No. 15-274

In The
Supreme Court of the United States

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WHOLE WOMAN'S HEALTH, *ET AL.*, *Petitioners*,

V.

JOHN HELLERSTEDT, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES, *ET AL.*, *Respondents*.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF *AMICUS CURIAE* OF PHYSICIANS WITH EXPERIENCE TREATING WOMEN IN RURAL OR EMERGENCY SETTINGS IN SUPPORT OF RESPONDENTS

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STATEMENTS OF INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae are physicians who have a profound interest in protecting the health and safety of women. Included are physicians who have witnessed firsthand the dangers posed by abortion procedures, and the life-saving results of close proximity to emergency care. As doctors with decades of combined experience in providing healthcare to women, many in rural and/or emergency settings, *amici* are uniquely well suited to address the questions regarding the safety interests advanced by Texas House Bill 2.

Amici are convinced that women's safety is enhanced by requiring abortion doctors to have local admitting privileges, and holding abortion clinics to ambulatory-surgical-center standards. This brief supports the states' ability to promote the health and safety of all women through reasonable regulation of abortion and post-abortion care. *Amici* address the unique nature of abortion care, the particular risks and conditions applicable to abortion in a state with large expanses of uninhabited or rural land, and the need to assure continuity of care in such a state.

A complete listing and brief description of *amici's* medical credentials and experience appear as an appendix to this brief.

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[1] *Amicus curiae* file this brief by consent of the parties, and copies of the letters of consent are on file with the Clerk of the Court. Counsel for *Amici* authored this brief in its entirety. No person or entity, other than the *amici curiae*, their supporters, or their counsel, has made a monetary contribution to the preparation or submission of this brief.

SUMMARY OF ARGUMENT

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." *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 315 (1993). Courts may, however, look outside the record to see if there is any conceivable basis for a legislative decision, and litigants defending a law on rational-basis review may invoke nonrecord evidence to establish a conceivable justification for the law. This brief argues that the unique nature of abortion practice as well as the challenges of delivering quality health care in a state the size of Texas provide a rational basis for the hospital admitting privileges requirement and ASC requirement found in HB2.

ARGUMENT

I. Abortion practice presents unique health risks and dangers.

This Court has long recognized that abortion is unique among medical procedures and practices. *See, e.g., Gonzales v. Carhart*, 550 U.S. 124 at 159; *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 852 (1992) ("Abortion is a unique act."); *Harris v. McRae*, 448 U.S. 297, 325 (1980) ("[a]bortion is inherently different from other medical procedures"); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 66–67 (1976) (upholding written-consent requirement that applied only to abortion); see also

City of Akron v Akron Ctr. for Reprod. Health, Inc., 462 U.S. 416, 464 n.9 (1983) (O'Connor, J., dissenting) ("the Court . . . has expressly rejected the view that differential treatment of abortion requires invalidation of regulations").

Three aspects of abortion practice distinguish it from most other medical procedures. First, abortion is an elective procedure that is often performed or provided by a doctor who neither practices nor resides in the community. Second, while follow-up visits are routinely offered by some abortion clinics, many women are not provided follow-up care. Finally, women often conceal their abortions, complicating post-operative care when problems arise. Each of these aspects of abortion are relevant in reviewing the constitutionality of Texas House Bill 2 ("HB2") requiring doctors performing abortions to have admitting privileges at a hospital within 30 miles from where the abortion is being performed, and that abortion clinics meet the standards for ambulatory surgical centers ("ASC").

a. Many doctors do not maintain practices or reside near the clinics where they perform abortions.

It is common for doctors performing abortions to travel significant distances from their respective homes to some or all of the clinics where they provide abortions. *See* Findings of Fact & Conclusions of Law, *June Med. Servs., L.L.C. v. Kliebert*, No. 3:14-cv-00525-JWD-RLB (M.D. La. Jan. 26, 2016), ECF No. 216, Para. 92, Page 31 of 112. Because of this, women experiencing post-abortion

complications may have difficulty obtaining proper care.

