Illinois Case

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No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,
Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

JURISDICTIONAL STATEMENT

NEIL F. HARTIGAN
Attorney General, State of Illinois

ROBERT J. RUIZ
Solicitor General, State of Illinois
100 West Randolph Street, 12th Floor
Chicago, Illinois 60601
(312) 917-3000

Attorneys for Appellants

MICHAEL J. HAYES *
KATHLEEN KREISEL FLAHAVEN
ROGER P. FLAHAVEN
GLADYS STEVENS
Assistant Attorneys General
100 West Randolph Street, 13th Floor
Chicago, Illinois 60601
(312) 917-3654

Of Counsel * Counsel of Record

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QUESTIONS PRESENTED

1. Whether Illinois can constitutionally license and regulate outpatient surgical facilities in which pregnancy terminations are performed to the same extent it licenses and regulates outpatient surgical facilities in which pregnancy terminations are not performed.

2. Whether a case or controversy existed with respect to the challenged statutes and regulations which were not being enforced by the State of Illinois prior to the filing of the complaint.

3. Whether statutes and regulations establishing standards for the construction, maintenance and operation of outpatient surgical facilities are constitutional as applied to outpatient surgical facilities in which pregnancy terminations are performed.

4. Whether the federal courts can refuse to give effect to severability requirements, thereby invalidating statutory and regulatory provisions which are constitutional.

PARTIES TO THE PROCEEDINGS

The defendants in the district court were Bernard J. Turnock, M.D., M.P.H., Director of the Illinois Department of Public Health; Neil F. Hartigan, Attorney General of Illinois; Gary L. Clayton, the Director of the Illinois Department of Registration and Education; and Richard M. Daley, State's Attorney of Cook County. Turnock, Hartigan and Clayton were the appellants in the court of appeals. Daley did not file a notice of appeal.

In addition, appellant Stephen F. Selcke, Director of the Illinois Department of Professional Regulation, is the successor in public office to Gary L. Clayton, Director of the Illinois Department of Professional Regulation.

The plaintiffs in the district court and appellees in the court of appeals were Richard M. Ragsdale, M.D., Margaret Moe, Northern Illinois Women's Center, Sarah Roe and Jane Doe.

TABLE OF CONTENTS

APPENDIX

(Separate Volume)

TABLE OF AUTHORITIES

Constitutional Provisions

Statutes

Regulations

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit entered March 10, 1988 is reported at 841 F.2d 1358 (7th Cir. 1988) and is reproduced at Appendix A. On August 12, 1988 the defendants' petition for rehearing and suggestion for rehearing en banc was denied. (Appendix D, E). The memorandum opinion of the United States District Court for the Northern District of Illinois rendered November 27, 1985 is reported at 625 F.Supp. 1212 (N.D. Ill. 1985) and is reproduced at Appendix G.

The judgment order of the United States District Court entered December 11, 1985 is not reported, but is reproduced at Appendix F.

JURISDICTION

This action, brought under 28 U.S.C. Sections 2201 and 2202 and 42 U.S.C. Section 1983 challenges the constitutionality of portions of the Illinois Medical Practice Act, Ambulatory Surgical Treatment Center Act, and Health Facilities Planning Act. Invoking the jurisdiction of the District Court under 28 U.S.C. Section 1343 plaintiffs filed a class action seeking declaratory and injunctive relief. Subsequent to an evidentiary hearing, the District Court entered on November 27, 1985 and December 11, 1985 a preliminary injunction in favor of plaintiffs and enjoined enforcement of the Acts and rules promulgated thereunder to the extent any person or facility offers or performs, or desires to offer or perform first and/or early second

trimester abortions or other abortion-related gynecological procedures.

On appeal, the United States Court of Appeals for the Seventh Circuit vacated as moot one portion of the District Court's decision, held unconstitutional the other challenged provisions, and affirmed the remainder of the decision. Its judgment was entered on March 10, 1988.

On August 12, 1988 a majority of the members of the original panel voted to deny the defendants' petition for rehearing, and the suggestion for rehearing en banc failed by an equally divided court. Judges Wood, Posner, Coffey, Manion, and Kanne voted to grant rehearing en banc. (Appendix D, E).

Defendants Turnock, Hartigan and Selcke filed their Notice of Appeal in the Court of Appeals on November 7, 1988. (Appendix H). Jurisdiction of the Supreme Court of the United States to review this judgment by appeal is conferred by 28 U.S.C. Section 1254(2).

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

Constitutional Provisions

U.S. Const. Amend. I:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

U.S. Const. Amend. IV:

> The right of the people to secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the person or things to be seized.

U.S. Const. Amend. V:

> No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

U.S. Const. Amend. IX:

> The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

U.S. Const. Amend. XI:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

U.S. Const. Amend. XIV, Section 1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any

person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

State Statutes

Ambulatory Surgical Treatment Center Act,
Ill. Rev. Stat. ch. 111½, pars. 157-8.1 *et seq.*
(Reprinted at Appendix I)

Health Facilities Planning Act,
Ill. Rev. Stat. ch. 111½, pars. 1151 *et seq.*
(Reprinted at Appendix J)

Medical Practice Act,
Ill. Rev. Stat. ch. 111, par. 4400-22
(Reprinted at Appendix K)

Regulations

Ambulatory Surgical Treatment Center
Licensing Requirements, 77 Ill. Adm. Code, Ch. 1, Section 205, Subchapter b
(Reprinted at Appendix L)

STATEMENT OF THE CASE

Plaintiff Ragsdale is a medical doctor licensed in Illinois, who performs abortions as part of his medical practice. Plaintiff Northern Illinois Women's Center is an Illinois corporation which provides abortion services to women in Rockford, Illinois. Plaintiff Margaret Moe is a registered nurse and the sole owner of a medical facility in Cook County, Illinois. Plaintiffs Sarah Roe and Jane Doe are female citizens of child-bearing age who had abortions in the past and may seek abortions in the future.

Plaintiffs claimed that the challenged statutes form a tripartite regulatory scheme which impermissibly restricts

the performance of first and second trimester abortions. Specifically, plaintiffs alleged that the challenged statutes and regulations were violative of rights secured by the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the United States Constitution. Plaintiffs contended that the "scheme" as applied singles out for discriminatory treatment facilities in which abortions are performed and substantially inhibits a woman from exercising her right to choose to have an abortion under medically safe and reasonably inexpensive conditions. Plaintiffs further averred that the challenged "scheme" impermissibly prevented physicians from implementing a woman's decision to choose abortion in that the "scheme" mandated that physicians and facilities comply with allegedly irrational and arbitrary requirements. (Compl., pars. 1-4).

On September 20, 1985 plaintiff Richard M. Ragsdale, M.D. filed a motion for preliminary injunction asking the district court to enjoin defendants from enforcing the challenged statutes and regulations. Plaintiff Ragsdale claimed that unless the statutes and regulations were enjoined he would be unable to perform abortion services after December 31, 1985.

The State Statutes

The Ambulatory Surgical Treatment Center Act [hereinafter ASTC Act] became law in 1973. (Appendix I). The stated purpose of the ASTC Act is to provide for the protection of the public health through the establishment and enforcement of standards for the construction and operation of ASTCs. ASTCs by definition are facilities which are primarily devoted to the performance of surgical procedures.[1]

[1] In addition to ASTCs, the Illinois Department of Public Health is responsible for licensing and surveying numerous other facilities

(Footnote continued on following page)

The Illinois Health Facilities Planning Act [HFP Act] became law in 1974. (Appendix J). The purpose of the HFP Act is to attempt to obtain a comprehensive health care delivery system involving all types of health care facilities, services and equipment. The HFP Act also represents an attempt to restrain the rising costs of health care by preventing unnecessary construction and duplication of unneeded health care facilities. (App. 166). Types of health care facilities included within the HFP Act's provisions include those licensed pursuant to the Health Maintenance Organization Act, the ASTC Act, the Nursing Home Care Reform Act of 1979, the Hospital Licensing Act, and kidney disease treatment centers. (App. 167).

The Medical Practice Act [MPA] provides the licensure requirements of physicians in Illinois and prohibits the practice of medicine by any person not holding a valid license. Ill. Rev. Stat. ch. 111, par. 4401 *et seq.* (1983). Now, par. 4400-1 *et seq.* of the Medical Practice Act of 1987. (Appendix K).

The Evidence Presented

At the time of trial, there were 42 licensed ASTCs in Illinois. The types of surgical procedures performed in licensed ASTCs include plastic surgery, removal of cysts and tumors, pregnancy terminations, tubal ligations, hernia repairs and rhinoplasty repairs of the nose. Some surgical procedures performed in ASTCs, including abortions, are done so under a general anesthesia. Of the 42 licensed

[1] *continued*
which provide health or medical services. These facilities include blood banks, clinical laboratories, alcohol treatment centers, hospitals, hospices, and nursing homes. Ill. Rev. Stat. ch. 111½, pars. 601-101 *et seq.*; 621-101 *et seq.*; 2301 *et seq.*; 142 *et seq.*; 6101 *et seq.*; and 4151-101 *et seq.*

ASTCs, 22 indicated that some pregnancy terminations would be performed.

For the 12 years prior to trial Dr. Ragsdale was the primary abortion provider in northwestern Illinois. Dr. Ragsdale is well known as a provider of abortion services in the Rockford area. In 1973 Dr. Ragsdale opened the plaintiff Northern Illinois Women's Center. The Center primarily provides first and early second trimester abortion services. Dr. Ragsdale performs approximately 3500 abortions per year at his facility. In the 12 years prior to trial, Dr. Ragsdale had performed in excess of 42,000 abortions.

At the time of trial, Dr. Ragsdale's facility had been licensed as an ASTC in Illinois for 12 years. The facility contained variations from the ASTC regulations. Any such variances had not substantially affected renewal of Dr. Ragsdale's license for those 12 years. Dr. Ragsdale was then informed by his landlord that his lease would not be renewed. The nonrenewal of the lease was a result of the landlord's decision to expand and renovate its building and desire to have as tenants doctors who admitted patients to Rockford Memorial Hospital. Dr. Ragsdale therefore planned to move his facility. The Illinois Department of Public Health preliminarily approved his plans for relocation. In addition, Dr. Ragsdale submitted an application for a certificate of need.

On March 14, 1985 Comprehensive Health Planning of Northern Illinois (CHPNI) held a public meeting regarding the proposed relocation. CHPNI is a federally funded organization which is a separate entity from the HFP Board. It is responsible for completing an independent review of a proposed project.

Dr. Ragsdale attended the CHPNI meeting. There were in Dr. Ragsdale's opinion some "rational" discussions at

the meeting, and some statements supporting the need issue. There were, in addition, more statements that there was no need for the facility. The meeting then degenerated into a shouting match over abortion.

Dr. Ragsdale was subsequently informed by CHPNI that his proposal met the review requirements, including the need requirement. However, the lease which Dr. Ragsdale had procured was withdrawn by the lessor.

In order to aid his testimony at trial, Dr. Ragsdale determined what it would cost on a rough basis and in broad terms to comply with the ASTC Act and regulations at his new facility. Dr. Ragsdale first estimated the cost of relocation of his practice as a result of the loss of his lease, and without complying with the ASTC Act and regulations. Dr. Ragsdale concluded that the cost would be an additional $22.45 per patient per year.

Dr. Ragsdale also prepared an estimate which represented his guess as to what it would cost in addition to the $22.45 in order to bring his new facility into "reasonable compliance" with the ASTC regulations. Dr. Ragsdale estimated that the cost would be an additional $22.21 per patient per year.

Abortion Procedures

It is uncontroverted that abortions are surgical procedures. According to the plaintiffs' expert witnesses, there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion. It is also agreed that all physicians licensed under the MPA do not have the qualifications, training and experience to perform safe first and early second trimester abortions.

Plaintiffs' expert maintained that medical education in this country has paid little attention to abortion services.

Abortions, more than any other types of procedures, require much experience and practice. It is not a procedure which can be done well after a few hundred or even a few thousand procedures.

There are several factors which affect the safety of first trimester and early second trimester abortion procedures. One factor is the skill, experience and professional integrity of the physician performing the abortion. Other factors include the duration of the pregnancy; choice of abortion technique; the existence of sterile conditions; the availability of qualified staff and appropriate equipment; the availability of emergency facilities; and the type of anesthesia which is used.

Enforcement Policies

In 1981, the Supreme Court of Illinois rendered its decision in *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406 (1981). In *Marcowitz* the court considered a village ordinance which had adopted the definition of an ASTC that was found in the State ASTC Act. The Supreme Court of Illinois held that the ordinance was unconstitutional to the extent that it defined an ASTC to be any facility in which abortions are performed, irrespective of whether devoted primarily to that purpose. *Marcowitz*, 86 Ill.2d at 420. The court then severed that portion of the definition of an ASTC from the remainder of the ordinance.

Four days after *Marcowitz* was decided, the Illinois Department of Public Health, pursuant to a written policy, ceased to enforce the identical abortion specific portion of the definition of an ASTC found in the State statute. Since 1981, therefore, licensure and enforcement proceedings were applicable only to those facilities primarily devoted to the performance of surgical procedures.

In 1982, United States District Judge Charles P. Kocoras enjoined the Illinois Department of Public Health from enforcing Section 4 of the Illinois Abortion Law of 1975 and "any related regulation." Section 4 was a second trimester hospitalization requirement. The Department interpreted this ruling as also enjoining the enforcement of ASTC Regulation Section 205.740 which prohibited the performance of second trimester abortions in ASTCs. (App. 222).

In 1983, this Court decided the cases of *City of Akron v. Akron Center For Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983); and *Simopoulos v. Virginia*, 462 U.S. 506 (1983). The decision in *Akron* reinforced the earlier order, and the Department's policy of not enforcing Section 205.740 of the Regulations therefore continued.

In December of 1982 or January of 1983 Dr. Ragsdale was informed that Section 205.740 of the ASTC Regulations was no longer being enforced. As a result, Dr. Ragsdale began to perform second trimester abortions at his facility.

In 1983, in *Charles v. Carey*, 579 F.Supp. 464 (N.D. Ill. 1983), Section 10 of the Illinois Abortion Law of 1975 (the reporting requirement) was permanently enjoined. As a result Section 205.760 (App. 223), an abortion specific reporting requirement of the ASTC Regulations was no longer enforced. Dr. Ragsdale was informed that this section was no longer being enforced.

The Illinois Department of Registration and Education (now Department of Professional Regulation) has absolute prosecutorial discretion in the initiation of disciplinary actions under the Medical Practice Act. Because of the *Marcowitz* decision and other decisions concerning the abortion issue, the challenged portion of the MPA (App.

193) was not being enforced by the Department to restrict the performance of all abortions to licensed facilities.

The evidence submitted regarding the State's enforcement policies in light of various decisions was not controverted.

The ASTC Regulations

There are a total of 59 ASTC Regulations (excluding subsections). Of that total very few are abortion specific. Of the abortion specific regulations, as previously noted, two were not being enforced prior to the filing of plaintiffs' complaint.

Plaintiffs' experts testified generally that the ASTC regulations were not medically necessary for the performance of a safe first or early second trimester abortion. Certain components of the regulations, however, were acknowledged to be consistent with safe and acceptable standards of medical care. Moreover, some regulations were described as belaboring the obvious, the kind of thing any competent practitioner would do, and superfluous.

For example, Section 205.240 of the regulations provides that the ASTC is to formulate a written policies and procedures manual. (App. 213). Dr. Ragsdale described this requirement as standard medical and administrative practice.

Likewise, Section 205.230(a) of the regulations provides that the management of a licensed ASTC is to appoint a qualified consulting committee. (App. 211). Dr. Ragsdale testified that this regulation is "belaboring the obvious."

Similarly, the plaintiffs' expert testified that either the medical director or principal physician of an abortion facility should have staff privileges at the nearest hospital, or there should be a hospital transfer agreement. Section

205.540(c) of the regulations provides that there should be written documentation of either a transfer agreement, a statement that the medical director has admitting privileges, or that each staff physician, podiatrist or dentist has admitting privileges. (App. 218).

Subpart G of the regulations sets forth additional requirements for facilities in which obstetrical/gynecological procedures are performed. (App. 220-23). This section applies to abortions as well as other gynecological and obstetric procedures. Plaintiffs' expert testified that there are aspects of Subpart G which are consistent with good standards of medical practice.

The American College of Obstetricians and Gynecologists' Standards for Obstetric-Gynecologic Services, Sixth Edition [ACOG standards], provide that ambulatory care facilities for abortion services should meet the same standards of care as for other surgical procedures. Section 205.710 of the ASTC regulations contains an essentially identical provision. (App. 220). The parties' expert witnesses agreed with this provision.

Likewise, plaintiffs' expert testified that counseling is an indispensable part of a thorough preoperative evaluation and preparation of a patient for an abortion procedure, and that counseling should include a discussion of the alternatives for dealing with pregnancy. Section 205.730(b) of the regulations provides that counseling is to be provided prior to obstetrical/gynecological procedures following diagnosis of pregnancy. (App. 221).

It is agreed that routine laboratory work for abortion procedures should include a urine screening exam for pregnancy, a hematocrit or hemoglobin, an Rh screening test, dip stick urinalysis and for black patients a sickle cell test. Section 205.520(b) of the regulations simply provides that a hemoglobin or hematocrit is to be performed prior to

certain surgical procedures. (App. 216-17). Section 205.730(a) provides that prior to obstetrical procedures blood Rh factor is to be determined and that prior to performing an abortion procedure the diagnosis of pregnancy is to be established. (App. 221).

It is similarly agreed that after every abortion, removed tissue should be examined. One of the purposes of the pathology report is to confirm pregnancies in early stages. Another purpose is to ensure that fetal parts are present and to be able to alert patients to the possibility of an ectopic pregnancy. Section 205.530(c) of the ASTC regulations merely provides that all tissues removed during surgery are to be examined by a consulting pathologist. (App. 217).

Building Design and Construction Requirements

Subparts (I) and (J) of the ASTC regulations set forth various building design, construction standards, and physical and mechanical requirements. (App. 225-44). Plaintiffs' expert, who did not consider himself a building design, construction, or mechanical expert testified that the provisions of Subparts (I) and (J) are not medically necessary for the operation of a facility in which first and early second trimester abortions are to be performed. The defendants introduced evidence demonstrating that many of these regulations reflect common, accepted and standard practices.

For example, Section 205.1510 of the regulations provides that after building heating, ventilating and air conditioning systems are installed they shall be tested and balanced to ensure that they are in proper working condition. (App. 240). The regulation also provides that upon completion of the facility, the owner of the ASTC is to be provided with operating and maintenance instructions.

Section 205.1520 provides, among other things, for insulation in the facility and in certain situations for a flame spread rating in accordance with the National Fire Protection Association. (App. 240-41). These requirements were described as standard for health facilities.

Similarly, various regulations dealing with hot water systems, ventilation systems, and plumbing fixtures were demonstrated to be standard requirements.

The Constitutional Challenge

The trial conducted by the district court was held on November 18-22 and 26, 1985. On November 27, 1985 and December 11, 1985 the district court entered orders granting Dr. Ragsdale's motion for preliminary injunction.

In the November 27, 1985 Order, the district court found that plaintiffs had prevailed on all four traditional factors the courts must consider in ruling on a motion for preliminary injunction. (App. 129). First, the district court decided that plaintiffs would suffer irreparable harm without an injunction and that no adequate remedy at law existed. Specifically, it found that the challenged statutes and regulations have the effect of raising the cost and limiting the availability of abortions. (App. 129). In addition, the district court found that the challenged provisions (1) force complying facilities to raise their fees, possibly beyond the economic means of some women; (2) discourage other non-complying facilities from offering abortion services; and (3) make it difficult, if not impossible, for current abortion facilities to move or new abortion facilities to be constructed. (App. 130). Further, the district court rejected defendants' argument that plaintiffs could not be irreparably harmed by those statutes and regulations which are not being enforced. (App. 133).

Next, the district court determined that the threatened harm to plaintiffs outweighed any possible harm to defendants. (App. 134).

Third, the district court considered the merits of plaintiffs' claims. It utilized the trimester standard established in *Roe v. Wade*, 410 U.S. 113 (1973), as interpreted in *City of Akron v. Akron Center for Reproductive Health*, 426 U.S. 416 (1983) and other cases, to provide the legal framework for the constitutional evaluation of the challenged statutes and regulations. (App. 134-35).

The district court noted that State regulations having no significant impact on a woman's exercise of her abortion right during the first trimester may be permissible where justified by important State health objectives. It held, however, that *Roe* does not stand for the proposition that general medical regulations which apply to the performance of first and early second trimester abortions are *per se* constitutional. (App. 136). Thus, the district court concluded that even general regulations which burden a woman's right to choose to terminate her pregnancy during the first trimester would have to meet the compelling governmental interest requirement. In addition, the district court decided that a regulation which burdens a woman's right to choose to terminate her pregnancy during the early second trimester must be reasonably related to the preservation and protection of maternal health. (App. 137).

Applying these standards to this case, the district court found that plaintiffs had demonstrated that the statutory and regulatory scheme places a burden on a woman's right to choose to terminate her pregnancy during the first and early second trimester. Specifically, it found that the challenged provisions (1) increase the cost and decrease the availability of abortions and (2) may delay the effectuation of a woman's decision to abort. (App. 137).

Further, the district court found that defendants had failed to produce any evidence of a compelling or even rational basis for the challenged statutes and regulations. It noted that defendants had shown that certain regulations are consistent with accepted medical practice, but that such showing is not equivalent to a demonstration that the challenged provisions are medically necessary. Thus, the district court found a reasonable likelihood that plaintiffs will succeed on the merits. (App. 137-38).

Lastly, the district court determined that the public interest would be served by the issuance of the preliminary injunction. (App. 139).

The defendants were preliminarily enjoined and restrained from enforcing the challenged provision of the Medical Practice Act (MPA); the Ambulatory Surgical Treatment Center Act (ASTC) and the rules and regulations promulgated thereunder; and the Health Facilities Planning Act (HFP): to the extent any person or facility offers or performs, or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures. (App. 110-11).

The district court also certified the following classes: (a) a plaintiff class of physicians and surgeons who perform or desire to perform abortions in Illinois; (b) a plaintiff class of all Illinois women of child-bearing age who desire or may desire an abortion sometime in the future; and (c) a defendant class of all State's Attorneys in Illinois. (App. 110).

On December 11, 1985 the district court orally clarified portions of its ruling. The district court specified that the Illinois Department of Public Health is not enjoined from regulating ASTCs in which abortions are performed or desired to be performed to the extent that such ASTCs are performing surgical procedures other than abortions.

In addition, the district court specified that in deciding whether a health care facility was devoted primarily to the performance of surgical procedures, and therefore required to be licensed under the ASTC Act, the Illinois Department of Public Health is not prohibited from counting the number of abortion procedures performed in the facility. The Department cannot, however, enforce the regulations as to the abortion procedures performed—but can enforce the regulations as to other procedures performed at the facility.

Defendants appealed from the district court's orders to the United States Court of Appeals for the Seventh Circuit. On March 10, 1988 that court rendered its decision in this matter. (App. 1). The majority opinion affirmed, with one exception, the district court's entry of a preliminary injunction. The exception is the challenge to one ASTC regulation—a second trimester hospitalization requirement—which the majority held was not being enforced, was moot, and should have been dismissed. Judge Coffey submitted a lengthy dissent from the majority opinion. (App. 34-80).

The majority opinion first considered whether certain of plaintiffs' challenges have been mooted by the State's policy of nonenforcement. It noted that the voluntary cessation of putatively illegal conduct ordinarily will not moot a controversy and prevent its adjudication by a federal court. (App. 10-11). Further, the majority stated that such cessation does render a controversy moot when there is no reasonable expectation that the putatively illegal conduct will be repeated and that there are no remaining effects of the alleged violation. (App. 11).

Applying these principles to this case, the majority found the challenge to the second trimester hospitalization requirement is moot because enforcement ceased in

1983. (App. 11-13). It held, however, that the challenge to the reporting requirement of the ASTC Act and regulations is not moot because the State did not produce preexisting documentation of the nonenforcement policy. (App. 13). Finally, it held that the challenge to the application of the ASTC Act and regulations to first trimester abortions is not moot. It noted that those requirements were no longer applied to the occasional abortion provider, but that such requirements were applied to doctors who exclusively perform first trimester abortions. Further, the majority stated that the evidence on this point—testimony from the legal counsel for the state agency charged with enforcement authority that the challenged provision of the MPA was not being enforced—was too ambiguous. (App. 13-14).

In considering the merits of the case, the majority opinion, like the district court, relied upon the "trimester" approach of *Roe v. Wade*, 410 U.S. 113 (1973). (App. 15). It analyzed various decisions of this Court and stated that where first trimester abortions are involved, not only must the impact of the challenged regulations be insignificant in terms of the woman's exercise of her right, but also the regulation must be justified by important state health objectives. (App. 17).

The majority found that statement consistent with existing Seventh Circuit precedent which holds that once such regulations are shown to have more than a *de minimus* impact on the abortion decision, the government must show a compelling basis for the law, *i.e.*, that the burden is not undue or unjustifiable. (App. 17). Thus, the majority opinion concluded that the district court's application of a "medical necessity" standard was consonant with the legal framework applicable to this case. (App. 18). Further, the majority rejected defendants' argument that because the regulations apply to all facilities primarily devoted to surgery, those regulations should be reviewed under a different standard than if they had singled out abortions. (App. 21). In addition, it decided that the district court's findings that the challenged provisions substantially burden the effectuation of the abortion decision were not clearly erroneous. (App. 22).

The first facet of the challenged statutes and regulations which the majority considered was the requirement that facilities performing abortions be licensed. (App. 23). It held that under *Roe* the State may not require separate licensure of facilities primarily devoted to performing abortions during the first trimester. (App. 24). Once the licensing requirement falls, the majority reasoned that the remaining requirements fall with it. (App. 25).

Nevertheless, the majority considered and ruled upon the constitutionality of three abortion-specific regulations. First, it construed section 205.730(a)(2) (App. 221) to unconstitutionally require the physician who is to perform the abortion to also perform a pregnancy test, even if such test had previously been done by another physician. (App. 27). Second, the majority held that section 205.730(b)(3) (App. 221-22) invalidly requires counseling to include a discussion of alternatives, citing *Thornburgh v. American College of Obstetricians*, 476 U.S. 747 (1986). (App. 27). Third, it construed section 205.730(b)(2)(D) (App. 221) to unconstitutonally preclude the performing physician from providing the counseling. (App. 28-29).

The generally applicable regulations regarding physical plant, equipment, and staffing were also struck down by the majority. It concluded that those provisions impose a substantial burden and are not justified by health objectives. (App. 29-31).

In addition, the majority found the "certificate of need" proceeding of the Health Facilities Planning Act unconsti-

tutional. It held the State's interest in preventing wasteful duplication of resources to be insufficient in this context. (App. 31-32).

Finally, the majority rejected defendants' request to sever those provisions which were held unconstitutional. It reasoned that severance was not appropriate because the licensure provision had been invalidated. (App. 32). Further, it found that the challenged provisions were "so riddled with exceptions resulting from judicial decisions and nonenforcement policies as to be unintelligible." Under those circumstances, the majority found that it could not untangle the constitutional from the unconstitutional provisions. (App. 32-33).

The dissenting opinion finds that the States are authorized under *Roe* to apply the same licensing standards to abortion facilities as those applied to facilities performing similar surgical procedures. (App. 35). Under that standard, the dissent would enjoin and sever the challenged portion of the Medical Practice Act and the abortion specific language of par. 157-8.3(A) of the ASTC Act. (App. 38). It argues that the States are free to regulate ambulatory surgical treatment centers, including those performing abortions, as long as the abortions are not singled out from other, similar surgical procedures, subject to the rational basis test governing social and economic legislation. Under the rational basis test, moreover, the dissent finds the ASTC Act and IHFP Act constitutional. (App. 64). In evaluating the abortion-specific statutes and regulations under the strict scrutiny test, the dissent would uphold all provisions but one [section 205.730(b)(2)(D)]. (App. 73). The dissent finds that the challenged provisions neither burden the abortion decision or its effectuation and are justified by important health objectives. (App. 80).

THE QUESTIONS PRESENTED ARE SUBSTANTIAL

This appeal is of exceptional importance because the majority opinion, under the guise of protecting a woman's constitutional right to privacy, has exempted outpatient surgical facilities in which abortions are performed from general licensure and regulatory provisions. In so doing, the majority emasculates the duty and authority of the State of Illinois to protect the health, safety, and welfare of its citizens by licensing and regulating outpatient surgical facilities in which first or early second trimester abortions are performed in the same manner that other surgical facilities are regulated.

Further, the majority opinion is in conflict with decisions of this Court with respect to the jurisdictional issues presented in this case. The opinion is also in conflict with decisions of this Court and other courts of appeals with respect to the authority of the State to license and regulate outpatient surgical facilities in which abortions are performed. Finally, the refusal of the majority opinion to sever any purportedly unconstitutional provisions is in conflict with decisions of this Court.

A.

THE COURT ERRONEOUSLY ASSUMED JURISDICTION OVER CERTAIN CHALLENGED PROVISIONS WHICH WERE NOT BEING ENFORCED.

At trial, the defendants introduced evidence that due to various court decisions which pre-date the complaint in this matter, certain challenged provisions were not being enforced by the State. Those provisions are: the abortion specific language of par. 157-8.3 of the ASTC Act (App. 149-50); Section 205.740 (App. 222) (prohibition of

second trimester abortions in ASTCs) and 205.760 (App. 223) (abortion specific reporting requirement) of the ASTC Regulations; and par. 4400-22 of the MPA. (App. 193). This evidence was not contradicted.

Nonetheless, the majority held with respect to the reporting requirement of Section 205.760 that the State's position of nonenforcement is "asserted only in this litigation." This conclusion is clearly erroneous. The evidence reveals that this provision has not been enforced since 1983. With respect to the challenged provision of the MPA, the majority held that the evidence of nonenforcement is "equivocal." This conclusion is also erroneous. Legal counsel to the Department of Registration and Education (now Department of Professional Regulation) testified that based upon various decisions in the abortion area, this section was not being enforced. The plaintiffs did not introduce any evidence to the contrary.

The defendants argued below that in light of the policies of nonenforcement which were articulated by the regulatory agencies and entered into evidence, plaintiffs had not presented a justiciable controversy as to certain challenged provisions. However, the majority opinion utilized a mootness analysis with respect to those nonenforced provisions. The majority concluded that plaintiffs' challenge to the second trimester hospitalization requirement (ASTC Regulation Section 205.740) (App. 222) was moot. The challenges to the other unenforced provisions, however, were not found to be moot.

Preliminarily, however, a mootness analysis is not appropriate in this context. Mootness issues arise when a challenged policy changes after the commencement of litigation. Here, the enforcement policies are based on court decisions and determinations which pre-date this lawsuit.

It is axiomatic that the court must look to the state of affairs as of the filing of the complaint in determining

whether a justiciable controversy exists. *International Harvester Co. v. Deere & Co.*, 623 F.2d 1207, 1210 (7th Cir. 1980). Even where fundamental rights are allegedly involved, "a litigant must establish a more immediate threat than simply a general policy of enforcing laws." *J.N.S., Inc. v. State of Ind.*, 712 F.2d 303, 305 (7th Cir. 1983) (lack of justiciable controversy found in challenge by seller of sexually explicit materials to state civil RICO statutes). Thus, the courts should not pass on the constitutionality of challenged provisions which are not being enforced. *Poe v. Ullman*, 367 U.S. 497, 507 (1961) (lack of justiciable controversy found in challenge to prohibition against provision of contraceptive advice and use of contraceptive devices); *C.I.O. v. McAdory*, 325 U.S. 472, 475 (1945) (lack of justiciable controversy found in light of agreement not to enforce challenged state law).

The majority's assumption of jurisdiction over the unenforced provisions in this case is not only in conflict with the foregoing decisions regarding justiciability standards, but also with certain decisions governing the jurisdictional bar created by the Eleventh Amendment. That amendment limits the power of federal courts to grant relief in cases where there are no ongoing violations of federal law. *Green v. Mansour*, 474 U.S. 64, 71 (1985). That limitation is applicable even in those instances where mootness is at issue. *Watkins v. Blinzinger*, 789 F.2d 474, 484 (7th Cir. 1986). Thus, even if an underlying claim is not moot, the Eleventh Amendment bars further proceedings in federal court where there is no continuing conduct the State must change to comply with federal law. *Id.* Accordingly, the majority's assumption of jurisdiction over unenforced provisions is in conflict with decisions governing justiciability standards and with decisions dealing with Eleventh Amendment standards because there is no ongoing violation of federal law.

B.

THE MAJORITY OPINION ERRONEOUSLY FOUND THAT THE CHALLENGED STATUTES AND REGULATONS VIOLATE THE CONSTITUTIONAL RIGHT TO PRIVACY.

The majority opinion affirmed the district court's exemption of abortion procedures from the licensure and regulatory provisions which generally apply to outpatient surgical facilities. In addition, the majority held that "the State may not require separate licensure of facilities primarily devoted to performing abortions." The majority opinion is in conflict with decisions of this Court and other courts of appeals as to the authority of the State to license and regulate outpatient surgical facilities in which pregnancy terminations are performed. The State has the duty and authority to license and regulate such facilities in the same manner as facilities in which other outpatient surgical procedures are performed.

This Court has consistently held, even with respect to first trimester abortions, that the State has an interest in making sure that certain factual assumptions made in *Roe v. Wade*, 410 U.S. 113 (1973) continue to exist. As explained in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 430 n.12 (1983):

> Of course, the State retains an interest in ensuring the validity of Roe's factual assumption that "the first trimester abortion [is] as safe for the woman as normal childbirth at term," an assumption that "holds true only if the abortion is performed by medically competent personnel under conditions insuring maximum safety for the woman." *Connecticut v. Menillo*, 423 U.S. 9, 11, 46 L.Ed.2d 152, 96 S.Ct. 170 (1975) (per curiam).

The ASTC Act seeks to effectuate that interest by "assuring that all medical procedures, including abortions, are performed under conditions that insure maximum safety." (App. 149).

Thus, two other courts of appeals have upheld licensing standards of outpatient surgical facilities in which pregnancy terminations are performed. *Baird v. Department of Public Health*, 599 F.2d 1098, 1102 (1st Cir. 1979) ("There is room under *Roe* for states to apply the same licensing standards to abortion facilities as they apply to like facilities performing medically analogous procedures."); *Hodgson v. Lawson*, 542 F.2d 1350, 1358 (8th Cir. 1976) ("A state can impose the same regulations on a clinic, specifically built to perform abortions during the first trimester, that are imposed on other clinics that perform surgical procedures requiring approximately the same degree of skill and care as the performance of first trimester abortions.").

In this case, the HFP Act and the ASTC Act, as enforced, are abortion-neutral and are applicable to all licensed ASTCs, irrespective of the types of surgical procedures performed. These statutes were clearly enacted to further the State's interests in regulating the ever increasing number of outpatient surgical facilities. The State has responsibilities to its citizens to insure that medical procedures performed at these facilities are performed under circumstances enhancing their safety. Further, the State can legitimately seek to establish a comprehensive and less costly health care delivery system. Those responsibilities do not cease when an abortion is the surgical procedure which is to be performed.

In addition, the majority rejected the argument that abortion-neutral regulations should be scrutinized under a different standard than abortion-specific regulations. Defendants maintain that such argument is clearly supported by the two previously cited opinions from the First and Eighth Circuit Courts of Appeals. *Accord, Westchester*

Women's Health Org. v. Whalen, 475 F.Supp. 734 (S.D. N.Y. 1979) (requirements governing "diagnostic and treatment centers" applicable to facilities performing first trimester abortions); *Abortion Coalition of Mich. Inc. v. Mich. Dep't of Public Health*, 426 F.Supp. 471 (E.D. Mich. 1977) (requirements for "free standing surgical outpatient facilities" applicable to facilities performing first trimester abortions).

The argument that abortion-neutral regulations should be scrutinized under a less exacting standard than abortion-specific regulations is also supported by decisions of this Court in other contexts. *City of Renton v. Playtime Theatres, Inc.*, 475 U.S. 41, 46-47 (1986) (standards under First Amendment for "content-based" and "content-neutral" zoning regulations); *Minneapolis Star & Tribune Co. v. Minn. Comm'n of Revenue*, 460 U.S. 575, 582-83 (1983) (standards under First Amendment for general and special taxes as applied to the press). *Accord, Arcara v. Cloud Books, Inc.*, 478 U.S. 697, 106 S.Ct. 3172, 3177 (1986) (First Amendment is not implicated by the enforcement of a public health regulation of general application against the physical premises in which sexually explicit books and magazines are sold). Thus, defendants maintain that the lower courts applied an erroneous legal standard to the abortion-neutral provisions.

Even if the strict scrutiny test was correctly determined to apply, the majority erred in determining that plaintiffs had established a sufficiently substantial interference with the abortion decision. The majority opinion misapprehended the testimony regarding the purported cost of compliance with the State regulations.[2] While the majority opinion states that Dr. Ragsdale's estimated compliance with the regulations would entail a per patient cost of between $25 and $40 (App. 22), the actual testimony was that reasonable compliance would only result in an estimated $25.21 per patient fee increase. That increase would be reduced to $10.90 after two years and $3.40 after five years due to the retirement of certain debts. This increase is *de minimis* and did not sustain plaintiffs' burden of proof even under the standards found applicable by the majority. (App. 23).

[2] The majority opinion also incorrectly found that Dr. Ragsdale was permitted to testify as to the substance of his handwritten

(Footnote continued on following page)

For example, in *Planned Parenthood Ass'n v. Ashcroft*, 462 U.S. 476 (1983), this Court considered the impact on the woman's exercise of her right to decide whether to have an abortion caused by the cost of a State required pathology report. This Court held that the estimated cost of $19.40 per patient did not "significantly burden a pregnant woman's abortion decision." *Id.* at 490.

Similarly, in the instant matter, plaintiffs' cost estimates did not establish a "sufficiently substantial" interference with a pregnancy termination decision. Thus, the lower courts erred in applying a strict scrutiny standard to the challenged provisions, and in determining that those provisions were invalid under that standard.

[2] *continued*
cost estimates, without objection. (App. 22). As correctly stated in the dissenting opinion, "the defendants objected throughout the hearing as to the relevancy and admissibility of Ragsdale's alleged cost sheets" (App. 67). At the outset, defendants objected to any use of those documents. Further objections were raised when plaintiffs moved for their admission into evidence.

C.

THE MAJORITY OPINION CONFLICTS WITH DECISIONS OF THIS COURT REGARDING SEVERANCE OF PURPORTEDLY UNCONSTITUTIONAL PROVISIONS.

Assuming, *arguendo*, that the lower courts appropriately assumed jurisdiction over the challenged provisions which are not being enforced, those courts should have severed any purportedly unconstitutional statutes or regulations. For instance, the abortion-specific language of par. 157-8.3 of the ASTC Act has not been enforced since 1981 due to the decision of the Illinois Supreme Court in *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406 (1981). In that case, the court struck down a portion of a local ordinance that incorporated the ASTC Act definition of an ASTC. The disputed portion covered "any facility where a medical or surgical procedure is performed for the termination of pregnancy, regardless of whether the facility is primarily devoted to that purpose." *Id.* at 420. The court severed that portion, but found the remaining portion of the ordinance to be "complete in itself and susceptible to independent enforcement." *Id.* at 421.

In the instant appeal, the majority opinion rejected the argument that any purportedly unconstitutional provision be severed. It characterized the regulatory scheme as being "so riddled with exceptions resulting from judicial decisions and nonenforcement policies as to be unintelligible." (App. 33).

Defendants submit that a court should focus upon the provisions independently and on their own merit. Otherwise, litigants will be encouraged to base their litigation strategy upon the sheer number or volume of statutes and regulations to be attacked on constitutional grounds. The more broad based the attack, the greater the purported burden on constitutional guarantees.

As this Court has noted, a court should refrain from invalidating more of a statute than is necessary. *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). It is, moreover, the duty of the court to "maintain the act in so far as it is valid." *Id.* at 652, quoting *El Paso & Northeastern R. Co. v. Gutierrez*, 215 U.S. 87, 96 (1909). Likewise, this Court has held that "[u]nless it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law." *Buckley v. Valeo*, 424 U.S. 1, 108-09 (1976), quoting *Champlin Refining Co. v. Corporation Commission*, 286 U.S. 210, 234 (1932).

Given the ASTC Act's declared purpose of assuring that *all* medical procedures, including abortion be performed under circumstances insuring maximum safety, the Supreme Court of Illinois' holding on severability in *Marcowitz*, and the State's policy of nonenforcement, there is no doubt that the abortion-specific language of the ASTC Act should have been severed if declared unconstitutional. Likewise, any purportedly unconstitutional provisions of the HFP Act and the ASTC regulations should have been severed. By failing to appropriately address the severability issue, the majority opinion has improperly frustrated the intent of the elected representatives of the people of the State of Illinois. *Regan v. Time, Inc.*, 468 U.S. at 653.

No. 88-750

In The

Supreme Court of the United States

October Term, 1988

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, *et al.*,

Appellants,

v.

RICHARD M. RAGSDALE, M.D., *et al.*,

Appellees.

On Appeal From the United States Court of Appeals For the Seventh Circuit

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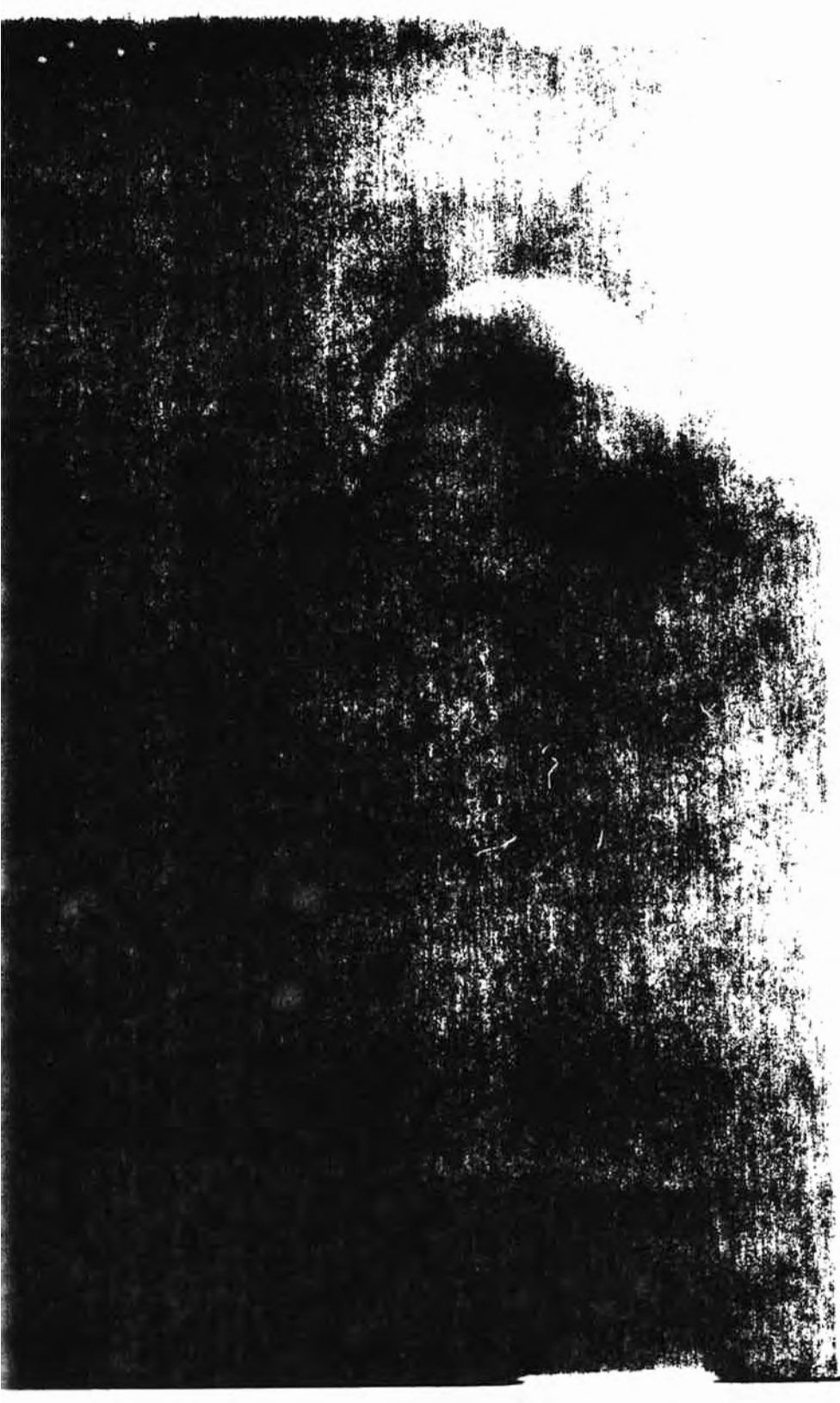
MOTION TO DISMISS OR AFFIRM

ALAN S. GILBERT
LORIE A. CHAITEN
SONNENSCHEIN CARLIN NATH & ROSENTHAL
8000 Sears Tower
233 S. Wacker Drive
Chicago, IL 60606
(312) 876-8000

COLLEEN K. CONNELL
(Counsel of Record)
ROGER BALDWIN FOUNDATION OF ACLU OF ILLINOIS
Suite 1600
20 E. Jackson Blvd.
Chicago, IL 60604
(312) 427-7330

Pandick Technologies, Inc., Chicago • (312) 236-0200



QUESTION PRESENTED

Whether the Court of Appeals correctly affirmed a preliminary injunction, based on factual findings entered after an expedited hearing, prohibiting the enforcement against plaintiffs of three Illinois statutes intended to restrict the performance of early abortions to "the functional equivalent of small hospitals," and which the Court of Appeals found burdened the abortion right without any "medical justification whatsoever"?

PARTIES TO THE PROCEEDINGS

(See Jurisdictional Statement)*

* Pursuant to Rule 28.1 of the Supreme Court Rules, plaintiffs state that the Northern Illinois Women's Center is a medical corporation wholly owned by Richard Ragsdale, M.D., and has no parent, no subsidiaries and no affiliate corporations.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CONSTITUTIONAL PROVISIONS

STATUTES

REGULATIONS

OPINIONS BELOW

(See Jurisdictional Statement)

CONSTITUTIONAL, STATUTORY AND REGULATORY PROVISIONS INVOLVED

(See Jurisdictional Statement)

MOTION TO DISMISS OR AFFIRM

The United States Court of Appeals for the Seventh Circuit affirmed a preliminary injunction prohibiting the enforcement against plaintiffs of Illinois laws that operate together to require that all first and early second trimester abortions be performed in specially licensed facilities that are "'the functional equivalent of small hospitals.'" App. 19 (citation omitted). The Court of Appeals based its decision on District Court factual findings that the challenged statutes burdened the abortion right without any "medical justification whatsoever." App. 29.

The interlocutory decision below is not a final order subject to review under this Court's mandatory appeal jurisdiction. Review under a writ of certiorari also is inappropriate. The Court of Appeals' decision adheres closely to, and to a great extent replicates, prior Supreme Court decisions. Defendants offer no reason to disturb this precedent. Nor do defendants present any conflict or important federal question that warrants the Court's consideration at this interlocutory juncture.

STATEMENT OF THE CASE

As the courts below found, the challenged statutes are directed at providers of abortion services and are, in large part, intended to restrict abortion services. App. 21. As drafted, the Ambulatory Surgical Treatment Center Act ("ASTC Act") requires special licensure of all ASTCs, which, by definition, include "any . . . place or building devoted primarily to . . . the performance of surgical procedures" and "*any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. . ..*" Ill. Rev. Stat. ch. 111 1/2, § 157-8.3(A) (emphasis added)[1].

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[1] The ASTC Act provides that failure to obtain an ASTC license constitutes a business offense punishable by a fine of $10,000 per day. *Id.* at § 157-8.12. Section 16-1 of the Medical Practice Act ("MPA"), Ill. Rev. Stat. ch. 111, § 4433(1), provides the second link of the scheme and grants employees of the Illinois Department of Registration and Education ("DRE") "absolute prosecutorial discretion" (Defendant's Jurisdictional Statement at 10) to revoke or suspend the license of any physician who performs even one first trimester abortion outside of a hospital or licensed ASTC. The Health Facilities Planning Act ("HFPA"), Ill. Rev. Stat. ch. 111 1/2, § 1151 *et. seq.*, provides the final link and requires ASTCs, like hospitals, to submit to the lengthy public hearings and potential public veto of the certificate of need ("CON") process prior to constructing, renovating, or relocating their facilities.

References to defendants' Jurisdictional Statement appear as "Juris. St." References to the Court of Appeals' opinion and other documents from defendants' Appendix to Jurisdictional Statement appear as "App." References to the trial transcript appear as "Tr." or "Dep."

The ASTC Act does not single out any type of surgical procedure, other than abortion, for special regulation. While defendants posit benevolent "general" health regulations, applied even-handedly to all health care providers (Juris. St. 24-25), such a regulatory scheme simply is not at issue here.

The trial court below concluded, as a matter of fact, and the Court of Appeals affirmed as not clearly erroneous, that the tripartite regulatory scheme burdened, without medical justification, the rights of women to choose to have first and early second trimester abortions. The challenged statutes drive up the cost of each abortion procedure; substantially impede women who seek access to abortion services; and prevent potential health care providers from offering abortions because the cost of compliance is "prohibitive." App. 22-23, 31. Defendants failed to supply any evidence that the statutory provisions either enhanced the safety of early abortion procedures or protected the pregnant woman's health. App. 29-30. Indeed, rather than "protect[ing] public health" (Juris. St. 5), the challenged scheme actually proved to be harmful, from a medical standpoint, for some women seeking abortions. App. 27-28.

Thus, the Court of Appeals affirmed the District Court's preliminary injunction, applying established Supreme Court precedent, which directs that when a state statute, whether abortion-neutral or abortion-specific, burdens the exercise of a woman's decision to have an abortion, that statute can withstand constitutional scrutiny only if it is justified by a compelling governmental interest and is carefully crafted to advance that interest. In addition, the Court of Appeals indicated that this scheme lacked even a reasonable basis. App. 24.

Defendants' contention that the decision below "has exempted outpatient surgical facilities in which abortions are performed from general licensure and regulatory provisions" (Juris. St. 21) is belied by the express terms of the injunction issued. Contrary to defendants' claim that the decision below "emasculates" the State's general authority to regulate physicians or outpatient medical facilities (Juris. St. 21), the injunction left the defendants free to apply their regulatory scheme to non-abortion medical procedures, even when abortion and non-abortion procedures are performed in the same facility. App. 110-11. The State also remains free to enforce against physicians who perform abortions the professional censure and licensing provisions of the MPA, for with the exception of Section 16-1, which requires abortions to be performed in ASTCs, the MPA was not challenged. *Compare Doe v. Bolton*, 410 U.S. 179, 200 (1973). Further, even facilities exclusively devoted to abortion practice remain subject to general state and local safety regulations such as fire and building codes.

Thus the courts below preliminarily enjoined the challenged statutory scheme, but did so only insofar as necessary to protect the constitutional rights of women seeking first and early second trimester abortion procedures.

REASONS FOR DISMISSING THE APPEAL OR IN THE ALTERNATIVE AFFIRMING THE JUDGMENT BELOW.

I. THIS COURT LACKS MANDATORY JURISDICTION AND SHOULD NOT EXERCISE ITS DISCRETIONARY JURISDICTION TO REVIEW THIS AFFIRMANCE OF A PRELIMINARY INJUNCTION ORDER WITHOUT A FULL AND FINAL RESOLUTION OF ALL FEDERAL ISSUES BY THE LOWER FEDERAL COURTS.

In their attempt to attract this Court's attention under its waning mandatory jurisdiction, defendants overlook a fundamental prerequisite to the exercise of such jurisdiction. Under 28 U.S.C. § 1254(2), Supreme Court jurisdiction exists only to review a final judgment by the court of appeals declaring a state statute invalid as repugnant to the Constitution. *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 754-755 (1986).

In this case, the District Court held its hearing on an expedited basis in response to plaintiffs' plea that preliminary injunctive relief issue before the threatened termination of Dr. Ragsdale's medical practice when his lease expired on December 31, 1985. (Juris St. 5); App. 118. As defendants themselves acknowledge, the injunction the Court of Appeals affirmed was preliminary in nature. (Juris. St. 1, 14, 16.) This interlocutory judgment is not a final judgment within "the ordinary meaning of that term." *Thornburgh*, 476 U.S. at 754 (dismissing state appeal of

preliminary injunction of abortion law). Thus, defendants' attempt to invoke this Court's mandatory jurisdiction is premature.

The concerns about premature review which underlie the finality requirement of § 1254(2) further caution against the grant of a writ of certiorari to review this preliminary injunction. Although plaintiffs filed suit on behalf of a class of physicians and a class of Illinois women, the preliminary injunction hearing focused primarily on Dr. Ragsdale's need for immediate relief. (Tr. 20.) The District Court made clear that, given the emergency nature of Dr. Ragsdale's case, it was conducting only a "preliminary injunction hearing and not a final injunction [hearing]." (Tr. 622.) The Court, as well as the parties, anticipated that a more complete evidentiary record would be made at a future permanent injunction hearing. (*See* Tr. 20, 531, 622.)

Nowhere is the need for such factual development more important than in the adjudication of fundamental rights, such as the right to privacy. *See United States v. Carolene Products Co.*, 304 U.S. 144, 152 n.4 (1938); *see generally Wisconsin v. Yoder*, 406 U.S. 205, 209-213 (1972). Further fact-finding may have a profound impact upon the rulings made by the lower federal courts on the constitutionality of the Illinois statutes and thereby sharpen the presentation of the ultimate issues should the case come before this Court at some future date.

