Medicare-approved reference laboratories or practitioners' offices, and the reports shall be on the patient's charts before surgery.

(A) Written criteria describing the length of time tests can be done prior to surgery shall be developed by the medical staff and approved by the governing body.

(B) Laboratory work shall be performed in a Medicare-approved reference laboratory or in the patient's healthcare practitioner's office. This shall be written in a policy accepted by the medical staff and governing body.

(9) If it is the ASC's policy to administer blood, policies shall be developed on administration of blood transfusions to include autologous blood units in accordance with the ASC's operative procedures. If the operative procedure(s) performed in the ASC requires or may require the necessity for transfusions, policies and procedures shall include provisions for stat and routine transfusions. These policies and procedures shall include, but are not limited to, collection, labeling, and transportation of specimen in accordance with the ASC or contract service policies. All patient results shall appear in the patient's chart.

(10) If the ASC performs surgery which incorporates the removal of a tissue specimen or the freezing of a tissue specimen, the specimen shall be submitted to a Medicare-approved reference laboratory. The following shall be maintained:

(A) procedures governing the Medicare-approved reference laboratory specimen requirements, identification, collection, labeling, storage, and transportation of the specimen;

(B) documentation to include patient name and identification number, practitioner's name, date the tissue specimen was collected and referred to the Medicare-approved reference laboratory, and date the final report came back from the Medicare-approved reference laboratory. Final copies shall be placed in the patient's chart, with copies kept in the ASC; and

(C) the medical staff bylaws may exempt tissue specimens from pathology examination, and the list of exemptions shall be available for review.

(11) The medical staff bylaws shall define those specimens for macroscopic pathology examination only and both macroscopic and microscopic pathology examinations.

(12) The original pathology report shall be included in the patient's chart.

(13) Pathology tissue reports and positive cytology reports shall have the authorized signature of the pathologist interpreting the report.

§135.14. Radiology Services.

(a) Radiology services shall be provided or made available when appropriate to meet the needs of the patients and adequately support the ambulatory surgical center's (ASC's) clinical capabilities. Policy and procedures shall be available for emergency and/or routine radiological procedures.

(b) A radiologist shall authenticate all examination reports, except reports of specific procedures that may be authenticated by physicians who are not radiologists, but who have been granted privileges by the governing body or its designee to authenticate such reports.

(c) Services shall be provided either directly within or through a Medicare-approved facility, and the contracts shall be available for review.

(d) If X-ray services are performed within the ASC, the X-ray department shall be surveyed according to 42 Code of Federal Regulations §482.26 or §§486.100 – 486.110.

(e) Procedure manuals shall include procedures for all examinations performed, infection control in the ASC and operating rooms to include dress code of personnel and cleaning of equipment.

(f) Policies shall address the quality aspects of radiology services, including, but not limited to:

(1) performing radiology services only upon the written order of a physician, dentist, advanced practice registered nurse, or other authorized health care practitioner (such orders shall be accompanied by a concise statement of the reason for the examination); and

(2) limiting the use of any radioactive sources in the ASC to physicians who have been granted privileges for such use on the basis of their training, experience, and current competence.

(g) Policies shall address the safety aspects of radiology services, including, but not limited to:

(1) regulation of the use, removal, handling, and storage of any radioactive material which is required to be licensed by the Department of State Health Services, Radiation Safety Licensing Branch;

(2) precautions against electrical, mechanical, and radiation hazards;

(3) proper shielding where radiation sources are used;

(4) acceptable monitoring devices for all personnel who might be exposed to radiation (monitoring devices shall be worn by such personnel in any area with a radiation hazard);

(5) maintenance of radiation exposure records on personnel; and

(6) authenticated, dated reports of all examinations performed shall be made a part of the patient's medical record.

(h) Laser equipment shall be licensed as required by the Department of State Health Services, Radiation Safety Licensing Branch. Policies and procedures shall be established and implemented for laser technology which include laser safety programs, education and training of laser personnel, credentialing for each specific laser, and a requirement for all personnel working with lasers to be adequately trained in the safety and use of each type of laser utilized.

§135.15. Facility Staffing and Training.

(a) Nursing services.

(1) There shall be an organized nursing service under the direction of a qualified registered nurse (RN). The ambulatory surgical center (ASC) shall be staffed to assure that the nursing needs of all patients are met.

(2) There shall be a written plan of administrative authority for all nursing services with responsibilities and duties of each category of nursing personnel delineated and a written job description for each category. The scope of nursing service shall include, but is not limited to, nursing care rendered to patients preoperatively, intraoperatively, and postoperatively.

(A) The responsible individual for nursing services shall be a qualified registered nurse (RN) whose responsibility and authority for nursing service shall be clearly defined and includes supervision of both personnel performance and patient care.

(B) There shall be a written delineation of functions, qualifications, and patient care responsibilities for all categories of nursing personnel.

(C) Surgical technicians and licensed vocational nurses may be permitted to serve in the scrub nurse role under the direct supervision of an RN; they shall not be permitted to function as circulating nurses in the operating rooms. Licensed vocational nurses and surgical technicians may assist in circulatory duties under the direct supervision of a qualified RN.

(D) Nursing services shall be provided in accordance with current recognized standards or recommended practices.

(E) The facility shall adopt, implement and enforce policies and procedures to comply with Health and Safety Code, Chapter 259 (relating to Surgical Technologists at Health Care Facilities).

(3) There shall be an adequate number of RNs on duty to meet the following minimum staff requirements: director of the department (or designee), and supervisory and staff personnel for each service area to assure the immediate availability of an RN for emergency care or for any patient when needed.

(A) An RN shall assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the preparation and qualifications of the nursing staff available.

(B) There shall be other nursing personnel in sufficient numbers to provide nursing care not requiring the service of an RN.

(4) An RN qualified, at a minimum, with current certification in basic cardiac life support shall be on duty and on the premises at all times whenever patients are present in the facility.

(b) Additional staffing requirements. In addition to meeting the requirements for nursing staff under subsection (a) of this section, facilities shall comply with the following minimum staffing requirements.

(1) Facilities that provide only topical anesthesia, local anesthesia and/or minimal sedation are required to have a second individual on duty on the premises who is trained and currently certified in basic cardiac life support until all patients have been discharged from the facility.

(2) Facilities that provide moderate sedation/analgesia are required to have the following additional staff:

(A) a second individual on duty on the premises who is trained and currently certified in basic cardiac life support until all patients have been discharged from the facility; and

(B) an individual trained and currently certified in advanced cardiac life support and, if surgery is performed on pediatric patients, pediatric advanced life support shall be available until all patients have been discharged from the postanesthesia care unit.

(3) Facilities that provide deep sedation/analgesia, general anesthesia, and/or regional anesthesia shall have the following additional staff:

(A) a second individual on duty on the premises who is trained and currently certified in basic cardiac life support until all patients have been discharged from the facility; and

(B) an individual who is trained and currently certified in advanced cardiac life support and, if surgery is performed on pediatric patients, pediatric advanced life

support shall be on duty on the premises and sufficiently free of other duties to enable the individual to respond rapidly to emergency situations until all patients have been discharged from the postanesthesia care unit.

§135.16. Teaching and Publication.

(a) Policies concerning teaching activities shall be developed, implemented, and enforced which address:

(1) the terms and conditions of reimbursement or other compensation;

(2) the reasonableness of the time spent away from direct patient care and administrative activities; and

(3) the training of all students and postgraduate trainees, including the extent of their involvement in patient care activities.

(b) A policy concerning the provision of health care by personnel in any student or postgraduate trainee status shall be developed, implemented, and enforced, and provide for close and adequate supervision and for informing the patient of the status of the provider.

(c) A policy shall be developed, implemented, and enforced concerning publishing activities. The policy shall address:

(1) the need for governing body approval when the views, policies, and procedures expressed in the publication are attributed to the ASC; and

(2) the terms and conditions of compensation from publication and the cost of publication.

§135.17. Research Activities.

(a) Research activities shall be performed in accordance with ethical and professional practices and legal requirements, and these activities shall be periodically monitored by the governing body.

(b) The protocols for conducting research shall be approved by the governing body or its designee after medical and legal review.

(c) Any research activities carried out within the ambulatory surgical center (ASC) shall be appropriate to the expertise of staff and the resources in the ASC.

(d) Individuals engaged in research shall be provided with adequate facilities.

(e) Provisions shall be made to assure that the rights and welfare of all research subjects are adequately protected and that the informed consent of the subject, in the language spoken by him or her, is obtained by adequate and appropriate methods.

(f) All professional staff shall be informed of the ASC's research policies.

§135.18. Unlicensed Ambulatory Surgical Center.

(a) If the department has reason to believe that a person or facility may be providing ambulatory surgical services without a license as required by the Act, the person or facility shall be so notified in writing by certified mail, return receipt requested, and shall submit to the department the following information within 20 days of receipt of the notice:

(1) an application for a license and the license fee, which is nonrefundable;

(2) a claim for exemption under §135.19 of this title (relating to Exemptions); or

(3) any and all documentation necessary to establish that ambulatory surgical services are not being provided. Documentation shall include a notarized statement attesting to the fact that ambulatory surgical services are not provided and a statement of the type(s) of service(s) that are provided.

(b) If the person or facility has submitted an application for a license, the application shall be processed in accordance with §135.20 of this title (relating to Initial Application and Issuance of License).

(c) If the person or facility submits a claim for exemption, the exemption claim shall be processed in accordance with §135.19 of this title.

(d) If the person or facility submits sufficient documentation to establish that ambulatory surgical services are not provided, the department shall so notify the person or facility in writing within 30 days that no license is required. If the documentation submitted is determined to be insufficient by the department, the person or facility shall be so notified in writing and shall have 10 days to respond. Following receipt of the response, if any, the department shall then notify the person or facility in writing within 10 days of the determination.

§135.19. Exemptions.

(a) The following facilities are not required to be licensed under the Act:

(1) an office or clinic of a licensed physician, dentist, or podiatrist;

(2) a licensed nursing home; or

(3) a licensed hospital.

(b) If a person or facility is uncertain about whether or not licensing under the Act is required, a written claim for exemption, including all documentation supporting the exemption claim, may be submitted to the department.

(c) The department shall evaluate the claim for exemption and notify the person or facility in writing of the proposed decision within 30 days following receipt of the claim for exemption.

(d) If the proposed decision is to grant the claim for exemption, the department shall provide written notice according to subsection (c) of this section.

(e) If the claim for exemption is proposed to be denied, the person or facility so affected shall have the right to appeal the determination to the department by written letter with the reasons supporting exemption within 10 days following receipt of the proposed denial.

(f) If the person or facility does not request an appeal as provided in subsection (e) of this section, the right to appeal is deemed to be waived and the denial of the exemption becomes final 30 days following the person or facility's receipt of the proposed denial.

(g) The person or facility shall submit a completed application and nonrefundable licensing fee to the department within 20 days following the final denial of exemption.

§135.20. Initial Application and Issuance of License.

(a) All first-time applications for licensing, including those from unlicensed operating ambulatory surgical centers (ASCs) and licensed ASCs for which a change of ownership or relocation is anticipated, are applications for an initial license.

(b) Upon written or verbal request, the department shall furnish a person with an application form for an ASC license. The applicant shall submit to the department a completed original application and the nonrefundable license fee.

(1) The applicant shall provide:

(A) the name and address of the owner of the ASC, or a list of names and addresses of persons who own an interest in the ASC;

(B) the name, Texas license number, and license expiration date of the medical chief of staff;

(C) the number of physicians, dentists, podiatrists and advanced practice registered nurses on staff at the ASC;

(D) the name, Texas license number, and license expiration date of the director of nursing of the ASC;

(E) whether the ASC has applied for certification under Title XVIII of the Social Security Act; and

(F) number of surgery suites.

(G) the following data concerning the applicant, the applicant's affiliates, and the managers of the applicant:

(i) denial, suspension, probation, or revocation of an ambulatory surgical center license in any state, a license for any health care facility or a license for a home and community support services agency (agency) in any state; or any other enforcement action, such as (but not limited to) court civil or criminal action in any state;

(ii) denial, suspension, probation, or revocation of or other enforcement action against an ambulatory surgical center license in any state, a license for any health care facility in any state, or a license for an agency in any state which is or was proposed by the licensing agency and the status of the proposal;

(iii) surrendering a license before expiration of the license or allowing a license to expire in lieu of the department proceeding with enforcement action;

(iv) federal or state (any state) criminal felony arrests or convictions;

(v) Medicare or Medicaid sanctions or penalties relating to the operation of a health care facility or agency;

(vi) operation of a health care facility or agency that has been decertified or terminated from participation in any state under Medicare or Medicaid; or

(vii) debarment, exclusion, or contract cancellation in any state from Medicare or Medicaid; and

(H) for the two-year period preceding the application date, the following data concerning the applicant, the applicant's affiliates, and the managers of the applicant:

(i) federal or state (any state) criminal misdemeanor arrests or convictions;

(ii) federal or state (any state) tax liens;

(iii) unsatisfied final judgments;

(iv) eviction involving any property or space used as an ambulatory surgical center or health care facility in any state;

(v) injunctive orders from any court; or

(vi) unresolved final federal or state (any state) Medicare or Medicaid audit exceptions.

(2) Upon receipt of the application, the department shall review the application to determine whether it is complete. All documents submitted to the department shall be originals. The address provided on the application shall be the address at which the ASC is operating.

(3) If the department determines that the application for an unlicensed ASC is complete and correct, a representative of the department shall schedule a pre-survey conference with the applicant in order to inform the applicant of the standards for the operation of the ASC. A pre-survey conference may, at the department's discretion, be waived for an applicant of a licensed ASC for which a change of ownership is anticipated.

(4) After a pre-survey conference has been held or waived at the department's discretion and the facility has received an approved architectural inspection conducted by the department, the department may issue a license to an ASC to provide ambulatory surgical services in accordance with these sections.

(c) When it is determined that the facility is in compliance with subsection (b) of this section, the department shall issue the license to the applicant.

(1) Effective date. The license shall be effective on the date the facility is determined to be in compliance with subsection (b) of this section.

(2) Expiration date.

(A) If the effective date of the license is the first day of a month, the license expires on the last day of the 23rd month after issuance.

(B) If the effective date of the license is the second or any subsequent day of a month, the license expires on the last day of the 24th month after issuance.

(d) If an applicant decides not to continue the application process for a license, the application may be withdrawn. The applicant shall submit a written request to withdraw to the department. The department shall acknowledge receipt of the request to withdraw.

(e) During the initial licensing period, the department shall conduct a survey of the ASC to ascertain compliance with the provisions of the Health and Safety Code, Chapter 243, and this chapter.

(1) The ASC shall request that an on-site survey be conducted after the ASC has provided services to a minimum of one patient.

(2) The ASC shall be providing services at the time of the survey.

(3) If the ASC has applied to participate in the federal Medicare program, the Medicare survey may be conducted in conjunction with the licensing survey.

(4) The initial licensing survey may be waived if the ASC provides documented evidence of accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities and Medicare deemed status.

§135.21. Inspections.

(a) The department shall conduct an on-site inspection to evaluate the ambulatory surgical center's (ASC's) compliance with the standards for licensing set forth in these sections.

(1) The department shall evaluate the ASC on a standard-by-standard basis before the first renewal license is issued, unless waived in accordance with §135.20(e)(4) of this title (relating to Initial Application and Issuance of License).

(2) An on-site licensing inspection may be conducted once every three years.

(3) The department may make any survey or investigation that it considers necessary. A department representative(s) may enter the premises of a facility at any reasonable time to make a survey or an investigation to ensure compliance with or prevent a violation of Health and Safety Code, Chapter 243, an order or special order of the commissioner, a special license provision, a court order granting injunctive relief, or other enforcement procedures. Ensuring compliance includes permitting photocopying of any records or other information by or on behalf of the department as necessary to determine or verify compliance with the statute or rules adopted under the statute, except that the department may not photocopy, reproduce, remove or dictate from any part of the root cause analysis or action plan required in §135.27 of this title (relating to Patient Safety Program).

(b) If an on-site inspection is conducted at an ASC and deficiencies are cited, the surveyor shall request the applicant or person in charge to sign the statement of deficiencies as an acknowledgment of receipt of a copy of the statement of deficiencies. Signing the statement of deficiencies does not indicate agreement with any deficiencies. If the applicant or person in charge declines to sign the form, the surveyor shall note the declination on the statement of deficiencies and the name of the person so declining. The surveyor shall leave a copy of the statement of deficiencies at the ASC and, if the person in charge is not the applicant, mail a copy of the statement of deficiencies to the applicant.

(c) After an inspection is completed, the surveyor shall prepare a survey report which contains the following:

(1) a completed survey report form;

(2) a statement of which standards were evaluated;

(3) a statement of deficiencies, if any, and the signature of the applicant or person in charge;

(4) a plan of correction which has been provided by the ASC and the date(s) by which correction(s) will be made; and

(5) any comments by the applicant or person in charge concerning the survey.

(d) The survey report form shall be submitted as follows.

(1) The surveyor shall submit the survey report to their supervisor for evaluation and decision.

(2) A license shall be issued to an ASC that is in compliance with minimum standards in accordance with these sections at the time of the on-site inspection.

(3) If deficiencies are cited and the plan of correction is acceptable, written notice shall be sent to the applicant acknowledging same.

(4) If deficiencies are cited and the plan of correction is not acceptable, the department shall notify the applicant in writing and request that the plan of correction be resubmitted. Upon resubmission of the acceptable plan of correction, written notice shall be sent to the applicant acknowledging same.

(5) The ASC shall come into compliance at least 30 days prior to the expiration date of the license.

(6) The department shall verify the correction of deficiencies by mail or by an on-site inspection.

(7) If the ASC does not timely come into compliance, the department may take action in accordance with §135.24 of this title (relating to Enforcement).

§135.22. Renewal of License.

(a) The department shall send written notice of expiration of a license to an ambulatory surgical center (ASC) at least 60 days before the expiration date. If the applicant has not received notice, it is the duty of the ASC to notify the department and request a renewal application.

(b) The department shall issue a renewal license to an ASC that meets the minimum standards for a license set forth in these sections.

(1) The ASC shall submit the following to the department no later than 30 days prior to the expiration date of the license:

(A) a completed renewal application form;

(B) a nonrefundable license fee; and

(C) if the ASC is accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities, documented evidence of current accreditation status.

(2) Renewal licenses shall be valid for two years.

(c) If the applicant fails to timely submit an application and fee in accordance with subsection (b) of this section, the department shall notify the applicant that the ASC shall cease providing ambulatory surgical services. If the ASC can provide the department with sufficient evidence that the submission was completed in a timely manner and all dates were adhered to, the cease to perform shall be dismissed. If the ASC cannot provide sufficient evidence, the ASC shall immediately thereafter return the license by certified mail. If the applicant wishes to provide ambulatory surgical services after the expiration date of the license, the applicant shall reapply for a license under §135.20 of this title (relating to Initial Application and Issuance of License).

§135.23. Conditions of Licensure.

(a) An ambulatory surgical center (ASC) license is issued only for the premises and person or governmental unit named on the application.

(b) An ASC license is issued for a single physical location, and shall not include multiple buildings or offsite locations.

(c) Multiple ASCs may share a single building, provided that:

(1) each ASC is separately licensed; and

(2) no part of the building may be dually licensed by more than one ASC.

(d) No license may be transferred or assigned from one person to another person. If a change of ownership of a licensed ASC is anticipated, in order to ensure continuity of patient services, the department shall be informed in writing and the applicant shall submit a license application and nonrefundable fee at least 30 days prior to the change of ownership of each ASC. The procedure shall be handled in accordance with §135.20 of this title (relating to Initial Application and Issuance of License), with the exception of the presurvey conference and the on-site inspection, unless deemed necessary by the department. A license shall be issued for the newly acquired ASC effective on the date the ownership changed. The previous license shall be void on the date of acquisition.

(e) No license may be transferred from one ASC location to another. If an ASC is relocating, the ASC shall complete and submit a license application and nonrefundable fee at

least 30 days prior to the relocation of the ASC. The procedure shall be handled in accordance with §135.20 of this title, with the exception of the pre-survey conference, unless deemed necessary by the department. An initial license shall be issued for the relocated ASC effective on the date the relocation occurred. The previous license shall be void on the date of relocation.

(f) Written notice to the department of any change in telephone number shall be received within 30 days after the number has changed.

(g) If the name of an ASC is changed, the department shall be notified in writing within 30 days after the effective date of the name change.

§135.24. Enforcement.

(a) Reasons for enforcement action.

(1) The Department of State Health Services (department) may deny, suspend, or revoke an ambulatory surgical center's (ASC's) license in accordance with Health and Safety Code (HSC), §243.011 if the applicant or licensee:

(A) fails to comply with any provision of the Act;

(B) fails to comply with any provision of this chapter or any other applicable laws;

(C) fails to comply with a special license condition;

(D) fails to comply with an order of the commissioner or another enforcement procedure under the statute;

(E) has a history of noncompliance with the rules adopted under this chapter relating to patient health, safety, and rights which reflects more than nominal noncompliance;

(F) has aided, committed, abetted, or permitted the commission of an illegal act;

(G) fails to provide an adequate application or renewal information;

(H) fails to timely pay assessed administrative penalties in accordance with the Act;

(I) fails to comply with applicable requirements within a designated probation period;

(J) fails to submit an acceptable plan of correction for cited deficiencies; or

(K) if the facility is participating under Title XVIII, and the Centers for Medicare and Medicare Services terminates the ASC's Medicare provider agreement.

(2) The department may suspend or revoke an existing valid license or disqualify a person from receiving a license because of a person's conviction of a felony or misdemeanor, if the crime directly relates to the duties and responsibilities of the ownership or operation of an ambulatory surgical center.

(A) In determining whether a criminal conviction directly relates, the department shall consider the provisions of Occupations Code, Chapter 53.