For example, in 2013 Dr. Leroy Carhart was accused of abandoning his patient Lisa Morbelli. Lisa died within forty-eight hours after Dr. Carhart performed a late-term abortion on her. According to a complaint filed with the Maryland Board of Physicians, at the time of her discharge Lisa's condition was not stable notwithstanding extended time in the recovery room of Carhart's clinic. When she returned to her hotel room, she began to experience increasing distress due to chest pains and heavy breathing. Lisa and her family made repeated efforts to contact Dr. Carhart or a member of the clinic staff, but were unable to do so. The morning after her abortion Lisa was taken to a nearby emergency room where diagnosis and treatment were delayed because hospital personnel could not immediately contact Dr. Carhart or any member of his clinic staff. Eventually Dr. Carhart responded to calls from the hospital, but it was too late to be helpful. Lisa died later that day. It was later learned that Dr. Carhart was unavailable because he had left the state the evening Lisa was discharged. Md. Board of Physicians, Complaint Form regarding Leroy Harrison Carhart, http://operationrescue.org/pdfs/Carhart%20Complaint-MD%20Death%2002192013.pdf.

While the board ultimately imposed no discipline, the case illustrates the danger to patients when abortion providers are not integrated into the local medical community. *See Abortionist Leroy Carhart Cleared in Mother's Death*, Nat'l Cath. Reg.

(Oct. 18, 2013), at http://www.ncregister.com/daily-news/abortionist-leroy-carhart-cleared-in-mothers-death.

Itinerant practice by physicians has been a subject of concern for over a century. In an early case challenging an Iowa medical licensure law, the court noted:

> Continuing in the profession several years in a particular locality indicates a degree of merit not likely to be found in a person moving from place to place. Indeed, it is a matter of general observation that the itinerant doctor, roving about, without remaining in one locality longer that a few days or weeks, is usually wanting in honesty, and too frequently but a charlatan or quack.

State v. Bair, 84 N.W. 532, 533 (Iowa 1900).

The language of the opinion may seem overblown, yet the underlying concern about the quality of care provided by itinerant doctors is valid and continues to this day. In 1987 the Office of the Inspector General (OIG) for the Department of Health and Human Services conducted an extensive study of the use of itinerant surgeons in rural hospitals. Office of Tech. Assessment, *Health Care in Rural America* (1990). The study concluded that there is a greater than average risk of poor quality care in itinerant surgery as compared to the overall rate of such care identified by OIG in an earlier national diagnosis-related group validation study.

Id. Patient files in the study reflected poor quality care in over one-quarter (26.6%) of the cases compared to only 3.3 percent of surgical cases in the earlier national validation study. The OIG recommended that rural physicians and hospital administrators institute procedures to provide the patient an opportunity for a second surgical opinion; ensure an adequate preoperative workup; and improve postoperative communication between the itinerant surgeon and the attending physician. *Id*.

The extensive use of itinerant surgeons by abortion clinics and the eight-fold increase in risks of poor quality care by itinerant surgeons in other settings provides more than a rational basis of the Texas law at issue in this case. Texas has a strong interest in promoting adequate channels of postoperative communication between physicians who perform abortions and medical staff in nearby hospitals where a woman experiencing complications is likely to seek help. The Texas requirement that physicians who perform abortions have admitting privileges at a hospital within 30 miles of where the abortion occurs is a reasonable means to promote the safety of women obtaining abortions.

b. Many women do not obtain follow-up care from their abortion providers.

As with other surgical procedures, abortion providers traditionally have recommended a routine follow-up appointment two to four weeks after abortion in order to confirm that the pregnancy has been terminated and there is no evidence of any complications. Eve Espey & Laura MacIsaac,

Contraception and Surgical Abortion Aftercare, in Management of Unintended and Abnormal Pregnancy at 208 (Maureen Paul et al., eds. 2009).

With the advent of medical abortions, follow-up appointments became required as a condition for the U.S. Food and Drug Administration's approval of mifepristone (popularly known as RU-486). Manufacturers and distributors are required to obtain prescribers' agreement to confirm pregnancy termination fourteen days after initiating a medical abortion. *See* FDA, *Historical Information on Mifepristone (Marketed as Mifeprex)* at http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111334.htmhttp://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111334.htm; and FDA, *Mifeprex (mifepristone) Information* at http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111323.htm.

In spite of similar concerns related to continued pregnancy and post-abortion complications, there are no legal requirements for follow-up visits after surgical abortions.

The FDA follow-up requirement for medical abortions generated considerable controversy among abortion providers, resulting in various legal challenges to state laws regulating medical abortions. *See Okla. Coal. for Repro. Justice v. Cline*, No. CV-2011-1722, slip op., (Dist. Ct. Okla. Cnty. May 11, 2012) and *Planned Parenthood*

Southwest Ohio Region v. Dewine, 696 F.3d 490 (6th Cir. 2012). It also generated academic interest in the question of whether and when follow-up visits after any abortion are necessary. *See* Daniel Grossman, et al., *Routine follow-up visits after first-trimester induced abortion*, 103 Obstetrics & Gynecology 738 (2004) and Mary Gatter, *Eliminating the routine postoperative surgical abortion visit*, 86 Contraception 397 (2012).