In addition, as shown below, the Court of Appeals' decision follows closely the directives of this Court with regard to regulation of early abortion services. As a result, defendants cannot support their contention that this case presents issues important enough to warrant review at this

stage. Review by this Court now would be limited to the question of whether the preliminary injunction constituted an abuse of the District Court's discretion and whether the District Court's factual findings, subject to change based on future factual development, were clearly erroneous.[2]

"Problems of prematurity and abstractness may well present 'insuperable obstacles' to the exercise of the Court's jurisdiction. . . ." *Socialist Labor Party v. Gilligan*, 406 U.S. 583, 588 (1972) (citation omitted). Thus, in the past, even where jurisdiction technically existed, this Court has declined to exercise it "unless the case 'tenders the underlying constitutional issues in clean-cut and concrete form.'" *Id.* (citation omitted).

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2 In *Thornburgh*, which held that mandatory jurisdiction exists only to review final judgments, this Court exercised its certiorari jurisdiction to review the preliminary injunction imposed by the Court of Appeals after the trial court had denied injunctive relief. *Thornburgh*, 476 U.S. at 755. There, the District Court had analyzed a facial challenge to an abortion statute based on a stipulated record. *Id.* By way of contrast, the District Court here made preliminary findings on a contested factual record in an as-applied challenge.

II. NO ISSUES OF EXCEPTIONAL IMPORTANCE ARE PRESENTED FOR REVIEW.

A. The Court Of Appeals' Decision Replicates Recent Decisions Of This Court And Is In Accord With Decisions Of Other Courts of Appeals That Have Enjoined Regulatory Schemes That Burden The Abortion Right.

The case at bar is not of exceptional importance meriting review because the decision below merely replicates this Court's decisions in *City of Akron v. Akron Center For Reproductive Health, Inc.*, 462 U.S. 416 (1983), and *Thornburgh*, 476 U.S. 747. Contrary to the inference left by defendants (Juris St. 24), this Court did not uphold a comprehensive licensing and regulatory scheme in *Akron*. Instead, in *Akron*, and again in *Thornburgh*, this Court held that health and safety regulations that burden the abortion right without medical justification are unconstitutional. *See Akron*, 462 U.S. 416 (health regulations restricting second trimester abortions to hospital are unconstitutional); *Thornburgh*, 476 U.S. at 763, 765-66 (counseling regulations which limit physician's professional discretion are unconstitutional, as are abortion-specific reporting requirements).

Other courts of appeals, in cases defendants do not cite, have displayed little difficulty in applying this Court's precedents to enjoin similar state attempts to burden providers of first and early second trimester abortions through purported health and safety regulations. Indeed,

most courts that have examined comprehensive regulatory schemes, either specifically directed at abortion services in the early stages of pregnancy or general in nature but having an impact on the abortion right, have found that such regulations unconstitutionally interfere with a woman's fundamental right to make and effectuate the decision to terminate a pregnancy. *See, e.g., Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352, 364-65 (6th Cir. 1984) (staffing, structural and equipment requirements, similar to those challenged here, declared unconstitutional because compliance would be difficult and would increase the cost of each individual abortion); *Mahoning Women's Center v. Hunter* , 610 F.2d 456, 458-60 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918 (1980) (mem.) (city ordinance that required first trimester abortions to be performed in clinics nearly identical to hospital surgical wards found unconstitutional); *Friendship Medical Center, Ltd. v. Chicago Bd. of Health*, 505 F.2d 1141, 1144-45 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975) (regulatory scheme imposed upon first trimester abortion providers, remarkably similar to the tripartite scheme the State defends here, found unconstitutional). *See also Fox Valley Reproductive Health Care Center, Inc. v. Arft*, 446 F. Supp. 1072, 1074-75 (E.D. Wis. 1978) (general clinic licensing provisions preliminarily enjoined as applied to first trimester abortion provider because of "burdensome interference"); *Indiana Hospital Licensing Council v. Women's Pavilion*, 420 N.E.2d 1301 (Ind. App. 1981)

(licensing scheme found impermissibly to burden right to first trimester abortion).[3]

Defendants overlook this unequivocal support for the Court of Appeals' decision and rely instead on cases that have been superseded by more recent authoritative decisions. Defendants' reliance on *Abortion Coalition of Michigan, Inc. v. Michigan Dep't of Public Health*, 426 F. Supp. 471 (E.D. Mich. 1977) (Juris. St. 26), is particularly inappropriate because the regulations at issue were struck down later in *Reizen*, 743 F.2d 352, a post-*Akron* decision.[4] *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976) (*per curiam*) (Juris. St. 25), is similarly inapposite. In *Hodgson*, the court stated its approval of a requirement, clearly invalid after this Court's 1983 decision in *Akron*, that all second trimester abortions be performed in hospitals. 542 F.2d at 1354. Moreover, on remand for an evidentiary hearing, the three-judge District Court held unconstitutional the regulations, like those at issue here, found to impose significant and unjustified burdens on the fundamental right

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[3] *Simopoulos v. Virginia*, 462 U.S. 506 (1983), is not to the contrary. In *Simopoulos*, this Court upheld only state regulation of a late second trimester abortion performed at 22 weeks of pregnancy. 462 U.S. at 508, 510 n.2. At this advanced stage of pregnancy, a state's interest in the health of the woman becomes compelling. *Roe v. Wade*, 410 U.S. 113, 163 (1973); *see also* App. 19 n.8.

[4] *See Reizen*, 508 F. Supp. 1366, 1369 n.1 (E.D. Mich. 1981), *aff'd in part, rev'd in part*, 743 F.2d 352 (6th Cir. 1984) (stating that the challenged provisions are identical to those in *Abortion Coalition*); *see also Ragsdale v. Turnock*, 625 F. Supp. 1212, 1229 n.22 (1985); App. 144-45 (same).

of a woman to choose to have an abortion. *Hodgson v. Lawson*, No. 4-74-155 (D. Minn., March 7, 1977).[5]

B. The Court Of Appeals Correctly Applied Legal Standards Established By This Court For Review Of Provisions Affecting The Fundamental Right Of Abortion During The Early Stages Of Pregnancy.

State regulation of abortion during the first and early second trimesters of pregnancy is constitutionally permissible only if: 1) such regulation does not in any way burden the abortion decision or its effectuation, *see Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976); or 2) the regulation is integral to the procedure, as contemplated by the *Roe* decision. *See Connecticut v. Menillo*, 423 U.S. 9 (1975) (*per curiam*) (Court upheld statute requiring that abortions be performed by licensed

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[5] *Westchester Women's Health Organization v. Whalen*, 475 F. Supp. 734 (S.D.N.Y. 1979), also cited by defendants (Juris. St. 26), is of doubtful validity, having approved a second trimester hospitalization requirement. The *Westchester* court, unlike this Court in *Akron*, failed to consider an increase in cost as an unconstitutional burden to the effectuation of the abortion decision. The First Circuit's decision in *Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979), upon which defendants also rely (Juris. St. 25), suffers from the same flaw as the Eighth Circuit's decision in *Hodgson*. That case, which upheld a regulatory scheme, was decided on a stipulated record with no evidence of the impact on a fundamental right or of the safety of the abortion procedure as compared to other surgical procedures. *Compare* App. 21.

physicians because *Roe* contemplated that physician would be integral part of abortion process). Thus, during the early stages of pregnancy, a "woman must be permitted, in consultation with her physician, to decide to have an abortion and to effectuate that decision 'free of interference by the State.'" *Akron* 462 U.S. at 429-30, (quoting *Roe*, 410 U.S. at 163).

Where, as here, the evidence demonstrates that a regulatory scheme significantly burdens first and early second trimester abortions, the State must show, by strict factual proof, that such regulation is necessary to the safe performance of the abortion procedure. *See Thornburgh*, 476 U.S. at 759.[6] As this Court repeatedly has warned, "[t]he States are not free, under the guise of protecting maternal health," to create obstacles that burden a woman's effectuation of her decision to have an abortion. *Id.* at 759. The Court of Appeals' decision adheres to this well-settled principle, which defendants show no reason to disturb.

As discussed above, the abortion-directed regulatory scheme here significantly burdens the ability of a woman to effectuate her choice to have an abortion. In addition, defendants failed to offer any justification to support the burdensome scheme.

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6 Medical technology now has made early second trimester abortions, as well as first trimester abortions, extremely safe. *Akron*, 462 U.S. at 429 n.11; *see also* App. 16, 20 n.8. Thus, the Court has struck down purported health regulations burdening early second trimester procedures in the same manner as it has struck regulations burdening first trimester procedures. This Court has recognized that States may have a compelling interest in applying narrowly tailored regulations only in the later stages of pregnancy. *Akron*, 462 U.S. at 427.

Each of the three physicians who testified as an expert witness at trial, including the defendants' expert, testified emphatically that first and early second trimester abortions are among the safest of outpatient procedures. Contrary to the defendants' implications (Juris. St. 8-9), these physicians testified that the State had no legitimate medical reason to single out abortion providers for the imposition of an additional layer of regulation. (Barton, Dep. 95-96, 174, Tr. 466, 475; Ragsdale, Tr. 66-68, 80; Hern, Tr. 238-42, 274, 279.) *See also* App. 30.[7]

The factual findings further demonstrate that the regulatory provisions imposed under the ASTC Act, particularly the costly physical plant requirements, "do not have 'any medical justification.'" App. 29 (citations to the record omitted). Indeed some of the provisions were shown to be "medically poor." App. 29. Thus, as the courts below found, this scheme imposes requirements that force first trimester abortion providers to incur the great costs of building "small hospitals," yet fails to further the safety of the procedure. App. 29.

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7 Nonetheless, defendants continue to defend the statutory scheme, especially the ASTC Act, with its abortion-specific subparts, as medically necessary. Among the provisions lauded by defendants (Juris. St. 12) is a counseling requirement nearly identical to that struck in *Thornburgh*. The ASTC regulations demand that each woman, even if faced with a life-threatening pregnancy, be advised of the alternatives to abortion, although that information might well, as found by the Court of Appeals, "'be cruel as well as destructive of the physician-patient relationship.'" App. 27-28, (quoting *Thornburgh*, 476 U.S. at 763).

Defendants' presentation of this complex regulatory scheme obscures all but its most innocent provisions. (Juris. St. 11-14.) Defendants disregard all of the essential requirements for licensing that impose significant burdens. *See* Ambulatory Surgical Treatment Center Licensing Requirements, 77 Ill. Adm. Code, Chapter I, Subchapter b, Part 205. For example, a facility must have, among other things: (a) a procedure room that is the same size as that recommended for a tertiary care hospital, Section 205.1360(b); App. 232; (b) a "control station" located to allow visual surveillance of traffic entering the operating suite, Section 205.1370(a); App. 233; and (c) an elaborate air-conditioning, heating and ventilation system to provide specified filter efficiencies and airflow relationships between rooms that would be found in a sophisticated operating room suite in a complete care hospital. Section 205.1540; App. 242-43; *see also* App. 5. By the admission of the State's own witnesses, these and other burdensome requirements were designed to accommodate major surgical procedures, not minor procedures such as early abortions. (Linder, Dep. 48; Ramsay, Tr. 764.)

Although a few regulations are, as defendants suggest, consistent with medical standards for abortion providers, the cumulative effect of the ASTC Act, which defendants ignore, is to regulate every minute facet of a first or early second trimester procedure. App 23-25. As a result, physicians are locked into a statutory "straitjacket," *see Danforth*, 428 U.S. 52, 67 n.8, which denies them the professional flexibility needed to make the "best medical

judgment" for each individual woman. App. 27.[8] Further, the cost of compliance with these onerous requirements was found to be prohibitive to potential abortion providers, as well as to women seeking early abortions. App. 22-23.[9]

Defendants' assertion of a general regulatory objective that "'all medical procedures, including abortions, [be] performed under conditions that insure maximum safety'" (Juris. St. 24-25 [citation omitted]) will not support this burdensome regulatory scheme. As the Court of Appeals found, the ASTC Act "was enacted primarily with abortion

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8 The American College of Obstetricians & Gynecologists' Standards for Obstetric-Gynecological Services, Sixth Edition, explicitly approves the performance of first and early second trimester abortions in a physician's office, the specifications of which are left to the doctor's professional discretion. (ACOG Standards 60, 64 [6th Ed. 1985].) Defendants seriously misconstrue these standards with their claim that ACOG recommends uniformly applying the hospital-like standards established in the ASTC Act to first and early second trimester abortion procedures. (Juris. St. 12.)

9 Defendants' contention that "reasonable compliance" with the regulatory scheme would increase the cost of each abortion by only a moderate amount (Juris. St. 27) disregards the District Court's factual finding, affirmed by the Court of Appeals, that compliance would increase the cost per procedure by almost 100 percent more than defendants' claimed amount. *Id.* Defendants do not define "reasonable compliance" nor does the statute specify a consistent standard of required compliance. Indeed, the evidence introduced at trial shows that defendants demand inconsistent levels of compliance. For example, prior to termination of Dr. Ragsdale's lease, his facility had been licensed as "'substantially complying;'" however, "officials charged with enforcing the regulations told Dr. Ragsdale that they would require 'considerably more substantial compliance'" when he moved to a new facility. App 9-10.

clinics in mind. . .." App. 21. In *Thornburgh*, the Court sent a strong message to states, such as Illinois, with a history of anti-abortion legislation, that it will not tolerate government interference with a woman's decision to have an abortion, or her physician's medical discretion in effectuating that decision, under the guise of regulating general health and welfare. *Thornburgh*, 477 U.S. at 759.

Further, defendants' own contention that they no longer apply these purported health regulations to all who provide early abortion services (*see* Juris. St. 9) undercuts their claimed concern for safety. As the Court of Appeals noted, "[t]he State's attempt to regulate experienced, and therefore safer, physicians, more heavily than the occasional abortion provider thus appears . . . to lack even a reasonable basis." App. 24.[10]

In light of the lower courts' findings that the challenged scheme was directed at abortions, defendants cannot obtain review by arguing that the challenged scheme is "abortion-neutral" and therefore subject only to a rational basis standard of review. (Juris. St. 25.) Moreover, defendants' proposed rational basis analysis, which they claim is "supported by decisions of this Court in other contexts" (Juris. St. 26), has been expressly rejected by the Court in the abortion context. State regulations, whether

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[10] Likewise, the attempt to justify the CON portion of the scheme as a cost-containment measure (Juris. St. 6) cannot provide a compelling interest because "the State has discontinued use of [the CON] method, [and] the State has never made such payments for abortions." App. 31. Further, "[w]here the exercise of constitutional rights is concerned, the government may play no role in determining whether outlets for their exercise are 'needed.'" App. 31.

abortion-neutral or abortion-specific, found to impose restrictions on first and early second trimester procedures must be strictly reviewed and enjoined unless justified by a compelling governmental interest. *Akron*, 462 U.S. at 420-21 n.1. Accordingly, in *Akron*, this Court expressly declined the City of Akron's invitation to apply the rational basis analysis to abortion regulations.[11]

Given the substantial burdens resulting from the scheme, and the absence of any compelling justification, the Court of Appeals appropriately affirmed the preliminary injunction ordered by the District Court. Not only is a rational basis standard "wholly incompatible with the existence of the fundamental right recognized in *Roe v. Wade*," *Akron*, 462 U.S. 420-21 n.1, but the Court of Appeals indicated that this burdensome scheme lacked even a reasonable basis. App. 24.

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[11] The Supreme Court cases defendants cite (Juris. St. 26) do not support their argument that a rational basis standard is appropriate. In none of those cases did the Court apply a rational basis standard. Indeed, in *Minneapolis Star & Tribune Co. v. Minn. Comm'r of Revenue*, 460 U.S. 575 (1983), this Court strictly scrutinized a special tax on newspapers, even though there was no evidence of legislative intent to restrict newspapers. Nonetheless, the Court struck down the tax which, like the challenged scheme here, was found to impose a financial burden on the exercise of a fundamental right and which did not serve any compelling governmental interest.

None of defendants' cases refutes the well-established principle that when a general regulatory provision is applied in a manner that burdens a fundamental right, it is unconstitutional. *Compare Wisconsin v. Yoder*, 406 U.S. at 220 (neutral compulsory education law applied to members of Amish religion unconstitutionally burdened their right to the free exercise of religion).

C. The Decision Below Is Consistent With This Court's Decisions In The Areas Of Justiciable Controversies And Severability.

1. In Light Of Defendants' Continuing Policy Of Enforcement, The Court Of Appeals Appropriately Affirmed The Preliminary Injunction.

Defendants' claim that the ruling below conflicts with Supreme Court decisions concerning justiciable controversies (Juris. St. 21-23) does not present an issue within the ambit of 28 U.S.C. § 1254(2); the Court of Appeals' ruling that the case was not moot does not constitute a declaration that a state statute is invalid "as repugnant to the Constitution, treaties or laws of the United States. . .." 28 U.S.C. § 1254(2). Further, defendants present no conflict that would warrant the exercise of certiorari jurisdiction.

Without an injunction, Dr. Ragsdale would have been forced to close his practice, and plaintiff Margaret Moe would not have been able to offer abortion services to her patients. App. at 22. Defendants' employees are given "absolute prosecutorial discretion" as to when and how to enforce statutory provisions (Juris. St. 10). Testimony by defendants' own enforcement personnel revealed that defendants have no consistent policy as to nonenforcement, nor have they publicized in any consistent fashion their alleged nonenforcement policy. App. 10, 14.

In light of the threat of continued enforcement, the Court of Appeals properly rejected defendants' claim that their alleged nonenforcement somehow rendered the controversy moot or nonjusticiable. App. 13-14. Regardless of the label (Juris. St. 21-23), this Court has made clear, in cases relied upon by the Court of Appeals, App. 11, but disregarded by defendants, that voluntary cessation of illegal conduct does not deprive a lower federal court of jurisdiction to affirm a preliminary injunction unless the wrongful conduct could not reasonably be expected to recur, *City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289 n.10 (1982), and all harm caused by the illegal conduct has been "'irrevocably eradicated.'" *City of Los Angeles v. Lyons*, 461 U.S. 95, 101 (1983) (citation omitted). Defendants could not meet this standard here. Particularly considering Illinois' history of enacting restrictive abortion legislation and reenacting such legislation after it previously has been stricken, *see Charles v. Daley*, 749 F.2d 452, 458 (7th Cir. 1984), *appeal dism'd sub nom., Diamond v. Charles*, 476 U.S. 54 (1986), physicians "should not have to risk loss of their professional licenses to explore the contours of the asserted non-enforcement position." App. 14. *Contrast Poe v. Ullman*, 367 U.S. 497 (1961) (cited at Juris. St. 23) (no justiciable controversy because statute essentially not enforced in 82 years).[12]

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12 Defendants inappropriately rely on *J.N.S. v. State of Indiana*, 712 F.2d 303 (7th Cir. 1983), and *C.I.O. v. McAdory*, 325 U.S. 472 (1945), to argue that no justiciable controversy existed before the Court of Appeals. In those cases, a constitutional violation would have occurred only had the challenged statutes been given a particular construction, and the courts in both cases found no threat of such a construction. *See also Alabama State Federation of Labor v. McAdory*, 325 U.S. 450 (1945), *relied on in C.I.O.*, 325 U.S. 472. By contrast,

(Footnote continued on the following page)

Defendants' alternative argument, that the Eleventh Amendment barred the entry of portions of the preliminary injunction, mischaracterizes this Court's decision in *Green v. Mansour*, 474 U.S. 64 (1985), and the Court of Appeals' decision in *Watkins v. Blinzinger*, 789 F.2d 474 (7th Cir. 1986), *cert. denied*, ___ U.S. ___, 107 S. Ct. 1976 (1987). In those cases, the Eleventh Amendment was a barrier to further federal litigation because a ruling by the federal court effectively would have resulted in financial consequences for the State because of past violations of federal law. No such risks exists here, where plaintiffs have not sought damages or economic relief from the State. Further, when the purpose of the federal court remedy is to require the state officer to conform future conduct to the dictates of federal law, it has long been established that the Eleventh Amendment erects no barrier to suit. *Ex Parte Young*, 209 U.S. 123 (1908).

2. The Court Of Appeals Properly Enjoined The Entire Regulatory Scheme As It Applies To Early Abortion Services.

Cognizant of the policies underlying the severability doctrine, both the District Court and the Court of Appeals tailored the injunction to apply only to the extent required to protect plaintiffs' constitutional rights, thereby leaving the State free to apply the regulatory scheme to all non-abortion

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(Continued)
in the present case, the State defends unconstitutional laws by claiming they will not enforce the express terms of the statutes as they were enacted by the Legislature.

procedures. *Compare Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984). This narrow injunction, limiting application of the law as opposed to striking it entirely, is consistent with the Illinois General Assembly's expressed intention in the ASTC Act. *See* Ill. Rev. Stat. ch. 111 1/2, § 157-8.15; App. 165 (to the extent that the Act is held unconstitutional as applied to particular person(s), court appropriately can sever by allowing the statute to remain enforceable as to all others).

The Court of Appeals correctly refused defendants' invitation to rewrite the challenged legislation. App. 32-33. It held that the licensing provision, "'an integral part' of the scheme as a whole," was itself unconstitutional as it applied to plaintiffs. App. 32, *see also* App. 23-24. Without the licensing requirement, the remaining provisions, many of which themselves were unconstitutionally burdensome, would not be applicable. Thus, the Court of Appeals held that it could not "'untangle the constitutional from the unconstitutional provisions . . .,'" App. 33 (quoting *Mahoning*, 610 F.2d at 460), without impermissibly usurping the Illinois General Assembly's legislative function. App. 33.

This is consistent with defendants' own cases. Severing specific provisions is not appropriate "'if what is left is [not] fully operative as a law,'" or if "'it is evident that the Legislature would not have enacted those provisions which are within its power, independently of that which is not.'" *Buckley v. Valeo*, 424 U.S. 1, 108-09 (1976) (*per curiam*) (quoting *Champlin Refining Co. v. Corporation Commission*, 286 U.S. 210, 234 [1932]); *see also* Juris. St. 29. Here, neither condition is met.

CONCLUSION

For all of the foregoing reasons, this appeal should be dismissed, or in the alternative, the judgment below should be affirmed.

Respectfully submitted,

ALAN S. GILBERT
LORIE A. CHAITEN
SONNENSCHEIN CARLIN
NATH & ROSENTHAL
8000 Sears Tower
Chicago, Illinois 60606
(312) 876-8000

COLLEEN K. CONNELL
(COUNSEL OF RECORD)
ROGER BALDWIN
FOUNDATION OF
AMERICAN CIVIL
LIBERTIES UNION OF
ILLINOIS
20 E. Jackson Boulevard
Suite 1600
Chicago, Illinois 60604
(312) 427-7330

Dated: January 14, 1989

No. 88-790

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,
Appellants,

v.

RICHARD M. RAGSDALE, M.D., et al.,
Appellees.

On Appeal From The United States Court Of Appeals For The Seventh Circuit

APPELLANTS' REPLY TO MOTION TO DISMISS OR AFFIRM

NEIL F. HARTIGAN
Attorney General, State of Illinois

ROBERT J. RUIZ
Solicitor General, State of Illinois
100 West Randolph Street, 12th Floor
Chicago, Illinois 60601
(312) 917-3000

Attorneys for Appellants

MICHAEL J. HAYES*
KATHLEEN KREISEL FLAHAVEN
ROGER P. FLAHAVEN
GLADYS STEVENS
Assistant Attorneys General
100 West Randolph Street, 13th Floor
Chicago, Illinois 60601
(312) 917-3654

Of Counsel * Counsel of Record

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

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THIS COURT HAS APPELLATE JURISDICTION TO REVIEW THE JUDGMENT OF THE COURT OF APPEALS PURSUANT TO 28 U.S.C. SECTION 1254(2)

In their Jurisdictional Statement (pp. 1-2), defendants demonstrated that this Court has appellate jurisdiction to review the final judgment entered by the Court of Appeals. That judgment held unconstitutional the challenged

provisions of the Illinois Medical Practice Act (MPA), the Illinois Ambulatory Surgical Treatment Center Act (ASTC) and related regulations, and the Illinois Health Facilities Planning Act (HFPA) to the extent any person or facility offers or performs, or desires to offer or perform first and early second trimester abortions or abortion-related gynecological procedures.

The plaintiffs attempt to argue that this matter is not subject to review under 28 U.S.C. Section 1254(2). In so arguing, the plaintiffs incorrectly focus upon the district court preliminary injunction order, rather than the decision of the Court of Appeals. (Pls.' Motion, pp. 5-7). In addition to affirming the preliminary injunction, the Court of Appeals invalidated the licensure requirement and struck the other challenged provisions as applied to first and early second trimester abortions.

In discussing the severability issues presented by the case, moreover, the plaintiffs acknowledge that the Court of Appeals has held that the Illinois general "licensing provision . . . was itself unconstitutional as it applied to plaintiffs." (Pls.' Motion, p. 21; App. 25). Similarly, the Court of Appeals need not have considered the severability issues unless the statutes and regulations had been held unconstitutional. In light of the holding by the Court of Appeals, this Court has appellate jurisdiction under 28 U.S.C. Section 1254(2).

In addition, the plaintiffs misstate that they and the district court contemplated further evidentiary hearings after the preliminary injunction trial. (Pls.' Motion, p. 6). That statement is contradicted by the comments of plaintiffs' counsel and the district court judge subsequent to the issuance of the preliminary injunction decision. At that time, plaintiffs' counsel volunteered the following statements:

> MR. GILBERT: One other matter, and this doesn't relate directly to this order, and that is, just in terms of the future course of this proceeding, given the scope of the evidentiary hearing and the briefing that has gone on and the scope of your Honor's order, it seems to us that there probably isn't a need to have another trial in this matter and that we have pretty much aired the issues here and relatively completely and, to that end, we have made a suggestion to the state, a request, that we would be willing to turn this into a final injunction order pursuant to Rule 65, which allows a proceeding for preliminary injunction to be a proceeding for a final and permanent injunction as well. (Tr. 861-62).

In the same vein, the district court judge and plaintiffs' counsel stated as follows:

> THE COURT: . . . I can't really think of anything more that either side would put in that would really make all that much difference in the Seventh Circuit's decision in the case. It is really—the guts of the argument on both sides are in and the evidence is in. It is really a question of interpreting the Supreme Court decisions and maybe drawing a few reasonable inferences. But there really isn't all that much in the way of factual disputes, it is really more a question of interpretation of the existing laws. (Tr. 864-65).
>
> MR. GILBERT: Yes. Right. That's how we see it. . . . (Tr. 865).

In *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), this Court concluded that it had no appellate jurisdiction under Section 1254(2). 476 U.S. at 755. This Court reached that conclusion because the Third Circuit had not held the entire Act unconstitutional, had invalidated only some provisions, and had remanded the case for further development of the facts. 476 U.S. at 754-55.

In this case, however, the Seventh Circuit did hold the challenged acts unconstitutional, thereby invalidating all of the regulatory provisions as applied to first and early second trimester abortions. The Seventh Circuit did not remand for further development of the facts. Clearly, the Seventh Circuit judgment is final and this Court has appellate jurisdiction under 28 U.S.C. Section 1254(2).

THE QUESTIONS PRESENTED ARE SUBSTANTIAL

A.

THE COURT OF APPEALS ERRONEOUSLY FOUND THAT THE CHALLENGED STATUTES AND REGULATIONS ARE UNCONSTITUTIONAL.

In enacting the ASTC Act, Illinois recognized the increasing trend toward the development of free-standing or outpatient surgical facilities. Abortions are performed in 22 of the 42 outpatient surgical facilities which are licensed in Illinois. The decision of the Court of Appeals has exempted those 22 surgical facilities from licensure and regulation to the extent they perform first and early second trimester abortions.

This exemption has undermined Illinois' duty and authority to protect patients who are undergoing abortions at such facilities in the same manner that the state can protect patients who are undergoing other surgical procedures. This exemption is inconsistent with decisions of other circuits and, contrary to the plaintiffs' suggestions, is not supported by decisions of this Court.

The plaintiffs suggest that this case is unimportant and attempt to argue that the decision of the Court of Appeals "replicates" this Court's decisions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). (Pls.' Motion, p. 8). That argument is incorrect.

At issue in this case is the State's authority to license and regulate outpatient surgical facilities in which abortions are performed to the same extent it licenses and regulates outpatient surgical facilities in which other surgical procedures are performed. Neither *Akron* nor *Thornburgh* involved such generally applicable statutes and regulations. Both of those cases addressed challenges to abortion-specific statutes.

In fact, none of the cases relied upon by the plaintiffs support the Court of Appeals' decision to exempt outpatient surgical facilities in which abortions are performed from a general licensure provision. For example, plaintiffs cite *Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352 (6th Cir. 1984). In that case, however, the Sixth Circuit did not invalidate on privacy grounds the State's authority to license outpatient surgical facilities in which abortions are performed. In fact, the licensure question was not perceived to involve privacy rights and was dealt with as an equal protection issue. More importantly, the court upheld the requirement as reasonable. 743 F.2d at 358-59.

Plaintiffs also rely upon *Mahoning Women's Center v. Hunter*, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds, mem.*, 447 U.S. 918 (1980). In that case, the Sixth Circuit invalidated in its entirety an ordinance which singled out for extensive regulation only medical clinics

performing abortions. Similarly, plaintiffs cite the decisions in *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975) and *Fox Valley Reproductive Health Care Center, Inc. v. Arft*, 446 F.Supp. 1072 (E.D. Wis. 1978). Again, these cases dealt with abortion-specific ordinances, rather than generally applicable licensure provisions. Thus, these cases do not support the decision of the Seventh Circuit to exempt from general licensure provisions outpatient surgical facilities in which first and early second trimester abortions are performed.

Contrary to plaintiffs' assertion, *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 420 n.1 does not hold that abortion-neutral statutes and regulations "must be strictly reviewed and enjoined unless justified by a compelling government interest." (Pls.' Motion, pp. 16-17). *Akron* involved a challenge to an ordinance enacted "to regulate the performance of abortions" (*id.* at 419), rather than abortion-neutral provisions. Defendants maintain that the rational basis test should have been applied to the abortion-neutral provisions at issue in this case. (Juris. St., pp. 25-26).

Plaintiffs' attempts to distinguish *Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979) and *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976) also miss the mark. Those cases uphold licensing standards of outpatient surgical facilities in which pregnancy terminations are performed. Thus, those decisions conflict with the ruling of the Seventh Circuit in this case which held that licensing of such facilities constitutes an unconstitutional invasion of privacy.

Plaintiffs state that defendants failed to offer any justification to support the challenged statutes and regulations. (Pls.' Motion, p. 12). That statement ignores the record

in this case. In the Jurisdictional Statement, defendants demonstrated the legitimate and substantial purposes of the challenged statutes (Juris. St., pp. 5-6 and 25) and regulations (Juris. St., pp. 11-14).

In addition, the plaintiffs suggest that it is not reasonable for the State to regulate surgical facilities in which abortions are performed more heavily than doctor's offices in which abortions are performed. (Pls.' Motion, p. 16). The Sixth Circuit dealt with a similar argument in *Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352 (6th Cir. 1984). The court recognized that in private offices the physician generally has direct control over staff and office functions, while in outpatient surgical facilities nonphysicians may have control over personnel, equipment and the design of the facility. The Sixth Circuit concluded, therefore, that it was not unreasonable for Michigan to decide to regulate free-standing surgical facilities including abortion clinics while not regulating physicians' offices. 743 F.2d at 358-59. The statutes and regulations which were invalidated in this case reflect a similar reasonable decision by the State of Illinois.

The State has the duty and the power to protect the health, safety and welfare of its citizens by licensing and regulating outpatient surgical facilities. The State's important interests in assuring that certain minimal standards be complied with at such facilities do not cease to exist when abortions are performed at such facilities.[1] In

[1] The American College of Obstetricians and Gynecologists' Standards for Obstetric-Gynecologic Services, Sixth Edition [ACOG Standards] provides that "[A]mbulatory care facilities for abortion services should meet the same standards of care as for other surgical procedures." (ACOG Standards 62). The Standards further provide that "Ambulatory surgical facilities that are free-standing or hospital-based should maintain the same surgical, anesthetic, and personnel standards that hospitals do." (ACOG Standards 61).

fact, the plaintiffs' trial experts testified that medical education in this country has paid little attention to abortion services and that there are few surgical procedures given so little attention and so underrated in its potential hazard as abortion.

B.

THE MAJORITY OPINION CONFLICTS WITH DECISIONS OF THIS AND OTHER COURTS REGARDING SEVERANCE OF PURPORTEDLY UNCONSTITUTIONAL PROVISIONS.

In the Jurisdictional Statement, defendants demonstrated that the majority opinion of the Seventh Circuit erred in rejecting the argument that any purportedly unconstitutional provisions be severed. (Juris. St., pp. 28-29). Plaintiffs ignore the thrust of defendants' argument. (Pls.' Motion, pp. 20-21). In this case, the lower courts and plaintiffs argue that the appropriate analysis entails the estimation of the cost of compliance with all of the challenged regulations. (App. 22). This aggregated sum supposedly substantiates the "impact on the abortion decision." *Id.* The nature and degree of the alleged burden on constitutional rights should not depend upon the number or volume of statutes and regulations which are challenged. Rather, those statutes and regulations should be scrutinized independently and on their own merit.

Birth Control Center, Inc. v. Reizen, 743 F.2d 352 (6th Cir. 1984) offers further support for the defendants' argument that the Seventh Circuit improperly invalidated all of the challenged provisions. In *Reizen*, the Sixth Circuit upheld the licensure requirement, upheld certain regulations and struck other regulations. That court did not refuse to sever those provisions which it found unconstitutional. Rather, the challenged statutes and regulations

were individually analyzed. The same procedure should have been utilized by the Seventh Circuit in this case.

C.

THE COURT OF APPEALS ERRONEOUSLY ASSUMED JURISDICTION OVER UNENFORCED PROVISIONS.

In the Jurisdictional Statement, defendants demonstrated that the Seventh Circuit's assumption of jurisdiction over unenforced provisions conflicts with decisions of this Court and Courts of Appeals regarding justiciability standards as well as with decisions addressing the jurisdictional bar created by the Eleventh Amendment. (Juris. St., pp. 21-23). The plaintiffs, however, attempt to posit the case as one involving mootness issues. (Pls.' Motion, p. 19).

The uncontradicted evidence of record established that due to various court decisions, well prior to the commencement of this action, the State ceased to enforce certain challenged provisions: the abortion-specific language of par. 157-8.3 of the ASTC Act (App. 149-50); Sections 205.740 (App. 222) (prohibition of second trimester abortions in ASTCs) and 205.760 (App. 223) (abortion-specific reporting requirement) of the ASTC Regulations; and par. 4400-22 of the MPA. (App. 193).

While the plaintiffs now suggest that there is a "threat of continued enforcement" of those provisions, they do not specify what future conduct State officials must change to conform to the dictates of federal law. (Pls.' Motion, pp. 18-20). Even the Seventh Circuit noted that State officials cannot be required to remove or amend regulations which are not being enforced. (App. 13).

Defendants maintain that no justiciable controversy existed at the time of the filing of this case with respect to those challenged provisions which were no longer being

enforced. Further, the exception to the Eleventh Amendment's jurisdictional bar relied upon by the plaintiffs (Pls.' Motion, p. 20) is inapplicable to the challenge to the unenforced provisions. Absent some ongoing violation of federal law, *Ex Parte Young*, 209 U.S. 123 (1908) does not apply and the jurisdictional barrier created by the Eleventh Amendment remains intact.

CONCLUSION

For these reasons, this Court should deny plaintiffs' Motion to Dismiss or Affirm and should note probable jurisdiction of this appeal.

Respectfully submitted,

NEIL F. HARTIGAN
Attorney General, State of Illinois

ROBERT J. RUIZ
Solicitor General, State of Illinois
100 West Randolph Street, 12th Floor
Chicago, Illinois 60601
(312) 917-3000

Attorneys for Appellants

MICHAEL J. HAYES *
KATHLEEN KREISEL FLAHAVEN
ROGER P. FLAHAVEN
GLADYS STEVENS
Assistant Attorneys General
100 West Randolph Street, 13th Floor
Chicago, Illinois 60601
(312) 917-3654

Of Counsel * Counsel of Record

January 27, 1989

88-790

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NEIL F. HARTIGAN
Attorney General, State of Illinois

ROBERT J. RUIZ
Solicitor General, State of Illinois
100 West Randolph Street, 12th Floor
Chicago, Illinois 60601
(312) 917-3000

Attorneys for Appellants

MICHAEL J. HAYES *
KATHLEEN KREISEL FLAHAVEN
ROGER P. FLAHAVEN
GLADYS STEVENS
Assistant Attorneys General
100 West Randolph Street, 13th Floor
Chicago, Illinois 60601
(312) 917-3654

Of Counsel * Counsel of Record

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INDEX TO APPENDIX

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APPENDIX TO JURISDICTIONAL STATEMENT

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

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Plaintiffs-Appellees,

v.

BERNARD J. TURNOCK, Director of the Illinois Department of Public Health, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85-C-6011—**John A. Nordberg,** *Judge.*

ARGUED OCTOBER 22, 1986—DECIDED MARCH 10, 1988

Before BAUER, *Chief Judge,* COFFEY, *Circuit Judge,* and ESCHBACH, *Senior Circuit Judge.*

ESCHBACH, *Senior Circuit Judge.* Plaintiffs consist of a class of all duly licensed physicians and surgeons performing or who desire to perform pregnancy terminations in Illinois and a class of all women in the State of Illinois of child-bearing age who desire or may desire an abortion at sometime in the future. Defendants are a class of the State's Attorneys of all of the counties of the State of Illinois,[1] the Director of the Illinois Department of Public

[1] Class certification as to both the defendant and plaintiff classes was challenged below. The district court granted certification. 625 F. Supp. at 1219-24. That ruling is not challenged on appeal.

Health, the Illinois Attorney General, and the Director of the Illinois Department of Registration and Education. Plaintiffs sued under 42 U.S.C. § 1983 and 28 U.S.C. §§ 2201-02, seeking declaratory and injunctive relief to the effect that three Illinois statutes and the regulations thereunder violate the constitutional right to privacy, specifically to abortion, as established in *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973), and subsequent Supreme Court cases. This case comes to us on appeal from the district court's grant of plaintiffs' motion for a preliminary injunction. 625 F. Supp. 1212 (N.D. Ill. 1985). Because we believe certain of the claims are moot, we vacate in part. In most respects, however, we affirm the preliminary injunction.

I

A. Statutory and Regulatory Provisions

The statutory and regulatory scheme is somewhat complex. Therefore, we set it out in some detail. Section 16(1) of the Medical Practice Act ("the MPA"), 111 Ill. Rev. Stat. ¶ 4433(1), allows for revocation or suspension of the license of any physician who performs an "elective abortion" in any place other than a licensed Ambulatory Surgical Treatment Center ("ASTC"), a hospital, or a facility run by the state or federal governments.[2] The Am-

[2] Section 16(1) of the Medical Practice Act reads, in pertinent part:

> The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license . . . of any person . . . in this state to practice medicine . . . upon any of the following grounds:
>
> (1) Performance of an elective abortion in any place . . . other than:
>
> (a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" . . .;

(Footnote continued on following page)

bulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.* (the "ASTCA" or the "Act"), provides for the licensure of all ASTCs, which it defines as "any . . . place . . . devoted primarily to . . . the performance of surgical procedures or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. . . ." 111½ Ill. Rev. Stat. ¶ 157-8.3(A). In addition, plaintiffs have challenged those sections of the Health Facilities Providers Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.* ("HFPA"), which require anyone seeking to open an ASTC to obtain a certificate of need for the facility from the Department of Public Health after a public hearing and 120-day review period. *See* 111½ Ill. Rev. Stat. ¶¶ 1155-1160.[3]

[2] *continued*

> (b) [a licensed hospital];
>
> (c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof . . .;
>
> (d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government, or
>
> (e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation. . . .

[3] Section 1158 of the Health Facilities Planning Act reads, in pertinent part:

> . . . When an application for a permit is initially reviewed by a recognized areawide health planning organization or [the Department of Public Health] . . . [they] shall afford an opportunity for a public hearing within a reasonable time after receipt of the complete application. . . . Such hearing shall be conducted in the area or community where the proposed project is to occur, and shall be for the purpose of allowing the applicant and any interested person to present public testimony concerning the approval, denial, renewal or revocation of the permit. . . . The State Board shall promulgate reasonable rules and regulations governing the procedure and conduct of such hearings.

The bulk of plaintiffs' specific challenges, however, are directed at the ASTCA and the regulations promulgated thereunder, and their application, via the MPA, to physicians desiring to perform first and early second trimester abortions. Accordingly, we set forth the ASTCA and its accompanying regulations in some detail.[4]

The Act itself is largely procedural in operation and grants the Department of Public Health the authority to promulgate specific regulations governing ASTCs. 111½ Ill. Rev. Stat. ¶ 157-8.10. However, certain specific provisions of the statute also prescribe requirements for ASTCs. Section 6.1 of the ASTCA requires any corporation operating an ASTC devoted primarily to providing facilities for abortion to have on its board of directors a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the ASTC. Sections 157-8.5 and 8.6 generally provide for licensing with an initial fee of $500 and an annual renewal fee of $300. Additionally, those sections require that a licensed facility be under the supervision of one or more physicians and that at least one physician have admitting and surgical privileges at an Illinois hospital. Sections 157-8.7a and 8.7b require statements regarding the ownership of and financial condition of the facility. Section 157-8.8 requires Department approval of construction of, alterations of, or additions to a facility. Section 157-8.9 provides for quarterly inspections of facilities and provides for confidentiality of information received by the Department.

The remedial sections of the Act provide an array of enforcement mechanisms. Section 157-8.9a provides that a facility may be closed by administrative order if its continued operation constitutes an imminent and serious menace to the health or safety of the patients or if the operator thereof has been convicted of a violation of section 157-8.12. Section 157-8.12 provides for a fine of $10,000 per day for operating a facility without a license or otherwise violating the Act. Section 157-8.13 makes the operation of a facility in violation of the Act or regulations a public nuisance subject to injunction.

[4] Selected regulations that are discussed in detail in our analysis *infra* in the text are set forth in an Appendix to this opinion.

Section 157-8.15 provides, in broad terms, for severability of the provisions of the Act.

The general regulations under the ASTCA, found in Title 77 of the Illinois Administrative Code, are detailed and govern many aspects of an ASTC.

For example, there are quite specific physical plant regulations which require: (1) a minimum size of 250 sq. ft. or at least one procedure room (any additional ones must be no smaller than 120 sq. ft.) and a minimum of 80 sq. ft. for examinations rooms; (2) that an ASTC be "identifiably separate from other medical facilities and functions"; (3) that a "control station" be located to allow visual surveillance of traffic entering the operating suite; (4) that facilities including a lounge, lockers, separate toilets, and a space for changing clothes be provided for male and female personnel; (5) a separate janitorial closet for the surgical suite; (6) a "diagnostic facility" if pre-admission evaluation tests are to be performed; and (7) minimum corridor (5′ or 8′ depending on whether stretchers are to be used) and door (3′ or 3′8″) widths. § 205.1310-1390. Also, an elaborate air-conditioning, heating, and ventilation system to provide for specific filter efficiencies and airflow relationships between rooms is required. § 205.1540 and Table A.

The licensure regulation provides for a detailed application including identification of the owners and operators of the facility, its location, a description and architectural plans, documentation of compliance with building and safety codes, a description of the services to be performed, and a list of all personnel and their qualifications. A new application is required for a change in ownership, location of the facility, remodeling, or addition of services or programs. Notice to the Department must be given of any

change in the administrative staff, medical director, staff physicians, supervising nurse, addition or deletion of surgical procedures, or change in any shareholder interest of five percent or more. § 205.120.

Other general requirements include an organizational plan which is available for public information, a policies and procedures manual, and written personnel policies including job descriptions. § 205.310. All facilities are required to have the following personnel present during the operative and post-operative period for all patients: a physician, a registered professional nurse with post-graduate education or experience in surgical nursing, and a person certified in "Basic Life Support" by the American Heart Association. Sections 205.320-40. Additionally, each facility must have either a certified medical technician or a written agreement with a licensed laboratory to perform required laboratory procedures. § 205.350. A consulting committee must be established to develop standards of professional work and a physician must serve as the medical director of the facility. § 250.230.

With regard to equipment, all facilities are required to have monitoring equipment, suction apparatus, oxygen, and cardiac pulmonary resuscitation equipment. § 205.410. Additional written procedures are required to govern care, use, sterilization, storage and disposal of all materials, and to govern storage and use of all medications. *Id.* Additional written procedures are required for garbage and refuse removal, insect and rodent control, and maintenance of heating, ventilation and utility service. § 205.420.

Patient care regulations include a requirement of a written "emergency" procedure in case of fire, explosion, or "other non-patient medical emergency," and preparation to manage the emergencies normally associated with the surgical procedures performed. § 205.510. A "complete physical" is required and specified tests are required to be performed by a qualified laboratory technician for any procedures performed under general anesthesia, local anesthesia with sedation, or any pregnancy termination. A signed, written informed consent for any procedure is to

be maintained with the patient's clinical records. § 205.520. All removed tissues are to be examined by a consulting pathologist. § 205.530.

Post-operative care regulations provide that any patient who has had general anesthesia, local anesthesia with sedation, or pregnancy termination is required to be observed for a period of time sufficient to detect any immediate post-operative complications, and that no patient be required to leave in less than one hour. § 205.540. Additionally, written documentation is required of a transfer agreement with a licensed hospital within fifteen minutes of the facility, or that the medical director of the ASTC (or each staff physician of the ASTC) has admitting privileges at such a hospital. § 205.540.

Detailed clinical records are also required to be maintained. § 205.610. Additionally, facilities are required to make annual statistical reports that include the number and type of procedures performed, the number and type of complications reported, the number of patients requiring transfer to a hospital due to complications, the number of patients returning for follow-up, and the number of deaths.

The regulations also have an abortion-specific subpart which requires: (1) at least one registered professional nurse with post-graduate education or experience in obstetrical or gynecological nursing, section 205.720; (2) testing and reporting of the results to the patient of blood Rh factor and diagnosis of pregnancy, section 205.730(a); and (3) counseling by someone specifically trained to give it and who has no financial interest in the patient's decision, which counseling must include a discussion of alternatives, description of the procedure to be performed, and an explanation of risks and possible complications, section 205.730(b). Contraceptive information may be provided post-operatively, and shall be provided if desired by the patient. *Id.* Counseling must take place in a room separate from the procedure room, and a record of the counseling given is to be included in the patient's clinical record. *Id.*

The subpart contains its own reporting requirement which requires monthly reporting of each procedure "on forms provided by [the Department]." Additionally, the regulations prohibit an ASTC from performing abortions on patients with a gestational age exceeding twelve weeks. § 205.740.

B. Enforcement Policies

Not all of the provisions of challenged statutes and regulations are being enforced. Since 1981, the Act and regulations have been applied only to facilities which are primarily devoted to the performance of surgical procedures (including abortions). This enforcement policy was adopted in response to *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981), which refused to enforce, in a criminal proceeding, that portion of a local ordinance which incorporated the ASTCA definition of an ASTC which covered "any facility where a medical or surgical procedure is performed for the termination of pregnancy, regardless of whether the facility is primarily devoted to that purpose." The defendants also contend that the MPA's revocation or suspension sanction for performing abortions outside an ASTC is similarly not being enforced, but the evidence on this point is equivocal.

The defendants also contend that the prohibition on performance of second trimester abortions in ASTCs is not being enforced because it was considered enjoined by the order in *Paula Poe v. IDPH*, No. 78-C-4126 (N.D. Ill. 1982). In that case, enforcement of section 4 of the Illinois Abortion Law of 1975, 38 Ill. Rev. Stat. § 81-24, which required all second trimester abortions to be performed in a hospital, along with "any related regulation" was enjoined pending decision of three Supreme Court cases involving a second trimester hospitalization requirement. *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 103 S. Ct. 2481 (1983); *Planned Parenthood Association, Inc. v. Ashcroft*, 462 U.S. 476, 103 S. Ct. 2517 (1983); and *Simopoulos v. Virginia*, 462 U.S. 506, 103 S. Ct. 2532 (1983). An internal memorandum of the Department of Public Health following the decisions in those cases opined that they confirmed the unconstitutionality of the second trimester hospitalization requirement in the Illinois statutes and regulations. *See* Deft. Ex. 4. Representatives of the defendants testified at trial that the requirement is not currently being enforced for this reason.

Defendants also contend that section 10 of the Illinois Abortion Law of 1975, an abortion-specific reporting requirement, was enjoined by Judge Kocoras in *Charles v. Carey*, 579 F. Supp. 464 (N.D. Ill. 1983), *aff'd in part, rev'd in part on other grounds Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984) (*Charles II*), *appeal dismissed sub nom. Diamond v. Charles*, 106 S. Ct. 1697 (1986), and that the abortion-specific reporting requirement in the ASTC regulations has not been enforced since that time.

These non-enforcement policies are not publicly stated, but persons who inquire of the various enforcement agencies are informed of them.

C. Individual Plaintiff Dr. Ragsdale

The individual plaintiff physician was required to relocate his practice, the Northern Illinois Women's Center ("the NIWC"), which is the only facility of its kind (that is, a non-hospital clinic) offering abortion services in a large area of northwestern Illinois because his landlord refused to renew his lease. The facility which he had been operating was not in full compliance with the ASTCA regulations, but was nonetheless licensed as "substantially complying" with them. When he sought another location, he had to go through the certificate-of-need proceedings. The required public hearing on the application degenerated into a shouting match between "pro-choice" and "pro-life" members of the public, after which the doctor's prospective landlord withdrew his lease commitment. In addition, officials charged with enforcing the regulations told him that they would require "considerably more substantial compliance" than had been the case with his prior facili-

ty, particularly with respect to the architectural requirements. The cost of either building a facility or renovating one to comply with the regulations was estimated by the plaintiff at between $25.21 and $47.66 per patient. Because of his inability to find a location that can be renovated to comply with the ASTCA, particularly the structural and physical plant requirements of the regulations, at a reasonable cost, Dr. Ragsdale will close the NIWC unless the statute is enjoined.

D. Individual Plaintiff Margaret Moe

Margaret Moe is a registered nurse who currently operates two medical facilities in the State of Illinois. The facilities offer family planning education and medical care that includes the prescription of contraceptives, prenatal care, and delivery assistance for pregnant women. Her clinics receive approximately sixty requests for abortions each week. She would like to offer abortion services at her clinics, and she has on staff physicians who are competently trained and willing to perform such abortions. However, her facilities do not comply with the structural requirements of the Act and regulations and cannot be renovated to so comply without prohibitive cost. Accordingly, she does not offer such services.

II

We first consider whether certain of plaintiffs' challenges have been mooted by the State's non-publicized policy of non-enforcement.[5] It is well established that voluntary cessation of putatively illegal conduct ordinarily will not

[5] We note that the defendants did not argue that portions of the case were moot until their reply brief, arguing in their initial brief only that the non-enforcement policy meant that the plaintiffs were not being irreparably harmed by the statutory scheme. Nonetheless, as we are under a duty to determine our own jurisdiction, we must consider the question of mootness even if no party properly raises it.

moot a controversy and prevent its adjudication by a federal court. *City of Mesquite v. Aladdin's Castle, Inc.*, 455 U.S. 283, 289 & n.10, 102 S. Ct. 1070, 1074 & n.10 (1982); *County of Los Angeles v. Davis*, 440 U.S. 625, 631, 99 S. Ct. 1379, 1383 (1979); *United States v. W.T. Grant Co.*, 345 U.S. 629, 632-33, 73 S. Ct. 894, 897 (1953); *see also Charles v. Daley*, 749 F.2d 452, 456-58 (7th Cir. 1984) (*Charles II*), *appeal dismissed sub nom., Diamond v. Charles*, 106 S. Ct. 1697 (1986). However, such cessation does render a controversy moot where there is no reasonable expectation that the putatively illegal conduct will be repeated, and there are no remaining effects of the alleged violation. *Davis*, 440 U.S. at 631, 99 S. Ct. at 1383; *W.T. Grant*, 345 U.S. at 633, 73 S. Ct. at 897. Defendants bear a heavy burden of persuading the court that a controversy is moot. *United States v. Phosphate Export Association, Inc.*, 393 U.S. 199, 203, 89 S. Ct. 361, 364 (1968); *W.T. Grant*, 345 U.S. at 633, 73 S. Ct. at 897; *Charles II*, 749 F.2d at 457; *Sanchez v. Edgar*, 710 F.2d 1292, 1294-95 (7th Cir. 1983).

We note additionally that cessation of the allegedly illegal conduct by government officials has been treated with more solicitude by the courts than similar action by private parties. According to one commentator, such self-correction provides a secure foundation for a dismissal based on mootness so long as it appears genuine. *See* 13A Wright, Miller & Kane *Federal Practice and Procedure* § 3533.7, at 353 (2d ed. 1984).

A.

We believe that application of these general principles to the present circumstances mandates a conclusion that plaintiffs' challenge to the second trimester hospitalization requirement is moot. As we have noted above, the defendants have conceded, at least since 1983, that this requirement is unconstitutional under governing Supreme Court decisions and is therefore not enforced. Plaintiffs have not attempted to counter the defendants' showing

on this point, nor do we believe they could. The individual plaintiff Dr. Ragsdale testified that he was informed by a State inspector that the hospitalization requirement was not being enforced and that after that time he began performing early second trimester abortions at his facility.

