No. 12-1168

IN THE

Supreme Court of the United States

ELEANOR MCCULLEN, JEAN ZARRELLA, GREGORY A. SMITH, MARK BASHOUR, AND NANCY CLARK,

Petitioners,

v.

MARTHA COAKLEY, ATTORNEY GENERAL FOR THE COMMONWEALTH OF MASSACHUSETTS, *et al.*,

Respondents.

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

BRIEF OF NATIONAL ABORTION FEDERATION & 31 OTHER ORGANIZATIONS COMMITTED TO PROTECTING THE HEALTH AND SAFETY OF REPRODUCTIVE HEALTHCARE PROVIDERS AND THEIR PATIENTS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS AND AFFIRMANCE

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AMICI CURIAE

Abortion Care Network
American Association of University Women
Association of Reproductive Health Professionals
Black Women's Health Imperative
Catholics for Choice
Feminist Majority Foundation
Hadassah, Women's Zionist Org. of America
Ibis Reproductive Health
Law Students for Reproductive Justice
League of Women Voters of Massachusetts
Medical Students for Choice
NARAL Pro-Choice America
NARAL Pro-Choice Massachusetts
NARAL Pro-Choice New York
National Abortion Federation
National Asian Pacific Women's Forum
National Association of Social Workers and its Massachusetts Chapter
National Council of Jewish Women
National Family Planning and Reproductive Health Association
National Institute for Reproductive Health
National Latina Institute for Reproductive Health
National Organization for Women Foundation
National Partnership for Women and Families
National Women's Health Network
National Women's Law Center
Nursing Students for Choice
Physicians for Reproductive Health
Provide, Inc.
Reproductive Health Access Project
Reproductive Health Technologies Project
Unitarian Universalist Association
Women's Bar Association of Massachusetts

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INTEREST OF AMICI[1]

Amici Curiae are 32 organizations dedicated to women's safe access to reproductive healthcare. Individual statements of interest of the *Amici* are contained in Appendix A. *Amici* believe that buffer zones are critical to the continued safety of reproductive healthcare facilities, patients and providers because they provide a safe area for providers to access their workplace and for patients to obtain reproductive healthcare services. Because this case presents the question whether buffer zone laws are constitutional, *Amici* have a keen interest in the outcome of this case and urge the Court to uphold such laws as being necessary to protect safe access for patients seeking healthcare services.

SUMMARY OF ARGUMENT

Given the severe violence, obstruction and harassment targeting reproductive healthcare facilities, the States have a strong interest in securing the safety of their citizens and women's safe access to reproductive healthcare by appropriately-tailored buffer zone laws. Reproductive healthcare facilities, including in Massachusetts, have faced years of violence and obstruction, persisting to this day. The Massachusetts fixed buffer zone law, Massachusetts Gen. Laws, Ch. 266 § 120E1/2 ("the Act"), is a

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[1] The parties in this case have consented to the filing of this brief. Pursuant to Rule 37.6, *Amici* state that no counsel for a party has authored this brief, in whole or in part, and no person, other than *Amici* or their counsel, has made a monetary contribution to the preparation or submission of this brief.

constitutional time, place and manner regulation that is narrowly tailored to serve significant State interests in safety and access, while providing ample alternative channels of communication. *Amici* urge this Court to uphold the Act as a constitutional means of protecting reproductive healthcare facilities from continued violence, and ensuring women's safe access to healthcare services.

Indeed, the Act is a necessary response to the State's significant interest in protecting reproductive healthcare providers and their patients. Hundreds of reproductive healthcare facilities have fallen victim to bombings, arsons and butyric acid attacks, causing severe physical injury and millions of dollars of property damage. Numerous physicians and facility workers have been murdered or maimed by individuals opposed to abortion. More than 700 facilities have been blockaded, preventing women seeking a variety of reproductive healthcare services from accessing the facility. Abortion providers have received innumerable threats, pieces of hate mail and harassing phone calls. As a result of these numerous targeted attacks, reproductive healthcare facilities—unlike other healthcare facilities—have spent millions of dollars on security measures, from hiring armed guards to installing bullet-proof glass.

Despite these precautions, reproductive healthcare facilities regularly encounter violence and obstructed access to this day. The most recent murder of a physician who provided abortions occurred in 2009. By 2010, one out of every five reproductive healthcare facilities was afflicted by anti-abortion violence. In 2012 alone, five facilities suffered arsons. From 2007 to 2012, there were at least eight arsons, six attempted arsons or

bombings, 41 incidents of assault and battery, and more than 200 acts of vandalism of facilities.

Much of this violence occurs in the areas immediately surrounding reproductive healthcare facilities. Given this continuing reality, a buffer zone immediately surrounding facility entrances helps secure patient and staff access to the facilities, and is a narrowly-tailored response to the States' significant law enforcement interests. In fact, surveys show that buffer zones have decreased violence, obstruction and intimidation outside of reproductive healthcare facilities. This improved situation compels the continuation, and not the dismantling, of buffer zone laws.

This Court has previously recognized the States' significant interests in securing women's safe access to reproductive healthcare facilities. *See Schenck* v. *Pro-Choice Network of Western NY*, 519 U.S. 357, 376 (1997) (Rehnquist, C.J.) ("[W]e conclude that the governmental interests . . . [in] ensuring public safety and order, promoting the free flow of traffic on streets and sidewalks, protecting property rights, and protecting a woman's freedom to seek pregnancy-related services . . . are certainly significant enough to justify an appropriately tailored" response); *Hill* v. *Colorado*, 530 U.S. 703, 715 (2000) ("It is a traditional exercise of the States' police powers to protect the health and safety of their citizens. . . . That interest may justify a special focus on unimpeded access to health care facilities.") (internal citations and quotation marks omitted).

The Massachusetts buffer zone law promotes substantial governmental interests that cannot be achieved as effectively without the regulation. The Act extends only 35 feet from facility entrances,

protecting safe patient access by preventing persons from entering and remaining in the areas immediately surrounding entrances to reproductive healthcare facilities, yet still providing ample alternative means of communication, as individuals may engage in *any* type of protected First Amendment activity outside its 35-foot radius.

The Act is a valid content- and viewpoint-neutral time, place and manner regulation. It was passed to ensure safe access to facilities, not to suppress any content, and the statute does not distinguish based on content. The statute's application to reproductive healthcare facilities does not make it content-based; rather, it reflects the Commonwealth's substantial interests in ensuring safe access to these facilities given the unrelenting violence targeting such locations. The exception for employee access similarly does not make the statute viewpoint-based: whether employees are allowed to enter the zone does not turn on the content or viewpoint of any message. Rather, the exception simply allows facility staff to enter their workplace.

Accordingly, *Amici* urge this Court to uphold the Massachusetts statute, and allow the States to continue to enact tailored measures to prevent violence and secure safe access for patients in the areas immediately surrounding reproductive healthcare facilities.

ARGUMENT

I. BUFFER ZONE LAWS ARE NECESSARY TO FURTHER THE STATES' INTERESTS IN PUBLIC SAFETY AND WOMEN'S ACCESS TO HEALTHCARE

The States have a significant, indeed compelling, interest in ensuring safe access in the areas immediately surrounding reproductive healthcare facilities, given the extent and current reality of violence, obstruction and harassment targeting such facilities. To this day, reproductive healthcare facilities face the very real threat of violence and obstruction. States should be permitted to pass tailored buffer zone laws in an effort to reduce violence at such facilities and ensure women's safe access to healthcare, particularly because buffer zone laws have been shown to be effective. Massachusetts, like many other States, has a tragic history of anti-abortion violence, and its legislature appropriately concluded that the buffer zone law at issue is both necessary and narrowly tailored to address the Commonwealth's compelling law enforcement concerns.

This Court previously has held that governmental interests in safety and access to reproductive healthcare are "certainly significant enough to justify an appropriately tailored" response. *Schenck*, 519 U.S. 357, 376 (1997) (Rehnquist, C.J.); *see also Hill*, 530 U.S. at 715 (recognizing the state's interest in "unimpeded access to health care facilities").

Moreover, outside of the abortion context, this Court repeatedly has upheld content-neutral (or

even content-based) regulations affecting speech. *See, e.g.*, *Ward* v. *Rock Against Racism*, 491 U.S. 781, 791 (1989); *Burson* v. *Freeman*, 504 U.S. 191 (1992). And this Court has recognized the strong governmental interests in regulating access to public fora even where violence is not the primary concern. *See Ward*, 491 U.S. at 784, 796 (Kennedy, J.) (New York City has a substantial interest in "ensuring the sufficiency of sound amplification at bandshell events" in Central Park, to protect citizens from unwelcome noise); *Burson*, 504 U.S. at 193-94 (upholding content-based restriction prohibiting the display of campaign material and solicitation of votes within 100 feet of polling place, to protect the right of citizens to vote freely); *Frisby* v. *Schultz*, 487 U.S. 474, 488 (1988) (upholding time, place and manner restriction that prohibited picketing of a single residence); *see also Snyder* v. *Phelps*, 131 S. Ct. 1207, 1218 (2011) (Roberts, C.J.) ("even protected speech is not equally permissible in all places and at all times"; "Westboro's choice of where and when to conduct its [peaceful funeral] picketing is not beyond the Government's regulatory reach—it is subject to reasonable time, place, or manner restrictions.") (internal quotation marks omitted).[2] The Court likewise should uphold the Massachusetts statute here.

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[2] In *Snyder*, this Court recognized that 44 states and the federal government now have laws imposing time, place and manner restrictions on funeral picketing, and expressly distinguished those laws from the tort verdict at issue. *Snyder* at 1218. So too, here, the Massachusetts statute is a constitutional time, place and manner restriction.

A. Buffer Zone Laws Are Necessary to Address the Violence, Obstruction and Harassment of Reproductive Healthcare Facilities and Providers That Continues to Jeopardize Their Safety

The history of anti-abortion violence in this country is an important backdrop to the Massachusetts buffer zone law. Indeed, Massachusetts has a tragic history with anti-abortion violence, including shootings at two Boston facilities. Reproductive healthcare facilities uniquely require buffer zones to address the targeted violence and obstruction that continues to this day.

Over the past forty years, abortion opponents have targeted reproductive healthcare facilities with violence, ranging from assaults and blockades to arsons, bombings and murders. Statistical surveys for the years 1977 to 1994 (*see infra* pp. 7-9), 1995 to 2006 (*see infra* p. 13) and 2007 to 2012 (*see infra* pp. 14-16), demonstrate the gravity of this problem. Today, while providers, with law enforcement assistance, have been successful in reducing some forms of violence, the violence has continued and remains a serious concern. As recently as 2009, a physician was murdered by an abortion opponent, and additional anti-abortion violence continues to this day.

1. Violence Against Reproductive Healthcare Facilities from 1977-1994

Initially, the violence against providers took the form of bombings and arsons, continuing through

the 1980s and to today. Beginning in the 1990s, the violence escalated to the murders of abortion providers. For the survey period 1977 to 1994, there were 124 recorded arsons, 29 bombings, and 64 attempted arsons and bombings of facilities.[3] One fire attack destroyed an entire shopping center valued at $1.5 million. David A. Grimes et al., *An Epidemic of Antiabortion Violence in the United States*, 165 AM. J. OBSTET. GYNECOL. 1263, 1265 (1991). Various facilities were forced to interrupt or entirely discontinue providing healthcare services as a result of similar attacks. *Id.* at 1267.

During this same time period, 1,801 incidents of violence against abortion providers were recorded by NAF. *See* Appendix B. These included five murders, 11 attempted murders, 585 acts of vandalism, 225 death threats, and 80 butyric acid attacks. *Id.* In this same time period, abortion providers received at least 311 bomb threats and 1,833 incidents of hate mail or harassing calls. *Id.*

Access to clinic entrances has also been impeded for years, and continues to this day. Thousands of anti-abortion activists have targeted facility entrances, as a tactic to physically prevent access to abortion care. JESSICA STERN, TERROR IN THE NAME OF GOD: WHY RELIGIOUS MILITANTS KILL 154 (2004). From 1977 to 1994, there were 634 recorded

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[3] *See NAF Violence and Disruption Statistics*, National Abortion Federation (1977-2012), attached as Appendix B. NAF's data derives from law enforcement sources and a monthly member survey, for the U.S. and Canada. The actual number of incidents is likely to be significantly higher, because not all providers report to NAF and not all incidents are reported.

blockades of facility entrances, forcibly preventing patients and staff from entering and temporarily shutting down the affected clinics. *See* Appendix B. At least 33,661 individuals were arrested for incidents of violence and disruption against abortion providers from 1977 to 1994. *Id.* Notably, many of the persons arrested for violent acts had been known around facilities as protesters, who later transitioned to committing bombings and even murder.[4]

These statistics do not account for other forms of terror directed at facility workers, physicians, their children, and even their pets. To cite just a few examples, anti-abortion protesters have followed the children of one physician, have beheaded a facility worker's cat, and have poisoned a physician's three dogs. Michele Wilson & John Lynxwiler, *Abortion Clinic Violence as Terrorism*, 11 TERRORISM 236, 265 (2008).

Abortion opponents attempted to murder at least 11 physicians, clinic employees and volunteers from 1977 to 1994, and succeeded in murdering five in 1993 and 1994 alone. *See* Appendix B.[5] The first

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[4] Shelley Shannon, for example, began by holding signs outside of facilities, and later set fire to multiple facilities and attempted the murder of a physician. JIM RISEN & JUDY L. THOMAS, WRATH OF ANGELS: THE AMERICAN ABORTION WAR 351 (1998). Similarly, Paul Hill was a protester outside the facility where he later murdered a physician and his volunteer escort. *Id.* at 349, 351, 362-64 (1998).