The few available studies on post-abortion follow-up care indicate that between thirty-five and sixty percent of women have no follow-up appointment with their abortion provider. Eve Espey & Laura MacIsaac, *Contraception and Surgical Abortion Aftercare, in Management of Unintended and Abnormal Pregnancy* at 211 (Maureen Paul *et al.*, eds. 2009). The National Abortion Federation, a professional association of abortion providers, recommends members offer post-abortion follow-up visits, but notes "no evidence suggests that routine post-procedure visits are helpful." Nat'l Abortion Fed'n, *2015 Clinical Policy Guidelines, Recommendation 12.8.1*, (2015), at http://prochoice.org/wpcontent/uploads/2015_NAF_CPGs.pdf.

Given the tepid nature of this "recommendation," it seems unlikely that abortion clinics actively encourage women to return for follow-up visits.

Nor are follow-up visits something that all post-abortion women value. While some women feel secure about the decisions they have made in obtaining abortions, others are ambivalent or troubled by their choices. "The referring centre and

hospital will always remain associated with the abortion and as well as acting as a reminder, can be instilled with 'badness' making it less likely that women want to return there." Joanna Brien and Ida Fairbairn, *Pregnancy and Abortion Counseling* 139 (1996).

One new study provides limited reliable data about low-income post-abortive women seeking care in emergency rooms. Dr. Ushma D. Upadhyay, *et al.*, *Incidents of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015). Using 2009–2010 abortion data for women covered by the fee-for-service California Medicaid program researchers discovered that one in sixteen women sought medical care in an emergency room within six weeks of obtaining an abortion. *Id*. Approximately one out of thirty-two of these emergency department visits were abortion-related or related to conditions that were concurrent with the abortion. The authors discounted this number further by excluding all visits in which the patient did not receive "a pathologic diagnosis or treatment" related to abortion, concluding that less than one percent of women who visit an emergency department within six weeks after obtaining an abortion are seeking care related to their abortion. *Id*. at 181.

Others have reported that abortion-related complications are commonly encountered in emergency departments. "Complications following abortions performed in free-standing clinics is one of the most frequent gynecologic emergencies . . . encountered. Even life-endangering complications

rarely come to the attention of the physician who performed the abortion unless the incident entails litigation." Leslie Iffy, *Second Trimester Abortions*, 249 J. Am. Med. Ass'n 588 (1983).

Based on abortion industry's research and the National Abortion Federation recommendation, it is possible that up to two-thirds of Texas women obtaining abortions may not have a follow-up visit with their doctor. More than six percent of low-income post-abortive women may end up in Texas emergency departments within six weeks after their abortions. Each of these visits will result in significant costs – in pain and worry for the women and their families, and in time and resources of the emergency departments and staff.

In testimony before a Texas legislative committee Dr. Jim Mauldin stated: "Without hospital privileges, other physicians are left to take care of an abortion provider's most serious complications. By requiring privileges, not only would there be continuity of care but the peer review processes of the hospital would be brought to bear and ensure quality." Hearing on S.B. 1 Before the S. Comm. on Health & Human Servs., 83d Leg., 2d C.S. at 7:03:11-7:03:27 (July 8, 2013) (Mauldin testimony on Senate version of HB2), http://tlcsenate.granicus.com/MediaPlayer.php?clip_id=495.

These facts provide more than a rational basis for HB2's requirements that abortions occur only in up-to-date facilities with modern medical protocols and staffed by physicians who can readily facilitate transfer of care to a nearby hospital in the event of

unexpected conditions or complications.

c. Women often conceal their abortions, complicating post-operative care when problems arise.

Compounding the problems of itinerant abortion doctors and limited follow-up care is the fact that women are reluctant to disclose their abortions to friends, family, and healthcare providers. Underreporting of induced abortions in surveys is widespread. Fewer than one–half of induced abortions performed in the United States in 1997–2001 (47 percent) were reported by women during face-to-face interviews in the 2002 National Survey of Family Growth (NSFG). R. K. Jones & K. Kost, *Underreporting of Induced and Spontaneous Abortion in the United States: An Analysis of the 2002 National Survey of Family Growth*, 38 Stud. Fam. Plan. 187 (2007).