Analogous assurances of discontinuance of the challenged conduct have been held to render challenges moot in other cases. For example, in *McRary v. Polythress*, 638 F.2d 1308 (5th Cir.), *cert. denied*, 454 U.S. 865, 102 S. Ct. 325 (1981), election officials conceded that they had erred by attempting to compel a political candidate to file certain financial disclosure reports and wrote the candidate abandoning their request for such reports. This, according to the court, mooted the challenge to the officials' action because "Appellant 'has presented no evidence creating a reasonable expectation that the [Commission] will repeat its purportedly unauthorized actions in subsequent elections. Appellant's conclusory assertions that the actions are capable of repetition are not sufficient. . . . .'" *Id.* at 1310 & n.1 (quoting *Illinois State Board of Elections v. Socialist Workers Party*, 440 U.S. 173, 187, 99 S. Ct. 983, 992 (1979). In *Northern Virginia Women's Medical Center v. Balch*, 617 F.2d 1045 (4th Cir. 1980), an even more questionable assurance of discontinuance was held to moot the controversy. There, a local prosecuting attorney's policy of not enforcing a state trespass statute against anti-abortion protestors who unlawfully entered and blocked access to an abortion clinic was challenged as a denial of Equal Protection. The court held that the prosecutor's assertion at oral argument that the non-enforcement policy had been abandoned, coupled with the fact that prosecutions had in fact occurred during the pendency of the litigation, rendered the challenge moot. According to the court, "[s]ince the good faith of this representation is not questioned, we conclude that the controversy between the Center and the commonwealth attorney is now moot and that it is not likely to be revived." *Id.* at 1049.

We believe that the defendants' now public policy of non-enforcement of the hospitalization requirement, particularly in view of the reasons therefor (*i.e.*, that enforcement is barred by clear Supreme Court precedent), moots any challenge to that requirement. While we share plaintiffs' concern that the State has not acted to remove or amend the statute and regulations, we know of no authority by which we can require it to do so. The most we could do, and all plaintiffs request of us, is to enjoin their enforcement. Federal courts do not, as a rule, enjoin conduct which has been discontinued with no real prospect that it will be repeated. Accordingly, the challenge to the second trimester hospitalization requirement should have been dismissed. Therefore we vacate the portion of the injunction that pertains to it.

B.

However, we do not believe that the challenge to the reporting requirement of the ASTCA and regulations is moot. Although defendants testified that this requirement is no longer being enforced in light of *Charles v. Carey*, 579 F. Supp. 464 (N.D. Ill. 1983), we have reviewed that decision and cannot find anything in it which remotely supports the conclusion that the requirement under challenge here was enjoined. The only reporting requirement addressed by that decision was section 11(d) of the Illinois Abortion Act, which required the reporting to the Department of the name of any patient diagnosed as having complications from abortion. The more general requirements here are quite different. Unlike its representations of non-enforcement of the other sections, the State produced no pre-existing documentation of the policy. We share the district court's concern that the State's position on this provision is asserted only in this litigation.

C.

The challenge to the application of the ASTCA and regulations to first trimester abortions is similarly not moot.

While the requirement is apparently no longer applied to the "occasional" abortion provider, the State continues to maintain that it is free to apply the ASTCA to abortion providers whose practice is "primarily devoted to" performing surgery, even if that "surgery" consists exclusively of first trimester abortions. This is in fact the situation facing at least one of the named plaintiffs, Dr. Ragsdale.

Additionally, the evidence regarding the suspension/ revocation sanction in the MPA was, as we have noted, ambiguous. A representative of the Department merely testified that any complaint regarding this provision would be "examined by the General Counsel's office for a determination of whether there would be any enforcement action taken pursuant to that section." He additionally testified that "to the best of [his] knowledge" the Department would not enforce the section. While we admit that it would be anomalous for the Department to take the position that "occasional" abortion providers need not be licensed but that performance of such abortions could subject the physicians to revocation of their licenses to practice medicine, the Department's position is sufficiently murky and the sanctions sufficiently severe, that we believe a live controvery exists regarding this requirement. Doctors should not have to risk loss of their professional licenses to explore the contours of the asserted non-enforcement position.

III

On the merits,[6] we must consider whether the requirements of the statutory and regulatory scheme violate the

[6] On appeal, various of the defendants and amici contend that the district court did not properly weigh various of the factors which are normally considered in issuing a preliminary injunction. We note that the presentation of the case below focused almost exclusively on the constitutionality *vel non* of the statutory scheme or its component parts. None of the parties argued the traditional factors governing the granting of preliminary relief to the district

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right to privacy (and to abortion) as established in *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 710 (1973), and its progeny. In *Roe*, the Court first set out the now familiar "trimester" approach:

> (a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
>
> (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

410 U.S. at 164-65, 93 S. Ct. at 732.

In elaborating on this approach, the Court noted that the State's interest in the health of the mother becomes compelling:

[6] *continued*
court. Although no doubt its task was made more difficult by the lack of assistance from the parties, the district court undertook a thorough examination of those traditional factors, *i.e.*, the lack of an adequate remedy at law, irreparable harm, balance of harms, likelihood of success on the merits, and the public interest. We confine our discussion to the likelihood of success on the merits, that is, the governing legal standards and their relationship to the facts found below for two related reasons. First, the balancing of the other factors is typically reviewed on an "abuse of discretion standard" and we see no abuse, and second, we find insufficient merit to any of the defendants' or the amicus' belated assertions that this or that factor was given insufficient weight to add to this already lengthy opinion.

> in the light of present medical knowledge, . . . at approximately the end of the first trimester. This is so because of the now-established medical fact, . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.
>
> This means, on the other hand, that, for the period of pregnancy prior to this "compelling" point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.

Id. at 163, 93 S. Ct. at 731-32.

Since *Roe*, the Court, along with the lower federal courts, has on numerous occasions clarified the constitutional standards which apply to regulations aimed at both first and second trimester abortions. Few restrictions on first trimester abortions have been upheld. For example, the Court upheld a requirement that all abortions be performed by a licensed physician. *Connecticut v. Menillo*, 423 U.S. 9, 96 S. Ct. 170 (1975) (*per curiam*). This requirement, apart from being endorsed in *dictum* in *Roe*, was upheld because "the State retains an interest in ensuring the validity of Roe's factual assumption that 'the first trimester abortion [is] as safe for a woman as normal childbirth at term,' an assumption that 'holds true only

if the abortion is performed by medically competent personnel under conditions insuring the maximum safety of the woman.' " *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 430 n.12, 103 S. Ct. 2481, 2492 n.12 (quoting *Menillo*, 423 U.S. at 11, 96 S. Ct. at 171).

Likewise, the Court upheld a state-required pathology examination which required tissues removed by abortion, like all other removed tissues, to be examined by a pathologist. *Planned Parenthood Association, Inc. v. Ashcroft*, 462 U.S. 476, 103 S. Ct. 2517 (1983). This was because such an examination was considered "absolutely necessary" from a medical standpoint and " 'abnormalities in the tissue may warn of serious, possibly fatal disorders.' " *Id.* at 487-89, 103 S. Ct. at 2523-24. According to the Court, certain regulations of even first trimester abortions that " 'have no significant impact on the woman's exercise of her right [to have an abortion] may be permissible where justified by important state health objectives.' " *Id.* at 489-90, 103 S. Ct. at 2524 (quoting *Akron*, 462 U.S. at 430, 103 S. Ct. at 2492-93 (alterations by the Court)).

The quoted language clearly indicates that, where first trimester abortions are involved, not only must the impact of the challenged regulation be insignificant in terms of the woman's exercise of her right, but also that the regulation must be "justified by important state health objectives." This is consistent with our own case law to the effect that once such regulations are shown to have more than a *de minimus* impact on the abortion decision, the government must show a compelling basis for the law, *i.e.*, that the burden is not undue or unjustifiable. *Charles v. Carey*, 627 F.2d 772, 777 (7th Cir. 1980) (*Charles I*), *on remand*, 579 F. Supp. 464 (N.D. Ill. 1983).[7]

[7] Appellants make much of the fact that the district court connected the two parts of the *Charles I dictum* with "and" rather than "that is," claiming that the district court thus applied an improper standard. *See* 625 F.2d at 1230. This claim is meritless.

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Appellants contend that the district court's application of a "medical necessity" standard was error. We disagree. First, we believe that a "medical necessity" standard, at least as the term was used in the testimony below, is entirely consonant with the standards to be applied to regulations regarding first trimester abortions. *See Akron*, 462 U.S. at 430, 103 S. Ct. at 2492-93 (such restrictions must be "justified by important state health objectives"); *Ashcroft*, 462 U.S. at 487, 103 S. Ct. at 2523 (pathology examination requirement upheld because "absolutely necessary" from a medical standpoint). Additionally, it is clear from a review of the transcript that when the experts below testified that a requirement was not "medically necessary," they meant by that term that it had no real relationship to safety or health. *See, e.g.*, R. Vol. I at 112 (testimony of Dr. Ragsdale) (certain provisions not medically necessary because without "any real relationship to the particular circumstances" of physician performing abortions). According to the testimony, the minimum size requirements for examination rooms, procedure rooms, recovery rooms, corridors and doors, for example, not only were not "medically necessary," but do not enhance the safety of the abortion procedure "in any way" or did not have "any medical justification." R. Vol. I at 263-72 (testimony of Dr. Hern); *see also* R. Vol. I at 154 (testimony of Dr. Ragsdale) (large procedure room "not only medically unnecessary but medically poor"). The district court found, with full support from the record, that the physical plant requirements of the regulations required ASTCs to

[7] *continued*
Charles I in fact reiterated the standard enunciated by the Supreme Court, that the state must justify its regulation with a compelling interest and show that the regulation is narrowly drawn to express only that interest. *See* 627 F.2d at 776-78. Scrutiny of such laws always involves two questions: (1) how important the asserted state interest is, and (2) how well the regulation is drawn to achieve only that interest. *Charles I* did not intend to suggest that the second inquiry was unnecessary, and appellants' reliance on it for that purpose is misplaced.

be "the functional equivalent of small hospitals," 625 F. Supp. at 1216, and that these requirements "may be medically detrimental." *Id.* at 1230 n.23.

We note as well that the question whether some or all of the requirements of the statute and regulations could be constitutionally applied to early second trimester abortions is a more nettlesome one, but it is a question which we need not decide.[8] The statute and regulations do not

[8] A number of the regulations involved may well pass muster under the less stringent standard of review applied to state regulation of second trimester abortions. That standard allows the state to regulate second trimester abortions to the extent that the regulation "reasonably relates to the preservation and protection of maternal health," but it may not "adopt abortion regulations that depart from accepted medical practice." *Akron*, 462 U.S. at 430-31, 103 S. Ct. at 2493. The experts who testified at hearing described many of the requirements as "consistent with accepted medical practice." While it is true, as the district court found, that "[t]his is not equivalent to a showing of medical necessity," such a showing is not required for regulations which apply only to the second trimester.

We note that the Supreme Court stated in *Roe* that the state's interest in maternal health during the second trimester extends to "the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic of some other place of less-than-hospital status; as to the licensing facility; and the like." 410 U.S. at 163, 93 S. Ct. at 732. Further, in *Simopoulos v. Virginia*, 462 U.S. 506, 103 S. Ct. 2532 (1983), the Court rejected an attack on a criminal conviction, upholding against a charge of facial invalidity a statute requiring all second trimester abortions to be performed in a "hospital," where that term was defined to include facilities which were not full-fledged acute care hospitals. Thus, it appears that at least some licensing of facilities performing second trimester abortions would be permissible. However, we caution that the Court in *Simopoulos* specifically noted that "[w]e need not consider whether Virginia's regulations are constitutional in every particular. . . . [A]ppellant has not attacked them as being insufficiently related to the State's interest in protecting health." *Id.* at 513, 103 S. Ct. at 2539. Also, *Simopoulos*, unlike the present case, involved a late second trimester abortion performed using the saline instillation method.

(Footnote continued on following page)

distinguish between the two. Indeed, as written, due to the (now unenforced) second trimester hospitalization requirement, they originally applied *only* to first trimester abortions. Accordingly, as we have in other cases, we apply the legal standards applicable to restrictions on first trimester abortions. *See Charles I*, 627 F.2d at 782; *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1149 (7th Cir. 1974), *cert. denied*, 420 U.S. 955, 95 S. Ct. 1438 (1975). We are simply not at liberty to insert the words "except with regard to first trimester abortions" into either the statute or the regulations. To do so would result in a scheme with little resemblance to that enacted by the Illinois legislature or the Department of Public Health. *See Thornburgh v.*

[8] *continued*

Much of the testimony below was to the effect that the requirements of the regulations bore little relationship to safe performance of early second trimester abortions as well as first trimester abortions. This should come as little surprise, since the medical procedures utilized are quite similar if not identical. We remind the State of the Supreme Court's admonition in *Akron* that:

> [I]f it appears that during a substantial portion of the second trimester the State's regulation "depart[s] from accepted medical practice," supra, at 2493, the regulation may not be upheld simply because it may be reasonable for the remaining portion of the trimester. Rather, the State is obligated to make a reasonable effort to limit the effect of its regulations to the period in the trimester during which its health interest will be furthered.

462 U.S. at 434, 103 S. Ct. at 2495.

Thus, while the trimester approach remains the applicable legal framework for weighing the competing interests involved in the abortion decision, it does not necessarily follow that all state regulations of abortion which are keyed to it are reasonable. Instead, the state should endeavor to draw its regulations designed to further maternal health in medically relevant terms (for example, certain of the requirements of the statute involved here may well make sense for late second trimester abortions which are performed under a general anesthetic, but not for simple "dilation and evaculation" abortions performed early in the second trimester).

American College of Obstetricians, 106 S. Ct. 2169, 2181 (1986).

Defendants suggest that, because the regulations apply to all facilities primarily devoted to surgery, we must review them under a different standard than if they had singled out abortions. We disagree. Defendants have cited us to no cases, and we have found none, which would justify such a distinction. In fact, *Friendship* suggests, albeit in *dictum*, exactly the opposite. 505 F.2d at 1153-54; *see also Birth Control Centers, Inc. v. Reizen*, 743 F.2d 352, 361-62 (6th Cir. 1984) (applying strict scrutiny notwithstanding general applicability of regulations).

We adhere to the statement in *Friendship* for several reasons. First, we cannot ignore the fact that the ASTCA was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally in an effort to save the statute from unconstitutionality. *See* Pf. Ex. 22-24 (minutes of ASTC Licensing Board meetings). Secondly, the State cannot, merely by applying the expedient and conclusory label "surgery" to a medical procedure, apply requirements which would be necessary to major surgical procedures in the abortion context where they would be wholly inappropriate. It is as much a vice to treat abortion similarly to dissimilar procedures as it is to treat it differently from analogous procedures. In either case, imposition of burdensome requirements which are completely unnecessary to the performance of safe abortions is attempted. A prime example of this problem is the fact that many of the physical plant requirements of the regulations are designed with procedures to be performed under general anesthesia in mind, although the testimony in this case clearly established that first and early second trimester abortions of the type at issue here are not usually performed using such anesthesia and that, in fact, the use of a general anesthetic increases the risk of death and major complications from such procedures.

With the standards enunciated above in mind, we now turn to evaluation of the constitutionality of the challenged statutes and regulations.

IV

A.

The State initially contends that the plaintiffs have not met their threshold burden of showing an impact on the abortion decision. We must reject this contention. The district court found that the regulations at issue do substantially burden the effectuation of the decision to have an abortion. Specifically, the lower court found that the regulations raised the cost of abortions, by $25-$40 for abortions performed at Dr. Ragsdale's clinic, and, more importantly, that they would limit the availability of abortions in that, unless the regulations were enjoined, the clinic would close for lack of a suitable location that could be renovated to comply with them.[9] Additionally, the district court found that the regulations prevented individual plaintiff Moe from offering abortion services at her clinic because the cost of compliance was prohibitive. We cannot say these findings are clearly erroneous.

Dr. Ragsdale testified that he estimated compliance with the regulations would entail a per-patient cost of between $25 and $40.[10] While the defendants point out, correctly,

[9] The Americans United for Life Legal Defense Fund, as amicus curiae, contends that, because individual plaintiff Dr. Ragsdale would have had to relocate his clinic regardless of the regulations (due to an ostensibly unrelated business decision of his landlord), plaintiffs have presented no direct injury flowing from the challenged government conduct. However, this argument misses the critical point that the regulations make difficult, if not impossible, the relocation of an existing abortion practice or the commencement of a new one. As such, we have little doubt that plaintiffs have established a sufficient injury both to satisfy Article III and to warrant the grant of injunctive relief.

[10] Defendants place considerable emphasis on the allegedly erroneous admission of Dr. Ragsdale's handwritten cost estimates. We need not decide whether these constituted inadmissible hearsay, however, because Dr. Ragsdale testified at length, and without objection, to the substance of the estimates. Therefore, the admission of the written estimates themselves, if error, was surely harmless.

that this is not a great deal more than the cost of the pathology examination upheld in *Ashcroft*, they seem to have missed the import of that case. The Court did not hold that the impact was so small that the state was not required to justify it at all. It merely held that, during even the first trimester, requirements having an insignificant impact on the abortion decision were constitutional "where justified by important State health objectives." Thus, the regulations at issue here, which have a *greater* financial impact than that in *Ashcroft*, must be justified by at least similar state interests.

Additionally, although the financial per-patient cost of compliance might not seem overwhelming, it is not the only burden which must be considered. The lack of availability of abortions caused by the up-front cost and difficulty of obtaining a complying facility is at least as real and possibly more burdensome to women seeking abortions. Furthermore, there was testimony of the psychological burdens which would result from having to undergo an abortion in a hospital-like facility when the more psychologically comforting setting of a doctor's office would serve just as well from a medical standpoint. We cannot say that these burdens are "*de minimus*." *Cf. Charles I*, 627 F.2d at 777 ("direct interference" is shown where impact is not *de minimus* or where regulation imposes restrictions "that did not already exist"). Therefore, they must be justified by important state health objectives.

B.

The first facet of the scheme we consider is the requirement that facilities performing first trimester abortions be licensed at all. While this may not seem a particularly onerous requirement, we note Supreme Court precedent suggests only that a licensing requirement may be permissible in the second trimester. The Court stated in *Roe* that the state's interest in maternal health during the second trimester extends to "the facility in which the procedure is to be performed, that is, whether it must be

a hospital or may be a clinic of some other place of less-than-hospital status; as to the licensing of the facility; and the like." 410 U.S. at 163, 93 S. Ct. at 732. By contrast, the Court stated that during the first trimester "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectutated by an abortion *free from interference by the State.*" *Id.* (emphasis added).

While we realize that the last quoted statement has been qualified by the Court in subsequent decisions (that is, where the "interference" does not have a significant impact and furthers important state health concerns), we nonetheless believe it retains force here. Thus, we are persuaded in this case that the State may not require separate licensure of facilities primarily devoted to performing abortions.

A primary factor which persuades us is that the State has in no way shown that performance of first trimester abortions in physicians' offices rather than heavily regulated ASTCs in any way undermines the safety of the operation. We further note that *Akron* itself seems to reject such an argument. 462 U.S. at 429 n.11. The State in fact basically concedes that it cannot prevent doctors from performing at least some abortions in their offices.

To the extent that there is any basis for distinguishing between a doctor who occasionally performs an abortion in his office and one whose practice is primarily devoted to such procedures, the regulations appear to run contrary to sound health policy. All of the expert testimony in the record is in agreement that the physician who performs many abortions in general will have more expertise and therefore a better safety record. The State's attempt to regulate experienced, and therefore safer, physicians, more heavily than the occasional abortion provider thus appears, as the district court noted, to lack even a reasonable basis.

We realize that the Sixth Circuit upheld a similar general licensing requirement in *Reizen*. However, in doing so, the court did not address a challenge based on the constitutional right to abortion, but rather an Equal Protection challenge based upon the physician's right to practice. Accordingly, the court applied a highly deferential "rational basis" standard of review. 743 F.2d at 358-59. As we have already held, such a standard of review is not appropriate in this case. Additionally, none of the evidence of the type mentioned above was apparently present in *Reizen*. There, the district court found that a private physician was more likely to have direct control over staff and procedures, but that the absence of this control might characterize a "clinic." Such findings are absent in this case.

Purely as a matter of the plain language of the statutory and regulatory scheme, once the licensing requirement falls, the remainder of the requirements fall with it (or, more properly, are inapplicable). The specific substantive requirements are not (leaving aside the unenforced requirement that all abortions must be performed in an ASTC) applicable to abortions, *per se*, but rather to ASTCs. In the alternative, however, we analyze those specific substantive aspects of the regulations focused on at trial which render the scheme unconstitutional as a whole.[11]

[11] We do not decide whether particular provisions of the regulations not specifically mentioned in the text would, standing alone, pass constitutional muster. In particular, the pathology examination required by the general regulations seems nearly identical to that upheld in *Ashcroft*. Also the reporting requirement does not appear particularly onerous, nor does it appear calculated to raise the fear of harassment by physicians and patients by raising the spectre of public disclosure. Section 205.760 of the regulations merely requires a report of each procedure performed in an ASTC within ten days, and that such reports be made in such a manner and at such time so as not to avoid accurate reporting of complications. If complications become known to the ASTC, it is required to submit a supplemental report. Section 205.620, a non-abortion-specific reporting requirement, merely requires reporting

(Footnote continued on following page)

C.

The abortion-specific subpart of the regulations is of particular concern. Many of the requirements set forth in that subpart seem clearly contrary to either prior Supreme

[11] *continued*
of the number and type of procedures performed, the number and type of complications reported, the number of patients requiring transfer to hospitals, the number of patients returning for follow-up, and the number of deaths. These requirements appear to be consistent with *Planned Parenthood Association, Inc. v. Danforth*, 428 U.S. 52, 79-81, 96 S. Ct. 2831, 2846-47 (1976). The requirements are considerably less stringent than those previously enjoined. In particular, the name of the patient is in no way required to be disclosed to the State.

Additionally, a number of the other general requirements seem as though they would place no real burden at all on the abortion right. Requirements which may fall in this category might include the general provisions relating to personnel and administrative procedures governing ASTCs, such as those calling for a written policies and procedures manual, consulting committee, organization plan, personnel policies, and maintenance of a sanitary facility. Similarly, the operative care and post-operative care regulations may be in accord with accepted medical practice. Dr. Ragsdale objected to many of these requirements as "stating the obvious." However, so far as we are aware, there is no constitutional bar to "stating the obvious" even where abortion procedures are concerned.

Fewer of the abortion-specific regulations, as is evident from our discussion in the text, fall in this category. However, there was testimony below that the counselor qualification requirements of section 205.730(b)(2) were consistent with accepted medical practice. Additionally, subsection (1) of the same regulation merely requires, in general terms, that some counseling be given prior to the performance of an abortion (and that it occur in a room separate from the procedure room). As noted in the text *infra*, other aspects of the counseling requirements suffer from constitutional defects. Also, section 205.710 merely provides that "Abortions shall be provided to the public with the same standards of safety effectiveness, and regard for patients rights as any other health service."

Of course, we need not and do not decide the ultimate constitutionality of any of the requirements mentioned above.

Court precedent or our own cases. In particular, we note that section 205.730(a)(2) apparently requires the physician who is to perform the abortion to also perform a pregnancy test on the patient regardless of whether such testing had previously been done by another physician. We previously invalidated a similar "same doctor" requirement in an Illinois statute. *See Charles I*, 627 F.2d at 784, 786. The requirement in the instant regulation is, if anything, more burdensome and less justified than the one we invalidated there, which required only that the performing physician provide the patient with "a true copy" of her pregnancy test, rather than to possibly conduct a second test. For the same reasons as in *Charles I*, the provision in this case is invalid.

The counseling requirements too suffer from constitutional defects. Section 205.730(b)(3) attempts to prescribe the precise content of such counseling in mandatory terms applicable to all cases. The regulation states that counseling "shall include a discussion of alternatives, description of the procedure to be performed, explanation of the risks and possible complications." We believe that this provision, particularly the requirement of a "discussion of alternatives" is unconstitutional under the Supreme Court's recent decision in *Thornburgh v. American College of Obstetricians*, 106 S. Ct. 2169 (1986). The requirement "that a specific body of information be given in all cases, irrespective of the particular needs of the patient, intrudes upon the discretion of the pregnant woman's physician and thereby imposes the 'undesired and uncomfortable straitjacket' " which the Court has rejected. *Id.* at 2179 (quoting *Planned Parenthood Association, Inc. v. Danforth*, 428 U.S. 52, 67 n.8, 96 S. Ct. 2831, 2840 n.8). The informational requirements of the regulation are certainly not as intrusive or as specific as those previously stricken by the Court, but they are just as inflexible. Dr. Ragsdale testified below that some of the information, particularly the "discussion of alternatives" might not be appropriate for some patients. We agree that "for a patient with a life-threatening pregnancy, the 'information' in its

very rendition may be cruel as well as destructive of the physician-patient relationship." *Thornburgh*, 106 S. Ct. at 2180. We bear in mind that, during the second trimester at least, "the validity of an informed consent requirement . . . rests on the State's interest in protecting the health of the pregnant woman." *Id.* at 2179 (quoting *Akron*, 462 U.S. at 443, 103 S. Ct. at 2499). Viewed in this light, the provision at issue here may, like that in *Thornburgh*, "require[ ] the dissemination of information that is not relevant to such consent, and thus, it advances no legitimate state interest." *Id.* at 2180.

Another aspect of the counseling requirements is troubling. Section 205.730(b)(2)(D) requires that "counselors shall have no financial interest in the patient's decision." We find it impossible to read this provision in such a way that it does not, at least in some cases, preclude the performing physician from providing the counseling. This, we believe, is fundamentally at odds with the emphasis placed on the patient-physician relationship by *Roe* and its progeny. The woman desiring an abortion, according to those cases, is to reach that decision in consultation with "her responsible physician." *Roe*, 410 U.S. at 153, 93 S. Ct. at 727; *cf. Akron*, 462 U.S. at 449, 103 S. Ct. at 2502 (striking down a requirement that the attending physician, rather than other professionals, *must* provide the requisite counseling). The state cannot preclude that dialogue, or demand that others be a party to it merely because the physician has a "financial interest" in the woman's decision. In all other areas of medicine, the state relies on the physician's professional and ethical obligations to prevent his "financial interest" from clouding his perspective to the detriment of his patient. It may not do otherwise merely because an abortion decision is involved. *See Doe v. Bolton*, 410 U.S. 179, 197-200, 93 S. Ct. 739, 750-51 (1973). In *Doe*, the Court struck down requirements that an abortion be approved by a hospital abortion committee and by two other physicians independent of the woman's own consulting physician because, *inter alia*, the state required such additional approval for "no other voluntary

medical or surgical procedure. . . ." According to the Court:

> If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice.

Id. at 199, 93 S. Ct. at 751.

We believe those principles are equally applicable here. Accordingly, we hold that the requirement that counseling be conducted by one who has no "financial interest" in the patient's decision is unconstitutional.

D.

Of the requirements applicable to ASTCs generally, the physical plant equipment and staffing requirements, in particular, seem totally unjustified from a medical standpoint. The testimony regarding many of the physical plant requirements makes clear that they have "no medical justification whatsoever" when applied to first and early second trimester abortions of the type involved in this case.

According to the testimony, the minimum size requirements for examination rooms, procedure rooms, recovery rooms, and corridors and doors not only are not "medically necessary," but do not enhance the safety of the abortion procedure "in any way" and do not have "any medical justification." R. Vol. I at 263-72 (testimony of Dr. Hern); *see also* R. Vol. I. at 154 (testimony of Dr. Ragsdale) (large procedure room "not only medically unnecessary but medically poor"). We agree that the requirements that ASTCs performing first and early second trimester abortion(s) be "the functional equivalent of small hospitals" are not sufficiently justified by "important state health objectives" to be sustained.

Additionally, the ventilation requirements of the regulations, which require specific air pressure relationships between rooms and specific air change ratios are unrelated to the safety of first and early second trimester abortions. The purpose of such requirements is to prevent infection from airborne bacteria. All of the medical experts, including defendants', testified that airborne bacteria simply is not relevant to the procedures involved in this case, because the procedures do not involve an incision. The sole testimony to the effect that such requirements might be advisable came from the State's architectural expert, who apparently believed that an incision was required. It can scarcely be doubted that such a witness lacks any expertise to enable him to form an opinion regarding the medical justification for a particular requirement.[12]

More importantly, perhaps, the defendants failed to adduce any evidence at all of a medical justification for the physical plant requirements. Although the defendants protest on appeal that plaintiffs' experts who testified as to the lack of medical justification were not building and construction experts, the relevant test is whether the standards are "justified by important state health objectives." It seems clear to us that medical experts can offer testimony relevant to that standard, and it is questionable whether those without a health care background can. As we have noted above, only defendants' architectural expert testified as to the need for the ventilation requirements. This witness similarly testified regarding room sizes, although he stated that the requirements were drafted with procedures involving general anesthesia in mind. At one point, he testified that he relies on the

[12] Defendants' medical expert, Dr. Barton, lacked significant experience performing first trimester abortions. Those which he did perform were generally performed under a general anesthetic in a hospital setting. Due to his lack of experience relevant to the procedures at issue in this case, the district court properly accorded his testimony little weight. Defendants similarly do not rely on it heavily in this court.

physician operating a facility to determine what is medically required. Linder Dept. at 42.

The structural, equipment, and staffing requirements of the regulations are quite similar to those invalidated in *Reizen*. *See* 743 F.2d at 364-65. They also bear a remarkable resemblance to the abortion-specific scheme we invalidated in *Friendship*. While the evidence in *Reizen* indicated a per-patient cost increase considerably greater than that in this case (*Friendship* did not consider particularized cost estimates), the regulations there, as here, would have required considerable up-front expenditures. Also, as we have noted above, per-patient financial cost is not the only relevant burden. We have little trouble concluding that these requirements, which impose a substantial burden and are not justified by health objectives, are unconstitutional.

E.

We also believe that the "certificate of need" proceeding requirement of the Health Facilities Planning Act is unconstitutional. The only interest which the State has articulated is the desire to keep costs down under the "cost-plus" disbursement method which was at one time used by the State in making certain health care payments for its residents. Apart from the fact that this interest no longer exists because the State has discontinued use of this method, the State has never made such payments for abortions. Furthermore, the interest cannot be said to be compelling in any event. While a state may have some interest in preventing wasteful duplication of resources, the interest must give way where the exercise of constitutional rights is concerned. Certainly it would be unconstitutional for a state to require that anyone desiring to publish a newspaper demonstrate "need" for the publication, though it can scarcely be gainsaid that at least some few involve wasteful duplication. Where the exercise of constitutional rights is concerned, the government may play no role in determining whether outlets for their exercise are "needed."

The unconstitutionality of the "certificate of need" proceedings as applied to ASTCs that wish to perform abortions is exacerbated by the failure of the State to prevent the process from becoming essentially a public veto of the ASTCs' existence. As we noted above, the proceedings attended by the individual plaintiff physician was allowed to degenerate into a shouting match between abortion foes and advocates of free choice. The State's unwillingness or inability to confine the proceedings to its even arguably legitimate goals bolsters our conclusion that this requirement cannot stand because it is not justified by any legitimate State interest.

V

While, as we have noted above, there may well be facets of the statute and regulations which would individually pass constitutional muster, *supra* nn. 8 & 11, we are constrained to affirm the district court's injunction of the scheme as a whole. Defendants, citing *Zbaraz v. Haritgan*, 763 F.2d 1532, 1545 (7th Cir. 1985), *appeal pending*, No. 85-673 and *Charles I*, 627 F.2d at 779, urge that we specifically analyze each provision and sever those portions which are unconstitutional. However, in neither *Zbaraz* nor *Charles I* were we confronted with a comprehensive scheme which either applied or not depending on whether a licensing requirement could stand. In *Zbaraz*, we noted that severability applies only to "any provisions which can be given effect without the invalid provisions," and that "severance is improper if the unconstitutional provision is 'an integral part of the statutory enactment viewed in its entirety.'" 763 F.2d at 1545 (quoting *Scheinberg v. Smith*, 659 F.2d 476, 481 (5th Cir. 1981)). Here, where we are dealing with a licensing scheme and the provision for separate licensure is itself invalid, not only can none of the other provisions "be given effect without the invalid provisions," but the licensing provision is certainly "an integral part" of the scheme as a whole. Additionally, in neither *Zbaraz* nor *Charles I* was the scheme

already so riddled with exceptions resulting from judicial decisions and non-enforcement policies as to be unintelligible. In such circumstances, we simply "cannot untangle the constitutional from the unconstitutional provisions. . . ." *Mahoning Women's Center v. Hunter*, 610 F.2d 456, 460 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918, 100 S. Ct. 3006 (1980).

As originally written, the statute and regulations represented at least a coherent, if unconstitutional, whole which regulated all aspects of abortion practice in Illinois. However, as a result of various judicial decisions, and the defendants' change of enforcement policies in response to them, the scheme has long since lost that coherence. The statute and regulations as written bear very little resemblance to the way they are currently enforced. As is clear from portions of our opinion, we have at times encountered considerable difficulty discerning just what the law in Illinois is. Yet, the State expects physicians, on pain of professional censure (possibly including loss of their licenses) and a $10,000 a day fine, to divine the contours of the rules under which they must operate.

Under these circumstances, we fully agree with the Sixth Circuit's decision in *Mahoning Women's Center*. There, in invalidating, in its entirety, a local ordinance that required "the functional equivalent of a hospital" for first trimester abortions, the court held "[i]n this situation, we do not believe a useful purpose would be served by attempting to rewrite the minor provisions of the ordinance in order to make them constitutional." 610 F.2d at 461. We could not agree more.

Accordingly with the exception of the portion of the injunction regarding the second trimester hospitalization requirement, which is VACATED AS MOOT, the preliminary injunction is

AFFIRMED.

COFFEY, *Circuit Judge*, dissenting. A decade and one-half ago the Supreme Court announced "that the right of personal privacy includes the abortion decision, but that this right is not unqualified and must be considered against important state interests in regulation." *Roe v. Wade*, 410 U.S. 113, 154, 93 S.Ct. 705, 727 (1973). Today, under the guise of protecting the woman's constitutional privacy rights, the majority holds that the State of Illinois' health services statutory scheme, enacted in an attempt to regulate the ever-escalating costs of medical care without sacrificing its citizens' health and safety, is unconstitutional. Specifically, now some 14 years after its enactment, the majority declares the Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1 *et seq.* (the "ASTCA" or the "ASTC Act") and the regulations promulgated thereunder unconstitutional, holding that the State may not require licensure of facilities devoted primarily to performing semi-complicated (minor) surgery, including first-trimester abortions. As an alternative approach, the majority chooses and carves out a select few ASTC regulations among various others, discusses their validity, and then proceeds to invalidate those regulatory sections of the ASTC Act that apply to first-trimester abortion facilities in Illinois, stating that it was unable to sever those provisions of the Act it deemed unconstitutional from those that were constitutional. Thus, the majority strikes down the ASTCA and baldly asserts that "the [statutory] scheme has long since lost . . . coherence." Unfortunately, it is the majority's decision, rather than the Illinois legislative scheme, that lacks coherence.[1] I am convinced that under *Roe* and its

[1] The majority's precise holding is confusing. On the one hand, the majority affirms the district court's preliminary injunction which only enjoined Illinois from regulating ASTCs to the extent those facilities were performing abortions. On the other hand, the majority apparently strikes down not only § 16(1) of the MPA, but the ASTCA and the IHFPA as well, stating it could not "untangle the constitutional from the unconstitutional," and further asserts that specific substantive aspects of the statutes and regulations are unconstitutional and "render the scheme unconstitutional as a whole."

progeny that the individual states have the authority to ensure that all surgical procedures, including first-trimester abortions, are performed "under conditions insuring maximum safety for the woman." *Connecticut v. Menillo*, 423 U.S. 9, 11, 96 S.Ct. 170, 171 (1975) (per curiam). Certainly states have the power and authority, if not the duty, to apply the same licensing standards to abortion facilities as those applied to facilities performing similar surgical procedures.[2] I know of no law to the contrary.

Moreover, the majority decision ignores the legislative intent and the historical context of the enactment of the challenged provisions: section 16(1) of the Medical Practice Act (the "MPA"), 111 Ill. Rev. Stat. ¶ 4433(1); the Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.*, and the regulations promulgated thereunder; and the Illinois Health Facilities Planning Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.*, particularly ¶¶ 1155-1160. Research reveals that the Illinois legislature enacted § 16(1) of the MPA[3] intending to limit the performance of abortions only to licensed ambulatory surgical treatment centers, hospitals, or similar facilities and expressed such intention by requiring licensure of "any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose," (definitions section—

[2] As demonstrated, *infra*, the most significant undisputed fact in the record is that an abortion, regardless of the trimester in which it is performed, is considered a surgical procedure, albeit a minor surgical procedure, accompanied all too frequently by concomitant medical, physical, and psychological complications.

[3] As noted by the majority, § 16(1) of the MPA "allows for revocation or suspension of the license of any physician *who performs an 'elective abortion' in any place other* than a licensed Ambulatory Surgical Treatment Center (ASTC), a hospital, or a facility run by the state or federal governments." (Emphasis added.)

ASTCA, ¶ 157-8.3(A)).[4] However, the legislature's primary purpose for enacting the *Ambulatory Surgical Treatment Center Act* was to regulate and prescribe safeguards for the rapidly developing trend of cost-effective ambulatory surgical medical services. The majority unfortunately disregards this primary purpose which provided the impetus for the enactment of the ASTCA and through mere speculation holds that the ASTCA is solely an abortion statute. Further, in its determination to do away with the duly enacted legislation, the majority completely disregards the statute's severability clauses as if they didn't exist, stating it could not "untangle the constitutional from the unconstitutional" and thus refuses to give effect to the challenged acts.[5] Rather than recognize and effectuate the true intent and legitimate purpose of the acts and enjoin only those provisions which might impinge on a woman's limited right to terminate her pregnancy (§ 16(1) of the MPA, its companion clause in ¶ 157-8.3(A) and § 205.730(b)(2)(D) of the ASTCA regulations), the majority, in over-expansive language, declares, " '[W]e do not believe a useful purpose would be served by attempting to rewrite minor provisions of the ordinance [in this case

[4] ¶ 157-8.3 provides:

"(A) 'Ambulatory surgical treatment center' means any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures *or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose.* Such facility shall not provide beds or other accommodations for the overnight stay of patients. Individual patients shall be discharged in an ambulatory condition without danger to the continued well being of the patients or shall be transferred to a hospital."

(Emphasis added to highlight the clause included in the ASTCA restricting the availability of an abortion.)

[5] The severability clauses of the MPA, ASTCA, and the IHFPA are found respectively at 111 Ill. Rev. Stat. ¶ 4458, 111½ Ill. Rev. Stat. ¶ 157-8.15, and 111½ Ill. Rev. Stat. ¶ 1166.

the statutes and regulations] in order to make them constitutional.' " In so holding, the majority improperly substitutes its judgment for that of the legislature which enacted the statute because of its concern for the safety of its citizens. In the end, the majority decision severely limits (or casts aside) the state's ability to implement cost-effective schemes and regulate rapidly developing and modern methods of providing medical services simply because abortion (surgical) procedures may be involved. The majority's misdirected holding ultimately protects only the financial interests of abortion providers, like Dr. Ragsdale, rather than following the Supreme Court's limited mandate in *Roe* aimed at protecting the patient's privacy rights. If we allow the majority's "reasoning" to stand, surgeons, as well as other ASTC operators whose facilities are devoted primarily to the performance of abortions, will be allowed to operate without regulation while those ASTCs primarily performing other types of minor surgical procedures will remain regulated (assuming the majority's decision merely affirms the district court's preliminary injunction). Thus having treated facilities devoted *primarily* to abortions differently from those facilities *primarily* devoted to other surgical procedures, the majority carves out an "abortionist exception" to the general rule that states can reasonably regulate how medical services are provided to its citizens. Ultimately, the majority in effect creates a legal vehicle for the non-abortionists primarily performing other surgical procedures to challenge the ASTCA on equal protection grounds; for what rational basis exists for regulating ambulatory surgical centers differently than those facilities, like Ragsdale's abortion enterprise, devoted primarily to the termination of pregnancies?

The task of a reviewing court, contrary to the majority's reasoning, is, "of course, . . . to resolve the issue by constitutional measurement, free of emotion and predilection." *Roe v. Wade*, 410 U.S. at 116, 93 S.Ct. at 709. Consistent with this Supreme Court directive, our decision must neither reflect pro choice nor anti-abortion sen-

timent. The Illinois legislation at issue, specifically the ASTCA, is fundamentally different from other Illinois abortion-related legislation and merits thorough, reflective, and separate consideration. I would enjoin § 16(1) of the MPA and sever and further enjoin its companion clause in ¶ 157-8.3(A) of the ASTCA requiring licensure of "any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose" because these provisions prevent a physician from performing a first-trimester abortion in his or her office. Under *Roe* and its progeny this prohibition may very well be considered unconstitutional. I am convinced that the states, including Illinois, are free to regulate ambulatory surgical treatment centers, including those performing abortions, as long as abortions are not singled out from other, similar surgical procedures, subject only to the well-known rational basis test governing social and economic legislation. Under the rational basis test the ASTCA and IHFPA are constitutional. Consistent with this analysis, I further evaluate the remaining abortion-specific statute sections and regulations[6] promulgated thereunder under the strict scrutiny test articulated in *Roe* and its progeny[7] and would hold all but one of these constitutional because these statutory sections and regulations neither burden the abortion decision nor its effectuation, and are justified with important health objectives in mind.

[6] For example, ¶ 157-8.6-1 of the ASTCA requires that any corporation operating an ASTC "devoted primarily to providing facilities for abortion" must have a licensed physician who is "actively engaged in the practice of medicine at the Center, on the board of directors as a condition of licensure." Additionally, subpart G of Title 77 of the Illinois Administrative Code contains abortion-specific regulations. The validity of all but one of these provisions is demonstrated, *infra*.

[7] I concur with the majority that the challenge to the second-trimester hospitalization requirement is moot. It appears that the majority effortlessly utilized and applied the severability clause of the Act to the second-trimester hospital requirement, but lost this analytical ability with respect to the other challenged provisions.

When the alleged "tripartite" legislative scheme is thus analyzed, neither a woman's right to terminate her pregnancy, nor the state's right to rationally regulate modern medical services for the protection of its citizens is adversely affected. Thus, I would reverse the district court's order enjoining Illinois' health services laws, except to the extent it enjoined § 16(1) of the Medical Practice Act, its companion clause in ¶ 157-8.3(A) of the ASTCA, and § 205.730(b)(2)(D) of the ASTCA regulations.

I

The majority decision properly notes that the "statutory and regulatory scheme is somewhat complex," but then proceeds to further confuse the challenged acts and their interrelationships, completely disregarding the legislature's intent regarding the various acts. The record of the legislative history reveals that § 16(1) of the MPA, 111 Ill. Rev. Stat. § 4433(1), and the Ambulatory Surgical Treatment Center Act (ASTCA), 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.*, were initially companion bills to the initial comprehensive Illinois Abortion Act (IAA), 38 Ill. Rev. Stat. ¶¶ 81-11, *et seq.*[8] The IAA, § 16(1) of the MPA, and the ASTCA, were Senate bills (S.B.) 1049, 1050, and 1051, respectively. The legislative history further reveals that S.B. 1049 and S.B.

[8] The initial Illinois Abortion Law, ¶¶ 81-11, *et seq.*, became effective July 19, 1973, but was subsequently repealed by the Abortion Law of 1975, effective October 30, 1979. The Abortion Law of 1975 has been challenged on more than one occasion. *See, e.g., Charles v. Carey*, 579 F.Supp. 464 (N.D. Ill. 1983), *aff'd in part, rev'd in part on other grounds, Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *appeal dismissed sub nom. Diamond v. Charles*, 106 S.Ct. 1697 (1986). The initial IAA had a completely different purpose than the ASTCA and IHFPA. However, the majority confuses the purposes of the IAA from that of the ASTCA and IHFPA, and in doing so clouds its ability to analyze the challenged statutes and regulations.

1050 were integrally related; their purpose was to regulate abortions in Illinois in light of, and in an attempt to comply with, the Supreme Court's then-recent *Roe* and *Doe* decisions. As noted by the majority, § 16(1) of the MPA provided for the "revocation or suspension of the license of any physician who performs 'elective abortions' in any place other than a licensed Ambulatory Surgical Treatment Center (ASTC), a hospital, or a facility run by the state or federal governments." Apparently, members of the Illinois legislature were concerned that the State would eventually be responsible for the cost of abortions performed on indigents in hospitals, so to reduce the State's anticipated abortion costs, less-expensive ASTC facilities were included in the list of approved locations for the performance of pregnancy termination procedures. At the same time the legislature was debating the regulation of abortions, ASTCs were just coming into existence and thus not regulated. Thus, S.B. 1051, an independent health regulatory bill creating and regulating ASTCs, was made a companion bill to the abortion bills.

Contrary to the majority's assertions, the ASTCA, unlike the IAA and § 16(1) of the MPA, was not primarily enacted for the purpose of regulating abortions. The record and legislative history reveal that the ASTC Act became law in Illinois in 1973 with the express policy of insuring maximum safety in all medical procedures, providing:

> "for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in ambulatory surgical treatment centers, and (2) for the construction, maintenance and operation of ambulatory surgical treatment centers, which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in ambulatory surgical treatment centers."

Ill. Rev. Stat. ch. 111½, ¶ 157-8.2. Further, the ASTCA was intended to regulate the cost-effective and rapidly developing ambulatory outpatient surgical medical services. The minutes of the March 7, 1974, Ambulatory Surgical Treatment Center Licensing Board meeting provide relevant historical facts relating to the enactment of the ASTCA:[9]

> "In July 1971 . . . a member of the hospital licensing board, was appointed chairman of a committee appointed to formulate regulations for those facilities that were presently unlicensable. Consideration was given to a large number of classifications and actually there were 32 types of health facilities listed. . . . On July 12, 1972, the final draft (after four drafts) of proposed standards were submitted to the Hospital Licensing Board. . . . [O]n August 16 [a member of the Board] sent these proposed regulations forward [to the legislation liaison]. . . . About August 1972 [the Board] began to get involved more with the

[9] The majority improperly relies on the ASTC Licensing Board minutes for the legislative intent of the act. The March 7, 1974, minutes conclude that "the legislation was written specifically for regulation of the performance of abortions." On this basis, the majority states, "First, we cannot ignore the fact that the ASTCA was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally in an effort to save the statute from unconstitutionality." Initially *I point out that the district court specifically and properly rejected the plaintiff's request to admit the minutes of the licensing board meeting as proof of the legislature's intent.* Tr. at 616. The district court's evidentiary ruling was proper because "a court should adhere to the enacting legislature's purposes," Posner, *The Federal Courts*, p. 279 (1985), rather than post-enactment statements regarding legislative intent, particularly when those statements are not even made by the legislators involved. The district court received the licensing board minutes only for the limited purpose of establishing the Board's state of mind regarding its enforcement procedures. However, the historical facts regarding the development of the ASTC legislation and regulations are reliable, material, and relevant to understanding the historical context in which the ASTCA was enacted. Thus, I make limited reference to the minutes of the Board meeting only to draw attention to the historical facts contained therein.

question of abortions which became the primary target for discussion."

The significance of these Board minutes lies in the fact that as early as 1971 a state agency began preparing the proposed regulations in response to the changing needs and practices of medical services. Cost-effective "[f]reestanding ambulatory surgical centers (FASCs) are independent entities which first opened in 1970. . . . [T]hese facilities were conceived to fill a gap between the doctor's office and the hospital for minor surgical procedures not requiring overnight hospitalization." Note, *Freestanding Emergency Centers: Regulation and Reimbursement*, 11 Am. J. L. & Med. 105, 118 (1985).[10] "The first successful freestanding ambulatory surgery center (FASC), [well known as Surgicenter], was opened in February 1970 in Phoenix, Arizona." D. Ermann and J. Gabel, *The Changing Face of American Health Care, Multi-Hospital System, Emergency Centers, and Surgery Centers*, 23 Medical Care 401, 406 (May 1985). As early as 1976 one commentator observed:

> "From a societal point of view, perhaps the greatest impetus behind the ambulatory surgery concept is its potential for reducing the cost of services. This potential applies to both freestanding and hospital-based facilities, the two major prototypes for ambulatory surgery. By eliminating overnight hospital stays, expenditures for hospital services for inpatient health care, which now account for about 40 percent of our

[10] Much has been written regarding trends in ambulatory medical services, including ambulatory surgical treatment centers. *See generally* T. O'Donovan, *Ambulatory Surgical Centers, Development and Management* (1976); L. Burns, *Ambulatory Surgery, Developing and Managing Successful Programs* (1984); M. Roemer, *Ambulatory Health Services in America* (1981); D. Ermann and J. Gabel, *The Changing Face of American Health Care*, 23 Medical Care 401 (May 1985); Pavarini, *Setting Up and Operating Ambulatory Care Centers in a Competitive Environment*, 29 St. Louis U. L. J. 747 (1985).

> total national health expenditure, may be reduced directly and dramatically, at least on a short-term basis. By focusing on reducing inpatient surgery (accounting for 60 percent of all hospital expenditures and about 25 percent of total health care expenditures), ambulatory surgery may further reduce costs."

T. O'Donovan, *Ambulatory Surgical Centers, Development and Management*, p. 143 (1976). Further, by 1984 the ASTC trend was well established:

> "The success of the Phoenix center precipitated rapid growth of a new type of facility for the delivery of ambulatory surgery, the freestanding, independent, ambulatory surgery center. Since that time, the Surgicenter has become a model for an increasing number of both independent and hospital-sponsored freestanding ambulatory surgery programs.
>
> According to the Freestanding Ambulatory Surgical Association (FASA), there are approximately 125 independent freestanding ambulatory surgery centers, 86 of which are members of FASA. According to FASA, which has been keeping statistics on its members since 1974, the membership performed 94,499 ambulatory surgery procedures in 1981, an increase of 6 percent over the number performed in 1980. This figure can be compared to 3.2 million ambulatory surgical procedures performed by hospitals offering ambulatory surgery in 1980."

L. Burns, *Ambulatory Surgery, Developing and Managing Successful Programs*, pp. 11-12 (1984). Lastly, I observe that freestanding ambulatory surgical centers are properly subject to licensure and regulation (as are the vast majority of medical facilities performing surgeries) throughout the country, and not only in Illinois. One writer pointed out that:

> "a FASC must obtain a state CON [Certificate of Need] in order to build the facility. In some states FASCs must also seek accreditation. In Illinois, FASCs are licensed and regulated by the State De-

partment of Public Health. In Minnesota, surgical centers are covered by licensing rules. They must be staffed and equipped to handle surgical procedures, anesthesia, and post-surgical care."

Note, *Freestanding Emergency Centers, Regulation and Reimbursement*, 11 Am. J. L. & Med. 105, 118 (1985).

Obviously the Illinois Legislature was not privy to all this information regarding ambulatory surgical treatment centers in 1973, at the time it enacted the ASTCA. However, as I stated, the record and legislative history reveal that the legislature was well aware of the new and fast developing medical trend in outpatient ambulatory care and specifically sought to regulate it. During the Senate debates, state Senator Wooten summarized S.B. 1051 as follows:

> "This is another one of those bills that cuts across lines in all kinds of ways. The Illinois State Medical Society asked that it be presented in a series with the two previous bills [S.B. 1049 and S.B. 1050], one changing the law relating to abortion, the other changing the Medical Practices Act. *While this has a relationship to abortion, it actually goes much beyond that. It [S.B. 1051] provides for the establishment and licensing of facilities which can perform minor surgery.* This would be things like tonsilectomy, hernias, abortions would be included, facial surgery, plastic surgery and so on. In other words procedures which would not require an overnight stay. And indeed these ambulatory surgical treatment centers are forbidden to keep patients overnight. However, those of you who have kept close to medical practices know that untoward things can occur at any time, and so provision is made in here that *doctors who function in such a center must also be licensed to practice in a hospital nearby so that if any complications occur they can quickly move the patient to that place.* Now, I handed out an outline to explain to you how these things would work, definitions, they must get

> a license, some of these things are left open as to regulations. The Department would like to take a hand in that. *This is something doctors have been urging us to do for a couple of years now, and ambulatory surgical treatment centers are . . . in effect out west. The idea is that they can be a great saving to a patient.* One of the big costs in a hospital, if you remember it's kind of like a hotel which has special services and if you don't need that overnight stay, you can save a great deal of money. So there's a great savings possible for the patient who needs this kind of one-day surgical treatment. *It does include abortion, and everything would be rather closely regulated and inspected.*"

(Emphasis added). Another state senator further pointed out that:

> "This bill is a good bill. It's not related in any way to abortions. It's sponsored by the Medical Association. There's nothing wrong with ambulatory medical services."

Thus, contrary to the majority's mere speculative assertions, the legislative history clearly and unequivocally supports the proposition that the ASTCA was not enacted primarily to regulate abortions, but rather for the regulation of all semi-complicated (minor) surgical procedures performed in the rapidly developing ambulatory surgical treatment centers. Finally, I observe that just prior to the ASTCA's enactment, Senator Wooten specifically stated: "The *main thrust of [S.B. 1051] is to try to save some money by getting minor surgical treatment out of the hospital where it is hideously expensive and into a clinic.*" (Emphasis added).

The record and the legislative history further reveal that the Illinois Health Facilities Planning Act (IHFPA) was enacted one year after the enactment of § 16(1) of the MPA and the ASTCA and was clearly not part of a "tripartite" legislative scheme to limit the availability of abortions. The legislative history of the IHFPA reveals

that it neither mentions abortions, nor referred to them, nor was it enacted for purposes of regulating abortions. The IHFPA was intended to address the problem of expensive, overexpanded and underpopulated medical facilities and underutilized medical equipment in the State of Illinois. In the words of a legislator, the IHFPA was to

> "provide a means *for proper planning with local input and decision making to cut down on empty hospital facilities*, nursing home facilities, sheltered care . . . facilities and . . . *ambulatory surgical facilities.*"

(Emphasis added).

Thus, the legislative history of the acts supports the valid premise that the legislature intended to regulate abortions when it enacted the Illinois Abortion Act. It also appears that section 16(1) of the MPA and its companion clause in ¶ 157-8.3(A) of the ASTC were probably enacted to prevent abortions from being performed in a physician's office. On the contrary, there is no proof in this record that either the ASTCA or the IHFPA were enacted primarily to regulate abortions; rather, these laws were adopted to regulate the delivery of medical services to its citizens and to attempt to prevent and control the further unnecessary overexpansion of Illinois' medical facilities. That the ASTCA was initially a companion bill to the abortion bills is more of a historical coincidence relished by political opportunists who, in this case, apparently fully utilized it to their advantage. As the minutes of the licensing board reflect, for whatever their worth: "Without the public interest in abortions, we would not have any of the present legislation." That is to say that the state legislators and other interested parties who were primarily interested in regulating ambulatory medical services would not have been able to enact the legislation without the statewide and even nationwide interest in the abortion question at the time.