(B) The following felonies and misdemeanors directly relate because these criminal offenses indicate an ability or a tendency for the person to be unable to own or operate an ambulatory surgical center:

(i) a misdemeanor violation of the statute;

(ii) a misdemeanor or felony involving moral turpitude;

(iii) a conviction relating to deceptive business practices;

(iv) a misdemeanor of practicing any health-related profession without a required license;

(v) a conviction under any federal or state law relating to drugs, dangerous drugs, or controlled substances;

(vi) an offense under the Penal Code, Title 5, involving a patient or a client of any health care facility, a home and community support services agency, or a health care professional;

(vii) a misdemeanor or felony offense under various titles of the Penal Code, as follows:

(I) Title 4 concerning offenses of attempting or conspiring to commit any of the offenses in this subsection;

(II) Title 5 concerning offenses against the person;

(III) Title 7 concerning offenses against property;

(IV) Title 9 concerning offenses against public order and decency; or

(V) Title 10 concerning offenses against public health, safety, and morals; and

(viii) other misdemeanors and felonies which indicate an inability or tendency for the person to be unable to own or operate an ambulatory surgical center.

(C) Upon a licensee's felony conviction, felony probation revocation, revocation of parole, or revocation of mandatory supervision, the license shall be revoked.

(3) If the department proposes to deny, suspend, or revoke a license, the department shall give the applicant written notification of the reasons for the proposed action and offer the applicant an opportunity for a hearing. The applicant may request a hearing within 30 days after the date the applicant receives notice. The request shall be in writing and submitted to the department as instructed in the notice of violation letter. A hearing shall be conducted pursuant to the Government Code, Chapter 2001, Administrative Procedure Act, and §§1.21, 1.23, 1.25, and 1.27 of this title (relating to Formal Hearing Procedures). If a hearing is not requested in writing within 30 days after receiving notice of the proposed action, the applicant is deemed to have waived the opportunity for a hearing and the proposed action shall be taken.

(4) If the department finds that a violation of the standards or licensing requirements prescribed by the Act creates an immediate threat to the health and safety of patients of an ASC, the department may petition the district court for a temporary restraining order to restrain continuing violations.

(5) The provisions of Occupations Code, Chapter 53, Consequences of Criminal Conviction, apply to an ASC.

(6) If a person violates the licensing requirements or the standards prescribed by the Act, the department may petition the district court for an injunction to prohibit the person from continuing the violation or to restrain or prevent the establishment or operation of an ASC without a license issued under the Act.

(b) Emergency suspension of a license. The department may issue an emergency order to suspend a license issued under this chapter, if the department has reasonable cause to believe that the conduct of a license holder creates an immediate danger to the public health and safety.

(1) An emergency suspension is effective immediately without a hearing on notice to the license holder.

(2) On written request of the license holder, the department shall conduct a hearing not earlier than the 10th day or later than the 30th day after the date the hearing request is received to determine if the emergency suspension is to be continued, modified, or rescinded. The hearing and any appeal are governed by the department's rules for a contested case hearing and Government Code, Chapter 2001.

(c) Probation. In lieu of denying, suspending or revoking the license under subsection (a) of this section, the department may schedule the ASC for a probation period of not less than thirty days, if the ASC's noncompliance does not endanger the health and safety of the public.

(1) The department shall provide notice of the probation to the ASC not later than the 10th day before the date the probation begins. The notice shall include the items of noncompliance that resulted in placing the ASC on probation, and shall designate the period of the probation.

(2) During the probationary period, the ASC shall correct the items of noncompliance and provide a written report to the department that describes the corrective actions taken.

(3) The department may verify the corrective actions through an on-site inspection.

(d) Administrative penalty. The department may impose an administrative penalty on a person licensed under this chapter who violates the Act, this chapter, or order adopted under this chapter.

(1) A penalty collected under this section shall be deposited in the state treasury in the general revenue fund.

(2) A proceeding to impose the penalty is considered to be a contested case under Government Code, Chapter 2001.

(3) The amount of the penalty may not exceed $1,000 for each violation, and each day a violation continues or occurs is a separate violation for purposes of imposing a penalty. The total amount of the penalty assessed for a violation continuing or occurring on separate days under this paragraph may not exceed $5,000.

(4) In determining the amount of an administrative penalty assessed under this section, the department shall consider:

(A) the seriousness of the violation, including the nature, circumstances, extent, and gravity of the violation;

(B) the threat to health or safety caused by the violation;

(C) the history of previous violations;

(D) the amount necessary to deter a future violation;

(E) whether the violator demonstrated good faith, including when applicable whether the violator made good faith efforts to correct the violation; and

(F) any other matter that justice may require.

(5) If the department initially determines that a violation occurred, the department shall give written notice of the report by certified mail to the person alleged to have committed the violation following the survey exit date. The notice shall include:

(A) a brief summary of the alleged violation;

(B) a statement of the amount of the recommended penalty; and

(C) a statement of the person's right to a hearing on the occurrence of the violation, the amount of the penalty, or both.

(6) Within 20 days after the date the person receives the notice under paragraph (5) of this subsection, the person in writing may:

(A) accept the determination and recommended penalty of the department; or

(B) make a request for a hearing on the occurrence of the violation, the amount of the penalty, or both.

(7) If the person accepts the determination and recommended penalty or if the person fails to respond to the notice, the commissioner or the commissioner's designee by order shall approve the determination and impose the recommended penalty.

(8) If the person requests a hearing, the commissioner shall refer the matter to the State Office of Administrative Hearings (SOAH). The hearing shall be conducted in accordance with Government Code, Chapter 2001, and all applicable SOAH and department rules.

(9) Based on the proposal for decision made by the administrative law judge under paragraph (8) of this subsection, the commissioner by order may find that a violation occurred and impose a penalty, or may find that a violation did not occur. The commissioner or the commissioner's designee shall give notice of the commissioner's order under paragraph (7) of this subsection to the person alleged to have committed the violation in accordance with Government Code, Chapter 2001. The notice shall include:

(A) a statement of the right of the person to judicial review of the order;

(B) separate statements of the findings of fact and conclusions of law; and

(C) the amount of any penalty assessed.

(10) Within 30 days after the date an order of the commissioner under paragraph (7) of this subsection that imposes an administrative penalty becomes final, the person shall:

(A) pay the penalty; or

(B) appeal the penalty by filing a petition for judicial review of the commissioner's order contesting the occurrence of the violation, the amount of the penalty, or both.

(11) Within the 30-day period prescribed by paragraph (10) of this subsection, a person who files a petition for judicial review may:

(A) stay enforcement of the penalty by:

(i) paying the penalty to the court for placement in an escrow account; or

(ii) giving the court a supersedeas bond that is approved by the court for the amount of the penalty, and that is effective until all judicial review of the commissioner's order is final; or

(B) request the court to stay enforcement of the penalty by:

(i) filing with the court a sworn affidavit of the person stating that the person is financially unable to pay the penalty and is financially unable to give the supersedeas bond; and

(ii) sending a copy of the affidavit to the commissioner by certified mail.

(C) If the commissioner receives a copy of an affidavit under subparagraph (B) of this paragraph, the commissioner may file with the court, within five days after the date the copy is received, a contest to the affidavit. In accordance with Health and Safety Code, §243.016(c), the court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person who files an affidavit has the burden of proving that the person is financially unable to pay the penalty or to give a supersedeas bond.

(12) If the person does not pay the penalty and the enforcement of the penalty is not stayed, the department may refer the matter to the attorney general for collection of the penalty. As provided by the Health and Safety Code, §243.016(d), the attorney general may sue to collect the penalty.

(13) A decision by the court is governed by Health and Safety Code, §243.016(e) and (f), and provides the following.

(A) If the court sustains the finding that a violation occurred, the court may uphold or reduce the amount of the penalty and order the person to pay the full or reduced amount of the penalty.

(B) If the court does not sustain the finding that a violation occurred, the court shall order that a penalty is not owed.

(14) The remittance of penalty and interest is governed by Health and Safety Code, §243.016(g) and provides the following.

(A) If the person paid the penalty and if the amount of the penalty is reduced or the penalty is not upheld by the court, the court shall order, when the court's judgment becomes final, that the appropriate amount plus accrued interest be remitted to the person within 30 days after the date that the judgment of the court becomes final.

(B) The interest accrues at the rate charged on loans to depository institutions by the New York Federal Reserve Bank.

(C) The interest shall be paid for the period beginning on the date the penalty is paid and ending on the date the penalty is remitted.

(15) The release of supersedeas bond is governed by Health and Safety Code, §243.016(h), and provides the following.

(A) If the person gave a supersedeas bond and the court does not uphold the penalty, the court shall order, when the court's judgment becomes final, the release of the bond.

(B) If the person gave a supersedeas bond and the amount of the penalty is reduced, the court shall order the release of the bond after the person pays the reduced amount.

§135.25. Complaints.

(a) In response to a complaint, the department or its authorized representative may enter the premises of an ambulatory surgical center (ASC) during normal business hours as necessary to assure compliance with the Act and these sections. The investigation may be conducted on-site, unannounced or announced, or may be investigated by phone or mail.

(b) All licensed ambulatory surgical centers are required to provide the patient and his/her guardian at time of admission a written statement identifying the department as the responsible agency for ambulatory surgical centers complaint investigations. The statement shall inform persons to direct complaint to the Department of State Health Services, Manager, Health Facility Compliance Group, Post Office Box 149347, Austin, Texas 78714-9347, (888) 973-0022. This information shall also be prominently and conspicuously posted for display in an area of the facility that is readily available to patients, families and visitors. Complaints may be registered with the department by phone or in writing. A complainant may provide his/her name, address, and phone number to the department. Anonymous complaints may be registered. All complaints are confidential.

(c) The department shall evaluate all complaints against all ambulatory surgical centers. Only those allegations determined to be relevant to the Act shall be authorized for investigation.

(d) Conduct of the investigation shall include, but is not limited to:

(1) a conference prior to commencing the on-site inspection for the purpose of explaining the nature and scope of the inspection between the department's authorized representative and the person who is in charge of the ASC;

(2) inspection of the ASC;

(3) inspection of medical and personnel records, including administrative files, reports, records, or working papers;

(4) an interview with any willing recipient of ambulatory surgical center services at the ASC or in the recipient's home if the recipient grants permission in writing;

(5) an interview with any health care practitioner or ambulatory surgical center personnel who care for the recipient of ambulatory surgical services; and

(6) a conference at the conclusion of the inspection between the department's representative and the person who is in charge of the ASC.

(A) The department's representative shall identify any records that have been reproduced.

(B) Any records that are removed from an ASC (other than those reproduced) shall be removed only with the consent of the ASC. The ASC shall furnish copies of all records pertinent to the investigation at the department's request.

(e) The department shall review the report of the investigation and determine the validity of the complaint.

§135.26. Reporting Requirements.

(a) The ambulatory surgical center (ASC) shall make a report of the following incidents to the department. A written letter of explanation with supporting documents shall be mailed to the department within 10 business days of the incident. The mailing address is Department of State Health Services, Facility Licensing Group, Post Office Box 149347, Austin, Texas 78714-9347.

(1) The death of a patient while under the care of the ASC;

(2) The transfer of a patient to a hospital;

(3) Patient development of complications within 24 hours of discharge from the ASC resulting in admission to a hospital; and

(4) A patient stay exceeding 23 hours.

(b) On an annual basis, the ASC shall report the types and numbers of procedures performed and the average length of stay during the previous 12-month period. The report shall be made using a form to be prescribed by the department.

(c) Any theft of drugs and/or diversion of controlled drugs shall be reported to the local police agency, the Texas State Board of Pharmacy, the Texas Department of Public Safety, and/or the Drug Enforcement Administration, and the Department of State Health Services.

(d) An ASC that performs abortions shall comply with the reporting requirements specified in the Health and Safety Code, §245.011.

(e) The ASC shall submit reports to the department in accordance with the reporting requirements in Health and Safety Code, §98.103, §98.104, and §98.1045 (relating to Reportable Infections, Alternative for Reportable Surgical Site Infections, and Reporting of Preventable Adverse Events).

(f) Occurrences of fire in the ASC shall be reported as specified under §135.41(a)(2) of this title (relating to Fire Prevention and Protection) and §135.43(b)(6) of this title (relating to Handling and Storage of Gases, Anesthetics, and Flammable Liquids).

§135.27. Patient Safety Program.

(a) Definitions.

(1) Adverse event--An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.

(2) Medical error--The failure of a planned action to be completed as intended, the use of a wrong plan to achieve an aim, or the failure of an unplanned action that should have been completed, that results in an adverse event.

(3) Reportable event--A medical error or adverse event or occurrence which staff are required to report internally.

(4) Root cause analysis--An interdisciplinary review process for identifying the basic or contributing causal factors that underlie a variation in performance associated with an adverse event or reportable event. It focuses primarily on systems and processes, includes an analysis of underlying cause and effect, progresses from special causes in clinical processes to common causes in organizational processes, and identifies potential improvements in processes or systems.

(b) Content. The ambulatory surgical center (ASC) shall develop, implement and maintain an effective, ongoing, organization-wide, data driven patient safety program (PSP).

(1) The governing body shall ensure that the PSP reflects the complexity of the ASC's organization and services, including those services furnished under contract or arrangement, and focuses on the prevention and reduction of medical errors and adverse events.

(2) The PSP shall be in writing, approved by the governing body and made available for review by the department. It shall include the following components:

(A) the definition of medical errors, adverse events and reportable events;

(B) the process for internal reporting of medical errors, adverse events and reportable events;

(C) a list of events and occurrences which staff are required to report internally, including at least the following events:

(i) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient;

(ii) the suicide of a patient in a setting in which the patient received care 24 hours a day;

(iii) the sexual assault of a patient during treatment or while the patient was on the premises of the ASC;

(iv) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities;

(v) a surgical procedure on the wrong patient or on the wrong body part of a patient;

(vi) a foreign object accidentally left in a patient during a procedure;

(vii) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended;

(D) time frames for internal reporting of medical errors, adverse events and reportable events;

(E) consequences for failing to report events in accordance with ASC policy;

(F) mechanisms for preservation and collection of event data;

(G) the process for conducting root cause analysis;

(H) the process for communicating action plans; and

(I) the process for feedback to staff regarding the root cause analysis and action plan.

(c) Education and training. The ASC shall provide patient safety education and training to staff who have responsibilities related to the implementation, development, supervision, or evaluation of the PSP. Training shall include all PSP components as set out in subsection (b)(2) of this section.

(d) Management. The ASC shall designate one or more individuals, or an interdisciplinary group, qualified by training or experience to be responsible for the management of the patient safety program. These responsibilities shall include:

(1) coordinating all patient safety activities;

(2) facilitating assessment and appropriate response to reported events;

(3) monitoring the root cause analysis and resulting action plans; and

(4) serving as liaison among ASC departments and committees to ensure facility-wide integration of the PSP.

(e) Reportable event. Within 45 days of becoming aware of a reportable event specified under subsection (b)(2)(C) of this section, the ambulatory surgery center shall:

(1) complete a root cause analysis to examine the cause and effect of the event through an impartial process; and

(2) develop an action plan identifying the strategies that the ASC intends to employ to reduce the risk of similar events occurring in the future. The action plan shall:

(A) designate responsibility for implementation and oversight;

(B) specify time frames for implementation; and

(C) include a strategy for measuring the effectiveness of the actions taken.

(3) The ASC shall make the root cause analysis and action plan available for on-site review by department representatives.

§135.28. Confidentiality.

Request for information and access to records are governed by the Texas Public Information Act, Government Code, Chapter 552.

(1) A written request for information is required. The request shall sufficiently identify the information requested.

(2) The department may ask for a clarification if it cannot reasonably understand a particular request.

§135.29. Time Periods for Processing and Issuing a License.

(a) General.

(1) The date a license application is received is the date the application reaches the Department of State Health Services (department).

(2) An application for an initial license is complete when the department has received, reviewed, and found acceptable the information described in §135.20 of this title (relating to Initial Application and Issuance of License).

(3) An application for a renewal license is complete when the department has received, reviewed, and found acceptable the information described in §135.22 of this title (relating to Renewal of License).

(b) Time Periods. An application from a facility for an initial license or a renewal license shall be processed in accordance with the following time periods.

(1) The first time period begins on the date the department receives the application and ends on the date the license is issued, or if the application is received incomplete, the period ends on the date the facility is issued a written notice that the application is incomplete. The written notice shall describe the specific information that is required before the application is considered complete. The first time period is 45 calendar days.

(2) The second time period begins on the date the last item necessary to complete the application is received and ends on the date the license is issued. The second time period is 45 calendar days.

(c) Reimbursement of fees.

(1) In the event the application is not processed in the time periods stated in subsection (b) of this section, the applicant has the right to request that the department reimburse in full the fee paid in that particular application process. If the department does not agree that the established periods have been violated or finds that good cause existed for exceeding the established periods, the request shall be denied.

(2) Good cause for exceeding the period established is considered to exist if:

(A) the number of applications for licenses to be processed exceeds by 15% or more the number processed in the same calendar quarter the preceding year;

(B) another public or private entity utilized in the application process caused the delay; or

(C) other conditions existed giving good cause for exceeding the established periods.

(d) Appeal. If the request for reimbursement as authorized by subsection (c) of this section is denied, the applicant may then appeal to the commissioner for a resolution of the dispute. The applicant shall give written notice to the commissioner requesting reimbursement of the fee paid because the application was not processed within the established time period. The department shall submit a written report of the facts related to the processing of the application and good cause for exceeding the established time periods. The commissioner shall make the final decision and provide written notification of the decision to the applicant and the department.

(e) Hearings. If a hearing is proposed during the processing of the application, the hearing shall be conducted pursuant to the Government Code, Chapter 2001, Administrative Procedure Act (APA), the hearing procedures of the State Office of Administrative Hearings (Texas Government Code, Chapter 2003 and 1 Texas Administrative Code, Chapter 155, Rules of Procedures).

Subchapter B. Fire Prevention and Safety Requirements.

§135.41. Fire Prevention and Protection.

(a) Compliance. An ambulatory surgical center (ASC) shall comply with the provisions of this section with respect to fire prevention and protection.

(1) Fire inspections. An ASC shall comply with local fire codes.

(2) Fire reporting. Except as required under §135.43(b)(6) of this title (relating to Handling and Storage of Gases, Anesthetics, and Flammable Liquids), an ASC shall report all occurrences of fire to the local fire authority and in writing to the department's facility licensing group manager as soon as possible but not later than 10 calendar days following the occurrence. Any fire occurrence causing injury to a person shall be reported no later than the next business day to the facility licensing group manager by fax, (512) 834-4514, or overnight mail to Department of State Health Services, Facility Licensing Group Manager, Post Office Box 149347, Austin, Texas 78714-9347.

(3) Smoking policy. An ASC shall adopt, implement and enforce a written smoking policy. The policy shall include the minimum provisions of National Fire Protection

Association 101, Life Safety Code, 2003 Edition (NFPA 101), §20.7.4. All documents published by National Fire Protection Association (NFPA) as referenced in this section may be obtained by writing or calling the NFPA at the following address or telephone number: National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02269-9101 or (800) 344-3555.

(b) Fire extinguishing systems. An ASC shall adopt, implement, and enforce a written policy for periodic inspection, testing and maintenance of fire-fighting equipment, portable fire extinguishers, and when installed sprinkler systems. If installed, fire sprinkler systems shall comply with National Fire Protection Association 13, Standard for the Installation of Sprinkler Systems, 2002 Edition (NFPA 13).

(1) Water-based fire protection systems. All fire sprinkler systems, fire pumps, fire standpipe and hose systems, water storage tanks, and valves and fire department connections shall be inspected, tested and maintained in accordance with National Fire Protection Association 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2002 Edition.

(2) Portable fire extinguishers. Every portable fire extinguisher located in an ASC or upon ASC property shall be installed, tagged, and maintained in accordance with National Fire Protection Association 10, Standard for Portable Fire Extinguishers, 2002 Edition.

(c) Fire protection and evacuation plan. A plan for the protection of patients in the event of fire and their evacuation from the building when necessary shall be formulated according to NFPA 101, §20.7. Copies of the plan shall be available to all staff.

(1) Posting requirements. An evacuation floor plan shall be prominently and conspicuously posted for display throughout the ASC in public areas that are readily visible to patients, employees, and visitors.

(2) Annual training. Each ASC shall conduct an annual training program for instruction of all personnel in the location and use of fire-fighting equipment. All employees shall be instructed regarding their duties under the fire protection and evacuation plan.

(3) Fire drills. The ASC shall conduct at least one fire drill per shift, per quarter. Each drill shall include the use of communication of alarms, use of fire-fighting equipment, simulation of evacuation of patients, discussion with patients, visitors, other occupants, employees and staff about the evacuation plan. Written reports shall be maintained to include evidence of staff and patient participation. Fire exit drills shall incorporate the minimum requirements of NFPA 101, §§20.7.1.2 through 20.7.2.3.

(4) Fire-fighting equipment. All staff shall be familiar with the locations of fire-fighting equipment. Fire-fighting equipment shall be located so that a person shall not have to travel more than 75 feet from any point to reach the equipment.

(d) Fire alarm system. A fire alarm system shall be installed, maintained and tested, in accordance with National Fire Protection Association 72, National Fire Alarm Code, 2002 Edition (NFPA 72) and NFPA 101, §20.3.4.

(e) System for communicating an alarm of fire. A reliable communication system shall be provided as a means of reporting a fire to the fire department. This is in addition to the automatic alarm transmission to the fire department required by NFPA 101, §20.3.4.4.

(f) Fire department access. As an aid to fire department services, every ASC shall provide the following.

(1) Driveways. The ASC shall maintain driveways, free from all obstructions, to main buildings for fire department apparatus use.

(2) Submission of plans. Upon request, the ASC shall submit a copy of the floor plans of the building to the local fire department officials.

(3) Outside identification. The ASC shall place proper identification on the outside of the main building showing the locations of siamese connections and standpipes as required by the local fire department services.

(g) Fire department protection. When an ASC is located outside of the service area or range of the public fire protection, arrangements shall be made to have the nearest fire department respond in case of a fire.

(h) Physical environment. A facility shall provide a physical environment that protects the health, welfare, and safety of patients, personnel and the public. The physical premises of the facility and those areas of the facility's surrounding physical structure that are used by the patients (including all stairwells, corridors and passageways) must meet the local building and fire safety codes as they relate to safe access and patient privacy.

§135.42. General Safety.

