No. 19-1392

IN THE

Supreme Court of the United States

THOMAS E. DOBBS, M.D., M.P.H., STATE HEALTH OFFICER, MISSISSIPPI DEPARTMENT OF HEALTH, *et al.*,
Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS, ET AL. IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI CURIAE[1]

The American College of Obstetricians and Gynecologists ("ACOG"), American Medical Association ("AMA"), American Academy of Family Physicians ("AAFP"), American Academy of Nursing ("AAN"), American Academy of Pediatrics ("AAP"), American Association of Public Health Physicians ("AAPHP"), American College of Medical Genetics and Genomics ("ACMG"), American College of Nurse-Midwives ("ACNM"), American College of Osteopathic Obstetricians and Gynecologists ("ACOOG"), American College of Physicians ("ACP"), American Gynecological and Obstetrical Society ("AGOS"), American Medical Women's Association ("AMWA"), American Psychiatric Association ("APA"), American Society for Reproductive Medicine ("ASRM"), Association of Women's Health, Obstetric and Neonatal Nurses ("AWHONN"), Council of University Chairs of Obstetrics and Gynecology ("CUCOG"), GLMA: Health Professionals Advancing LGBTQ Equality ("GLMA"), North American Society for Pediatric and Adolescent Gynecology ("NASPAG"), National Medical Association ("NMA"), National Association of Nurse Practitioners in Women's Health ("NPWH"), Society for Academic Specialists in General Obstetrics and Gynecology ("SASGOG"), Society of Family Planning ("SFP"), Society of General Internal Medicine ("SGIM"), Society of Gynecologic Oncology ("SGO"), and Society of OB/GYN Hospitalists ("SOGH") submit this amici curiae brief in support of Respondents.

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[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than amici curiae, their members, and their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Letters from the parties consenting to the filing of this brief are on file with the Clerk.

ACOG is the nation's leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG has appeared as amicus curiae in courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including this Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.[2]

AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represent-

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[2] *See, e.g.*, *June Medical Servs. LLC* v. *Russo*, 140 S. Ct. 2103 (2020); *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292 (2016); *Stenberg* v. *Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson* v. *Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG in assessing disputed parental notification requirement); *Simopoulos* v. *Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *see also Gonzales* v. *Carhart*, 550 U.S. 124, 170-171, 175-178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's brief and congressional submissions regarding abortion procedure).

ed in the AMA's policymaking process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every State. This Court and the federal courts of appeals have cited the AMA's publications and amicus curiae briefs in cases implicating a variety of medical questions.[3]

AAFP, founded in 1947, is one of the largest national medical organizations, representing 133,500 members nationwide who provide continuous comprehensive health care to the public.

AAN represents more than 2,800 of nursing's most accomplished leaders and serves the public by advancing health policy through the generation, synthesis, and dissemination of nursing knowledge.

AAP is a professional medical organization dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Founded in 1930, its membership is comprised of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists.

AAPHP represents public health physicians in promoting public health and preventive services.

ACMG is the only nationally recognized medical professional organization solely dedicated to improving

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[3] *See, e.g.*, *Birchfield* v. *North Dakota*, 136 S. Ct. 2160 (2016) (citing AMA research on blood-alcohol levels that constitute drunk driving); *Graham* v. *Florida*, 560 U.S. 48 (2010) (citing AMA brief as medical authority on juvenile development); *Ferguson* v. *City of Charleston*, 532 U.S. 67 (2001) (citing AMA brief in assessing patient privacy).

health through the practice of medical genetics and genomics.

ACNM works to advance the practice of midwifery to achieve optimal health for women. Its members include approximately 7,000 certified nurse midwives and certified midwives who provide primary and maternity care services to help women and their newborns.

ACOOG is a nonprofit organization committed to excellence in women's health representing over 2,500 osteopathic providers.

ACP is the largest medical specialty organization in the U.S. Its membership includes 161,000 internal medicine physicians, related subspecialists, and medical students.

AGOS is an organization composed of individuals attaining national prominence in scholarship in the discipline of Obstetrics, Gynecology, and Women's Health. For over a century it has championed the highest quality of care for women and the science needed to improve women's health.

AMWA is the oldest multispecialty organization dedicated to advancing women in medicine and improving women's health.

APA is a nonprofit organization representing over 37,400 physicians who specialize in the practice of psychiatry.

ASRM is dedicated to the advancement of the science and practice of reproductive medicine. Its members include approximately 8,000 professionals.

AWHONN is a nonprofit organization representing the interests of 350,000 specialty nurses. Its mission is

to empower and support nurses caring for women, newborns, and their families.

CUCOG is an association promoting excellence in medical education in the fields of obstetrics and gynecology. Its members represent the departments of obstetrics and gynecology of schools of medicine across the country.

GLMA is the largest and oldest association of lesbian, gay, bisexual, transgender and queer (LGBTQ) health professionals and their allies whose mission is to ensure health equity for LGBTQ and all sexual and gender minority (SGM) individuals, and equality for LGBTQ/SGM health professionals.

NASPAG is composed of gynecologists, adolescent medicine specialists, pediatric endocrinologists, and other medical specialists dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth.