[5] NAF's statistics do not include every shooting. For example, as reported by the Senate Report to Freedom of Access to Clinic Entrances Law (FACE), in December 1991, a man wearing a ski mask opened fire at a clinic in Springfield,

reported murder occurred in 1993 when Michael Griffin shot Dr. David Gunn three times in the back as Dr. Gunn emerged from his car in the parking lot behind the facility where Dr. Gunn performed abortions. JIM RISEN & JUDY L. THOMAS, WRATH OF ANGELS: THE AMERICAN ABORTION WAR 339-340 (1998).

Shortly after Dr. Gunn's death, Paul Hill wrote a paper in defense of the "justifiable homicide" of abortion providers, and circulated a "Defensive Action" petition endorsing violence. *Id.* at 347. In June 1994, Hill began protesting outside the facility where Dr. John Britton began performing abortions after Dr. Gunn's death. *Id.* at 362. A month later, Hill shot Dr. Britton and his volunteer security escorts, Jim and June Barrett, as their car pulled into the driveway of the facility. *Id.* at 363-64. Hill stood at the facility entrance with pamphlets, waiting for Dr. Britton to arrive. As the Barretts' truck pulled into the driveway, Hill opened fire at point-blank range, killing Dr. Britton and Jim Barrett with shots to the head, and wounding June Barrett. *Id.* at 363-64.

In the same time period, Shelley Shannon, not yet arrested for numerous bombings of west coast facilities, began corresponding with Griffin in jail. After visiting two other anti-abortion convicts in prison, Shannon began preparations for the murder of Dr. George Tiller of Wichita, Kansas. *Id.* at 355. On August 19, 1993, Shannon arrived at Dr. Tiller's facility early in the morning, and remained outside with local activists all afternoon. *Id.* at 356. As Dr.

Missouri, seriously wounding two clinic workers. S. Rep. No. 117, 103d Cong., 1st Sess. 3 (1993), at 3-5.

Tiller left the facility shortly after 7 p.m., driving out of the parking lot, Shannon fired six shots in close range of his car. Although Dr. Tiller survived this attack, in 2009, anti-abortion activist Scott Roeder murdered Dr. Tiller. *Id.*

The violence continued unabated, reaching the Commonwealth of Massachusetts. On December 30, 1994, John Salvi began a rampage that took him to three reproductive healthcare facilities over two days. *Id.* at 367. In Brookline, Massachusetts, Salvi opened fire at a Planned Parenthood facility, killing the receptionist Shannon Lowney. After murdering Ms. Lowney, Salvi sprayed the room with bullets, and left. J.A. at 57; *Salvi Convicted of Murder in Shootings*, WASHINGTON POST (Mar. 19, 1996). Salvi proceeded to a second Brookline facility, killing the receptionist there, Lee Ann Nichols. RISEN & THOMAS, WRATH OF ANGELS at 367. The next day, he fired gunshots at a reproductive healthcare facility in Norfolk, Virginia, where he was arrested. *Id.* All told, Salvi left seven victims: Lowney and Nichols, plus five others he wounded during his spree. *Id.*

2. Violence Against Reproductive Healthcare Facilities Continued Unabated in the Period 1995-2006

The violence did not subside. Surveys for the second referenced period, between 1995 and 2006, recorded two murders, six attempted murders, two kidnappings, 20 butyric acid attacks, 49 facility arsons, and 12 facility bombings. *See* Appendix B. Physical altercations near reproductive healthcare facilities have been far too common as well, with 62 assaults reported. *Id.* By 2005, nearly one fifth of facilities reported being the target of anti-abortion

violence. *See* Mireille Jacobson & Heather Royer, *Aftershocks: The Impact of Clinic Violence on Abortion Services*, 3 AM. ECON. J. 189,190 (2011), *citing* FEMINIST MAJORITY FOUNDATION, *2005 National Clinic Violence Survey*, http://www.feminist.org/research/cvsurveys/clinic_survey2005.pdf (last visited November 14, 2013).

In addition, from 1995 to 2006, 113 blockades were so severe that the facilities were forced to temporarily shut down all services. *See* Appendix B. Facility staff reported receiving 160 death threats. *Id*. Facilities also reported 309 bomb threats and 655 anthrax/bioterrorism threats. *Id*. In fact, while the entire country was terrorized by anthrax attacks after 9/11, reproductive healthcare facilities received 96 hoax devices or suspicious packages between 2002 and 2006. Over 275 facility staff and patients reported being stalked between 1995 and 2006. Such terror takes its toll: a 2005 survey found that 20% of reproductive healthcare facilities experiencing high violence had at least one staff member resign *in that year* due to anti-abortion violence and intimidation. *See* Jacobson & Royer, *Aftershocks: The Impact of Clinic Violence on Abortion Services,* at 190, *citing* FEMINIST MAJORITY FOUNDATION, *2005 National Clinic Violence Survey*, http://www.feminist.org/research/cvsurveys/clinic_survey2005.pdf (last visited November 14, 2013).

Tragically, another physician was murdered in 1998. Anti-abortion activist James Kopp waited for Dr. Barnett Slepian, who provided abortions in Buffalo, New York, to return with his family from Synagogue one evening. Kopp shot Dr. Slepian through the doctor's kitchen window, shattering his spine and tearing through his aorta; Dr. Slepian died shortly thereafter. *Murder of New York*

abortion doctor denounced as 'terrorism', CNN, Oct. 24, 1998; *Doctor's Killer Tries to Make Abortion the Issue*, N.Y. TIMES, Jan. 13, 2007.

Kopp was captured in France years later. The FBI reported that Kopp "did not leave the US without assistance, and he did not remain a fugitive without assistance." Ed Vulliamy, Henry McDonald, and Stuart Jeffries, *Abortion death hunt muzzles 'Atomic Dog'*, THE GUARDIAN, Mar. 31, 2001. Sure enough, anti-abortion activists Dennis Malvesi and Laura Marra were arrested in New York for helping Kopp hide from authorities. Frederick Clarkson, *Our Own Terror Cells*, SALON, Jan. 8, 2002. Kopp is also believed to have committed three shootings of abortion providers in Canada and another in New York State. *See* Vuillamy, McDonald, & Jeffries, *Abortion death hunt muzzles 'Atomic Dog.'*

Also in 1998, Eric Rudolph bombed a reproductive healthcare facility in Birmingham, Alabama, killing Robert Sanderson, an off-duty police officer working as a security guard, and permanently injuring nurse Emily Lyons. *Among his victims: A nurse loses sight; receptionist, police officer die in blasts*, USA TODAY, July 5, 2005; SOUTHERN POVERTY LAW CENTER, *Abortion Clinic Bombing Victim Emily Lyons Speaks Out: A terrorist's bombing victim speaks out*, 91 INTELLIGENCE REPORT (Summer 1998). Upon his capture years later, Rudolph also was convicted of bombing the Centennial Olympic Park in Atlanta, Georgia during the 1996 Summer Olympics, killing one mother and injuring 111 bystanders. *See* ARMY OF GOD, *Statement by Eric Rudolph*, http://www.armyofgod.com/EricRudolphStatement.html.

3. Reproductive Healthcare Facilities Remain Threatened by Violence and Obstructed Access to This Day

Unfortunately, severe anti-abortion violence has continued in recent years. Just four years ago, in 2009, Dr. George Tiller, who survived the 1993 attempt on his life, was murdered in Wichita, Kansas. *Roeder: No regrets after shooting doctor*, CNN (Jan. 28, 2010). A week earlier, his killer, Scott Roeder, had been seen vandalizing a Kansas facility by putting glue in the door locks. *Suspect in Doctor's Killing Tied to Vandalism Case*, N.Y. TIMES, June 2, 2009. Also in 2009, letters laced with anthrax and signed by the "Army of God" were sent to reproductive healthcare facilities in 12 states. *'Army Of God' Anthrax Threats*, CBS NEWS, February 11, 2009.

Indeed, in 2010, 23.5% of all facilities surveyed by FMF (or approximately 83 out of 357) were affected by severe violence—up from 20% in 2008 and 18.4% in 2005. *See* Appendix D. In addition, in early 2011, when anti-abortion activists discovered that Dr. Mila Means intended to provide abortion services in Wichita after the murder of Dr. Tiller, they began disruptive protests against Dr. Means' family practice, and repeatedly stalked Dr. Means. FEMINIST MAJORITY FOUNDATION, *Anti- Abortion Protesters Block Wichita Abortion Doctor,* http://feminist.org/blog/index.php/2011/02/18/wichita-dr-seeking-to-provide-abortion-blocked/ (last visited November 14, 2013). On New Year's Day 2012, the same facility in Pensacola, Florida where Dr. Britton was murdered was completely destroyed by arson. FEMINIST MAJORITY FOUNDATION, *Anti-Abortion Protesters Block Wichita Abortion Doctor.* Later that year, a New Orleans facility and two

Georgia facilities suffered arson attacks, and a Planned Parenthood in Wisconsin was bombed. FEMINIST MAJORITY FOUNDATION, *Overview of Violence Against Women's Health Clinics*, http://feministcampus.org/wp-content/uploads/2013/08/AdoptAClinic_2013.pdf (last visited November 14, 2013). Also in 2012, activists launched a new website, AbortionDocs.org, to collect detailed information on every abortion provider in the country. Since then, anti-abortion protesters have stalked numerous doctors listed on the site. *Id.*[6]

In all, from 2007 to 2012, there have been 8 reported arsons, 41 incidents of assault and battery and more than 200 acts of vandalism. *See* Appendix B. Five of the arsons and seven incidents of assault and battery occurred in 2012 alone. *Id.* In addition, in this recent period, 6 bombings and arsons were attempted but carried out unsuccessfully. *Id.* Reproductive healthcare facilities also reported 37 bomb threats and 41 death threats. *Id.* And they continue to receive hoax devices and suspicious packages (81 reported during this period). *Id.* Facility staff and patients also continue to be stalked—over 50 reports from 2007 to 2012—often in areas surrounding the facility. *Id.*

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[6] Abortion opponents continue to support the "justifiable murder" of abortion providers. *See* http://www.armyofgod.com/. A "how to" guide for clinic violence remains available. *See* http://www.armyofgod.com/AOGhistory.html; *see also* NATIONAL CONSORTIUM FOR THE STUDY OF TERRORISM AND RESPONSES TO TERRORISM, *Army of God*,http://www.start.umd.edu/start/data_collections/tops/terrorist_organization_profile.asp?id=28 (last visited November 14, 2013).

Today, 92% of recently surveyed facilities report that they are concerned about the safety of their patients and employees in the areas approaching the facility, and nearly 90% report that, within the past two years, patients entering the facility have expressed concern about their personal safety.[7] Additionally, nearly 60% of facilities report that, within the past two years, facility employees have expressed concerns for their personal safety. And, over 80% of facilities have called law enforcement because of safety, access or criminal activity concerns. *See* Appendix C.[8]

Access to healthcare facilities is also a serious, continuing problem. In just the past six years, there have been nearly 30 facility blockades by anti-abortion activists that shut down facilities, preventing patients from accessing healthcare. *See* Appendix B. In 2010, "for the first time since 1999, the percentage of clinics reporting potential FACE

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[7] One *amicus* supporting Petitioners misguidedly argues that protestors have limited psychological or emotional impact on patients. *See* Cato Institute Br. 16. Most significantly, the claim does not address the access and safety concerns that a buffer zone is designed to ameliorate. Moreover, the referenced study actually concluded that "interacting with protesters can be upsetting to women at the time of the visit and may prompt facility staff to provide extra support." Diana Green Foster et al., *Effect of Abortion Protesters on Women's Emotional Response to Abortion*, 87 CONTRACEPTION 87 (2013). In fact, within the past two years, patients of 90% of clinics have expressed concerns for their safety. *See* Appendix C.

[8] NAF's survey of U.S. members, summarized in Appendix C, was conducted in September 2013, with 112 reporting facilities.

violations to federal law enforcement authorities increased." *See* Appendix D. This is consistent with a recent survey finding that almost 9 out of every 10 facility managers has concerns about a patient's ability to access the facility free from unwanted contact. *See* Appendix C. Similarly, at 71% percent of surveyed facilities, patients have reported that within the past two years they had difficulty entering the facility due to persons blocking or attempting to block their access. *Id*.[9]

Unlike other healthcare providers, reproductive healthcare facilities have had to spend substantial sums on safety precautions to protect themselves from the criminal activity that has targeted abortion providers. Eighty-eight percent of facilities report installing alarm systems, and 81% have installed security cameras. Seventy-four percent of facilities

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[9] An American Journal of Obstetrics and Gynecology article called this "epidemic of violence directed against health care providers . . . unique in American medicine," with profound medical and social implications. David A. Grimes et al., *An Epidemic of Antiabortion Violence in the United States*, 165 AM. J. OBSTET. GYNECOL. 1263, 1263 (1991). Hospitals, facilities and doctors have stopped providing abortion services because of the violence. Christopher W. Tomlin, *The Reign of Terror: The Judiciary's Inability to Stop Anti-Abortion Violence Forces Congress Back to the Drawing Board*, 18 LAW & PSYCHOL. REV. 423, 423 (1994). Today, abortions are not available in 87% of U.S counties. THE ALAN GUTTMACHER INSTITUTE, *Facts on Induced Abortion in the United States*, http://www.guttmacher.org/pubs/fb_induced_abortion.html (last visited November 14, 2013) ("The most recent survey found that 87% of all U.S. counties have no identifiable abortion provider. In non-metropolitan areas, the figure rises to 97%").

provide access via buzz entry only. Forty-four percent of facilities have bullet proof or resistant glass, and 40% have security personnel.