Accurate medical histories directly impact the quality of care a woman receives. Yet nearly half of post-abortive women keep their abortions secret from their own physicians or family members. Anne Speckhard, *Psycho-Social Aspects of Stress Following Abortion* 74 (1987). This can delay proper diagnosis and treatment, which can result in more serious complications and even death.

When considering earlier abortion legislation, Texas legislators heard several stories of medical crises that were exacerbated because of the secrecy that often surrounds abortion.

> Leslie French, a nineteen year-old student at the University of Texas testified regarding "Amy," who was fifteen and pregnant. Amy obtained an abortion on Friday, suffered terrible complications, and subsequently died on Sunday. Because Amy's parents did not know of her abortion, they delayed taking her to hospital until she was unconscious. Hospital personnel originally told the parents that Amy died of septic shock syndrome, but one of her friends who knew of the abortion told them after Amy's death. The parents then confirmed her death was due to complications from the abortion. Healthcare providers explained that they initially refused to discuss the abortion as the cause of death because of their concern for Amy's right to privacy.

Teresa Stanton Collett, *Transporting Minors for Immoral Purposes: The Case for the Child Custody Protection Act and the Child Interstate Abortion Notification Act*, 16 Health Matrix 107, 113 (2006) *citing* Audio Tape: Hearings on Tex. H.B. 623 Before the H.R. Comm. on State Affairs, 76th Leg., R.S. 13 (Apr. 19, 1999) (testimony by Leslie French, a healthcare provider) (tapes available from Office of House Comm. Coordinator).

When emergency room personnel are unaware that a woman has recently undergone abortion, or being aware have no details regarding her procedure, they are stymied in their efforts to provide care and women are at higher risk for serious negative outcomes.

Texas legislators heard first-hand accounts of the difficulties healthcare professionals encounter. Dr. Ingrid Skop testified, "In my experience a lot of these young girls, they're scared. They come away from the abortion. They don't know what procedure they had and they don't know who the doctor was. And so it's very, very difficult to get a good history out of them." Hearing on H.B. 2816 Before the H. Comm. on State Affairs, 83d Leg., R.S. at 2:46:56-2:47:12 (Mar. 27, 2013) (Skop testimony on prior version of HB2), http://tlchouse.granicus.com/MediaPlayer.php?clip_id=6765.

Requiring physicians to have hospital admitting privileges and perform abortions in ASCs are aimed at protecting women's health through continuity of care and adequate communication.

II. The ASC requirement promotes women's safety and is consistent with the trend in abortion practice.

Almost 75% of all surgery today is performed on an outpatient basis. In 1980 that figure was only 15%. Slightly more than half of all outpatient surgeries are done in an ambulatory surgery center. *See* Texas Ambulatory Surgical Center Society, Ambulatory Surgery Center Facts, available at http://www.texasascsociety.org/surgery-center-facts. ASCs are seeing increased use for many procedures because they are cost effective and safe from infection. These procedures include cataract removal, colonoscopies, knee arthroscopies, and

tonsillectomies. *Id*. Abortion providers have turned to ASCs as well.

Annual reports from the Texas Department of Health show that the trend of abortions being performed in ASCs began in 2004 and by 2013, the last year for which statistics are available, almost one-quarter of all abortions in the state were performed at ASCs.

Year	Number of Abortions by Ambulatory Surgical Centers*	Total Abortions for Year*	Percentage of Abortions Performed in ASC
2004	257	75,053	0.3
2005	5,387	77,374	7.0
2006	6,374	82,056	7.8
2007	6,189	81,079	7.6
2008	6,503	81,591	8.0
2009	4,652	77,850	6.0
2010	9,821	77,592	12.6
2011	16,237	72,470	22.4
2012	14,361	68,298	21.0
2013	14,491	63,849	22.7

The voluntary use of ASCs by abortion providers prior to the pass of HB2 undercuts Petitioners' argument that requiring abortion providers to meet ASC standards is unrelated to

* Numbers are drawn from the Texas Department of State Health Services, Vital Statistics Annual Reports for years 2001-2013, Table 37, indexed and available at http://www.dshs.state.tx.us/chs/vstat/annrpts.shtm. Percentages are calculated by counsel.

maternal health or economically impossible.

III. The admitting privileges requirement facilitates post-abortion care by providers other than the physician performing the abortion.