(a) Safety officer. The governing body shall appoint a safety officer who is knowledgeable in safety practices in health care facilities. The safety officer shall carry out the functions of the safety program.

(b) Safety activities.

(1) Incident reports. The safety officer shall establish an incident reporting system which includes a mechanism to ensure that all incidents recorded are evaluated, and documentation is provided to show follow-up and corrective actions.

(2) Safety policies and procedures. Safety policies and procedures for each department or service shall be developed, implemented, and enforced.

(3) Safety training and continuing education. Safety training shall be established as part of new employee orientation and in the continuing education of all employees.

(c) Written authority. The authority of the safety officer to take action, when conditions exist that are a possible threat to life, health, or building damage, shall be defined in writing and approved by the governing body.

(d) Safety manual. Each department or service shall have a safety policy and procedure manual within its own area that becomes a part of the overall facility safety manual.

(e) Emergency communication system. An emergency communication system shall be provided in each facility. The system shall be self-sufficient and capable of operating without reliance on the building's service or emergency power supply. Such system shall have the capability of communicating with the available community or state emergency networks, including police and fire departments.

(f) Fans. All portable fans and ceiling fans shall not be utilized in any patient treatment areas/rooms.

(g) Electrical extension cords and cables. Electrical extension cords and cables shall not be used for permanent wiring. Temporary electrical cords or cables shall be secured and protected to prevent tripping.

§135.43. Handling and Storage of Gases, Anesthetics, and Flammable Liquids.

(a) An ambulatory surgical center (ASC) shall comply with the requirements of this section for handling and storage of gases, anesthetics, and flammable liquids. The ASC premises shall be kept free from accumulations of combustible materials not necessary for immediate operation of the facility.

(b) Flammable germicides. If flammable germicides, including alcohol-based products, are used for preoperative surgical skin preparation, the facility shall:

(1) use only self-contained, single-use, pre-measured applicators to apply the surgical skin preparations;

(2) follow all manufacturer product safety warnings and guidelines;

(3) develop, implement, and enforce written policies and procedures outlining the safety precautions required related to the use of the products, which, at a minimum, shall include minimum drying times, prevention and management of product pooling, parameters related to draping and the use of ignition sources, staff responsibilities related to ensuring safe use of the product, and documentation requirements sufficient to evaluate compliance with the written policies and procedures;

(4) ensure that all staff working in the surgical environment where flammable surgical skin preparation products are in use have received training on product safety and the facility policies and procedures related to the use of the product;

(5) develop, implement and enforce an interdisciplinary team process for the investigation and analysis of all surgical suite fires and alleged violations of the policies; and

(6) provide a written report of all occurrences of surgical suite fires within two business days to the department in care of the facility licensing group, and complete an investigation of the occurrence and develop and implement a corrective action plan within 30 days.

(c) Flammable and nonflammable gases and liquids. Flammability of liquids and gases shall be determined by National Fire Protection Association 329, Handling Releases of Flammable and Combustible Liquids and Gases, 2002 Edition. All documents published by National Fire Protection Association (NFPA) as referenced in this section may be obtained by writing or calling the NFPA at the following address or telephone number: National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02269-9101 or (800) 344-3555.

(1) Nonflammable gases (examples include, but are not limited to, oxygen and nitrous oxide) shall be stored and distributed in accordance with Chapter 5 of the National Fire Protection Association 99, Standard for Health Care Facilities, 2002 Edition (NFPA 99).

(A) Medical gases and liquefied medical gases shall be handled in accordance with the requirements of NFPA 99, Chapter 9.

(B) Oxygen shall be administered in accordance with NFPA 99, §9.6.

(2) Piped flammable gas systems intended for use in laboratories and piping systems for fuel gases shall comply with requirements of NFPA 99, §11.11.

(3) Flammable gases shall be stored in accordance with NFPA 99, §11.10.

(4) Flammable and combustible liquids used in laboratories shall be handled and stored in accordance with NFPA 99, §11.7, and National Fire Protection Association 101, Life Safety Code, 2003 Edition, §20.3.2.2.

(5) Other flammable agents shall be stored in accordance with NFPA 99, Chapter 7, Materials.

(d) Alcohol-based hand rubs. Alcohol-based hand rubs (ABHRs) are considered flammable. When used, the ABHRs shall meet the following requirements.

(1) The dispensers may be installed in a corridor so long as the corridor width is six feet or greater. The dispensers shall be installed at least four feet apart.

(2) The maximum individual dispenser fluid capacity is 1.2 liters for dispensers in rooms, corridors, and areas open to corridors, and 2.0 liters for dispensers in suites of rooms.

(3) The dispensers shall not be installed over or directly adjacent to electrical outlets and switches.

(4) Dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments.

(5) Each smoke compartment may contain a maximum aggregate of 10 gallons of ABHR solution in dispensers and a maximum of five gallons in storage.

(e) Gasoline and gasoline powered equipment. No motor vehicles including gasoline powered standby generators or any amount of gasoline shall be located within the ASC building. Other devices which may cause or communicate fire, and which are not necessary for patient treatment or care, shall not be stored within the ASC building. All such devices and materials when necessary shall be used within the building only with precautions ensuring a reasonable degree of safety from fire.

(f) Gas fired appliances. The installation, use, and maintenance of gas fired appliances and gas piping installations shall comply with the National Fire Protection Association 54, National Fuel Gas Code, 2002 Edition. The use of portable gas heaters and unvented open flame heaters is specifically prohibited.

Subchapter C. Physical Plant and Construction Requirements.

§135.51. Construction Requirements for an Existing Ambulatory Surgical Center.

(a) Compliance.

(1) A licensed ambulatory surgical center (ASC) which is licensed prior to the effective date of these rules is considered to be an existing licensed ASC and shall continue, at a minimum, to meet the licensing requirements under which it was originally licensed.

(2) In lieu of meeting the requirements in paragraph (1) of this subsection, an existing licensed ASC may, instead, comply with National Fire Protection Association (NFPA) 101, Life Safety Code 2003 Edition (NFPA 101), Chapter 21, Existing Ambulatory Health Care Occupancies. All documents published by NFPA as referenced in this section may be obtained by writing or calling the NFPA at the following address or telephone number: National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02269-9101 or (800) 344-3555.

(b) Remodeling and additions. All remodeling, renovations, additions and alterations to, or relocation of an existing ASC shall be done in accordance with the requirements for new construction in §135.52 of this title (relating to Construction Requirements for a New

Ambulatory Surgical Center). When existing conditions make such changes impractical, the department may grant a conditional approval of minor deviations from the requirements of §135.52 of this title (relating to Construction Requirements for a New Ambulatory Surgical Center), if the intent of the requirements is met and if the care, safety, and welfare of patients will not be jeopardized. The operation of the ASC, accessibility of individuals with disabilities, and safety of the patients shall not be jeopardized by a condition(s) which is not in compliance with these sections.

(1) Building equipment alterations or installations. Any alteration or any installation of new building equipment, such as mechanical, electrical, plumbing, fire protection, or piped medical gas system, shall comply with the requirements for new construction and shall not be replaced, materially altered, or extended in an existing ASC until complete plans and specifications have been submitted to the department, and the department has reviewed and approved the plans and specifications in accordance with §135.54 of this title (relating to Preparation, Submittal, Review and Approval of Plans, and Retention of Records).

(2) Minor remodeling or alterations. Minor remodeling or alterations within an existing ASC which do not involve alterations to load bearing members and partitions, change functional operation, affect fire safety, add or subtract services, or involve any of the major changes listed in paragraph (3) of this subsection are considered to be minor projects and require evaluation and approval by the department. An ASC shall submit a written request for evaluation, a brief description of the proposed changes, and sketches of the area being remodeled. Based on such submittal, the department shall evaluate and determine whether any additional submittals or inspections are required. The department shall notify the ASC of its decision.

(3) Major remodeling or alterations. All remodeling or alterations which involve alterations to load bearing members or partitions, change functional operation, affect fire safety, or add or delete services are considered major projects. An ASC shall comply with this paragraph prior to beginning construction of major projects.

(A) Submittal of plans. Plans shall be submitted in accordance with §135.54 of this title for all major remodeling or alterations.

(B) Phasing of construction in existing facilities.

(i) Projects involving alterations of or additions to existing buildings shall be programmed and phased so that on-site construction will minimize disruptions of existing functions.

(ii) Access, exit access, and fire protection shall be maintained so that the safety of the occupants will not be jeopardized during construction.

(iii) A noncombustible or limited combustible dust and vapor barrier shall be provided to separate areas undergoing demolition and construction from occupied

areas. When a fire retardant plastic material is used for temporary daily usage, it shall be removed at the end of each day.

(iv) The air inside the construction area shall be protected by mechanical filtration that recirculates inside the space or is exhausted directly to the exterior.

(v) The area shall be properly ventilated and maintained. The area under construction shall have a negative air pressure differential to the adjoining areas and shall continue to operate as long as construction dust and odors are present.

(vi) Temporary sound barriers shall be provided where intense, prolonged construction noises will disturb patients or staff in the occupied portions of the building.

(c) Previously licensed ASCs. A previously licensed ASC which has been vacated or used for other purposes shall comply with all the requirements for new construction contained in §135.52 of this title in order to be licensed.

§135.52. Construction Requirements for a New Ambulatory Surgical Center.

(a) Ambulatory surgical center (ASC) location. Any proposed new ASC shall be easily accessible to the community and to service vehicles such as delivery trucks, ambulances, and fire protection apparatus. No building may be converted for use as an ASC which, because of its location, physical condition, state of repair, or arrangement of facilities, would be hazardous to the health and safety of the patients. An ASC may be a distinct separate part of an existing hospital, it may occupy an entire separate independent structure, or it may be located within another building such as an office building or commercial building.

(1) Means of egress. An ASC shall have at least two exits remotely located in accordance with National Fire Protection Association (NFPA) 101, Life Safety Code, 2003 Edition (NFPA 101), §20.2.4.1. When a required means of egress from the ASC is through another portion of the building, that means of egress shall comply with the requirements of NFPA 101 which are applicable to the occupancy of that other building. Such means of egress shall be open, available, unlocked, unrestricted, and lighted at all times during the ASC hours of operation. All documents published by National Fire Protection Association (NFPA) as referenced in this section may be obtained by writing or calling the NFPA at the following address or telephone number: National Fire Protection Association, 1 Batterymarch Park, Quincy, Massachusetts 02269-9101 or 800-344-3555.

(2) Hazardous location.

(A) Underground and above ground hazards. A new ASC or an addition(s) to an existing ASC shall not be constructed within 150 feet of easement boundaries or setbacks of hazardous underground locations including but not limited to liquid butane or propane, liquid petroleum or natural gas transmission lines, high pressure lines, and not within the easement of high voltage electrical lines.

(B) Fire hazards. A new ASC and an addition to an existing ASC shall not be built within 300 feet of above ground or underground storage tanks containing liquid petroleum or other flammable liquids used in connection with a bulk plant, marine terminal, aircraft refueling, bottling plant of a liquefied petroleum gas installation, or near other hazardous or hazard producing plants.

(3) Undesirable locations.

(A) Nuisance producing sites. A new ASC shall not be located near nuisance producing sites such as industrial sites, feed lots, sanitary landfills, or manufacturing plants which produce excessive noise or air pollution.

(B) Flood plains.

(i) New construction. When a new ASC is constructed in a designated 100-year flood plain, the building finished floor elevation shall be one foot above the set base flood plain elevation. The building shall meet all local flood code ordinances and local flood control requirements.

(ii) Previously licensed ASC. To obtain a license as an ASC, a previously licensed ASC and an existing building or a portion of an existing building located in a designated 100-year flood plain shall meet the requirement of subparagraph (B)(i) of this paragraph.

(iii) Existing ASC. ASC required functional components shall be constructed above the designated flood plain in a new addition to an existing ASC located in a designated 100-year flood plain. The new addition shall meet the requirement of subparagraph (B)(i) of this paragraph.

(b) ASC site. The ASC site shall include paved roads, walkways, and parking in accordance with the requirements set out in this subsection.

(1) Paved roads and walkways.

(A) Paved roads shall be provided within lot lines for access from public roads to the main entrance and to service entrances.

(B) Finished surface walkways shall be provided for pedestrians. When public transportation or walkways serve the site, finished surface walkways or paved roads shall extend from the public conveyance to the building entrance.

(2) Parking and disability requirements.

(A) Parking requirements. Off-street parking shall be provided at the minimum ratio of two spaces for each operating room, one space for each staff member, and one visitor's space for each operating room.

(B) Design for the handicapped. Special considerations benefiting handicapped staff, visitors, and patients shall be provided. Each ASC shall comply with the Americans with Disabilities Act (ADA) of 1990, Public Law 101 - 336, 42 United States Code, Chapter 126, and Title 36 Code of Federal Regulations, Part 1191, Appendix A, Accessibility Guidelines for Buildings and Facilities or 16 Texas Administrative Code, §68.20 (relating to Buildings and Facilities Subject to Compliance with the Texas Accessibility Standards), Texas Accessibility Standards (TAS), April 1, 1994 edition, issued by the Texas Department of Licensing and Regulation, under the Texas Architectural Barriers Act, Texas Government Code, Chapter 469.

(c) Building design and construction requirements. Every building and every portion thereof shall be designed and constructed to sustain all dead and live loads in accordance with accepted engineering practices and standards and local governing building codes. Where there is no local governing building code, the ASC shall be constructed in accordance with the International Building Code, 2003 edition, published by the International Code Council, 500 New Jersey Avenue, Northwest, 6th Floor, Washington, District of Columbia 20001-2070, (888) 422-7233.

(1) General architectural requirements. All new construction, including conversion of an existing building to an ASC or establishing a separately licensed ASC within another existing building, shall comply with NFPA 101, Chapter 20, New Ambulatory Health Care Occupancies, of the National Fire Protection Association 101, Life Safety Code, 2003 Edition (NFPA 101), and Subchapters B and C of this chapter (relating to Fire Prevention and Safety Requirements, and Physical Plant and Construction Requirements, respectively). Construction documents shall be submitted to the department in accordance with §135.54 of this title (relating to Preparation, Submittal, Review and Approval of Plans, and Retention of Records).

(A) Construction types for multiple building occupancy.

(i) When an ASC is part of a larger building which complies with NFPA 101, §20.1.6, Minimum Construction Requirements for (fire resistance) construction type, the designated ASC shall be separated from the remainder of the building with a minimum of one-hour fire-rated construction.

(ii) When an ASC is located in a multistory building of two or more stories, the entire building shall meet the construction requirements of NFPA 101, §20.1.6.3. An ASC shall not be located in a multistory building which does not comply with the minimum construction requirements of NFPA 101, §20.1.6.3.

(iii) When an ASC is part of a one-story building that does not comply with the construction requirements of NFPA 101, §20.1.6.2, the ASC shall be separated

from the remainder of the building with a two-hour fire-rated construction. The designated ASC portion shall have the construction type upgraded to comply with NFPA 101, §20.1.6.2.

(B) Special design provisions. Special provisions shall be made in the design of a facility if located in a region where local experience shows loss of life or extensive damage to buildings resulting from hurricanes, tornadoes, or floods.

(2) Physical environment. A physical environment that protects the health, welfare, and safety of patients, personnel, and the public shall be provided in each facility. The physical premises of the facility and those areas of the facility's physical structure that are used by the patients (including all stairwells, corridors, and passageways) shall meet the local building and fire safety codes and the requirements of this chapter.

(3) Other regulations. The more stringent standard, code or requirement shall apply when a difference in requirements for construction exists.

(4) Exceeding minimum requirements. Nothing in this subchapter shall be construed to prohibit a better type of building construction, more exits, or otherwise safer conditions than the minimum requirements specified in this subchapter.

(5) Equivalency. Nothing in this subchapter is intended to prevent the use of systems, methods, or devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety to those prescribed by this subchapter, provided technical documentation which demonstrates equivalency is submitted to the department for approval.

(6) Freestanding buildings (not for patient use). Separate freestanding buildings for nonpatient use such as the heating plant, boiler plant, laundry, repair workshops, or general storage may be of unprotected noncombustible construction, protected noncombustible construction, or fire-resistive construction and be designed and constructed in accordance with other occupancy classifications requirements listed in NFPA 101.

(d) Spatial requirements.

(1) Administration and public areas.

(A) Entrance. Entrances shall be located at grade level, be accessible to individuals with disabilities, and be protected against inclement weather from the point of passenger loading/unloading to the building entrance. When an ASC is located on a floor above grade level, elevators shall be accessible and shall meet the requirements of §135.53 of this title (relating to Elevators, Escalators, and Conveyors).

(B) Waiting area. A waiting area or lobby shall be provided within the ASC and include having the following rooms and items:

(i) public toilet facilities;

(ii) telephone(s) for public use; and

(iii) access to potable drinking water.

(C) Reception area. A designated reception area with desk or counter shall be provided.

(D) Interview space(s). Space shall be provided for private interviews or family members, relating to social services, credit, or admission.

(E) General or individual office(s). An office(s) shall be provided for business transactions, records, and administrative and professional staff.

(F) Medical records area. The medical records area shall have adequate space for reviewing, dictating, sorting, or recording records. If electronic imaging devices are employed (i.e., microfilm, digital, or optical disc), the medical records area shall have adequate space for transcribing records in the electronic format. Medical record storage space shall be located within a secure designated area under direct visual supervision of administrative staff.

(G) General storage room.

(i) A minimum of 30 square feet per operating room shall be provided exclusive of soiled holding, sterile supplies, clean storage, drug storage, locker rooms, and surgical equipment storage. General storage may be located in one or more rooms or closets, and shall be located outside of the patient treatment areas.

(ii) General storage room(s) shall be separated from adjacent areas by fire-rated construction in accordance with the NFPA 101, §38.3.2.1 and §38.3.2.2.

(H) Wheelchair storage space or alcove. Storage space for wheelchairs shall be provided and shall be out of the direct line of traffic.

(2) Engineering services and equipment areas. Equipment rooms with adequate space shall be provided for mechanical and electrical equipment. These areas shall be separate from public, patient, and staff areas.

(3) Examination room. An examination room is not required, but when provided, the room shall have:

(A) a minimum clear floor area of at least 80 square feet exclusive of fixed or moveable cabinets, counters, or shelves; and

(B) a work counter with space for writing and a hand washing fixture with hands-free operable controls.

(4) Janitor's closet. In addition to the janitor's closet exclusive to the surgery suite, a sufficient number of janitor's closets shall be provided throughout the facility to maintain a clean and sanitary environment. The closet shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment.

(5) Laboratory.

(A) General. Laboratory services shall be provided within the ASC or through a contract or other arrangement with a hospital or accredited laboratory.

(B) Special requirements. When the laboratory is located on site the following minimum items shall be provided:

(i) a room with work counter, utility sink, and storage cabinets or closet(s); and

(ii) specimen collection facilities. For dip stick urinalysis, urine collection rooms shall be equipped with a water closet and lavatory. Blood collection facilities shall have space for a chair, work counter, and a hand washing fixture with hands-free operable controls.

(C) Code compliance. An on-site laboratory shall comply with the following codes.

(i) Construction for fire protection in laboratories employing quantities of flammable, combustible, or other hazardous material shall be in accordance with the National Fire Protection Association 99, Health Care Facilities, 2002 Edition, (NFPA 99).

(ii) Laboratories shall comply with the requirements of NFPA 99, Health Care Facilities, 2002 Edition, Chapter 11, as applicable and the requirements of NFPA 45, Standards on Fire Protection for Laboratories Using Chemicals, 2000 Edition, as applicable.

(6) Laundry and linen processing area(s). Laundry and linen processing may be done within the center or off site at a commercial laundry.

(A) On-site linen processing. When on-site linen processing is provided, soiled and clean processing operations shall be separated and arranged to provide a one-way traffic pattern from soiled to clean areas. The following rooms and items shall be provided:

(i) a soiled linen processing room which includes areas for receiving, holding, sorting, and washing;

(ii) a clean linen processing room which includes areas for drying, sorting, folding, and holding prior to distribution;

(iii) supply storage cabinets in the soiled and clean linen processing rooms;

(iv) a hand washing fixture with hands-free operable controls within the soiled linen processing room; and

(v) a storage room for clean linen located within the surgical suite. Clean linen storage may be combined with the clean work room.

(B) Off-site linen processing. When linen is processed off site, the following rooms or items shall be provided:

(i) a storage room for clean linen located within the surgical suite. Clean linen storage may be combined with the clean work room; and

(ii) a soiled linen holding room or area located within the surgical suite. Soiled linen holding may be combined with the soiled workroom.

(7) Medical waste processing. Space and facilities shall be provided for the safe storage and disposal of waste as appropriate for the material being handled and in compliance with all applicable rules and regulations.

(8) Pharmacy. A pharmacy work room or alcove shall be provided and located separate from patient and public areas and under the direct supervision of staff. A work counter, refrigerator, medication storage, and locked storage for biologicals and drugs shall be provided. A hand washing fixture with hands-free operable controls shall be located in the pharmacy room or alcove.

(9) Postoperative recovery suite.

(A) General. A postoperative recovery suite shall be distinct and separate from preoperative areas. The postoperative recovery suite shall be arranged to provide a one-way traffic pattern from the restricted surgical corridor to the postoperative recovery suite, and then to the extended observation rooms or discharge.

(B) Postanesthesia care unit. A minimum of one patient station per operating room, plus one additional station, shall be provided.

(i) In a multiple-bed postoperative recovery area, the clearance between the side of a bed/gurney and a wall/partition shall be a minimum of three feet. The clearance between sides of beds/gurneys shall be a minimum of four feet six inches. The minimum distance at the foot of the bed/gurney shall not be less than six feet for single load area/room or nine feet for double load area/room. Four feet of the passage space at the foot of the bed may be shared between two beds/gurneys. The fixed and moveable cabinets and shelves shall not encroach upon the bed/gurney clear floor space/area.

(ii) The minimum clear floor space in a private postoperative recovery room shall be 100 square feet exclusive of aisles and fixed and moveable cabinets and selves. A minimum of nine feet width shall be provided for the head wall.

(C) Patient toilet. A toilet room with a water closet and a hand washing fixture with hands-free operable controls shall be provided. The toilet room may be shared with the preoperative patient holding area, if located conveniently between both areas.