In sum, staggering amounts of violence, obstruction and intimidation continue to target abortion providers in this country. Existing laws that target criminal enforcement simply do not—and cannot—sufficiently ensure safe access near reproductive healthcare facilities, resulting in the critical need for buffer zone laws like the Massachusetts Act.

B. Buffer Zones Around Facility Entrances Have Been Shown to Reduce Violence, Obstruction and Harassment

It is both unfortunate and indisputable that a significant amount of violence, obstruction and intimidation has occurred at or near the entrances of reproductive healthcare facilities. By definition, bombings and arsons require close proximity to a facility. Blockades likewise must occur at or near a facility entrance. Moreover, the majority of the murders and attempted murders committed against reproductive healthcare providers have occurred within feet of the facility doors. And almost all of the assault and batteries reported by facilities have occurred at or near the facility entrance, where facility staff and patients must traverse.

Significantly, the evidence shows that buffer zone laws have resulted in decreased violence against, and increased access to, reproductive healthcare facilities. The evidence also shows that buffer zone laws have resulted in improved law enforcement protection of facilities. A national survey of all reproductive healthcare facilities,

including NAF members, Planned Parenthood and independent facilities, has found a positive relationship between buffer zone protection and improved law enforcement responses to anti-abortion violence, and between increased levels of law enforcement around facilities and lower levels of violence. *See* Appendix E. In fact, "[n]early half of those clinics with buffer zones or injunctions (46%) believe that these legal protections have prompted improved law enforcement responses to anti-abortion violence and harassment at their clinics." *Id*.

NAF's recent 2013 survey further confirms the safety benefits of buffer zone laws. Fifty-one percent of facilities with buffer zones reported a decrease in criminal activity near the facility after the buffer zone was instituted, and more than half of the responding facilities with buffer zones reported that the zones ameliorated safety concerns. *See* Appendix C. Moreover, 75% of responding facilities with buffer zones stated that the zones improved patient and staff access to the facilities. *Id*. And, of the surveyed facilities without a buffer zone law, three out of four believe that such a law would be beneficial. *Id*. Given the positive relationship between buffer zone laws and improved safety and access, such laws should be maintained and expanded, rather than overturned as Petitioners request.

Indeed, given the evidence, the Massachusetts Act is more than an appropriate legislative response to the continuing violence, intimidation and obstruction that targets reproductive healthcare facilities, staff and patients. Passed in 2007, the Act's purpose is "to increase forthwith public safety at reproductive health care facilities." Act Relative

to Public Safety at Reproductive Health Care Facilities, S.B. 1353, 185th Gen. Court (Mass. Nov. 13, 2007). The preamble to the 2000 predecessor statute provides further detail regarding Massachusetts' purposes: (a) increase public safety in and around facilities; (b) maintain the flow of traffic around the facilities; (c) "enact reasonable time, place and manner restrictions to reconcile and protect first amendment rights of persons to express their views . . . and the rights of persons seeking access to such facilities to be free from hindrance, harassment, intimidation and harm"; and (d) create an environment conducive to safe and effective medical services, including surgical procedures, for patients. 2000 Mass. Acts 1030, 2000 Mass. Legis. Serv. Ch. 217 (West).

To these ends, the Act carves out a safe zone around facilities, prohibiting persons from "knowingly enter[ing] or remain[ing] on a public way or sidewalk adjacent to a reproductive health care facility within a radius of 35 feet of any portion of an entrance, exit or driveway" unless the person is (1) "entering or leaving such facility"; (2) an employee or agent "of such facility acting within the scope of . . . employment"; (3) law enforcement, ambulance, firefighting, construction, utilities, public works and other municipal agents acting within the scope of . . . employment"; or (4) "using the public sidewalk or street right-of-way adjacent to such facility solely for the purpose of reaching a destination other than such facility." The Act's legislative history amply demonstrates that reproductive healthcare providers in Massachusetts face threats of violence and intimidation at the Boston facilities now protected by the law. J.A. at 37-44, 61.

While Petitioners suggest that there is no need for a buffer zone law in Massachusetts, they do not—because they cannot—provide evidence that obstruction and violence are no longer a problem at reproductive healthcare facilities in Massachusetts. Petitioners note only that from 2000 to 2007, there were no convictions under the prior floating buffer zone law in Massachusetts. Pet. Br. at 7. This proves nothing. That there were no convictions under the floating buffer zone law, if true, either means (1) that people who previously obstructed facility access generally complied with the ordinance—strong assurance that a buffer zone law is effective; or (2) if record testimony is credited, many violations of the old ordinance occurred, but were difficult to enforce given the floating zone, necessitating passage of the fixed buffer zone law at issue. J.A. 36, 41-63, 67-89. Under either scenario, the Commonwealth's interest in securing safety and patient access remains paramount today.

Indeed, with the Act, the Massachusetts legislature properly recognized the safety and access concerns facing reproductive healthcare facilities and fashioned a buffer zone law that effectively addresses these important governmental interests, while preserving First Amendment activity. As this Court has held, women should not be required to undergo Herculean efforts to obtain reproductive healthcare services. *See Madsen* v. *Women's Health Center, Inc.,* 512 U.S. 753, 772-773 (1994) (Rehnquist, C.J.); *Hill*, 530 U.S. at 716. The Massachusetts Act is a constitutional time, place and manner restriction that falls squarely within this Court's precedents.

II. MASSACHUSETTS' BUFFER ZONE LAW IS A CONSTITUTIONALLY PERMISSIBLE TIME, PLACE AND MANNER RESTRICTION

As demonstrated above, the States have undeniably significant, indeed compelling, law enforcement interests in securing the safety of their citizens and providing safe access to reproductive healthcare facilities. Under the Court's existing precedent, a content-neutral time, place and manner regulation—such as the Act—must be narrowly tailored to serve a significant government interest and leave open ample alternative channels of communication. *Ward*, 491 U.S. at 791. The Massachusetts statute fully meets this standard: it is narrowly tailored to serve significant State interests and provides ample alternative channels of communication.

A. The Statute is Narrowly Tailored to Serve the Commonwealth's Significant Interests in Safety and Access

This Court twice has upheld fixed buffer zones around reproductive healthcare facilities, under a more stringent tailoring standard than that applied to the content-neutral regulation at issue here. *Madsen*, 512 U.S. at 765, 770 (upholding 36-foot fixed buffer zone); *Schenck,* 519 U.S. at 380 (upholding 15-foot fixed buffer zone). This Court also has upheld a floating buffer zone under the same standard applicable to this case. *Hill*, 530 U.S. at 708, n.1 (upholding 100-foot zone with eight-foot floating bubble). This Court should likewise uphold the Massachusetts statute.

In *Madsen*, the Court upheld a 36-foot buffer zone as applied to the streets, sidewalks and driveways, as a narrowly-tailored "way of ensuring access to the clinic," burdening "no more speech than necessary to accomplish the governmental interest at stake." *Madsen*, 512 U.S. at 768, 770. In *Schenck*, this Court upheld a 15-foot fixed buffer zone "around the doorways, driveways, and driveway entrances" of the facility after recognizing the governmental interests in "ensuring public safety and order, promoting the free flow of traffic on streets and sidewalks, protecting property rights, and protecting a woman's freedom to seek pregnancy-related services." 519 U.S. 357, 376, 380 (1997). The governmental interests in those cases are precisely the interests at stake here, requiring the same result. Indeed, Petitioners' argument that the Act is unconstitutional, if accepted, would call *Schenck* and *Madsen* into doubt—and even Petitioners do not suggest that *Schenck* or *Madsen* should be overruled. *Schenck*, 519 U.S. at 376; *Madsen*, 512 U.S. at 771. [10]

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[10] *Madsen* and *Schenck* addressed injunctions and, thus, required a more "exacting" First Amendment analysis than that required for the Massachusetts statute. "[S]ince the [Supreme] Court upheld the buffer zones in *Madsen* and *Schenck* . . . finding them sufficiently tailored under a test more exacting than the one applicable here, the buffer zone established by the . . . Ordinance is *a fortiori* constitutionally valid." *Brown* v. *City of Pittsburgh*, 586 F.3d 263, 276 (3d Cir. 2009) (Scirica, C.J.); *see also Madsen*, 512 U.S. at 765 (differences between legislative ordinances and court-ordered injunctions "require a somewhat more stringent application of general First Amendment principles in [the injunction] context.").

Moreover, the Act promotes a substantial governmental interest that could not be achieved as effectively without the law. *Ward*, 491 U.S. at 799. The 35-foot zone is one foot smaller than the fixed zone upheld in *Madsen,* 512 U.S. at 768, 770, and is 65 feet smaller than the floating zone upheld in *Hill*, 530 U.S. at 708, n.1. The Commonwealth has tailored its Act to the well-documented governmental interests in safety and access, consistent with this Court's precedents.

Petitioners' suggestion that the Massachusetts statute is unnecessary because law enforcement has the means to arrest law violators misses the point. The State's interest in safe access is not fully served by prosecuting individuals *after* a crime has been committed. While the Petitioners in this case may be non-violent protesters who aim to speak to patients in a "compassionate and non-confrontational way," the States have a compelling interest in preventing violence by those protestors who do seek to do harm or obstruct access, as the history detailed above and in the Appendix amply demonstrates. *See Hill*, 530 U.S. at 729. Moreover, while injunctions may be effective against a particular enjoined individual, they do not prevent violence by others. Similarly, FACE is an important federal statute that provides criminal and civil remedies after a crime is committed, but it cannot fully address Massachusetts' interest in providing safe access to facilities on a daily basis. Given the repeated violence and obstruction surrounding reproductive healthcare facilities to this day,

Massachusetts properly recognized that the States, too, must act to protect patient access and safety.[11]

Simply put, prosecuting law violators as a penal matter, while critically important, does not address the State's significant interests in securing safe access to healthcare at the point when women are seeking services. Here, the Massachusetts legislature considered the particular facts and circumstances of its jurisdiction, determined that there is a need to protect facility staff and patients rather than wait for the violence to occur, and tailored a zone to ensure safe access. Notably, the Massachusetts legislature passed the current buffer zone law after years of pursuing injunctions and after a seven-year attempt with a floating buffer zone failed to solve the pervasive problems with safety and access around reproductive healthcare facilities. Pet. App. 137a-149a. Although the least restrictive means of ensuring access is not required, *Ward*, 491 U.S. at 798, in Massachusetts no other means has proven effective.

Amici submit that this Court should defer to the Commonwealth's—and other States'—judgment as to the appropriate buffer zone that serves its

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[11] Petitioners' reliance on *Kunz* is misplaced because the law there made it unlawful to hold public worship meetings on any streets without first obtaining a permit, a more sweeping prohibition not justified by a governmental interest in public safety. *Kunz* v. *People of New York*, 340 U.S. 290, 293-4 (1951). The same holds true for *Riley*, where public safety was not an issue and the Court invalidated a definition of reasonable fees applicable to charitable solicitations as not narrowly tailored to the State's interest in preventing fraud. *Riley* v. *National Fed'n of Blind*, 487 U.S. 781, 800-01 (1988).

governmental interests, a judgment that is amply supported by the record and this Court's prior precedents. *See Hill*, 530 U.S. at 729 (upholding state buffer zone as a preventative measure "to protect those who wish to enter health care facilities" as "justified by the great difficulty of protecting, say, a pregnant woman from physical harassment with legal rules that focus exclusively on the individual impact of each instance of behavior" and "the best way to provide protection, and, at the same time [offer] clear guidance and avoiding subjectivity, to protect speech itself."); *see also Ward,* 491 U.S. at 800-801; *Schenck,* 519 U.S. at 381; *Madsen,* 512 U.S. at 769-70.

B. The Statute Provides Ample Alternative Means of Communication

The Act, by carving out a limited amount of space around the facility, provides Petitioners ample alternative means to communicate their message, satisfying this Court's First Amendment precedents.

In challenging the Act, Petitioners point to certain differences between the Act and the Colorado statute in *Hill*, but in so doing Petitioners ignore *other* differences that compel affirmance. *See* Pet. Br. 48, 53. First, Petitioners note that under the Colorado statute, willing listeners could be approached within 35 feet while under the Act they could not, ignoring that outside of 35 feet, willing *and* unwilling listeners can be approached under the Act but not under the Colorado statute. Similarly, while leafletters can stand within 35 feet of the facility under the Colorado statute but not under the Act, leafletters under the Act *can*

approach anyone 35 feet outside of the facility, which they could not do under the Colorado statute.

These differences aside, under this Court's time, place and manner precedents, the Massachusetts fixed buffer zone provides ample alternative means of communication and thus satisfies the First Amendment. Under the Act, protesters may engage in *any* type of protected activity just 35 feet away from the facility, including leafleting, picketing, praying, engaging in one-on-one conversations, chanting, screaming, displaying signs and any other First Amendment activity.

Petitioners misguidedly argue that they cannot engage in one-on-one conversations 35 feet away because they cannot identify at that distance those persons who intend to enter the facility. Pet. Br. 13. But, Petitioners can *never* identify with any certainty those persons planning to enter a facility until the person actually enters, nor can they know the particular health service the patient is seeking without having a conversation. Thus, under Petitioners' own theory, whether they are within or without the 35-foot radius, they must confront a walking stranger and ask whether she is intending to obtain an abortion and, if so, whether she would like to discuss that topic with Petitioners. There is no significant difference between making this approach 10 feet outside of a facility or 35 feet outside of the facility.[12]

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[12] Petitioners' challenge to the Act is based almost entirely on the premise that they allegedly are prevented from having one-on-one communications. Notably, Petitioners do not contend that the *public* debate on abortion is impacted by the buffer zone law. *See, e.g. Snyder,* 131 S. Ct. at 1222-23, 12227

Accordingly, since the one-on-one approaches advocated by Petitioners are available 35 feet from the facility, the Act provides ample alternative means of this form of communication as well as all other forms of First Amendment activity. *Hill*, 530 U.S. at 715, 719; *see also Frisby*, 487 U.S. at 483-84; *Ward*, 491 U.S. at 802. It is constitutional.