Texas, like all states, has a strong interest in promoting communication between doctors providing abortions, and the local medical community where women may seek follow-up care for complications. Lack of coordination between medical providers delays treatment and can endanger women's lives. This risk is even more acute outside major metropolitan areas where specialized emergency care is limited, if available at all.

Researchers at the nonpartisan Center for Studying Health System Change have found that "[t]wenty-one percent of patient deaths or permanent injuries related to ED [emergency department] treatment delays are attributed to lack of availability of physician specialists" and "[t]wo-thirds of ED directors in level I and II trauma centers say that more than half of all patient transfers they receive stem from lack of timely access to specialist physicians at the referring hospital." Ann S. O'Malley et al., *Hospital Emergency On-Call Coverage: Is There a Doctor in the House?* (Nov. 2007) at http://hschange.com/CONTENT/956/.

These issues are of particular concern in a state the size of Texas with broad swathes of rural areas. A 2011 survey of Texas health care revealed

that of the 254 counties in Texas, 144 did not have a gynecologist or obstetrician, 138 did not have a pediatrician, and 29 did not have a primary care physician. Becca Aaronson, *Interactive: Mapping Access to Health Care in Texas*, Tex. Tribune (May 8, 2012) at http://www.texastribune.org/library/data/texas-shortage-health-care-providers/.

These access problems are compounded by the fact that there simply is no emergency care to be had in a growing number of counties. Across Texas, ten rural hospitals have closed since 2012, according to data from the National Rural Health Association. Phil Latham and David A. Lieb, *Rural Hospitals in East Texas, state, nation struggle to stay open, adapt*, Longview News J. (May 2, 2015) at http://www.news-journal.com/news/2015/may/02/rural-hospitals-in-east-texas-state-nation-struggl/.

The admitting privileges requirement is a rational mean to advance the state's interest in women's safety, especially given the unique geography of Texas and the need for communication between abortion providers and other local medical professionals.

CONCLUSION

HB2 does not provide an undue burden on abortion providers, nor does it create a substantial obstacle to a large fraction of women seeking abortions in Texas. Requiring abortion providers to conduct abortions in a safe ASC setting and

maintain admitting privileges in a nearby hospital is a common-sense way to increase the safety of all women who seek to terminate their pregnancies through abortion.

For the foregoing reasons, amici respectfully urge this Court to uphold the judgment of the Court of Appeals.

Respectfully submitted,

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Appendix

Listing of *Amici* Physicians with Experience Treating Women in Rural or Emergency Settings

Jon M. Adcock, M.D., is a Fellow of the American College of Obstetricians and Gynecologists and a practicing obstetrician/gynecologist who has treated patients suffering from health complications following an abortion.

Stephen W. Burgher, M.D., is a board certified Emergency Medicine physician and Fellow of the American College of Emergency Physicians with decades of medical experience. He is currently practicing at Baylor University Medical Center, a Level I trauma center in Dallas, Texas.

Mark G. Doherty, M.D., is a Fellow of the American College of Surgeons and a Fellow of the American College of Obstetricians and Gynecologists who is currently practicing Gynecologic Oncology in Arlington, Virginia.

Michael K. Garver, M.D., is a pediatrician in Great Falls, Montana, a member of Physicians for Life, and a board member of the American College of Pediatricians. He previously worked for the Indian Health Service.

Alma L. Golden, M.D., is a retired Associate Professor of Pediatrics at Texas A&M Health Science Center, McLane Children's Baylor Scott and White

Health. Her career has included private pediatrics, directing indigent health services in sixteen rural sites with University of Texas Medical Branch's Maternal Child Health program, and teaching and administration in the Texas A&M Health Science Center at McLane Children's Hospital. From 2002–2006, as a Presidential Appointee, she served as Deputy Assistant Secretary for Population Affairs in the U.S. Department of Health and Human Services, managed the portfolio of Family Planning, Teen Pregnancy, Embryo Adoption and Abstinence Education, advised the White House and Congress on Family Planning, and spoke internationally on adolescent health.

Anthony F. Graziano, M.D., M.A., is board certified in Emergency Medicine through the American Board of Emergency Medicine, and a Fellow of the American Academy of Emergency Medicine. He is the Wisconsin Representative for the Christian Medical and Dental Associations. He has practiced emergency medicine in Grand Rapids, Michigan, in the greater Milwaukee area, and Fort Atkinson, Wisconsin, where he currently practices in the emergency room of Fort Health Care.