(D) Hand washing fixture. One hand washing fixture with hands-free operable controls shall be provided for every four recovery beds or fraction thereof in open wards. Fixtures shall be uniformly distributed. One hand washing fixture shall be provided within each single-bed recovery room.

(E) Extended observation rooms. Separate supervised rooms or areas may be provided for patients who are sufficiently stabilized to leave the postanesthesia care unit, but require additional time in the facility for observation or comfort measures prior to being discharged.

(i) When individual rooms are provided for extended observation, the rooms shall have an area of at least 60 square feet. When such rooms include a bed or recliner, a minimum clearance of three feet at the foot and on each side of the bed or recliner shall be provided.

(ii) When an open or ward area for extended observation is provided, the minimum clearance from the bed or recliner to the side wall shall not be less than three feet; and a space of four feet shall be provided at the foot of each bed or recliner. The minimum clearance between beds or recliners shall not be less than three feet.

(iii) A toilet room with a water closet and a hand washing fixture with hands-free operable controls shall be provided. The toilet room may be shared with the postoperative recovery area, if located conveniently between both areas.

(10) Preoperative patient holding room.

(A) General. A preoperative holding area shall be provided and arranged in a one-way traffic pattern so that patients entering from outside the surgical suite can change, gown, and move directly into the restricted corridor of the surgical suite. The holding area shall be separate from the postoperative recovery suite and the restricted corridor.

(B) Patient station. A minimum of one patient station per operating room shall be provided.

(i) When individual rooms are provided, the minimum clear floor space in a private preoperative holding room shall be 80 square feet exclusive of aisles and fixed and moveable cabinets and shelves. The rooms shall include a bed or recliner with a minimum clearance of three feet at the foot and on each side of the bed or recliner.

(ii) In a multiple-bed preoperative holding area, a minimum area of 60 square feet shall be provided for each patient station. The minimum clearance from the gurney or bed to a sidewall shall not be less than three feet. A space of four feet shall be provided at the foot of the gurney or bed and the minimum clearance between gurneys or beds shall not be less than four feet six inches.

(iii) Space shall be made available for storing and securing patient's personal effects.

(iv) One hand washing fixture with hands-free operable controls shall be provided for every four preoperative beds or fraction thereof in open wards. Fixtures shall be uniformly distributed. One hand washing fixture shall be provided within each single-bed preoperative holding room.

(C) Patient toilet. A toilet room with handicapped accessible water closet and hand washing facilities shall be provided. The toilet room may be shared with the postoperative recovery suite, if located conveniently between both areas.

(D) Duty station. A hand washing fixture with hands-free operable controls and a counter or shelf space for writing shall be provided for staff use within or convenient to the preoperative area. The staff hand washing fixture with hands-free operable controls shall be separate from and in addition to patient toilet accommodations.

(11) Radiology.

(A) Special requirements. When radiology services are provided on site, the following minimum facilities shall be provided:

(i) film processing facilities, if used;

(ii) viewing capabilities;

(iii) storage facilities for exposed film, if used, located in rooms or areas constructed in accordance with the NFPA 101, §38.3.2.1 and §38.3.2.2; and

(iv) dressing area(s) shall be required, depending on services provided, with convenient access to toilets, and may be shared with patient changing/preoperative rooms.

(B) Fluoroscopy room. When fluoroscopy services are provided on site in a dedicated fluoroscopy room, a toilet room with a water closet and a hand washing fixture with hands-free operable controls shall be directly accessible to the room.

(12) Soiled workroom. In addition to the soiled workroom provided in the surgical suite, a separate soiled workroom(s) shall be required when a treatment room is provided, except as allowed in subparagraph (B) of this paragraph.

(A) Special requirements. The workroom(s) shall contain a clinical sink or equivalent flushing type fixture, work counter, designated space for waste and linen receptacles, and a hand washing fixture with hands-free operable controls.

(B) Shared functions. The soiled workroom required in support of a treatment room may be combined with a surgical suite soiled work room with two means of entry. A separate door into the soiled workroom shall serve a treatment room located outside the surgical suite.

(13) Surgical staff clothing change area.

(A) Surgical staff changing rooms. Appropriately sized areas shall be provided for male and female personnel working within the surgical suite. These areas shall contain lockers, showers, toilets, hand washing fixtures with hands-free operable controls, and space to change into scrub suits and boots. Separate locker/changing rooms shall be provided for male and female staff. The shower and toilet room(s) may be unisex. These areas shall be arranged to provide a traffic pattern so that personnel entering from outside the surgical suite can shower, change, and move directly into the restricted areas of the surgical suite.

(B) Surgical staff lounge. When a surgical staff lounge is provided, the lounge shall be located to permit the use without leaving the surgical suite and may be accessed from the clothing changing rooms. The surgical staff lounge shall not have direct access from outside the surgical suite. When the lounge is remote from the clothing change rooms, toilet facilities and a hand washing fixture with hands-free operable controls accessible from the lounge shall be provided.

(14) Sterilizing facilities. A system for sterilizing equipment and supplies shall be provided. Sterilizing procedures may be done on site or off site, or disposables may be used to satisfy functional needs.

(A) Off-site sterilizing. When sterilizing is provided off site and disposables and prepackage surgical supplies are used, the following rooms shall be provided near the operating room.

(i) Soiled holding room. A room for receiving contaminated/soiled material and equipment from the operating room shall be provided. The room shall be physically separate from all other areas of the suite. The room shall include a work counter(s) or a table(s), clinical sink or equivalent flushing type fixture, equipment for initial disinfection and preparation for transport to off-site sterilizing, and a hand washing fixture with hands-free operable controls. The soiled holding room may be combined with the surgical suite soiled workroom.

(ii) Clean workroom. A clean workroom shall be provided for the exclusive use of the surgical suite. The workroom shall contain a work counter with space for receiving, disassembling and organizing clean supplies, storage cabinets or shelving, and a hand washing fixture with hands-free operable controls.

(iii) Sterilizer equipment. Sterilizer equipment shall be located in a separate room convenient to the operating room(s), in an alcove adjacent to the restricted corridor, or in the clean workroom.

(B) On-site sterilizing facilities. When sterilizing facilities are provided on site they shall be located near the operating room and provide the following rooms.

(i) Receiving/decontamination room. The receiving/ decontamination room shall be physically separate from all other areas of the surgical suite. The room shall include a work counter(s) or table(s), clinical sink or equivalent flushing type fixture, equipment for initial washing/disinfection, and a hand washing fixture with hands-free operable controls. Pass-through dutch doors, windows, and washer/sterilizer decontaminators shall serve in delivering material to the clean workroom. The receiving/decontamination room may be combined with the surgical suite soiled workroom.

(ii) Clean/assembly workroom. The clean/assembly workroom shall include a counter(s) or table(s) with space for organizing, assembling, and packaging of medical/surgical supplies and equipment, equipment for terminal sterilizing, and a hand washing fixture with hands-free operable controls. Clean and soiled work areas shall be physically separated.

(iii) Sterile storage. A storage room for clean and sterile supplies shall be provided. The storage room shall have adequate areas and counters for breakdown of manufacturers' clean/sterile medical/surgical supplies. This room may be combined with the clean assembly/workroom.

(iv) Cart storage room or alcove. The storage space for distribution carts shall be adjacent to clean and sterile storage area(s) and close to main distribution points.

(15) Surgical suite. The surgical suite shall be arranged to preclude unrelated traffic through the suite. The surgical suite shall contain at least one operating room and all surgical service areas required under subparagraph (B) of this paragraph.

(A) Operating room. The operating room(s) shall have a clear floor area of at least 240 square feet exclusive of fixed or moveable cabinets, counters, or shelves. The minimum clear dimension between built-in cabinets, counters, and shelves shall be 14 feet.

(B) Surgical service areas.

(i) Restricted corridor. The restricted corridor shall serve as the primary passageway for staff and patients within the surgical suite. The following rooms and areas shall have direct access to the restricted corridor:

(I) preoperative patient holding area;

(II) operating room(s);

(III) postoperative recovery suite;

(IV) soiled workroom;

(V) clean workroom;

(VI) janitor's closet;

(VII) equipment storage;

(VIII) sterilizing facilities;

(IX) anesthesia workroom when provided; and

(X) area for emergency crash cart.

(ii) Soiled workroom. A soiled workroom shall be provided for the exclusive use of the surgical suite staff. The workroom shall contain a clinical sink or equivalent flushing type fixture, work counter, designated space for waste and linen receptacles, and a hand washing fixture with hands-free operable controls. The soiled workroom shall not have direct connection with operating room(s) or other sterile activity room(s).

(iii) Clean linen storage. A storage room or alcove shall be provided for storing clean linen.

(iv) Scrub facilities. A scrub station shall be located in the restricted corridor within five feet of the entrance of each operating room. One scrub station with dual faucets with hands free operable controls may serve two operating rooms if the scrub stations are located adjacent to the entrance of both operating rooms. Scrub facilities shall be arranged to minimize any incidental splatter on nearby personnel, medical equipment, or supply carts. Viewing panels shall be provided for observation of the surgical room interior. The scrub sinks shall be recessed out of the main traffic areas. The scrub sink alcove shall be located within the restricted areas of the surgical suite. Scrub sinks shall not be located inside the sterile area.

(v) Janitor's closet. A janitor's closet shall be provided for the exclusive use of the surgical suite. The closet shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment.

(vi) Equipment storage. A room, alcove, or designated area shall be provided for storing equipment and supplies used in the surgical suite. The storage room or area shall be a minimum of 50 square feet per operating room.

(vii) Medical gas storage room. When provided or required by NFPA 101, a medical gas storage room shall comply with the requirements of NFPA 99, 2002, Chapter 5, Gas and Vacuum Systems.

(viii) Area for emergency crash cart. An area or alcove located out of traffic and convenient to the operating room(s) shall be provided for an emergency crash cart.

(ix) Stretcher storage area. An area or alcove shall be located convenient for use and out of the direct line of traffic for the storage of stretchers as required. Stored stretchers shall not encroach on corridor widths.

(16) Treatment room.

(A) A treatment room is not required, but when provided, it shall be used only for minor procedures.

(B) If inhalation anesthesia is administered in the treatment room, the room shall comply with NFPA 99, §14.4.1 requirements for an anesthetizing location.

(C) The treatment room shall have a clear floor area of at least 120 square feet exclusive of fixed or moveable cabinets, counters, or shelves.

(D) The treatment room shall contain an examination table, a counter for writing, and a hand washing fixture with hands-free operable controls.

(e) General detail and finish requirements. Details and finishes in new construction projects, including additions and alterations, shall be in compliance with this subsection, with NFPA 101, Chapter 20, and with local building codes.

(1) General detail requirements.

(A) Fire safety. Fire safety features, including smoke compartmentation, means of egress, automatic extinguishing systems, inspections, smoking regulations, and other details relating to fire prevention and fire protection shall comply with NFPA 101, Chapter 20. The Fire Safety Evaluation System for Health Care Occupancies contained in the National Fire Protection Association 101A, Alternative Approaches to Life Safety, 2001 Edition, Chapter 3, shall not be used in new building construction, renovations, or additions to existing ASCs.

(B) Exits, corridors and doors.

(i) Number of exits. A facility shall provide two exits remote from each other in accordance with NFPA 101, §20.2.4.1. At least one exit door shall be accessible by

an ambulance from the outside. This door may also serve as an entry for loading or receiving goods.

(ii) Encroachment into the means of egress. Items such as drinking fountains, telephone booths or stations, and vending machines shall be so located as to not project into and restrict exit corridor traffic or reduce the exit corridor width below the required minimum. Portable equipment shall not be stored so as to project into and restrict exit corridor traffic or reduce the exit corridor width below the required minimum.

(iii) Corridors.

(I) Public corridor. The minimum clear and unobstructed width of a public corridor shall be at least four feet.

(II) Communicating corridor. The communicating corridor shall be used to convey patients by stretcher, gurney, or bed.

(III) The communicating corridor shall link the preoperative holding area, operating room(s), and postoperative recovery suite, and shall be continuous to at least one exit.

(IV) The minimum clear and unobstructed width of the communicating corridor shall be eight feet.

(iv) Door types. Doors at all openings between corridors and rooms or spaces subject to occupancy shall be swing type. Elevator doors are excluded from this requirement.

(v) Door swing. Doors, except doors to spaces such as small closets which are not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the required corridor width. Large walk-in type closets are considered as occupiable spaces.

(vi) Patient access doors. The minimum width of doors for patient access to examination and consultation rooms shall be three feet. The minimum width of doors requiring access for beds and gurneys (preoperative holding area, operating room, postoperative recovery suite, treatment rooms) shall be three feet eight inches.

(vii) Emergency access. Rooms containing a water closet, intended for patient use, shall be provided with at least one door having hardware which will permit access from the outside in any emergency. Door leaf width of such doors shall not be less than 36 inches.

(viii) Sliding doors. Horizontal sliding doors serving an occupant load of fewer than 10 shall be permitted. The area served by the door shall have no high hazard contents. The door shall be readily operable from either side without special knowledge or effort.

The force required to operate the door in the direction of door travel shall be not more than 30 pounds per foot to set the door in motion, and shall be not more than 15 pounds per foot to close the door or open in the minimum required width. The door assembly shall comply with any required fire protection rating, and, where rated, shall be self-closing or automatic closing. The sliding doors opening to the egress corridor doors shall have a latch or other mechanism that ensures that the doors will not rebound into a partially open position if forcefully closed. The sliding doors may have breakaway provisions and shall be installed to resist passage of smoke. The latching sliding panel shall have a minimum clear opening of 36 inches in the fully open position. The fixed panels may have recessed tracks.

(ix) Fire doors. All fire doors shall be listed by an independent testing laboratory and shall meet the construction requirements for fire doors in National Fire Protection Association 80, Standard for Fire Doors and Fire Windows, 1999 Edition. Reference to a labeled door shall be construed to include labeled frame and hardware.

(C) Glazing. Glass doors, lights, sidelights, borrowed lights, and windows located within 12 inches of a door jamb or with a bottom-frame height of less than 18 inches and a top-frame height of more than 36 inches above the finished floor which may be broken accidentally by pedestrian traffic shall be glazed with safety glass or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken. Similar materials shall be used for wall openings in activity areas such as recreation and exercise rooms, unless otherwise required for fire safety. Safety glass, tempered or plastic glazing materials shall be used for shower doors and bath enclosures, interior windows and doors. Plastic and similar materials used for glazing shall comply with the flame spread ratings of NFPA 101, §18.3.3.

(D) Grab bars. Grab bars shall be provided at patient toilets and showers. The bars shall be one and one-half inches in diameter, shall have either one and one-fourth or one and one-half inches clearance to walls, and shall have sufficient strength and anchorage to sustain a concentrated vertical or horizontal load of 250 pounds. Grab bars intended for use by the disabled shall also comply with ADA requirements.

(E) Hand washing facilities. Location and arrangement of fittings for hand washing facilities shall permit their proper use and operation. Hand washing fixtures with hands-free controls shall be provided in each examination room, treatment room, preoperative area, postoperative recovery suite, extended observation room or area, soiled utility room, fluoroscopy room, clean work room, and toilet room. Particular care shall be given to the clearances required for blade-type operating handles. Lavatories and hand washing facilities shall be securely anchored to withstand an applied vertical load of not less than 250 pounds on the front of the fixture. In addition to the specific areas noted, hand washing facilities shall be conveniently located for staff use in rooms and areas noted under spatial requirements in subsection (d) of this section and throughout the center where patient care services are provided.

(F) Soap dispensers. A liquid or foam soap dispenser shall be located at each hand washing facility.

(G) Hand drying. Provisions for hand drying shall be included at all hand washing facilities. There shall be hot air dryers or individual paper or cloth units enclosed in such a way as to provide protection against dust or soil and ensure single-unit dispensing.

(H) Signage. A sign shall be posted at the entrance to each toilet/restroom to identify the facility for public, staff, or patient use.

(I) Ceiling heights. The minimum ceiling height shall be eight feet six inches with the following exceptions.

(i) Rooms containing ceiling-mounted light fixtures or equipment. Operating rooms or other rooms containing ceiling-mounted light fixtures or equipment shall have ceiling heights of not less than nine feet. Additional ceiling height may be required to accommodate special fixtures or equipment.

(ii) Minor rooms. Ceilings in storage rooms, toilet rooms, and other minor rooms shall be not less than seven feet six inches

(iii) Boiler rooms. Boiler rooms shall have ceiling clearances not less than two feet six inches above the main boiler header and connecting piping.

(iv) Overhead clearance. Suspended tracks, rails, pipes, signs, lights, door closers, exit signs, and other fixtures that protrude into the path of normal traffic shall not be less than six feet eight inches above the finished floor.

(J) Areas producing impact noises. Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over operating rooms or special procedure rooms unless special provisions are made to minimize noise.

(K) Rooms with heat-producing equipment. Rooms containing heat-producing equipment, such as mechanical and electrical equipment and laundry rooms, shall be insulated and ventilated to prevent floors of any occupied room located above it from exceeding a temperature differential of 10 degrees Fahrenheit above the ambient room temperature.

(L) Radiation protection. Shielding shall be designed, tested, and approved by a medical physicist licensed under the Medical Physics Practice Act, Occupations Code, Chapter 602. The ASC shall obtain a certificate of registration issued by the Radiation Safety Licensing Branch to use radiation machines.

(f) General finishes requirements.

(1) Privacy screens, cubicle curtains, and draperies.

(A) Cubicle curtains or privacy screens shall be provided to assure patient privacy when required or requested by a patient.

(B) Cubicle curtains, draperies and other hanging fabrics shall be noncombustible or flame retardant and shall pass both the small-scale and the large-scale tests of National Fire Protection Association 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films, 1999 Edition. Copies of laboratory test reports for installed materials shall be submitted to the department at the time of the final construction inspection.

(2) Flame spread, smoke development and noxious gases. Flame spread and smoke developed limitations of interior finishes shall comply with Table 4 of §135.56(d) of this title (relating to Construction Tables) and NFPA 101, §10.2. The use of materials known to produce large or concentrated amounts of noxious or toxic gases shall not be used in exit accesses or in patient areas. Copies of laboratory test reports for installed materials tested in accordance with National Fire Protection Association 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 Edition, and National Fire Protection Association 258, Standard Research Test Method for Determining Smoke Generation of Solid Materials, 2001 Edition, shall be provided.

(3) Floor finishes.

(A) Flooring shall be easy to clean and have wear resistance appropriate for the location involved. Floors that are subject to traffic while wet (such as shower and bath areas, and similar work areas) shall have a nonslip surface. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. The following are acceptable floor finishes:

(i) painted concrete for mechanical, electrical, communication rooms, and janitor’s closets;

(ii) vinyl and vinyl composition tiles and sheets tiles for offices, lobbies, administrative areas, storage, staff and public toilet rooms, examination rooms, support spaces, and nontreatment areas;

(iii) monolithic or seamless flooring shall be provided for all operating rooms, special procedure rooms, treatment rooms, patient toilet rooms, soiled workrooms, and sterilizing facility(ies). Seamless flooring shall be impervious to water, coved and installed integral with the base, tightly sealed to the wall, and without voids that can harbor insects or retain dirt particles. The base shall not be less then six inches in height. Welded joint flooring is acceptable;

(iv) marble, ceramic and quarry tile for offices, lobbies, staff and public toilet rooms, administrative areas, wet areas, and similar spaces;

(v) carpet flooring for offices, lobbies, and administrative areas. Carpeting shall not be installed in any preoperative holding, toilet rooms, treatment rooms, examination rooms, and similar spaces; and

(vi) terrazzo for offices, lobbies, administrative areas, and similar spaces.

(B) Threshold and expansion joint covers. Thresholds at doorways shall not exceed 3/4 inch in height for exterior sliding doors or 1/2 inch for other type doors. Raised thresholds and floor level changes at accessible doorways shall be beveled with a slope no greater than 1:2. Expansion joint covers shall not exceed 1/2 inch in height and shall have beveled edges with a slope no greater than 1:2.

(4) Wall finishes. Wall finishes shall be smooth, washable, moisture resistant, and cleanable by standard housekeeping practices. Wall finishes shall be in compliance with the requirements of NFPA 101, §38.3.3, relating to flame spread.

(A) Finishes at plumbing fixtures. Wall finishes shall be water-resistant in the immediate area of plumbing fixtures.

(B) Wet cleaning methods. Wall finishes in areas subject to frequent wet cleaning methods shall be impervious to water, tightly sealed, and without voids.

(5) Ceiling finishes. All occupied rooms and spaces shall be provided with finished ceilings, unless otherwise noted. Ceilings which are a part of a rated roof/ceiling assembly or a floor/ceiling assembly shall be constructed of listed components and installed in accordance with the listing. Three types of ceilings that are required in various areas of the ASC are:

(A) ordinary ceilings. Ceilings are required in all areas or rooms in the ASC unless otherwise noted. This includes ceilings such as acoustical tiles installed in a metal grid which are dry cleanable with equipment used in daily housekeeping activities such as dusters and vacuum cleaners;

(B) washable ceilings. When ceilings that dictate this type of cleaning or protection for these spaces such as soil utility or soil workroom, the ceilings shall be made of washable, smooth, moisture impervious materials such as painted lay-in gypsum wallboard or vinyl faced acoustic tile in a metal grid; and

(C) monolithic ceilings. Ceilings which are monolithic from wall to wall (painted solid gypsum wallboard), smooth and without fissures, open joints, or crevices and with a washable and moisture impervious finish shall be provided in the operating rooms, special procedure rooms, and sterilizing facilities.

(D) Nonceiling requirements. Finished ceilings may be omitted in mechanical, electrical, communication rooms and equipment spaces, shops, and similar spaces unless required for fire-resistive purposes.

(6) Floor, wall, and ceiling penetrations. Floor, wall, and ceiling penetrations by pipes, ducts, and conduits, or any direct openings shall be tightly sealed to minimize entry of dirt particles, rodents, and insects. Joints of structural elements shall be similarly sealed.

(7) Materials finishes. Materials known to produce noxious gases when burned shall not be used for mattresses, upholstery, and wall finishes.