The majority, acting and reasoning as if living in a social and economic vacuum (overlooking the developing nationwide trend of ASTCs), ignores the dual purpose of the

legislative scheme presently at issue, selectively carving out the regulatory motive of the ASTCA to support its abortion theory of enactment. Thus, the majority states: "As originally written, the statute [I assume the ASTCA] and regulations represented at least a coherent, if unconstitutional, whole which regulated all aspects of abortion practice in Illinois." Having ignored or at least overlooked the State's legitimate intent to regulate the new and rapidly developing trend of ambulatory surgical medical services, the majority treats the ASTCA and the regulations promulgated thereunder as "minor" abortion provisions. Further, the majority rejects the basic principle of severability when interpreting the construction of a duly adopted legislative enactment which should give effect to the State's legitimate purposes; and thus fails to apply the correct legal standard to the different acts and regulations and affirms the preliminary injunction. Thus, the majority limits and fails to effectuate the legitimate legislative purposes behind the ASTCA. As a noted commentator has observed, limiting the scope of a legislature's intent constitutes undesirable judicial activism as much as a decision construing a statute beyond its intended scope. *See* Posner, *Statutory Interpretation, in the Classroom and in the Courtroom*, 50 U. Chi. L. Rev. 800, 822 (1983). The majority's failure to give full effect to the real and legitimate legislative intent to regulate ASTCs is the basis of my dissent.

Recently, this court observed:

> "In *Immigration and Naturalization Service v. Chadha*, 462 U.S. 19, 103 S.Ct. 2764, 77 L.Ed.2d 317 (1983), the Supreme Court stated that unconstitutional provisions in a statute shall be severed if it appears that the legislature would have enacted constitutional provisions of the statute independently of those provisions. 103 S.Ct. at 2774 (citing *Buckley v. Valeo*, 424 U.S. 1, 108, 96 S.Ct. 612, 677, 46 L.Ed.2d 659 (1976))."

Zbaraz v. Hartigan, 763 F.2d 1532, 1545 (7th Cir. 1985), *aff'd*, 108 S.Ct. 479 (1987). The Illinois laws in question all have their own severability provisions; thus, it is clear that the Illinois legislature intended that the constitutional provisions of the acts should be given effect even if other provisions were held unconstitutional. Accordingly, I analyze the challenged statutes and regulations recognizing that "severance is improper [only] if the unconstitutional provision is 'an integral part of the statutory enactment viewed in its entirety.' " *Id.* (quoting *Scheinberg v. Smith*, 659 F.2d 476, 481 (5th Cir. 1981)). On the other hand, the challenged provisions which burden a woman's right to privacy may be severed as long as the severed provisions do not affect "the essential purposes of the act." *Id.*

II

The abortionist, Dr. Richard M. Ragsdale, plaintiff-appellee, testified at the preliminary injunction hearing that the alleged "[f]irst and major burden [affecting a woman's right to terminate her pregnancy] is simply the requirement for an independent licensure as an abortion provider." This licensing requirement, applicable to any physician who wishes to perform an abortion outside of a hospital, an ASTC, or other regulated facility, regardless of the gestational period of the embryo or fetus, was created when the legislature enacted § 16(1) of the MPA and its companion clause in the ASTC definitions section. As previously noted by the majority, "[s]ection 16(1) of the Medical Practice Act . . . allows for revocation or suspension of the license of any physician who performs an 'elective abortion' in any place other than a licensed Ambulatory Surgical Treatment Center . . ., a hospital, or a facility run by the state or federal governments." The following clause in ¶ 157-8.3(A) of the ASTCA is the companion clause to § 16(1) of the MPA, and brought all surgeons who wished to perform abortions under the ASTCA licensing and regulatory scheme:

> " 'Ambulatory Surgical Treatment Center' means . . . any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose . . . ."

Significantly, the defendant-appellant, the State of Illinois, asserts that it no longer enforces § 16(1) of the MPA. Additionally, the majority observes that Illinois alleges that the clause in ¶ 157-8.3(A) above is no longer being enforced, noting that:

> "Since 1981, the [ASTC] act and regulations have been applied only to facilities which are primarily devoted to the performance of surgical procedures (including abortions). This enforcement policy was adopted in response to *Village of Oak Lawn v. Marcowitz*, 86 Ill.2d 406, 427 N.E.2d 36 (1981), which refused to enforce, in a criminal proceeding, that portion of the local ordinance which incorporated the ASTCA definition of an ASTC which covered 'any facility where a medical or surgical procedure is performed for the termination of pregnancy, regardless of whether the facility is primarily devoted to that purpose.' "

The majority holds, and I agree, that Illinois' alleged nonenforcement policy does not render the issues moot.

Although several justices have persuasively argued that *Roe v. Wade* and its progeny articulate an "unworkable scheme for constitutionalizing the regulation of abortion," *Thornburgh v. American College of Obstetricians*, 476 U.S. 747, 814, 106 S.Ct. 2169, 2207 (1986) (Justice O'Connor, dissenting), or represent a "venture . . . fundamentally misguided since its inception," *Id.* at 786, 106 S.Ct. at 2192 (Justice White, dissenting), this court should be bound by *Roe* and its progeny. The Supreme Court's recent *Thornburgh* decision "reaffirm[ed] the principles laid down in *Roe* and *Akron*." *Id.* at 759, 106 S.Ct. at 2178. Thus, we analyze the abortion licensing requirement created when the Illinois legislature enacted § 16(1) of the MPA and its companion provision contained in the ASTC definition of

ambulatory surgical treatment center, ¶ 157-8.3(A), under the standards articulated in *Roe* and its progeny.

"In *Roe v. Wade*, the Court held that the 'right of privacy, . . . founded in the the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.' . . .

* * * *

The Court also has recognized, because abortion is a medical procedure, that the full vindication of the woman's fundamental right necessarily requires that her physician be given 'the room he needs to make his best medical judgment.' . . .

At the same time, the Court in *Roe* acknowledged that the woman's fundamental right '*is not unqualified and must be considered against important state interests in abortion.*' . . . But restrictive state regulation of the right to choose abortion, as with other fundamental rights subject to searching judicial examination, must be supported by a compelling state interest. . . . [The Supreme Court] recognized two such interests that may justify state regulation of abortions.

First, a state has an 'important and legitimate interest in protecting the potentiality of human life.' . . . Although this interest exists 'throughout the course of the woman's pregnancy,' . . . it becomes compelling only at viability, the point at which the fetus 'has the capability of meaningful life outside the mother's womb.' . . .

Second, because *a State has a legitimate concern with the health of women who undergo abortions, 'a State may properly assert important interests in safeguarding health [and] in maintaining medical standards.'* . . . [The Court further] held in *Roe*, however, that this health interest does not become compelling until 'approximately the end of the first trimester' of pregnancy. . . . Until that time, a pregnant woman must be permitted, in consultation with her physician, to decide to have an abortion and to effectuate that decision 'free of interference by the State.'

This does not mean that a State never may enact a regulation touching on the woman's abortion right during the first weeks of pregnancy. Certain regulations that have no significant impact on the woman's exercise of her right may be permissible where justified by important state health objectives. . . .

From approximately the end of the first trimester of pregnancy, the State 'may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.' . . . The State's discretion to regulate on this basis does not, however, permit it to adopt abortion regulations that depart from accepted medical practice. [The Court has] rejected a State's attempt to ban a particular second trimester abortion procedure, where the ban would have increased the cost and limited the availability of abortions without promoting important health benefits. . . . *If a State requires licensing or undertakes to regulate the performance of abortions during this period, the health standards adopted must be 'legitimately related to the objective the state seeks to accomplish.'* "

City of Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 426-431, 103 S.Ct. 2481, 2490-93 (1983) (citations omitted) (emphasis added).

Initially one observes that the abortion licensing requirement as it exists pursuant to § 16(1) of the MPA and the ASTCA definition, fails to distinguish between first and second trimester abortions; thus, it prohibits the performance of first-trimester abortions in physicians' offices. The record reveals that a woman's qualified right under *Roe* to terminate her pregnancy is very probably impermissibly burdened because surgeons who would otherwise perform first-trimester abortions out of their offices are

precluded from doing so. Dr. Ragsdale, an abortionist and a board-certified obstetrician and gynecologist, testified that outpatient abortions, whether performed in a physician's office or a clinic, were as safe as an abortion performed in a hospital setting.

Plaintiffs additionally called another alleged abortion expert, Dr. Warren Martin Hern, a doctor and general practitioner without board certification in the specialty of obstetrics and gynecology. Hern testified that first-trimester abortions, performed six to eight weeks from the last menstrual period are "probably the safest surgical procedure being performed in the United States in this category of procedures."[11] Dr. Hern further testified that the safest surgical method of first-trimester abortion was the "vacuum aspiration" method. This procedure is basically "a suction removal of the uterine contents."[12]

The State of Illinois' expert, Dr. John J. Barton, a board-certified specialist in the fields of obstetrics and gynecology, also testified that first-trimester abortions performed in outpatient facilities (such as physicians' offices or ASTCs) present no greater risk than the risks and complication

[11] Dr. Hern defined "in this category of procedures" as "procedures that involve invasion of a body cavity or a major organ of some kind."

[12] Dr. Hern noted that the fatality rate for abortion was about five per one million, whereas, the case fatality rate for term delivery was about 11 per 100,000 live births, which meant that the risk of term birth is approximately 25 times greater in terms of risk of death than abortion. Dr. Hern compared the abortion surgery risk factors to the risk factors of other types of outpatient surgery. He testified that "some estimates . . . indicate tonsillectomies are at least twice as dangerous as abortions." Similarly, Hern stated only that he consulted a colleague who informed him that laparoscopic surgery resulted in a death rate of two per 100,000. Hern testified: "Laparoscopic surgery involves the introduction of a laparoscope into the abdominal cavity. A laparoscope is a tube, a metal tube, that is hollow and is something that permits the physician to look through it into the cavity and is introduced through the umbilicus, with or without operating instruments."

rates of abortions performed in hospitals. Based on the medical experts' testimony, it appears probable that first-trimester abortions could be safely performed in the surgeon's office. Thus, it appears that § 16(1) and its companion clause in ¶ 157-8.3(A) of the ASTCA would limit the availability of abortions by precluding the performance of abortions in a physician/surgeon's office.

In *Akron* the Supreme Court noted that where the abortion law "increased the cost and limited the availability of abortions," such a law would probably interfere with the woman's decision to have an abortion as well as its effectuation. *Akron*, 103 S.Ct. at 2492-93. Further, although dictum, the Supreme Court noted "that the medical evidence suggests that until approximately the end of the first trimester, the state's interest in maternal health would not be served by regulations that restrict the manner in which abortions are performed by a licensed physician." *Id.* at 2492 n.11. The Court further observed that "uncomplicated abortions generally may be performed in a physician's office or an outpatient clinic up to 14 weeks from the first day of the last menstrual period." *Id.* (American College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982)). In light of the Supreme Court's caveat in *Akron* noting the probability that physicians can perform first-trimester abortions in their offices; given the defendant's policy of nonenforcement regarding § 16(1) of the MPA and its companion clause in the ASTC, ¶ 157-8.3(A), requiring the licensure of any facility performing even one abortion; and after evaluating the evidence presented during the preliminary injunction hearing which established that first-trimester abortions performed in a controlled outpatient setting, including a physician's office, probably were as safe as abortions performed in hospitals, I would selectively enjoin the enforcement of § 16(1) of the MPA and its companion clause in the ASTCA definition without destroying the entire act because it is more likely than not that the plaintiffs would prevail on the merits in light of present Supreme Court precedent.

In so holding, I agree with the Illinois Supreme Court decision in *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981), which also held that the ASTCA definition was constitutionally invalid as incorporated in a local ordinance which "closely resemble[d] the state [ASTC] act and implementing regulations adopted by the Department of Health." *Id.* at 38. The local ASTC ordinance also required an "initial license fee of $5,000, plus annual renewal fees of $2,000." *Id.* at 39. In *Marcowitz* the Illinois court, foreshadowing the caveat in *Akron*, stated:

> "Given the substantial licensing fee required and the detailed regulation involved, it seems inevitable that medical practitioners who might otherwise perform abortions for their regular patients, but whose facilities were not primarily devoted to surgery, would choose not to qualify under the ordinance. The right of a woman considering a first-trimester abortion to seek the advice and services of her obstetrician, gynecologist, or other physician in whom she has trust and confidence may not be so drastically curbed."

Id. at 42.

Further, both § 16(1) of the MPA and the impermissible definition clause in the ASTCA,[13] can easily be severed from their respective acts without affecting the legislature's "essential purposes" for the acts' enactments. *See Zbaraz*, 763 F.2d at 1545. The MPA is virtually unaffected and capable of being enforced independently of § 16(1) and as such will continue to be used *inter alia* to revoke or suspend a malfeasant physician's license. Similarly, the ASTCA becomes "abortion neutral" once the invalid clause is removed from the definition of an ASTC. *See,*

[13] The unconstitutional clause of ¶ 157-8.3(A) of the ASTCA to be severed reads as follows:

> "or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose."

e.g., Village of Oak Lawn v. Marcowitz, 427 N.E.2d at 42.[14] So construed, the ASTCA fully effectuates the legislature's primary purpose for its enactment, i.e., to regulate the rapidly developing trend of cost-effective ambulatory surgical medical units. Thus, the State of Illinois remains free to license any facility pursuant to the "abortion neutral" ASTCA "devoted primarily to the maintenance and operation of facilities for performance of surgical procedures," including an abortion facility, like Dr. Ragsdale's, devoted *primarily* to the performance of abortions.[15] As with other social and economic legislation, the test traditionally applied is whether or not the law has a "rational relation" to a valid state objective. *See Williamson v. Lee Optical Company*, 348 U.S. 483, 491, 75 S.Ct. 461, 466 (1955). Thus, I would apply the "rational relation" test to the now "abortion neutral" ASTCA.

The majority, however, disagrees and would apply the strict scrutiny test relying on mere dictum in *Friendship Medical Center Ltd. v. Chicago Board of Health*, 505 F.2d 1141 (7th Cir. 1974), *cert. denied*, 420 U.S. 997 (1975). There the court observed:

> "Furthermore, any proposed regulation, even if applied universally to all similar medical procedures,

[14] As I discuss, *infra*, the abortion-specific ¶ 157-8.6-1, as well as the abortion-specific regulations, are also severable; however, all but one of these provisions survive the strict standard articulated in *Roe*.

[15] The majority baldly asserts that Dr. Ragsdale's practice consists exclusively of first-trimester abortions even though the record reveals that Ragsdale performed some 40,000 abortions between 1973 and 1985. Up until the Illinois court's 1982 decision in *Poe v. Illinois Department of Public Health*, No. 78-C-4126 (N.D. Ill. 1982), which found the second-trimester hospital requirement unconstitutional, Ragsdale limited his practice to the performance of first-trimester abortions. However, Ragsdale testified that subsequent to *Poe*, he began performing second-trimester abortions. This obviously makes economic sense since the physician had the available licensed ASTC and would only lose income by refusing to perform second-trimester abortions.

because of the fundamental right of a woman to procure an abortion during the first trimester, would have to meet a compelling governmental interest requirement. Thus, any general health regulations which would apply to first-trimester abortions would have to be limited so as to give effect to the fundamental rights as established by *Roe* and *Doe*; that is, not be burdensome on a woman's right to decide to abort a pregnancy. By this we mean that in all probability nothing broader than general requirements as to the maintaining of sanitary facilities and general requirements as to meeting minimal building code standards would be permissible."

Id. at 1153-54.

Initially, I point out that Judge Fairchild, concurring, rejected the *Friendship* majority's dictum, stating:

> "Nevertheless, regulation of the safety of all these procedures, incidentally including first-trimester abortions, through imposition of generally applicable regulations, would seem to be a valid exercise of the state's interest in protecting health and need only satisfy the traditional [rational basis] test of judicial scrutiny imposed in this area."

Id. at 1155 (Fairchild, J., concurring). Because *Friendship*'s dictum to the contrary "was not refined by the fires of adversary presentation," it "was not a fully measured judicial pronouncement," and thus "not authoritative." *United States v. Crawley*, 837 F.2d 291, ___ (7th Cir. 1988). This caveat is particularly applicable here where we are construing a legislative act regulating a broad field of medical services, including minor surgical procedures.

The majority gives two reasons, unsupported by this record, for relying on the *Friendship* dictum: "First, we cannot ignore the fact that the ASTCA was enacted primarily with abortion clinics in mind and only applied to outpatient surgical clinics generally in an effort to save the statute from unconstitutionality." However, as I demonstrated in part I, the legislative history establishes the contrary; the primary purpose of the ASTCA was to regulate the new cost-effective ASTCs in which semi-complicated (minor) surgery was performed. In effect the majority puts the cart before the horse because it rests its analysis of the ASTCA on the quagmire of legal dictum set forth in *Friendship* which ultimately clouds and confuses its analysis of the ASTCA.

The majority further states:

> "Secondly, the state cannot, merely by applying the expedient and conclusory label 'surgery' to a medical procedure, apply requirements which would be necessary to major surgical procedures in the abortion context where they would be wholly inappropriate. It is as much a vice to treat abortion similarly to dissimilar procedures as it is to treat it differently from analogous procedures."

The majority's conclusory statement is incredible in light of the record. First of all, the plaintiff's own medical experts testified that an abortion was a surgical procedure (regardless of the type of abortion method used). On direct examination Ragsdale stated that an abortion "is a *minor surgical* procedure." Tr. at 420. Dr. Hern also testified that an early abortion—one performed six to eight weeks from the last menstrual period—"is the safest *surgical procedure* being performed." Tr. at 241 and 260. Likewise, it was Dr. Barton's expert opinion that an *abortion constituted an operation*, Tr. at 452, and abortions "are classified as minor surgical procedures." Tr. at 467. Dr. Hern further stated that an abortion is a surgical procedure categorized as a procedure "that involve[s] invasion of a body cavity or a major organ of some kind." Tr. at 241. In reaching its conclusion that the state applied the "expedient and conclusory label 'surgery' " to an abortion, the majority once again disregards the record and strays far afield from its area of legal competence and makes medical judgments and pronouncements that are more properly reserved to those expertly trained in the medical

scientific fields such as physicians, surgeons, nurses, medical technicians, etc.

Further, I observe that the courts have consistently alluded to abortions as a surgical procedure. In *Roe*, for example, Justice Stewart noted that the "protection of the health and safety of a woman" was a legitimate objective, amply sufficient "to permit a state to regulate abortions as it does other surgical procedures." *Roe v. Wade*, 410 U.S. at 170, 93 S.Ct. at 735 (Justice Stewart, concurring). Still more recently, in *Akron* the Supreme Court observed that the district court had found that "an abortion generally is considered a 'minor surgical procedure.'" *Akron*, 462 U.S. at 444, 103 S.Ct. at 2500 n.35. Thus, the evidence establishes that an abortion is a surgical procedure, albeit a semi-complicated (minor) surgical procedure. Significantly, the ASTCA was intended to regulate all *minor surgical procedures*, including all types of abortive procedures performed in an ASTC; this the majority fails to recognize. There is no reason to apply strict scrutiny in this situation. There is no language in the Supreme Court's decisions upholding the majority's speculative and implicit theory that the Court intended to strike down social and economic legislation such as the ASTCA in the name of *Roe* or a woman's limited right to terminate her pregnancy.

Further, in *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976) (per curiam), the court addressed the issue of whether a state could subject the abortion decision, even during the first trimester, to regulations promulgated by the state board of health, including licensing requirements. The Eighth Circuit concluded:

> "A state can impose the same regulations on a clinic, specifically built to perform abortions during the first trimester, that are imposed on other clinics that perform surgical procedures requiring approximately the same degree of skill and care as the performance of first-trimester abortions. As long as the regulations applying to abortion clinics are the same as those applied to other clinics performing similar surgical procedures, it would not be impermissible to make them specifically applicable to abortion clinics."

Id. at 1358.

Moreover, in *Baird v. Department of Public Health*, 599 F.2d 1098 (1st Cir. 1979), the court upheld a state licensure statute applicable to any clinic providing medical, surgical, dental, restorative, or mental hygiene services, including facilities offering only first-trimester abortion services. The First Circuit held: "*There is room under* ***Roe*** *for states to apply the same licensing standards to abortion facilities as they apply to like facilities performing medically analogous procedures.*" *Id.* at 1102 (emphasis added). *See also Westchester Women's Health Organization v. Whelan*, 475 F.Supp. 734, 739-40 (S.D.N.Y. 1979); *Abortion Coalition v. Michigan Department of Public Health*, 426 F.Supp. 471, 477 (E.D. Mich. 1977); *Hallmark Clinic v. North Carolina Department of Human Resources*, 380 F.Supp. 1153, 1157 (E.D.N.C. 1974), *aff'd on other grounds*, 519 F.2d 1315 (4th Cir. 1975). Thus, Illinois' laws licensing and regulating ASTCs are proper.

The law is very clear that a state has right to enact legislation for the protection of its citizens. *See Quilici v. Village of Morton Grove*, 695 F.2d 261, 274 (7th Cir. 1982) (Coffey, J., dissenting), *cert. denied*, 464 U.S. 863 (1983). The Supreme Court specifically stated:

> "It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health."

Barsky v. Board of Regents, 347 U.S. 442, 449, 74 S.Ct. 650, 654 (1954). Thus, I am persuaded by the logic of Judge Fairchild's concurrence in *Friendship*, rather than by the unsupported and speculative conclusions of the majority, as well as the reasoning of the First and Eighth Circuits, that under *Roe* and its progeny a state has not only the power and authority, but also the duty, to reg-

ulate all medical facilities, particularly any facility where any surgical procedures are performed (including first-trimester abortions) as a valid exercise of its interest in protecting the health and welfare of its citizens while ensuring that the facilities will provide "conditions insuring maximum safety for the woman" who has decided to terminate her pregnancy. *Connecticut v. Menillo*, 423 U.S. at 11, 96 S.Ct. at 171.

The ASTCA and the regulations promulgated thereunder were intended to do just that, to protect the safety of its citizens, and is reason sufficient enough to sustain the validity of the statute. As in many other surgical procedures, there are a variety of similar medical and physical risks involved in having an abortion. Depending upon a particular woman's characteristics and development, medical and psychological problems may very well arise during the abortion procedure that only an experienced, well-trained, board-certified obstetrician and gynecologist is capable of recognizing and effectively treating in a properly designed, constructed, equipped, maintained, managed and medically approved facility. Depending upon the gestational duration of the embryo or fetus, such complications include, but are not limited to, trauma, permanent damage to vital organs, dysfunction of the cardiovascular or respiratory system requiring cardio-pulmonary resuscitation, internal bleeding or hemorrhaging of the uterine wall, cervical lacerations, uterine perforation, embolism of the blood vessels, allergic reaction to medication or anesthesia, if administered, and even the permanent impairment of reproductive organs. Other medical factors that must be considered in making an informed abortion decision include the type of abortion to be performed (dilation and curettage, dilation and vacuum aspiration, dilation and evacuation, hysterotomy, or hysterectomy), the woman's medical history, her reaction to previous surgical procedures, her tolerance to certain medications, the chance that she is an RH-negative female, the likelihood of contracting a uterine infection, the chance that the placenta and fetus will not be completely

removed, the potential for future difficulties in bearing children, and also the possibility of sexual sterility. It defies reason to allow the state to license an ASTC performing hernia surgery, cataract removals, and repairs of a torn or detached retina, but not permit the state to license ASTCs primarily performing abortions when there are many similar risks involved in the myriad types of abortive procedures.

Lastly, the majority asserts that it is irrational for the state to regulate the full-time provider of abortions (those primarily performing abortions) more heavily than the occasional provider. While it may be true that the full-time abortionist may consider himself or herself "more skilled" and so theoretically need less regulation, the majority overlooks that a state with limited resources may rationally choose to direct its energies to improving the lot of the greatest number. For example, if the state, after the proper enactment of legislation, chooses to regulate ASTCs and reduce the risk of minor surgery (as well as its cost) for 100,000 of its citizens, and more instrusive regulation of occasional providers would help only 2,000, the state may very properly deal with the 100,000 first. Further, the cost of regulation per patient will be lower if the state concentrates its attention on high-volume businesses; surely this constitutes a rational relation to a permissible end.

The majority's treatment of the ASTCA and the IHFPA under the strict scrutiny test is just another way the majority circumvents and fails to effectuate the purpose of the ASTCA, i.e., to regulate changes in the provision of medical services. Essentially, the majority substitutes its judgment for that of the legislature; this is truly unfortunate in this case since courts should defer above all to a legislature's judgments on social and economic matters. *See Dandridge v. Williams*, 397 U.S. 471, 90 S.Ct. 1153 (1970). Lawyers who are now judges are neither trained nor experienced in the medical disciplines possibly related to abortion procedures, e.g., obstetrics, gynecology, psychiatry, pathology, general surgery, or emergency medicine. Nor are judges versed in the nuances of the prac-

tices and techniques of the medical profession and thus are ill-equipped to substitute their views regarding what is medically adequate, proper, or antiseptic. "As recently stated by the Supreme Court, 'there certainly is no reason to think judges are better qualified than appropriate professionals in making such decisions.' " *St. Mary of Nazareth v. Dep't of Health & Human Services*, 698 F.2d 1337, 1346 (7th Cir. 1983) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 323, 102 S.Ct. 2452, 2462 (1982)). However, this majority decision is replete with such medical assertions. For example, the majority states, "The testimony regarding many of the physical plant requirements make clear that they have 'no medical justification whatsoever' when applied to first and early second trimester abortions of the type involved in this case." However, the ASTCA was intended to regulate *all minor surgical procedures*, and the legislature is free to enact reasonable legislation. Under these circumstances, and in light of the real risks that accompany minor surgical procedures, including abortions, it is dangerous for the majority to substitute its judgment as to what constitutes necessary and/or appropriate ASTC regulations. Although in *Dandridge* the Supreme Court was concerned with welfare assistance programs, the following admonition is as applicable today as it was then:

> "We do not decide today that the [Illinois] regulation is wise, that it best fulfills the relevant social and economic objectives that [Illinois] might ideally espouse, or that a more [reasonable] system could not be devised. Conflicting claims of morality and intelligence are raised by opponents and proponents of almost every measure, certainly including the one before us. *But the intractable economic, social and even philosophical problems presented by [regulating medical services] are not the business of this [c]ourt.* The Constitution may impose certain procedural safeguards upon [the regulatory] system . . . . *But the Constitution does not empower this [c]ourt to second-guess state officials charged with the difficult responsibility of [guaranteeing its citizens adequate, cost-effective but safe, medical services.]*"

Id. at 487, 90 S.Ct. at 1162-63 (citations omitted) (emphasis added). *See also In re U.S. ex rel. Missouri State High School, etc.*, 682 F.2d 147 (8th Cir. 1982) ("Once a rational relationship exists, and it exists here, judicial scrutiny must cease. Whether the rule is wise or creates undue individual hardship are policy decisions better left to legislative and administrative bodies").

Lastly, because the courts "have returned to the original constitutional proposition that courts do not substitute their social and economic beliefs for the judgment of legislative bodies," *Ferguson v. Skrupa*, 372 U.S. 276, 730, 83 S.Ct. 1028, 1031 (1963), the "abortion neutral" ASTCA is entitled to presumptive validity. It is a well-recognized principle that

> "The question, whether a law be void for its repugnancy to the constitution, is, at all times, a question of much delicacy, which ought seldom, if ever, to be decided in the affirmative, in a doubtful case. The court, when impelled by duty to render such a judgment, would be unworthy of its station, could it be unmindful of the solemn obligations which that station imposes. But it is not on slight implication and vague conjecture, that the legislature is to be pronounced to have transcended its powers, and its acts to be considered as void. *The opposition between the constitution and the law should be such that the judge feels a clear and strong conviction of their incompatibility with each other.*"

Fletcher v. Peck, 10 U.S. (6 Cranch) 85, 128 (1810) (emphasis added). " 'Every possible presumption . . . is in favor of the validity of a statute, and this continues until the contrary is shown beyond a rational doubt.' " *Powell v. Pennsylvania*, 127 U.S. 678, 684 (1887) (quoting *In re Sinking Fund Cases*, 99 U.S. 700, 718 (1879)). *See also Kelley v. Johnson*, 425 U.S. 238, 247, 96 S.Ct. 1440, 1445-46 (1976) (Justice Rehnquist, now Chief Justice, stated that

state decisions regarding social legislation are "entitled to the same sort of presumption of legislative validity as are state choices designed to promote other aims within the cognizance of the State's police power."). As the Supreme Court recently observed in *Pension Benefit Guaranty Corp. v. R.A. Gray & Co.*, 467 U.S. 717, 729, 104 S.Ct. 2709, 2717 (1984):

> " 'It is by now well established that legislative Acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality, and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way. *See, e.g., Ferguson v. Skrupa*, 372 U.S. 726, 83 S.Ct. 1028, 10 L.Ed.2d 93 (1963); *Williamson v. Lee Optical Co.*, 348 U.S. 483, 487-488, 75 S.Ct. 461, 464, 99 L.Ed. 563 (1955).' "

(quoting *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15, 96 S.Ct. 2882, 2892 (1976)). *See also Rhinebarger v. Orr*, No. 87-1738, slip op. at 3 (7th Cir. February 4, 1988) (Chief Judge Bauer observed: "It is well established that congressional legislation 'adjusting the burdens and benefits of economic life' are presumed constitutional and that 'the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way.' "). Here, the plaintiffs-appellees have not demonstrated that the Illinois legislature acted in an arbitrary or irrational way when enacting the ASTCA and the IHFPA. Thus, within the parameters of *Roe*, I am convinced that the state is free to regulate abortions to the same extent it regulates similar surgical procedures. I fail to understand how the majority holds otherwise since the Supreme Court has never held that *Roe* holds to the contrary. Thus, I would reverse the district court's order preliminarily enjoining the ASTCA and the IHFPA.

III

However, even if *Roe* and its progeny were to apply to the ASTCA and IHFPA as asserted by the majority, the Act would still be constitutionally valid. The holding of *Roe* and its progeny

> "does not mean that a state never may enact a regulation touching on the woman's abortion right during the first weeks of pregnancy. Certain regulations that have no significant impact on the woman's exercise of her right may be permissible where justified by important state objectives."

Akron, 462 U.S. at 430, 103 S.Ct. at 2492. The plaintiffs asserted that the ASTCA and IHFPA substantially burdened the woman's right to terminate her pregnancy in three ways: (1) by limiting the availability of abortions; (2) by increasing the cost of an abortion; and (3) by requiring the provider to fulfill the certificate of need requirements subjecting the abortionist to a "public veto of his [abortion] services." As I previously noted, § 16(1) of the MPA and its companion clause in ¶ 157-8.3(A) of the ASTCA could very well be considered unconstitutional and therefore should be enjoined. Thus, the licensure of facilities allegedly devoted primarily to the performance of abortions does not limit the availability of abortions since many other surgeons, if they so choose, could perform first-trimester abortions in their offices.[16] Thus, the ASTCA cannot be said to limit the availability of abortions. Further, the possibility that Ragsdale's clinic might possibly close does not significantly, if at all, affect the availability of abortions. The plaintiffs stated that "there are approximately 65,860 abortions performed in Illinois annually." *Ragsdale v. Turnock*, 625 F.Supp. 1212, 1219

[16] In *Akron* the Supreme Court reaffirmed its trimester approach. Thus, I am convinced that the state could constitutionally require that all second-trimester abortions be performed in an ASTC. Even the plaintiffs' experts testified that the risks of an abortion rise substantially in the second trimester.

(N.D. Ill. 1985). Of these, Ragsdale performs some 3,400 to 3,500 annually, or some 5 percent. Additionally, there are some 42 to 44 ASTCs in Illinois and "approximately half of these provide abortions services." *Id.* However, the district court found that Ragsdale was the only available abortionist in his area. The record reveals that Ragsdale initially testified that he was the "only provider" of abortions in his area. Subsequently, he qualified his testimony, stating he was "primarily, and, in many ways, the only abortion provider" in the area. However, Ragsdale concluded, stating: "To the best of my knowledge, no one else intends" to perform abortions in the area. These statements, contrary to the district court's finding that Ragsdale was the "only" abortion provider, do not establish that abortions would be unavailable in the area if Ragsdale had to close his facility (because he failed to lease or purchase a new facility). Inferring from the high volume of abortions performed at Ragsdale's clinic, it is apparent that the efficiency of the clinic had reached that of an "economy of scale," making it uneconomical for other physicians to enter the abortion market in the area. However, assuming *arguendo*, that abortionists receive anywhere from $250 to $400 per abortion,[17] it is unlikely that another operator (like Ragsdale) would not perform abortions in the area in the event Ragsdale's business closed. The physician-surgeon entrepreneur could not ignore Ragsdale's apparent potential annual gross income from abortions alone, approximately $875,000 ($250 per abortion x 3500 abortions per year). The district court's finding that the closing of Ragsdale's clinic would make abortions unavailable is mere speculation and clearly erroneous.

[17] Plaintiff's counsel stated during closing argument before the district court that the fee charged in a hospital for an abortion was $1,000 and that the hospital fee was 2.5 to 4 times greater than the cost of an abortion performed in an outpatient facility (including a physician's office). Thus, according to plaintiff's counsel, an outpatient abortion costs $250 to $400.

The district court found the second burden on a woman's right to terminate her pregnancy created by the ASTCA licensing requirement was that the licensing requirement raised the cost of an abortion "by $25 to $40 for abortions performed at Ragsdale's clinic." The defendants argue that the district court erroneously relied on hearsay for the basis of its factual findings regarding the increased cost. I couldn't agree more since the defendants objected throughout the hearing to the relevancy and admissibility of Ragsdale's alleged cost sheets. The alleged cost sheets consisted of Ragsdale's musings after allegedly discussing tentative plans to move his facility with contractors and other vendors. Ragsdale, a physician and surgeon, is no more an expert in cost accounting, contracting, architecture, etc., than the respective experts in these areas are knowledgeable about the problems and practice of surgery and/or medicine. Thus, just as the majority rejected the defendant's architectural expert's testimony regarding the medical "need for the ventilation requirements," so too should the majority, on proper balance, reject Ragsdale's compliance cost estimates.

On the other hand, assuming *arguendo*, that Ragsdale's cost-related testimony was properly received in evidence, I am convinced that the important state health objective of insuring safe, yet cost-effective, medical service by requiring minimum engineering and construction standards justified the *de minimis* financial impact that compliance with the regulations places on the cost of an abortion. The majority inaccurately asserts that "Dr. Ragsdale testified that he estimated compliance with the regulations would entail a per-patient cost of between $25 and $40." The record reveals that Dr. Ragsdale testified that he estimated the added costs of complying with the regulations *over and above the costs required simply to relocate his current practice in such a manner as he deemed appropriate for his needs*, as $25.21 per patient. (Ragsdale Tr. 400-01). This added cost of $25.21 certainly cannot be considered as significantly more than the $19.40 (less than a $5 difference) increase per abortion for tissue examina-

tion upheld by the Supreme Court in *Ashcroft* because "in light of the substantial benefits that a pathologist's examination can have, this small cost is clearly justified." 462 U.S. at 490, 103 S.Ct. at 2524. Moreover, it should be pointed out that the increased cost testified to herein, unlike the one in *Ashcroft*, would at best only be temporary and not one that would remain *ad infinitum*. Dr. Ragsdale admitted that "much of the debt would be retired after two to five years." Thus, after two years the fee increase would be reduced to $10.90 per patient, and after five years to a mere $3.40 per patient. I am convinced that the minimum engineering and construction design requirements allegedly at issue, which ensure only that all surgical procedures performed in ASTCs, including first-trimester abortions, are performed in clean, sanitary, and safe structures are a substantial benefit to the health and safety of patients, and the miniscule financial impact referred to is clearly *de minimis* and justified.

One last observation respecting the cost of an abortion. After searching the record, I found no evidence establishing the cost of an abortion performed in a doctor's office. However, the plaintiff's counsel during closing argument before the district court stated that the costs of an abortion performed in a hospital ($1,000) was 2.5 to 4 times as costly as that of one performed in a surgeon's office or in an outpatient clinic. These figures reflect that outpatient abortion costs, including those performed in a physician's office, range from $250 to $400 each. Thus, the $250 cost of an abortion performed in Ragsdale's ASTC, even if operating in full compliance with the Act, may in fact represent the low end of the abortion market price. This proposition supports my earlier observation that Ragsdale's clinic, because of its efficiency, dominated the local market. Further, assuming that Ragsdale's increased cost per abortion was $25.21, the percentage increase is in the range of 6 to 10 percent, certainly *de minimis*. It is not as if the price of an abortion went from $250 to $500, a significant burden.

This brings us to the third burden allegedly impinging upon a woman's qualified right to terminate her pregnancy, i.e., Certificate of Need (CON) for Ragsdale's ASTC and the related public hearing required pursuant to the IHFPA.[18] The majority unbelievably holds the certificate of need requirement unconstitutional for the reason, *inter alia*, that the public hearing accompanying a certificate of need created a public veto of a woman's qualified right to an abortion. The record establishes unequivocally that Ragsdale's landlord, a hospital, wished to terminate its lease with Ragsdale because Ragsdale failed to refer patients to the hospital. Ragsdale applied to the State of Illinois, pursuant to the ASTCA and IHFPA, for a license

[18] Pursuant to ¶¶ 1155-1160 of the IHFPA, and as noted by the majority, "anyone seeking to open an ASTC [must] obtain a certificate of need for the facility from the Department of Public Health after a public hearing and a 120-day review period." A CON is granted if the State Board finds

> "(1) that the applicant is fit, willing, and able to provide a proper standard of health care service for the community with particular regard to the qualification, background and character of the applicant, (2) *that economic feasibility is demonstrated in terms of effect on the existing and projected operating budget of the applicant and of the health care facility*; in terms of the applicant's ability to establish and operate such facility in accordance with licensure regulations promulgated under pertinent state laws; and in terms of the projected impact on the total health care expenditures in the facility and community, (3) that safeguards are provided which assure that the establishment, construction or modification of the health care facility is consistent with the public interest, and (4) *that the proposed establishment, construction or modification is consistent with the orderly and economic development of such facilities and is in accord with standards, criteria, or plans of need adopted and approved pursuant to the provisions of Section 12 of this Act* for such facilities for comprehensive health care in the community, area, or State served by such facilities."

111½ Ill. Rev. Stat. ¶ 1156 (emphasis added). In this manner the state has attempted to reduce skyrocketing health care costs by limiting the expansion of unnecessary medical facilities.

for his new facility. After a full investigation and subsequent to holding public hearings, the state agency found that there was *in fact a need for Ragsdale's medical services.* At the public hearing a number of citizens protested against abortions stating their pro-life positions. It stretches the imagination that one would write that the exercise of one's First Amendment rights to object to an issue be treated somehow as creating a burden on a woman's right to an abortion. The majority, however, asserts that "the state's unwillingness or inability to confine the proceedings [the public hearings on Ragsdale's CON for his ASTC] to its even arguably legitimate goals bolster our conclusion [that the CON] requirement cannot stand." This statement flies in the face of the fact that the state after due and considerate deliberations absent emotion or hysteria objectively analyzed and in fact found that need existed for Ragsdale's medical services. Although I have previously expressed that an individual, including an abortionist, should be free from picketing in front of his private home, *see Schultz v. Frisby*, 807 F.2d 1339, 1355 (7th Cir. 1986) (Coffey, J., dissenting), *reh'g granted and decision vacated*, 818 F.2d 1284 (7th Cir. 1987), *aff'd by equally divided vote* 619 F. Supp. 792, 822 F.2d 642 (7th Cir. 1987), *cert. granted*, 1988 U.S. L.W. 2211 (January 11, 1988), public hearings are a different matter. Public hearings are an open forum where *all citizens* should have the right to be heard in an organized manner in our democratic form of government. That some open forums or demonstrations sometimes "degenerate into a shouting match" is nothing new to our right of free speech, much less to our national system of justice and ordered liberty. I fail to comprehend the majority's contrary view.

Further, the record in this case establishes that the ASTCA regulations in question place *no burden whatsoever* on a woman's decision to terminate her pregnancy in the first trimester because they reflect nothing but the common, accepted, and approved standards of medical practice and procedure as testified to by the medical experts. For example, § 205.240 of the ASTC regulations

requires the management or owner of an ASTC to formulate written policies and a procedures manual. Dr. Ragsdale described this requirement as standard medical and administrative practice. Other administrative and organizational regulations, such as those requiring written safety plans (§ 205.510), appointment of a qualified consulting committee and medical director (§ 205.230), and written personnel policies (§ 205.310), as well as those requiring sanitary conditions (§ 205.420) and proper disposal of all materials from the abortion procedure and maintenance of the equipment in good working order (§ 205.410) are merely enunciations of universally recognized standard practice for performing surgical procedures in an outpatient facility. As Dr. Ragsdale conceded on direct examination, most of the regulations of this type simply "stated the obvious" and in no way impinged upon a woman's decision, much less her right, to an abortion. Moreover, the building design and construction requirements contained in the ASTC regulations reflect proper engineering design and practice from a medical service point of view and accepted minimum standards for medical facilities. Examples include requirements for testing and balancing heating, ventilation, and air conditioning systems to ensure that they are in proper working condition (§ 205.1510), insulation in appropriate locations (§ 205.1520), and a minimum ceiling height of eight feet with appropriate exceptions for certain rooms, such as storage rooms (§ 205.1400). I believe that the state has more than just a compelling interest, and in fact has an overriding interest, in ensuring that any and all ASTCs performing any surgical procedures, including first-trimester abortions, are designed and constructed to meet basic engineering standards for medical facilities in order that all fairly sophisticated medical procedures are conducted "under conditions ensuring the maximum safety" of the patient. *Connecticut v. Menillo*, 423 U.S. at 11, 96 S.Ct. at 171.

Dr. Hern, the plaintiff's alleged expert witness at trial, testified that "90 to 95 percent . . . of all first-trimester procedures in this country . . . are performed by vacuum

aspiration technique of some kind," and are "the safest surgical procedure[s] now performed." The record also established that other abortion procedures, such as the saline, urea, and installation techniques (involving inserting a needle into the amniotic cavity, withdrawing fluid, and installing a saline solution within the amniotic cavity) were also being performed in ASTCs. These abortion procedures have a higher complication and fatality rate than other abortion procedures, such as the vacuum aspiration and dilation and evacuation methods. Since more complicated and involved abortion procedures which require close supervision, control and regulation are also performed in ASTCs, I am persuaded that the state can, should, and must regulate its ASTCs in order that it might protect its citizens from possible serious medical problems which could very easily arise. The State of Illinois, through its legislators, has the authority, if it so determines, to require a higher standard for the operation of these clinics, including attending and supervising personnel, building specifications and design, as well as maintenance, in order that it might protect its citizens, just as the State of Wisconsin has the authority to require higher standards for its prisons and the State of Georgia to protect its inmates if it so wishes. *Cf.* Wis. Administrative Code §§ HHS 302, *et seq.* with Georgia Code Annotated § 42-5-50, *et seq.* Similarly, the State of Illinois can pass legislation mandating more all-inclusive immunization requirements for school-age children than those required by the State of Missouri. *Cf.* Illinois Revised Statute Chapter 111.5, ¶ 22.11 and Illinois Administrative Code Tit. 77, § 696.10 with Missouri Revised Statute § 167.181.

The Illinois legislature has determined that the ASTCA and the IHFPA, by their very enactment, are very important social and economic laws for the betterment and protection of its citizens. Neither the ASTCA nor the IHFPA burden a woman's qualified right to terminate a pregnancy, and both Acts further serve the state's important interest in the health and welfare of its citizens;

thus, even under *Roe* and its progeny the ASTCA and IHFPA must be held constitutional.

Finally, turning to those abortion-specific ASTCA regulations; I would hold that all but one of these abortion-specific regulations survive *Roe*'s scrutiny. Initially, I would hold that ¶ 157-8.6-1[19] properly requires a physician actively engaged in practice at an ASTC be on the board of directors of any ASTC "devoted primarily to providing facilities for abortions" as a condition of licensure. Since the Supreme Court's decision in *Connecticut v. Menillo*, it has been clear that states can require that only physicians perform abortions. Illinois' additional requirement that a practicing physician/surgeon be on the board of an ASTC primarily involved in providing abortion services simply guarantees that a physician be involved in the business decisions of the board of directors (exclusive of the patient-doctor abortion decision) and thus ensure safe medical procedures and practices. Further, Dr. Ragsdale testified that ¶ 157-8.6-1 did not burden the woman's right to an abortion. Additionally, Margaret Moe, who desired to offer abortions out of her clinic, is now free (in light of the probable unconstitutionality of § 16(1) of the MPA and its companion clause in the ASTC definition) to do so as long as the clinic is not devoted primarily to surgical procedures. If Moe chooses to incorporate her clinic as an ASTC, she, without any trouble, will be able to retain a surgeon performing abortions at her clinic to serve on her ASTC board of directors. This requirement neither limits the availability nor increases the cost of an

[19] Paragraph 157-8.6-1 provides:

"Abortions—Licensed physicians

§ 6.1 Notwithstanding any other provision of this Act, any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Center, on the board of directors as a condition to licensure of the Center."

abortion performed at an ASTC and in fact serves the important state interest in protecting the health of its citizens. Thus, ¶ 157-8.6-1 is constitutional.

Further, the record reveals that those regulations addressing operative care do not burden a woman's right to an abortion. Section 205.530(c) of the ASTC regulations requires that all tissues removed during surgery be examined by a qualified consulting pathologist. The Supreme Court upheld an almost identical regulation in *Ashcroft*. The Court held that a Missouri regulation requiring all tissues surgically removed (including tissue removed during first-trimester abortions) be examined by a pathologist "reasonably related to generally accepted medical standards and 'further[s] important health-related state concerns.'" 462 U.S. at 487, 103 S.Ct. at 2523 (quoting *City of Akron*, 462 U.S. at 430). The Court stated: "As a rule, it is accepted medical practice to submit *all* tissue to the examination of a pathologist. This is particularly important following abortion, because questions remain as to the long-range complications and their effect on subsequent pregnancies." 462 U.S. at 487-88, 103 S.Ct. at 2523 (emphasis in original). Further, the information and knowledge gained from the aggregated pathological testing and reports will aid other women in the future. The requirement for a pathological report on any abnormalities in the tissue in question is proper and constitutional in light of *Ashcroft*.

Section 205.760 of the ASTC regulations requires a report, on forms provided by the Department of Public Health, of each abortion procedure performed in an ASTC within ten days following the month in which the abortion was performed. If the doctor who performed the abortion later discovers a complication, such as hemorrhaging, then he or she is required to file a supplemental report.[20] In *Planned Parenthood v. Danforth*, 428 U.S. 52, 96 S.Ct. at 2831 (1975), the Supreme Court stated:

[20] In a companion regulation which is not abortion specific, § 205.620 requires each ASTC to submit annual statistical data to the De-

(Footnote continued on following page)

> "Recordkeeping and reporting requirements that are reasonably directed to the preservation of maternal health and that properly respect a patient's confidentiality and privacy are permissible. . . . Recordkeeping of this kind, if not abused or overdone, can be useful to the state's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment. . . . As so regarded, we see no legally significant impact or consequence on the abortion decision."

Id. at 80-81, 96 S.Ct. at 2846 (footnote omitted). Further, Dr. Hern, one of the plaintiffs' alleged experts, testified specifically that the reporting of statistics "is essential to public health evaluation." Thus, the reporting requirements at issue are consistent with the Court's holding in *Danforth* and are constitutional.

Other abortion-specific regulations require a determination of blood RH factor prior to performance of an obstetrical procedure, including an abortion (§ 205.730(a)(1)) and hemoglobin and hematocrit and urine analysis examinations before performing an abortion, as well as procedures performed with general anesthesia or local anesthesia with sedation (§ 205.520(b)). At trial, Dr. Ragsdale admitted that he had no disagreement with the need to perform appropriate laboratory tests. Thus, these provisions in no way impinge upon a woman's decision to have an abortion because they merely state the standard medical tests necessary to perform a safe abortion. In this respect, they are no more offensive or intrusive on a woman's right to an abortion than § 205.710 which states: "Abortions shall be provided to the public with the same

[20] *continued*
partment of Public Health. This data is to include the number and type of procedures performed and complications reported, the number of patients requiring transfer to a hospital due to complications, the number of patients returning for followup contact, and the number of deaths.

standards of safety, effectiveness, and regard for patients['] rights as any other health service." As Dr. Ragsdale's counsel concededly stated at trial, "Obviously, Dr. Ragsdale agrees with that statement. We agree with that, and I suspect everyone in this room agrees with that statement."

Finally, I do not agree with the majority's conclusion that the counseling requirements of § 205.730(b) run afoul of the Supreme Court's ruling in *Thornburgh v. American College of Obstetricians*, 476 U.S. 747, 106 S.Ct. 2169 (1986). In *Thornburgh* the Court found unconstitutional provisions of the state statute that required a woman to be informed of fetal characteristics, the availability of financial assistance, detrimental physical and psychological effects, and all particular medical risks. *Id.* at 759-765, 106 S.Ct. at 2178-81. But the Court held that this detailed information exceeded the state's interest in describing the general subject matter relevant to informed consent because it "is not medical information that is always relevant to the woman's decision and it may serve only to confuse and punish her and to heighten her anxiety contrary to accepted medical practice." *Id.* at 762, 106 S.Ct. at 2179.

In contrast, the counseling requirements of § 205.730(b) include a description of the procedure to be performed, an explanation of risks and possible complications, and a discussion of alternatives. These requirements are significantly less instrusive than the ones invalidated in *Thornburgh*, and the record establishes through Dr. Hern's testimony as an expert witness, that counseling is an indispensable part of a thorough pre-operative evaluation and preparation of a patient for an abortion procedure. Dr. Hern testified that appropriate counseling should include a discussion of the alternatives for dealing with pregnancy.[21] As the Supreme Court has repeatedly recognized,

[21] Dr. Hern, the court-qualified expert, testified as follows:

"Q Now, you testified earlier that you do provide counseling in your facility, is that right, doctor?

(Footnote continued on following page)

"The decision to abort . . . is an important, and often stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences." *Danforth*, 428 U.S. at 67, 96 S.Ct. at 2840. *See also City of Akron*, 462 U.S. at 442-43, 103 S.Ct. at 2499.[22] This is

[21] *continued*

A Yes.

Q . . . well, why do you provide [counseling], Dr. Hern?

A Well, I believe that it is important for each patient to have not only a good understanding of the procedure that she is going to be having *and how she got pregnant* [?!] and what the methods are for her, I mean, for her to be permitted or to permit her to avoid unwanted pregnancies in the future.

Q Well, do you say the same things to every patient, Dr. Hern? Do you give the same counseling?

A In general, yes. Although it really depends upon the individual patient as to how much we give as to that but I also think that—how much emphasis *we give* and as to what, but, as I say, it is also important for the patient to have an opportunity to express her feelings about the pregnancy and about the abortion and, perhaps, the relationship in which it occurred.

Q *Would you always*, Dr. Hern, for example, *include in your discussion with the woman a discussion of the alternatives for dealing with pregnancy*?

A *Yes.* And depending also to some extent on the patient's interest in this subject. *Some patients absolutely refuse to discuss alternatives; they come in and they have their minds absolutely made up about what they want to do and they are impatient to get on with the process and they really do not wish to spend a great deal of time talking about, for example, adoption.*"

(Emphasis added).

[22] According to the majority, the counseling requirement and in particular "the requirement of a 'discussion of alternatives' is unconstitutional." The majority relied on Ragsdale's testimony to the effect that discussions of *alternatives* might not be appropriate. Ragsdale speculated that it would be inappropriate to inform a woman of alternatives if her continuing health was dependent on

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true since "[a]bortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of potential life." *Harris v. McRae*, 448 U.S. 297, 325, 100 S.Ct. 2671, 2692 (1980). Thus, I emphasized in *Zbaraz v. Hartigan*, 763 F.2d at 1549-50 (Coffey, J., dissenting):

> "There are severe psychological and emotional stresses involved not only before and during the abortion procedure, but for days, months and even years following the procedure . . . . For many individuals . . . the abortion decision raises questions that are often influenced by sincere, deep-rooted religious beliefs, moral principles, and convictions. . . . [J]ust as in any surgical procedure, [a woman] is entitled to an explanation of the reasonable alternatives to abortion. . . ."

I am firmly convinced that Illinois can require a counselor to provide a woman with a description of the procedure to be performed, an explanation of risks and possible complications, and a discussion of alternatives so that the woman can make a *responsible enlightened choice* in light of the fact that no other medical procedure "involves the purposeful termination of a potential life." *Harris v. McRae*, 448 U.S. at 325, 100 S.Ct. at 2692. Further, the majority's rejection of the counseling requirements ignores the recent trend in medicine which encourages patients to seek second opinions before undergoing surgical procedures. In some instances insurance companies have even required a second opinion with respect to non-emergency surgeries before providing coverage. These developments reflect the importance the medical profession (as well as those footing

[22] *continued*

her undergoing a medically necessary abortion. Obviously, in this situation a "discussion of alternatives" is inappropriate simply because there are no *alternatives*. The majority's interpretation of the Illinois regulations would lead to absurd results. It is clear that a discussion of alternatives is required *only* when alternatives in fact exist.

the bill) places on informed consent. The Illinois counseling regulations merely require that a woman planning to terminate her pregnancy do so knowingly; *Roe* does not hold to the contrary. However, § 205.730(b)(2)(D) requires that "[c]ounselors shall have no financial interest in the patient's decision" and appears to interfere with the physician-patient relationship and should be severed and enjoined. Thus, I do not believe that the counseling requirements of § 205.730(b), except (2)(D), are improper and would uphold their validity.