NMA, established in 1895, is the nation's oldest and largest professional and scientific organization representing more than 50,000 African American physicians and their patients, and advocating for parity and justice in medicine, the elimination of disparities in health and promotion of health equity.

NPWH is the nonprofit organization that represents Women's Health Nurse Practitioners and other advanced practice registered nurses who provide women's and gender-related healthcare.

SASGOG seeks to enhance women's health by supporting academic generalist physicians in all phases of their careers.

SFP represents approximately 800 scholars and academic clinicians united by a shared interest in advancing the science and clinical care of family planning.

SGIM is a member-based internal medical association of over 3,300 of the world's leading academic general internists, who are dedicated to improving the access to care for all populations, eliminating health care disparities and enhancing medical education.

SGO is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers.

SOGH is a group of physicians, midwives, nurses and others who support the OB/GYN Hospitalist model and improving outcomes for hospitalized women.

INTRODUCTION AND SUMMARY OF ARGUMENT

Reproductive health care is essential to women's overall health. Access to abortion is an important component of reproductive health care. Amici curiae are leading medical societies representing physicians, nurses, and other clinicians who serve patients in Mississippi and nationwide, and whose policies represent the education, training, and experience of clinicians in this country. Amici's position is that laws regulating abortion should be evidence-based, supported by a valid medical or scientific justification, and designed to improve—not harm—women's health.

Mississippi's attempt to ban nearly all abortions after fifteen weeks of pregnancy[4] is fundamentally at odds with the provision of safe and essential health care, scientific evidence, and medical ethics. Contrary to the assertions made by the Mississippi legislature and the State below, there is no medical or scientific justification for House Bill 1510 (the "fifteen-week ban" or "Ban"). Instead, the Ban threatens the health of pregnant patients by arbitrarily barring their access to a safe and essential component of health care. In particular, patients of color, those with limited socioeconomic means, and those in rural communities would be most severely harmed should the Ban be allowed to go into effect.

The Ban threatens to impose these harms in a plainly unconstitutional manner—by banning abortion months before viability, the line this Court has drawn and long honored due to its significance as the first

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[4] Under Mississippi House Bill 1510 (2018), "gestational age" is measured from the first day of a patient's last menstrual period ("LMP"). *See* Pet. App. 69a.

point in pregnancy at which fetal life can be medically sustained outside the pregnant person's body. Indeed, the Ban reflects a fundamental misunderstanding and misrepresentation of the science of fetal development. The science conclusively establishes that a fetus at fifteen weeks gestational age is incapable of experiencing pain. The science also makes clear that, at fifteen weeks, a fetus is nowhere near viability because it is months away from when it could survive delivery, even with the latest advances in technology and medical care.

The Ban also impermissibly intrudes into the patient-physician relationship by limiting a physician's ability to provide the health care that the patient, in consultation with her physician, decides is best for her health. Moreover, the Ban undermines longstanding principles of medical ethics and places clinicians in the untenable position of choosing between providing care consistent with their best medical judgment, scientific evidence, and the clinicians' ethical obligations *or* risk losing their medical licenses. The provision of safe abortion services after careful consultation with a patient does not demean the practice of medicine. But infringement on a clinician's ability to honor patient autonomy, by allowing patients to make their own health care decisions, certainly does.

ARGUMENT

I. ABORTION IS A SAFE, COMMON, AND ESSENTIAL COMPONENT OF HEALTH CARE

Abortion is a common medical procedure. In 2017, over 860,000 abortions were performed nationwide,[5] including roughly 2,550 in Mississippi.[6] Approximately one quarter of American women have an abortion before the age of 45.[7]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[8] Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and easily treatable.[9] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gesta-

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[5] Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, at 7 (2019).

[6] Guttmacher Inst., *State Facts About Abortion: Mississippi* (Jan. 2021).

[7] Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).

[8] *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (2018) ("*Safety and Quality of Abortion Care*") ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E or induction—are safe and effective. Serious complications are rare.").

[9] *See, e.g.*, Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (finding 2.1% abortion-related complication rate); *Safety and Quality of Abortion Care* at 55, 60.

tional ages and types of abortion methods.[10] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[11] In contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[12] In fact, abortion is so safe that there is a greater risk of complications or mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[13]

Nor are there significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies have found that women who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and that receiving an abortion did not increase the likelihood of developing symptoms associat-

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[10] White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015).

[11] *See* Jatlaoui et al., *Abortion Surveillance—United States, 2015*, 67 Morbidity & Mortality Weekly Rep. 1, 45 tbl. 23 (2018) (finding mortality rate from 0.00052 to 0.00078% for approximately five-year periods from 1978 to 2014); Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 Obstetrics & Gynecology 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

[12] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

[13] ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014); American Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011); Grazer & de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000).

ed with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to carry a pregnancy to term.[14]

Moreover, access to abortion remains vital for pregnant patients' overall health and well-being. One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[15] The medical community recognizes abortion as a safe and essential component of women's health care.[16]

II. SCIENTIFIC EVIDENCE CONCLUSIVELY DEMONSTRATES THAT A FETUS IS NOT VIABLE AT FIFTEEN WEEKS

This Court has long recognized viability as the critical point of fetal development after which the State's asserted interest in protecting potential fetal life may outweigh a woman's privacy and autonomy interests in terminating her pregnancy. In *Planned Parenthood of*

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[14] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169, 177 (2017).