C. The Statute is Both Content- and Viewpoint-Neutral

The Massachusetts statute is both content- and viewpoint-neutral. A statute is content-based where the government adopted the regulation "because of disagreement with the message it conveys." *Ward*, 491 U.S. at 791. Similarly, a statute is viewpoint-based when it discriminates based on the speaker's viewpoint. *Hill*, 530 U.S. at 719-20. The Massachusetts statute is neither.

Indeed, there is no evidence that the Act was passed to suppress content either generally or with reference to a particular viewpoint. Rather, its Preamble makes clear that the purpose of the statute is to ensure public safety and access to healthcare. An Act Relative to Public Safety at Reproductive Health Care Facilities, S.B. 1353, 185th Gen. Court (Mass. Nov. 13, 2007) (the purpose

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(Alito, J., dissenting) (The First Amendment did not give Westboro church license to engage in any and all speech directed solely at a private person, even though the church had "strong opinions on certain moral, religious, and political issues"; further, "there is no reason why a public street in close proximity to the scene of a funeral should be regarded as a free-fire zone in which otherwise actionable verbal attacks are shielded from liability.").

of the act "is to increase forthwith public safety at reproductive health care facilities").

Petitioners do not argue that the Massachusetts legislature's motivation was to suppress particular content, suggesting instead that "as a practical matter" the law "affects speech on only one issue" and "only one side." Pet. Br. 23. But, "[a] regulation that serves purposes unrelated to the content of expression is deemed neutral, even if it has an incidental effect on some speakers or messages but not others." *Ward*, 491 U.S. at 791 (citation omitted). The Act serves such content-neutral purposes.

Put simply, the Massachusetts statute regulates conduct, not speech. The statute neither prohibits nor allows particular content, but simply regulates the place where individuals may not congregate, a regulation necessary to serve significant State interests in permitting safe entry to the facility within the 35-foot buffer zone. Notably, Petitioners concede that the statute regulates conduct and not speech when they argue that the space is off-limits to anyone "who wants to enter the area near the clinic entrances to speak about abortion (*or anything else*)." Pet. Br. 40 (*emphasis added*). Moreover, contrary to Petitioners' suggestion, the statute conforms with *Hill* because "[i]t is not limited to those who oppose abortion. . . . It applies . . . to all demonstrators whether or not the demonstration concerns abortion and whether they oppose or support . . . an abortion decision." Pet. Br. 20 (citing *Hill*, 530 U.S. at 725). Pro-choice picketers, and all other picketers, are equally disallowed from entering and remaining in the buffer zone. "That is the level of neutrality that the Constitution demands." *Id.*

Nor does the statute's application to reproductive healthcare facilities make it content-based. Pet. Br. 23-25. Indeed, Petitioners' argument makes little sense from a First Amendment perspective, as it would broaden the reach of buffer zones to facilities where they are not needed. Here, instead, the Act's targeted application is a narrowly-tailored, content-neutral response to documented safety and access problems near reproductive healthcare facilities, a status not applicable "outside every building in the State." Pet. Br. 24. As demonstrated above, the anti-abortion movement has a long history of violence and obstruction surrounding reproductive healthcare facilities that simply is not applicable to all buildings or even all healthcare facilities. *See, e.g.*, Grimes et al., *An Epidemic of Antiabortion Violence in the United States* at 1263 (the epidemic of violence against abortion providers is "unique in American medicine").

The law has long recognized that the government permissibly may target the locations where its interests in securing safety and access are most in jeopardy—and this principle applies fully to this case. *See, e.g.*, *Boos* v. *Barry*, 485 U.S. 312 (1985) (Washington D.C. statute prohibiting congregations within 500 feet of a foreign embassy upheld due to security concerns); *Burson*, 504 U.S. at 198-99 (upholding content-based state prohibition on electioneering within 100 feet of entrance to polling place, as serving state interests in protecting the right to vote freely and the integrity of elections); *Hill,* 530 U.S. at 724 (rejecting "theory that a statute restricting speech becomes unconstitutionally content-based because of its application to the specific locations where that discourse occurs"); s*ee also Menotti* v. *City of Seattle*, 409 F.3d 1113, 1120-21, 1123 (9th Cir. 2005) (order

establishing daytime curfew in downtown Seattle during WTO conference and accompanying protests upheld as constitutional time, place, and manner restriction to maintain order and peace, even though peaceful protesters were restricted).

The exception for employee access does not make the Act content- or viewpoint-based, either. Pet. Br. 27-28. The purpose of the employee exception has nothing to do with speech but instead ensures that facility staff are permitted passage to their workplace. That employees must enter the zone in order to access their workplace does not turn on the content or viewpoint of any message, but on their need to get to work. *Compare Snyder*, 131 S. Ct. at 1219 ("any distress occasioned by Westboro's picketing turned on the content and viewpoint of the message conveyed"); *Holder* v. *Humanitarian Law Project*, 130 S. Ct. 2705, 2723-24 (2010) (finding that statute outlawing material support to terrorists "regulates speech on the basis of its content" because whether plaintiffs may speak to particular groups "depends on what they say").

Petitioners' argument that the exception is viewpoint-based also relies on the incorrect assumption that, *by walking* through the zone into the facility, employees are expressing a particular viewpoint. Pet. Br. 28. Moreover, even putting aside that walking is conduct and not speech, Petitioners incorrectly assume that facility employees in the zone are there to advocate a particular viewpoint. Rather, they are there to access their workplace.

Likewise, other agents of the facility, such as escorts or armed guards, are permitted to enter the buffer zone because they are providing *services*

related to safety, not to express any particular viewpoint. In fact, of those reproductive healthcare facilities that train escorts, 82% train escorts that they shall *not* advocate views on abortion when servicing the facility. *See* Appendix C. Nor is there evidence that facility employees or volunteers utilize buffer zones to encourage women to get abortions.[13]

Petitioners also suggest, inaccurately, that women entering reproductive healthcare facilities are not informed of their options. In fact, like any other medical procedure, an abortion procedure is performed only after the patient is informed of alternatives. For example, NAF's *Clinical Policy Guidelines* dictate that the "practitioner must ensure that appropriate personnel have a discussion with the patient in which accurate information is provided about the procedure *and its alternatives*, *and the potential risks and benefits*." (emphasis added) "There must be documentation that the patient affirms that she understands the procedure and its alternatives, and the potential risks and benefits; and that her decision is voluntary." NATIONAL ABORTION FEDERATION, *2013 Clinical Policy Guidelines*, at 3 *available at* http://www.prochoice.org/pubs_research/publications/documents/2013NAFCPGsforweb.pdf (last visited November 14, 2013). Moreover, "[e]ach patient must have a private opportunity to discuss issues and concerns about her abortion," and "[i]nformation about clinical procedures, aftercare,

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[13] Petitioners' citations allegedly quoting clinic agents who "say things like 'abortion is legal'" are hearsay statements by anti-abortion protesters, allegedly characterizing speech. Pet. Br. 28.

and birth control must be available to patients at the facility." *Id.*[14]

In short, the employee exception simply allows people who provide medical and other services to enter the facility where they work. Without this exception, employees could not do their jobs and the facilities could not operate. The Act contains a separate exception for those who must enter and exit the facility (an exception that is not challenged by Petitioners), but that exception does not account for all staff activity. For example, armed guards must stand near the facility entrance, and thus would violate the buffer zone if not for the employee/agent exception.

It also is notable that the Massachusetts Attorney General has construed the statute so that employees are not permitted to engage in any partisan speech. J.A. at 93. "[I]n evaluating a facial challenge to a state law, a federal court must . . . consider any limiting construction that a state court or enforcement agency has proffered." *Ward*, 491 U.S. at 795-96 (citation omitted). As such, any prohibition on speech applies neutrally to all

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[14] Certain *amici* supporting Petitioners state that women may be receptive to alternatives when considering an abortion and that women benefit from hearing the full debate. *See* Democrats for Life Br. 12-16; Eagle Forum Br. 7-9. But, these *amici* incorrectly assume both that women entering a facility have not considered alternatives and that alternatives are not explained *as with any other medical procedure*. Moreover, there is nothing about the buffer zone itself that prevents women from hearing the full debate. That debate can still occur 35 feet away, if women are receptive to Petitioners' entreaties.

persons in the buffer zone. Petitioners' citation to *Hoye* v. *City of Oakland* does not support their argument. In that case, the Ninth Circuit found a buffer zone statute facially constitutional, but ruled that it was being applied in a content-based manner because the City of Oakland had a policy of enforcing the statute to favor speakers on one side of the debate. 553 F.3d 835, 843, 849 (9th Cir. 2011). The Massachusetts policy as issued by the Attorney General does exactly the opposite.

Accordingly, this Court should uphold the Act as a constitutional content- and viewpoint-neutral time, place and manner restriction.

III. THIS COURT SHOULD DEFER TO THE JUDGMENT OF INDIVIDUAL STATES THAT ENACT BUFFER ZONE LAWS AS NECESSARY TO PROTECT PUBLIC SAFETY AND WOMEN'S ACCESS TO HEALTHCARE IN THEIR JURISDICTION

As demonstrated above, given the continual violence and obstruction targeted at reproductive healthcare facilities, the staff and patients of such facilities are in particular need of protection in the areas at or near facility entrances. In fact, significant violence has occurred right outside facilities—including at least six of eight murders, 42 bombings, and 181 arsons. *See* Appendix B. Hundreds of facility blockades have occurred at facility entrances. *Id.* Death threats, bomb threats, and other forms of intimidation of facility staff number in the thousands. *Id.* Nowhere else in the United States can one find this kind of sustained

campaign of violence and intimidation targeting a particular place of business.

This violent experience has caused state and local governments, concerned about the safety of their citizens and women's access to healthcare, to fashion laws that take into account the particular needs of their locality, while providing ample means of First Amendment communication. That is precisely what Massachusetts did here, and for good reason: The evidence shows that buffer zone laws are effective in achieving these important governmental interests. In fact, over three-quarters of recently surveyed facilities with buffer zones state that the zones improved patient and staff access to the facilities, and over half of these facilities state that buffer zones also reduced safety concerns. *See* Appendix C.

As the Court recognized in *Hill*, "whether or not the [buffer zone] is the best possible accommodation of the competing interests at stake, we must accord a measure of deference to the judgment of the [State] Legislature." *Hill*, 530 U.S. at 727; *accord Madsen,* 512 U.S at 769-770 ("some deference must be given to the state court's familiarity with the facts and the background of the dispute . . . even under our heightened review"); *see also Shelby County* v. *Holder*, 133 S. Ct. 2612, 2623 (2013) ("States retain broad autonomy in structuring their governments and pursuing legislative objectives."). This principle holds true here.

Finally, this Court should not accept Petitioners' invitation to overrule *Hill*. While this case concerns abortion facilities, Petitioners' criticism of *Hill* amounts to a broadside attack on the Court's entire time, place and manner jurisprudence. *See* Pet. Br.

53-56. Petitioners argue that *Hill* upheld a law barring (at a particular time, place, and manner) peaceful speech about a "profound moral issue" on a public sidewalk. *Id*. at 54. But this argument, if accepted, cannot logically be limited to the abortion context. Indeed, the Court of Appeals here appropriately followed settled doctrine—applicable in all contexts—that allows States to regulate speech—even speech on a public sidewalk—when a governmental interest is at stake. *See, e.g., Frisby* 487 U.S. at 489 (upholding ordinance prohibiting picketing near a residence or dwelling of any individual as a valid time, place, and manner law); *see also Snyder*, 131 S. Ct. at 1218 ("Westboro's choice of where and when to conduct its picketing is not beyond the Government's regulatory reach—it is subject to reasonable time, place, or manner restrictions that are consistent with the standards announced in this Court's precedents.") (*dicta*); *Burson,* 504 U.S. at 211 (upholding content-based state statutes prohibiting solicitation of votes and display of campaign materials within 100 feet of entrance to polling place on election day).

Accordingly, under this Court's precedents, the judgment of the Court of Appeals should be affirmed, and this Court should hold that the Massachusetts buffer zone law is a constitutional time, place and manner regulation.

CONCLUSION

For all of the reasons above, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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APPENDIX

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Appendix A:
Individual Statements of Interest
of *Amici Curiae*

Abortion Care Network

The Abortion Care Network (ACN) is a national nonprofit made up of independent abortion providers and allies. ACN works to heal the stigma that harms both women and abortion providers and is committed to creating a community that supports the right of all people to experience dignified and respectful abortion care. ACN has been a pioneer in encouraging a deep and honest national conversation about the nuances and complexities of abortion. ACN knows that every day good women make tough choices—and sometimes they choose abortion. And ACN knows that for the past four decades abortion providers have endured unspeakable abuse that would not have been accepted if directed to any other segment of society. ACN has continued to provide excellent care because women need it.

American Association of University Women

In 1881, the American Association of University Women (AAUW) was founded by like-minded women who had defied society's conventions by earning college degrees. Since then, AAUW has worked to break through barriers for women and girls through research, advocacy, and philanthropy. Today, AAUW has approximately 170,000 bipartisan members and supporters, approximately 1,000 branches, and approximately 800 college and university partners nationwide. AAUW plays a major role in mobilizing advocates nationwide on AAUW's priority issues, and among them are

reproductive rights. In adherence to our member-adopted Public Policy Program, AAUW supports choice in the determination of one's reproductive life and increased access to quality, affordable healthcare and family planning services, including expansion of patients' rights.