IV

In conclusion, I am convinced that individual states have the obligation, the duty, and the power to license medical ASTC facilities where semi-complex (minor) surgical procedures, including first-trimester abortions, are performed as a valid exercise of a state's interest in protecting health and ensuring maximum safety for the patients. Determining where to strike the balance between competing interests is a matter for the legislature, not for the court. The Constitution wisely vests the legislative branch of the government with the power and authority to enact laws, for the legislature is better equipped to carry out that task in that interested parties, such as state and local governmental representatives, medical experts, etc., are able to present their respective positions before the legislative body in a more open, unrestricted, informal forum. Thereafter, the myriad of questions and problems, as well as their possible solutions, are brought before the entire legislative branch of government and are subject to the scrutiny of public hearing and debate. When dealing with the complex and ever-changing question of how to provide the best health care at a reasonable cost to its citizens, the factfinding and policy making capabilities of a court of law are far more limited and confined due to the very nature of a court of law. A truly independent judiciary must always exercise its powers of review and decision making with discretion and reservation, recognizing that we are not competent to make social and economic

policy decisions, and giving due deference to the legislative branch of government. Our judicial responsibility obligates us to declare an act by another governmental unit to be void only if we believe the enacted law is contrary to the Constitution. After reviewing the ASTCA and the challenged provisions of the IHFPA, I am convinced that the expressed will of the people as enacted in these Illinois statutes is not contrary to the principles of the Constitution; thus, I would not interfere with this well-reasoned judgment of the Illinois legislature, a coequal branch of the government. Surely the Illinois legislature is entitled to require that all surgical procedures, including first-trimester abortions, are performed "under conditions ensuring maximum safety for the woman [as well as the man]." *Connecticut v. Menillo*, 423 U.S. at 11, 96 S.Ct. at 171.

Moreover, other than § 16(1) of the MPA, its companion clause in the ASTCA, and § 205.730(b)(2)(D), I believe that the statutes and regulations in question do not place a burden on a woman's decision to terminate her pregnancy in the first trimester. Further, if one is able to find a burden, it is certainly below the level of *de minimis*. Lastly, the regulations reflect common, accepted and approved standards of medical practice and procedure and are designed to enhance the safety of Illinois' citizens, an important state interest. For the foregoing reasons, I would reverse the order of the district court.

APPENDIX

TITLE 77 ILLINOIS ADMINISTRATIVE CODE:
PUBLIC HEALTH

CHAPTER 1: DEPARTMENT OF PUBLIC HEALTH

SUBCHAPTER b: HOSPITALS AND AMBULATORY CARE FACILITIES

PART 205
MINIMUM STANDARDS, RULES AND REGULATIONS FOR THE LICENSURE OF AMBULATORY SURGICAL TREATMENT CENTERS.

SUBPART A: GENERAL

Section 205.120 Licensure

a) An application for license shall be made to the Department on forms provided by it. This application shall contain the information required under the Act and this Part. The application shall be submitted not less than sixty (60) days prior to the date of intended operation.

b) The application shall include but not be limited to the following information:

1) the name(s) and address(es) of person(s) who own and/or operate the facility and the name under which they do business. A corporation shall submit:
   A) a copy of its certificate of incorporation,
   B) list of the title, name, and address of each of its corporate officers,
   C) list of the name and address of each of its shareholders holding more than 5%, of the shares.
2) location of the facility.
3) description of the facility including but not limited to interviewing, examination, surgical, and recovery room facilities.

4) schematic architectural plans.
5) documentation of compliance with all applicable building, utility and Safety Codes.
6) description of services to be provided by the facility including a list of surgical procedures to be performed.
7) list of all personnel including their name, address, position, qualifications and licensure.
8) All applications shall be signed by the applicant and the application shall include a verification form acknowledging the application to be true and complete and certifying that the applicant has knowledge of and understands the action required to comply with the Act and licensing requirements. The form shall be verified by a notary public. The forms shall be accompanied by a license fee of $500.
9) As a condition of the issuance or renewal of the license of any Ambulatory Surgical Treatment Center:
   A) The applicant shall file a statement of ownership. The applicant shall agree to update the information required in the statement of ownership every 6 months from the initial date of filing,
   B) Each license shall file an attested financial statement with the Department by July 1, 1980 and at times thereafter as required,
   C) Financial statements shall be filed annually on or before April 1, of each year for the previous calendar year, or within three (3) months after the close of the fiscal period of the licensee,
   D) A financial statement shall be filed with the Department on forms provided by the Department or on annual financial statements prepared on forms used by the applicant. At minimum, they shall include detailed balance sheets, statements of income and statements of expense,

   E) Every facility licensed under this Act, and any premises proposed to be conducted as a facility by an applicant for a license shall be open during its regular business hours to an inspection authorized in writing by the Director. No notice need be given to any person prior to any inspection,
   F) Any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the center, on the Board of Directors as a condition to licensure of the center.

c) Only those facilities, services, programs and procedures included in the application shall be licensed. A new application is required for the following:
   1) change in ownership,
   2) change in location,
   3) remodeling of facility so as to change the interviewing, examination, surgical or recovery room space or number,
   4) addition of services or programs.

      AGENCY NOTE: The addition of new specialty services, for example, podiatry or obstetrics/gynecology, may require changes in consulting committee, procedures and/or staffing. Therefore, the Department finds that a new license is needed.

d) The license shall be valid for one (1) year, unless sooner suspended or revoked, shall be renewable annually upon approval by the Department and payment of a license fee of $300. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. The licenses shall be posted in a conspicuous place on the licensed premises. A placard or registry of all physicians on staff in the facility shall be centrally located and available for inspection to

any interested persons. The renewal application shall be on forms provided by the Department and shall be submitted to it not less than 30 days prior to the expiration date.

e) The facility shall give written notice to the Department within seven (7) days of any of the following:
   1) change of administrative staff,
   2) change of medical director,
   3) change of staff physicians,
   4) change of supervising nurse,
   5) addition or deletion of surgical procedures performed,
   6) in the case of a corporation change in any shareholders equity involving 5% or more interest.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

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SUBPART D: EQUIPMENT, SUPPLIES, AND FACILITY MAINTENANCE

Section 205.410 Equipment

Equipment shall be in good working order and shall be available in numbers sufficient to provide good patient care based on the procedures to be performed in the facility.

a) There shall be monitoring equipment, suction apparatus, oxygen and related items available within the surgical and postoperative recovery area. Cardiac pulmonary resuscitation equipment shall be available in all facilities.

b) There shall be written procedures governing the care, use, sterilization, storage and disposal of all materials to insure that an adequate supply of sterile equipment is available for each procedure. The section on "Sterilization and Disinfection" from Infection Control in the Hospital, most recent edition, American Hospital Association, shall be used as the guideline.

c) There shall be written procedures to assure safety in storage and use of inhalation anesthetics and

medical gases. The current edition of the National Fire Protection Association Code (Standard No. 56a) shall be used as the standard.

d) There shall be written procedures to assure the safety in storage and use of all narcotics and medications in accordance with state and federal law.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

* * *

SUBPART E: GENERAL PATIENT CARE

Section 205.520 Preoperative Care

a) Where medical evaluation, examination, and referral are made from a private physician's office, hospital, or clinic, pertinent records thereof shall be available and made part of the patient's clinical record at the time the patient is registered and admitted to the ambulatory surgical treatment center.

b) A complete medical history shall be obtained and the physical examination shall be complete. A hemoglobin or hematocrit and examination of the urine for sugar, protein, and acetone shall be performed by a qualified laboratory technician prior to the following procedures:
   1) those performed with general anesthesia,
   2) those performed with local anesthesia with sedation,
   3) those performed to terminate pregnancy.

c) A written statement indicating informed consent and a signed authorization by the patient for the performance of the specific surgical procedure shall be procured and made part of the patient's clinical record.

d) Surgical procedures shall not be performed on patient's having medical, surgical, or psychiatric conditions or complications as specified by the consulting committee in the facility's written policies.

(Source: Amended at 6 Ill. Reg. 10974, effective August 30, 1982)

Section 205.530 Operative Care

a) Surgical procedures shall be performed only by a qualified physician, dentist or podiatrist within the limits of his/her defined specific practice privileges.

b) A qualified anesthesiologist, a dental anesthesiologist or a certified registered nurse anesthetist, medically directed by a licensed physician who administers or directs the administration of anesthesia in an Illinois licensed hospital, shall be present for the administration of anesthetics and recovery of patients when any general or major regional anesthetic is used.

c) All tissues removed during surgery shall be examined by a consulting pathologist and all x-rays shall be read by a consulting radiologist who shall provide a written report of his/her examination to the attending physician. A copy of this report shall be filed in the patient's clinical record within seven (7) days.

(Source: Amended at 6 Ill. Reg. 13337, effective October 20, 1982)

* * *

SUBPART G: ADDITIONAL REQUIREMENTS FOR FACILITIES IN WHICH OBSTETRICAL/GYNECOLOGICAL PROCEDURES ARE PERFORMED.

Section 205.710 Abortions

Abortions shall be provided to the public with the same standards of safety, effectiveness, and regard for patients rights as any other health service.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.720 Personnel

At least one registered professional nurse with postgraduate education or experience in obstetrical or gynecological nursing shall supervise and direct the nursing personnel and care of patients having obstetrical procedures.

AGENCY NOTE: Procedures involving the pregnant uterus are subject to particular complications and postoperative care requires a special knowledge on the part of nursing staff.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.730 General Patient Care

a) Examination

1) Prior to obstetrical procedures blood Rh factor shall be determined by a qualified laboratory technician for every patient.

2) The physician performing an abortion procedure shall establish the diagnosis of pregnancy by appropriate clinical evaluation and testing prior to performing an abortion procedure.

3) Time shall be allowed between the initial examination and termination of pregnancy to permit the reporting to and reviewing of all laboratory tests with the patient by the facility physician.

b) Counseling

1) Counseling shall be provided following disclosure to the patient of the diagnosis of pregnancy, and prior to performance of any surgical procedure. It shall be done individually and in a room designated for such use which shall not be the procedure room.

2) All facilities shall provide orientation training for counselors and insure that each counselor is qualified to:

A) Counseling shall be done by a person qualified to:

i) discuss alternatives for dealing with an unwanted pregnancy;

ii) describe the procedures used in the facility;

iii) explain the risks and possible complications of each procedure;

iv) provide contraception information.

B) Demonstration of such counseling qualifications shall be required by the Department.
C) Documentation of orientation training shall be required by the Department.
D) Counselors shall have no financial interest in the patient's decision.

3) Counseling shall include a discussion of alternatives, description of the procedure to be performed, explanation of risks and possible complications. Contraceptive information may be provided postoperatively. Group counseling may be provided in addition to individual counseling. The patient's clinical record shall include documentation of the counseling received.

AGENCY NOTE: In the opinion of the Ambulatory Surgical Treatment Center Licensing Board, the patient should make a decision concerning the procedure in an atmosphere free from coercion. Consequently, the Board believes this is best accomplished in a room separate and apart from the procedure room. The Board believes that it is difficult to reach a truly voluntary decision while the patient is undressed and on the procedure table.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.740 Preoperative Requirements

Abortions may be performed in a ambulatory surgical treatment center on only those patients with gestation up to and including 12 weeks commencing with ovulation rather than computed on the basis of the menstrual cycle, as determined by the physician, if the patient's medical condition permits. Abortions shall not be performed in an Ambulatory Surgical Treatment Center on those patients whose gestation exceeds 12 weeks.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.750 Postoperative Requirements

a) Each obstetrical/gynecological service shall provide Rh factor sensitization prophylaxis to all Rh negative patients according to standard medical procedures.
b) Information on availability of family planning services shall be provided, when desired by the patient. When, in the physician's opinion, it is in the best interest of the patient and with the patient's consent, family planning services may be initiated prior to the discharge of the patient.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.760 Reports

a) A report of each abortion procedure performed in an ambulatory surgical treatment center shall be made to the Department on forms provided by it. These reports shall be submitted not later than ten (10) days following the month in which the abortion was performed. Reports shall be submitted on procedures performed whether or not the patient was pregnant.
b) Reports shall not be filled out in such a manner or at such a time as to avoid accurate reporting of complications.
c) If the facility becomes aware of a complication following the submission of the original report, then a supplemental report shall be submitted to the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

* * *

SUBPART I: BUILDING DESIGN, CONSTRUCTION STANDARDS, AND PHYSICAL REQUIREMENTS

Section 205.1320 General Considerations

a) Location

This facility shall be indentifiably separate from other facilities and functions.

b) Narrative Program
The sponsor for each project shall provide a narrative program of functions for the facility which contains space requirements, staffing patterns, departmental relationships and other basic information relating to the fulfillment of the institution's objectives. This may be a general or detailed description of each function to be performed, space needed for these functions, hours of operation, number of staff or other occupants of the various spaces, types of equipment required, interrelationship of various functions and spaces, and description of those services necessary for the complete functioning of the facility but which are available elsewhere in the community and, therefore, need not be duplicated in this facility. Explain the type of surgery or procedures, the volume of work, the number of doctors, etc.

c) Size
The extent (number and types) of the diagnostic, clinical, and administrative facilities to be provided shall be determined by the services contemplated and the estimated patient load as described in the narrative program.

d) Provisions for the Handicapped
The design shall provide for accessibility to the physically handicapped (public, staff, and patients).

e) Privacy for Patient
The design of the facility shall provide for the privacy and dignity of the patient during interview, examination, and treatment.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

* * *

Section 205.1360 Clinical Facilities

a) Examination room(s)
1) Each examination room(s) shall have a minimum clear floor area of 80 square feet, and a minimum dimension of 8 feet, excluding such spaces as vestibule, toilet, closet, and work counter (whether fixed or movable). Arrangements shall

permit at least 2'-6" clearance at each side and at both ends of the examination table.
2) A lavatory or sink equipped for handwashing with knee or foot control shall be provided.
3) A counter or shelf space for writing shall be provided.

b) Procedure room(s)
1) Provide at least one procedure room with a minimum clear area of 250 square feet and a minimum dimension of 14 feet, exclusive of fixed and movable cabinets and shelves. Any other procedure rooms shall not be less than 120 square feet with a minimum dimension of 10 feet.
2) Provide a communication system connecting with the control station.
3) Provide special features such as x-ray film illuminators, and storage space as required by the program.

c) Recovery room(s)
1) Room(s) for post-anesthesia recovery for surgical patients shall be provided.
2) Recovery room(s) shall contain a minimum of 100 square feet of usable floor space for single bed occupancy and at least 80 square feet per bed for multiple bed occupancy, so arranged that there will be at least 3 feet between beds and 4 feet of clear space at the foot of each bed.
3) This room(s) shall contain a drug distribution station, handwashing facility, charting facilities, nurses' station, and storage space for supplies and equipment.
4) Provide a toilet which is accessible to the recovery room, without having to leave the recovery room to reach it. The water closet shall be equipped with a gray diverter valve.
5) A separate supervised room may be provided for use by patients who are able to leave the recovery (post-anesthesia) room but need addi-

tional time for all vital signs to be stabilized to the point where the patient may leave the facility. This room shall be equipped with reclining or lounge type chairs for patients and shall contain a minimum of 50 square feet of usable floor space for each patient to be accommodated at any one time.

6) These recovery rooms may be combined, if desired.

7) Provide a minimum of four recovery beds or lounge chairs for each procedure room. At least one of the four must be a bed, and the other three may be lounge chairs or beds.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1370 Support Service Areas

a) A control station shall be located to permit visual surveillance of all traffic which enters the operating suite.

b) Provide sterilizing facility(ies) with high speed autoclave(s) conveniently located to serve all procedure rooms. Approved alternate provisions may be made for replacement of sterile instruments during surgery.

c) A drug distribution station shall be provided for storage and preparation of medication to be administered to patients.

d) Scrub stations with knee or foot or elbow actuated faucets shall be provided near the entrances to the procedure rooms. Scrub facilities shall be arranged to minimize splatter on nearby personnel or supply carts.

e) A soiled workroom for the exclusive use of the surgical suite staff shall be provided. The soiled workroom shall contain a work counter, sink equipped for handwashing, waste receptacle, and linen receptacle. This room may be used for cleaning anesthesia equipment.

f) Fluid waste disposal facilities shall be conveniently located with respect to the general procedure rooms.

g)

1) A clean workroom or a clean supply room is required when clean materials are assembled within the surgical suite prior to use. A clean workroom shall contain a work counter, sink equipped for handwashing, and space for clean and sterile supplies. A clean supply room shall be provided when the narrative program defines a system for the storage and distribution of clean and sterile supplies which would not require the use of a clean workroom.

2) An autoclave shall be incorporated into the clean workroom.

h) Anesthesia storage facilities shall be provided. Flammable anesthetics are prohibited.

i) Medical gas supply storage with space for reserve nitrous oxide and oxygen cylinders shall be provided, with all tanks properly secured.

j) Storage area for equipment and supplies used in surgical suite shall be provided.

k) Staff and personnel facilities shall be provided for male and female personnel (orderlies, technicians, nurses, and doctors) working within the surgical suite. The areas shall contain lounge, lockers, toilets, lavatories equipped for handwashing, and space for changing clothing. These areas shall be arranged to provide a one-way traffic pattern so that personnel entering from outside the surgical suite can change, gown, and move directly into the surgical suite. Space for removal of scrub suits and foot covers shall be designed so that personnel using it will avoid physical contact with clean personnel.

l) Provide change areas where patients can change from street clothing into hospital gowns in privacy, and be prepared for surgery. This shall include lockers, toilets, clothing change or gowning area(s), and space for the administration of medications.

m) Stretcher storage area shall be out of direct line of traffic.

n) Janitor's closet containing a floor receptor or service sink, and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1380 Diagnostic Facilities

If the pre-admission evaluation tests are to be performed within the facility, the following services shall be provided.

a) Radiographic suite, if provided, shall contain the following:
   1) film processing area
   2) viewing and administration area
   3) film storage facilities
   4) toilet room with handwashing facilities, directly accessible from each fluoroscopy room without entering the general corridor area.
   5) dressing area with convenient access to toilets.

b) Laboratory suite shall contain the following minimum facilities:
   1) Laboratory work counter with sink and vacuum, and electric services.
   2) Lavatory or counter sink equipped for handwashing.
   3) Storage cabinet or closet.
   4) Specimen collection facilities equipped with a toilet and lavatory.
   5) Blood collection facilities shall have space for a chair and work counter.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

* * *

Section 205.1400 Details and Finishes

a) Minimum public corridor width shall be 5'-0", except those corridors where patients are transported in stretchers or carts shall be 8'-0".

b) The facility or section shall have at least two exits remote from each other. Other details relating to exits and fire safety shall be in accordance with Section 13 (Business Occupancy) of the latest edition of NFPA Standard 101 and the requirements outlined herein. These Standards govern where different from the code.

c) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required minimum.

d) All doors to toilets which may be used by patients shall be equipped with hardware which will permit access in an emergency.

e) The minimum width of doors for patient access to examination and treatment rooms shall be 3'-0".

f) The minimum width of doors to rooms needing access for stretchers (procedure rooms, recovery) shall be 3'-8".

g) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be swing type.

h) 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.

i) Doors, sidelights, borrowed lights, and windows in which the glazing extends downs to within 18 inches of the floor (thereby creating possibility of accidental breakage by pedestrian traffic) shall be glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken in accordance with the State of Illinois Safety Glazing Materials Act (Ill. Rev. Stat. 1981, ch. 111½, par. 3101 et seq.). Similar materials shall be used in wall openings unless required otherwise for fire safety.

j) Thresholds and expansion joint covers shall be made flush with the floor surface to facilitate use of wheelchairs and carts.

k) Air dryers, or paper towel dispensers and waste receptacles shall be provided at all handwashing fixtures.

l) Where labeled fire doors are required, these shall be certified by an independent testing laboratory as meeting the construction requirements equal to those for fire doors in National Fire Protection Association (NFPA) Standard 80. Reference to a labeled fire door shall be construed to include labeled frame and hardware.

m) Radiation protection requirements of X-ray and gamma ray installations shall conform to the requirements of the Department of Nuclear Safety Rules for Protection Against Radiation (32 Ill. Adm. Code, Subchapter b) and should follow guidelines of NCRP reports #33 dated February 1968, and #49 dated September 1976. Provisions shall be made for testing and completed installation before use, and all defects must be corrected before use.

n) The minimum ceiling height shall be 8′-0″, with the following exceptions:

1) Boiler rooms, if provided, shall have ceiling clearance not less than 2′-6″ above the main boiler header and connecting piping.

2) Radiographic and other rooms containing ceiling-mounted equipment and including those with ceiling-mounted surgical light fictures shall have height required to accommodate the equipment and/or fixture.

3) Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms may be not less than 7′-8″.

4) Suspended tracks, rails, and pipes located in path of normal traffic shall be not less than 6′-8″ above the floor.

o) Flammable Anesthetics are prohibited.

p) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant and shall pass both the large and small scale tests of NFPA Standard 701.

q) Interior finish of walls and ceilings of all exit ways, storage rooms, and areas of unusual fire hazard shall have a flame spread rating of not more than 25.

r) Floor finish materials shall have a flame spread rating of not more than 75. If a separate underlayment is used with any floor finish material, the flame spread test assembly shall include the underlayment.

s) All interior finish materials shall have smoke developed rating of 450 or less. The use of materials known to produce large amounts of toxic gases shall be avoided.

t) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved.

1) In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions.

2) Floors that are subject to traffic while wet, shall have a nonslip surface.

u) Wall finishes shall be washable and in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.

v) Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

w) Ceilings shall be cleanable and those in sensitive areas such as surgical rooms shall be readily washable and without crevices that can retain dirt particles. These sensitive areas shall have a finished ceiling, covering all overhead ductwork and piping.

x) Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and

similar spaces, unless required for fire-resistive purposes.

y) Acoustical ceilings are recommended in corridors, multipurpose rooms, and waiting areas.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

* * *

SUBPART J: MECHANICAL

Section 205.1540 Air Conditioning, Heating and Ventilating Systems

a) The systems shall be designed to provide the comfort temperatures and humidities as recommended by ASHRAE Standards.

b) Air handling systems shall conform to "Installation of Air Conditioning and Ventilating Systems," NFPA 90A-1976.

c) For spaces not exceeding 25,000 cubic feet in volume, heating, air conditioning, and ventilating systems shall conform to "Standard for the Installation of Warm Air Heating and Air Conditioning Systems, NFPA 90-B, 1973, except return ducts shall be constructed of material equal to that specified for supply ducts, Chap. 2, paragraph 1.1., Duct Materials.

d) Outdoor air intakes shall be located as far as practical but not less than 15 feet from exhaust outlets of ventilation systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent stacks or from areas which may collect vehicular exhaust and other noxious fumes.

e) All ventilation air outlets and inlets shall conform to NFPA 90A-Chapter 2, paragraph 3.2. Location of Outlets and Inlets.

f) The ventilation systems shall be designed and balanced to provide the ventilation and pressure relationships as shown in Table A.

g) The ventilation air supplied to the procedure rooms shall be delivered at or near the ceiling of the area served, and all exhaust or return air from the area

shall be removed near the floor level. At least two exhaust outlets shall be used in each procedure room.

h) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies not less than those specified in the following table:

FILTER EFFICIENCIES FOR CENTRAL VENTILATION AND AIR CONDITIONING SYSTEMS IN AMBULATORY SURGICAL TREATMENT FACILITIES

Area Designation	Minimum Number of *Filter Beds*	Filter Efficiencies (Percent) Filter Bed *No. 1*	Filter Bed *No. 2*
Procedure and Recovery Rooms	2	25	90
All Other Areas	1	25	—

i) All filter efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with the American Society of Refrigeration and Heating, Air Conditioning Engineers (ASHRAE) Standards 52-68.

j) For systems serving procedure and recovery rooms, filter bed No. 1 shall be located upstream of the conditioning equipment and filter bed No. 2 shall be located downstream of the supply fan and conditioning equipment including humidifiers.

k) Filter frames shall be durable and shall provide an airtight fit with the enclosing duct work. All joints between filter segments and enclosing duct work shall be gasketed or sealed to provide a positive seal against air leakage.

l) A manometer shall be installed across each filter bed serving procedure and recovery rooms.

m) Fire and smoke dampers shall be constructed, located and installed in accordance with the requirements of NFPA 90A.

n) All systems, regardless of size, which serve more than one smoke or fire zone, shall be equipped with smoke detectors to shut down fans automatically as specified in paragraph 4-3.1 of NFPA 90A.

o) The ventilation system for anesthesia storage rooms shall conform to the requirements of "Standard for Inhalation Anesthetics" NFPA 56A, including the gravity option ventilation system.

p) Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and limit temperatures in working stations to 97° F Effective Temperature as defined by ASHRAE Handbook of Fundamentals.

q) Rooms containing heat-producing equipment, such as boiler rooms and heater rooms, shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 100° F.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205. TABLE A General Pressure Relationships and Ventilation Rates of Ambulatory Surgery Area

Within Area Room Units Designation	Pressure Relationship to Adjacent Areas	Minimum Total Air Changes per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated
Procedure Room	+	15	Optional	No
Examination Room	0	6	Optional	Optional
Recovery Room	+	6	Optional	Optional
Medication Area	+	4	Optional	Optional
X-Ray Room	0	6	Optional	Optional
Soiled Workroom or Soiled Holding	–	10	Yes	No
Clean Workroom or Clean Holding	+	4	Optional	Optional
Darkroom	–	10	Yes	No
Toilet Room	–	10	Yes	No
Janitors' Closet	–	10	Yes	No
Sterilizer Equip. Rm.	–	10	Yes	No
Linen and Trash Rm.	–	1–	Yes	No
Laboratory	–	6	Optional	Optional
Soiled Linen Storage	–	10	Yes	No
Clean Linen Storage	+	2	Optional	Optional
Anesthesia Storage	0	8	Yes	No
Central Services Area				
Soiled Area	–	6	Yes	No
Clean Area	+	4	Optional	Optional
Equipment Storage	0	2	Optional	Optional

\+ = Positive
– = Negative
0 = Equal

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

APPENDIX B

JUDGMENT – ORAL ARGUMENT

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

March 10, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

No. 85-3242 vs.

BERNARD J. TURNOCK, Director of Illinois Department of Public Health, NEIL F. HARTIGAN, Attorney General, State of Illinois, GARY L. CLAYTON, Director of the Illinois Department of Registration and Education,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85-C-6011—**John A. Nordberg**, *Judge*.

This cause was heard on the record from the United States District Court for the Northern District of Illinois, Eastern Division, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by this Court that with the exception of the portion of the injunction regarding the second trimester hospitalization requirement, which is VACATED AS MOOT, the preliminary injunction is AFFIRMED, in accordance with the opinion of this Court filed this date. Costs on appeal are assessed to appellants.

APPENDIX C

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

April 13, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, et al.,

Plaintiffs-Appellees,

No. 85-3242 v.

BERNARD J. TURNOCK, Director of the Illinois Department of Public Health, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85-C-6011—**John A. Nordberg**, *Judge*.

ORDER

The slip opinion in this matter issued on March 10, 1988, is amended as follows:

In footnote 6 at pages 14-15, strike the present third and fourth sentences and replace them with the following sentence.

However, the district court undertook a thorough examination of the traditional factors governing the granting of preliminary relief, i.e., the lack of an adequate remedy at law, irreparable harm, balance of harms, likelihood of success on the merits, and the public interest.

At page 3, line 10, strike the word "Providers" and substitute the word "Planning."

At page 5, line 13, strike the word "or" and substitute the word "for."

At page 32, lines 5-7, strike the citation "*Zbaraz v. Hartigan*, 763 F.2d 1532, 1545 (7th Cir. 1985), *appeal pending*, No. 85-673" and substitute the following "*Zbaraz v. Hartigan*, 763 F.2d 1532, 1545 (7th Cir. 1985) aff'd ___ U.S. ___, 108 S. Ct. 479 (1987)."

APPENDIX D

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

AMENDED ORDER

August 16, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

No. 85-3242 v.

BERNARD J. TURNOCK, Director of Illinois Dept. of Public Health; NEIL F. HARTIGAN, Attorney General, State of Illinois; and GARY L. CLAYTON, Director of Illinois Dept. of Registration & Education,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85 C 6011—**John A. Nordberg**, *Judge*.

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *en banc* filed by defendants-appel-

lants and the answer filed by plaintiffs-appellees, a vote was requested on the suggestion for a rehearing *en banc*. A majority of the members of the original panel voted to deny the petition for rehearing, and the suggestion of rehearing en banc failed by an equally divided court.* Judges Wood, Posner, Coffey, Manion, and Kanne voted to grant rehearing en banc. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing and suggestion for rehearing *en banc* is DENIED.

* Judge Kenneth F. Ripple did not participate in the consideration of the suggestion for rehearing en banc.

APPENDIX E

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

August 12, 1988.

Before

Hon. WILLIAM J. BAUER, *Chief Judge*
Hon. JOHN L. COFFEY, *Circuit Judge*
Hon. JESSE E. ESCHBACH, *Senior Circuit Judge*

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

No. 85-3242 v.

BERNARD J. TURNOCK, Director of Illinois Dept. of Public Health; NEIL F. HARTIGAN, Attorney General, State of Illinois; and GARY L. CLAYTON, Director of Illinois Dept. of Registration & Education,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division.
No. 85 C 6011—**John A. Nordberg**, *Judge*.

ORDER

On consideration of the petition for rehearing and suggestion for rehearing *en banc* filed by defendants-appel-

lants and the answer filed by plaintiffs-appellees, a vote was requested on the suggestion for a rehearing *en banc*. A majority of the judges in regular active service did not vote to rehear the case *en banc*, and a majority of the members of the original panel voted to deny the petition for rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing and suggestion for rehearing *en banc* is DENIED.

Judge Kenneth F. Ripple did not participate in the consideration of the suggestion for rehearing en banc.

APPENDIX F

[Entered December 11, 1985]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

RICHARD M. RAGSDALE, M.D., et al., Plaintiffs,

vs.

BERNARD J. TURNOCK, et al., Defendants.

No. 85 C 6011 — Judge Nordberg

CLASS CERTIFICATION AND PRELIMINARY INJUNCTION ORDER

This matter came to be heard upon plaintiffs' motion for class certification and upon plaintiff's motion for a preliminary injunction to enjoin and restrain defendants from enforcing § 16.1(a)-(e) of the Illinois Medical Practice Act, Ill. Rev. Stat. ch. 111, § 4433(a)-(e) ("the MPA"), the Illinois Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111½, ¶ 157-8.1, *et seq.* ("the ASTC Act"), regulations promulgated under the ASTC Act, and the Illinois Health Facilities Planning Act, Ill. Rev. Stat. ch. 111½, § 1152-1168 ("the HFP Act"), against persons offering, performing, or desiring to offer or perform first or early second trimester abortions. The parties presented evidence and argument to the Court in hearings November 18-22 and November 26, 1985, and memoranda of law. Based upon the evidence, arguments and memoranda presented to the Court, on November 27, 1985 the Court issued a Memorandum Opinion and Order granting plain-

lants and the answer filed by plaintiffs-appellees, a vote was requested on the suggestion for a rehearing *en banc*. A majority of the judges in regular active service did not vote to rehear the case *en banc*, and a majority of the members of the original panel voted to deny the petition for rehearing. Accordingly,

IT IS ORDERED that the aforesaid petition for rehearing and suggestion for rehearing *en banc* is DENIED.

Judge Kenneth F. Ripple did not participate in the consideration of the suggestion for rehearing en banc.

APPENDIX F

[Entered December 11, 1985]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

RICHARD M. RAGSDALE, M.D., et al., Plaintiffs,

vs.

BERNARD J. TURNOCK, et al., Defendants.

No. 85 C 6011 — Judge Nordberg

CLASS CERTIFICATION AND PRELIMINARY INJUNCTION ORDER

This matter came to be heard upon plaintiffs' motion for class certification and upon plaintiff's motion for a preliminary injunction to enjoin and restrain defendants from enforcing § 16.1(a)-(e) of the Illinois Medical Practice Act, Ill. Rev. Stat. ch. 111, § 4433(a)-(e) ("the MPA"), the Illinois Ambulatory Surgical Treatment Center Act, Ill. Rev. Stat. ch. 111½, ¶ 157-8.1, *et seq.* ("the ASTC Act"), regulations promulgated under the ASTC Act, and the Illinois Health Facilities Planning Act, Ill. Rev. Stat. ch. 111½, § 1152-1168 ("the HFP Act"), against persons offering, performing, or desiring to offer or perform first or early second trimester abortions. The parties presented evidence and argument to the Court in hearings November 18-22 and November 26, 1985, and memoranda of law. Based upon the evidence, arguments and memoranda presented to the Court, on November 27, 1985 the Court issued a Memorandum Opinion and Order granting plain-

tiffs' motion for class certification and plaintiffs' motion for preliminary injunction.

Based upon this Court's November 27, 1985 Memorandum Opinion and Order and the findings of fact and conclusions of law therein, IT IS HEREBY ORDERED, ADJUDGED AND DECREED as follows:

1. This matter shall be maintained as a class action. The Court hereby certifies the following classes:

(a) A plaintiff class consisting of all physicians and surgeons who perform or desire to perform abortions in the State of Illinois;

(b) A plaintiff class consisting of all Illinois women of child-bearing age who desire or may desire an abortion sometime in the future;

(c) A defendant class consisting of all State's Attorneys in the State of Illinois.

2. Until further order of this Court, defendants Bernard J. Turnock, Neil F. Hartigan, and Gary L. Clayton, in their official capacities, and their successors, officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them, and Richard M. Daley and the other 101 State's Attorneys in Illinois, their successors, officers, agents, servants, employees and attorneys and those persons in active concert or participation with them, are hereby enjoined from the following actions:

(a) Enforcing § 16.1(a)-(e) of the MPA, Ill. Rev. Stat. ch. 111, § 4433(a)-(e);

(b) Enforcing or applying the ASTC Act, Ill. Rev. Stat. ch. 111½, ¶ 157-8.1 *et seq.*, or any of its provisions, or rules or regulations promulgated thereunder, against any person or facility to the extent such person or facility offers or performs, or desires to offer or perform, first and/or early second trimester abortions or other abortion-related gynecological procedures, such as a dilation and curettage;

(c) Enforcing or applying the HFP Act, Ill. Rev. Stat. ch. 111½, § 1152-1168, against any person or facility to the extent such person or facility offers or performs, or desires to offer or perform, first and/or early second trimester abortions or other abortion-related gynecological procedures, such as a dilation and curettage;

(d) Initiating any prosecution against, including but not limited to civil and administrative proceedings, or imposing any sanction upon any person who offers or performs or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures, such as a dilation and curettage, in violation of § 16.1(a)-(e) of the MPA, the ASTC Act, or any of its provisions, or rules and regulations promulgated thereunder, or the HFP Act.

3. This order shall be effective immediately and shall supplement this Court's November 27, 1985 order.

4. The $2,000 bond given by plaintiffs on November 27, 1985 and then approved by the Court shall also secure the preliminary injunction order contained herein.

ENTER: /s/ JOHN A. NORDBERG
United States District
Court Judge

Date: December 11, 1985

APPENDIX G

[Entered November 27, 1985]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs,

v.

BERNARD J. TURNOCK, et al.,

Defendants.

No. 85 C 6011 — Judge Nordberg

MEMORANDUM OPINION AND ORDER

Plaintiffs bring this action against defendants pursuant to 42 U.S.C. §§ 1983, 1988 and 28 U.S.C. §§ 2201, 2202, seeking declaratory and injunctive relief. Plaintiffs challenge the constitutionality of three Illinois statutes, and the regulations thereunder, which, plaintiffs contend, form a scheme that in effect requires all abortions to be performed in a hospital or its functional equivalent. Plaintiffs charge that this scheme violates the equal protection rights of Illinois physicians who perform or desire to perform abortions, and the privacy rights of Illinois women who desire or may desire to obtain an abortion.

This matter is now before the court on the motions of plaintiffs to certify two plaintiff classes and one defendant class, and for a preliminary injunction against defendants. The plaintiffs have moved the court to maintain the following classes: (1) a plaintiff class of "all duly licensed physicians and surgeons performing or desiring to perform pregnancy terminations in Illinois," represented by

named plaintiff, Dr. Richard M. Ragsdale; (2) a plaintiff class of "all women in the state of Illinois of child-bearing age who desire or may desire an abortion sometime in the future," represented by named plaintiffs Sarah Roe and Margaret Moe; and (3) a defendant class of "the State's Attorneys for all of the counties of the state of Illinois," represented by named defendant, Richard M. Daley. The plaintiffs have also moved the court to enjoin defendants from enforcing, in derogation of a physician's right to perform, and a woman's right to obtain, first and early second trimester abortions, three Illinois statutes: (1) Section 16(1) of the Illinois Medical Practice Act ("MPA"), Ill. Rev. Stat. ch. 111, para. 4433(1); (2) the Ambulatory Surgical Treatment Center Act of Illinois ("ASTCA"), Ill. Rev. Stat. ch. 111½, para. 157-8.1 - 157-8.16, and the regulations promulgated thereunder; and (3) the Illinois Health Facilities Planning Act ("HFPA"), Ill. Rev. Stat. ch. 111½, para. 1151-1168, and the regulations promulgated thereunder.

The court has reviewed the pleadings of the parties dealing with the class certification motion. The court held a hearing on the motion for preliminary injunction on November 18-22 and 26, 1985. The court has reviewed the pleadings dealing with the preliminary injunction motion, and has heard the opening statements and closing arguments of counsel and the testimony of witnesses. The court has considered all the evidence presented, including the depositions of several witnesses who did not testify at the hearing. The court has drawn reasonable inferences from this evidence, and has evaluated the legal arguments presented by the parties. In judging the credibility of each witness and the weight to be given the testimony of each, the court has taken into account for each witness the intelligence, ability and opportunity to observe, the age, the memory, the manner while testifying, any interest, bias, or prejudice the witness may have, and the reasonableness of the testimony considered in the light of all the evidence in the case. The court has reviewed its extensive hearing notes and its references concerning credibility.

Based on all of the evidence and legal arguments presented, and for the reasons set forth below, the court grants, with some modification, plaintiffs' motion for certification of the three classes, and the court grants plaintiffs' motion for a preliminary injunction. A preliminary consideration of the challenged statutes and regulations, and of the facts, will greatly aid in the discussion of both motions. Therefore, the court now turns to the statutes and regulations, and to the facts.

I. The Challenged Statutes and Regulations

The statutes and regulations which plaintiffs challenge in this action present an unusual mixture of abortion-specific and general provisions.[1] First, section 16 of the MPA generally provides the grounds upon which the IDPH may revoke or suspend the medical license of any person. However, subsection (1), the only portion of section 16 which plaintiffs challenge, is abortion-specific. Under subsection (1), the IDPH may revoke or suspend the license of any physician who performs an "elective abortion" in any place other than an ASTC, a hospital, or a facility run by the state, the federal government, or a state university or college. Essentially, section 16(1) prohibits physicians from performing even one abortion in their offices, and requires physicians who wish to provide abortion services in non-hospital environments to comply with the ASTCA and HFPA.

The ASTCA defines what an ASTC is and provides for the licensure of all ASTCs. Section 3 of the ASTCA defines an ASTC as "any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose." Thus, the ASTCA applies generally to all ASTCs devoted primarily to the performance of surgical procedures, regardless of the specific procedure performed, while at the same time the ASTCA singles out, for more strict regulation, facilities at which abortions are performed. The remainder of the ASTCA concerns, for the most part, the requirements and the procedure for obtaining an ASTC license. One other provision of the ASTCA deals specifically with abortion, and that is section 6.1, which requires any corporation operating an ASTC devoted primarily to providing facilities for abortion to have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the ASTC, on the ASTC's board of directors as a condition to licensure of the ASTC.

The regulations promulgated pursuant to the ASTCA are comprehensive and detailed. They cover all aspects of the provision of abortion services, from personnel policies to physical plant requirements. Many of the regulations are abortion-specific. An entire section of the regulations, Subpart G, is abortion-specific. The regulations in subpart G include a prohibition upon the performance of abortions after the first trimester and reporting requirements for each abortion performed in an ASTC.

The physical plant requirements in the regulations cover building design, construction standards, physical requirements and mechanical and electrical systems. In effect, they require ASTCs to be the functional equivalent of small hospitals.[2] These regulations include, but are not limited to, the following:

(a) Regulation 205.1320(a), requires an ASTC to be "identifiably separate" from other [medical] facilities and functions.

(b) Regulation 205.1330, requires anyone seeking to build or substantially remodel an ASTC to submit work plans to the state for prior approval. These work plans include architectural drawings, structural drawings, and mechanical drawings (which include drawings of the heating, cooling, ventilation, plumbing, drainage, stand-pipe and electrical systems).

(c) Regulation 205.1360(a), requires that an examination room be at least 80 square feet in size.

(d) Regulation 205.1360(b), requires that a procedure room have a minimum clear area of 250 square feet.

(e) Regulation 205.1370(a), requires an ambulatory surgical treatment center to have a "control station" located to permit "visual surveillance of all traffic which enters the operating suite".

(f) Regulation 205.1370(k), requires that "staff and personnel facilities be provided for male and female personnel," including a lounge, lockers, separate toilets, and space for changing clothes.

(g) Regulation 205.1370(n), requires a separate janitorial closet exclusively for the surgical suite.

(h) Section 205.1380, requires an ambulatory surgical treatment center to establish a "diagnostic facility" equipped to perform diagnostic tests far more elaborate and complex than those performed during the course of a pregnancy termination.

(i) Regulation 205.1400 regulates the size of doors and halls to require that some corridors be at least 8 feet in width and that doors to procedure rooms be at least 3 feet 8 inches wide. These dimensions parallel the requirements for hospital corridors.

(j) Section 205.1540 regulates the air conditioning, heating and ventilation systems to require (a) specific filter efficiencies and (b) air flow systems "balanced" to comply with the detailed ventilation and pressure relationships established by the regulation. Different pressure relationships and air change requirements are specified for the following areas: (1) the procedure room, (2) the examination area, (3) the recovery room, (4) the instrument cleaning room, (5) the toilet room, (6) the janitors' closet, (7) the linen and trash area, (8) the anesthesia storage area, (9) the equipment storage area, (10) the clean linen and storage area, (11) the soiled linen storage area, (12) the laboratory area, and (13) miscellaneous other areas.

As can be seen, these regulations are extremely detailed. The regulations, without question, cause abortion providers to incure great construction or renovation costs.

The HFPA requires all "health Care facilities," which includes all ASTCs, to obtain a "permit," or certificate of need, before acquiring major medical equipment or constructing or modifying a health care facility. HFPA §§ 3, 5. The procedure which the HFPA established for acquiring a certificate of need is as follows: (1) the applicant must submit a comprehensive application to the Illinois Health Facilities Planning Board ("Board"), HFPA § 6; (2) if there is an Areawide Health Planning Organization, the Board forwards the application to this organization for a period of review which may last up to 120 days, HFPA § 8; (3) the Areawide Health Planning Organization, or the IDPH, must provide an opportunity for a public hearing on the application, and may schedule that hearing up to 90 days after the receipt of a complete application, HFPA § 8; and (4) ultimately, the Board will determine whether to grant or deny the application for a certificate of need based on factors such as the applicant's ability to provide a proper standard of health care service for the community, the economic feasibility of the project, and the project's consistency with the public interest and the orderly and economic development of such facilities, HFPA § 6.[3]

II. The Facts

The uncontroverted facts are as follows. Dr. Ragsdale is a licensed Illinois physician. He is the Director of the Northern Illinois Women's Center ("NIWC"), which is located in Rockford, Illinois. The NIWC provides gynecological, family planning and abortion services to women in northwest Illinois.

Since it opened in 1973, the NIWC has been the only provider of abortion services in the large area of northwest Illinois. This geographic area extends west to Chicago, east to Iowa, north to Wisconsin, and south to

Peoria. The NIWC offers first trimester and early second trimester "Dilation and Evacuation" abortions, all performed with a local anesthetic. The NIWC provides either reduced fee or free abortion services to indigent women. In 1984, physicians at the NIWC performed 3,480 abortions. Few complications resulted.[4]

The NIWC is currently licensed under the ASTC, and has been so since 1973, although at no time has the NIWC fully complied with the ASTCA and its regulations.[5] The current location of the NIWC is the Rockford Medical Arts Building, which is operated by the Rockford Services Company.

In early February, 1985, the Rockford Services Company informed Dr. Ragsdale that his lease would not be renewed. The fundamental reason the Rockford Services Company did not renew Dr. Ragsdale's lease, as set out in the telephonic deposition of Mr. Delts, the President of the Rockford Services Company, is that the premises of the NIWC are needed as office space for physicians that refer more patients to the adjoining Rockford Memorial Hospital. Deposition of William Delts, p. 15. Another factor in the decision, however, was the determination that it would cost approximately $240,000 for the building to be brought into compliance with the ASTCA and its regulations. *Id.* at 8, 9, 14.

Since the Rockford Services Company informed him that his lease would not be renewed, Dr. Ragsdale has attempted to find new facilities and secure a certificate of need for such facilities. Dr. Ragsdale, for reasons set forth below in detail, has not been able to secure a relocation site for the NIWC. On December 31, 1985, the NIWC must vacate its premises in the Rockford Medical Arts Building. At that time, because of a lack of a relocation site, the NIWC will be forced to close altogether.

Margaret Moe is a registered nurse, and she currently operates two medical facilities, one in Elgin, Illinois, and another in Palatine, Illinois. The Elgin facility is in Kane County, and the Palatine facility is in Cook County. Margaret Moe's facilities offer complete family planning education and medical care, including the prescription of contraceptives, pre-natal care and delivery-assistance for pregnant women.

Margaret Moe receives approximately 60 requests for abortions per week at her clinics. She would like to offer abortion services at her facilities, and the licensed physicians she employs are competently trained and willing to perform safe abortions. However, Margaret Moe's facilities do not comply with the physical plant, structural and administrative requirements of the ASTCA and its regulations. As set forth more fully below, Margaret Moe has not, and cannot, renovate her existing facilities or construct new facilities that would comply with the ASTCA and its regulations because of the prohibitive cost of such a project.

The two other named plaintiffs are Sarah Roe and Jane Doe. Sarah Roe is a female citizen of the United States, of child-bearing age and a resident of Rockford, Illinois. She is the mother of two children. Ms. Roe had an abortion at the Northern Illinois Women's Center for which she was charged only a minimal fee because of her current indigent financial situation. She may need another abortion in the future. Jane Doe is a female citizen of the United States and of child-bearing age. She is a resident of Rockford, married and the mother of several children. From other doctors in the Rockford area, Ms. Doe learned that uterine fibroids associated with a recent pregnancy posed a serious risk to her health; she was told that it was unlikely she would be able to carry her pregnancy past five months. Despite the severe pain and emotional trauma associated with this health threat, Ms. Doe was refused abortion services by several doctors in Rockford. Finally she was referred to Dr. Ragsdale at the NIWC from whom Ms. Doe received an abortion.

III. Motion For Class Certification

As stated above, plaintiffs have moved the court to maintain the following classes: (1) a plaintiff class of "all

duly licensed physicians and surgeons performing or desiring to perform pregnancy terminations in Illinois," represented by named plaintiff, Dr. Ragsdale; (2) a plaintiff class of "all women in the state of Illinois of child-bearing age who desire or may desire an abortion sometime in the future," represented by named plaintiffs, Margaret Moe and Sarah Roe; and (3) a defendant class of "the State's Attorneys for all of the counties of the State of Illinois," represented by named defendant, Richard M. Daley. Defendants Bernard J. Turnock, Director of the Illinois Department of Public Health ("IDPH"), Neil F. Hartigan, Attorney General of Illinois, and Gary L. Clayton, Director of the Illinois Department of Registration and Education ("IDRE"), through their counsel, have opposed the certification of the plaintiff classes. In addition, defendant Richard M. Daley, through his attorney, has objected to being named as the representative of the defendant class of Illinois State's Attorneys.

Rule 23 of the Federal Rules of Civil Procedure governs the certification of classes in federal courts. In order for a class to be certified, it must meet the four criteria set out in 23(a) and must also qualify under any one of the subsections of 23(b). The four criteria of 23(a) are that (1) the class is so numerous as to make joinder impracticable; (2) there are common questions of law or fact; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class. Subsection (b) provides that a class action may be maintained if the prosecution of separate actions would create certain risks, the party opposing the class has acted on grounds generally applicable to the class, making injunctive and declaratory relief appropriate, or the court finds that the questions of law or fact common to the members of the class predominate and that a class action is the superior method for adjudication of the controversy. The burden of establishing these class requirements rests on plaintiffs. *Eggleston v. Chicago Journeymen Plumbers Local Union No. 130*, 657 F.2d 890, 895 (7th Cir. 1981), *cert. denied*, 455 U.S. 1017 (1982). The

court now considers whether the proposed classes meet the class action requirements of Rule 23.

A. The Plaintiff Class of Physicians

This proposed class consists of all duly licensed physicians and surgeons performing or desiring to perform pregnancy terminations in Illinois, and the proposed representative of this class is Dr. Ragsdale. The court finds that the requirements of Rule 23 are met as to this class and its representative, Dr. Ragsdale.

First, this proposed class of plaintiffs is so numerous that it would be impracticable to individually join all of its members. Although plaintiffs did not present direct evidence of the number of class members, plaintiffs did state that there are approximately 65,860 abortions performed in Illinois annually. Plaintiffs' Motion to Maintain Class Actions, p. 3. In addition, during the hearing on the motion for preliminary injunction, plaintiff Margaret Moe stated that the physicians she employs in her two Illinois health care clinics desire to perform abortions, and that she knew of physicians in Cook, Kane and DuPage counties who would also perform abortions, but for the challenged statutes and regulations.[6] This evidence amounts to more than mere speculation or conclusory allegations as to the numerousity of the class. *See Valentino v. Howlett*, 528 F.2d 975, 978 (7th Cir. 1976). Also, although an exact number of class members has not been determined, due to the difficulty in making such a determination, this does not preclude class certification. *Vergara v. Hampton*, 581 F.2d 1281, 1284 (7th Cir. 1978), *cert. denied*, 441 U.S. 905 (1979). The court finds that plaintiffs have presented sufficient evidence of the numerousity of this class of physicians.

Second, there are questions of law or fact common to the members of this proposed class. Not all factual or legal questions raised in a lawsuit need be common, so long as a single issue of law or fact is common to all class members. *Thillens, Inc. v. Community Currency Exchange*

Assoc. of Illinois, 97 F.R.D. 668, 677 (N.D. Ill. 1983). Also, variance in class members' positions on the common issue should not be dispositive of the decision to certify the class action. *Id.* Here, all Illinois physicians who perform, or desire to perform, abortions are subject to the challenged statutes and regulations. The question of law common to all physicians in this class is whether the statutes and regulations unconstitutionally impede the equal protection right of physicians in this class to practice their profession.

Third, Dr. Ragsdale's claims are typical of the claims of the class. As a licensed Illinois physician who performs abortions in the course of his regular medical practice, Dr. Ragsdale is subject to the challenged statutes and regulations in the same manner as all other Illinois physicians performing, or desiring to perform, abortions.[7]

Fourth, Dr. Ragsdale will fairly and adequately protect the interests of the class. The test of adequacy of representation is two-pronged: (1) the representative must be able to conduct the litigation; and (2) the representative's interests must not be antagonistic to those of the class members. *Thillens*, 97 F.R.D. at 679. Dr. Ragsdale has clearly demonstrated his ability to conduct the litigation in the preliminary injunction proceedings. Furthermore, his attorneys have considerable experience in civil rights litigation. Also, Dr. Ragsdale does not have interests antagonistic to the interests of the class.

Finally, this proposed class meets the requirements of 23(b)(2), as the defendants, in either promulgating, administering or enforcing the challenged statutes and regulations, have acted on grounds generally applicable to the class, making injunctive and declaratory relief appropriate. Here, plaintiffs seek only injunctive and declaratory relief.[8] Finding this class meets the requirements of Rule 23, the court therefore certifies this plaintiff class and finds Dr. Ragsdale to be an adequate representative.

B. The Plaintiff Class of Women

This proposed class consists of all women in Illinois of child-bearing age who desire or may desire an abortion sometime in the future, and the proposed representatives are Margaret Moe and Sarah Roe. The court finds that the requirements of Rule 23 are met as to this class; however, the court appoints, as the named representatives of this class, Margaret Moe and Dr. Ragsdale. The defendants contend that Sarah Roe does not have standing to assert her own privacy rights, let alone the privacy rights of the proposed class members. Such contention need not detain the court at this time, and the court does not decide here whether Sarah Roe does have standing, for it is clear that Margaret Moe and Dr. Ragsdale have standing to litigate this lawsuit on behalf of themselves as well as on behalf of the proposed class of Illinois women. *See, e.g., Westchester Women's Health Organization v. Whalen*, 475 F. Supp. 734, 737 (S.D. N.Y. 1979). The court now turns to the requirements of Rule 23.

As stated previously, approximately 65,860 abortions are performed in Illinois annually. Clearly, the proposed class is so numerous as to make joinder impracticable. Also, as noted before, the difficulty in determining the exact number of class members does not preclude class certification.

There is a question of law common to all members of the proposed class. The common question of law is whether the challenged statutes and regulations unconstitutionally burden the right to privacy of the class members.

As for the typicality of the claims of Dr. Ragsdale and Margaret Moe, and the adequacy of their representation, the court finds that both of these named plaintiffs clearly have standing to assert the claims of Illinois women who desire, or may desire, to obtain an abortion. In *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1145-1148 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975), the Seventh Circuit held that both the physician and the corporate plaintiff had stand-

ing to assert that the abortion regulations unduly infringed upon the privacy rights of their patients. In so holding, the court relied on *Doe v. Bolton*, 410 U.S. 179 (1973), as making it clear that physicians threatened with criminal liability for the performance of an "illegal" abortion do have a sufficient interest to challenge the validity of a State's abortion law.