(g) General mechanical requirements. This subsection contains requirements for mechanical systems; air conditioning, heating and ventilating systems; steam and hot and cold water systems; and thermal and acoustical insulation.

(1) Cost. All mechanical systems shall be designed for overall efficiency and life cycle costing, including operational costs. Recognized engineering practices shall be followed to achieve the most economical and effective results except that in no case shall patient care or safety be sacrificed for conservation.

(2) Equipment location. Mechanical equipment may be located indoors or outdoors (when in a weatherproof enclosure), or in a separate building(s).

(3) Vibration isolation. Mechanical equipment shall be mounted on vibration isolators as required to prevent unacceptable structure-borne vibration. Ducts, pipes, etc. connected to mechanical equipment which is a source of vibration shall be isolated from the equipment with vibration isolators.

(4) Performance and acceptance. Prior to completion and acceptance of the facility, all mechanical systems shall be tested, balanced, and operated to demonstrate to the design engineer or his representative that the installation and performance of these systems conform to the requirements of the plans and specifications.

(A) Material lists. Upon completion of the contract, the owner shall obtain from the construction contractor parts lists and procurement information with numbers and descriptions for each piece of equipment.

(B) Instructions. Upon completion of the contract, the owner shall obtain from the construction contractor instructions in the operational use and maintenance of systems and equipment as required.

(5) Heating, ventilating, and air conditioning (HVAC) systems.

(A) All central HVAC systems shall comply with and shall be installed in accordance with the requirements of NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems, 2002 Edition, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, 2002 Edition, as applicable and the requirements contained in this paragraph. Air handling units serving two or more rooms are considered to be central units.

(B) Noncentral air handling systems, i.e., individual room units that are used for heating and cooling purposes (e.g., fan-coil units, heat pump units, and packaged terminal air conditioning units) shall be equipped with permanent (cleanable) or replaceable filters. The filters shall have an average efficiency of 25 - 30% and an average arrestance of 85% based on American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE), Inc., Standard 52.2, 1999 edition, Method of Testing General Ventilation Air Cleaning Devices for Removal Efficiency by Particle Size. These units shall be used as air recirculating units only. All outdoor air requirements shall be met by a separate central air handling system with the proper filtration, as required in Table 1 of §135.56(a) of this title.

(C) General ventilation requirements. All rooms and areas in the ASC shall have provision for positive ventilation. Fans serving exhaust systems shall be located at the discharge end and shall be conveniently accessible for service. Exhaust systems may be combined, unless otherwise noted, for efficient use of recovery devices required for energy conservation. The ventilation rates shown in Table 1 of §135.56(a) of this title shall be used only as minimum requirements, since they do not preclude the use of higher rates that may be appropriate.

(i) Cost reduction methods. To reduce utility costs, facility design may utilize energy conserving procedures including recovery devices, variable air volume, load shedding, systems shutdown, or reduction of ventilation rates (when specifically permitted) in certain areas when unoccupied. In no case shall patient care be jeopardized.

(ii) Economizer cycle. Mechanical systems shall be arranged to take advantage of outside air conditions by using an economizer cycle when appropriate to reduce heating and cooling systems loads. Innovative design that provides for additional energy conservation while meeting the intent of this section for acceptable patient care may be presented to the department for consideration.

(iii) Areas requiring fully ducted systems. Fully ducted supply, return and exhaust air for HVAC systems shall be provided for all critical care areas, sensitive care areas, all patient care areas, all areas requiring a sterile regimen, clean storage rooms, and where required for fire safety purposes. Combination systems, utilizing both ducts and plenums for movement of air in these areas, shall not be permitted. Ductwork access panels shall be labeled.

(iv) Temperatures and humidities. The designed capacity of the systems shall be capable of providing the ranges of temperatures and humidities as shown in Table 1 of §135.56(a) of this title.

(v) Thermometers and humidity gauges. Each operating room, special procedure room, and postoperative recovery suite shall have temperature and humidity indicating devices mounted at eye level.

(vi) Outside air intake locations.

(I) Outside air intakes shall be located at least 25 feet from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum system outlets, plumbing vents, or areas which may collect vehicular exhaust or other noxious fumes. (Prevailing winds and proximity to other structures may require other arrangements).

(II) Plumbing and vacuum vents that terminate five feet above the level of the top of the air intake may be located as close as 10 feet to the air intake.

(III) The bottom of outside air intakes serving central systems shall be located as high as practical but at least six feet above ground level, or if installed above the roof, three feet above the roof level.

(vii) Contaminated air exhaust outlets. Exhaust outlets from areas (laboratory hoods, etc.) that exhaust contaminated air shall be above the roof and be arranged to exhaust upward unless the air has been treated by an appropriate means where sidewall exhaust will be allowed. Exhaust outlets from areas containing ethylene oxide sterilizers and other contaminants, e.g., glutaraldehyde, shall terminate not less than eight feet above the roof level (or be appropriately labeled as "hazardous exhaust") and arranged to exhaust upward.

(viii) Directional air flow. Ventilation systems shall be designed and balanced to provide pressure relationships contained in Table 1 of §135.56(a) of this title. For reductions and shut down of ventilation systems when a room is unoccupied, the provisions in Note 4 of Table 1 of §135.56(a) of this title shall be followed.

(ix) Air distribution devices. Design shall consider turbulence and other factors of air movement to minimize airborne particulate matter. Where extraordinary procedures require special designs, the installation shall be reviewed on a case-by-case basis.

(I) All supply diffusers grilles shall be located on the ceiling or on a wall near the ceiling.

(II) Air supply for the operating rooms and special procedure rooms shall be from ceiling outlets near the center of the work area to efficiently control air movement.

(III) A minimum of two return air inlets located diagonally opposite from one another and near floor level shall be provided. Bottoms of return air grilles in operating rooms and other anesthetizing locations shall be located not more than 12 inches above the finished floor nor less than six inches above the finished floor.

(x) Ventilation start-up requirements. Air handling systems shall not be started or operated without the filters installed in place. This includes the 90% and 99.97% efficiency filters where required. This includes during construction operations. Ducts shall be cleaned thoroughly and throughout by a National Air Duct Cleaners Association (NADCA) certified air duct cleaning contractor when the air handling systems have been operating without

the required filters in place. When ducts are determined to be dirty or dusty, the department shall require a written report assuring cleanliness of duct and clean air quality.

(xi) Humidifier location. When duct humidifiers are located upstream of the final filters, they shall be located at least 15 feet from the filters. Duct work with duct-mounted humidifiers shall be provided with a means of removing water accumulation. An adjustable high-limit humidistat shall be located downstream of the humidifier to reduce the potential of condensation inside the duct. All duct takeoffs shall be sufficiently downstream of the humidifier to ensure complete moisture absorption. Reservoir-type water spray or evaporative pan humidifiers shall not be used.

(xii) Filtration requirements. All air handling units shall be equipped with filters having efficiencies equal to, or greater than, those specified in Table 2 of §135.56(b) of this title. Filter efficiencies shall be average dust spot efficiencies tested in accordance with American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE), Inc., Standard 52.2, 1999 edition, Method of Testing General Ventilation Air-Cleaning Devices for Removal Efficiency by Particle Size. All joints between filter segments, and between filter segments and the enclosing ductwork, shall have gaskets and seals to provide a positive seal against air leakage. Air handlers serving more than one room shall be considered as central air handlers. All documents published by ASHRAE as referenced in this section may be obtained by writing or calling the ASHRAE, Inc. at the following address or telephone number: ASHRAE, 1791 Tullie Circle, Northeast, Atlanta, Georgia 30329; telephone (404) 636-8400.

(I) Filtration requirements for air handling units serving single rooms requiring asepsis control. Dedicated air handlers serving only one room where asepsis control is required, such as, but not limited to, operating rooms, special procedure rooms, and treatment rooms shall be equipped with filters having efficiencies equal to, or greater than, those specified for patient care areas in Table 2 of §135.56(b) of this title.

(II) Filtration requirements for air handling units serving other single rooms. Dedicated air handlers serving all other single rooms shall be equipped with nominal filters installed at the return air system.

(III) Location of multiple filters. Where two filter beds are required by Table 2 of §135.56(b) of this title, filter bed number one shall be located upstream of the air conditioning equipment, and filter bed number two shall be downstream of the supply air blowers, cooling and heating coils.

(IV) Location of single filters. Where only one filter bed is required by Table 2 of §135.56(b) of this title, it shall be located upstream of the supply fan. Filter frames shall be durable and constructed to provide an airtight fit with the enclosing ductwork.

(V) Pressure monitoring devices. A manometer or draft gauge shall be installed across each filter bed having a required efficiency of 75% or more,

including laboratory hoods requiring high efficiency particulate air (HEPA) filters. The pressure monitoring device shall be mounted below the ceiling line within the ASC such that it can be observed by staff.

(D) Thermal and acoustical insulation for air handling systems. Asbestos containing insulation materials shall not be used.

(i) Thermal duct insulation. Air ducts and casings with outside surface temperature below the ambient dew point or temperature above 80 degrees Fahrenheit shall be provided with thermal insulation.

(ii) Insulation in air plenums and ducts. When installed, linings in air ducts and equipment shall meet the Erosion Test Method described in Underwriters Laboratories (UL), Standard 181, relating to Factory-Made Duct Materials and Air Duct Connectors, April 4, 1996 edition. This document may be obtained from the Underwriters Laboratories, 333 Pfingsten Road, Northbrook, Illinois 60062-2096.

(iii) Insulation flame spread and smoke developed ratings. Interior and exterior insulation, including finishes and adhesives on the exterior surfaces of ducts and equipment, shall have a flame spread rating of 25 or less and a smoke developed rating of 50 or less as required by NFPA 90A, Chapters 4 and 5 and as determined by an independent testing laboratory in accordance with NFPA 255, A Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 Edition.

(iv) Linings and acoustical traps. Duct lining and acoustical traps exposed to air movement shall not be used in ducts serving critical care areas. This requirement shall not apply to mixing boxes and acoustical traps that have approved nonabrasive coverings over such linings.

(v) Frangible insulation. Insulation of soft and spray-on types shall not be used where it is subject to air currents or mechanical erosion or where loose particles may create a maintenance problem or occupant discomfort.

(vi) Existing duct linings. Internal linings shall not be used in ducts, terminal boxes, or other air system components supplying operating rooms and the postoperative recovery suite, unless terminal filters of at least 90% efficiency are installed downstream of linings.

(E) Ventilation for anesthetizing locations. When anesthesia is administered, ventilation for anesthetizing locations, as defined in NFPA 99, §3-3, shall comply with NFPA 99, §13.4.1.2 and any specific ventilation requirements of clauses (i) - (iii) of this subparagraph.

(i) Smoke removal systems for anesthetizing locations. Smoke removal systems shall be provided in all windowless anesthetizing locations in accordance with NFPA 99, §6.4.1.2. Supply and exhaust systems for windowless anesthetizing locations shall be

arranged to automatically exhaust smoke and products of combustion, prevent recirculation of smoke originating within the surgical suite, and prevent the circulation of smoke entering the system intakes, without in either case interfering with the exhaust function of the system.

(ii) Smoke removal systems for surgical suites. Smoke removal systems shall be provided in all surgical suites in accordance with NFPA 99, §6.4.1.3.

(iii) Smoke exhaust grilles. Exhaust grilles for smoke evacuation systems shall be ceiling-mounted or wall-mounted within 12 inches of the ceiling.

(F) Location of return and exhaust air devices. The bottoms of wall-mounted return and exhaust air openings shall be at least four inches above the floor. Return air openings located less than six inches above the floor shall be provided with nominal filters. All exhaust air openings and return air openings located higher than six inches but less than seven feet above the floor shall be protected with grilles or screens having openings through which a one-half inch sphere will not pass.

(G) Ray protection. Ducts which penetrate construction intended for X-ray or other ray protection shall not impair the effectiveness of the protection.

(H) Fire damper requirements. Fire dampers shall be located and installed in all ducts at the point of penetration of a required two-hour or higher fire-rated wall or floor in accordance with the requirements of NFPA 101, §18.5.2.

(I) Smoke damper requirements. Smoke dampers shall be located and installed in accordance with the requirements of NFPA 101, §20 .3.7.3, and NFPA 90A, Chapter 5.

(i) Protection of ducts penetrating fire and smoke partitions. Combination fire and smoke leakage limiting dampers (Class II) shall be installed in accordance with manufacturer's instructions for all ducts penetrating one and two-hour rated fire and smoke partitions required by NFPA 101, §20.3.7, Subdivision of Building Space (not required in ASCs meeting the provisions of NFPA 101, §20.3.7.2, Exception Number 1).

(ii) Fail-safe installation. Combination smoke and fire dampers shall close on activation of the fire alarm system by smoke detectors installed and located as required by National Fire Protection Association 72, National Fire Alarm Code, 2002 Edition (NFPA 72), Chapter 8; NFPA 90A, Chapter 6; and NFPA 101, §20.3.5; the fire sprinkler system; and upon loss of power. Smoke dampers shall not close by fan shutdown alone unless it is a part of an engineered smoke removal system.

(iii) Interconnection of air handling fans and smoke dampers. Air handling fans and smoke damper controls may be interconnected so that closing of smoke dampers will not damage the ducts.

(iv) Frangible devices. Use of frangible devices for shutting smoke dampers is not permitted.

(J) Acceptable damper assemblies. Only fire damper and smoke damper assemblies integral with sleeves and listed for the intended purpose shall be acceptable.

(K) Duct access doors. Unobstructed access to duct openings in accordance with NFPA 90A, §4.3., shall be provided in ducts within reach and sight of every fire damper, smoke damper and smoke detector. Each opening shall be protected by an internally insulated door which shall be labeled externally to indicate the fire protection device located within.

(L) Restarting controls. Controls for restarting fans may be installed for convenient fire department use to assist in evacuation of smoke after a fire is controlled, provided that provisions are made to avoid possible damage to the system because of closed dampers. To accomplish this, smoke dampers shall be equipped with remote control devices.

(M) Make-up air. If air supply requirements in Table 2 of §135.56(b) of this title do not provide sufficient air for use by exhaust hoods and safety cabinets, filtered make-up air shall be ducted to maintain the required air flow direction in that room. Make-up systems for hoods shall be arranged to minimize short circuiting of air and to avoid reduction in air velocity at the point of contaminant capture.

(h) Piping systems and plumbing fixture requirements. All piping systems and plumbing fixtures shall be designed and installed in accordance with the requirements of the National Standard Plumbing Code Illustrated published by the National Association of Plumbing-Heating-Cooling Contractors (PHCC), 2003 edition, and this paragraph. The National Standard Plumbing Code may be obtained by writing or calling the PHCC at the following address or telephone number: Plumbing-Heating-Cooling Contractors, Post Office Box 6808, Falls Church, Virginia 22046; telephone (800) 533-7694.

(1) Piping systems.

(A) Water supply piping systems. Water service pipe to point of entrance to the building shall be brass pipe, copper tube (not less than type M when buried directly), copper pipe, cast iron water pipe, galvanized steel pipe, or approved plastic pipe. Domestic water distribution system piping within buildings shall be brass pipe, copper pipe, copper tube, or galvanized steel pipe. Piping systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand.

(i) Valves. Each water service main, branch main, riser, and branch to a group of fixtures shall be equipped with accessible and readily identifiable shutoff valves. Stop valves shall be provided at each fixture.

(ii) Backflow preventers. Backflow preventers (vacuum breakers) shall be installed on hose bibs, laboratory sinks, janitor sinks, bedpan flushing attachments, and all other fixtures to which hoses or tubing can be attached. Connections to high hazard sources,

e.g., X-ray film processors, shall be from a cold water hose bib through a reduced pressure principle type backflow preventer (RPBFP).

(iii) Flushing valves. Flush valves installed on plumbing fixtures shall be of a quiet operating type, equipped with silencers.

(iv) Capacity of water heating equipment. Water heating equipment shall have sufficient capacity to supply water for all clinical needs based on accepted engineering practices using actual number and type of fixtures and for heating, when applicable.

(v) Domestic hot water system. Hot water distribution system serving all patient care areas shall be under constant recirculation to provide continuous hot water at each hot water outlet.

(vi) Water temperature measurements. Water temperatures shall be measured at hot water point of use or at the inlet to processing equipment. Hot water temperature at point of use for patients, staff, and visitors shall be in the range of 105 to 120 degrees Fahrenheit.

(vii) Water storage tanks. Domestic water storage tank(s) shall be fabricated of corrosion-resistant metal or lined with noncorrosive material. When potable water storage tanks (hot and cold) are used, the water shall be used and replenished. Water shall not be stored in tanks for future use unless the water is tested weekly for contaminates/bacteria.

(viii) Purified water supply system. Purified water distribution system piping shall be task specific and include, but not necessarily be limited to, polypropylene (PP), polyvinylidene fluoride (PVDF) or polyvinyl chloride (PVC) pipe. Final installed purified water system piping assemblies shall be UL approved and fully comply with applicable American Society for Testing and Materials (ASTM) Fire Resistant/Smoke Density requirements. The applicable documents are available from ASTM International, 100 Barr Harbor Drive, Post Office Box C700, West Conshohocken, Pennsylvania 19428-2959.

(ix) Dead-end piping. Dead-end piping (risers with no flow, branches with no fixture) shall not be installed. In any renovation work, dead-end piping shall be removed. Empty risers, mains and branches installed for future use are permitted.

(B) Fire sprinkler systems. When provided, fire sprinkler systems shall comply with the requirements of NFPA 101, §9.7, Automatic Sprinklers and Other Extinguishing Equipment, and the requirements of this subparagraph. All fire sprinkler systems shall be designed, installed, and maintained in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems, 2002 Edition, and shall be certified as required by §135.55(c)(1)(C) of this title (relating to Construction, Inspections, and Approval of Project).

(C) Piped nonflammable medical gas and clinical vacuum systems. When provided, piped nonflammable medical gas and clinical vacuum system installations shall be

designed, installed, and certified in accordance with the requirements of NFPA 99, §5.1 for Level 1 Piped Systems and the requirements of this subparagraph.

(i) Outlets. Nonflammable medical gas and clinical vacuum outlets shall be provided in accordance with Table 3 of §135.56(c) of this title.

(ii) Installer qualifications. All installations of the medical gas piping systems including source tanks and related piping shall be done only by, or under the direct supervision of, a holder of a master plumber license or a journeyman plumber license with a medical gas piping installation endorsement issued by the Texas State Board of Plumbing Examiners.

(iii) Installer tests. Prior to closing of walls, the installer shall perform an initial pressure test, a blowdown test, a secondary pressure test, a cross-connection test, and a purge of the piping system as required by NFPA 99.

(iv) Qualifications for conducting verification tests and inspections. Verification testing shall be performed and inspected by a party, other than the installer, installing contractor, or material vendor. Testing shall be conducted by a medical gas system verifier registered with an acceptable organization by this department and is technically competent and experienced in the field of medical gas and vacuum pipeline testing and meets the requirements of The American Society of Safety Engineers (ASSE) Personnel Standard 6030, Professional Qualifications Standard for Medical Gas Systems. The document published by ASSE Personnel Standard 6030, Professional Qualifications Standard for Medical Gas Systems as referenced in this rule may be obtained by writing or calling The American Society of Safety Engineers (ASSE) at ASSE International Office, 901 Canterbury, Suite A, Westlake, Ohio 44145, telephone (440) 885-3040.

(v) Verification tests. Upon completion of the installer inspections and tests and after closing of walls, verification tests of the medical gas piping systems, the warning system, and the gas supply source shall be conducted. The verification tests shall include a cross-connection test, valve test, flow test, piping purge test, piping purity test, final tie-in test, operational pressure tests, and medical gas concentration test.

(vi) Verification test requirements. Verification tests of the medical gas piping system and the warning system shall be performed on all new piped medical gas systems, additions, renovations, or repaired portions of an existing system. All systems that are breached and components that are added, renovated, or replaced shall be inspected and appropriately tested. The breached portions of the systems subject to inspection and testing shall be all of the new and existing components in the immediate zone or area located upstream of the point or area of intrusion and downstream to the end of the system or a properly installed isolation valve.

(vii) Warning system verification tests. Verification tests of piped medical gas systems shall include tests of the source alarms and monitoring safeguards, master alarm systems, and the area alarm systems.

(viii) Source equipment verification tests. Source equipment verification tests shall include medical gas supply sources (bulk and manifold) and the compressed air source systems (compressors, dryers, filters, and regulators).

(ix) ASC responsibility. Before new piped medical gas systems, additions, renovations, or repaired portions of an existing system are put into use, ASC medical personnel shall be responsible for ensuring that the gas delivered at the outlet is the gas shown on the outlet label and that the proper connecting fittings are checked against their labels.

(x) Written certification. Upon successful completion of all verification tests, written certification for affected piped medical gas systems and piped medical vacuum systems including the supply sources and warning systems shall be provided by a party technically competent and experienced in the field of medical gas pipeline testing stating that the provisions of NFPA 99 have been adhered to and systems integrity has been achieved. The written certification shall be submitted directly to the ASC and the installer. A copy shall be available at final department construction inspection.

(xi) Documentation of medical gas and clinical vacuum outlets. Documentation of the installed, modified, extended or repaired medical gas piping system shall be submitted to the department by the same party certifying the piped medical gas systems. The number and type of medical gas outlets (e.g., oxygen, vacuum, medical air, nitrogen, nitrous oxide) shall be documented and arranged tabularly by room numbers and room types.

(D) Medical gas storage facilities. Main storage of medical gases may be outside or inside the ASC in accordance with NFPA 99, §5.1. Provision shall be made for additional separate storage of reserve gas cylinders necessary to complete at least one day's procedures.

(E) Multiple gas outlets on one medical gas outlet. Y-connections, "twinning", or other similar devices shall not be used on any medical gas outlet.

(F) Waste anesthetic gas disposal (WAGD) systems. Each space routinely used for administering inhalation anesthesia shall be provided with a WAGD system as required by NFPA 99, §5.1.3.7.

(2) Steam and hot water systems.