Association of Reproductive Health Professionals

Association of Reproductive Health Professionals (ARHP), founded in 1963, is a multidisciplinary association of professionals who provide reproductive health services and education, conduct reproductive health research, and impact reproductive health policy. ARHP educates all members of the healthcare team, and fosters research and advocacy to improve reproductive health. Our members define sexual and reproductive health in broad terms to incorporate family planning and abortion, and recognize that the best care is delivered through a team of professionals partnering with an informed patient. ARHP delivers on our educational mission by translating good science into practice through producing accredited, peer-reviewed training and education programs. We support all safety measures, including appropriate buffer zones, that help protect family planning and abortion providers and their clients.

The Black Women's Health Imperative

The Black Women's Health Imperative (Imperative) is the only organization devoted solely to advancing the health and wellness of America's 19.5 million Black women and girls through

advocacy, community health and wellness education and leadership development. The Imperative seeks to improve the health and wellness of Black women by providing health resources and information, promoting advocacy and health policies, and interpreting and issuing reports on relevant research about the health status of America's Black women. We offer our members culturally appropriate tools and information to be an informed and empowered healthcare consumer.

Catholics for Choice

Catholics for Choice is a nonprofit organization that shapes and advances sexual and reproductive ethics that are based on justice, reflect a commitment to women's well-being, and respect and affirm the moral capacity of women and men to make decisions about their lives.

Feminist Majority Foundation

The Feminist Majority Foundation (FMF), founded in 1987, is the largest feminist research and action organization dedicated to women's equality and reproductive health. FMF's programs focus on advancing the legal, social and political equality of women. To carry out these aims, FMF engages in research and public policy development, public education programs, grassroots organizing projects, and leadership training and development programs. FMF has filed numerous *amicus curiae* briefs in the United States Supreme Court and the federal circuit courts to advance the opportunities for women and girls.

Hadassah, The Women's Zionist Organization of America, Inc.

Hadassah, The Women's Zionist Organization of America, Inc., founded in 1912, has over 330,000 Members, Associates and supporters nationwide. In addition to Hadassah's mission of initiating and supporting pace-setting healthcare, education and youth institutions in Israel, Hadassah has a proud history of protecting the rights of women in the United States. Hadassah is a longstanding advocate for the right of reproductive choice and strongly supports ensuring safe access to healthcare facilities, while preserving freedom of speech.

Ibis Reproductive Health

Ibis Reproductive Health aims to improve women's reproductive autonomy, choices, and health worldwide. We conduct original clinical and social science research in order to identify barriers to access and test new ways to deliver services and inform women about their reproductive health options. We perform analysis to document the impact of existing policies and inform recommendations for change, and we partner with advocates, providers, and policymakers who can use our research to promote improvements in policy and service-delivery practice.

Law Students for Reproductive Justice

Law Students for Reproductive Justice (LSRJ) trains and mobilizes law students and lawyers across the country to foster legal expertise and support for the realization of reproductive justice. LSRJ believes that reproductive justice will exist when all people can exercise the rights and access

the resources they need to thrive and to decide whether, when, and how to parent children with dignity, free from discrimination, coercion, or violence. As such, LSJR believes that buffer zones are critical for the protection of an individual's right and ability to access safe reproductive healthcare services.

The League of Women Voters of Massachusetts

The League of Women Voters of Massachusetts (LWVMA) was founded in 1920, the year the 19th amendment gave women the right to vote. The LWVMA is part of a nonpartisan, citizens' organization with national, state, and local levels. In addition to the national LWV, there are more than 800 strong state and local Leagues in all 50 states and the District of Columbia, the Virgin Islands, and Hong Kong. A grassroots, volunteer-driven organization comprised of more than 140,000 members and supporters, Leagues form opinions after careful research, study and consensus of members. For 93 years, the mission of LWVMA, one of the nation's largest state Leagues, has been to encourage informed and active participation in government, increase understanding of major public policy issues, and to influence public policy through education and advocacy within the Commonwealth of Massachusetts. At all levels, the League has a long history of supporting a woman's right of privacy to make personal reproductive choices. Since 1973, LWVMA has actively worked, through both legislative and judicial means, to guarantee that women can exercise this right in a safe environment.

Medical Students for Choice

Medical Students for Choice works to preserve access to safe abortion services by ensuring that medical students are trained and willing to provide abortion care. The safety of abortion-providing physicians and staff is critical to ensuring that physicians continue to be willing to provide this vital service for women, and buffer zones have proven to be a useful legal protection for these courageous physicians.

NARAL Pro-Choice America

NARAL Pro-Choice America is a national advocacy organization, dedicated since 1969 to supporting and protecting, as a fundamental right and value, a woman's freedom to make personal decisions regarding the full range of reproductive choices through education, organizing, and influencing public policy. Enactment and enforcement of effective and appropriate clinic protection laws, like the Massachusetts buffer zone statute, is vital to this goal and to ensuring women safe access to critical healthcare.

NARAL Pro-Choice Massachusetts

NARAL Pro-Choice Massachusetts is a statewide grassroots organization with more than 20,000 members in Massachusetts dedicated to promoting full and equal access to reproductive healthcare services, including preventative care, preventing unintended pregnancies, choosing safe, legal abortion, and bearing healthy children. NARAL Pro-Choice Massachusetts advocates on behalf of women, family planning providers, and abortion providers across the state and recognizes that the

buffer zone has been a successful tool in allowing the women of Massachusetts to access basic healthcare without intimidation or fear.

NARAL Pro-Choice New York

NARAL Pro-Choice New York is a political and advocacy organization whose mission is to guarantee every woman the right to make personal decisions regarding the full range of reproductive choices, including preventing unintended pregnancy, bearing healthy children, and choosing legal abortion. We work in New York at the state and local levels to pass proactive, pro-choice legislation and were instrumental in the passage of a New York City ordinance protecting access to abortion care clinics.

National Abortion Federation

The National Abortion Federation (NAF), a nonprofit organization founded in 1977, is the professional association of abortion providers in North America. NAF's members include nearly 400 nonprofit and private facilities, women's health centers, hospitals and private physicians' offices. NAF acts as an advocate for provider protection with all levels of law enforcement; tracks and informs its members about anti-abortion violence; and conducts on-site security assessments and training for facility staff to assist with safety concerns.

National Asian Pacific American Women's Forum

National Asian Pacific American Women's Forum (NAPAWF) is the only national, multi-issue Asian and Pacific Islander (API) women's

organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for API women and girls.

National Association of Social Workers and its Massachusetts Chapter

Established in 1955, the National Association of Social Workers (NASW) is the largest association of professional social workers in the world with nearly 135,000 members and 55 chapters throughout the United States and internationally. The NASW-Massachusetts Chapter represents 7,700 members. With the purpose of developing and disseminating standards of social work practice while strengthening and unifying the social work profession as a whole, NASW provides continuing education, enforces the *NASW Code of Ethics*, conducts research, publishes books and studies, promulgates professional criteria, and develops policy statements on issues of importance to the social work profession. The NASW policy, *Family Planning and Reproductive Choice*, states, "The NASW position concerning family planning, abortion, and other reproductive health services is based on the bedrock principles of self-determination, human rights, and social justice: Every individual, within the context of her value system, must have access to family planning, abortion, and other reproductive health services… in a manner that is …voluntary and preserve[s] the individual's right to privacy." SOCIAL WORK SPEAKS 129, 132 (9th ed., 2012). NASW supports "[a] woman's right to obtain an abortion, performed according to accepted medical standards and in an environment free of harassment or threat for both patients and providers." *Id.* at 133.

National Council of Jewish Women

The National Council of Jewish Women (NCJW) is a grassroots organization of 90,000 volunteers and advocates who turn progressive ideals into action. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms. NCJW's Resolutions state that we endorse and resolve to work for laws, policies, programs, and services that protect every woman from all forms of abuse, exploitation, harassment and violence; comprehensive, confidential, accessible family planning and reproductive health services, regardless of age or ability to pay; and the protection of every female's right to reproductive choices, including safe and legal abortion, medically accurate information, access to contraception, and the elimination of obstacles that limit reproductive freedom.

National Family Planning and Reproductive Health Association

Founded in 1971 and located in Washington, D.C., the National Family Planning & Reproductive Health Association (NFPRHA) is a nonprofit membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men. NFPRHA's membership includes approximately 550 organizational members that operate or fund a network of nearly 5,000 safety-net health centers and service sites in 49 states and the District of Columbia. Given the long history of violence and intimidation that has occurred at reproductive

health clinics, NFPRHA supports measures such as buffer zones that help protect health center staff and the patients they serve.

National Institute for Reproductive Health

The National Institute for Reproductive Health engages in bold advocacy, creative education campaigns, and high-impact local partnerships in states and localities across the country to promote reproductive rights and expand access to reproductive healthcare, reduce unintended pregnancies, and empower youth to make healthy sexual and reproductive decisions. The Institute believes ensuring women have safe and unencumbered access to reproductive healthcare facilities is vital to women's health and well-being, and has supported efforts related to protecting access to abortion care clinics.

National Latina Institute for Reproductive Health

Amicus curiae National Latina Institute for Reproductive Health ("NLIRH") is the only national organization working on behalf of the reproductive health and justice of the 24 million Latinas, their families, and communities in the United States through public education, community mobilization, and policy advocacy. Latinas face a unique and complex array of reproductive health and rights issues that are exacerbated by poverty, geography, gender, racial and ethnic discrimination, sexual orientation and gender identity, and immigration status. These circumstances make it especially difficult for Latinas to access the full range of reproductive healthcare, including abortion services. Latinas are twice as likely to experience unintended

pregnancies than their white peers, making access to abortion care without barriers a priority for Latina health. Therefore, the issues addressed in this case are central concerns to the organization.

National Organization for Women Foundation

The National Organization for Women (NOW) Foundation is a nonprofit organization devoted to furthering women's rights through education and litigation. Created in 1986, NOW Foundation is affiliated with the National Organization for Women, the largest feminist activist organization in the United States, with hundreds of thousands of members and contributing supporters with chapters in every state and the District of Columbia. The litigation efforts of the Foundation seek to protect reproductive health options, as well as focus on other areas of concern to women, such as pregnancy discrimination, employment issues, discrimination against women in the military, sexual harassment and exploitation, lesbian and gay rights, civil rights, sex discrimination in insurance, and ending violence against women.

National Partnership for Women and Families

The National Partnership for Women & Families (formerly the Women's Legal Defense Fund) is a national advocacy organization that develops and promotes policies to help women achieve equal opportunity, quality health care, and economic security for themselves and their families. Since its founding in 1971, the National Partnership has worked to advance women's health and equal employment opportunities through several means,

including by challenging discriminatory employment practices in the courts.

National Women's Health Network

The National Women's Health Network (NWHN) works to improve the health of all women by influencing policy and supporting informed consumer decision-making. The NWHN is committed to ensuring that women have self-determination in all aspects of their reproductive and sexual health, including having full access to safe and affordable abortion care. We believe that the government has an obligation to safeguard the health of all people and that all women should have access to excellent healthcare. In support of these beliefs, the NWHN defends against threats that undermine access to contraceptive and abortion care and promotes provision of accurate information about reproductive health.

National Women's Law Center

The National Women's Law Center is a nonprofit legal advocacy organization that has worked since 1972 to advance and protect women's legal rights and opportunities. The fundamental right to abortion recognized in *Roe* v. *Wade* is of profound importance to the lives, health, and futures of women throughout the country. Because of the tremendous significance to women of the freedom to choose whether to bear children, the National Women's Law Center seeks to preserve women's right to a safe abortion without harassment, violence, or other interference, and has filed or participated in numerous amicus briefs in this Court in cases that affect this right.

Nursing Students for Choice

Nursing Students for Choice (NSFC) is a national nonprofit organization comprised of nursing students and practicing nurses across the United States. Nurses are vital clinicians in reproductive healthcare, who provide much of the pregnancy testing, birth control and options counseling, and post procedure care that affects patients every day. With more than 3 million nurses working in the US today, we counsel patients both formally and informally—in emergency rooms, health departments, federal and private offices, and on campuses across the country. We believe that both patients and clinicians can, and will, benefit from buffer zones which decrease the level of harassment for all who are providing care, as well as for those who are being provided for.

Physicians for Reproductive Health.

Physicians for Reproductive Health (PRH) is a doctor-led national nonprofit organization that relies upon evidence-based medicine to promote sound reproductive healthcare policies. Comprised of physicians, PRH brings medical expertise to discussions of public policy on issues affecting reproductive healthcare and advocates for the provision of comprehensive reproductive health services as part of mainstream medical care. Doctors in PRH's network have experienced violence and harassment and PRH recognizes the need for measures such as buffer zones that help ensure the safety of healthcare providers and the patients for whom they care.

Provide, Inc.

Provide, Inc. is a nonprofit organization based in Massachusetts and founded in 1992. Provide is committed to access to safe abortion for all women in the U.S. Provide believes all people should be able to obtain needed health care including abortion. Provide works in Southern and Midwestern states to train and social service providers to offer non-judgmental, all options counseling to their clients and patients. Provide also works with nursing faculty seeking to address the gaps in reproductive options curricula at nursing programs. Finally, Provide conducts trainings with clinicians that aims to expand women's access to manual vacuum aspiration and medication management of miscarriage. Provide recognizes that the ability to enter into a healthcare facility unobstructed and free of harassment is integral to both the provision of and access to care.