In the present case, Dr. Ragsdale and Margaret Moe are not threatened with criminal prosecution, and Margaret Moe is not a physician. However, as owners and operators of medical centers, both are threatened, under the ASTCA and the HFPA, with liability for a "business offense," punishable by a fine of $10,000.00 for each "violation." Each day may constitute a separate violation. ASTCA § 12, HFPA § 14. In addition, under the ASTCA, the IDPH may deny, suspend or revoke an ASTC license and may even "immediately" close a facility under certain conditions, and, under the HFPA, the Illinois Health Facilities Planning Board may deny an application for a permit needed for the acquisition of major medical equipment or the construction or modification of a health care facility. ASTCA §§ 7, 9(a), HFPA § 10.[9] Also, Dr. Ragsdale is threatened, under the MPA, with the revocation of his medical license. MPA § 16(1). Clearly, both Margaret Moe and Dr. Ragsdale have an extremely concrete interest in the outcome of this litigation, and both therefore have standing to assert the interests of their patients in this action. *See Birth Control Centers, Inc. v. Reizen*, 508 F. Supp. 1366, 1369 (E.D. Mich. 1981) (holding that corporate and physician plaintiffs have standing to assert the claims of their patients), *aff'd in part, vac. in part*, 743 F.2d 352 (6th Cir. 1984).

As the named plaintiffs have standing to assert the claims of this proposed class of women, the court finds that the requirements of typicality and adequacy of representation have been met.[10] The court finds that the named plaintiffs are adequate representatives despite the fact that they are not technically members of the proposed plaintiff class. *See Undergraduate Student Association v.*

Peltason, 359 F. Supp. 320, 323 (N.D. Ill. 1973) ("As to [the organization's] representation of its members, it would be absurd to hold that an organization has standing in the constitutional sense, but is barred by the technical requirements of Rule 23, Fed.R.Civ.P. [citations omitted].") In fact, these representatives seem particularly appropriate in light of the fact that persons remain in this class for only a short period of time.

As the above discussion establishes, this proposed plaintiff class meets the requirements of section (a) of Rule 23. The proposed class also meets the requirements of Rule 23(b)(2), for the same reasons as discussed with regard to the plaintiff class of physicians. The court therefore certifies this plaintiff class of Illinois women of childbearing age who desire, or may desire, to obtain an abortion, and finds Margaret Moe and Dr. Ragsdale to be adequate representatives of the class.

C. The Defendant Class of State's Attorneys

This defendant class consists of the State's Attorneys for all of the 102 counties in the State of Illinois. The named representative is Richard M. Daley, State's Attorney for Cook County, Illinois.

Rule 23 unquestionably authorizes the certification of defendant classes. Section 23(a) provides, in part:

> One or more members of a class may sue *or be sued* as representative parties on behalf of all only if . . . (3) the claims *or defenses* of the representative parties are typical of the claims *or defenses* of the class . . . [emphasis added].

Fed.R.Civ.P. 23(2). In addition, Section 23(b) provides that a class action may be maintained if the requisites of Section 23(a) are met, and "the prosecution of separate actions by *or against* individual members of the class" would create certain risks (emphasis added). *See Thillens*, 97 F.R.D. at 673.

Indeed, in other similar cases in which the plaintiffs have questioned the constitutionality of various sections of the Illinois abortion laws, the courts have certified defendant classes of State's Attorneys, with the State's Attorney of Cook County as the named representative. *Zbaraz v. Hartigan*, 584 F. Supp. 1452, 1454 (N.D. Ill. 1984), *modified on other grounds*, 763 F.2d 1532 (7th Cir. 1985) (challenging the Parental Notice Abortion Act and designating *Richard M. Daley* as the representative of all the State's Attorneys of all the counties in Illinois); *Wynn v. Scott*, 449 F. Supp. 1302, 1306 (N.D. Ill. 1978), *aff'd sub nom., Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979) (challenging certain sections of the Abortion Act of 1975); *Wynn v. Scott*, 448 F. Supp. 997, 1000 (N.D. Ill. 1978), *aff'd sub nom., Wynn v. Carey*, 582 F.2d 1375 (7th Cir. 1978) (challenging the Illinois Abortion Parental Consent Act of 1977). However, there is no indication that the State's Attorney of Cook County, Illinois objected to representing the class of all Illinois State's Attorneys in these cases.

In the present case, Richard M. Daley does object to being named as the representative of a defendant class of Illinois State's Attorneys. In his answer to the plaintiffs' complaint, Mr. Daley "denie[d] that he should be a class representative" and stated that (1) the class of State's Attorneys of all 102 counties in Illinois is not so numerous that joinder of all members is impracticable; (2) it is incorrect to assume that each State's Attorney in Illinois would assert the same defense to the plaintiff's claims; and (3) he, through his assistants, generally depends on the Illinois Attorney General for the defense in cases challenging Illinois abortion laws. Defendant Daley's Answer, pp. 2, 3. Mr. Daley, through his attorney, repeated his objection to representative status in a later notice of October 30, 1985 and at the hearing on plaintiffs' motion for preliminary injunction.

In *Thillens*, 97 F.R.D. 668, and in *Research Corp. v. Pfister Associated Growers, Inc.*, 301 F. Supp. 497 (N.D. Ill. 1969), *appeal dismissed sub nom., Research Corp. v.*

Asgrow Seed Co., 425 F.2d 1059 (7th Cir. 1970), the named defendant likewise objected to representing the defendant class. In both cases, the courts certified the defendant classes and found the named defendants to be adequate representatives. According to the *Research Corp.* court, the defendants' objection to being the named representatives "is hardly enough to overcome the overwhelming evidence of their ability and intention to challenge the plaintiff's assertions" and "this factor of 'desire,' as opposed to ability should not be given more than token weight." *Research Corp.*, 301 F. Supp. at 499. *See also Thillens*, 97 F.R.D. at 679.

The *Thillens* court, however, did discuss the special due process concerns which arise upon a motion for certification of a defendant class.[11] As the court noted, the Supreme Court has balanced the concurrent goals of preserving fundamental fairness to absent members of a defendant class and promoting judicial economy "by holding that due process is satisfied and absent members of a class are bound so long as the interests of the absentees are adequately represented [citations omitted]." *Thillens*, 97 F.R.D. at 674. As seen above, the adequacy of the named representative is not an additional requirement, but a requirement already found in Rule 23. The *Thillens* court, however, demanded that this requirement be "strictly observed" as to defendant classes, because of the special due process concerns. With this in mind, this court now turns to the requirements for class certification found in Rule 23.

First, the court finds that the class of 102 State's Attorneys, who are dispersed through the State of Illinois, is so numerous that it would be impracticable to individually join its members. Second, the court finds that there are questions of law common to the proposed class of defendants. Here, the plaintiffs' claim is that the challenged statutory and regulatory scheme is unconstitutional—that it violates the privacy rights of women desiring to obtain abortions and the equal protection rights of physicians desiring to provide abortion services. The overriding

common issue of law, therefore, is the constitutionality of the challenged statutes and regulations.

Third, the court finds that the defenses of Richard M. Daley are typical of the defenses of the class of Illinois State's Attorneys. Obviously, the primary defense of Mr. Daley and of all the State's Attorneys in this case will be that the challenged statutes and regulations are indeed constitutional.[12]

Finally, the court finds Mr. Daley to be an adequate representative of the interests of the class. Mr. Daley, through his staff, has already demonstrated, in the preliminary injunction hearing, his ability to conduct the litigation. Mr. Daley is sued in his official capacity; therefore, no serious question can be raised regarding his ability to carry the expense of the class defense. Furthermore, Mr. Daley and his staff have considerable litigation experience. Also, Mr. Daley is a member of the proposed class, and his interests in the subject matter of the litigation are not antagonistic to the interests of the members of the class of State's Attorneys.

The court therefore finds that this proposed class meets the requirements of section (a) of Rule 23. This class also meets the requirements of section (b)(1) of Rule 23. The prosecution of separate actions against individual members of the defendant class would indeed create a risk of inconsistent or varying adjudications, and plaintiffs would thereby be faced with incompatible standards of conduct. Having found that the requirements of Rule 23 have been met as to this class, the court now certifies this defendant class of Illinois State's Attorneys, represented by named defendant Mr. Daley.

IV. Motion For Preliminary Injunction

As stated above, plaintiffs have moved the court to preliminarily enjoin defendants from administering and enforcing, in derogation of the equal protection rights of physicians who perform, or desire to perform, abortions and privacy rights of women who desire, or may desire,

to obtain an abortion, Section 16(1) of the MPA, the ASTCA and the regulations thereunder, and the HFPA and the regulations thereunder. In ruling on a motion for a preliminary injunction, the court must consider the following factors: (1) whether the plaintiffs have no adequate remedy at law and will suffer irreparable harm if the court does not grant the preliminary injunction; (2) whether the irreparable harm the plaintiffs will suffer outweighs any irreparable harm that may reflect on the defendants if the court issues the injunction; (3) whether the plaintiffs have shown a "better than negligible" likelihood of succeeding on the merits; and (4) whether the injunction will disserve the public interest. *Roland Machinery Co. v. Dresser Industries*, 749 F.2d 380, 386-387 (7th Cir. 1984). Here, the court finds that all four factors weigh decidedly in favor of issuing a preliminary injunction.

A. No Adequate Remedy At Law And Irreparable Harm

Plaintiffs in this case have demonstrated that they will indeed experience irreparable harm should the court not issue this injunction. The challenged statutory and regulatory scheme, as written and as enforced, has the effect of raising the cost and limiting the availability of abortions. The scheme forces complying facilities to raise their fees, possibly beyond the economic means of some women, discourages other non-complying facilities from offering abortion services, and makes it difficult, if not impossible, for current abortion facilities to move or new abortion facilities to be constructed.

In *Fox Valley Reproductive Health Care v. Arft*, 446 F. Supp. 1072, 1073-1074 (E.D. Wisc. 1978), the court found that the plaintiff abortion clinic sufficiently established irreparable harm. The town ordinance challenged in that case is very similar to the ASTCA and its regulations here, in that (1) the town ordinance applied generally to any nonhospital facility at which surgical, diagnostic, or therapeutic procedures were performed; (2) certain provisions applied specifically to abortion clinics; and (3) the

ordinance was comprehensive, regulating licensing, building plans and specifications, supplies and equipment, medical policies and procedures, record keeping, patient care, and physician and nurse qualifications. The plaintiff in *Fox Valley* contended that irreparable harm was threatened, because the high cost of bringing the facility in compliance with the ordinance would force it to raise its current fee of $150 to a fee of between $300 and $500, an amount which would be beyond the economic means of poor women. The court held that this contention, "in conjunction with the solicitude courts have shown for a woman's right to freedom from interference in deciding whether to seek an abortion," supported a finding that irreparable harm was threatened. *Fox Valley*, 446 F. Supp. at 1074.

In the present case, plaintiffs have also demonstrated that the extensive regulations force those offering abortion services to raise their fees for abortion services.[13] This may indeed place the abortion procedure beyond the economic means of some women.

Plaintiffs have also demonstrated that the extensive ASTCA regulations discourage or "chill" those desiring to offer abortion services from opening an abortion facility or from adding abortion services to the services they already provide at their facilities. Margaret Moe testified at the hearing that she has desired to offer abortion services at the two health care clinics she operates since 1974. She contacted the IDPH on various occasions from 1974-1982, and was told on each occasion that abortion facilities must secure an ASTC license and comply with the ASTCA regulations.[14] Because of the extensive, expensive, and, indeed, prohibitive physical plant requirements in the regulations, Margaret Moe decided she could not offer abortion services at her clinics, and she still does not offer abortion services at her clinics.

In addition, plaintiffs have also shown that the certificate of need requirement of the HFPA makes it extremely difficult, if not impossible, for those desiring to provide abortion services to construct a facility or move to a new location. Under the certificate of need process set

out in the HFPA, those desiring to open or move to a new facility must complete a lengthy, detailed application,[15] in which the applicant must disclose the fact that abortions will be performed at the proposed facility and must identify the ownership of the proposed facility. The general public may obtain a copy of this application through the state freedom of information law.[16] Ill. Rev. Stat. ch. 116, para. 201, *et seq.* Also, as part of the certificate of need process, the "recognized areawide health planning organization" or the IDPH must provide an opportunity for, and notice of, a public hearing "for the purpose of allowing the applicant and any interested person to present public testimony concerning the approval, denial, renewal or revocation of the [certificate of need]." HFPA § 8.

Given the current climate of the abortion debate, placing information in the hands of the public, such as the ownership of a facility in which persons propose to provide abortion services, subjects both the owner of the building and the proposed provider to the possibility of harrassment and even threats of violence to themselves, their families and their friends.[17] In the case of Dr. Ragsdale, after the public received notice of a hearing on a proposed new site for the NIWC, but before the hearing took place, the landlord of the proposed site, with whom Dr. Ragsdale had an informal agreement, withdrew the site. Dr. Ragsdale secured a second site before the public hearing. Dr. Ragsdale entered a formal agreement with the landlord of this second site. Approximately 1,200 people attended the hearing on March 14, 1985. The hearing began at 7:00 p.m. with a statement by Dr. Ragsdale announcing the NIWC's proposed move. No other statement could be heard for the rest of the hearing, which lasted until 10:00 p.m., because of the shouting and generally riotous atmosphere. Friends of Dr. Ragsdale, fearing for his safety, escorted the Ragsdale family from the hearing. The landlord for the second site withdrew the site within 48 hours of the hearing, despite the formal agreement he had entered with Dr. Ragsdale. The areawide health planning organiza-

tion in the area of the proposed new sites of the NIWC did eventually determine that there was a need for the NIWC.[18] However, by the time this determination was made, Dr. Ragsdale no longer had a site to which he could move the NIWC. As it now stands, the NIWC, the only outpatient abortion facility in all of northwest Illinois, will close December 31, 1985 without a relocation site.

In her testimony at the hearing, Margaret Moe pointed out yet another way in which the certificate of need procedure under the HFPA impedes efforts to provide abortion services. Recently, many hospitals have had difficulty filling their available beds because of the emphasis on outpatient health care. With many empty hospital beds, it may be difficult for those who desire to provide abortion services to establish a "need" for an outpatient abortion facility.

As the above discussion makes clear, the challenged statutes and regulations do place a very real and a very heavy burden on the right of a woman to decide to terminate her pregnancy. The effect of the statutory and regulatory scheme is to increase the cost of abortions and decrease their availability. As a result of the scheme, Margaret Moe does not provide abortion services at her two Illinois clinics even though the physicians at the clinics are ready, willing, and able to perform abortions, and even though approximately sixty patients a week at the clinics request an abortion. Also, as a result of the scheme, the NIWC, the only outpatient abortion facility in northwest Illinois, will close at the end of this year without a relocation site.

The effect on women desiring to terminate their pregnancies, as clarified by the hearing testimony of Margaret Moe, is enormous. First, many women are not able to obtain an abortion in their own community, and they may find it difficult to secure a means of transportation to the nearest abortion facility, which may, in fact, be quite a distance from their community.[19] Having to make travel plans, arrange a day off and negotiate a loan, if needed, and then actually having to travel some distance to an

abortion facility may delay the abortion and thereby increase the health risk or prevent the abortion altogether. Also, travelling a distance subjects a woman to greater expense, as the woman must pay for the cost of transportation and may need to hire a babysitter or miss a day of work and lose that day's pay. In addition, other factors affecting a woman's decision to terminate her pregnancy, such as her confidence in the competency of the physician performing the abortion and her ability to return for follow-up care, would be adversely affected if the woman were required to travel a great distance to obtain an abortion.[20]

The court finds that plaintiffs have clearly established that irreparable injury will result if the injunction is not issued. *See Doe v. Charleston Area Medical Center*, 529 F.2d 638, 644 (4th Cir. 1975) ("*Roe v. Wade* and *Doe v. Bolton* . . . establish beyond argument that denial under color of law of the right to abort, implicit in the right to be let alone, constitutes irreparable injury."). *Accord*, *Gary-Northwest Indiana Women's Services, Inc. v. Bowen*, 496 F. Supp. 894, 902 (N.D. Ind. 1980).

The court finds that plaintiffs have established irreparable injury despite the argument of defendants that irreparable injury is not established because the IDPH does not enforce certain sections of the statutes and certain regulations. The State asserted in the hearing that the IDPH does not currently enforce the following statutes and regulations: (1) MPA § 16(1), requiring abortions to be performed in an ASTC or hospital; (2) ASTCA § 3(A), defining an ASTC as including any facility in which a medical procedure is utilized to terminate a pregnancy, regardless of whether the facility is primarily devoted to this purpose; (3) Regulation 205.740, prohibiting the performance of other than first trimester abortions in ASTCs; and (4) Regulation 205.760, requiring a report of each abortion procedure performed in an ASTC.

However, the IDPH has on no occasion formally notified physicians or abortion providers of its decision not to enforce these provisions. Also, the IDPH has not attempted

to amend the regulations or introduce amendatory legislation in the Illinois legislature. With no formal commitment of nonenforcement, the statutory and regulatory requirements, even if not in fact enforced, clearly "chill" potential abortion providers. Moreover, even if there were a formal nonenforcement agreement, the discussion above demonstrates that plaintiffs have established irreparable injury resulting from the statutory and regulatory scheme, as written *and as enforced.*

The court notes, at this time, the irony implicit in the defendants' nonenforcement argument. At the preliminary injunction hearing, Dr. Hern, an expert on abortion practice, testified that most important factor in determining the safety of an abortion is the skill and experience of the physician. According to Dr. Hern, a physician who performs only a few abortions a year will be less skilled than physicians with a practice "primarily devoted" to the performance of abortions. Under the statutory and regulatory scheme, as defendants contend it is now enforced, physicians performing thousands of abortions yearly are more strictly regulated than physicians performing a few abortions a year.

B. Harm To The Plaintiffs Outweighs Any Harm To Defendants

The threatened harm to the plaintiffs clearly outweighs any possible harm defendants may suffer if the court issues the preliminary injunction. Indeed, it is difficult to discern exactly what, if any, harm will befall defendants upon the issuance of this injunction, which will merely prevent defendants from enforcing the challenged statutes and regulations. *See e.g., Fox Valley,* 446 F. Supp. at 1074.

C. Likelihood of Success On The Merits

In the landmark case of *Roe v. Wade,* 410 U.S. 113 (1973), the Supreme Court established that the right of privacy, grounded in the concept of personal liberty guaranteed by the Constitution, encompasses a woman's right

to decide whether to obtain an abortion. *Id.* at 153. At the same time, the Court acknowledged that this fundamental right "is not unqualified and must be considered against important state interests in abortion." *Id.* at 154. However, as pointed out in *Roe,* 410 U.S. at 155, and more recently in *City of Akron v. Akron Center for Reproductive Health,* 462 U.S. 416, 427 (1983), restrictive state regulation of the right to choose abortion, as with other fundamental rights, must be supported by a compelling state interest.

In *Roe,* the Court identified the relevant state interests and the point at which those interests become compelling. According to the Court, the state has an interest in the health of the mother, and this interest becomes compelling at approximately the end of the first trimester. After the first trimester, the state may, in promoting this interest, "regulate the abortion procedure in ways that are reasonably related to maternal health." *Roe,* 410 U.S. at 164. Until that time, a pregnant woman must be allowed, in consultation with her physician, to decide to abort and to effectuate that decision "free of interference by the State." *Id.* at 163; *Akron,* 462 U.S. at 429-430.

The Court in *Roe* based its identification of the end of the first trimester as the "compelling point" on the finding that, according to medical literature available in 1973, first trimester abortions are as safe for a woman as normal childbirth. *Roe,* 410 U.S. at 163. In *Akron,* the Court noted that medical developments in the past decade "have extended the period in which abortions are safer than childbirth." *Akron,* 462 U.S. at 429, n. 11.[21] Still, the *Akron* Court held it "prudent . . . to retain *Roe*'s identification of the beginning of the second trimester *as the approximate time* at which the State's interest in maternal health becomes sufficiently compelling . . . (emphasis added)." *Id.* The court now turns to the *Roe* trimester standard, as interpreted in *Akron* and other cases, to provide the legal framework for the constitutional evaluation of the challenged statutes and regulations.

First, the court notes that the statutes and regulations here apply to all facilities in which any abortions are performed. None of the statutes or regulations exclude from their scope facilities in which first or early second trimester abortions are performed. However, this does not mean that the statutes and regulations are per se unconstitutional. As the *Akron* court noted, certain State regulations that have no "significant impact" on a woman's exercise of her abortion right during the first trimester may be permissible where justified by important State health objectives. *Akron*, 462 U.S. at 430. *See Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976) (upholding regulations which applied to first trimester abortions and required that a patient give written consent prior to the abortion, and that records be kept of all abortions); *Connecticut v. Menillo*, 423 U.S. 9 (1975) (upholding a statute requiring that only licensed physicians perform abortions, including first trimester abortions).

Neither does *Roe* stand for the proposition that any general medical regulation which applies to the performance of first and early second trimester abortions is per se constitutional.[22] As the Seventh Circuit stated in *Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1153-1154 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975):

> Furthermore, any proposed regulation, even if applied universally to all similar medical procedures, because of the fundamental right of a woman to procure an abortion during the first trimester, would have to meet a compelling governmental interest requirement. Thus, any general health regulations which would apply to first trimester abortions would have to be limited so as to give effect to the fundamental rights as established by *Roe* and *Doe*; that is, not be burdensome on a woman's right to decide to abort a pregnancy. *By this we mean that in all probability nothing broader than general requirements as to the maintaining of sanitary facilities and general requirements as to meeting minimal building code standards would be permissible.* (Emphasis added.)

Thus, any regulation, even a general regulation, which burdens a woman's rights to choose to terminate her pregnancy during the first trimester would have to meet the compelling governmental interest requirement. In addition, under *Roe* and *Akron*, a regulation which burdens a woman's right to choose to terminate her pregnancy during the early second trimester must be "reasonably relate[d]" to the preservation and protection of maternal health. *Akron*, 462 U.S. at 430-431; *Roe*, 410 U.S. at 163.

In the present case, plaintiffs have overwhelmingly demonstrated the burden that the challenged statutory and regulatory scheme places on a woman's right to choose to terminate her pregnancy during the first and early second trimester. As noted in the previous discussion of irreparable injury, the scheme, as written *and as enforced*, increases the cost and decreases the availability of abortions. Also, the scheme may delay the effectuation of a woman's decision to abort.

Charles v. Carey, 627 F.2d 772, 777 (7th Cir. 1980), *app. after remand, sub nom. Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), instructs that once a plaintiff has shown that interference in the pregnancy termination decision is "sufficiently substantial and not de minimus," the State must show that there is compelling basis for the law and that the burden is not undue or unjustifiable. Here, plaintiffs have demonstrated that the challenged scheme substantially interferes with the pregnancy termination decision during the first and early second trimester.

Defendants, however, have failed to produce any evidence at all of a compelling or even rational basis for the challenged statutes and regulations. The defendants presented no evidence in their pleadings or at the hearing that the statutes and regulations are medically necessary.[23] Dr. Barton, the defendant's expert in obstetrics and gynecology, testified at the hearing that he was of the opinion that there is a medical necessity for some regulation by the state of outpatient abortion facilities, but Dr. Barton did not testify as to the medical necessity of any of the statutes or regulations here challenged. Also, Dr. Barton

agreed that there is no medical reason to single out abortion from other medically analogous procedures for different regulation. Defendants, at best, have shown that selected regulations, such as Regulation 205.730(b)(2)(a), which sets out the qualifications for counselors, are consistent with accepted medical practice. This is not equivalent to a showing of medical necessity.

Plaintiffs have established the burdensome nature of the scheme as a whole. Defendants have failed to demonstrate a compelling, or even a rational, basis for the statutory and regulatory scheme. Therefore, the court now finds that there is a reasonable likelihood that plaintiffs will succeed on the merits.

D. Harm To The Public Interest

In *Fox Valley*, 446 F. Supp. at 1075, the court found that the public's interest would not be disserved by the issuance of the preliminary injunction. The court reasoned that the public's interest lies in the enforcement of that which is mandated by the Constitution, and the Constitution mandated that the abortion regulation challenged in that case not be imposed. Likewise, in the present case, the Constitution mandates that the challenged statute and regulations not be applied to physicians who perform first trimester abortions or early second trimester DE abortions, or to the facilities in which these procedures are performed.

Of course, the public also has an interest in the preservation and protection of a patient's health. However, contrary to the argument of the State's Attorney at the preliminary injunction hearing, the injunction which the court now issues will not disserve this interest. At the hearing, the State's Attorney argued that, if the court issued the injunction prayed for, this would "open the door" to substandard abortion facilities in Illinois. Not so. The injunction here will not leave abortion clinics, such as the NIWC, free from all state regulation. On the contrary, such facilities will still have to meet the standards set

by local building codes. Also, physicians performing abortions are obligated to practice surgery with care and will still be subject to disciplinary action under the remaining subsections of section 16 of the MPA. The court therefore finds that the public interest will be served by the issuance of this preliminary injunction.

E. Scope of The Preliminary Injunction

Having found preliminary injunctive relief is appropriate in this case, the court now turns to the scope of the preliminary injunctive relief granted. In the above discussion dealing with the plaintiffs' demonstration of the likelihood of their success on the merits, the court found that defendants have failed to show a compelling need or even a rational basis for the burdensome statutory and regulatory scheme. Accordingly, the court preliminarily enjoins defendants from enforcing the challenged statutes and regulations against any plaintiffs who offer or perform first or early second trimester abortions.

V. Conclusion

For the reasons set forth above, the court grants plaintiffs' motion for certification of two plaintiff classes and one defendant class, with some modification. Also, the court grants plaintiffs' motion for preliminary injunction, and hereby enjoins defendants from enforcing the challenged statutes and regulations against any plaintiff offering, performing, or desiring to offer or perform a first or early second trimester abortion.

ENTER: /s/ JOHN A. NORDBERG
United States District Judge

Date: November 27, 1985

[1] The challenged statutes are not part of the explicitly separate Illinois "Abortion Laws," Ill. Rev. Stat. ch. 38, para. 81-21 to 81-35, 81-51 to 81-55, 81-61 to 81-70, the constitutionality of which has been challenged on several occasions. *See, e.g., Zbaraz v. Hartigan*, 763 F.2d 1532 (7th Cir. 1985); *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980), *appeal after remand sub nom. Charles v. Daley*, 749 F.2d 452 (7th Cir. 1984), *probable jurisdiction noted sub nom. Diamond v. Charles*, 105 S.Ct. 2356 (1985); *Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979); *Wynn v. Carey*, 582 F.2d 1375 (7th Cir. 1978).

Likewise, there have been previous challenges to the constitutionality of the statutes involved in this case. In *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981), the Illinois Supreme Court struck down a portion of a village ordinance, on equal protection and privacy grounds, which incorporated the ASTCA's definition of an Ambulatory Surgical Treatment Center ("ASTC"). Also in *Bickham v. Lashof*, No. 76 C 4564, slip op. (N.D. Ill. Jan. 28, 1981), the court denied defendants' motion to dismiss the allegations in plaintiff's complaint that the ASTCA and MPA are unconstitutional. However, this case, which dealt with some of the exact issues presented here, was apparently dismissed for want of prosecution without a decision on the merits.

[2] Mr. Triemari, a Consulting Engineer and an expert in plumbing, heating and air conditioning, testified at the injunction hearing that the ASTC physical plant regulations are comparable, or generally equivalent, to those in the Illinois Hospital Licensing Act, Ill.Rev.Stat. ch. 111½, para. 142, *et seq.*, and the Chicago Hospital Ordinance. He also testified that many of the requirements, such as those dealing with air flow, are not required of physicians' offices.

[3] Raymond Passeri, the Chief of the Division of Facilities Development at the IDPH and the Executive Secretary of the Board, testified at the hearing that the HFPA was enacted in part because of the concern that allowing an unlimited number of health care facilities to be constructed would not fill a "need," but would instead waste the Illinois taxpayers' money because of the cost-plus disbursement arrangement. This arrangement is no longer in effect, and, certainly, abortion facilities do not utilize public funds for construction or renovation; therefore, the certificate of need procedure seems particularly inappropriate as applied to abortion facilities.

[4] Dr. Ragsdale presented the NIWC's complication statistics at the hearing. According to Dr. Ragsdale, approximately 9 women per 40,000 require immediate hospitalization after having an abortion at the NIWC, no deaths have resulted from abortions at the NIWC, and 10 to 15 women per 40,000 develop complications within a few days after an abortion at the NIWC, such as a fever from infection. These extremely low complication rates attest to Dr. Ragsdale's skill and experience as an abortion provider. Both Margaret Moe, an expert in the area of women's health care and family planning, and Dr. Hern, an expert on abortion practice, testified at the hearing that, in their opinion, Dr. Ragsdale is an extremely skilled and careful abortion provider. Indeed, even Dr. Barton, the defendants' expert on obstetrics and gynecology, testified that he has "some certainty" that the hospital in which he works, Illinois Masonic Medical Center, has referred patients to Dr. Ragsdale for abortions.

[5] There are currently 44 ASTCs in Illinois. Approximately half of these provide abortion services.

[6] In the preliminary injunction hearing, defendant Richard M. Daley, through his attorney, did point out on cross examination of Margaret Moe that Margaret Moe had personally worked with physicians in only Cook and Kane Counties.

[7] Defendants contend in their Response to the Motion for Class Certification that Dr. Ragsdale's claims are not typical of those of the proposed class because the NIWC has been a licensed ASTC since 1973; therefore, "Dr. Ragsdale is challenging the constitutionality of the statutes and regulations through which he has benefitted for more than ten years." Defendants' Response, p. 3. The court finds this argument without merit. Defendants do not articulate what "benefit" Dr. Ragsdale receives under the challenged statutes and regulations. Neither do defendants recognize that other members of the proposed class may also have operated licensed ASTCs for a number of years. It is axiomatic that those to whom statutes and regulations apply may challenge the constitutionality of such statutes and regulations despite a period of compliance. *See, e.g., Friendship Medical Center, Ltd. v. Chicago Board of Health*, 505 F.2d 1141, 1146 (7th Cir. 1974), *cert. denied*, 420 U.S. 955 (1975). Indeed, under the standing requirements of Article III of the United States Constitution, as interpreted by the courts, parties against whom statutes and regulations directly operate may be the "best" plaintiffs for a constitutional challenge, given their concrete personal stake in the outcome of the litigation.

[8] Defendants contend that the declaratory and injunctive relief plaintiffs request can be granted to all class members without certifying a class; therefore, plaintiffs' motion should be denied. In the Seventh Circuit, however, if a class meets the prerequisites of Rule 23, a court may not deny class certification on the ground of lack of "need." *Brown v. Scott*, 602 F.2d 791, 795 (7th Cir. 1979), *aff'd sub nom. Carey v. Brown*, 447 U.S. 455 (1980); *Vergara*, 581 F.2d at 1284.

[9] In *Friendship*, the challenged regulations empowered the city to deny authorization to those seeking to operate abortion facilities and to order the closing of a facility not in compliance with its regulations. According to the Seventh Circuit, "Surely, those subject to such deprivations through the use of governmental power have a sufficient interest to maintain this type of action. [citations omitted]" *Friendship*, 505 F.2d at 1146.

[10] Based on the preliminary injunction proceedings, it is clear that Dr. Ragsdale and Margaret Moe will adequately represent the interests of this proposed plaintiff class. In both the pleadings and the hearing on the preliminary injunction motion, the named plaintiffs, through their attorneys, focused almost exclusively on the alleged unconstitutional burden that these statutes and regulations place on the right of Illinois women to decide whether to obtain an abortion.

[11] The *Thillens* court also discussed the problems inherent in certifying both plaintiff and defendant classes in the same action. *Thillens*, 97 F.R.D. at 675-76. The court noted that courts are often reluctant to certify a defendant class when the action is brought by a plaintiff class because of the concern that each plaintiff member has not been injured by each defendant member. However, according to the court, as it interpreted *In re Gap Stores Securities Litigation*, 79 F.R.D. 283 (N.D. Cal. 1978), the requirement that each named plaintiff have a claim against each defendant may be waived where the defendant members are related by a conspiracy or "juridical link." The *Thillens* court went on to define a "juridical link" as "some legal relationship which relates all defendants in a way such that single resolution of the dispute is preferred to a multiplicity of similar actions. [citations omitted]"

There is clearly a "juridical link" between the Illinois State's Attorneys here. Under Ill. Rev. Stat. ch. 14, para. 5, each and every State's Attorney is charged with the duty of prosecuting all civil and criminal actions in which the people of the state or county may be concerned. Also, under section 14 of the HFPA, which deals with violations, the State's Attorneys are specifically charged with the duty of representing the people of Illinois in proceedings under that section. As all State's Attorneys are charged under the same statutes with the duty to take uniform enforcement action with respect to plaintiffs, the court therefore finds that the State's Attorneys are related in a way such that single resolution of the dispute is preferred to a multiplicity of similar actions.

[12] Some of the State's Attorneys may contend, as Mr. Daley did in his Answer, that the plaintiffs have not stated a cause of action specifically against them. This "affirmative defense" in Mr. Daley's answer apparently rested on the fact that Dr. Ragsdale's clinic was not in Cook County; therefore, Mr. Daley could not prosecute under the ASTCA or HFPA, and Dr. Ragsdale did not "state a cause of action" against Mr. Daley. Dr. Ragsdale is not the only plaintiff, however. Margaret Moe, another named plaintiff, owns and operates a medical facility in Cook County, and she clearly has stated a cause of action against Mr. Daley.

Given the certification of the two plaintiff classes in this order, it is expected that few, if any, State's Attorneys will be able to raise this defense. Accordingly, the court finds that the possibility that any one State's Attorney will raise this defense does not substantially affect the "typical" nature of the named defendants' defenses. *See Research Corp.*, 301 F. Supp. at 499.

[13] Dr. Ragsdale testified at the preliminary injunction hearing that his current fee for an abortion is approximately $250. Dr. Ragsdale estimated that if he were to move his practice to a facility similar to his current facility, which does not fully comply with the ASTCA regulations, he would have to increase by $22.45 the fee per patient over the next two years to cover his costs. Plaintiffs' Exhibit No. 17. Relocating his practice to a building in total compliance with the regulations, on the other hand, would add another $25.21 to the increase, making the total increase in fee per patient $47.66. Plaintiffs' Exhibit No. 18.

[14] Margaret Moe also testified that she telephoned the IDPH on November 18, 1985, to find out whether the IDPH still requires all abortion facilities to be licensed. At that time, an employee in the division of the ASTC licensing informed her that the IDPH was not currently requiring licenses for abortion facilities, but the IDPH "recommended" licensure. Margaret Moe had never before been informed that the IDPH was no longer requiring abortion facilities to obtain ASTC licenses. The court notes that it was not clear from this testimony whether the IDPH no longer requires ASTC licenses even for facilities "primarily devoted" to the performance of abortions. The testimony of Mary Lloyd Lowe, Deputy Chief Counsel for the Illinois Department of Public Health, and Defendants' Exhibit No. 2, an IDPH internal memorandum written by Michael Anderson, indicate that the IDPH still requires licensure for those facilities "primarily devoted" to providing abortion services.

[15] Dr. Ragsdale testified at the hearing that it took him five full working days to complete the HFPA application for a certificate of need.

[16] At the preliminary injunction hearing, Mary Lloyd Lowe testified that the IDPH also releases ASTC license applications, when

requested, pursuant to the Illinois Freedom of Information Act. Under the ASTCA and its regulations, such applications must also include a statement of ownership and a description of the services to be provided. ASTCA § 7(a), 77 Ill. Admin. Code § 205.120. The ASTC license application is also lengthy and detailed, as demonstrated by Plaintiffs' Exhibit No. 21, Dr. Ragsdale's 1985 ASTC license application.

[17] Dr. Ragsdale testified that the ASTCA requirements that an abortion facility be separately licensed and maintain an "identifiably separate" facility also subject abortion providers and their patients to threats and harrassment.

[18] *See* Plaintiffs' Exhibit No. 11, "Certificate of Need Investigative Staff Report to the Comprehensive Health Planning of Northern Illinois Regional Board and Project Review Committee."

[19] Margaret Moe testified at the hearing that approximately 90% of the patients at her Elgin, Illinois clinic have no means of transportation, and approximately 50% of the patients at her Palatine, Illinois clinic have no means of transportation.

[20] According to Margaret Moe, one of the greatest concerns of the patients at her clinics who desire to have an abortion is that Margaret Moe be able to refer them to a physician she knows is competent. Were Margaret Moe able to offer abortion services at her own clinics, she could, of course, assure her patients of the competency of the performing physicians.

[21] Dr. Ragsdale and Dr. Hern both testified at the hearing of the safety of the Dilation and Evacuation procedure, which has recently become the method most often utilized for abortions in the early part of the second trimester. In addition, defendants tendered as their Exhibit No. 6 the Standards for Obstetric-Gynecological Services, developed by the American College of Obstetricians and Gynecologists ("ACOG Standards") (6th ed. 1985). According to the ACOG Standards, and as noted by the *Akron* Court, uncomplicated abortions, up to 14 weeks from the last menstrual period, may be performed in a physician's office or an outpatient clinic. ACOG Standards, p. 60.

[22] In *Abortion Coalition v. Michigan Department of Public Health*, 426 F. Supp. 471, 474-476 (E.D. Mich. 1977), the court, in dicta, indicated that general regulations imposed upon medically analogous procedures are not invalid as applied to first trimester abortions. However, at the same time, the court held certain provisions of the "general" statute to be unconstitutional as applied to first trimester abortions. Moreover, in *Birth Control Centers, Inc. v. Reizen*, 508 F. Supp. 1366 (E.D. Mich. 1981), *aff'd in part, vac. in part*, 743 F.2d 352 (6th Cir. 1984), the court struck down

still more sections of the "general" Michigan Public Health Code, which required all freestanding surgical outpatient facilities to have transfer agreements with hospitals and to have six-foot corridors.

[23] Plaintiffs, on the other hand, presented testimony by Dr. Ragsdale and Dr. Hern that the regulations are not only medically unnecessary, but some of the regulations, particularly those requiring ASTCs to be hospital-like facilities, may be medically detrimental, for women often find it psychologically reassuring when they are able to effectuate their decision to abort in a comfortable, more personalized atmosphere.

Defendants' difficulty in providing evidence of the medical necessity of the burdensome statutes and regulations challenged here is understandable, given that other courts have already found that similar or identical provisions burden a woman's right to choose to terminate her pregnancy without furthering a compelling state interest. *See Arnold v. Sendak*, 416 F. Supp. 22 (S.D. Ind. 1976) (finding unconstitutional an Indiana statute requiring all abortions to be performed in hospitals or licensed health care facilities), *aff'd mem.*, 429 U.S. 968 (1976); *Village of Oak Lawn v. Marcowitz*, 86 Ill. 2d 406, 427 N.E.2d 36 (1981) (finding the portion of the definition of an ASTC including "any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose" to be unconstitutional).

APPENDIX H

NOTICE OF APPEAL

[Filed November 7, 1988]

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 85-3242

RICHARD M. RAGSDALE, M.D., et al.,

Plaintiffs-Appellees,

vs.

BERNARD J. TURNOCK, M.D., M.P.H., Director of the Illinois Department of Public Health, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division
No. 85 C 6011—John Nordberg, Judge Presiding

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES

Notice is hereby given that defendants-appellants Bernard J. Turnock, Director of the Illinois Department of Public Health; Neil F. Hartigan, Attorney General of Illinois; and Stephen F. Selcke, Director of the Illinois Department of

Professional Regulation,* hereby appeal to the Supreme Court of the United States from judgment of the United States Court of Appeals for the Seventh Circuit affirming an order of the United States District Court, Northern District of Illinois, Eastern Division, and holding unconstitutional and enjoining enforcement of the Ambulatory Surgical Treatment Center Act and the rules and regulations promulgated thereunder; the Health Facilities Planning Act; and par. 4433(1)(a)-(e) of the Illinois Medical Practice Act to the extent any person or facility offers or performs, or desires to offer or perform first and/or early second trimester abortions or other abortion-related gynecological procedures. The judgment was entered on March 10, 1988. On August 12, 1988 the appellants' petition for rehearing and suggestion for rehearing en banc was denied.

This appeal is taken pursuant to 28 U.S.C. Section 1254(a).

Respectfully submitted,

NEIL F. HARTIGAN
Attorney General of Illinois

BY: /s/ KATHLEEN KREISEL FLAHAVEN
Assistant Attorney General
General Law Division
100 West Randolph Street
13th Floor
Chicago, Illinois 60601

* Successor in public office to Gary L. Clayton, Director of the Illinois Department of Registration and Education.

AFFIDAVIT OF SERVICE

I hereby aver that a true and correct copy of the foregoing was served upon all parties required to be served at the listed addresses by depositing same in the United States mail chute located at 100 West Randolph Street, Chicago, Illinois 60601 on the 7th day of November, 1988 with proper postage prepaid.

Alan S. Gilbert
Lorie A. Chaiten
Sonnenschein, Carlin,
Nath & Rosenthal
8000 Sears Tower
Chicago, Illinois 60606

Colleen K. Connell
The Roger Baldwin
Foundation of ACLU
20 East Jackson Boulevard
Suite 1600
Chicago, Illinois 60604

Randolph T. Kemmer
Assistant State's Attorney
500 Richard J. Daley Center
Chicago, Illinois 60602

/s/ KATHLEEN KREISEL FLAHAVEN

SUBSCRIBED AND SWORN TO
BEFORE ME THIS 7th DAY
OF NOVEMBER, 1988.

/s/ JANET M. VOLDRICH
Notary Public

APPENDIX I

Ambulatory Surgical Treatment Center Act, 111½ Ill. Rev. Stat. ¶¶ 157-8.1, *et seq.*

AMBULATORY SURGICAL TREATMENT CENTER ACT

AN ACT relating to the inspection, licensing and regulation of ambulatory surgical treatment centers. P.A. 78-227, approved and eff. July 19, 1973.

157-8.1. Short title

§ 1. This act may be cited as the Ambulatory Surgical Treatment Center Act.

157-8.2. Declaration of public policy—Purpose

§ 2. It is declared to be the public policy that the State has a legitimate interest in assuring that all medical procedures, including abortions, are performed under circumstances that insure maximum safety. Therefore, the purpose of this Act is to provide for the better protection of the public health through the development, establishment, and enforcement of standards (1) for the care of individuals in ambulatory surgical treatment centers, and (2) for the construction, maintenance and operation of ambulatory surgical treatment centers, which, in light of advancing knowledge, will promote safe and adequate treatment of such individuals in ambulatory surgical treatment centers.

157-8.3. Definitions

§ 3. As used in this Act, unless the context otherwise requires, the following words and phrases shall have the meanings ascribed to them:

(A) "Ambulatory surgical treatment center" means any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures or any facility in which a medical or

surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. Such facility shall not provide beds or other accommodations for the overnight stay of patients. Individual patients shall be discharged in an ambulatory condition without danger to the continued well being of the patients or shall be transferred to a hospital.

The term "ambulatory surgical treatment center" does not include (1) any institution, place, building or agency required to be licensed pursuant to the "Hospital Licensing Act", approved July 1, 1953, as amended.[1]

(2) any person or institution required to be licensed pursuant to the "Nursing Home Care Reform Act of 1979" approved August 23, 1979, as amended;[2]

(3) hospitals or ambulatory surgical treatment centers maintained by the State of any department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control;

(4) hospitals or ambulatory surgical treatment centers maintained by the Federal Government or agencies thereof; or

(5) any place, agency, clinic, or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures.

(B) "Person" means any individual, firm, partnership, corporation, company, association, or joint stock association, or the legal successor thereof.

(C) "Department" means the Department of Public Health of the State of Illinois.

(D) "Director" means the Director of the Department of Public Health of the State of Illinois.

(E) "Physician" means a person licenced to practice medicine in all of its branches in the State of Illinois.

(F) "Dentist" means a person licensed to practice dentistry under the "Illinois Dental Practice Act."[3]

(G) "Podiatrist" means a person licensed to practice podiatry under "An Act to regulate the practice of podiatry in the State of Illinois", approved April 26, 1917, as amended.[4]

Amended by P.A. 83-333, § 60, eff. Sept. 14, 1983.

[1] Paragraph 142 et seq. of this chapter.

[2] Paragraph 4151-101 et seq. of this chapter.

[3] Chapter 111, ¶ 2201 et seq.

[4] Chapter 111, ¶ 4901 et seq.

157-8.4. Necessity of license—Municipal regulation

§ 4. No person shall open, conduct or maintain an ambulatory surgical treatment center without first obtaining a license from the Department.

Nothing in this Act shall be construed to impair or abridge the power of municipalities to license and regulate ambulatory surgical treatment centers, provided that the municipal ordinance requires compliance with at least the minimum requirements developed by the Department pursuant to this Act.

The Administrative Review Law, as heretofore or hereafter amended,[1] shall be applicable to the judicial review of final administrative decisions of the regulatory agency of the municipality. Any municipality having an ordinance licensing and regulating ambulatory surgical treatment centers which provides for minimum standards and regulations which meet at least the minimum requirements established pursuant to this Act shall make such periodic reports to the Department as the Department may deem necessary. This report shall include a list of ambulatory surgical treatment centers meeting standards substantially equivalent to those promulgated by the Department under this Act. The Department may issue a license to such ambulatory surgical treatment centers based upon such reports or the Department may conduct investigations or

inspections to determine whether a license should be issued to these ambulatory surgical treatment centers.

Amended by P.A. 82-783, Art. XI, § 201, eff. July 13, 1982.

[1] Chapter 110, ¶ 3-101 et seq.

157-8.5. Application for license

§ 5. An application for a license to operate an ambulatory surgical treatment center shall be made to the Department upon forms provided by it and shall contain such information as the Department reasonably requires, which may include affirmative evidence of ability to comply with the provisions of this Act and the standards, rules and regulations, promulgated by virtue thereof.

All applications required under this Section shall be signed by the applicant, verified, and accompanied by a license fee of $500.

Amended by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.6. Issuance of license—Requirements—Renewal of license—Provisional licenses

§ 6. Upon receipt of an application for a license, the Director may deny the application for any of the following reasons:

(1) Conviction of the applicant, or if the applicant is a firm, partnership or association, of any of its members, or if a corporation, of any of its officers or directors, or of the person designated to manage or supervise the facility, of a felony, or of 2 or more misdemeanors involving moral turpitude, as shown by a certified copy of the record of the court of conviction, or, in the case of the conviction of a misdemeanor by a court not of record, as shown by other evidence, if the Director determines, after investigation, that such person has not been sufficiently rehabilitated to warrant the public trust; or other satisfactory evidence that the moral character of the applicant, or manager, or supervisor of the facility is not reputable;

(2) The licensure status or record of the applicant, or if the applicant is a firm, partnership or association, of any of its members, or if a corporation, of any of its officers or directors, or of the person designated to manage or supervise the facility, from any other state where the applicant has done business in a similar capacity indicates that granting a license to the applicant would be detrimental to the interests of the public; or

(3) The applicant has insufficient financial or other resources to operate and conduct the facility in accordance with the requirements of this Act and the minimum standards, rules and regulations promulgated thereunder.

The Director shall only issue a license if he finds that the applicant facility complies with this Act and the rules, regulations and standards promulgated pursuant thereto and:

(a) is under the medical supervision of one or more physicians;

(b) permits a surgical procedure to be performed only by a physician, podiatrist or dentist who at the time is privileged to have his patients admitted by himself or an associated physician and is himself privileged to perform surgical procedures in at least one Illinois hospital; and

(c) maintains adequate medical records for each patient.

A license, unless sooner suspended or revoked, shall be renewable annually upon approval by the Department and payment of a license fee of $300. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. The licenses shall be posted in a conspicuous place on the licensed premises. A placard or registry of all physicians on staff in the facility shall be centrally located and available for inspection to any interested person. The Department may, either before or after the issuance of a license, request the cooperation of the State Fire Marshal. The report and recommendations of this agency shall be in writing and shall state with particularity its findings with

respect to compliance or noncompliance with such minimum standards, rules and regulations.

The Director may issue a provisional license to any ambulatory surgical treatment center which does not substantially comply with the provisions of this Act and the standards, rules and regulations promulgated by virtue thereof provided that he finds that such ambulatory surgical treatment center will undertake changes and corrections which upon completion will render the ambulatory surgical treatment center in substantial compliance with the provisions of this Act, and the standards, rules and regulations adopted hereunder, and provided that the health and safety of the patients of the ambulatory surgical treatment center will be protected during the period for which such provisional license is issued. The Director shall advise the licensee of the conditions under which such provisional license is issued, including the manner in which the facilities fail to comply with the provisions of the Act, standards, rules and regulations, and the time within which the changes and corrections necessary for such ambulatory surgical treatment center to substantially comply with this Act, and the standards, rules and regulations of the Department relating thereto shall be completed.

Amended by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.6-1. Abortions—Licensed physicians

§ 6.1. Notwithstanding any other provision of this Act, any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician, who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the Center, on the board of directors as a condition to licensure of the Center.

Added by P.A. 81-771, § 1, eff. Jan. 1, 1980.

157-8.7. Denial, suspension and revocation of license—Notice—Hearings—Subpoenas—Depositions

§ 7. The Director after notice and opportunity for hearing to the applicant or licensee may deny, suspend, or revoke a license to open, conduct and maintain an ambulatory surgical treatment center in any case in which he or she finds that there has been a substantial failure to comply with the provisions of this Act or the standards, rules and regulations established by virtue thereof.

Such notice shall be effected by registered mail or by personal service setting forth the particular reasons for the proposed action and fixing a date, not less than 15 days from the date of such mailing or service, at which time the applicant or licensee shall be given an opportunity for a hearing.

A copy of the notice shall be displayed in a conspicuous place adjacent to the license required to be displayed under Section 6 of this Act[1] until such time as the Department renders its final administrative order. At the end of each fiscal quarter the Department shall prepare and publish a report regarding the status or final disposition of its actions against licensees or applicants that have been served with notice regarding a contemplated denial, a refusal to renew or revocation of a license by the Department. The report shall identify the facility and the licensee or applicant that are the subject of contemplated action and summarize the facts and charges that constitute the grounds for such action. The reports shall be conveyed to the Governor and the General Assembly and shall be made available to the general public free of charge. Copies of such reports shall be available for distribution through local health departments and regional and sub-regional offices of the Department.

The hearing shall be conducted by the Director or by an individual designated in writing by the Director as Hearing Officer to conduct the hearing. On the basis of any such hearing, or upon default of the applicant or licensee, the Director shall make a determination specify-

ing his or her findings and conclusions. A copy of such determination shall be sent by registered mail or served personally upon the applicant or licensee.

The procedure governing hearings authorized by this Section shall be in accordance with rules promulgated by the Department. A full and complete record shall be kept of all proceedings, including the notice of hearing, complaint, and all other documents in the nature of pleadings, written motions filed in the proceedings, and the report and orders of the Director and Hearing Officer. All testimony shall be reported but need not be transcribed unless the decision is sought to be reviewed pursuant to the Administrative Review Law.[2] A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy or copies.

The Director or Hearing Officer, shall upon his or her own motion, or on the written request of any party to the proceeding, issue subpoenas requiring the attendance and the giving of testimony by witnesses, and subpoenas duces tecum requiring the production of books, papers, records or memoranda. All subpoenas and subpoenas duces tecum issued under the terms of this Act may be served by any person of legal age. The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the Circuit Court of this State, such fees to be paid when the witness is excused from further attendance. When the witness is subpoenaed at the instance of the Director or Hearing Officer, such fees shall be paid in the same manner as other expenses of the Department, and when the witness is subpoenaed at the instance of any other party to any such proceeding the Department may require that the cost of service of the subpoena or subpoena duces tecum and the fee of the witness be borne by the party at whose instance the witness was summoned. In such case, the Department in its discretion, may require a deposit to cover the cost of such service and witness fees. A subpoena or subpoena duces tecum so issued as above stated shall be served in the same manner as a subpoena issued by a circuit court.

Any circuit court of this State, upon the application of the Director, or upon the application of any other party to the proceeding, may, in its or his or her discretion, compel the attendance of witnesses, the production of books, papers, records or memoranda and the giving of testimony before the Director or Hearing Officer conducting an investigation or holding a hearing authorized by this Act, by an attachment for contempt or otherwise, in the same manner as production of evidence may be compelled before the court.

The Director or Hearing Officer, or any party in an investigation or hearing before the Department, may cause the depositions of witnesses within the State to be taken in the manner prescribed by law for like depositions in civil actions in courts of this State, and to that end compel the attendance of witnesses and the production of books, papers, records, or memoranda.

Amended by P.A. 82-783, Art. XI, § 201, eff. July 13, 1982; P.A. 83-334, § 87, eff. Sept. 14, 1983; P.A. 83-345, § 67, eff. Sept. 14, 1983.

[1] Paragraph 157-8.6 of this chapter.

[2] Chapter 110, ¶ 3-101 et seq.

P.A. 83-334, in the first paragraph, inserted "or she"; in the second paragraph, substituted "15" for "fifteen"; in the fourth paragraph, inserted "or her"; in the sixth paragraph, inserted "or her", substituted "above stated" for "aforesaid", and, at the end of the sixth paragraph, substituted "by a circuit court" for "out of a court of record"; in the seventh paragraph, following "State", deleted "or any judge thereof, either in term time or vacation", and, also in the seventh paragraph, inserted "or her", and substituted "the" for "said" the last place it appears in the seventh paragraph.

P.A. 83-345, in the second paragraph, substituted "15" for "fifteen"; in the sixth paragraph, inserted "or her", and substituted "legal" for "full"; in the last sentence of the sixth paragraph, inserted "so" and "circuit", and, following "issued", deleted "as aforesaid", and, following "court", deleted "of record"; in the seventh paragraph, following "State", deleted "or any judge thereof, either in term time or vacation"; in the seventh paragraph, preceding "discretion", deleted "or his"; and substituted "the" for "said" the last place it appears in the seventh paragraph.