Patricia Lee June, M.D., is certified by the American Board of Internal Medicine and the American Board of Pediatrics. She has practiced as a solo practitioner pediatrician for over thirty-one years in a small, rural community in Moultrie, Georgia.

Brian N. Kilpatrick, M.D., is board certified in Internal Medicine and Pediatrics. He practices at

Community Health Centers of the Rutland Region, Mettowee Valley Family Health Center, a federally qualified health center in West Pawlet, Vermont. His rural practice, forty-five minutes from the two major hospitals in the area, provides him with insight into the needs of a rural location as it related to emergency services.

Sister Hanna Klaus, M.D., is a Fellow of the American College of Obstetrics and Gynecology who has international experience as a practicing obstetrician/gynecologist working with life-threatening post-abortion complications. She is currently providing healthcare education at the Natural Family Planning Center of Washington, D.C. and Teen STAR Program.

Mark D. Lacy, M.D., is an Associate Professor of Internal Medicine and Pediatrics at Texas Tech University School of Medicine. He practiced primary care in rural Arizona for seven years, holds a Master's Degree in bioethics, and is certified by both the American Board of Pediatrics and the American Board of Internal Medicine. Dr. Lacy personally attended a woman who had developed a post-abortion hemorrhage following a D&C abortion.

Nancy Q. Lefever, M.D., is a practitioner at Tate Medical Associates who spent six years at a rural Community Health Center in McCormick, South Carolina.

Harry M. Maller, M.D., is a board certified pediatrician and member of the American College of Pediatricians with forty-nine years of experience in

practice. For the past three years, he has practiced at Northeast Valley Health Corporation in San Fernando, California, a federally qualified community facility with over a dozen clinics. He has served as the Medical Director of the Pregnancy Counseling Center in Mission Hills, California for ten years. He holds a clinical professorship in pediatrics at Keck/USC School of Medicine, and is a CDC-trained epidemiologist.

Patrick J. Marmion, M.D., is a Diplomate of the American Board of Obstetrics and Gynecology, a Diplomate of the American Board of Preventive Medicine, and has a Master's degree in Public Health. He provides emergency care as an Obstetrics Hospitalist in the Family Birth Center for Legacy Health System in Portland, Oregon. He previously practiced at Southern Ohio Health Services, a rural federally qualified health center in southern Ohio.

Richard G. Moutvic, M.D., is a Fellow of the American College of Obstetricians and Gynecologists and a Clinical Professor of obstetrics and gynecology at the Loyola University Stritch College of Medicine.

Jerry M. Obritsch, M.D., is a Fellow of the American College of Obstetricians and Gynecologists, clinical professor and Vice-Chairman at the University of North Dakota School of Medicine and Health Sciences, and an attending physician at the Mid Dakota Clinic Center for Women in Bismarck, North Dakota.

Walter Stalter, M.D., is a Fellow of the American College of Obstetricians and Gynecologists, and a

Diplomate of the American Board of Obstetricians and Gynecologists. He practices part-time at the Miami Valley Women's Center and has served as President of his local Montgomery County Medical Society, Chief of Medical Staff at Miami Valley Hospital, and as a Board Member of Premier Healthcare.

Michael Valley, M.D., is a licensed physician in Minnesota with over twenty-three years of experience who is currently practicing Obstetrics, Gynecology, and Urogynecology. He is board certified in Obstetrics and Gynecology, and Female Pelvic Medicine and Reconstructive Surgery. He previously taught medical students and residents at the University of Oklahoma and the University of Florida, Jacksonville.

Stephen T. Walker, M.D., is board certified in both Internal Medicine and Pediatrics. Dr. Walker has practiced medicine for twenty-three years in a small rural community in Elkin, North Carolina.

Deacon William V. Williams, M.D., is board certified in internal medicine and rheumatology with a current practice in community health, focused on rheumatology, in Philadelphia, Pennsylvania. He is a Fellow of the American College of Physicians, member of the American College of Rheumatology, member of the Catholic Medical Association, Editor in Chief of The Linacre Quarterly, and Vice President of Exploratory Development, Incyte Corp. He has experience working in emergency rooms in Boston, Massachusetts, rural Missouri, and suburban Philadelphia.

Jerry A. Wittingen, M.D., is a retired Fellow of the American College of Obstetricians and Gynecologists with over thirty-six years of experience as an obstetrician/gynecologist.

Patrick Yeung Jr., M.D., is an associate professor and a board certified obstetrician/gynecologist who handles gynecologic consults in an emergency room.