Reproductive Health Access Project

Reproductive Health Access Project (RHAP) is a national nonprofit dedicated to integrating contraception and abortion into primary care. Through training, advocacy and mentoring programs, RHAP helps family physicians and other clinicians make birth control and abortion a part of routine medical care. RHAP is guided by the principle that everyone has the right to access birth control and abortion services in safe, secure settings. We believe that reproductive health choices are highly individual and must be made by individual families in consultation with caregivers for whom the individual's ability to meet their full potential is of paramount importance. We believe that these choices must be supported by healthcare

policies that ensure everyone has fair and equal access to the means to control their reproductive futures. Ensuring the safety of clinicians and staff who provide abortion care as well as the safety of individuals seeking this care is critical.

The Reproductive Health Technologies Project

The Reproductive Health Technologies Project (RHTP) works to advance the ability of every woman to achieve full reproductive freedom with access to the safest, most effective, and preferred methods for controlling her fertility and protecting her health. RHTP's long-term goal is to change the political and commercial climate in the United States so women have access to technologies they want to become pregnant when they are ready, end a pregnancy when they are not, and promote their health and well-being throughout their reproductive lives.

The Unitarian Universalist Association

The Unitarian Universalist Association (UUA) comprises more than 1,000 religious congregations nationwide. Many years ago, the UUA General Assembly passed a resolution urging individuals to ensure that every woman shall have the right to choose to terminate a pregnancy legally and with all possible safeguards.

The Women's Bar Association of Massachusetts

The Women's Bar Association of Massachusetts (WBA) is a professional association comprised of 1,500 attorneys, judges, and policy-makers

dedicated to advancing and protecting the interests of women in society. To fulfill this mission, the WBA has submitted amicus briefs, supported legislation, and provided pro bono representation in the areas of, *inter alia*, domestic violence, alimony, nursing mothers, and reproductive health. Indeed, since its creation in 1978, the WBA has successfully advocated for Massachusetts laws that protect a woman's right to access reproductive healthcare. Specifically, in 2000, the WBA testified before the legislature in support of the Commonwealth's first buffer zone bill. In 2007, the WBA along with the Massachusetts Attorney General, District Attorneys, legislators, and a coalition of other advocacy organizations, worked to pass the buffer zone law that is at issue in this case. Therefore, the WBA has an interest in the outcome of this case, and it represents an appropriate issue for the WBA to offer its guidance.

Appendix B:
NAF Violence and Disruption Statistics
(1977 – 2012)

2b

NATIONAL ABORTION FEDERATION

NAF VIOLENCE AND DISRUPTION STATISTICS

INCIDENTS OF VIOLENCE & DISRUPTION AGAINST ABORTION PROVIDERS IN THE U.S. & CANADA

VIOLENCE	1977-94	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	TOTAL
Murder[1]	5	0	0	0	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	8
Attempted Murder	11	1	1	2	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Bombing[1]	29	1	2	6	1	1	0	1	0	0	0	0	0	0	0	0	0	1	0	42
Arson[1]	124	14	3	8	4	8	2	2	1	3	2	2	0	2	0	0	0	1	5	181
Attempted Bomb/Arson[1]	64	1	4	2	5	1	3	2	0	0	1	6	4	2	1	1	1	1	0	99
Invasion	347	4	0	7	5	3	4	2	1	0	0	0	4	7	6	1	0	0	0	391
Vandalism	585	31	29	105	46	63	56	58	60	48	49	83	72	59	45	40	22	27	12	1490
Trespassing	0	0	0	0	0	193	81	144	163	66	67	633	336	122	148	104	45	69	47	2218
Butyric Acid Attacks	80	0	1	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100
Anthrax/Bioterrorism Threats	0	0	0	0	12	35	30	554	23	0	1	0	0	1	3	2	1	1	0	663
Assault & Battery	95	2	1	9	4	2	7	2	1	7	8	8	11	12	6	9	4	3	7	198
Death Threats	225	41	13	11	25	13	9	14	3	7	4	10	10	13	2	16	2	2	6	426
Kidnapping	2	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	4
Burglary	34	3	6	6	6	4	5	6	1	9	5	11	30	12	7	12	13	8	5	183
Stalking[2]	200	61	52	67	13	13	17	10	12	3	15	8	6	19	19	1	7	1	6	530
TOTAL	1801	159	112	223	144	336	215	795	265	143	152	761	474	249	237	187	95	114	88	6462

3b

NATIONAL ABORTION FEDERATION

NAF VIOLENCE AND DISRUPTION STATISTICS

INCIDENTS OF VIOLENCE & DISRUPTION AGAINST ABORTION PROVIDERS IN THE U.S. & CANADA

DISRUPTION	1977-94	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	TOTAL
Hate Mail/Harassing Calls	1833	255	605	2829	915	1646	1011	404	230	432	453	515	548	522	396	1699	404	365	417	15479
Email/Internet Harassment	0	0	0	0	0	0	0	0	24	70	51	77	25	38	44	16	44	17	41	447
Hoax Device/Susp. Package	0	0	0	0	0	0	0	0	41	13	9	16	17	23	24	17	8	2	7	177
Bomb Threats	311	41	13	79	31	39	20	31	7	17	13	11	7	6	13	4	12	1	1	657
Picketing [4]	7768	1356	3932	7518	8402	8727	8478	9969	10241	11348	11640	13415	13505	11113	12503	8388	6347	4780	4519	163949
Obstruction [5]																			79	79
TOTAL	9912	1652	4550	10426	9348	10412	9509	10404	10543	11880	12166	14034	14102	11702	12980	10124	6815	5165	5064	180788
CLINIC BLOCKADES																				
Number of Incidents	634	5	7	25	2	3	4	2	4	10	34	4	13	7	8	1	1	5	6	775
Number of Arrests [3]	33661	54	65	29	16	5	0	0	0	0	0	0	0	3	1	0	0	0	4	33838

All numbers represent incidents reported to or obtained by NAF. Actual incidents are likely much higher. Tabulation of trespassing began in 1999 and tabulation of email harassment and hoax devices began in 2002.

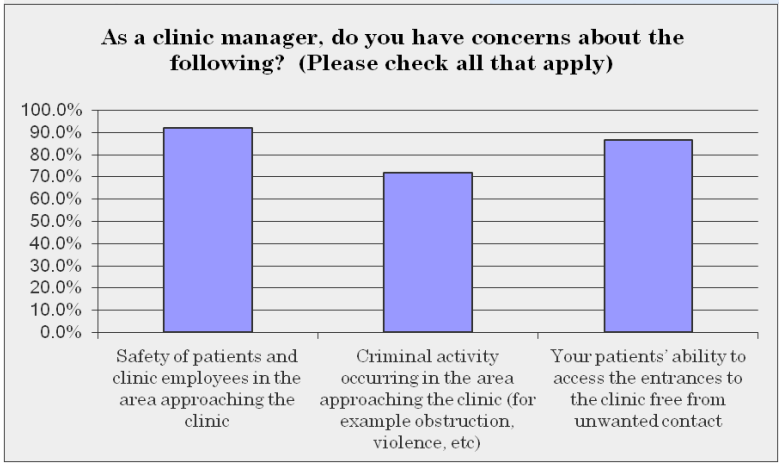
1. Incidents recorded are those classified as such by the appropriate law enforcement agency. Incidents that were ruled inconclusive or accidental are not included.
2. Stalking is defined as the persistent following, threatening, and harassing of an abortion provider, staff member, or patient away from the clinic. Tabulation of stalking incidents began in 1993.
3. The "number of arrests" represents the total number of arrests, not the total number of persons arrested. Many blockaders are arrested multiple times.
4. NAF changed its method of collecting this data in 2011.
5. Tabulation of Obstruction began in 2012. Obstruction is defined as the act of causing a delay or an attempt to cause a delay in the conduct of buisness or prevent persons from entering or exiting an area. This would apply to violations of the FACE Act.

Appendix C:
NAF 2013 Survey

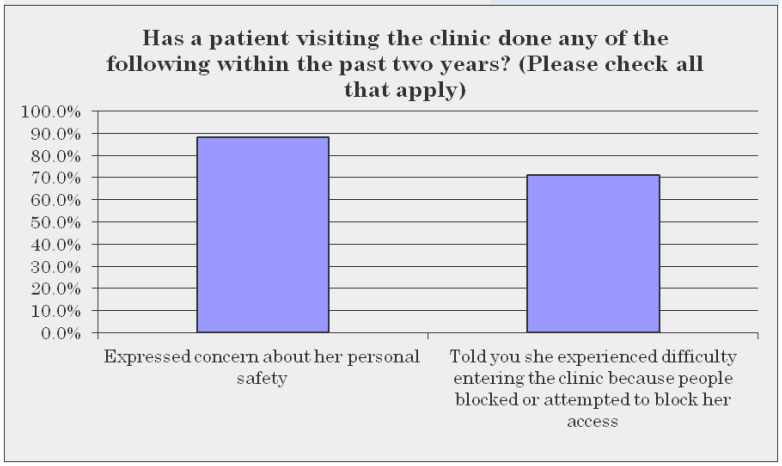
Anti-Abortion Violence and Disruption
Survey Results
September 2013

At the National Abortion Federation, the safety of our members and their patients is our highest priority. Each month, we collect reports from our members in the United States and Canada on the incidents of violence and disruption they have faced during the previous month. Periodically, we conduct surveys of our members on particular areas of concern. These results are from a survey we conducted in September 2013 of our member facilities in the United States. A link to the online survey was sent to each member facility, and 112 facilities responded to the survey.

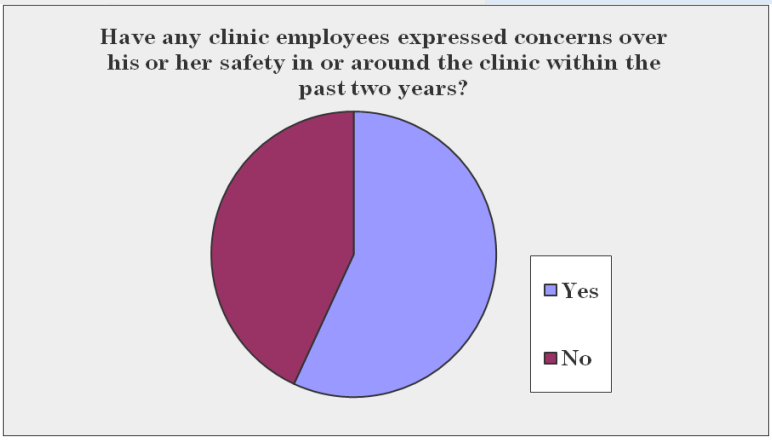
As a clinic manager, do you have concerns about the following? (Please check all that apply)	
Answer Options	**Response Percent**
Safety of patients and clinic employees in the area approaching the clinic	92.1%
Criminal activity occurring in the area approaching the clinic (for example, obstruction, violence, etc.)	71.9%
Your patients' ability to access the entrances to the clinic free from unwanted contact	86.5%



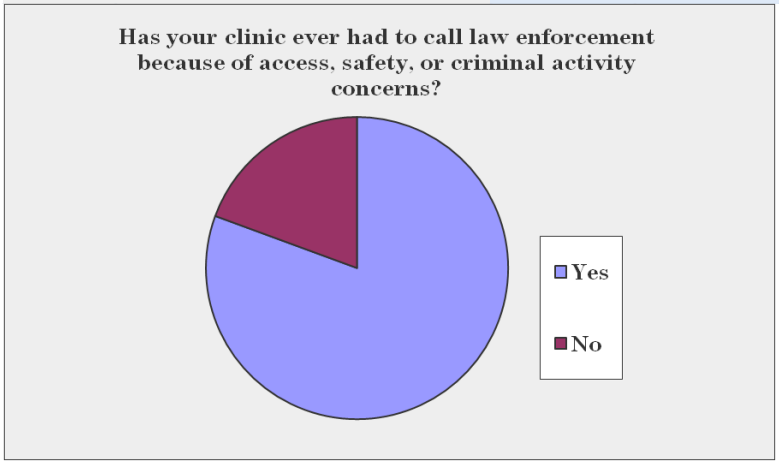
Has a patient visiting the clinic done any of the following within the past two years? (Please check all that apply)	
Answer Options	**Response Percent**
Expressed concern about her personal safety	88.4%
Told you she experienced difficulty entering the clinic because people blocked or attempted to block her access	71.0%



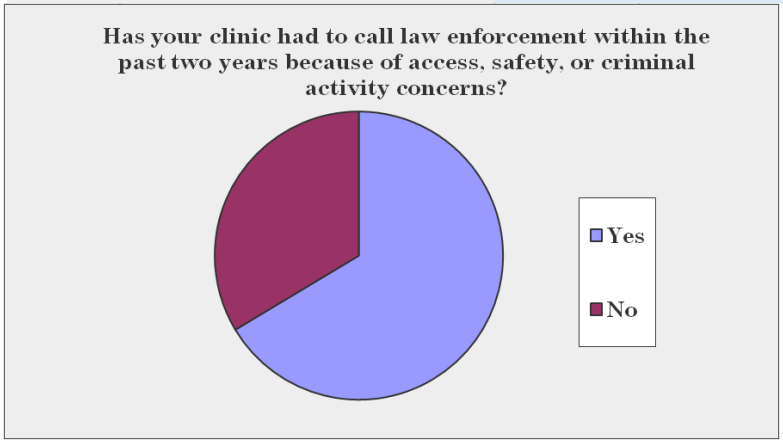
Have any clinic employees expressed concerns over his or her safety in or around the clinic within the past two years?	
Answer Options	**Response Percent**
Yes	56.9%
No	43.1%