Final legislative action, 83rd General Assembly:

P.A. 83-334—June 20, 1983

P.A. 83-345—June 20, 1983

See Ill.Rev.Stat. ch. 1, ¶ 1105 as to the effect of (1) more than one amendment of a section at the same session of the General Assembly or (2) two or more acts relating to the same subject matter enacted by the same General Assembly.

157-8.7a. Statement or ownership

§ 7a. (a) As a condition of the issuance or renewal of the license of any ambulatory surgical treatment center, the applicant shall file a statement of ownership. The applicant shall agree to update the information required in the statement of ownership every 6 months from the initial date of filing.

(b) The statement of ownership shall include the following:

(1) The name, telephone number and occupation of every person who has entered into a contract to manage or operate or who owns or controls, directly or indirectly, any of the shares of stock of, or any other financial interest in, the facility which is the subject of the application or license, and the percentage of such interest; and

(2) The address of any facility, wherever located, any financial interest in which is owned or controlled, directly or indirectly, by the applicant, if the facility is required to be licensed if it were located in this State.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.7b. Financial statements

§ 7b. (a) Each licensee shall file an attested financial statement with the Department by July 1, 1980 and at times thereafter as required. An audited financial statement may be required of a particular facility, if the Director determines that additional information is needed.

(b) No public funds shall be expended for the care or treatment of any patient in an ambulatory surgical treatment center which has failed to file the financial statement required by this Section, and no public funds shall be paid to or on behalf of a facility which has failed to file a statement.

(c) The Director shall promulgate regulations for the filing of financial statements, and shall provide in these regulations for forms, information required, intervals and dates of filing, and such other provisions as he may deem necessary. Regulations shall be published in sufficient time to permit those licensees who must first file financial statements time in which to do so.

(d) The Director shall seek the advice and comments of other State and Federal agencies which require the submission of financial data from facilities licensed under this Act and shall incorporate the information requirements of these agencies into the forms it adopts or issues under this Act and shall otherwise coordinate its regulations with the requirements of these agencies so as to impose the least possible burden on licensees. No other State agency may require submission of financial data except as expressly authorized by law or as necessary to meet requirements of federal law or regulation. Information obtained under this Section shall be made available, upon request, by the Department to any other State agency or legislative commission to which such information is necessary for investigations or to execute the intent of State or Federal law or regulation.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.8. Construction, alterations or additions to treatment centers—Approval by Department

§ 8. Before commencing construction of new facilities or specified types of alteration or additions to an existing ambulatory surgical treatment center, architectural drawings and specifications therefor shall be submitted to the Department for review and approval. Final approval of

the drawings and specifications for compliance with design and construction standards shall be obtained from the Department before the alteration, addition, or new construction is begun.

157-8.9. Inspections and investigations—Confidentiality of information

§ 9. The Department shall make or cause to be made such inspections and investigations as it deems necessary but in no case less than 4 inspections of any licensed facility in a fiscal year. Information received by the Department through filed reports, inspection, or as otherwise authorized under this Act shall not be disclosed publicly in such manner as to identify individual patients, except to another State agency for purposes of investigation of professional or business practices in a licensed ambulatory surgical treatment center, which State agency shall not disclose such individual patient information publicly.

Every facility licensed under this Act and any premises proposed to be conducted as a facility by an applicant for a license shall be open at all reasonable times to an inspection authorized in writing by the Director. No notice need be given to any person prior to any inspection.

Amended by P.A. 81-1509, Art. I, § 69, eff. Sept. 26, 1980.

Article I of P.A. 81-1509 was the 1980 Combining Revisory Act, which resolved multiple actions of the 81st General Assembly through P.A. 81-1224.

157-8.9a. Closings—Orders—Hearings and reinspections

§ 9a. Whenever an inspection of any ambulatory surgical treatment center discloses that the continued operation of such facility constitutes an imminent and serious menace to the health or safety of the patients thereof, or in the event of a conviction of a licensee under Section 12 of this Act,[1] the inspector is authorized to immediately close such facility. Once the facility has been closed, the personnel employed there shall cease any activity re-

lated to the patients, unless continued treatment of any given patient is necessary to protect his or her health or life. A written order setting forth the grounds on which any action under this Section is based shall be served on the licensee within 24 hours after such action is taken. Any licensee whose ambulatory surgical treatment center has been closed may, within 10 days thereafter, by written notice, request that the Director conduct a hearing and a reinspection under the provisions of this Act. If a subsequent inspection discloses that the violations of this Act or rules, regulations or standards have been abated, the Director shall cancel the order of closing and permit patients to be treated therein. The remedies provided in this Section are in addition to and not exclusive of any other remedy provided by law.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

[1] Paragraph 157-8.12 of this chapter.

157-8.9b. Complaints—Ambulatory surgical treatment center

§ 9b. The Department shall establish by rule a procedure for receiving and investigating complaints regarding any ambulatory surgical treatment center or any physician practicing in any such facility.

Added by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.10. Standards, rules and regulations—Construction—Personnel—Equipment—Facilities, programs and services

§ 10. The Department shall prescribe and publish minimum standards, rules and regulations necessary to implement the provisions of this Act which shall include, but not be limited to:

(a) construction of the facility including, but not limited to, plumbing, heating, lighting, and ventilation which shall ensure the health, safety, comfort and privacy of patients and protection from fire hazard;

(b) number and qualifications of all personnel, including administrative and nursing personnel, having reponsibility for any part of the care provided to the patients;

(c) equipment essential to the health, welfare and safety of the patients; and

(d) facilities, programs and services to be provided in connection with the care of patients in ambulatory surgical treatment centers.

157-8.10a. Administrative Procedure Act—Application

§ 10a. The provisions of "The Illinois Administrative Procedure Act", approved September 22, 1975,[1] are hereby expressly adopted and shall apply to all administrative rules and procedures of the Department of Public Health under this Act, except that in case of conflict between "The Illinois Administrative Procedure Act" and this Act the provisions of this Act shall control, and except that Section 5 of the Illinois Administrative Procedure Act[2] relating to procedures for rule-making does not apply to the adoption of any rule required by federal law in connection with which the Department is precluded by law from exercising any discretion.

Added by P.A. 79-1347, § 17, eff. July 1, 1977.

[1] Chapter 127, ¶ 1001 et seq.

[2] Chapter 127, ¶ 1005.

157-8.11. Review under Administrative Review Law

§ 11. Whenever the Department refuses to grant, or revokes or suspends a license to open, conduct or maintain an ambulatory surgical treatment center, the applicant or licensee may have such decision judicially reviewed. The provisions of the Administrative Review Law[1] and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Department hereunder. The term "administrative decisions" is defined as in Section 3-101 of the Code of Civil Procedure.[2]

Amended by P.A. 82-783, Art. XI, § 201, eff. July 13, 1982.

[1] Chapter 110, ¶ 3-101 et seq.

[2] Chapter 110, ¶ 3-101.

157-8.12. Violations—Penalties

§ 12. Any person opening, conducting or maintaining an ambulatory surgical treatment center without a license issued pursuant to this Act shall be guilty of a business offense punishable by a fine of $10,000 and each day's violation shall constitute a separate offense. Any person opening, conducting or maintaining an ambulatory surgical treatment center who violates any other provision of this Act shall be guilty of a business offense punishable by a fine of not more than $10,000.

Amended by P.A. 81-224, § 1, eff. Jan. 1, 1980.

157-8.13. Violation of Act or rules and regulations as nuisance—Injunction

§ 13. The operation or maintenance of an ambulatory surgical treatment center in violation of this Act or of the Rules and Regulations promulgated by the Department is declared a public nuisance inimical to the public welfare. The Director of the Department, in the name of the People of the State, through the Attorney General or the State's Attorney of the county in which the violation occurs, may, in addition to other remedies herein provided, bring action for an injunction to restrain such violation or to enjoin the future operation or maintenance of any such ambulatory surgical treatment center.

157-8.14. Licensing Board—Appointment—Qualifications—Term—Vacancy—Expenses—Meetings—Duties

§ 14. The Governor shall appoint an Ambulatory Surgical Treatment Center Licensing Board composed of 12 persons. Four members shall be practicing physicians; one member shall be a practicing podiatrist; one member shall

be a dentist who has been licensed to perform oral surgery; one member shall be an Illinois registered professional nurse who is employed in an ambulatory surgical treatment center; one member shall be a person actively engaged in the supervision or administration of a health facility; and 4 members shall represent the general public and shall have no personal economic interest in any institution, place or building licensed pursuant to this Act. In making Board appointments, the Governor shall give consideration to recommendations made through the Director by appropriate professional organizations.

Each member shall hold office for a term of 3 years and the terms of office of the members first taking office shall expire, as designated at the time of appointments, 3 at the end of the first year, 3 at the end of the second year, and 6 at the end of the third year, after the date of appointment. The term of office of each original appointee shall commence October 1, 1973; and the term of office of each successor shall commence on October 1 of the year in which his predecessor's term expires. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. Board members, while serving on business of the Board shall receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. The Board shall meet as frequently as the Director deems necessary, but not less than once a year. Upon request of 3 or more members, the Director shall call a meeting of the Board.

The Board shall advise and consult with the Department in the administration of this Act, provided that no rule, regulation or standard shall be adopted by the Department concerning the operation of ambulatory surgical treatment centers licensed under this Act which has not had prior approval of the Ambulatory Surgical Treatment Center Licensing Board.

Amended by P.A. 79-339, § 1, eff. Oct. 1, 1975.

157-8.15. Severability of invalid provisions

§ 15. If any provision of this Act or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions of application of the Act which can be given effect without the invalid provision or application, and to this end the provisions of the Act are declared to be severable.

157-8.16. Effective date

§ 16. This Act shall take effect upon its becoming a law.

APPENDIX J

Health Facilities Planning Act, 111½ Ill. Rev. Stat. ¶¶ 1151, *et seq.*

ILLINOIS HEALTH FACILITIES PLANNING ACT

AN ACT to provide for the planning of Illinois health facilities. P.A. 78-1156, approved and eff. Aug. 27, 1974.

1151. Short title

§ 1. This Act shall be known and may be cited as the Illinois Health Facilities Planning Act.

1152. Purpose of Act

§ 2. The purpose of this Act is to establish a procedure designed to reverse the trends of increasing costs of health care resulting from unnecessary construction or modification of health care facilities. Such procedure shall represent an attempt by the State of Illinois to improve the financial ability of the public to obtain necessary health services, and to establish an orderly and comprehensive health care delivery system which will guarantee the availability of quality health care to the general public.

This Act shall establish a procedure (1) which requires a person establishing, constructing or modifying a health care facility, as herein defined, to have the qualifications, background, character and financial resources to adequately provide a proper service for the community; (2) that promotes through the process of recognized local and area-wide health facilities planning, the orderly and economic development of health care facilities in the State of Illinois that avoids unnecessary duplication of such facilities; (3) that promotes planning for and development of health care facilities needed for comprehensive health care especially in areas where the health planning process has identified unmet needs; and (4) that carries out these purposes in coordination with the Agency and the comprehensive State health plan developed by that Agency.

Amended by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1153. Definitions

§ 3. As used in this Act: "Health care facilities" means and includes the following facilities and organizations:

1. An ambulatory surgical treatment center required to be licensed pursuant to the "Ambulatory Surgical Treatment Center Act", approved July 19, 1973, as amended;[1]

2. An institution, place, building, or agency required to be licensed pursuant to the "Hospital Licensing Act", approved July 1, 1953, as amended;[2]

3. Any institution required to be licensed pursuant to the "Nursing Home Care Reform Act of 1979", approved August 23, 1979, as amended;[3]

4. Hospitals, nursing homes, ambulatory surgical treatment centers or kidney disease treatment centers, or health maintenance organizations maintained by the State or any department or agency thereof;

5. Kidney disease treatment centers, including a free-standing hemodialysis unit; and

6. Any health maintenance organization required to be operated pursuant to the "Health Maintenance Organization Act", approved August 27, 1974, as now or hereafter amended,[4] and which:

(A) is a qualified health maintenance organization under Section 1310(d) of the Public Health Services Act;[5] or

(B) (i) provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out of area coverage; (ii) is compensated (except for co-payments) for the provision of the basic health care services listed in clause (i) to enrolled participants by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health service actually provided; and (iii) provides physicians' services primarily (I) direct-

ly through physicians who are either employees or partners of such organization, or (II) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

No federally owned facility shall be subject to the provisions of this Act, nor facilities used solely for healing by prayer or spiritual means.

With the exception of those health care facilities specifically included in this Section, nothing in this Act shall be intended to include facilities operated as a part of the practice of a physician or other licensed health care professional, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional group. Further, this Act shall not apply to physicians or other licensed health care professional's practices where such practices are carried out in a portion of a health care facility under contract with such health care facility by a physician or by other licensed health care professionals, whether practicing in his individual capacity or within the legal structure of any partnership, medical or professional corporation, or unincorporated medical or professional groups. This Act shall apply to construction or modification and to establishment by such health care facility of such contracted portion which is subject to facility licensing requirements, irrespective of the party responsible for such action or attendant financial obligation.

"Person" means any one or more natural persons, legal entities, governmental bodies other than federal, or any combination thereof.

"Consumer" means any person other than a person (a) whose major occupation currently involves or whose official capacity within the last 12 months has involved the providing, administering or financing of any type of health care facility, (b) who is engaged in health research or the teaching of health, (c) who has a material financial interest

in any activity which involves the providing, administering or financing of any type of health care facility, or (d) who is or ever has been a member of the immediate family of the person defined by (a), (b), or (c).

"State Board" means the Health Facilities Planning Board.

"Construction or modification" means the establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment or service for diagnostic or therapeutic purposes or for facility administration or operation, or any capital expenditure made by or on behalf of a health care facility which exceeds the capital expenditure minimum.

"Establish" means the construction of a health care facility or the replacement of an existing facility on another site.

"Major medical equipment" means medical equipment which is used for the provision of medical and other health services and which costs in excess of the capital expenditure minimum, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act[6] to meet the requirements of paragraphs (10) and (11) of Section 1861(s) of such Act.[7] In determining whether medical equipment has a value in excess of the capital expenditure minimum, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.

"Capital Expenditure" means an expenditure: (A) made by or on behalf of a health care facility (as such a facility is defined in this Act); and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made

to obtain by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and which exceeds the capital expenditure minimum.

For the purpose of this paragraph, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if such expenditure exceeds the capital expenditures minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review under this Act shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of this Act if a transfer of the equipment or facilities at fair market value would be subject to review.

"Capital expenditure minimum" means $400,000 for major medical equipment and $600,000 for all other capital expenditures, both of which shall be annually adjusted to reflect the increase in construction costs due to inflation.

"Areawide" means a major area of the State delineated on a geographic, demographic, and functional basis for health planning and for health service and having within it one or more local areas for health planning and health service. The term "region", as contrasted with the term "subregion", and the word "area" may be used synonymously with with term "areawide".

"Local" means a subarea of a delineated major area that on a geographic, demographic, and functional basis may be considered to be part of such major area. The term "subregion" may be used synonymously with the term "local".

"Areawide health planning organization" or "Comprehensive health planning organization" means the health systems agency designated by the Secretary, Department of Health, Education, and Welfare, pursuant to federal Public Law 93-641,[8] or any successor agency.

"Local health planning organization" means those local health planning organizations that are designated as such by the areawide health planning organization of the appropriate area.

"Physician" means a person licensed to practice in accordance with the Medical Practice Act, as amended.[9]

"Licensed health care professional" means a person licensed to practice a health profession under pertinent licensing statutes of the State of Illinois.

"Director" means the Director of the Illinois Department of Public Health.

"Agency" means the Illinois Department of Public Health.

"Comprehensive health planning" means health planning concerned with the total population and all health and associated problems that affect the well-being of people and that encompasses health services, health manpower, and health facilities; and the coordination among these and with those social, economic, and environmental factors that affect health.

Amended by P.A. 82-745, § 1, eff. May 7, 1982; P.A. 83-333, § 63, eff. Sept. 14, 1983.

[1] Paragraph 157.8-1 et seq. of this chapter.
[2] Paragraph 142 et seq. of this chapter.
[3] Paragraph 4151-101 et seq. of this chapter.
[4] Paragraph 1401 et seq. of this chapter.
[5] 42 U.S.C.A. § 300e-9.
[6] 42 U.S.C.A. § 1395 et seq.
[7] 42 U.S.C.A. § 1395x.
[8] 42 U.S.C.A. § 300k et seq.
[9] Chapter 111, ¶ 4401 et seq.

1153.1. Major medical equipment—Acquisition

§ 3.1. Until January 1, 1984 and not thereafter, any person proposing to acquire major medical equipment (as defined in this Act) is subject to the provisions of this

Act regarding obtaining a permit or exemption. The provisions of this Section shall be in effect until January 1, 1984, or the repeal of Public Law 93-641, as amended,[1] whichever shall come first.

Added by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. § 300k et seq.

Paragraph effective until Jan. 1, 1984, or the repeal of the National Health Planning and Resources Development Act of 1974 (42 U.S.C.A. § 300k et seq.).

1154. Health Facilities Planning Board—Membership—Appointment—Term—Compensation—Quorum

§ 4. There is created the Health Facilities Planning Board, which shall perform such functions as hereinafter described in this Act.

The State Board shall consist of 13 voting members, including: 7 consumer members; one member representing the commercial health insurance industry in Illinois; one member representing the hospital service corporations in Illinois; one member who is actively engaged in the field of hospital management; one member who is a professional nurse registered in Illinois; one member who is a physician in active private practice licensed in Illinois to practice medicine in all of its branches; and one member who is actively engaged in the field of skilled nursing or intermediate care facility management.

The State Board shall be appointed by the Governor, with the advice and consent of the Senate. In making the appointments, the Governor shall give consideration to recommendations made by (1) the professional organizations concerned with hospital management for the hospital management appointment and (2) professional organizations concerned with long term care facility management for the long term care facility management appointment and (3) professional medical organizations for the physician appointment and (4) professional nursing organizations for the nurse appointment, and shall appoint as consumer

members individuals familiar with community health needs but whose interest in the operation, construction or utilization of health care facilities are derived from factors other than those related to his profession, business, or economic gain, and who represent, so far as possible, different geographic areas of the State. Not more than 7 of the appointments shall be of the same political party.

The Directors of the Illinois Departments of Public Aid, Mental Health and Public Health, or their designated representatives, shall serve as ex-officio, non-voting members of the State Board.

Of those appointed by the Governor as voting members, each member shall hold office for a term of 3 years: provided, that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term and the term of office of each successor shall commence on July 1 of the year in which his predecessor's term expires. In making original appointments to the State Board, the Governor shall appoint 5 members for a term of one year, 5 for a term of 2 years, and 3 for a term of 3 years, and each of these terms of office shall commence on July 1, 1974. Each member shall hold office until his successor is appointed and qualified.

No member shall serve more than 3 consecutive 3-year terms, except for those members who are ex-officio, non-voting members.

State Board members, while serving on business of the State Board, shall receive actual and necessary travel and subsistence expenses while so serving away from their places of residence. In addition, while serving on business of the State Board, each member shall receive compensation of $150 per day for each day served at regular or special meetings of the State Board or at committee meetings approved by the Chairman of the State Board, except that such compensation shall not exceed $7,500 in any one year for any member.

The State Board shall provide for its own organization and procedures, including the selection of a Chairman and such other officers as deemed necessary. The Director, with concurrence of the State Board, shall name as full-time Executive Secretary of the State Board, a person qualified in health care facility planning and in administration. The Agency shall provide administrative and staff support for the State Board. The State Board shall advise the Director of its budgetary and staff needs and consult with the Director on annual budget preparation.

The State Board shall meet at least once each quarter, or as often as the Chairman of the State Board deems necessary, or upon the request of a majority of the members.

Seven members of the State Board shall constitute a quorum. The affirmative vote of 7 of the members of the State Board shall be necessary for any action requiring a vote to be taken by the State Board. A vacancy in the membership of the State Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the State Board as provided by this Act.

Amended by P.A. 81-149, § 1, eff. Jan. 1, 1980.

1155. Permits or exemptions—Construction, modification or establishment of health care facilities—Acquisition of major medical equipment

§ 5. After effective dates set by the State Board, no person shall construct, modify or establish a health care facility or acquire major medical equipment without first obtaining a permit or exemption from the State Board. The State Board shall set effective dates applicable to all or to each classification or category of health care facilities and applicable to all or each type of transaction for which a permit is required. Varying effective dates may be set, providing the date or dates so set shall apply uniformly statewide.

Notwithstanding any effective dates established by this Act or by the State Board, no person shall be required to

obtain a permit for any purpose under this Act until the State health facilities plan referred to in paragraph (4) of Section 12 of this Act[1] has been approved and adopted by the State Board subsequent to public hearings having been held thereon.

A permit or exemption shall be obtained prior to the acquisition of major medical equipment or to the construction or modification of a health care facility which:

(a) requires a total capital expenditure in excess of the capital expenditure minimum; or

(b) substantially changes the scope or changes the functional operation of the facility; or

(c) changes the bed capacity of a health care facility by increasing or decreasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility or site to another by more than 10 beds or more than 10% of total bed capacity as defined by the State Board, whichever is less, over a 2 year period.

A permit shall be valid only for the defined construction or modifications, site, amount and person named in the application for such permit and shall not be transferable or assignable. A permit shall be valid until such time as the project has been completed, provided that (a) obligation of the project occurs within 12 months following issuance of the permit except for major construction projects such obligation must occur with 18 months following issuance of the permit; and (b) the project commences and proceeds to completion with due diligence. Major construction projects, for the purposes of this Act, shall include but are not limited to: projects for the construction of new buildings; additions to existing facilities; modernization projects whose cost is in excess of $1,000,000 or 10% of the facilities' operating revenue, whichever is less; and such other projects as the State Board shall define and prescribe pursuant to this Act. The State Board may renew that permit for an additional reasonable length of time upon showing by the applicant that additional time

is required to complete the establishment, construction or modification of the health care facility or acquisition of major medical equipment.

Persons who otherwise would be required to obtain a permit shall be exempt from such requirement if the State Board finds that with respect to establishing a new facility or construction of new buildings or additions or modifications to an existing facility, final plans and specifications for such work have prior to October 1, 1974, been submitted to and approved by the Department of Public Health in accordance with the requirements of applicable laws. Such exemptions shall be null and void after December 31, 1979 unless binding construction contracts were signed prior to December 1, 1979 and unless construction has commenced prior to December 31, 1979. Such exemptions shall be valid until such time as the project has been completed provided that the project proceeds to completion with due diligence.

The acquisition by any person of major medical equipment that will not be owned by or located in a health care facility and that will not be used to provide services to inpatients of a health care facility shall be exempt from review provided that a notice is filed in accordance with exemption requirements.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] Paragraph 1162 of this chapter.

1156. Application for permit or exemption—Exemption regulations

§ 6. An application for a permit or exemption shall be made to the State Board upon forms provided by the State Board. This application shall contain such information as the State Board deems necessary. Such application shall include affirmative evidence on which the Director may make the findings required under this Section and upon which the State Board may make its decision on the approval or denial of the permit or exemption.

The State Board shall establish by regulation the procedures and requirements regarding issuance of exemptions. Such exemptions shall be limited to those transactions specified by Title XV of the federal Public Health Services Act[1] and shall include acquisitions of existing health care facilities by any person.

All applications shall be signed by the applicant and shall be verified by any 2 officers thereof.

Upon receipt of an application for a permit, the State Board shall approve and authorize the issuance of a permit if it finds (1) that the applicant is fit, willing, and able to provice a proper standard of health care service for the community with particular regard to the qualification, background and character of the applicant, (2) that economic feasibility is demonstrated in terms of effect on the existing and projected operating budget of the applicant and of the health care facility; in terms of the applicant's ability to establish and operate such facility in accordance with licensure regulations promulgated under pertinent state laws; and in terms of the projected impact on the total health care expenditures in the facility and community, (3) that safeguards are provided which assure that the establishment, construction or modification of the health care facility or acquisition of major medical equipment is consistent with the public interest, and (4) that the proposed project is consistent with the orderly and economic development of such facilities and equipment and is in accord with standards, criteria, or plans of need adopted and approved pursuant to the provisions of Section 12 of this Act.[2]

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. § 300u et seq.

[2] Paragraph 1162 of this chapter.

1156.1. Submission of applications—Timetable

§ 6.1. The State Board shall require applications to be submitted in accordance with a timetable established by the State Agency, and review all completed applications

pertaining to similar types of services, facilities, or equipment affecting the same health service area in relation to each other (but no less often than twice a year).

The State Board shall specify when applications may be exempted from this timetable and from being reviewed in relation to each other.

The provisions of this Section shall be in effect until January 1, 1984, or the repeal of Public Law 93-641, as amended,[1] whichever shall come first.

Added by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. § 300k et seq.

Paragraph effective until Jan. 1, 1984, or the repeal of the National Health Planning and Resources Development Act of 1974 (42 U.S.C.A. § 300k et seq.).

1157. Cooperation of other agencies in obtaining information relating to applications

§ 7. The Director of the State Board may request the cooperation of county and multiple-county health departments, municipal boards of health, and other governmental and nongovernmental agencies in obtaining information and in conducting investigations relating to applications for permits.

Amended by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1158. Areawide health planning organizations

§ 8. The Agency shall assist communities and regions throughout the State to establish areawide health planning organizations and, in particular, shall assist such organizations to develop health care facilities planning which meets the criteria for recognition thereof. Areawide health planning organizations may be recognized to do health facilities planning by providing this component of health planning within the organization or by contracting with a special-purpose health planning organization that meets the criteria for health facilities planning.

Recognition of these organizations with regard to health facilities planning, including establishment of the criteria for such recognition, shall be the responsibility of the State Board, as provided elsewhere in this Act.

The Agency is authorized to make grants-in-aid or to furnish direct services to organizations in the development of health facilities planning capability, as a part of other financial and service assistance which the Agency is empowered and required to provide in support of health planning organizations.

Upon receipt of an application for a permit to establish, construct or modify a health care facility, the Agency shall notify the applicant in writing within 10 working days either that the application is complete or the reasons why the application is not complete. If the application is complete, the Agency shall notify affected persons of the beginning of a review and the review time cycle for the purposes of this Act shall begin on the date this notification is mailed.

Upon notifying affected persons of the beginning of a review of an application for a permit, a complete copy of such application shall be transmitted to the areawide health planning organization serving the area or community where the health care facility or major medical equipment is proposed to be acquired, established, constructed or modified. The Agency shall also transmit a complete copy of such application to any reasonably contiguous areawide health planning organization. The Agency shall afford a reasonable time as established by the State Board, but not to exceed 120 days in length, for the areawise planning organizations' review of the application. After reviewing the application, each recognized areawide planning organization shall certify its findings to the State Board as to whether or not the application is approved or disapproved in accordance with standards, criteria or plans of need adopted and approved by the recognized areawide health planning organization pursuant to its recognition by the State Board for health care facilities planning. The 120-day period shall begin on the day the ap-

plication is found to be substantially complete, as that term is defined by the State Board. During such 120-day period, the applicant may request an extension. An applicant may modify the application at any time prior to a final administrative decision on the application.

Upon its receipt of an application, the areawide health planning organization or the Agency, as the case may be, may submit a copy of such application to the federally-recognized professional standards review organization, if any, and appropriate local health planning organization, if any, existing in the area where the proposed project is to occur. Such organizations may review the application for a permit and submit, within 30 days from the receipt of the application, a finding to the agency or to the areawide health planning organization, as the case may be. A review and finding by a federally-recognized professional standards review organization must be relevant to the activities for which such organization is recognized, and shall be considered by the Agency or the areawide health planning organization, as the case may be, in its review of the application.

The State Board shall prescribe and provide the forms upon which the review and finding of the organization shall be made. The recognized areawide health planning organizations shall submit their review and finding to the Agency for its finding on the application and transmittal to the State Board for its consideration of denial or approval. Whenever the State Board renders a decision on an application which is contrary to the finding of the areawide health planning organization or agency thereon, that organization shall be provided a written detailed statement of the reasons for the inconsistency and shall be afforded an opportunity for a hearing before a hearing officer, who is appointed by the State Board. Such hearing shall be conducted in accordance with the provisions specified in Section 10 of this Act.[1]

If there is no areawide health planning organization in the area where the proposed establishment, construction or modification of a health care facility is to occur, then

the Agency shall be afforded a reasonable time, but not to exceed 120 days, for its review and finding thereon. The Agency shall submit its review and finding to the State Board for its approval or denial of the permit.

When an application for a permit is initially reviewed by a recognized areawide health planning organization or the Agency, as herein provided, the organization or the Agency, as the case may be, shall afford an opportunity for a public hearing within a reasonable time after receipt of the complete application, not to exceed 90 days. Notice of such hearing shall be made promptly by certified mail to the applicant and, within 10 days of the hearing, by publication in a newspaper of general circulation in the area or community to be affected. Such hearing shall be conducted in the area or community where the proposed project is to occur, and shall be for the purpose of allowing the applicant and any interested person to present public testimony concerning the approval, denial, renewal or revocation of the permit. All interested persons attending such hearing shall be given reasonable opportunity to present their views or arguments in writing or orally, and a record of all such testimony shall accompany any recommendation of the Agency or the recognized areawide health planning organization for the issuance, denial, revocation or renewal of a permit to the State Board. The State Board shall promulate reasonable rules and regulations governing the procedure and conduct of such hearings.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] Paragraph 1160 of this chapter.

1159. Certificate of recognition—Application—Hearing

§ 9. An application for a certificate of recognition for an areawide health planning organization for health facilities planning shall be made to the State Board upon forms provided by it and shall contain evidence that standards, criteria and plans of need have been adopted and approved by the organization for health care facilities planning for

the area which the applicant intends to serve and such other information as may reasonably be required. All such applications for a certificate of recognition shall be submitted to the State Board and evaluated by the Agency. If the Agency finds that the applicant for a certificate of recognition for health facilities planning meets the criteria established under this Act, it shall submit its recommendation of approval to the State Board. A certificate of recognition shall be approved by the State Board and shall be valid for such period as the State Board, upon its findings determines that the recognized areawide health planning organization continues to comply with the criteria for recognition. The State Board shall annually review the certificate of recognition and afford an opportunity for public comment in order to determine that the recognized areawide health planning organization continues to comply with the criteria for recognition. A certificate of recognition may be revoked by the State Board, following opportunity for appeal and hearing as provided in this Act. Upon loss of recognition, funds awarded to the areawide health planning organization by the Agency pursuant to this Act shall be terminated.

When an application for a certificate of recognition of an areawide health planning organization for health facilities planning is made to the State Board, the Agency shall conduct a public hearing within a reasonable period after receipt of the application, not to exceed 90 days. Notice of such hearing shall be made promptly to the applicant by certified mail and by publication in a newspaper of general circulation in the area where the applicant intends to conduct health facilities planning. Such hearings shall be conducted by the Agency in the area affected, and shall be for the purpose of allowing the applicant and all interested parties to present public testimony concerning the approval, denial or revocation of a certificate of recognition. All interested parties attending such hearing shall be given reasonable opportunity to present their views orally or in writing, and a record of such testimony shall be transmitted to the State Board by the Agency. The State Board shall consider all testimony submitted by the

Agency pursuant to the public hearing in conjunction with the recommendation of the Agency for the approval, denial or revocation of the certificate of recognition.

Amended by P.A. 81-149, § 1, eff. Jan. 1, 1980.

1160. Denial of application for permit or renewal thereof or a certificate of recognition—Appearance—Hearing—Record—Review under Administrative Review Law—Witnesses

§ 10. When a motion by the State Board, to approve an application for a permit, a renewal thereof or a certificate of recognition, fails to pass, or when a motion to deny an application for permit, a renewal thereof or a certificate of recognition, is passed, the applicant or a holder of a permit, as the case may be, and such other parties as the State Board permits, will be given an opportunity to appear before the State Board and present such information as may be relevant to the approval of a permit or certificate or renewal or in resistance of a denial of the application.

Subsequent to an appearance by the applicant before the State Board or default of such opportunity to appear, a motion by the State Board to approve an application for permit, a renewal thereof or a certificate of recognition which fails to pass or a motion to deny an application for permit, a renewal thereof or a certificate of recognition which passes shall be considered denial of the application for permit, renewal thereof, or certificate of recognition, as the case may be. Such action of denial or an action by the State Board to revoke a permit or a certificate of recognition shall be communicated to the applicant or holder of the permit or certificate of need. Such person or organization shall be afforded an opportunity for a hearing before a hearing officer, who is appointed by the State Board. A written notice of a request for such hearing shall be served upon the Chairman of the State Board within 30 days following notification of the decision of the State Board. The State Board shall schedule

a hearing within 30 days thereafter. Following its consideration of the report of the hearing, or upon default of the party to the hearing, the State Board shall make its final determination, specifying its findings and conclusions. A copy of such determination shall be sent by certified mail or served personally upon the party.

A full and complete record shall be kept of all proceedings, including the notice of hearing, complaint, and all other documents in the nature of pleadings, written motions filed in the proceedings, and the report and orders of the State Board or hearing officer. All testimony shall be reported but need not be transcribed unless the decision is appealed in accordance with Administrative Review Law, as now or hereafter amended.[1] A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy or copies.

The State Board or hearing officer shall upon its own or his motion, or on the written request of any party to the proceeding who has, in the State Board's or hearing officer's opinion, demonstrated the relevancy of such request to the outcome of the proceedings, issue subpoenas requiring the attendance and the giving of testimony by witnesses, and subpoenas duces tecum requiring the production of books, papers, records, or memoranda. The fees of witnesses for attendance and travel shall be the same as the fees of witnesses before the circuit court of this State.

When the witness is subpoenaed at the instance of the State Board, or its hearing officer, such fees shall be paid in the same manner as other expenses of the Agency, and when the witness is subpoenaed at the instance of any other party to any such proceeding the State Board may, in accordance with the rules of the Agency, require that the cost of service of the subpoena or subpoena duces tecum and the fee of the witness be borne by the party at whose instance the witness is summoned. In such case, the State Board in its discretion, may require a deposit to cover the cost of such service and witness fees. A subpoena or subpoena duces tecum so issued shall be served in the same manner as a subpoena issued out of a court.

Any circuit court of this State upon the application of the State Board or upon the application of any other party to the proceeding, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records, or memoranda and the giving of testimony before it or its hearing officer conducting an investigation or holding a hearing authorized by this Act, by an attachment for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

The State Board or its hearing officer, or any party to a hearing under this Act, may cause the depositions of witnesses within the State to be taken in the manner prescribed by law for like depositions in civil actions in courts of this State, and to that end compel the attendance of witnesses and the production of books, papers or memoranda.

Amended by P.A. 82-783, Art. XI, § 215, eff. July 13, 1982.

[1] Chapter 110, ¶ 3-101 et seq.

1161. Review under Administrative Review Law

§ 11. Any person who is adversely affected by a final decision of the State Board may have such decision judicially reviewed. The provisions of the Administrative Review Law, as now or hereafter amended,[1] and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of final administrative decisions of the State Board. The term "administrative decisions" is as defined in Section 3-101 of the Code of Civil Procedure.[2]

Amended by P.A. 82-745, § 1, eff. May 7, 1982; P.A. 82-783, Art. XI, § 215, eff. July 13, 1982; P.A. 82-1057, Art. II, § 16, eff. Feb. 11, 1983.

[1] Chapter 110, ¶ 3-101 et seq.

[2] Chapter 110, ¶ 3-101.

Article II of P.A. 82-1057, the 2nd 1982 Revisory Act, resolved multiple actions of the 82nd General Assembly through P.A. 82-1016.

1162. Powers and duties of agency

§ 12. For purposes of this Act, the Agency shall exercise the following powers and duties:

(1) Prescribe, with prior approval of the State Board, rules, regulations, standards, criteria, procedures or reviews which may vary according to the purpose for which a particular review is being conducted or the type of project reviewed and which are required to carry out the provisions and purposes of this Act;

(2) Adopt, with approval of the State Board, procedures for public notice and hearing on all proposed rules, regulations, standards, criteria, and plans required to carry out the provisions of this Act;

(3) Prescribe, with prior approval of the State Board, criteria for recognition for areawide health planning organizations, including, but not limited to, standards for evaluating the scientific bases for judgments on need and procedure for making these determinations;

(4) Develop criteria and standards for health care facilities planning, conduct statewide inventories of health care facilities, and develop health care facility plans which, upon adoption by the State Board, shall be utilized in the review of applications for permit under this Act. Such health facility plans shall be coordinated by the Agency with the health care facility plans areawide health planning organizations and with other pertinent State Plans.

In developing health care facility plans, the Agency should consider but not be limited to the following:

(a) The size, composition and growth of the population of the area to be served;

(b) The number of existing and planned facilities offering similar programs;

(c) The extent of utilization of existing facilities;

(d) The availability of facilities which may serve as alternatives or substitutes;

(e) The availability of personnel necessary to the operation of the facility;

(f) Multi-institutional planning and the establishment of multi-institutional systems where feasible;

(g) The financial and economic feasibility of proposed construction or modification;

(h) In the case of health care facilities established by a religious body or denomination, the needs of the members of such religious body or denomination may be considered to be public need; and

(i) The provisions of Sections 1527, 1531 and 1532, Title XV, of the federal Public Health Services Act.[1]

The health care facility plans which are developed and adopted in accordance with this Section shall form the basis for the plan of the State to deal most effectively with statewide health needs in regard to health care facilities.

(5) Coordinate with other state agencies having responsibilities affecting health care facilities, including those of licensure and cost reporting;

(6) Coordinate with Federal agencies the procedures established by this Act and the required functions to be established by the Agency for purposes of carrying out the duties and powers which have been designated to the Agency under the provisions of Sec. 1122, Title XI, of the Social Security Act;[2]

(7) Solicit, accept, hold and administer on behalf of the State any grants or bequests of money, securities or property to the Agency for use by the State Board, the Agency or recognized areawide health planning organizations in the administration of this Act;

(8) Charge and collect from the permit applicant an amount determined by the State Board to be a reasonable

application fee for the processing of the application by the State Board, the Agency and the appropriate recognized areawide health planning organization. The State Board shall set the amount by regulation. All fees collected under the provision of this Act shall be deposited with the State Treasurer;

(9) Where local resources are not sufficient, to provide the necessary technical and financial assistance to recognized areawide health planning organizations to assist in the planning which will enable the organization to effectively carry out the functions provided for it in this Act;

(10) In addition to all powers and duties required of the Agency and the State Board pertaining to applications for a permit for the construction or modification of health care facilities, the Agency shall prescribe, with the prior approval of the State Board and in consultation with the recognized areawide health planning organizations, procedures for review, standards and criteria which the State Board, upon adoption thereof, shall utilize to make periodic areawide reviews and determinations of the appropriateness of any existing health services being rendered by health care facilities subject to the Act. The State Board shall consider recommendations of the areawide health planning organization and the Agency in making its determinations;

(11) Prescribe, with prior approval of the State Board in consultation with the recognized areawide health planning organizations, rules, regulations, standards and criteria for the conduct of an expeditious review of applications for permits for projects of construction or modification of a health care facility, which projects are non-substantive in nature. Such rules shall not abridge the right of areawide health planning organizations to make recommendations on the classification and approval of projects, nor shall such rules prevent the conduct of a public hearing upon the timely request of an interested party. Such reviews shall not exceed 60 days from the date the application is declared to be complete by the Agency;

(12) Prescribe, with prior approval of the State Board, rules, regulations, standards and criteria pertaining to the granting of permits for construction and modifications which are emergent in nature and must be undertaken immediately to prevent or correct structural deficiencies or hazardous conditions that may harm or injure persons using the facility, as defined in the rules and regulations of the State Board. This procedure is exempt from public hearing requirements of this Act.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

[1] 42 U.S.C.A. §§ 300m-6, 300n and 300n-1.

[2] 42 U.S.C.A. § 1320a-1.

1163. Investigations of applications for permits and certificates of recognition

§ 13. The Agency or the State Board shall make or cause to be made such investigations as it or the State Board deems necessary in connection with an application for a permit or an application for a certificate of recognition, or in connection with a determination of whether or not construction or modification which has been commenced is in accord with the permit issued by the State Board or whether construction or modification has been commenced without a permit having been obtained. The State Board may issue subpoenas duces tecum requiring the production of records and may administer oaths to such witnesses.

Any circuit court of this State, upon the application of the State Board or upon the application of any party to such proceedings, may, in its discretion, compel the attendance of witnesses, the production of books, papers, records, or memoranda and the giving of testimony before the State Board, by a proceeding as for contempt, or otherwise, in the same manner as production of evidence may be compelled before the court.

The Agency shall require all health facilities operating in this State to provide such reasonable reports at such times and containing such information as is needed by it

to carry out the purposes and provisions of this Act. Health facilities not complying with this requirement shall be reported to licensing, accrediting, certifying, or payment agencies as being in violation of State law. Health care facilities and other parties at interest shall have reasonable access, under rules established by the State Board, to all planning information submitted in accord with this Act pertaining to their area.

Amended by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1163.1. Necessity of permit

§ 13.1. Any person constructing or modifying a health care facility or portion thereof without obtaining a required permit shall not be eligible to apply for any necessary operating licenses or be eligible for payment by any State agency for services rendered in that facility or portion thereof until the required permit is obtained.

Added by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1164. Violations—Fine

§ 14. Any person acquiring major medical equipment or establishing, constructing or modifying a health care facility without a permit issued under this Act or in violation of the terms of such a permit is guilty of a business offense and may be fined up to $10,000. The State's Attorneys of the several counties or the Attorney General shall represent the People of the State of Illinois in proceedings under this Section.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

1165. Proceedings to prevent acquisition of major medical equipment or the establishment, construction or modification of health care facility

§ 15. Notwithstanding the existence or pursuit of any other remedy, the Agency may, in the manner provided by law, upon the advice of the Attorney General who shall

represent the Agency in the proceedings, maintain an action in the name of the State for injunction or other process against any person or governmental unit to restrain or prevent the acquisition of major medical equipment, the establishment, construction or modification of a health care facility without the required permit, or to restrain or prevent the occupancy or utilization of the equipment acquired or facility which was constructed or modified without the required permit.

Amended by P.A. 82-745, § 1, eff. May 7, 1982.

1165.1. Individual liability for damages

§ 15.1. No individual who, as a member of the State Board or of an areawide health planning organization board, or as an employee of the State or of an areawide health planning organization, shall, by reason of his performance of any duty, function, or activity required of, or authorized to be undertaken by this Act, be liable for the payment of damages under any law of the State, if he has acted within the scope of such duty, function, or activity, has exercised due care, and has acted, with respect to that performance, without malice toward any person affected by it.

Added by P.A. 80-941, § 1, eff. Sept. 22, 1977.

1166. Partial invalidity

§ 16. If any provision of this Act or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of this Act which can be given effect without the invalid provision or application, and to this end the provisions of the Act are declared to be severable.

1167. Home rule unit—Exercise of powers and functions

§ 17. It is hereby specifically declared that the powers and functions exercised and performed by the State pursuant to this Act are exclusive to the State of Illinois and

that these powers and functions shall not be exercised, either independently or concurrently, by any home rule unit.

1168. Administrative Procedure Act—Application

§ 18. The Illinois Administrative Procedure Act, as now or hereafter amended,[1] is hereby expressly adopted and incorporated herein and shall apply to the State Board and the Agency as if all of the provisions of such Act were included in this Act; except that in case of a conflict between the Administrative Procedure Act and this Act the provisions of this Act shall control. This Section applies to the Agency and the State Board 6 months after the effective date of this amendatory Act of 1977.

Added by P.A. 80-818, § 1, eff. Sept. 20, 1977.

[1] Chapter 127, ¶ 1001 et seq.

APPENDIX K

Medical Practice Act
111 Ill. Rev. Stat. ¶ 4400-22

4400-22. Disciplinary action—Grounds

§ 22. A. The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license or visiting professor permit of any person issued under this Act to practice medicine, or to treat human ailments without the use of drugs and without operative surgery upon any of the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:

(a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;[1]

(b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing, and regulation of hospitals" approved July 1, 1953, as heretofore or hereafter amended;[2] or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Performance of an abortion procedure in a wilful and wanton manner on a woman who was not pregnant at the time the abortion procedure was performed;

3. The conviction of a felony in this or any other jurisdiction, except as otherwise provided in subsection B of this Section, whether or not related to practice under this Act, or the entry of a guilty or nolo contendere plea to a felony charge;

4. Gross negligence in practice under this Act;

5. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

6. Obtaining any fee by fraud, deceit, or misrepresentation;

7. Habitual or excessive use or abuse of drugs defined in law as controlled substances, of alcohol, or of any other substances which results in the inability to practice with reasonable judgment, skill or safety;

8. Practicing under a false or, except as provided by law, an assumed name;

9. Fraud or misrepresentation in applying for, or procuring, a license under this Act or in connection with applying for renewal of a license under this Act;

10. Making a false or misleading statement regarding their skill or the efficacy or value of the medicine, treatment, or remedy prescribed by them at their direction in the treatment of any disease or other condition of the body or mind;

11. Allowing another person or organization to use their license, procured under this Act, to practice;

12. Disciplinary action of another state or jurisdiction against a license or other authorization to practice as a medical doctor, doctor of osteopathy or doctor of chiropractic, a certified copy of the record of the action taken by the other state or jurisdiction being prima facie evidence thereof;

13. Violation of any provision of this Act or of the "Medical Practice Act", approved June 30, 1923, as amended,[3] prior to the repeal of that Act, or violation of the rules, or a final administrative action of the Director, after consideration of the recommendation of the Disciplinary Board;

14. Dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association or Medical or Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act", as now or hereafter amended,[4] or as an association authorized by "The Professional Association Act" as now or hereafter amended,[5] or under "The Professional Corporation Act" as now or hereafter amended,[6] or from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection prohibits 2 or more corporations authorized by "The Medical Corporation Act", as now or hereafter amended, from forming a partnership or joint venture of such corporations, and providing medical, surgical and scientific research and knowledge by employees of these corporations if such employees are licensed under this Act, or from pooling, sharing, dividing, or apportioning the fees and monies received by the partnership or joint venture in accordance with the partnership or joint venture agreement. Nothing contained in this subsection shall abrogate the right of 2 or more persons, holding valid and current licenses under this Act, to each receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division

is made in proportion to the services performed and responsibility assumed by each;

15. A finding by the Medical Disciplinary Board that the registrant after having his or her license placed on probationary status or subjected to conditions or restrictions violated the terms of the probation or failed to comply with such terms or conditions;

16. Abandonment of a patient;

17. Prescribing, selling, administering, distributing, giving or self-administering any drug classified as a controlled substance (designated product) or narcotic for other than medically accepted therapeutic purposes;

18. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician;

19. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department;

20. Immoral conduct in the commission of any act related to the licensee's practice;

21. Wilfully making or filing false records or reports in his or her practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code;[7]

22. Wilful omission to file or record, or wilfully impeding the filing or recording, or inducing another person to omit to file or record, medical reports as required by law, or wilfully failing to report an instance of suspected abuse or neglect as required by law;

23. Being named as a perpetrator in an indicated report by the Department of Children and Family Services pur-

suant to the Abused and Neglected Child Reporting Act, approved June 26, 1975, as now or hereafter amended,[8] and upon proof by clear and convincing evidence that the licensee has caused a child to be an abused child or neglected child as defined in the Abused and Neglected Child Reporting Act;

24. Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee;

25. Gross and wilful and continued overcharging for professional services, including filing false statements for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Public Aid under the Public Aid Code;

26. A pattern of practice or other behavior which demonstrates incapacity or incompetence to practice under this Act;

27. Mental illness or disability which results in the inability to practice under this Act with reasonable judgment, skill or safety;

28. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice under this Act with reasonable judgment, skill or safety;

29. Cheating on or attempt to subvert the licensing examinations administered under this Act;

30. Wilfully or negligently violating the confidentiality between physician and patient except as required by law;

31. The use of any false, fraudulent, or deceptive statement in any document connected with practice under this Act;

32. Aiding and abetting an individual not licensed under this Act in the practice of a profession licensed under this Act;

33. Violating state or federal laws or regulations relating to controlled substances;

34. Failure to report to the Department any adverse final action taken against them by another licensing jurisdiction (any other state or any territory of the United States or any foreign state or country), by any peer review body, by any health care institution, by any professional society or association related to practice under this Act, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section;

35. Failure to report to the Department surrender of a license or authorization to practice as a medical doctor, a doctor of osteopathy or doctor of chiropractic in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society, while under disciplinary investigation by any of those authorities or bodies, for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section;

36. Failure to report to the Department any adverse judgment, settlement, or award arising from a liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section;

37. Failure to transfer copies of medical records as required by law;

38. Failure to furnish the Department, its investigators or representatives, relevant information, legally requested by the Department after consultation with the Chief Medical Coordinator or the Deputy Medical Coordinator;

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper, with regard to a license on any of the foregoing grounds, must be commenced within

3 years next after receipt by the Department of a complaint alleging the commission of or notice of the conviction order for any of the acts described herein. Except for the grounds numbered (8), (9) and (29), no action shall be commenced more than 5 years after the date of the incident or act alleged to have violated this Section. In the event of the settlement of any claim or cause of action in favor of the claimant or the reduction to final judgment of any civil action in favor of the plaintiff, such claim, cause of action or civil action being grounded on the allegation that a person licensed under this Act was negligent in providing care, the Department shall have an additional period of one year from the date of such settlement or final judgment in which to investigate and commence formal disciplinary proceedings under Section 36 of this Act,[9] except as otherwise provided by law. The time during which the holder of the license was outside the State of Illinois shall not be included within any period of time limiting the commencement of disciplinary action by the Department.

The entry of an order or judgment by any circuit court establishing that any person holding a license under this Act is a person in need of mental treatment operates as a suspension of that license. That person may resume their practice only upon the entry of a Departmental order based upon a finding by the Medical Disciplinary Board that they have been determined to be recovered from mental illness by the court and upon the Disciplinary Board's recommendation that they be permitted to resume their practice.

The Department may refuse to issue or may suspend the license of any person who fails to file a return, or to pay the tax, penalty or interest shown in a filed return, or to pay any final assessment of tax, penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirements of any such tax Act are satisfied.

The Department, upon the recommendation of the Disciplinary Board, shall adopt rules which set forth standards to be used in determining:

(a) When a person will be deemed sufficiently rehabilitated to warrant the public trust;

(b) What constitutes dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud, or harm the public;

(c) What constitutes immoral conduct in the commission of any act related to the licensee's practice; and

(d) What constitutes gross negligence in the practice of medicine.

However, no such rule shall be admissible into evidence in any civil action except for review of a licensing or other disciplinary action under this Act.

In enforcing this Section, the Illinois State Medical Disciplinary Board, upon a showing of a possible violation, may compel any individual licensed to practice under this Act, or who has applied for licensure or certification pursuant to this Act, to submit to a mental or physical examination, or both, as required by and at the expense of the Department. The examining physician or physicians shall be those specifically designated by the Disciplinary Board. The individual to be examined may have, at his or her own expense, another physician of his or her choice present during all aspects of the examination. Failure of any individual to submit to mental or physical examination, when directed, shall be grounds for suspension of his or her license until such time as the individual submits to the examination if the Disciplinary Board finds, after notice and hearing, that the refusal to submit to the examination was without reasonable cause. If the Disciplinary Board finds a physician unable to practice because of the reasons set forth in this Section, the Disciplinary Board shall require such physician to submit to care, counseling, or treatment by physicians approved or designated

by the Disciplinary Board, as a condition for continued, reinstated, or renewed licensure to practice. Any physician, whose license was granted pursuant to Sections 9, 17, or 19 of this Act,[10] or, continued, reinstated, renewed, disciplined or supervised, subject to such terms, conditions or restrictions who shall fail to comply with such terms, conditions or restrictions, or to complete a required program of care, counseling, or treatment, as determined by the Chief Medical Coordinator or Deputy Medical Coordinators, shall be referred to the Director for a determination as to whether the licensee shall have their license suspended immediately, pending a hearing by the Disciplinary Board. In instances in which the Director immediately suspends a license under this Section, a hearing upon such person's license must be convened by the Disciplinary Board within 15 days after such suspension and completed without appreciable delay. The Disciplinary Board shall have the authority to review the subject physician's record of treatment and counseling regarding the impairment, to the extent permitted by applicable federal statutes and regulations safeguarding the confidentiality of medical records.

An individual licensed under this Act, affected under this Section, shall be afforded an opportunity to demonstrate to the Disciplinary Board that they can resume practice in compliance with acceptable and prevailing standards under the provisions of their license.

The Department may promulgate rules for the imposition of fines in disciplinary cases, not to exceed $5,000 for each violation of this Act. Fines may be imposed in conjunction with other forms of disciplinary action, but shall not be the exclusive disposition of any disciplinary action arising out of conduct resulting in death or injury to a patient. Any funds collected from such fines shall be deposited in the Medical Disciplinary Fund.

B. The Department shall revoke the license or visiting professor permit of any person issued under this Act to practice medicine or to treat human ailments without the

use of drugs and without operative surgery, who has been convicted a second time of committing any felony under the Illinois Controlled Substances Act,[11] as amended, or who has been convicted a second time of committing a Class 1 felony under Sections 8A-3 and 8A-6 of The Illinois Public Aid Code, as amended.[12] A person whose license or visiting professor permit is revoked under this subsection B of Section 22 of this Act shall be prohibited from practicing medicine or treating human ailments without the use of drugs and without operative surgery.

Amended by P.A. 85-686, § 2, eff. Sept. 22, 1987.

[1] Chapter 111½, ¶ 157-8.1 et seq.

[2] Chapter 111½, ¶ 142 et seq.

[3] Paragraph 4401 et seq. of this chapter (repealed; see, now, ¶ 4400-1 et seq. of this chapter).

[4] Chapter 32, ¶ 631 et seq.

[5] Chapter 106½, ¶ 101 et seq.

[6] Chapter 32, ¶ 415-1 et seq.

[7] Chapter 23, ¶ 1-1 et seq.

[8] Chapter 23, ¶ 2051 et seq.