(A) Boilers. When provided, the boilers shall have the capacity, based upon the net ratings as published in The I-B-R Ratings Book for Boilers, Baseboard Radiation and Finned Tube (commercial) by the Hydronics Institute Division of GAMA, to supply the normal heating, hot water, and steam requirements of all systems and equipment. The document published by the Hydronics Institute Division of GAMA as referenced in this rule may be obtained by writing or calling the Hydronics Institute Division of GAMA at 35 Russo Place, Post Office Box 218, Berkeley Heights, New Jersey 07922, telephone (908) 464-8200.

(i) Boiler accessories. Boiler feed pumps, heating circulating pumps, condensate return pumps, and fuel oil pumps shall be connected and installed to provide normal and standby service.

(ii) Valves. Supply and return mains and risers of cooling, heating, and process steam systems shall be valved to isolate the various sections of each system. Each piece of equipment shall be valved at the supply and return ends except that vacuum condensate returns need not be valved at each piece of equipment.

(B) Boiler certification. When required, the ASC shall ensure compliance with Texas Department of Licensing and Regulation, Boiler Section, Texas Boiler Law, (Health and Safety Code, Chapter 755, Boilers), which requires certification documentation for boilers to be posted on site at each boiler installation.

(3) Drainage systems. Building sewers shall discharge into a community sewage system. Where such a system is not available, a facility providing sewage treatment shall conform to applicable local and state regulations.

(A) Above ground piping. Soil stacks and roof drains installed above ground within buildings shall be drain-waste-vent (DWV) weight or heavier and shall be: copper pipe, copper tube, cast iron pipe, or Schedule 40 polyvinyl chloride (PVC) pipe. Buildings or portions of buildings remodeled to an ASC need not comply with this requirement.

(B) Underground piping. All underground building drains shall be cast iron soil pipe, hard temper copper tube (DWV or heavier), acrylonitrile-butodiene-styrene (ABS) plastic pipe (DWV Schedule 40 or heavier), or PVC pipe (DWV Schedule 40 or heavier. Underground piping shall have at least 12 inches of earth cover or comply with local codes. Existing buildings or portions of buildings that are being remodeled need not comply with this subparagraph.

(C) Drains for chemical wastes. Separate drainage systems for chemical wastes (acids and other corrosive materials) shall be provided. Materials acceptable for chemical waste drainage systems shall include chemically resistant borosilicate glass pipe, high silicone content cast iron pipe, polypropylene plastic pipe, or plastic lined pipe.

(D) Drainage and waste piping. Drainage and waste piping shall not be installed above or below ceilings in operating rooms, special procedure rooms, and sterile processing rooms unless precautions are taken to protect the space below from leakage and condensation from necessary overhead piping. Secondary protection shall be required to drain. Any required secondary protection shall be labeled, "code required secondary drain system" every 20 feet in a highly visible print or label.

(4) Thermal insulation for piping systems and equipment. Asbestos containing insulation materials shall not be used.

(A) Insulation. Insulation shall be provided for the following:

(i) boilers, smoke breeching, and stacks;

(ii) steam supply and condensate return piping;

(iii) hot water piping and all hot water heaters, generators, converters, and storage tanks;

(iv) chilled water, refrigerant, other process piping, equipment operating with fluid temperatures below ambient dew point, and water supply and drainage piping on which condensation may occur. Insulation on cold surfaces shall include an exterior vapor barrier; and

(v) other piping, ducts, and equipment as necessary to maintain the efficiency of the system.

(B) Insulation flame spread. Flame spread shall not exceed 25 and smoke development rating shall not exceed 50 for pipe insulation as determined by an independent testing laboratory in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 Edition.

(5) Plumbing fixtures. Plumbing fixtures shall be made of nonabsorptive, acid-resistant materials and shall comply with the requirements of the National Standard Plumbing Code, and this paragraph.

(A) Sink and lavatory controls. All lavatories used by medical and nursing staff and by patients shall be trimmed with valves or electronic controls which can be operated without the use of hands. Blade handles used for this purpose shall not be less than four inches in length. Single lever or wrist blade devices may also be used.

(B) Clinical sink traps. Clinical sinks shall have an integral trap in which the upper portion of a visible trap seal provides a water surface.

(C) Sinks for disposal of plaster of paris. Sinks that are used for the disposal of plaster of paris shall have a plaster trap.

(D) Back-flow or siphoning. All plumbing fixtures and equipment shall be designed and installed to prevent the back-flow or back-siphonage of any material into the water supply. The over-the-rim type water inlet shall be used wherever possible. Vacuum-breaking devices shall be properly installed when an over-the-rim type water inlet cannot be utilized.

(E) Drinking fountain. Each drinking fountain shall be designed so that the water issues at an angle from the vertical, the end of the water orifice is above the rim of the bowl, and a guard is located over the orifice to protect it from lip contamination.

(F) Sterilizing equipment. All sterilizing equipment shall be designed and installed to prevent not only the contamination of the water supply but also the entrance of contaminating materials into the sterilizing units.

(G) Hose attachment. No hose shall be affixed to any faucet if the end of the hose can become submerged in contaminated liquid unless the faucet is equipped with an approved, properly installed vacuum breaker.

(H) Bedpan washers and sterilizers. When provided, bedpan washers and sterilizers shall be designed and installed so that both hot and cold water inlets shall be protected against back-siphonage at maximum water level.

(I) Flood level rim clearance. The water supply spouts for lavatories and sinks required in patient care areas shall be mounted so that their discharge points are a minimum of five inches above the rim of the fixture.

(J) Scrub sink controls. Freestanding scrub sinks and lavatories used for scrubbing in procedure rooms shall be trimmed with foot, knee, or electronic hands-free controls. Single lever wrist blades are not acceptable at scrub sinks.

(K) Floor drains or floor sinks. Where floor drains or floor sinks are installed, they shall be of a type that can be easily cleaned by removal of the cover. Removable stainless steel mesh shall be provided in addition to a grilled drain cover to prevent entry of large particles of waste which might cause stoppages.

(L) Under counter piping. Under counter piping and above floor drains shall be arranged (raised) so as not to interfere with cleaning of the floor below the equipment.

(M) Ice machines. All ice-making machines used for human consumption shall be of the self-dispensing type. Copper tubing shall be provided for supply connections to ice machines.

(i) General electrical requirements. This paragraph contains common electrical and essential emergency system requirements.

(1) Electrical requirements. All electrical material and equipment, including conductors, controls, and signaling devices, shall be installed in compliance with applicable sections of the NFPA 70, National Electrical Code, 2002 Edition, §517; NFPA 99, Chapter 14; the requirements of this subsection; and as necessary to provide a complete electrical system. Electrical systems and components shall be listed by nationally recognized listing agencies as complying with available standards and shall be installed in accordance with the listings and manufacturer’s instructions.

(A) All fixtures, switches, sockets, and other pieces of apparatus shall be maintained in a safe and working condition.

(B) Extension cords and cables shall not be used for permanent wiring.

(C) All electrical heating devices shall be equipped with a pilot light to indicate when the device is in service, unless equipped with a temperature limiting device integral with the heater.

(D) All equipment, fixtures, and appliances shall be properly grounded in accordance with NFPA 70.

(E) Under counter electrical installations shall be arranged (raised) to not interfere with cleaning of the floor below the equipment.

(2) Installation testing and certification.

(A) Installation testing. The electrical installations, including grounding continuity, fire alarm, nurses calling system and communication systems, shall be tested to demonstrate that equipment installation and operation is appropriate and functional. A written record of performance tests on special electrical systems and equipment shall show compliance with applicable codes and standards and shall be available to the department upon request.

(B) Grounding system testing. The grounding system shall be tested as described in NFPA 99, §4.3.3, for patient care areas in new or renovated work. The testing shall be performed by a qualified electrician or their qualified electrical testing agent. The electrical contractor shall provide a letter stating that the grounding system has been tested in accordance with NFPA 99, the testing device use complies with NFPA 99, and whether the grounding system passed the test. The letter shall be signed by the qualified electrical contractor, or their designated qualified electrical testing agent, certifying that the system has been tested and the results of the test are indicated.

(3) Electrical safeguards. Shielded isolation transformers, voltage regulators, filters, surge suppressors, and other safeguards shall be provided as required where power line disturbances are likely to affect fire alarm components, data processing, equipment used for treatment, and automated laboratory diagnostic equipment.

(4) Services and switchboards. Electrical service and switchboards serving the required ASC components shall be installed above the designated 100-year flood plain. Main switchboards shall be located in separate rooms, separated from adjacent areas with one-hour fire-rated enclosures containing only electrical switchgear and distribution panels and shall be accessible to authorized persons only. These rooms shall be ventilated to provide an environment free of corrosive or explosive fumes and gases, or any flammable and combustible materials. Switchboards shall be located convenient for use and readily accessible for maintenance as required by NFPA 70, Article 384. Overload protective devices shall operate properly in ambient temperatures.

(5) Panelboard. Panelboards serving normal lighting and appliance circuits shall be located on the same floor as the circuits they serve. Panelboards serving critical branch

emergency circuits shall be located on each floor that has major users (operating rooms, special procedure room, etc.) and may also serve the floor above and the floor below. Panelboards serving life safety branch circuits may serve three floors, the floor where the panelboard is located, and the floors above and below.

(6) Wiring. All conductors for controls, equipment, lighting and power operating at 100 volts or higher shall be installed in metal or metallic raceways in accordance with the requirements of NFPA 70, Article 517. All surface mounted wiring operating at less than 100 volts shall be protected from mechanical injury with metal raceways to a height of seven feet above the floor. Conduits and cables shall be supported in accordance with NFPA 70, Article 300.

(7) Mechanical protection of the emergency system. The wiring of the emergency system shall be mechanically protected by installation in nonflexible metal raceways in accordance with NFPA 70, §517.30(C)(3).

(8) Lighting.

(A) Lighting intensity for staff and patient needs shall comply with guidelines for health care facilities set forth in the Illuminating Engineering Society of North America (IESNA) Handbook, 2000 edition, published by the IESNA, 120 Wall Street, Floor 17, New York, New York 10005.

(i) Consideration shall be given to controlling light intensity and wavelength to prevent harm to the patient's eyes.

(ii) Approaches to buildings and parking lots, and all spaces within buildings shall have fixtures that can be illuminated as necessary. All rooms including storerooms, electrical and mechanical equipment rooms, and all attics shall have sufficient artificial lighting so that all spaces shall be clearly visible.

(iii) Consideration shall be given to the special needs of the elderly. Excessive contrast in lighting levels that makes effective sight adaptation difficult shall be minimized.

(B) Means of egress and exit sign lighting intensity shall comply with NFPA 101, §§7.8, 7.9, and 7.10.

(C) Electric lamps, which may be subject to breakage or which are installed in fixtures in confined locations when near woodwork, paper, clothing, or other combustible materials, shall be protected by wire guards, or plastic shields.

(D) Ceiling mounted surgical and examination light fixtures shall be suspended from rigid support structures mounted above the ceiling.

(E) Operating rooms shall have general lighting in addition to local lighting provided by special lighting units at the surgical tables. Each fixed special lighting unit at the tables, except for portable units, shall be connected to an independent circuit.

(F) X-ray film illuminators for handling at least two films simultaneously shall be provided in each operating room and special procedure room. When the entire surgical suite is provided with digital imaging system capabilities the film illuminators may be omitted.

(9) Receptacles. Only listed hospital grade single-grounding or duplex-grounding receptacles shall be used in the operating rooms, special procedure rooms, postoperative recovery suite, and all patient care areas. This does not apply to special purpose receptacles.

(A) Installations of multiple-ganged receptacles shall not be permitted in patient care areas.

(B) Electrical outlets powered from the critical branch shall be provided in all patient care, procedure and treatment locations in accordance with NFPA 99, §4.4.2.2.2.3. At least one receptacle at each patient treatment or procedure location shall be powered from the normal power panel. All receptacles powered from the critical branch shall be colored red.

(C) Replacement of malfunctioning receptacles and installation of new receptacles powered from the critical branch in existing facilities shall be accomplished with receptacles of the same distinct color as the existing receptacles.

(D) All critical care area receptacles shall be identified. The face plate for the receptacle(s) shall have a nonremovable label or be engraved indicating the panel and circuit number.

(E) In locations where mobile X-ray or other equipment requiring special electrical configuration is used, the additional receptacles shall be distinctively marked for the special use.

(F) Each receptacle shall be grounded to the reference grounding point by means of a green insulated copper equipment grounding conductor in accordance with NFPA 70, §517-13.

(G) Each operating room and special procedure room shall have at least four duplex receptacles located convenient to the head of the procedure table and one receptacle on the other walls.

(H) Each work table or counter shall have access to one duplex receptacle for every six feet of table or counter space or fraction thereof.

(I) A minimum of one duplex receptacle in each wall shall be installed in each work area or room other than storage or lockers.

(J) Appliances shall be grounded in accordance with NFPA 99, Chapter 9.

(K) Ground fault circuit interrupters (GFCI) receptacles shall be provided for all general use receptacles located within three feet of a wash basin or sink. When GFCI receptacles are used, they shall be connected to not affect other devices connected to the circuit in the event of a trip. Receptacles connected to the critical branch that may be used for equipment that should not be interrupted do not have to be GFCI protected. Receptacles in wet locations, as defined by NFPA 70, §§517.20 and 517.21, shall be GFCI protected regardless of the branch of the electrical system serving the receptacle.

(10) Equipment.

(A) The following shall be powered from the Type I essential electrical system in accordance with the requirements of NFPA 99, §§3-4.2.2.3, when such a system is required for safe operation of the ASC referenced in paragraph (14) of this subsection.

(i) Boiler accessories including feed pumps, heat-circulating pumps, condensate return pumps, fuel oil pumps, and waste heat boilers shall be connected to the equipment system.

(ii) Ventilating system serving preoperative areas, operating rooms, and the postoperative recovery suite shall be connected to the equipment system in accordance with the requirements of NFPA 99, Chapter 3.

(B) Laser equipment shall be installed according to manufacturer recommendations and shall be registered with Department of State Health Services, Radiation Safety Licensing Branch, Post Office Box 149347, Austin, Texas 78714-9347.

(C) A "kill switch" shall be provided for disconnection of each HVAC serving the building in accordance with the requirements of NFPA 90A, §6.2.1.

(11) Wet patient care location. Wet patient care locations shall be protected against shock in accordance with the requirements of NFPA 99, §4.3.2.2.9.1.

(12) Grounding requirements. Fixed electrical equipment shall be grounded in accordance with the requirements of NFPA 99, §4.3.3.1, and NFPA 70, Article 517.

(13) Nurses calling systems.

(A) A nurse emergency calling system shall be installed in all toilets used by patients to summon nursing staff in an emergency. Activation of the system shall sound an audible signal which repeats every five seconds at a staffed location, and shall activate a distinct visible signal outside of toilet room where the call originated. The visible and audible signals shall be cancelable only at the patient calling station. Activation of the system shall also activate distinct visible signals in the clean workroom, in the soiled workroom, and if provided, in the nourishment station.

(B) A staff emergency assistance calling system station shall be located in each operating room, treatment room, examination room, postoperative recovery, and preoperative holding area to be used by staff to summon additional help in an emergency. Activation of the system shall sound an audible signal at a staffed location, indicate type and location of call on the system monitor, and activate a distinct visible signal in the corridor at the door. Additional visible signals shall be installed at corridor intersections in multi-corridor facilities. Distinct visible and audible signals shall be activated in the clean workroom, in soiled workroom, sterile processing room, equipment storage, and if provided, in the nourishment station.

(14) Essential electrical system. The essential electrical system shall comply with the requirements of NFPA 99, §4.4.

(A) A Type 1 essential electrical system shall be installed, maintained and tested in each ASC in accordance with requirements of NFPA 99, §4.4; NFPA 101, §20.2.9; and National Fire Protection Association 110, Standard for Emergency and Standby Power Systems, 2002 Edition.

(i) At least one autoclaving/sterilizing equipment shall be connected to the emergency electrical essential power system.

(ii) One electrical outlet connected to the life safety branch of the electrical system shall be provided adjacent to (or on) the emergency generator.

(iii) The battery charger for emergency lighting at the emergency generator shall be connected to the life safety branch of the electrical system.

(B) Fuel storage capacity for an on-site generator for a Type 1 essential electrical system shall allow continuous operation, under full load for eight hours of testing as required by NFPA 99, §4.4.4.1.1.2.

(C) When a vapor liquefied petroleum gas (LPG - natural gas) system is used, the 24-hour fuel capacity on-site is not required. The vapor withdrawal LPG system shall require a dedicated fuel supply.

(D) When the emergency generator(s) and electrical transformer(s) are located within the same area, they shall be located at least 10 feet apart.

(15) Fire alarm system. A fire alarm system which complies with NFPA 101, §20.3.4, and with NFPA 72, Chapter 6 requirements, shall be provided in each facility. The required fire alarm system components are as follows.

(A) A fire alarm control panel (FACP) shall be installed at a visual location such as the main lobby. A remote fire alarm annunciator listed for fire alarm service and installed at a continuously attended location and capable of indicating both visual and audible

alarm, trouble, and supervisory signals in accordance with the requirements of NFPA 72 may be substituted for the FACP.

(B) Manual fire alarm pull stations shall be installed in accordance with NFPA 101, §20.3.4.

(C) Ceiling-mounted smoke detector(s) shall be installed in room containing the FACP when this room is not attended continuously by staff as required by NFPA 72, §4.4.5.

(D) Smoke detectors shall be installed in air ducts in accordance with NFPA 72, §5.14.4.2 and §5.14.5 and NFPA 90A, §6.4.2.

(E) Smoke detectors shall be installed in return air ducts in accordance with requirements of NFPA 72 §5.14.4.2.2 and §5.14.5 and NFPA 90A, §6.4.2.2.

(F) Fire sprinkler system water flow switches shall be installed in accordance with requirements of NFPA 101, §9.6.2; NFPA 13, §6.9; and NFPA 72, §8.5.3.3.3.4.

(G) Sprinkler system valve supervisory switches shall be installed in accordance with the requirements of NFPA 72, §6.8.5.5.

(H) A fire alarm signal notification which complies with NFPA 101, §9.6.3, shall be provided to alert occupants of fire or other emergency.

(I) Audible alarm indicating devices shall be installed in accordance with the requirements of NFPA 101, §20.3.4, and NFPA 72, §7.4.

(J) Visual fire alarm indicating devices which comply in accordance with the requirements of NFPA 72, §7.5, shall be provided.

(K) Devices for transmitting alarm for alerting the local fire brigade or municipal fire department of fire or other emergency shall be provided. The devices shall be listed for the fire alarm service by a nationally recognized laboratory, and be installed in accordance with such listing and the requirements of NFPA 72.

(L) Wiring for fire alarm detection circuits and fire alarm notification circuits shall comply with requirements of NFPA 70, Article 760.

§135.53. Elevators, Escalators, and Conveyors.

(a) Elevators. All buildings that have patient services located on other than the main entrance floor shall have electric or electrohydraulic elevators. The elevators shall be installed in sufficient quantity, capacity, and speed to ensure that the average interval of dispatch time will not exceed one minute, and average peak loading can be accommodated. Elevators shall also give access to all building levels normally used by the public. Escalators and conveyors are not

required but, when provided, shall comply with these requirements and the requirement of §20.3 of the National Fire Protection Association 101, Life Safety Code, 2003 Edition (NFPA 101), published by the National Fire Protection Association. All documents published by the NFPA as referenced in this section may be obtained by writing or calling the NFPA at the following address and telephone number: Post Office Box 9101, 1 Batterymarch Park, Quincy, Massachusetts 02269-9101, (800) 344-3555.

(b) Requirements for new elevators, escalators, and conveyors. New elevators, escalators and conveyors shall be installed in accordance with the requirements of Health and Safety Code, Chapter 754, Elevators, Escalators, and Related Equipment, and A17.1 Safety Code for Elevators and Escalators, 2000 edition, published by the American Society of Mechanical Engineers (ASME) and the American National Standards Institute (ANSI). All documents published by the ASME/ANSI as referenced in this section may be obtained by writing the ANSI, United Engineering Center, 345 East 47th Street, New York, New York 10017.

(1) Location. Elevators shall not open to an exit.

(2) Elevator car size. A facility located above the ground floor must have an elevator of sufficient size to accommodate a gurney available at all times. Minimum elevator car size shall be five feet wide and seven feet deep. When an operating room(s) is located on a different floor than the preoperative area or the postoperative recovery suite, a hospital-type elevator shall be provided. Cars of hospital-type elevators shall be at least five feet eight inches wide by eight feet six inches deep.

(3) Car door opening. The smallest elevator car door opening shall be at least three feet wide and seven feet high.

(4) Elevator and elevator shaft doors. When light beams are used for operating door opening devices, the beams shall be used in combination with door edge devices and shall be interconnected with a system of smoke detectors. The light control feature shall be disengaged when smoke is detected in any elevator lobby.

(5) Type of controls and alarms. Elevator call buttons, controls, and door safety stops shall be of a type that will not be activated by heat or smoke.

(6) Leveling. All elevators shall be equipped with an automatic leveling device of the two-way automatic maintaining type with an accuracy of one-half inch.

(7) Operation. All elevators, except freight elevators, shall be equipped with a two-way key operated service switch permitting cars to bypass all landing button calls and be dispatched directly to any floor.

(8) Accessibility of controls and alarms. Elevator controls, alarm buttons, and telephones shall be accessible to wheelchair occupants in accordance with the Americans with Disabilities Act.

(9) Smoke detection system. A smoke detection system for elevator recall shall be located in elevator lobbies, elevator machine rooms and at the top of elevator hoist ways as required by NFPA 72, §6.15.3.10.

(A) The elevator recall smoke detection system in new construction shall comply with requirements of American Society of Mechanical Engineers/American National Standards Institute (ASME/ANSI) A17.1, Safety Code for Elevators and Escalators, 2000 edition. The publications of the ASME/ANSI referenced in this section may be obtained by writing ASME/ANSI, United Engineering Center, 345 East 47th Street, New York, New York 10017.

(B) The elevator recall smoke detection system in existing ambulatory surgical centers (ASCs) shall comply with requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators, 2002 edition.