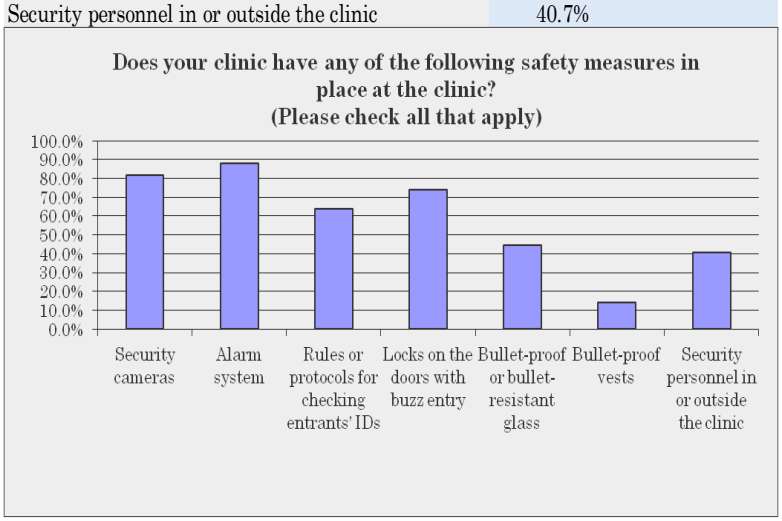
Has your clinic ever had to call law enforcement because of access, safety, or criminal activity concerns?	
Answer Options	**Response Percent**
Yes	80.6%
No	19.4%



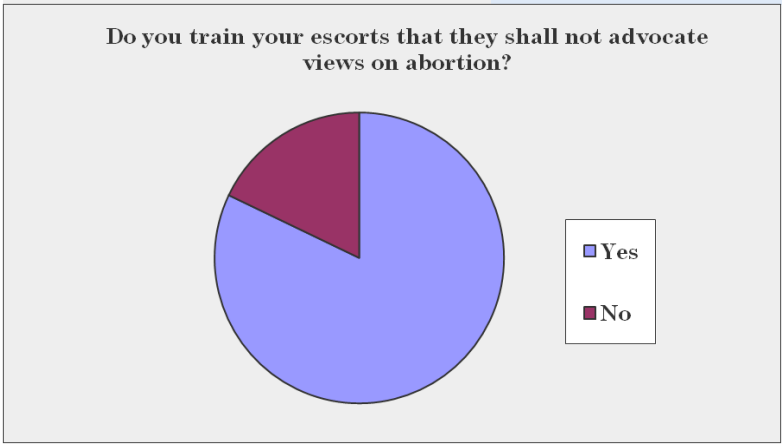
Has your clinic had to call law enforcement within the past two years because of access, safety, or criminal activity concerns?	
Answer Options	**Response Percent**
Yes	66.4%
No	33.6%



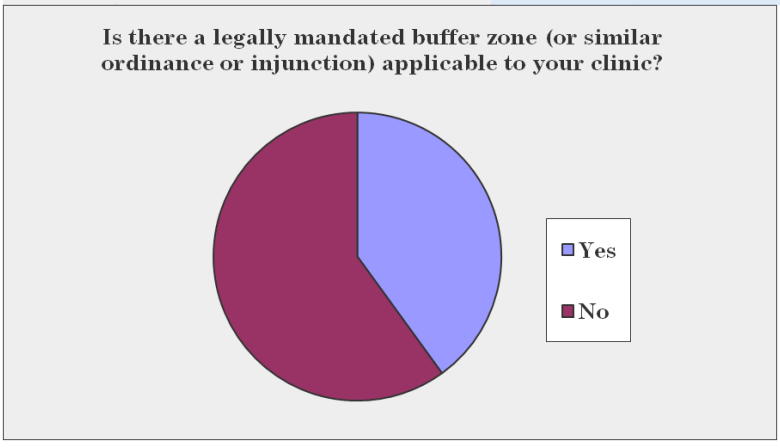
Does your clinic have any of the following safety measures in place at the clinic? (Please check all that apply)	
Answer Options	**Response Percent**
Security cameras	81.5%
Alarm system	88.0%
Rules or protocols for checking entrants' IDs	63.9%
Locks on the doors with buzz entry	74.1%
Bullet-proof or bullet-resistant glass	44.4%
Bullet-proof vests	13.9%
Security personnel in or outside the clinic	40.7%



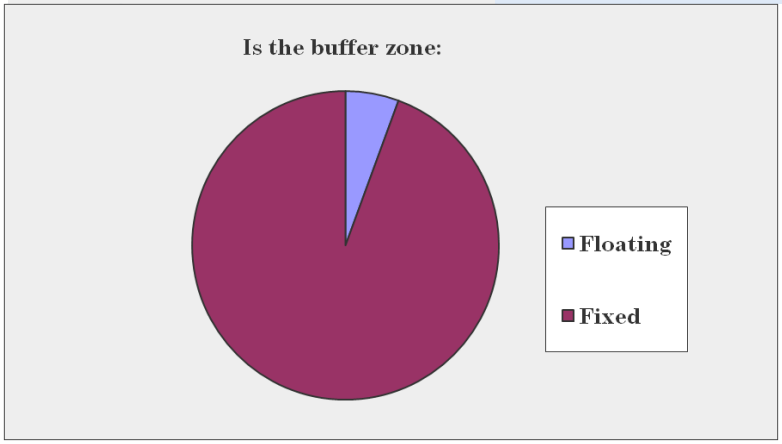
Do you train your escorts that they shall not advocate views on abortion?	
Answer Options	**Response Percent**
Yes	82.1%
No	17.9%



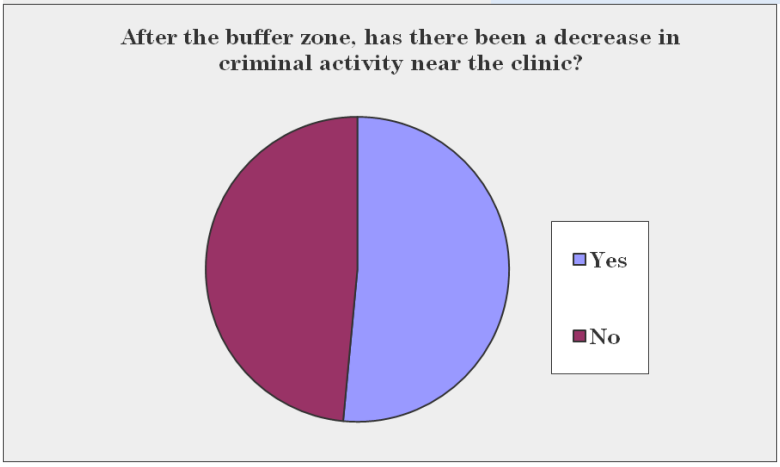
Is there a legally mandated buffer zone (or similar ordinance or injunction) applicable to your clinic?	
Answer Options	**Response Percent**
Yes	40.0%
No	60.0%



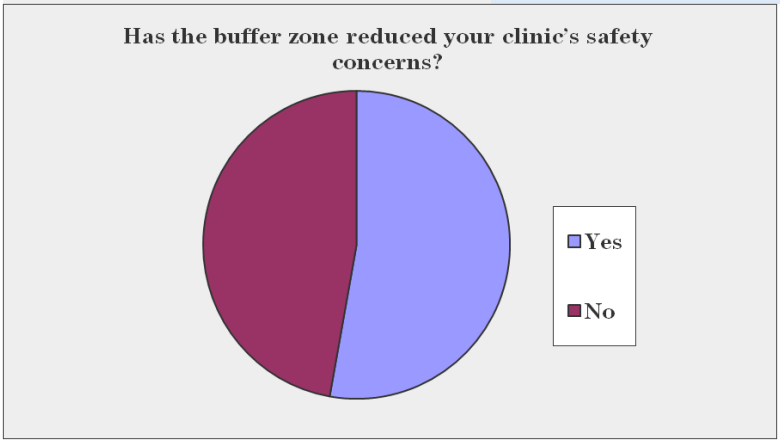
Is the buffer zone:	
Answer Options	**Response Percent**
Floating	5.6%
Fixed	94.4%



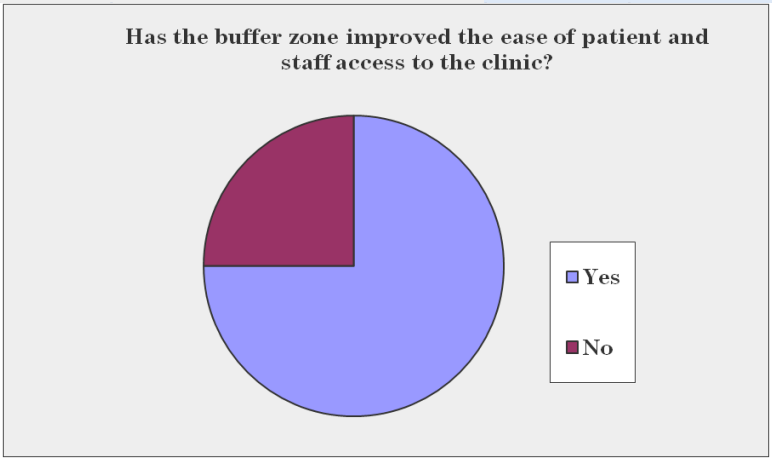
After the buffer zone, has there been a decrease in criminal activity near the clinic?	
Answer Options	**Response Percent**
Yes	51.5%
No	48.5%



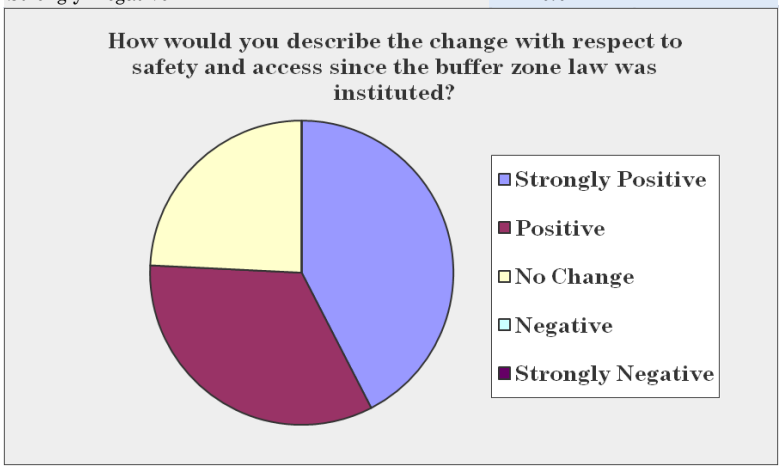
Has the buffer zone reduced your clinic's safety concerns?	
Answer Options	**Response Percent**
Yes	52.8%
No	47.2%



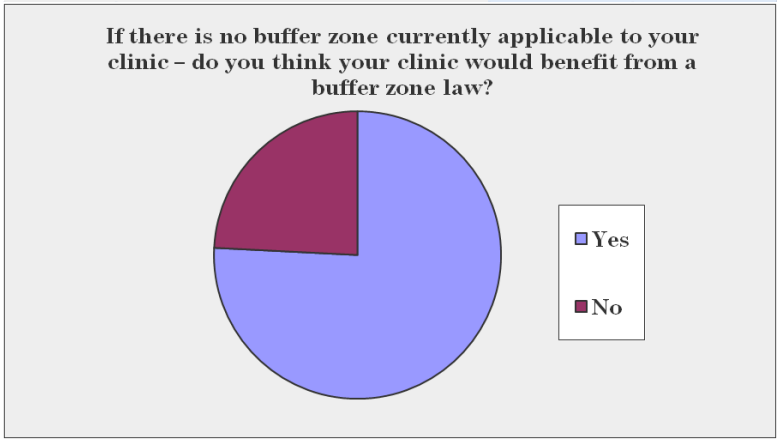
Has the buffer zone improved the ease of patient and staff access to the clinic?	
Answer Options	**Response Percent**
Yes	75.0%
No	25.0%



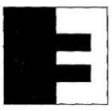
How would you describe the change with respect to safety and access since the buffer zone law was instituted?	
Answer Options	**Response Percent**
Strongly Positive	42.4%
Positive	33.3%
No Change	24.2%
Negative	0.0%
Strongly Negative	0.0%



If there is no buffer zone currently applicable to your clinic – do you think your clinic would benefit from a buffer zone law?	
Answer Options	**Response Percent**
Yes	75.8%
No	24.2%



Appendix D:
Excerpts from Feminist Majority Foundation 2010 National Clinic Violence Survey



2010 NATIONAL CLINIC VIOLENCE SURVEY

Conducted by
FEMINIST MAJORITY FOUNDATION

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EXECUTIVE SUMMARY

Almost immediately following the November 2008 elections, women's health clinics began reporting increased incidents of hostile threats and activity. Then again, after the murder of Dr. George Tiller by an anti-abortion extremist in May 2009, reports of threats against abortion providers increased. The data in this nationwide survey of women's health clinics – the first comprehensive survey since the summer of 2008 – bear out these observations.

Overall, the percentage of clinics experiencing severe violence[1] has increased to 23.5% of all abortion providers participating in the survey in 2010, compared to 20% in 2008 and 18.5% in 2005. Moreover, this marked the highest level of violence recorded since 1997 when 25.0% of all clinics experienced one or more incidents of severe violence.