[9] Paragraph 4400-36 of this chapter.

[10] Paragraph 4400-9, 4400-17 or 4400-19 of this chapter.

[11] Chapter 56½, ¶ 1100 et seq.

[12] Chapter 23, ¶¶ 8A-3 and 8A-6.

APPENDIX L

77 Illinois Administrative Code,
Chapter 1, § 205, Subchapter b

TITLE 77: PUBLIC HEALTH
CHAPTER 1: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES

PART 205
AMBULATORY SURGICAL TREATMENT CENTER LICENSING REQUIREMENTS

SUBPART A: GENERAL

SUBPART B: OWNERSHIP AND MANAGEMENT

SUBPART C: PERSONNEL

SUBPART D: EQUIPMENT, SUPPLIES, AND FACILITY MAINTENANCE

SUBPART E: GENERAL PATIENT CARE

SUBPART F: RECORDS AND REPORTS

SUBPART G: ADDITIONAL REQUIREMENTS FOR FACILITIES IN WHICH OBSTETRICAL/ GYNECOLOGICAL PROCEDURES ARE PERFORMED

SUBPART H: PROCEDURES FOR INVESTIGATION OF COMPLAINTS

SUBPART I: BUILDING DESIGN, CONSTRUCTION STANDARDS, AND PHYSICAL REQUIREMENTS

SUBPART J: MECHANICAL

SUBPART K: PLUMBING AND OTHER PIPING SYSTEMS

SUBPART L: ELECTRICAL

TABLE A General Pressure Relationships and Ventilation Rates of Ambulatory Surgery Area

AUTHORITY: Implementing and authorized by the Ambulatory Surgical Treatment Center Act (Ill. Rev. Stat. 1981, ch. 111½, pars. 157-8.1 et seq.).

SOURCE: Amended July 18, 1974; emergency amendment at 3 Ill. Reg. 10, p. 43, effective February 23, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979; amended at 5 Ill. Reg. 12756, effective November 4, 1981; amended at 6 Ill. Reg. 6220, 6225, and 6226, effective May 17, 1982; amended at 6 Ill. Reg. 10974, effective August 30, 1982; amended at 6 Ill. Reg. 13337, effective October 20, 1982; amended at 7 Ill. Reg. 7640, effective June 14, 1983; codified at 8 Ill. Reg. 9367.

SUBPART A: GENERAL

Section 205.110 Definitions

"Ambulatory Surgical Treatment Center." The term ambulatory surgical treatment center shall have meaning as ascribed in the "Ambulatory Surgical Treatment Center Act" of 1973 as now and hereafter amended. (The Act) (Ill. Rev. Stat. 1979, ch. 111½, pars. 157-8.1 et seq.).

"Certified Registered Nurse Anesthetist" means a registered professional nurse who has been certified as a

nurse-anesthetist by the American Association of Nurse Anesthetists.

"Department" means the Department of Public Health of the State of Illinois.

"Licensed Practical Nurse" means a person licensed under The Illinois Nursing Act (Ill. Rev. Stat. 1979, ch. 111, par. 3401 et seq.) to practice practical nursing.

"Qualified Anesthesiologist" means a physician who is licensed to practice medicine in all its branches in the State of Illinois and who is a Diplomate of the American Board of Anesthesiology; or American College of Anesthesiology; or who is a Diplomate of the American Osteopathic Board of Anesthesiology; or who is Board eligible or possess training and experience equivalent to such eligibility; or who possess training and experience acceptable to the Department and whose primary practice is anesthesiology.

"Qualified Consulting Committee" means a committee whose members are qualified Surgeons, Obstetricians, Gynecologists, Anesthesiologists or Pathologists or other Consulting Physicians consisting of not less than 3 members who shall establish the required standards commensurate with the size, scope, extent and complexity of service programs and procedures for which the facility is licensed. The consulting committee shall act as the credentials committee.

"Qualified Consulting Surgeon, Obstetrician, Gynecologist, Anesthesiologist, Pathologist, or other Consulting Physician" means a physician who is licensed in the State of Illinois and who is a Diplomate of an appropriate specialty board or who has completed the training and experience required for specialty board certification.

"Qualified Physician" means an individual who is licensed to practice medicine in all branches in the State of Illinois.

"Qualified Dentist" means a dentist who is licensed to practice under the Dental Practice Act, (Ill. Rev. Stat. 1979, ch. 111, pars. 2202 et seq.).

"Qualified Podiatrist" means a podiatrist who is licensed to practice under "An Act to regulate the practice of

podiatry in the State of Illinois", (Ill. Rev. Stat. 1979, ch. 111, pars. 4901 et seq.).
"Registered Professional Nurse" means a registered nurse or a registered professional nurse who is registered under the Illinois Nursing Act (Ill. Rev. Stat. 1979, ch. 111, pars. 3401 et seq.), and practices professional nursing.
"Student Nurse" means a person enrolled in a course of instruction at an approved school of professional or practical nursing and who is supervised by a nursing instructor of the school.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.120 Licensure

a) An application for license shall be made to the Department on forms provided by it. This application shall contain the information required under the Act and this Part. The application shall be submitted not less than sixty (60) days prior to the date of intended operation.
b) The application shall include but not be limited to the following information:
   1) the name(s) and address(es) of person(s) who own and/or operate the facility and the name under which they do business. A corporation shall submit:
      A) a copy of its certificate of incorporation,
      B) list of the title, name, and address of each of its corporate officers,
      C) list of the name and address of each of its shareholders holding more than 5%, of the shares.
   2) location of the facility.
   3) description of the facility including but not limited to interviewing, examination, surgical, and recovery room facilities.
   4) schematic architectural plans.
   5) documentation of compliance with all applicable building, utility and Safety Codes.

   6) description of services to be provided by the facility including a list of surgical procedures to be performed.
   7) list of all personnel including their name, address, position, qualifications and licensure.
   8) All applications shall be signed by the applicant and the application shall include a verification form acknowledging the application to be true and complete and certifying that the applicant has knowledge of and understands the action required to comply with the Act and licensing requirements. The form shall be verified by a notary public. The forms shall be accompanied by a license fee of $500.
   9) As a condition of the issuance or renewal of the license of any Ambulatory Surgical Treatment Center:
      A) The applicant shall file a statement of ownership. The applicant shall agree to update the information required in the statement of ownership every 6 months from the initial date of filing,
      B) Each license shall file an attested financial statement with the Department by July 1, 1980 and at times thereafter as required,
      C) Financial statements shall be filed annually on or before April 1, of each year for the previous calendar year, or within three (3) months after the close of the fiscal period of the licensee,
      D) A financial statement shall be filed with the Department on forms provided by the Department or on annual financial statements prepared on forms used by the applicant. At minimum, they shall include detailed balance sheets, statements of income and statements of expense.
      E) Every facility licensed under this Act, and any premises proposed to be conducted as a facility by an applicant for a license shall

be open during its regular business hours to an inspection authorized in writing by the Director. No notice need be given to any person prior to any inspection,

F) Any corporation operating an Ambulatory Surgical Treatment Center devoted primarily to providing facilities for abortion must have a physician who is licensed to practice medicine in all of its branches and is actively engaged in the practice of medicine at the center, on the Board of Directors as a condition to licensure of the center.

c) Only those facilities, services, programs and procedures included in the application shall be licensed. A new application is required for the following:
   1) change in ownership,
   2) change in location,
   3) remodeling of facility so as to change the interviewing, examination, surgical or recovery room space or number,
   4) addition of services or programs.

      AGENCY NOTE: The addition of new specialty services, for example, podiatry or obstetrics/gynecology, may require changes in consulting committee, procedures and/or staffing. Therefore, the Department finds that a new license is needed.

d) The license shall be valid for one (1) year, unless sooner suspended or revoked, shall be renewable annually upon approval by the Department and payment of a license fee of $300. Each license shall be issued only for the premises and persons named in the application and shall not be transferable or assignable. The licenses shall be posted in a conspicuous place on the licensed premises. A placard or registry of all physicians on staff in the facility shall be centrally located and available for inspection to any interested persons. The renewal application shall be on forms provided by the Department and shall be submitted to it not less than 30 days prior to the expiration date.

e) The facility shall give written notice to the Department within seven (7) days of any of the following:
   1) change of administrative staff,
   2) change of medical director,
   3) change of staff physicians,
   4) change of supervising nurse,
   5) addition or deletion of surgical procedures performed,
   6) in the case of a corporation change in any shareholders equity involving 5% or more interest.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART B: OWNERSHIP AND MANAGEMENT

Section 205.210 Ownership, Control and Management
Ownership, control and management shall be disclosed at the time of application. The names and addresses of each person with financial interest in the facility shall be submitted to the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.220 Organizational Plan
An organizational plan shall be known to the staff and available for public information in the facility. The document shall clearly set forth the organization, duties, responsibility, accountability and relationships of professional staff and other personnel. All owners, administrators, professional staff and ancillary personnel shall act in accordance with this document. This document shall be submitted to the Department with the initial application and thereafter will be reviewed at regular inspections by the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.230 Standards of Professional Work
Management and/or the owner of the ambulatory surgical treatment center shall maintain proper standards of professional work in the licensed facility.

a) A qualified consulting committee shall be appointed in writing by the management and/or owner of the ambulatory surgical treatment center and shall establish and enforce standards for professional work in the facility and standards of competency for physicians. The consulting committee shall meet not less than quarterly and shall document all meetings with written minutes. These written minutes shall be maintained at the facility and shall be available for inspection by the Department.
   1) The membership of the consulting committee shall reflect the types of procedures performed. If the facility performs more than 50 procedures per month or more than 10% of the total procedures performed are in a specific speciality area then there shall be a consulting physician of that specialty on the consulting committee.
   2) The consulting committee shall review development and content of the written policies and procedures of the center, the procedures for granting privileges, and the quality of the surgical procedures performed. Evidence of such review shall be recorded in the minutes.
   3) Credentials shall be provided by those physicians seeking practice privileges. These credentials shall be reviewed by the credentials committee and specific practice privileges identified and recorded. Record of such accepted practice privileges shall be available for facility staff use and public information within the facility.
   4) A physician granted specific practice privileges shall provide evidence that he/she has equivalent practice privileges in at least one licensed Illinois hospital. Documentation of said evidence shall be available for inspection by the Department. A list of such privileges granted each physician on the staff of the ambulatory surgical treatment center shall be posted at all times for the staff of the center.

   5) The consulting committee shall act as a tissue committee and shall review at least quarterly pathological reports from procedures performed by each physician on the staff. Evidence of such review shall be recorded in the minutes.

b) A qualified physician shall be designated "Medical Director."
   1) The Medical Director shall secure compliance with the policies and procedures pertaining to medical and surgical procedures, approved by the consulting committee.
   2) The Medical Director shall medically supervise the professional personnel involved directly in the care of patients undergoing surgical procedures, including their preoperative and postoperative care and follow-up.
   3) The Medical Director shall establish and secure compliance of standards for the observation of patients by nursing personnel during the postoperative period.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.240 Policies and Procedures Manual

The management/owner of the ambulatory surgical treatment center shall formulate a written policies and procedures manual. This shall be done in cooperation with the medical and professional staff and shall be approved by the consulting committee. These procedures shall provide for the acceptance, care, treatment, anesthesia services, discharge, referral, and follow-up of all patients and all incidental operations of the facility. This manual shall be available to all staff in the center and shall be followed by them at all times in the performance of their duties.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART C: PERSONNEL

Section 205.310 Personnel Policies
Each ambulatory surgical treatment center shall have written personnel policies including job descriptions for each staff position, which shall include minimum qualifications required for the position. There shall be a documented procedure for orientation of new employees to the facility's policies and procedures as well as the personnel policies including a copy of the appropriate job description.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.320 Presence of Qualified Physician
A qualified physician shall be present at the facility at all times during the operative and postoperative period for all patients.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.330 Nursing Personnel
At least one registered professional nurse with postgraduate education or experience in surgical nursing shall direct and supervise the nursing personnel and the nursing care of patients and shall be on duty at all times on the premises when patients are present.

Nursing care may be provided by student nurses and licensed practical nurses who have been trained in observation and emergency techniques for preoperative and postoperative care of surgical patients and who are under the direct personnel supervision of a registered nurse at all times.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.340 Basic Life Support
At least one person who is certified in "Basic Life Support" by the American Heart Association shall be on the premises while patients are present.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.350 Ambulatory Surgical Treatment Center
Each ambulatory surgical treatment center shall have one of the following:

a) a qualified medical technician who is certified by the American Society of Clinical Pathologists or is the holder of a letter, certificate, or record from the Bureau of Quality Assurance of the Department of Health, Education, and Welfare that he/she has passed the Federal Proficiency Examination Program for Clinical Laboratory Technologists, to perform required laboratory procedures.

b) A written agreement with a laboratory, licensed by the Department, to perform required laboratory procedures.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART D: EQUIPMENT, SUPPLIES, AND FACILITY MAINTENANCE

Section 205.410 Equipment
Equipment shall be in good working order and shall be available in numbers sufficient to provide good patient care based on the procedures to be performed in the facility.

a) There shall be monitoring equipment, suction apparatus, oxygen and related items available within the surgical and postoperative recovery area. Cardiac pulmonary resuscitation equipment shall be available in all facilities.

b) There shall be written procedures governing the care, use, sterilization, storage and disposal of all materials to insure that an adequate supply of sterile equipment is available for each procedure. The section on "Sterilization and Disinfection" from Infection Control in the Hospital, most recent edition, American Hospital Association, shall be used as the guideline.

c) There shall be written procedures to assure safety in storage and use of inhalation anesthetics and medical gases. The current edition of the National

Fire Protection Association Code (Standard No. 56a) shall be used as the standard.

d) There shall be written procedures to assure the safety in storage and use of all narcotics and medications in accordance with state and federal law.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.420 Sanitary Facility

The ambulatory surgical treatment center shall insure maintenance of a sanitary facility with all equipment in good working order. Written procedures shall include provision for garbage and refuse removal, insect and rodent control, maintenance of water, heat, ventilation and air conditioning, and electrical service.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART E: GENERAL PATIENT CARE

Section 205.510 Emergency Care

a) Each facility shall have a written plan of procedure to be followed in case of fire, explosion, or non-patient medical emergency. This plan shall specify persons to be notified and actions to be taken and shall be known by all staff of the facility.

b) Each facility shall be prepared to manage those emergencies which may be associated with procedures performed there.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.520 Preoperative Care

a) Where medical evaluation, examination, and referral are made from a private physician's office, hospital, or clinic, pertinent records thereof shall be available and made part of the patient's clinical record at the time the patient is registered and admitted to the ambulatory surgical treatment center.

b) A complete medical history shall be obtained and the physical examination shall be complete. A hemo-

globin or hematocrit and examination of the urine for sugar, protein, and acetone shall be performed by a qualified laboratory technician prior to the following procedures:

1) those performed with general anesthesia,
2) those performed with local anesthesia with sedation,
3) those performed to terminate pregnancy.

c) A written statement indicating informed consent and a signed authorization by the patient for the performance of the specific surgical procedure shall be procured and made part of the patient's clinical record.

d) Surgical procedures shall not be performed on patient's having medical, surgical, or psychiatric conditions or complications as specified by the consulting committee in the facility's written policies.

(Source: Amended at 6 Ill. Reg. 10974, effective August 30, 1982)

Section 205.530 Operative Care

a) Surgical procedures shall be performed only by a qualified physician, dentist or podiatrist within the limits of his/her defined specific practice privileges.

b) A qualified anesthesiologist, a dental anesthesiologist or a certified registered nurse anesthetist, medically directed by a licensed physician who administers or directs the administration of anesthesia in an Illinois licensed hospital, shall be present for the administration of anesthetics and recovery of patients when any general or major regional anesthetic is used.

c) All tissues removed during surgery shall be examined by a consulting pathologist and all x-rays shall be read by a consulting radiologist who shall provide a written report of his/her examination to the attending physician. A copy of this report shall be filed in the patient's clinical record within seven (7) days.

(Source: Amended at 6 Ill. Reg. 13337, effective October 20, 1982)

Section 205.540 Postoperative Care

a) Patients who have had general anesthesia, local anesthesia with sedation, or a pregnancy termination shall be observed in the facility for a period of time sufficient to ensure that no immediate postoperative complications are present. No patient shall be required to leave the center in less than one (1) hour following the procedures.

b) Patients in whom a complication is known or suspected to have occurred during or after the performance of a surgical procedure, shall be informed of such condition and arrangements made for treatment of the complication. In the event of admission to an inpatient facility a summary of care given in the ambulatory surgical treatment center concerning the suspected complication shall accompany the patient.

c) To insure availability of follow-up care at a licensed hospital, the ambulatory surgical treatment center shall provide written documentation of one of the following:
   1) A transfer agreement with a licensed hospital within approximately fifteen (15) minutes travel time of the facility.
   2) A statement that the medical director of the facility has full admitting privileges at a licensed hospital within approximately fifteen (15) minutes travel time and that he/she will assume responsibility for all facility patients requiring such follow-up care.
   3) A statement that each staff physician, dentist, or podiatrist has admitting privileges in a licensed hospital within fifteen (15) minutes travel time of the facility.

d) Written instructions shall be issued to all patients in accordance with the standards approved by the consulting committee of the ambulatory surgical treatment center and shall include the following:
   1) Symptoms of complications associated with procedures performed.

   2) Limitations and/or restrictions of activities of the patient.
   3) Specific telephone number to be used by the patient, at anytime, should any complication or question arise.
   4) A date for follow-up or return visit after the performance of the surgical procedure which shall be scheduled within six weeks.

e) Patients shall be discharged only on the written signed order of a physician.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART F: RECORDS AND REPORTS

Section 205.610 Clinical Records

Accurate and complete clinical records shall be maintained for each patient and all entries in the clinical record shall be made at the time the surgical procedure is performed and when care, treatment, medications, or other medical services are given. The record shall include, but not be limited to, the following:

a) patient identification.
b) admitting information including patient history, physical examination findings, diagnosis or need for medical services.
c) pre-counseling notes.
d) signed informed consent.
e) confirmation of pregnancy (when abortion is performed).
f) signed physician orders.
g) laboratory test reports, pathologist's report of tissue, and radiologist's report of x-rays.
h) anesthesia record.
i) operative record.
j) medication and medical treatments.
k) recovery room progress notes.
l) physician and nurses' progress notes.
m) condition at time of discharge.

n) patient instructions.
o) post-counseling notes.
(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.620 Statistical Data
Each ambulatory surgical treatment center shall submit to the Department annually, clinical statistical data including the following:
a) the number and type of procedures performed.
b) the number and type of complications reported.
c) the number of patients requiring transfer to a licensed hospital for treatment of complications.
d) the number of patients returning for follow-up contact.
e) the number of deaths.
(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART G: ADDITIONAL REQUIREMENTS FOR FACILITIES IN WHICH OBSTETRICAL/GYNECOLOGICAL PROCEDURES ARE PERFORMED

Section 205.710 Abortions
Abortions shall be provided to the public with the same standards of safety, effectiveness, and regard for patients rights as any other health service.
(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.720 Personnel
At least one registered professional nurse with postgraduate education or experience in obstetrical or gynecological nursing shall supervise and direct the nursing personnel and care of patients having obstetrical procedures.

AGENCY NOTE: Procedures involving the pregnant uterus are subject to particular complications and postoperative care requires a special knowledge on the part of nursing staff.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.730 General Patient Care
a) Examination
1) Prior to obstetrical procedures blood Rh factor shall be determined by a qualified laboratory technician for every patient.
2) The physician performing an abortion procedure shall establish the diagnosis of pregnancy by appropriate clinical evaluation and testing prior to performing an abortion procedure.
3) Time shall be allowed between the initial examination and termination of pregnancy to permit the reporting to and reviewing of all laboratory tests with the patient by the facility physician.
b) Counseling
1) Counseling shall be provided following disclosure to the patient of the diagnosis of pregnancy, and prior to performance of any surgical procedure. It shall be done individually and in a room designated for such use which shall not be the procedure room.
2) All facilities shall provide orientation training for counselors and insure that each counselor is qualified to:
A) Counseling shall be done by a person qualified to:
i) discuss alternatives for dealing with an unwanted pregnancy;
ii) describe the procedures used in the facility;
iii) explain the risks and possible complications of each procedure;
iv) provide contraception information.
B) Demonstration of such counseling qualifications shall be required by the Department.
C) Documentation of orientation training shall be required by the Department.
D) Counselors shall have no financial interest in the patient's decision.
3) Counseling shall include a discussion of alternatives, description of the procedure to be per-

formed, explanation of risks and possible complications. Contraceptive information may be provided postoperatively. Group counseling may be provided in addition to individual counseling. The patient's clinical record shall include documentation of the counseling received.

AGENCY NOTE: In the opinion of the Ambulatory Surgical Treatment Center Licensing Board, the patient should make a decision concerning the procedure in an atmosphere free from coercion. Consequently, the Board believes this is best accomplished in a room separate and apart from the procedure room. The Board believes that it is difficult to reach a truly voluntary decision while the patient is undressed and on the procedure table.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.740 Preoperative Requirements
Abortions may be performed in an ambulatory surgical treatment center on only those patients with gestation up to and including 12 weeks commencing with ovulation rather than computed on the basis of the menstrual cycle, as determined by the physician, if the patient's medical condition permits. Abortions shall not be performed in an Ambulatory Surgical Treatment center on those patients whose gestation exceeds 12 weeks.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

Section 205.750 Postoperative Requirements

a) Each obstetrical/gynecological service shall provide Rh factor sensitization prophylaxis to all Rh negative patients according to standard medical procedures.
b) Information on availability of family planning services shall be provided, when desired by the patient. When, in the physician's opinion, it is in the best interest of the patient and with the patient's consent, family planning services may be initiated prior to the discharge of the patient.

(Source: Amended at 5 Ill. Reg. 12756, effective November 4, 1981)

Section 205.760 Reports

a) A report of each abortion procedure performed in an ambulatory surgical treatment center shall be made to the Department on forms provided by it. These reports shall be submitted not later than ten (10) days following the month in which the abortion was performed. Reports shall be submitted on procedures performed whether or not the patient was pregnant.
b) Reports shall not be filled out in such a manner or at such a time as to avoid accurate reporting of complications.
c) If the facility becomes aware of a complication following the submission of the original report, then a supplemental report shall be submitted to the Department.

(Source: Amended at 3 Ill. Reg. 30, p. 371, effective July 23, 1979)

SUBPART H: PROCEDURES FOR INVESTIGATION OF COMPLAINTS

Section 205.810 Complaints
All complaints against ambulatory surgical treatment centers shall be reported to the Illinois Department of Public Health. Complaints should preferably be in writing and contain sufficient facts to facilitate the investigation. Complaints by telephone will be accepted. Complaints will be required in writing if needed to support legal action against applicant.

(Source: Amended at 6 Ill. Rev. 6220, effective May 17, 1982)

Section 205.820 Acknowledgement of Complaint
Upon receipt of each complaint the Department will, with-

in seven (7) days, acknowledge by letter receipt of the complaint.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.830 Investigation

If the complaint contains allegations which, if true, would constitute a prima facie violation of the Ambulatory Surgical Treatment Center Act or this Part an investigation will be conducted. Whenever the complaint concerns matters outside the jurisdiction of the Department of Public Health, or may concern matters which are within the jurisdiction of another agency, the complaint also will be referred to the appropriate agency whenever so doing does not violate patient confidentiality.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.840 Prompt Investigation

The Department will promptly investigate each complaint within thirty (30) days of receipt of the complaint. Complaints which constitute a threat to the public health will be investigated within ten (10) days of receipt of the complaint.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.850 Methods

The Department will utilize the most efficient and effective methods to investigate each complaint. This may include inspections pursuant to Section 9 of the Act and the issuance of subpoenas and subpoenas duce tecum pursuant to Section 7 of the Act, when appropriate.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.860 Notification of Results

Upon the conclusion of the investigation the complainant will be notified of the results of the investigation and any action taken by the Department.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART I: BUILDING DESIGN, CONSTUCTION STANDARDS, AND PHYSICAL REQUIREMENTS

Section 205.1310 Plant and Service Requirements

All ambulatory surgical treatment centers are required to meet the following physical plant and service requirements.

a) All proposed facilities shall meet these requirements before licensure will be granted.

b) All existing facilities that are not in compliance with this Section, and subsequent Sections, shall come into compliance no later than May 17, 1984.

(Source: Amended at 7 Ill. Reg. 7640, effective June 14, 1983)

Section 205.1320 General Considerations

a) Location

This facility shall be identifiably separate from other facilities and functions.

b) Narrative Program

The sponsor for each project shall provide a narrative program of functions for the facility which contains space requirements, staffing patterns, departmental relationships and other basic information relating to the fulfillment of the institution's objectives. This may be a general or detailed description of each function to be performed, space needed for these functions, hours of operation, number of staff or other occupants of the various spaces, types of equipment required, interrelationship of various functions and spaces, and description of those services necessary for the complete functioning of the facility but which are available elsewhere in the community and, therefore, need not be duplicated in this facility. Explain the type of surgery or procedures, the volume of work, the number of doctors, etc.

c) Size

The extent (number and types) of the diagnostic, clinical, and administrative facilities to be provided shall be determined by the services contemplated

and the estimated patient load as described in the narrative program.

d) Provisions for the Handicapped
The design shall provide for accessibility to the physically handicapped (public, staff, and patients).

e) Privacy for Patient
The design of the facility shall provide for the privacy and dignity of the patient during interview, examination, and treatment.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1330 New Construction, Additions and Major Alterations

Requirements and procedures for new construction, additions, and major alterations are as follows:

a) Preliminary drawings and outline specifications whether for new construction or for substantial alterations, shall be submitted to the Department with a program narrative description for review and approval prior to starting final working drawings and specifications.

b) The final working drawings and specifications shall be submitted to the Department for review and approval prior to release of contract documents for bidding. Change orders which affect scope and/or function shall be submitted for approval prior to execution.

c) The Department shall be notified of the award of contracts, and when construction has been completed. Approval by the Department prior to occupancy is required.

d) The preparation and submission of drawings and specifications shall be executed by, or under the immediate supervision of an architect registered in the State of Illinois.

e) First stage submission. Design Development Drawings and Outline Specifications.

f) Development of the preliminary sketch plans indicating in detail the assignment of all spaces, size of areas and rooms, indicating in outline, the fixed and movable equipment and furniture.

1) The plans shall be drawn at a scale sufficiently large to clearly present the proposed design.
2) The drawings shall include:
   A) a plan of each floor including the basement or ground floor,
   B) plan showing roads, parking areas, sidewalks, etc.,
   C) elevations of all facades,
   D) sections through the building,
   E) and all adjacent areas clearly labeled if addition or alteration.
3) The total gross floor area shall be shown on the drawings.
4) Outline specifications shall provide a general description of the construction including finishes; acoustical material, its extent and type; heating and ventilating systems; and the type of elevators.
5) A brief narrative of the proposed program.

g) Second stage submission. Working Drawings and Specifications.
All working drawings shall be well prepared so that clean and distinct prints may be obtained; be accurately dimensioned and include all necessary explanatory notes, schedules and legends. Working drawings shall be complete and adequate for contract purposes. Separate drawings shall be prepared for each of the following branches of work: Architectural, Structural, Mechanical, Electrical. They shall include or contain the following:

1) Architectural Drawings.
   A) Site plan showing all new topography, newly established levels and grades, existing structures on the site (if any), new buildings and structures, roadways, walks, and the extent of the areas to be landscaped. All structures and improvements which are to be removed under the construction contract shall be shown.
   B) Plan of each floor.
   C) Elevations of each facade.
   D) Sections through building.

E) If elevators and dumbwaiters are provided, drawings are required showing shaft details and dimensions, sizes of cab platforms and doors, travel distances including elevation height of landings, pit sizes, and machine rooms.

F) Special care areas, and similar areas shall be detailed at a scale to show the location, type, size and connection of all fixed and movable equipment.

G) Schedule of finishes.

2) Structural Drawings.

A) Plans of foundations, floors, roofs and all intermediate levels shall show a complete design with sizes, sections, and the relative location of the various members. Schedule of beams, girders and columns.

B) Floor levels, column centers, and off-sets shall be dimensioned.

C) Special openings and pipe sleeves shall be dimensioned or otherwise noted for easy reference.

D) Details of all special connections, assemblies and expansion joints shall be given.

E) Notes on design data shall include the name of the governing building code, values or allowable unit stresses, assumed live loads, including wind loads, earthquake load, and soil bearing pressures.

3) Mechanical Drawings. The drawings with specifications shall show the complete heating, cooling and ventilation systems; plumbing, drainage, stand pipe, and sprinkler systems.

A) Heating, Cooling and Ventilation.

i) Any radiators, coils and steam heated equipment, such as sterilizers.

ii) Heating and steam mains and branches with pipe sizes.

iii) Diagram of heating and steam risers with pipe sizes.

iv) Sizes, types and heating surfaces of boilers, furnaces, with stokers and oil burners, if any.

v) Pumps, tanks, boiler breeching and piping and boiler room accessories.

vi) Air conditioning systems with required equipment, water and refrigerant piping, and ducts.

vii) Supply and exhaust ventilating systems with connections and piping.

viii) Air quantities for all room supply and exhaust ventilating duct openings.

B) Plumbing, Drainage and Stand Pipe Systems.

i) Size and elevation of: street sewer, house sewer, house drains, street water main and water service into the building.

ii) Location and size of soil, waste, and vent stacks with connections to house drains, cleanouts, fixtures and equipment.

iii) Size and location of hot, cold and circulating mains, branches, and risers from the service entrance, and tanks.

iv) Riser diagram of all plumbing stacks with vents, water risers and fixture connections.

v) Any gas, oxygen and similar piped systems.

vi) Any standpipe and sprinkler systems.

vii) All fixtures and equipment that require water and drain connections.

4) Electrical Drawings. Drawings shall show all electrical wiring, outlets, and equipment which require electrical connections.

A) Electrical service entrance with switches and feeders to the public service feeders, characteristics of the light and power current, transformers and their connections if located in the building.

B) Location of main switchboard, power panels, light panels and equipment. Feeder and conduit sizes shall be shown with schedule of feeder breakers or switches.
C) Light outlets, receptacles, switches, power outlets, and circuits.
D) Telephone layout showing service entrance, telephone switchboard, strip boxes, telephone outlets and branch conduits as approved by the telephone company. Where public telephones are used for inter-communication, provide separate room and conduits for racks and automatic switching equipment as required by the telephone company.
E) Fire alarm system with stations, signal devices, control board and wiring diagrams.
F) Emergency electrical system with outlets, transfer switch, source of supply, feeders, and circuits as required by the approved program as required under the electrical part of these Standards.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1340 Minor Alterations and Remodeling Changes

Minor alterations and remodeling changes which do not affect the structural integrity of the building, or change functional operation, or which do not affect safety, need not be submitted for prior approval.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1350 Administration Department and Public Areas

Administration Department and Public Areas are facilities to be provided when indicated by the approved program.

a) The entrance shall be sheltered from the weather, located by grade level and must be able to accommodate wheelchairs and stretchers, if applicable.

b) The lobby shall include, if indicated by the approved program for the facility, the following:
   1) wheelchair and cart storage
   2) reception and information counter
   3) waiting area
   4) public toilets
   5) public telephones
   6) drinking fountain
c) Interview spaces for private interviews relating to social services, credit, and admissions shall be provided.
d) Adequate office space for records, business, meeting, and staff shall be provided.
e) A multipurpose room for conferences, and health education purposes including provisions for showing visual aids shall be provided if required by the program.
f) Storage spaces shall be provided for:
   1) office supplies
   2) sterile supplies, medical/surgical supplies and equipment
   3) pharmaceutical supplies
   4) housekeeping supplies and equipment

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1360 Clinical Facilities

a) Examination room(s)
   1) Each examination room(s) shall have a minimum clear floor area of 80 square feet, and a minimum dimension of 8 feet, excluding such spaces as vestibule, toilet, closet, and work counter (whether fixed or movable). Arrangements shall permit at least 2'-6" clearance at each side and at both ends of the examination table.
   2) A lavatory or sink equipped for handwashing with knee or foot control shall be provided.
   3) A counter or shelf space for writing shall be provided.

b) Procedure room(s)
   1) Provide at least one procedure room with a minimum clear area of 250 square feet and a minimum dimension of 14 feet, exclusive of fixed and movable cabinets and shelves. Any other procedure rooms shall not be less than 120 square feet with a minimum dimension of 10 feet.
   2) Provide a communication system connecting with the control station.
   3) Provide special features such as x-ray film illuminators, and storage space as required by the program.

c) Recovery room(s)
   1) Room(s) for post-anesthesia recovery for surgical patients shall be provided.
   2) Recovery room(s) shall contain a minimum of 100 square feet of usable floor space for single bed occupancy and at least 80 square feet per bed for multiple bed occupancy, so arranged that there will be at least 3 feet between beds and 4 feet of clear space at the foot of each bed.
   3) This room(s) shall contain a drug distribution station, handwashing facility, charting facilities, nurses' station, and storage space for supplies and equipment.
   4) Provide a toilet which is accessible to the recovery room, without having to leave the recovery room to reach it. The water closet shall be equipped with a gray diverter valve.
   5) A separate supervised room may be provided for use by patients who are able to leave the recovery (post-anesthesia) room but need additional time for all vital signs to be stabilized to the point where the patient may leave the facility. This room shall be equipped with reclining or lounge type chairs for patients and shall contain a minimum of 50 square feet of usable floor space for each patient to be accommodated at any one time.

   6) These recovery rooms may be combined, if desired.
   7) Provide a minimum of four recovery beds or lounge chairs for each procedure room. At least one of the four must be a bed, and the other three may be lounge chairs or beds.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1370 Support Service Areas

a) A control station shall be located to permit visual surveillance of all traffic which enters the operating suite.

b) Provide sterilizing facility(ies) with high speed autoclave(s) conveniently located to serve all procedure rooms. Approved alternate provisions may be made for replacement of sterile instruments during surgery.

c) A drug distribution station shall be provided for storage and preparation of medication to be administered to patients.

d) Scrub stations with knee or foot or elbow actuated faucets shall be provided near the entrances to the procedure rooms. Scrub facilities shall be arranged to minimize splatter on nearby personnel or supply carts.

e) A soiled workroom for the exclusive use of the surgical suite staff shall be provided. The soiled workroom shall contain a work counter, sink equipped for handwashing, waste receptacle, and linen receptacle. This room may be used for cleaning anesthesia equipment.

f) Fluid waste disposal facilities shall be conveniently located with respect to the general procedure rooms.

g)
   1) A clean workroom or a clean supply room is required when clean materials are assembled within the surgical suite prior to use. A clean workroom shall contain a work counter, sink equipped for handwashing, and space for clean

and sterile supplies. A clean supply room shall be provided when the narrative program defines a system for the storage and distribution of clean and sterile supplies which would not require the use of a clean workroom.

2) An autoclave shall be incorporated into the clean workroom.

h) Anesthesia storage facilities shall be provided. Flammable anesthetics are prohibited.

i) Medical gas supply storage with space for reserve nitrous oxide and oxygen cylinders shall be provided, with all tanks properly secured.

j) Storage area for equipment and supplies used in surgical suite shall be provided.

k) Staff and personnel facilities shall be provided for male and female personnel (orderlies, technicians, nurses, and doctors) working within the surgical suite. The areas shall contain lounge, lockers, toilets, lavatories equipped for handwashing, and space for changing clothing. These areas shall be arranged to provide a one-way traffic pattern so that personnel entering from outside the surgical suite can change, gown, and move directly into the surgical suite. Space for removal of scrub suits and foot covers shall be designed so that personnel using it will avoid physical contact with clean personnel.

l) Provide change areas where patients can change from street clothing into hospital gowns in privacy, and be prepared for surgery. This shall include lockers, toilets, clothing change or gowning area(s), and space for the administration of medications.

m) Stretcher storage area shall be out of direct line of traffic.

n) Janitor's closet containing a floor receptor or service sink, and storage space for housekeeping supplies and equipment shall be provided exclusively for the surgical suite.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1380 Diagnostic Facilities

If the pre-admission evaluation tests are to be performed within the facility, the following services shall be provided.

a) Radiographic suite, if provided, shall contain the following:

1) film processing area
2) viewing and administration area
3) film storage facilities
4) toilet room with handwashing facilities, directly accessible from each fluoroscopy room without entering the general corridor area.
5) dressing area with convenient access to toilets.

b) Laboratory suite shall contain the following minimum facilities:

1) Laboratory work counter with sink and vacuum, and electric services.
2) Lavatory or counter sink equipped for handwashing.
3) Storage cabinet or closet.
4) Specimen collection facilities equipped with a toilet and lavatory.
5) Blood collection facilities shall have space for a chair and work counter.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1390 Other Building Services

a) Engineering service and equipment areas shall have sufficient space for equipment rooms for boilers, furnaces, mechanical equipment, and electrical equipment.

b) Waste processing services shall be provided for the sanitary storage and disposal of waste by incineration, mechanical destruction, compaction, containerization, removal, or by a combination of these techniques.

c) Storage rooms for building maintenance supplies and yard equipment shall be provided.

d) Janitor's closets shall be provided with a floor receptor or service sink.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1400 Details and Finishes

a) Minimum public corridor width shall be 5'-0", except those corridors where patients are transported in stretchers or carts shall be 8'-0".

b) The facility or section shall have at least two exits remote from each other. Other details relating to exits and fire safety shall be in accordance with Section 13 (Business Occupancy) of the latest edition of NFPA Standard 101 and the requirements outlined herein. These Standards govern where different from the code.

c) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required minimum.

d) All doors to toilets which may be used by patients shall be equipped with hardware which will permit access in any emergency.

e) The minimum width of doors for patient access to examination and treatment rooms shall be 3'-0".

f) The minimum width of doors to rooms needing access for stretchers (procedure rooms, recovery) shall be 3'-8".

g) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be swing type.

h) 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.

i) Doors, sidelights, borrowed lights, and windows in which the glazing extends down to within 18 inches of the floor (thereby creating possibility of accidental breakage by pedestrian traffic) shall be glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken in accordance with the State of Illinois Safety Glazing Materials Act (Ill. Rev. Stat. 1981, ch. 111½, par. 3101 et seq.). Similar materials shall be used in wall openings unless required otherwise for fire safety.

j) Thresholds and expansion joint covers shall be made flush with the floor surface to facilitate use of wheelchairs and carts.

k) Air dryers, or paper towel dispensers and waste receptacles shall be provided at all handwashing fixtures.

l) Where labeled fire doors are required, these shall be certified by an independent testing laboratory as meeting the construction requirements equal to those for fire doors in National Fire Protection Association (NFPA) Standard 80. Reference to a labeled fire door shall be construed to include labeled frame and hardware.

m) Radiation protection requirements of X-ray and gamma ray installations shall conform to the requirements of the Department of Nuclear Safety Rules for Protection Against Radiation (32 Ill. Adm. Code, Subchapter b) and should follow guidelines of NCRP reports #33 dated February 1968, and #49 dated September 1976. Provisions shall be made for testing and completed installation before use, and all defects must be corrected before use.

n) The minimum ceiling height shall be 8'-0", with the following exceptions:

1) Boiler rooms, if provided, shall have ceiling clearance not less than 2'-6" above the main boiler header and connecting piping.

2) Radiographic and other rooms containing ceiling-mounted equipment and including those with ceiling-mounted surgical light fixtures shall have height required to accommodate the equipment and/or fixture.

3) Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms may be not less than 7'-8".

4) Suspended tracks, rails, and pipes located in path of normal traffic shall be not less than 6'-8" above the floor.

o) Flammable Anesthetics are prohibited.

p) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant and shall pass both the large and small scale tests of NFPA Standard 701.

q) Interior finish of walls and ceilings of all exit ways, storage rooms, and areas of unusual fire hazard shall have a flame spread rating of not more than 25.

r) Floor finish materials shall have a flame spread rating of not more than 75. If a separate underlayment is used with any floor finish material, the flame spread test assembly shall include the underlayment.

s) All interior finish materials shall have smoke developed rating of 450 or less. The use of materials known to produce large amounts of toxic gases shall be avoided.

t) Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved.
   1) In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions.
   2) Floors that are subject to traffic while wet, shall have a nonslip surface.

u) Wall finishes shall be washable and in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.

v) Floor and wall penetrations by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects. Joints of structural elements shall be similarly sealed.

w) Ceilings shall be cleanable and those in sensitive areas such as surgical rooms shall be readily washable and without crevices that can retain dirt particles. These sensitive areas shall have a finished ceiling, covering all overhead ductwork and piping.

x) Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

y) Acoustical ceilings are recommended in corridors, multipurpose rooms, and waiting areas.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1410 Construction, Including Fire-Resistive Requirements

a) Buildings shall be of the following heights and construction types with automatic extinguishment system identified in the table below:

Construction Type	Stories 1	2	3	Over 3
2-hour Fire Resistive	X	X	X	X
1-hour Protected Noncombustible	X	X	X	
Noncombustible	X	X		
Heavy Timber	X	X*		
1-hour Protected Ordinary	X	X*		
1-hour Protected Wood Frame	X*			
Ordinary	X*			

Key:

X = Permitted types of construction.

* = Building requires automatic extinguishment protection except in procedure rooms. Smoke detectors must be installed in procedure rooms and all rooms not normally occupied (janitor's closet, storage, locker rooms, etc.).

b) Walls enclosing stairways, elevator shafts, chutes, and other vertical shafts, boiler rooms, and storage rooms (containing combustible materials) shall be of not less than one-hour fire resistive construction, except in buildings over 3 stories in height, where 2 hour enclosure is required.

c) Building insulation materials, unless sealed on all sides and edges, shall have a flame spread rating

of 25 or less and a smoke developed rating of 450 or less when tested in accordance with NFPA Standard 258.

d) Elevators and Dumbwaiters
   1) All ambulatory surgical treatment centers located above the first floor of the building shall have an electric or electrohydraulic elevator.
   2) Inspections and tests shall be made, and written certification be furnished, that the installation meets the requirements of all applicable safety regulations and codes.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART J: MECHANICAL

Section 205.1510 General

a) Mechanical systems shall be tested, balanced, and operated to demonstrate that the installation and performance of these systems conform to the requirements of these Standards.

b) Upon completion of the contract, the owner shall be provided with a complete set of manufacturer's operating, maintenance and preventive maintenance instructions, and parts list with numbers and description for each piece of equipment. The owner shall also be provided with instruction in the operational use of the systems and equipment as required.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1520 Thermal and Acoustical Insulation

a) Insulation shall be provided for the following within the building:
   1) Boilers, smoke breeching and stacks.
   2) Steam supply and condensate return piping.
   3) Hot water piping above 180° F and all hot water heaters.
   4) Hot water piping above 125° F which is exposed to contact by patients.

   5) Chilled water, refrigerant, other process piping and equipment operating with fluid temperatures below ambient dew point.
   6) Water supply and drainage piping with fluid temperatures below ambient dew point.
   7) Air ducts and casings with outside surface temperatures below ambient dew point.
   8) Other piping, ducts, and equipment necessary to maintain the efficiency of the system.

b) Insulation may be omitted from hot water and steam condensate piping not subject to contact by patients when such insulation is unnecessary for preventing excessive system heat loss or excessive heat gain in the surrounding space.

c) Insulation on cold surfaces shall include an exterior vapor barrier.

d) Insulation, including finishes and adhesives on exterior surfaces of ducts, pipes, and equipment, shall have a flame spread rating of 25 or less and a smoke developed rating of 450 or less as determined by an independent testing laboratory in accordance with NFPA 255. Exception: Duct, pipe, and equipment coverings shall not be required to meet these requirements where they are located entirely outside the building, or do not penetrate a wall or roof or do not create an exposure hazard.

e) Linings in air ducts and equipment shall meet the Erosion Test Method described in UL Pub. No. 181. These linings, including coatings and adhesives, and insulation on exterior surfaces of pipes and ducts in building spaces used as air supply plenums, shall have a flame spread rating of 25 or less and a smoke developed rating of 450 or less as determined by an independent testing laboratory in accordance with NFPA 255.

f) Duct linings shall not be used in systems supplying procedure and recovery rooms unless terminal filters of at least 90 percent efficiency are installed downstream of the linings.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1530 Steam and Hot Water Systems

a) Boilers and/or hot water heaters shall have the capacity, based upon the net ratings published by the Hydronics Institute, to supply the normal requirements of all the systems and equipment.

b) Supply and return mains and risers of space 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.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1540 Air Conditioning, Heating and Ventilating Systems

a) The systems shall be designed to provide the comfort temperatures and humidities as recommended by ASHRAE Standards.

b) Air handling systems shall conform to "Installation of Air Conditioning and Ventilating Systems," NFPA 90A-1976.

c) For spaces not exceeding 25,000 cubic feet in volume, heating, air conditioning, and ventilating systems shall conform to "Standard for the Installation of Warm Air Heating and Air Conditioning Systems, NFPA 90-B, 1973, except return ducts shall be constructed of materials equal to that specified for supply ducts, Chap. 2, paragraph 1.1., Duct Materials.

d) Outdoor air intakes shall be located as far as practical but not less than 15 feet from exhaust outlets of ventilation systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent stacks or from areas which may collect vehicular exhaust and other noxious fumes.

e) All ventilation air outlets and inlets shall conform to NFPA 90A-Chapter 2, paragraph 3.2. Location of Outlets and Inlets.

f) The ventilation systems shall be designed and balanced to provide the ventilation and pressure relationships as shown in Table A.

g) The ventilation air supplied to the procedure rooms shall be delivered at or near the ceiling of the area served, and all exhaust or return air from the area shall be removed near the floor level. At least two exhaust outlets shall be used in each procedure room.

h) All central ventilation or air conditioning systems shall be equipped with filters having efficiencies not less than those specified in the following table:

FILTER EFFICIENCIES FOR CENTRAL VENTILATION AND AIR CONDITIONING SYSTEMS IN AMBULATORY SURGICAL TREATMENT FACILITIES

Area Designation	Minimum Number of *Filter Beds*	Filter Efficiencies (Percent) Filter Bed *No. 1*	Filter Bed *No. 2*
Procedure and Recovery Rooms	2	25	90
All Other Areas	1	25	—

i) All filter efficiencies shall be average atmospheric dust spot efficiencies tested in accordance with the American Society of Refrigeration and Heating, Air Conditioning Engineers (ASHRAE) Standards 52-68.

j) For systems serving procedure and recovery rooms, filter bed No. 1 shall be located upstream of the conditioning equipment and filter bed No. 2 shall be located downstream of the supply fan and conditioning equipment including humidifiers.

k) Filter frames shall be durable and shall provide an airtight fit with the enclosing duct work. All joints between filter segments and enclosing duct work shall be gasketed or sealed to provide a positive seal against air leakage.

l) A manometer shall be installed across each filter bed serving procedure and recovery rooms.

m) Fire and smoke dampers shall be constructed, located and installed in accordance with the requirements of NFPA 90A.

n) All systems, regardless of size, which serve more than one smoke or fire zone, shall be equipped with smoke detectors to shut down fans automatically as specified in paragraph 4-3.1 of NFPA 90A.

o) The ventilation system for anesthesia storage rooms shall conform to the requirements of "Standard for Inhalation Anesthetics" NFPA 56A, including the gravity option ventilation system.

p) Boiler rooms shall be provided with sufficient outdoor air to maintain combustion rates of equipment and limit temperatures in working stations to 97° F Effective Temperature as defined by ASHRAE Handbook of Fundamentals.

q) Rooms containing heat-producing equipment, such as boiler rooms and heater rooms, shall be insulated and ventilated to prevent any floor surface above from exceeding a temperature of 100° F.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART K: PLUMBING AND OTHER PIPING SYSTEMS

Section 205.1610 General

All plumbing systems shall be designed and installed in accordance with the requirements of the Illinois Plumbing Code (77 Ill. Adm. Code 890).

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1620 Plumbing Fixtures

a) Plumbing fixtures shall be of nonabsorptive acid-resistant materials.

b) The water supply spout, for lavatories and sinks required for filling pitchers, for medical and nursing staff handwashing, shall be mounted so that its discharge point is a minimum perpendicular distance of 5 inches above the rim of the fixture.

c) All fixtures for use by medical and nursing staff shall be trimmed with valves which can be operated without the use of hands.

1) When blade handles are used for this purpose, the blade handles shall not exceed 4½ inches in length.

2) The scrub sinks for surgery shall be trimmed with valves which are aseptically operated (i.e., knee or foot or elbow actuated) without the use of hands. Wrist blade handles are not acceptable.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1630 Water System

a) Water systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

b) Each water service main, branch main, riser, and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture.

c) Approved backflow preventers or vacuum breakers shall be installed on hose bibbs, laboratory sinks, janitors' sinks, and on all other fixtures to which hoses or tubing are, or can be attached.

d) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1640 Drainage Systems

a) Building sewers shall discharge into a community sewage system.

b) Where a community sewage system is not available, sewage and liquid wastes shall be collected, treated and disposed of in a private treatment system which must conform to local and State regulations.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1650 Identification
All piping for, heating, ventilating and air conditioning, and service water systems shall be coded and marked for easy identification.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

SUBPART L: ELECTRICAL

Section 205.1710 General

a) All material including equipment, conductors, controls, and signaling devices shall be installed to provide a complete electrical system with the necessary characteristics and capacity to supply the required electrical facilities. All materials shall be listed as complying with available standards of Underwriters' Laboratories, Inc., or other similarly established standards.

b) All electrical installations and systems shall be tested to show that the equipment is installed and operates as required. A written record of performance tests on special electrical systems and equipment shall be supplied to the owner. Such tests shall show compliance with the governing codes and shall include grounding continuity and alarm systems.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1720 Switchboards and Power Panels
Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboards and panelboards shall be enclosed or guarded to provide a dead-front type of assembly.

a) The main switchboard shall be located in a separate enclosure accessible only to authorized persons.

b) The switchboards shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space free of corrosive fumes or gases.

c) Overload protection devices shall be suitable for operating properly in the ambient temperature conditions.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1730 Panelboards
Panelboards serving lighting and appliance circuits shall be located on the same floor as the circuits they serve. This requirement does not apply to any emergency system circuits.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1740 Lighting

a) All spaces occupied by people, machinery, and equipment within buildings, approaches to the buildings, and parking lots shall have lighting.

b) A portable or fixed examination light shall be provided in each examination and treatment room.

c) Procedure rooms shall have general lighting, in addition to local lighting provided by adequate lighting units at the procedure tables. Each lighting unit at the tables, except for portable units, shall be connected to an independent circuit.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1750 Receptacles (Convenience Outlets)

a) Duplex grounding type receptacles shall be installed in all areas or rooms in sufficient quantities for the tasks to be performed.

b) A minimum of one duplex receptacle for each wall shall be installed in each work area or room, other than storage or locker rooms.

c) A minimum of two duplex receptacles shall be located convenient to each examination and work table.

d) Duplex receptacles for cleaning equipment and general use shall be installed approximately 50'0" apart in all corridors and within 25'0" of ends of corridors.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1760 Grounding
In areas used for patient care or treatment, all receptacles operating at over 100 volts, shall be grounded by an insulated copper conductor, sized in accordance with Table 250-95 of the 1975 National Electrical Code, and installed with the branch conductors supplying these receptacles.
(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Standard 205.1770 Equipment Installation in Special Areas
a) X-ray Installations. Fixed and mobile X-ray equipment installations, if installed, shall conform to Article 660 of NFPA Standards 70, 1975 Edition.
b) Installation in non-flammable anesthetizing locations of all electrical equipment and devices, receptacles, and wiring shall comply with NFPA Standard 70, 1975 Edition. Exception: Isolated electrical systems are not required.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1780 Emergency Electric Service
a) An emergency source of electricity shall be provided and connected to certain circuits for lighting to provide electricity during an interruption of the normal electric supply.
b) The source of this emergency electric service shall be a generator set, storage batteries or unit equipment as described in Art. 700-6 NFPA Standard 70.
c) Emergency electric service shall be provided to the following:
   1) Illumination of means of egress as required in NFPA Standard 101.
   2) Illumination for exit signs and exit directional signs as required in NFPA Standard 101.
   3) Alarm systems including fire alarms activated at manual stations, water flow alarm devices of sprinkler system if electrically operated, fire and smoke detecting systems, and alarms required for nonflammable medical gas systems if installed.

   4) General illumination and selected receptacles in the vicinity of the generator set, if installed.
   5) Illumination in procedure and recovery room.
   6) If 110 volt equipment will be utilized to maintain heart action, breathing, to control bleeding or other essential functions, receptacles connected to emergency power sources shall be installed.

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205.1790 Fire Alarm System
A manually operated electrically supervised fire alarm system shall be installed in each facility.
(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)

Section 205. TABLE A General Pressure Relationships and Ventilation Rates of Ambulatory Surgery Area

Within Area Room Units Designation	Pressure Relationship to Adjacent Areas	Minimum Total Air Changes per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated
Procedure Room	+	15	Optional	No
Examination Room	0	6	Optional	Optional
Recovery Room	+	6	Optional	Optional
Medication Area	+	4	Optional	Optional
X-Ray Room	0	6	Optional	Optional
Soiled Workroom or Soiled Holding	–	10	Yes	No
Clean Workroom or Clean Holding	+	4	Optional	Optional
Darkroom	–	10	Yes	No
Toilet Room	–	10	Yes	No
Janitors' Closet	–	10	Yes	No
Sterilizer Equip. Rm.	–	10	Yes	No
Linen and Trash Rm.	–	1–	Yes	No
Laboratory	–	6	Optional	Optional
Soiled Linen Storage	–	10	Yes	No
Clean Linen Storage	+	2	Optional	Optional
Anesthesia Storage	0	8	Yes	No
Central Services Area				
Soiled Area	–	6	Yes	No
Clean Area	+	4	Optional	Optional
Equipment Storage	0	2	Optional	Optional

\+ = Positive
– = Negative
0 = Equal

(Source: Amended at 6 Ill. Reg. 6220, effective May 17, 1982)