(10) Elevator machine rooms. Elevator machine rooms that contain solid-state equipment for elevators having a travel distance of more than 50 feet above the level of exit discharge or more than 30 feet below the level of exit discharge shall be provided with independent ventilation or air conditioning systems with the capability to maintain an operating temperature during fire fighter service operations. The operating temperature shall be established by the elevator equipment manufacturer's specifications and shall be posted in each such elevator machine room. When standby power is connected to the elevator, the machine room ventilation or air conditioning shall be connected to standby power. These requirements are not applicable to existing elevators.

(11) Testing. An ASC shall have all elevators and escalators routinely and periodically inspected and tested as specified in ASME/ANSI A17.1, Safety Code for Elevators and Escalators, 2000 edition. All elevators equipped with fire fighter service shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by NFPA 101, §9.4.6.

(12) Certification. An ASC shall obtain a certificate of inspection evidencing that the elevators, escalators, conveyors, and related equipment were inspected in accordance with the requirements in Health and Safety Code (HSC), Chapter 754, Subchapter B, and determined to be in compliance with the safety standards adopted under HSC, §754.014, administered by the Texas Department of Licensing and Regulation. The certificate of inspection shall be on record in each ASC.

(c) Requirements for existing elevators, escalators, and conveyors. Existing elevators and escalators shall comply with the ASME/ANSI A17.3, Safety Code for Elevators and Escalators, 1996 edition. All existing elevators having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for fire fighting or rescue purposes shall conform to Fire Fighters' Service Requirements of ASME/ANSI A17.3 as required by NFPA 101, §9.4.3.

§135.54. Preparation, Submittal, Review and Approval of Plans, and Retention of Records.

(a) General.

(1) Ambulatory surgical center (ASC) owners/operators shall not begin construction of a new building, additions to or renovations or conversions of existing buildings until the department approves final construction documents.

(2) Plans and specifications describing the construction of new buildings and additions to or renovations and conversions of existing buildings shall be prepared by registered architects and/or licensed professional engineers and meet the requirements of this subchapter.

(3) The names of spaces used in the functional program narrative, preliminary documents, final construction documents and specifications shall be consistent with the names of the spaces used in this chapter.

(4) The department shall notify the ASC owner/operator of the result of its review of each type of submission discussed in this section.

(5) The ASC owner/operator shall respond to all department requests for additional information, including providing a plan of correction for deficiencies cited by the department.

(6) Once final construction documents are approved, the ASC owner/operator shall request inspections in accordance with §135.55 of this title (relating to Construction, Inspections, and Approval of Project).

(7) When construction is delayed for longer than one year from the plan approval or self-certification approval date, construction documents shall be resubmitted to the department for review and approval. The plans shall be accompanied by a new application for plan review and functional program narrative.

(8) The ASC owner/operator shall provide written notification to the department when a project has been placed on hold, canceled, or abandoned.

(9) The department may close a project file after one year of assigning an application number to a project if the project has been placed on hold.

(b) Submission of projects and assignment of application number.

(1) The ASC owner/operator or representative shall submit the following items to the department in care of the mailing or overnight delivery address that appears on the application for plan review:

(A) a completed and signed application for plan review. The application for plan review may be obtained by calling the department’s architectural review group by telephone at (512) 834-6649 or visit the Architectural Review at www.dshs.state.tx.us/hfp;

(B) a functional program narrative in accordance with subsection (d) of this section; and

(C) final construction documents in accordance with subsection (f) of this section.

(2) The cost of submitting documents/plans and specifications shall be borne by the sender.

(3) Once the department has determined that the submission required in paragraph (1) of this subsection is complete, the department shall assign an application number to the project that shall be referenced on all documents and correspondence related to the project. Final construction documents shall be reviewed in the chronological order received.

(4) All deficiencies noted in the final plan review shall be satisfactorily resolved before approval of project for construction will be granted.

(5) Construction shall not begin until the ASC owner/operator of the facility receives written notification from the department that the final construction documents have been approved.

(c) Feasibility conference. An ASC owner/operator or representative may request a feasibility conference. A feasibility conference is an informal meeting between a member of the department's architectural review group staff and the ASC owner/operator or representative to determine the feasibility of a project, for consultation and informational purposes, and to facilitate and establish understanding of compliance with the rules and codes.

(1) A feasibility conference is not a substitute for plan review.

(2) An ASC owner/operator or representative may schedule a feasibility conference by calling the department's architectural review group by telephone number (512) 834-6649.

(3) The ASC owner/operator or representative shall provide at the feasibility conference the items in subsection (b)(1)(A) - (C) of this section and a set of preliminary plans or final construction documents.

(4) The ASC owner/operator or representative is responsible for recording conference notes and shall submit the notes to the department.

(d) Functional program narrative. The ASC owner/operator shall submit a functional program narrative to the department with each new project in accordance with subsection (b)(1)(B) of this section. The functional program narrative shall be presented on facility letterhead, signed by ASC administration, include the functional description of each space, and the following:

(1) departmental relationships and other basic information relating to the fulfillment of the facility's objectives;

(2) a description of each function to be performed, approximate space needed for these functions, occupants of the various spaces, projected occupant load, types of equipment required, interrelationship of various functions and spaces, and any special design features;

(3) energy conservation measures, included in building, mechanical, and electrical designs;

(4) a description of the type of asepsis control in diagnostic and treatment areas; and

(5) the type of construction (existing or proposed) as stated in §20.1.6 of National Fire Protection Association 101, Life Safety Code, 2003 Edition (NFPA 101), published by the National Fire Protection Association. All documents published by the NFPA as referenced in this section may be obtained by writing or calling the NFPA at the following address and telephone number: 1 Batterymarch Park, Quincy, Massachusetts 02169-7471, (800) 344-3555.

(e) Preliminary documents. The department may request preliminary documents. If requested by the department, the submission shall consist of the items in subsection (b)(1)(A) - (C) of this section, preliminary plans, and outline specifications. The documents shall contain sufficient information to establish the project scope, description of functions to be performed, project location, required fire safety and exiting requirements, building construction type, compartmentation showing fire and smoke barriers, and the usage of all spaces, areas, and rooms on every floor level.

(f) Final construction documents. Final construction documents and specifications shall be submitted to the department for review and approval prior to start of construction. All final documents and specifications shall be appropriately sealed and signed by the projects's registered architect and professional engineer(s) licensed by the State of Texas.

(1) Submission of final construction documents. The ASC owner/operator shall submit to the department for review and approval the items in subsection (b)(1)(A) - (C) of this section (if not previously submitted with preliminary documents) and one set of final construction documents and specifications covering the construction of new buildings or alterations, additions, conversions, modernizations, or renovations to existing buildings.

(2) Preparation of final construction documents. Construction documents shall be well-prepared so that clear and distinct prints may be obtained, shall be accurately and adequately dimensioned, shall include all necessary explanatory notes, schedules, and legends, and shall be adequate for contract purposes. Compliance with model building codes and this chapter shall be indicated. The type of construction, as classified by National Fire Protection Association 220, Standard on Types of Building Construction, 1999 Edition, shall be provided for existing and new facilities. Final plans shall be drawn to a sufficiently large-scale to clearly

illustrate the proposed design but not less than one-eighth inch equals one foot. All spaces shall be identified by usage (using the names of spaces used in this chapter) on all plans (architectural, fire safety, mechanical, electrical, etc.) submitted. Separate drawings shall be prepared for each of the following branches of work.

(A) Architectural plans. Architectural drawings shall include the following:

(i) a map of the area within a 500 foot radius of the facility site shall be provided and any hazardous and undesirable location noted in §135.52(a) of this title (relating to Construction Requirements for a New Ambulatory Surgical Center) shall be identified;

(ii) site plan showing all new topography, newly established levels and grades, existing structures on the site (if any), new buildings and structures, roadways, parking, walks, easement, overhead or underground utilities or service lines, and the extent of the areas to be landscaped. All structures which are to be removed under the construction contract and improvements shall be shown. A general description of the immediate area surrounding the site shall be provided;

(iii) plan of each floor and roof to include fire and smoke separation, means of egress, and identification of all spaces;

(iv) schedules of doors, windows, and finishes;

(v) elevations of each facade;

(vi) sections through building; and

(vii) scaled details as necessary.

(B) Fire safety plans. These drawings shall be provided for all newly constructed buildings, conversions of existing buildings for facilities, additions to existing licensed facilities, and remodeled portions of existing buildings containing licensed facilities. Fire safety plans shall be of a sufficiently large-scale to clearly illustrate the proposed design but not less than one-sixteenth inch equals one foot and shall include the following information:

(i) separate fire safety plans (preferably one floor plan per sheet) shall indicate location of fire protection rated walls and partitions, location and fire resistance rating of each fire damper, and the required means of egress (corridors, stairs, exits, exit passageways);

(I) when a new building is to contain a proposed facility, when an existing building is converted to a facility, or when an addition is made to an existing facility building, plans of each floor and roof shall be provided;

(II) when a portion of a building is remodeled or when a new service is added, only the plan of the floor where the remodeling will take place or new service will be introduced, and the plan of the floor of discharge shall be provided;

(ii) designated smoke compartments with floor areas of each compartment, location, and fire resistance rating (one or two hour) of each smoke partition, location, type, and fire resistance rating of each smoke damper;

(iii) location of all required fire alarm devices, including all fire alarm control panels, manual pull stations, audible and visual fire alarm signaling devices, smoke detectors (ceiling and duct-mounted), fire alarm annunciators, fire alarm transmission devices, fire sprinkler flow switches, and control valve supervisory switches on each of the floor plans; and

(iv) areas protected with fire sprinkler systems (pendant, sidewall or upright, normal or quick response, and temperature rating shall be indicated), stand pipe system risers and sizes with valves and inside and outside fire department connections, fire sprinkler risers and sizes, location and type of portable fire extinguishers.

(C) Equipment drawings. Equipment drawings shall include the following:

(i) all equipment necessary for the operation of the facility as planned. The design shall indicate provisions for the installation of large and special items of equipment and for service accessibility;

(ii) fixed equipment (equipment which is permanently affixed to the building or which must be permanently connected to a service distribution system designed and installed during construction for the specific use of the equipment). The term "fixed equipment" includes items such as laundry extractors, walk-in refrigerators, communication systems, and built-in casework (cabinets);

(iii) movable equipment (equipment not described in clause (ii) of this subparagraph as fixed). The term "moveable equipment" includes wheeled equipment, plug-in type monitoring equipment, and relocatable items; and

(iv) equipment which is not included in the construction contract but which requires mechanical or electrical service connections or construction modifications. The equipment described in this clause shall be identified on the drawings to ensure its coordination with the architectural, mechanical, and electrical phases of construction.

(D) Structural drawings. Structural drawings shall include:

(i) plans for foundations, floors, roofs, and all intermediate levels;

(ii) a complete design with sizes, sections, and the relative location of the various members;

(iii) a schedule of beams, girders, and columns;

(iv) dimensioned floor levels, column centers, and offsets;

(v) details of all special connections, assemblies, and expansion joints; and

(vi) special openings and pipe sleeves dimensioned or otherwise noted for easy reference.

(E) Mechanical drawings. Mechanical drawings shall include:

(i) complete ventilation systems (supply, return, exhaust), all fire and smoke partitions, locations of all dampers, registers, and grilles, air volume flow at each device, and identification of all spaces (e.g., corridor, patient room, operating room);

(ii) boilers, chillers, heating and cooling piping systems (steam piping, hot water, chilled water), and associated pumps;

(iii) cold and warm water supply systems, water heaters, storage tanks, circulating pumps, plumbing fixtures, emergency water storage tank(s) (if provided), and special piping systems such as for deionized water;

(iv) nonflammable medical gas piping (oxygen, compressed medical air, vacuum systems, nitrous oxide), emergency shutoff valves, pressure gages, alarm modules, gas outlets;

(v) drain piping systems (waste and soiled piping systems, laboratory drain systems, roof drain systems);

(vi) fire protection piping systems (sprinkler piping systems, fire standpipe systems, water or chemical extinguisher piping system for cooking equipment);

(vii) piping riser diagrams, equipment schedules, control diagrams or narrative description of controls, filters, and location of all duct-mounted smoke detectors; and

(viii) laboratory exhaust and safety cabinets.

(F) Electrical drawings. Electrical drawings shall include:

(i) electrical service entrance with service switches, service feeders to the public service feeders, and characteristics of the light and power current including transformers and their connections;

(ii) location of all normal electrical system and essential electrical system conduits, wiring, receptacles, light fixtures, switches, and equipment which require permanent electrical connections, on plans of each building level:

(I) light fixtures marked distinctly to indicate connection to critical or life safety branch circuits or to normal lighting circuits; and

(II) outlets marked distinctly to indicate connection to critical, life safety, or normal power circuits;

(iii) telephone and communication, fixed computers, terminals, connections, outlets, and equipment;

(iv) nurses calling system showing all stations, signals, and annunciators on the plans;

(v) in addition to electrical plans, single line diagrams prepared for:

(I) complete electrical system consisting of the normal electrical system and the essential electrical system including the on-site generator(s), transfer switch(es), emergency system (life safety branch and critical branch), equipment system, panels, subpanels, transformers, conduit, wire sizes, main switchboard, power panels, light panels, and equipment for additions to existing buildings, proposed new facilities, and remodeled portions of existing facilities. Feeder and conduit sizes shall be shown with schedule of feeder breakers or switches;

(II) complete nurses calling system with all stations, signals, annunciators, etc. with room number noted by each device and indicating the type of system (nurses regular calling system, nurses emergency calling system, or staff emergency assistance calling system);

(III) a single line diagram of the complete fire alarm system showing all control panels, signaling and detection devices and the room number where each device is located; and

(vi) schedules of all panels indicating connection to life safety branch, critical branch, equipment system or normal system, and connected load at each panel.

(3) Construction document changes. Any changes to the final construction documents which affect or change the function, design, or designated use of an area shall be submitted to the department for approval prior to authorization of the modifications.

(g) Special submittals.

(1) Self-certification.

(A) In an effort to shorten the plan review and approval process, the ASC owner/operator or representative may request approval of final construction documents under the self-certification review process.

(i) The owner/operator shall submit the items in subsection (b)(1)(A) - (C) of this section and a completed self-certification form, signed by the ASC owner/operator, architect of record, and engineer(s) of record attesting that the plans and specifications are based upon and comply with the requirements of this chapter.

(ii) By signing and submitting the self-certification form, the ASC owner/operator accepts the following conditions.

(I) The department retains the right to review the final construction documents, conduct inspections of the project, and withdraw its approval.

(II) The ASC owner/operator has a continuing obligation to make any changes the department requires to comply with the licensing rules whether or not physical plant construction or alterations have been completed.

(III) The ASC owner/operator is ultimately responsible for compliance with Health and Safety Code, Chapter 243, Texas Ambulatory Surgical Center Licensing Act, and this chapter.

(B) The department shall review the request for self-certification and notify the ASC owner/operator if the request is approved or denied. If denied, the department shall review the final construction documents in the chronological order in which the documents were received. Construction shall not begin until the final construction documents have been reviewed and approved.

(2) Minor project. If a ASC owner/operator believes that a proposed project is a minor project, the ASC owner/operator shall provide to the department a brief written description of the proposed project and floor plans of the areas of work. The minor project request shall be mailed or faxed.

(A) If it is determined that the proposed project is a minor project, the department shall notify the ASC owner/operator of the approval, and state the number of inspections that shall be required. A minimum of one inspection shall be conducted.

(B) The department shall notify the ASC owner/operator that a proposed project is not approved as a minor project, if the project involves any of the following:

(i) remodeling or alterations which involve alterations to load bearing members or partitions;

(ii) a change in functional operation;

(iii) a change that affects fire safety (e.g., modifications to the fire, smoke, and corridor walls);

(iv) additional services for which the ASC is not currently licensed; and

(v) a significant change to the mechanical, electrical, plumbing, fire protection, or piped medical system.

(C) The ASC owner/operator shall submit final construction documents in accordance with subsection (f) of this section if the department determines the project is not a minor project.

(3) Fire sprinkler systems.

(A) When the sole purpose of a project is installation of a sprinkler system, whether a partial or complete system, the ASC owner/operator shall submit to the department for approval the items in subsection (b)(1)(A) - (C) of this section and sprinkler documents.

(B) Fire sprinkler systems shall comply with the requirements of National Fire Protection Association 13, Standard for the Installation of Sprinkler Systems, 2002 Edition (NFPA 13), and shall be designed or reviewed by an engineer who is registered by the Texas Board of Professional Engineers in fire protection specialty or is experienced in hydraulic design and fire sprinkler system installation. A short resume shall be submitted if registration is not in fire protection specialty.

(i) Fire sprinkler working plans, complete hydraulic calculations and water supply information shall be prepared in accordance with NFPA 13, §§14.1, 14.2 and 14.3, for new fire sprinkler systems, alterations of and additions to existing ones.

(ii) One set of fire sprinkler working plans, calculations, and water supply information shall be forwarded to the department together with the professional engineer's (P.E. licensed in the State of Texas) certification letter stating that the sprinkler system design complies with the requirements of NFPA 13. Certification of the fire sprinkler system shall be submitted prior to system installation.

(iii) Upon completion of the fire sprinkler system installation and any required corrections, written certification by the engineer, stating that the fire sprinkler system is installed in accordance with NFPA 13 requirements, shall be submitted prior to or with the written request for the final construction inspection of the project.

(h) Retention of drawings, manuals, and design data.

(1) As built drawings. Upon occupancy of the building or portion thereof, the owner shall retain as part of the ASC's permanent records, a complete set of legible architectural plans of each building level, fire safety plans as described in subsection (f)(2)(B) of this section for each floor reflecting fire safety requirements, and all single line diagrams described in subsection (f)(2)(F)(v) of this section, drawings for fixed equipment, and mechanical and electrical systems, as installed or built.

(2) Manuals. Upon completion of the contract, the owner shall retain as part of the ASC's permanent records a complete set of manufacturers' operating, maintenance, and preventive maintenance instructions; parts lists; and procurement information with numbers and a description for each piece of equipment. Facility staff shal1 also be provided with instructions on how to properly operate systems and equipment. Required information shall include energy ratings as needed for future conservation calculations.

(3) Design data. The owner shall retain in the ASC's permanent records complete design data for the facility. This shall include structural design loadings; summary of heat loss assumption and calculations; estimated water consumption; medical gas outlet listing; list of applicable codes; and electric power requirements of installed equipment. All such data shall be supplied to facilitate future alterations, additions, and changes, including, but not limited to, energy audits and retrofit for energy conservation.

§135.55. Construction, Inspections, and Approval of Project.

(a) Construction.

(1) Major construction. Construction, of other than minor alterations, shall not commence until the final plan review deficiencies have been satisfactorily resolved, the appropriate licensing fee has been paid, and the department has issued a letter granting approval to begin construction. Such authorization does not constitute release from the requirements contained in this chapter. If the construction takes place in or near occupied areas, adequate provision shall be made for the safety and comfort of occupants.

(2) Construction commencement notification. The architect of record or the ambulatory surgical center (ASC) owner/operator shall provide written notification to the department when construction will commence. The department shall be notified in writing of any change in the completion schedules.

(3) Completion. Construction shall be completed in compliance with the construction documents including all addenda or modifications approved for the project.

(b) Construction inspections. All ASCs including those which maintain certification under Title XVIII of the Social Security Act (42 United States Code, §§1395 et seq), and those which maintain accreditation by a Centers for Medicare and Medicaid Services-approved organization are subject to construction inspections.

(1) Number of construction inspections. A minimum of two construction inspections of the project is generally required for the purpose of verifying compliance with subchapters B and C of this chapter and the approved plans and specifications. The final plan approval letter or the self-certification approval letter shall inform the architect of record and the owner as to the minimum number of inspections required for the project.

(2) Requesting an inspection. The architect of record or the ASC owner/operator shall request an inspection by submitting, at least three weeks in advance of the requested inspection date, an application for inspection for each intermediate inspection, final inspection, and reinspection requested. Inspection requests by contractors shall not be honored.

(A) The architect of record or the ASC owner/operator shall request an intermediate construction inspection to occur at approximately 80% completion. All major work above the ceiling shall be completed at the time of the intermediate inspection; however, ceilings shall not be installed.

(B) The architect of record or the ASC owner/operator shall request a final construction inspection at 100% completion. One hundred percent completion means that the project is completed to the extent that all equipment is operating in accordance with specifications, all necessary furnishings are in place, and patients could be admitted and treated in all areas of the project.

(3) Reinspections. Depending upon the number and nature of the deficiencies cited during the final inspection, the inspector may require that a reinspection be conducted to confirm correction of all deficiencies cited. The inspector may also require a reinspection, if he determines that the project was not sufficiently complete to warrant a final inspection. The request for reinspection shall be submitted in accordance with paragraph (2) of this subsection.

(c) Approval of project. Patients and staff shall not occupy a new structure or remodeled or renovated space until approval has been received from the local building and fire authorities and the department.

(1) Documentation requirements. The ASC owner/operator shall submit the following documents to the department before the project will be approved:

(A) written approval of the project by the fire authority;

(B) a certificate of occupancy for the project issued by the local building authority;

(C) a copy of a letter or certification from a professional engineer (P.E.) licensed in the State of Texas indicating the fire sprinkler working plans, hydraulic calculation, the testing, and field inspection of the installation of the new or modified sprinkler system is in compliance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems, 2002 Edition, if applicable. A copy of a letter or certification of changes in existing fire

sprinkler system is not required, when relocation of not more than twenty sprinkler heads and hydraulic calculation is involved;

(D) fire alarm system certification (form FML-009A of the State Fire Marshal's Office), if applicable;

(E) a signed copy of a letter of certification from a qualified certification agency or individual for the piped-in medical gas system that was installed or modified and verification inspection testing in this project in accordance with §135.52(h)(1)(C)(iv), (x) and (xi) of this title (relating to Construction Requirements for a New Ambulatory Surgical Center), if applicable;

(F) a copy of the test and a letter from the electrical contractor certifying that the electrical system was tested and complies with the standards of NFPA 99, Health Care Facilities, 2002 Edition, §4.3.2.2.8 (Special Grounding) and §4.3.3.1 (Grounding System Testing), if applicable to the project;

(G) a copy of documentation indicating the flame spread rating and the smoke development rating of any wall covering installed in this project. A signed letter or statement corroborating the installation of the product in the project shall be provided;

(H) a copy of documentation indicating that draperies, curtains (including cubicle curtains), and other similar loosely hanging furnishings and decorations are flame-resistant as demonstrated by passing both the small and large-scale tests of NFPA 701, Standard Methods of Fire Tests for Flame-Resistant Textiles and Films, 1999 Edition, as required by NFPA 101, §18-7.5, and a signed letter or statement corroborating the installation of the product in the project;

(I) a written plan of correction signed by the ASC owner/operator for any deficiencies noted during the final inspection; and

(J) any other documentation or information required or requested due to the type of the project.