Not only did the incidence of severe violence increase, but the violence became more highly concentrated. While a larger percentage of clinics reported "no violence" or only moderate violence, the percentage of clinics reporting three or more incidents of severe violence and harassment rose significantly in 2010 to 11.2% of all clinics compared to 9% in 2008—an increase of nearly one-third. Thus, while a majority of clinics reported no violence, a smaller number reported numerous acts of violence and harassment, with one clinic reporting a total of 11 incidents in 2010 alone.

Moreover, the types of violence shifted to more intensive targeting of doctors and clinic personnel and staff: the incidence of stalking reported by clinics grew from 4% in 2008 to 6.4% in 2010 and the percentage of clinics reporting pamphlets targeting staff increased from 16.1% in 2008 to 19% in 2010. Anti-abortion extremists clearly aim to create a climate of terror to intimidate and drive out abortion providers. Indeed, the data demonstrates a strong correlation between the incidence of violence and harassment and staff resignations: clinics with high violence are more than twice as likely to have a staff member resign.

For targeted clinics, effective law enforcement is essential in preventing incidents of violence. Clinics which rated their experience with local law enforcement as "poor" were twice as likely to experience high levels of violence in 2010 as clinics rating their experience as "good" or "excellent." Disturbingly, however, although the percentage of clinics reporting FACE violations increased in 2010, the number of clinics reporting that investigations were opened into these FACE violations decreased dramatically.

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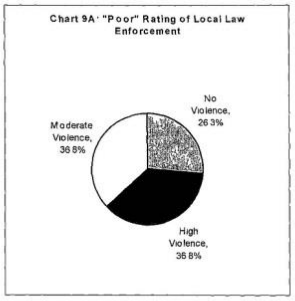
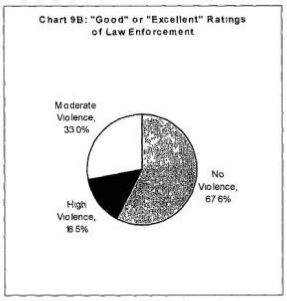
[1] This longitudinal measure of severe violence includes eleven tactics: blockades, invasions, arson, chemical attacks, stalking, physical violence, gunfire, bomb threats, death threats, and arson threats.

LAW ENFORCEMENT

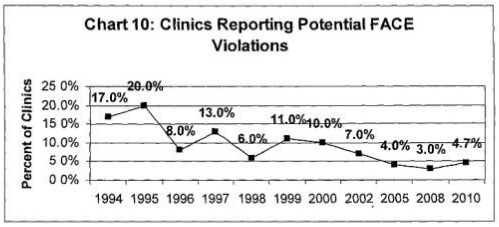
A strong, positive relationship with law enforcement continues to be crucial for abortion clinics threatened by violence and harassment. **Clinics which rated their experience with local law enforcement as "poor" were twice as likely to experience high levels of violence in 2010 as clinics rating their experience as "good" or "excellent."** This strong correlation is demonstrated in Chart 9.





Of those clinics in contact with state law enforcement, 54.7% rated the experience "good" or "excellent" and 55.9% of clinics with federal law enforcement contact rated the experience as "good" or "excellent."

In 2010, for the first time since 1999, the percentage of clinics reporting potential FACE violations to federal law enforcement authorities increased. Some 4.7% of clinics reported a potential violation in 2010. However, of the reported violations, only 35.3% resulted in the opening of an investigation, a decrease from 56% in 2008.



Appendix E:
Excerpts from Feminist Majority Foundation 1999 National Clinic Violence Survey

1999 NATIONAL CLINIC VIOLENCE SURVEY REPORT

Conducted by the Feminist Majority Foundation

Prepared by:
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Amy Hennessy, BA
Elizabeth Gavrilles, MFA
Jennifer Jackman, Phd

Released January 19, 2000

KEY FINDINGS

One in five clinics experienced severe anti-abortion violence in 1999. The percentage of clinics reporting one or more types of severe anti-abortion violence (including death threats, stalking, bombings, arsons, blockades, invasions, chemical attacks, bomb threats, and arson threats) declined slightly from 22% in 1998 to 20% in 1999.[1] [2]

Fewer clinics were free from violence in 1999, reversing a trend from previous years. Anti-abortion violence and harassment appears more widely distributed, as the percentage of clinics reporting no violence, vandalism, or harassment has declined from 64% in 1998 to 54% in 1999. For the first time, the gap between the percentage of clinics experiencing no violence and those facing moderate violence has narrowed. **Moreover, the percentage of clinics experiencing high levels of concentrated anti-abortion violence is relatively unchanged at 5% in 1999 compared with 4% in 1998.**

Vandalism at clinics has more than doubled; bomb threats are slightly up. A major increase in vandalism is detected. Over one-third of clinics (34%) reported one or more forms of vandalism, a figure more than doubled from 16% in 1998. In 1999, 13% of clinics were the target of bomb threats, which is a small increase from 11% in 1998.

Measured in this survey for the first time, 18% of clinics report harassment via the Internet or Web. Abortion clinic providers are open targets in cyberspace. With ever-increasing access to computer technology, clinic staff, providers, and patients have become vulnerable to this form of harassment, which may include divulging personal information such as home address and phone numbers, or advocating the targeting of specific abortion providers.

Anthrax threat attacks were prevalent in 1999, with 11% of clinics affected. Clinics in every region of the country have been subjected to these disruptive threats (newly measured in the 1999 National Clinic Violence Survey), all of which have thus far proved to be hoaxes. Additionally, in early January 2000 alone, over thirty clinics in twenty-two states have also received anthrax threats.

All levels of law enforcement received higher "excellent" ratings in 1999, with local law enforcement yielding the largest net increase. This year, 52% of clinics rated local law enforcement as excellent, up 15% from 1998 Federal law enforcement excellent ratings increased from 21% to 35%, a 14% increase Excellent ratings for state law enforcement also went up, rising 8% in 1999 to 20% In addition, clinics reported much stronger enforcement of buffer zones and injunctions **The percentage of clinics that identified "strong" enforcement of their buffer zones nearly tripled from 14% to 39% in 1999.**

Lower levels of violence are again associated with higher law enforcement response ratings. For example, of those clinics that rated local law enforcement response as "excellent," only 16% experienced high violence Conversely, one-third of clinics rating local law enforcement poorly were subjected to high levels of anti-abortion violence

METHODOLOGY

The seventh annual National Clinic Violence Survey measured anti-abortion violence and harassment over the past twelve months This survey is one of the most comprehensive studies of anti-abortion violence and harassment directed at clinics, patients, health care workers and volunteers in the United States and includes abortion providers of various organizational affiliations as well as independent clinics In September 1999, surveys were mailed to 839 clinics in the United States The universe of clinics was compiled by the Feminist Majority Foundation's National Clinic Access Project Follow-up telephone and fax contacts were made from mid-October to December Three hundred and sixty abortion providers responded, yielding a response rate of 43% [3] Participants in this survey were assured that their individual responses would remain confidential

PROFILE OF RESPONDENTS

This sample of 360 clinics includes clinics and private doctors' offices in 47 states and the District of Columbia (See Appendix A for a list of respondents by state) Types of facilities in this sample included non-profit (41%), for-profit (36%) and doctor's offices (23%)

While 62% of the clinics were affiliated with Planned Parenthood and/or the National Abortion Federation, the remaining 38% were unaffiliated with either organization The majority of facilities are free-standing (64%) and have uncovered parking lots (84%) On-site, volunteer clinic escorts assist patients at 29% of all reporting facilities

The percentage of clinics' practices devoted to abortion services ranges from 10% or less (23% of all clinics) to over 76% (45% of all clinics) Virtually all facilities (99%) offer a variety of other women's reproductive health care services These include birth control services (96%), pregnancy counseling (90%), emergency contraception (84%), adoption counseling and referral (67%), cancer screening (67%), and HIV/AIDS testing (60%)

Methotrexate, a method of early medical abortion, is administered at 27% of

responding clinics Also, clinics' interest in offering mifepristone (formerly known as RU-486) once it becomes available in the United States continues to grow (up 3% to 65% in 1999) Consistent with previous reports, non-profit clinics are most enthusiastic about offering mifepristone (75%)

RESULTS

abortion violent tactics from 1999 to 1998, clinics report that the frequency of threatened anthrax attacks increased 13%, much more than all other tactics

Clinics who receive threatened anthrax attacks are subjected to extensive evacuation, testing, and safety procedures Such attacks are also disruptive to the larger community, evidenced in a recent anthrax threat at a Toledo OH abortion clinic where law enforcement officials closed a ten-block area Although the FBI reports that a spate of letters received in 1999 contained only a sticky substance or dark powder, clinic staff and abortion providers are nonetheless disrupted by the necessary evacuation, decontamination, and testing procedures

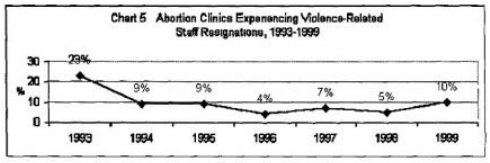
In the first two weeks of January 2000, over thirty clinics in twenty-two states have also received anthrax threats [11] Investigations are ongoing

FOLLOWING A VIOLENT 1998, MORE STAFF RESIGNATIONS REPORTED

Overall, Clinic Staff and Administrators Prove Resilient to Campaign of Violence

The percentage of clinics reporting staff resignations as a result of anti-abortion violence increased. Following a violent 1998, with a fatal clinic bombing in Birmingham AL and the murder of Dr Barnett A Slepian in his Amherst NY home, **10% of clinics reported staff resignations due to anti-abortion violence, an increase from 5% of clinics in 1998.** Of those few clinics reporting violence-related resignations, 32% lost a physician, 29% lost a receptionist, 26% lost a lab technician, 23% lost a counselor, and 20% lost a nurse Clinic administrators proved most resilient, with only 6% resigning

These resignations can be understood in the broad context of severe clinic violence and persistent harassment Indeed, the longitudinal trend displayed below (Chart 5) reflects increases in staff resignations that correspond with horrific acts of violence like the murders of doctors, clinic staff, and volunteers in 1993 and 1994



Within this overall picture, as well, is a strong relationship between violence-related staff resignations and the level of violence at a given clinic **In 1999, 22% of clinics experiencing high violence lost staff members; in fact, twice as many clinics experiencing high violence lost staff compared with clinics not subjected to high violence.** In the wake of a year that saw a fatal clinic bombing and a physician murdered in his own home, staff vulnerability at "high violence" clinics, while intuitive, is disturbing

REMEDIES TO VIOLENCE: BUFFER ZONES AND OTHER LEGAL PROTECTIONS

More clinics were protected by buffer zones in this year's reporting period, nearly one-third (114 clinics, 32%) compared with 27% of clinics in 1998. Buffer zones are areas determined by courts, legislatures, or municipal officials in which distance is specified between demonstrators and their intended targets Buffer zones may apply to clinic facilities as well as staff members' homes This

year, ten clinics reported home buffer zones for staff members or physicians, compared with 1998, when only five clinics reported such protections

More clinics conferred positive law enforcement ratings for their buffer zones and injunctions in 1999 than in 1998 **A significant portion of clinics (35%) reported that their buffer zones and injunctions were strongly enforced.** This finding is dramatically higher than 1998, when buffer zones were strongly enforced at only 14% of clinics and injunctions strongly enforced at 11% of clinics

Clinics' perceptions of stronger buffer zone and injunction enforcement are also reflected in lowered "poor" ratings **Fewer clinics in this reporting period reported weak or no enforcement of buffer zones and injunctions compared to 1998.** In 1999, 23% of clinics rated their legal protections as weakly or not enforced In 1998, buffer zones were weakly or not enforced at 28% of clinics, and injunctions weakly or not enforced at 36% of clinics

Nine percent (9%) of clinics turned to the legal system for legal remedies other than buffer zones, consistent with 10% of clinics seeking legal remedies in 1998 Temporary restraining orders and permanent injunctions were the most frequently sought remedies, with eighteen (5%) and fourteen clinics (4%) seeking such measures respectively

Nearly half of those clinics with buffer zones or injunctions (46%) believe that these legal protections have prompted improved law enforcement responses to anti-abortion violence and harassment at their facilities.

In addition to legal remedies sought, legal victories in this reporting period were also analyzed Thirteen clinics won temporary restraining orders (4%), five won preliminary injunctions (1%), and nine won permanent injunctions (3%) Twenty-nine clinics (8%) were awarded money damages as a result of anti-abortion activities, though less than one in five of those clinics (17%) have yet to collect monies owed to them [12]

Even though, for the most part, clinics have not been able to collect judgments, they have not given up and are still pursuing anti-abortion extremists At the end of

1999, four of the twelve anti-abortion defendants in the high-profile *Planned Parenthood v ACLA* filed for bankruptcy just prior to their federal court-ordered depositions in an effort to avoid disclosing financial information in the post-judgment phase of the lower court proceeding Increasingly, anti-abortion extremists are using bankruptcy filings in an effort to avoid paying damage awards

MORE CLINICS REPORT POTENTIAL FACE VIOLATIONS; LAW ENFORCEMENT FOLLOW-UP DECLINES

Thirty-nine clinics (11%) contacted law enforcement officials to report potential violations of FACE These numbers have essentially doubled from the 20 clinics contacting law enforcement regarding potential FACE violations in 1998 (Chart 6) Although the number of clinics making FACE-related law enforcement contacts has increased, clinics report that the handling of such contacts by law enforcement officials has declined

Several indices of authorities' responses to FACE complaints suggest that more aggressive investigations and prosecutions are necessary Of those clinics initiating contact with officials, the majority (66%) did not receive clear direction for pursuing their complaints This is an increase from 1998, when 55% of clinics did not receive clear directions from officials Fifteen percent (15%) of clinics were advised that authorities would not prosecute their cases, a slight increase from