(2) Temporary occupancy approval

(A) If, during the final inspection, the inspector finds only a few minor deficiencies that do not jeopardize patient health, safety and welfare, the inspector may grant temporary approval for occupancy by staff only contingent upon the documents listed in paragraph (1)(A) - (E) of this subsection being provided to and approved by the inspector at the time of the final inspection. The inspector shall issue a completed signed final architectural inspection form as testament for temporary approval for occupancy by staff only. The ASC shall complete the licensing process and receive a license before patients may be admitted or treated.

(B) Temporary approval for occupancy allows the ASC owner/operator to occupy the project. However, the ASC owner/operator shall submit the documents required in paragraph (1)(F) - (J) of this subsection before the project receives final approval.

(3) Final approval. Upon its receipt and acceptance of the documents required in paragraph (1) of this subsection, the department shall issue written final approval of the project.

§135.56. Construction Tables.

(a) Table 1. Ventilation requirements for ambulatory surgical centers.

Figure: 25 TAC §135.56(a)

(b) Table 2. Filter efficiencies for central ventilation and air conditioning systems.

Figure: 25 TAC §135.56(b)

(c) Table 3. Station outlets for oxygen, vacuum, and medical air systems.

Figure: 25 TAC §135.56(c)

(d) Table 4. Flame spread and smoke production limitations for interior finishes.

Figure: 25 TAC §135.56(d)

TABLE 1

VENTILATION REQUIREMENTS FOR AMBULATORY SURGICAL CENTERS [1]

Area Designation	Air movement relationship to adjacent areas [2,11]	Minimum air changes of outdoor air per hour [3]	Minimum total air changes per hour [4]	All air exhausted directly to outdoors [5]	Recirculated by means of room units [6]	Relative humidity [7] (%)	Design temperature [8] (degrees F)
Operating/Surgical, cystoscopic rooms [9,11]	Out	4	20	----	No	30-60	68-73 [12]
Postanesthesia Recovery room [9]	----	2	6	----	No	30-60	70-75
Special Procedure room	Out	4	20	----	No	30-60	70-75
Laser eye room	Out	4	20	----	No	30-60	70-75
Endoscopy	Out	2	6	----	No	30-60	68-73
Bronchoscopy	In	2	12	Yes	No	30-60	68-73
Fluoroscopy	In	2	6	----	----	30-60	68-73
X-ray (Surgical/Critical care, catheterization)	Out	3	15	----	No	30-60	70-75
Examination, Treatment, and preoperative rooms	----	----	6	----	----	30-60	70-75
Observation room	----	2	6	----	----	----	70-75
Clean linen storage	Out	----	2	----	----	----	----
Pharmacy	Out	----	4	----	----	----	75
Medication room	Out	----	4	----	----	----	75
Laboratory General [10]	----	2	6	----	----	----	75
Sterilizer equipment room [2]	In	----	10	Yes	No	----	----
Anesthesia gas storage	In	----	8	Yes	----	----	----
Radiology [10] X-ray (diagnostic and treatment)	----	----	6	----	----	----	75
Darkroom	In	----	10	Yes	No	----	----
Toilet room	In	----	10	Yes	----	----	70-75
Janitor's closet	In	----	10	Yes	No	----	----
Decontamination room	In	----	6	Yes	No	----	68-73
Soiled linen (sorting and storage)	In	----	10	Yes	No	----	----
Soiled linen and	In	----	10	Yes	No	----	----

trash chute room							
Soiled workroom or soil holding	**In**	**----**	**10**	**Yes**	**No**	**----**	**----**
Clean workroom or clean holding	**Out**	**----**	**4**	**----**	**----**	**----**	**----**
Sterile Supply/Storage	**Out**	**----**	**4**	**----**	**----**	**70 Max**	**----**
Equipment storage	**----**	**----**	**2**	**----**	**----**	**----**	**----**
Administrative and support service	**----**	**----**	**2**	**----**	**----**	**30 Min**	**68-73**

Notes applicable to Table 1:
"Ventilation Requirements for Ambulatory Surgical Centers"

[1] The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of ambulatory surgical centers that directly affect patient care and are determined based on health care facilities being predominantly "No Smoking" facilities. Where smoking may be allowed, ventilation rates will need adjustment. Areas where specific ventilation rates are not given in the table shall be ventilated in accordance with American Society of Heating Refrigeration and Air-Conditioning Engineers (ASHRAE) Standard 62.1, 2004 edition, Ventilation for Acceptable Indoor Air Quality, and American Society of Heating Refrigeration and Air-Conditioning Engineers, Handbook of Applications, 2003 edition. Specialized patient care areas, specialty procedure rooms, etc. shall have additional ventilation provisions for air quality control as may be appropriate. Occupational Safety and Health Administration (OSHA) standards and/or The National Institute for Occupational Safety and Health (NIOSH) criteria require special ventilation requirements or employee health and safety within health care facilities.

[2] Design of the ventilation system shall provide air movement which is generally from clean to less clean areas. If any form of variable air volume or load shedding system is used for energy conservation, it must not compromise the corridor-to-room pressure balancing relationships or the minimum air changes required by the table. Except where specifically permitted by exit corridor plenum provisions of National Fire Protection Association (NFPA) 90A, 2002 Edition, the volume of infiltration or exfiltration shall be the volume necessary to maintain a minimum of 0.01 inch water gauge.

[3] To satisfy exhaust needs, replacement air from the outside is necessary. Table 1 does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice. Minimum outside air quantities shall remain constant while the system is in operation. In variable volume systems, the minimum outside air setting on the air handling unit shall be calculated using the ASHRAE Standard 62.1, 2004 edition.

[4] Number of air changes may be reduced when the room is unoccupied if provisions are made to ensure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not indicated as having continuous directional control may have ventilation systems shut down when space is unoccupied and ventilation is not otherwise needed, if the maximum infiltration or exfiltration permitted in Note 2 is not exceeded and if adjacent pressure balancing relationships are not compromised. Air quantity calculations must account for filter loading such that the indicated air change rates are provided up until the time of filter change-out. The minimum total air change requirements shall be based on the supply air quantity in positive pressure rooms and

Notes applicable to Table 1:
"Ventilation Requirements for Ambulatory Surgical Centers"

the exhaust air quantity in negative pressure rooms. Air change requirements indicated are minimum values. Higher values shall be used when required to maintain indicated room conditions (temperature and humidity, based on the cooling load of the space: lights, equipment, people, exterior walls and windows, etc.).

[5] Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas. Note that individual circumstances may require special consideration for air exhaust to the outside.

[6] Recirculating room heating, ventilating, and air conditioning (HVAC) units refers to those local units that are used primarily for heating and cooling of air, and not disinfection of air. Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." Gravity-type heating or cooling units such as radiators or convectors shall not be used in operating rooms and other special care areas.

[7] The ranges listed are the minimum and maximum limits where control is specifically needed. The minimum and maximum limits are not intended to be independent of a space's associated temperature. The relative humidity is expected to be at the lower end of the range when the temperature is at the higher end, and vice versa.

[8] Where temperature ranges are indicated, the systems shall be capable of maintaining the rooms at any point within the range. A single figure indicates a heating or cooling capacity of at least the indicated temperature. This is usually applicable when patients may be undressed and require a warmer environment. Additional heating may be required in these areas to maintain temperature range. Nothing in these rules shall be construed as precluding the use of temperatures lower than those noted when the patients' comfort and medical conditions make lower temperatures desirable. Unoccupied areas such as storage rooms shall have temperatures appropriate for the function intended.

[9] NIOSH Criteria Documents regarding Occupational Exposure to Waste Anesthetic Gases and Vapors, and Control of Occupational Exposure to Nitrous Oxide indicate a need for both local exhaust (scavenging) systems and general ventilation of the areas in which the respective gases are utilized.

[10] When required, appropriate hoods and exhaust devices for the removal of noxious gases or chemical vapors shall be provided. Laboratory hoods shall meet the following general standards.

1. Have an average face velocity of at least 75 feet per minute.
2. Be connected to an exhaust system to the outside which is separate from the building exhaust system.

Notes applicable to Table 1:
"Ventilation Requirements for Ambulatory Surgical Centers"

3. Have an exhaust fan located at the discharge end of the system.
4. Have an exhaust duct system of noncombustible corrosion-resistant material as needed to meet the planned usage of the hood.

Laboratory hoods shall meet the following special standards:

1. Fume hoods and their associated equipment in the air stream, intended for use with perchloric acid and other strong oxidants, shall be constructed of stainless steel or other material consistent with special exposures, and be provided with a water wash and drain system to permit periodic flushing of duct and hood. Electrical equipment intended for installation within the duct shall be designed and constructed to resist penetration by water. Lubricants and seals shall not contain organic materials. When perchloric acid or other strong oxidants are only transferred from one container to another, standard laboratory fume hoods and associated equipment may be used in lieu of stainless steel construction. Fume hood intended for use with radioactive isotopes shall be constructed of stainless steel or other material suitable for the particular exposure and shall comply with National Fire Protection Association 801, Facilities for Handling Radioactive Materials, 2003 Edition (NFPA 801).

NOTE: RADIOACTIVE ISOTOPES USED FOR INJECTIONS, ETC. WITHOUT PROBABILITY OF AIRBORNE PARTICULATES OR GASES MAY BE PROCESSED IN A CLEAN WORKBENCH-TYPE HOOD WHERE ACCEPTABLE TO THE NUCLEAR REGULATORY COMMISSION.

2. In new installations and construction or major renovation work, each hood used to process infectious or radioactive materials shall have a minimum face velocity of 150 feet per minute with suitable static pressure operated dampers and alarms to alert staff of fan shutdown. Each hood shall have filters with an efficiency of 99.97% (based on the dioctyl-phtalate test method) in the exhaust stream, and be designed and equipped to permit the removal, disposal, and replacement of contaminated filters. Filters shall be as close to the hood as practical to minimize duct contamination. Hoods that process radioactive materials shall meet the requirements of the Nuclear Regulatory Commission.

[11] Differential pressure shall be a minimum of 0.01 inch water gauge. If alarms are installed, allowances shall be made to prevent nuisance alarms of monitoring devices.

Notes applicable to Table 1:
"Ventilation Requirements for Ambulatory Surgical Centers"

[12] Some surgeons may require room temperatures that are outside of the indicated range. All operating room design conditions shall be developed in consultation with surgeons, anesthesiologists, infection control and nursing staff.

TABLE 2
FILTER EFFICIENCIES FOR CENTRAL VENTILATION AND AIR CONDITIONING SYSTEMS

Area Designation	Number of Filter Beds	Filter Bed No. 1 (Percent, MERV*)	Filter Bed No. 2 (Percent, MERV*)
General procedure operating rooms, patient care areas, treatment, diagnostic, those areas providing direct service or clean supplies such as sterile and clean processing, and related areas.	2	30, 8	90, 14
Laboratories	1	80, 13	----
Administrative, bulk storage, soiled holding areas, and laundries	1	30, 8	----

***** MERV – Minimum efficiency rating value (American Society of Heating Refrigeration and Air-Conditioning Engineers (ASHRAE) Standard 52.2, 1999 edition.

NOTES:

- ☐ Additional roughing or prefilters should be considered to reduce maintenance required for filters with efficiency higher than 75%.
- ☐ The filtration efficiency ratings are based on ASHRAE Standard 52.1, 1992 edition.

Figure: 25 TAC §135.56(c) Page 1 of 1

TABLE 3

MEDICAL GAS and VACUUM SYSTEMS

STATION OUTLETS FOR OXYGEN, VACUUM, AND MEDICAL AIR SYSTEMS

	Station Outlets		
Location	**Oxygen** see notes 1, 4	**Vacuum** see notes 1, 4	**Medical Air** see notes 1, 2, 3, 4
Operating room (general, cardio-vascular, neurological and orthopedic surgery)	2/room	3/room	1/room
Operating room (cystoscopic and endoscopic surgery)	1/room	3/room	---
Postanesthetic care unit	1/bed	3/bed	1/bed
Special procedure rooms	2/room	2/room	1/room
Special procedure recovery	1/bed	1/bed	---
Endoscopic procedure room	2/room	2/room	1/room
Endoscopy work room	---	1	1 (note 3)
Treatment rooms	1/room	1/room	---
Decontamination room (part of sterile processing)	---	1	1 (note 3)

Notes:

1. Prohibited uses of medical gases include fueling torches, blowing down or drying any equipment such as lab equipment, endoscopy or other scopes, or any other purposes. Also prohibited is using the oxygen or medical air to raise, lower, or otherwise operate booms or other devices in operating rooms (ORs) or other areas.

2. Medical air sources shall be connected to the medical air distribution system only and shall be used only for air in the application of human respiration, and calibration of medical devices for respiratory application. The medical air piping distribution system shall support only the intended need for breathable air for such items as intermittent positive pressure breathing (IPPB) and long-term respiratory assistance needs, anesthesia machines, and so forth. The system shall not be used to provide engineering, maintenance, and equipment needs for general facility support use. The life safety nature of the medical air system shall be protected by a system dedicated solely for its specific use.

3. Instrument air shall be used for purposes such as the powering of medical devices unrelated to human respiration (e.g., surgical tools, ceiling arms). Medical air and instrument air are distinct systems for mutually exclusive applications. Nitrogen shall be allowed for decontamination and endoscopy workroom uses if provided with reducing regulator. This shall be supplied from existing medical gas support nitrogen system and installed in accordance to NFPA 99, 2002 Edition.

4. Central supply systems for oxygen, medical air, nitrous oxide, carbon dioxide, nitrogen and all other medical gases shall not be piped to, or used for, any other purpose except patient care applications.

TABLE 4
FLAME SPREAD AND SMOKE PRODUCTION LIMITATIONS
FOR INTERIOR FINISHES

		Flame Spread Rating	Smoke Development Rating
Walls and Ceilings [1]	**Exit Access, Storage Rooms, and Areas of Unusual Fire Hazard**	**Class A**[2] **NFPA 255**	**450 or less NFPA 258** [3]
	All other Areas	**Class B**[2] NFPA 255	**450 or less NFPA 258** [3]
Floors[4]		**No requirements**	**No requirements**

[1] Textile materials having a napped, tufted, looped, woven, nonwoven, or similar surface shall not be applied to walls or ceilings unless such materials have a Class A rating and are installed in rooms or areas protected by an approved automatic sprinkler system. Cellular or foamed plastic materials shall not be used as interior wall and ceiling finishes.

[2] Products required to be tested in accordance with National Fire Protection Association 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, 2000 Edition, shall be Class A (flame spread 0 - 25) or Class B (flame spread 26 - 75).

[3] Smoke development rating, an average of flaming and nonflaming values as determined by National Fire Protection Association 258, Standard Research Test Method for Determining Smoke Generation of Solid Materials, 2001 Edition.

[4] See §135.52(b)(2)(B) of this title for requirements relative to carpeting in areas that may be subject to use by handicapped individuals. Such areas include offices and waiting spaces as well as corridors that might be used by handicapped employees, visitors, or staff.

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25 TAC § 139.40
Tex. Admin. Code tit. 25, §139.40

§ 139.40. Adoption by Reference of Ambulatory Surgical Centers Rules

Currentness

(a) Effective September 1, 2014, the department adopts by reference the following sections of Chapter 135 of this title (relating to Ambulatory Surgical Centers) that were in effect on January 1, 2014:

(1) Subchapter A (relating to Operating Requirements for Ambulatory Surgical Centers):

(A) The following definitions are incorporated by reference:

(i) § 135.2(2) (defining “Action plan”);

(ii) § 135.2(6) (defining “Autologous blood units”);

(iii) § 135.2(7) (defining “Available”);

(iv) § 135.2(10) (defining “Dentist”);

(v) § 135.2(12) (defining “Disposal”);

(vi) § 135.2(13) (defining “Extended observation”);

(vii) § 135.2(14) (defining “Health care practitioners”);

(viii) § 135.2(16) (defining “Medicare”);

(ix) § 135.2(21) (defining “Surgical technologist”);

(x) § 135.2(22) (defining “Title XVIII”);

(B) The following sections relating to ambulatory surgical centers operating requirements:

(i) § 135.4 (relating to Ambulatory Surgical Center (ASC) Operation), except as specifically noted in subsection (d)(2) of this section;

(ii) § 135.5 (relating to Patient Rights);

(iii) § 135.6 (relating to Administration);

(iv) § 135.7 (relating to Quality of Care);

(v) § 135.8 (relating to Quality Assurance);

(vi) § 135.9 (relating to Medical Records);

(vii) § 135.10 (relating to Facilities and Environment);

(viii) § 135.11(a) and (b)(1)-(18) (relating to Anesthesia and Surgical Services);

(ix) § 135.12 (relating to Pharmaceutical Services);

(x) § 135.13 (relating to Pathology and Medical Laboratory Services);

(xi) § 135.14 (relating to Radiology Services);

(xii) § 135.15 (relating to Facility Staffing and Training);

(xiii) § 135.16 (relating to Teaching and Publication);

(xiv) § 135.17 (relating to Research Activities);

(xv) § 135.26 (relating to Reporting Requirements); and

(xvi) § 135.27 (relating to a Patient Safety Program);

(2) Subchapter B (relating to Fire Prevention and Safety Requirements):

(A) § 135.41 (relating to Fire Prevention and Protection);

(B) § 135.42 (relating to General Safety); and

(C) § 135.43 (relating to Handling and Storage of Gases, Anesthetics, and Flammable Liquids); and

(3) Subchapter C (relating to Physical Plant and Construction Requirements):

(A) § 135.51 (relating to Construction Requirements for an Existing Ambulatory Surgical Center), except as specifically noted in subsection (d)(3) of this section;

(B) § 135.52 (relating to Construction Requirements for a New Ambulatory Surgical Center);

(C) § 135.53 (relating to Elevators, Escalators, and Conveyors);

(D) § 135.54 (relating to Preparation, Submittal, Review and Approval of Plans, and Retention of Records);

(E) § 135.55 (relating to Construction, Inspections, and Approval of Project); and

(F) § 135.56 (relating to Construction Tables).

(b) As required by § 4 of House Bill 2, passed in the Second Session, 83rd Legislature, 2013, the department intends by this adoption of rules to impose minimum standards for the health and safety of a patient of a licensed abortion facility, and that those minimum standards be equivalent to the minimum standards adopted under Health and Safety Code, § 243.010, for ambulatory surgical centers.

(c) The minimum standards adopted by reference under this section are not applicable to a licensed abortion facility before September 1, 2014.

(d) Interpretive conventions. For purposes of this chapter:

(1) The words “ambulatory surgical center” and “ASC” and their plural forms in the rules that are adopted by reference in subsection (a) of this section are understood to mean “licensed abortion facility” or “licensed abortion facilities,” as appropriate, for purposes of this chapter.

(2) The text of § 135.4(c)(11)(B) that reads “or all physicians performing surgery at the ASC shall have admitting privileges at a local hospital” is not adopted by reference into this chapter.

(3) The text of § 135.51(a)(1) and the portion of the text of § 135.51(a)(2) that reads, “In lieu of meeting the requirements in paragraph (1) of this subsection,” are not adopted by reference into this chapter.

(e) If the application of any particular rule that is incorporated by reference from Chapter 135 of this title is found by a state or federal court to violate the Constitution or impose an “undue burden” on women seeking abortions, the department shall continue to enforce the remaining incorporated rules that do not violate the Constitution or impose an “undue burden” on women seeking abortions, and shall continue to enforce all rules incorporated by reference from Chapter 135 of this title against abortion facilities for whom the application of such rules does not violate the Constitution or impose an “undue burden” on women seeking abortions.

Credits

Source: The provisions of this §139.40 adopted to be effective January 1, 2014, 38 TexReg 9577.

Current through 39 Tex.Reg. No. 5832, dated July 25, 2014, as effective on or before July 31, 2014

25 TAC § 139.40, 25 TX ADC § 139.40

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Texas Administrative Code
Title 25. Health Services
Part 1. Department of State Health Services
Chapter 139. Abortion Facility Reporting and Licensing
Subchapter A. General Provisions

25 TAC § 139.9
Tex. Admin. Code tit. 25, § 139.9

§ 139.9. Severability

Currentness

(a) The 83rd Legislature, in enacting House Bill 2 during its Second Session (2013), confirmed its intent that the provisions and the applications of the Health and Safety Code relating to the licensure and operation of abortion facilities were intended to be separately enforceable, if any of these separate provisions or the application of those provisions was determined unconstitutional, invalid, or unenforceable.

(b) Consistent with the intent of the Legislature, the department intends, that with respect to the application of this chapter to each woman who seeks or obtains services from a facility licensed under this chapter, every provision, section, subsection, sentence, clause, phrase, or word in this chapter and each application of the provisions of this chapter remain severable from every other provision, section, subsection, sentence, clause, phrase, word, or application of this chapter.

(c) The department further intends that if the application of any provision of this chapter is determined by a court of competent jurisdiction to impose an impermissible or undue burden on any pregnant woman or group of pregnant women, the application of the chapter to those women will be severed from the remaining applications of the chapter that do not impose an undue burden, and those remaining applications of this chapter will remain in force and unaffected, consistent with the intent of the Legislature.

(d) Accordingly, to the extent that any parts or applications of this chapter or this section are enjoined, the department may enforce the parts and applications of this chapter that do not violate the Constitution or impose an undue burden on women seeking abortions.

Credits
Source: The provisions of this §139.9 adopted to be effective January 1, 2014, 38 TexReg 9577.

Current through 39 Tex.Reg. No. 5832, dated July 25, 2014, as effective on or before July 31, 2014

25 TAC § 139.9, 25 TX ADC § 139.9

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