[15] Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS ONE 1, 7 (2015).

[16] *See, e.g.*, Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with "several key organizations in obstetrics, gynecology, and maternal-fetal medicine" including the American Board of Obstetrics and Gynecology, that "[a]ccess to legal and safe pregnancy termination … is essential to the public health of women everywhere"); ACOG, *Abortion Policy* (Nov. 2014, reaff'd Nov. 2020); Soc'y for Maternal-Fetal Med., *Access to Pregnancy Termination Services* (2017).

Southeastern Pennsylvania v. *Casey*, the Court reaffirmed *Roe*'s holding that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." 505 U.S. 833, 846 (1992). But it explained that, in weighing a woman's privacy and autonomy interests in obtaining an abortion against the State's asserted interest in protecting potential fetal life, viability is where "the line should be drawn" and "the point at which the balance of interests tips." *Id.* at 860-861, 870.

This Court explained that the balance shifts because viability "is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman" and accordingly "there is no line other than viability which is more workable." *Casey*, 505 U.S. at 870. As Justice Blackmun explained in his concurrence in *Webster* v. *Reproductive Health Services*, "[t]he viability line reflects the biological facts and truths of fetal development; it marks the threshold moment prior to which a fetus cannot survive separate from the woman and cannot reasonably and objectively be regarded as a subject of rights or interests distinct from, or paramount to, those of the pregnant woman." 492 U.S. 490, 553 (1989); *see also Roe* v. *Wade*, 410 U.S. 113, 117, 162-163 (1973).

This Court's recognition of viability as a meaningful point in a pregnancy at which the interests at play may shift necessarily reflects an understanding of scientific, medical, and clinical realities. Viability is the capacity of the fetus for prolonged survival outside of the woman's uterus. Once a fetus reaches viability, medical

support alone could sustain it, and its continued existence is no longer entirely dependent on the pregnant patient. As relevant here, there is an undisputed scientific, medical, and clinical consensus that fifteen-weeks LMP is *months* before fetal viability is possible.[17]

In *Casey*, this Court acknowledged that "advances in neonatal care have advanced viability to a point somewhat earlier" than it had been when *Roe* was decided, but explained that "the divergences from the factual premises of 1973 have no bearing on the validity of *Roe*'s central holding," which "in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity can somehow be advanced in the future." 505 U.S. at 860. In 2021, fifteen-weeks LMP remains long before there is any possibility of viability. The Ban therefore admittedly bans abortions long before constitutionally permissible under the framework set forth in *Roe* and *Casey*.[18]

Mississippi attempts to distract from the fact that its Ban unconstitutionally prohibits abortion well before viability by alleging concerns about "fetal pain." But, in asserting any interest in preventing "fetal pain" to justify its fifteen-week ban, Pet. Br. 44, Mississippi

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[17] ACOG, *Abortion Policy* (Nov. 2014, reaff'd Nov. 2020) ("Whether [a fetus is viable] is a medical determination" and "a matter for the judgment of the responsible health care provider.").

[18] *See Casey*, 505 U.S. at 860 ("Whenever [viability] may occur, [its] attainment … may continue to serve as the critical fact, just as it has done since Roe was decided; which is to say that no change in *Roe's* factual underpinning has left its central holding obsolete, and none supports an argument for overruling it.").

attempts to manufacture a concern that medical consensus rejects as scientifically unfounded. There is no credible scientific evidence of fetal pain perception previability, and certainly none at fifteen weeks LMP, approximately two months before a fetus approaches viability. Every major medical organization that has examined the issue of fetal pain and peer-reviewed studies on the matter have consistently reached the conclusion that pre-viability abortion does not result in fetal pain perception.[19]

The medical consensus is that fetal pain perception is not possible before at least twenty-four weeks gestation because the neural circuitry required to sense, perceive, or experience pain is not developed in earlier gestations. Pain perception requires an intact neural pathway from the periphery of the body (the skin), through the spinal cord, into the thalamus (the gray matter in the brain that relays sensory signals) and on to the region of the cerebral cortex.[20] These neural connections do not develop until after at least twenty-

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[19] *See* ACOG, *Facts Are Important—Fetal Pain* (July 2013); Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice* (Mar. 2010) (concluding fetal pain is not possible before 24 weeks gestation, based on expert panel review of over 50 papers in medical and scientific literature); SMFM et al., *SMFM Consult Series #59: The use of analgesia and anesthesia for maternal-fetal procedures*, Am. J. Obstetrics & Gynecology 4-5 (2021); Apkarian et al., *Human Brain Mechanisms of Pain Perception and Regulation in Health and Disease*, 9 Eur. J. Pain 463 (2005); Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 J. Am. Med. Ass'n 947 (2005).

[20] *See, e.g.*, Apkarian et al., 9 Eur. J. Pain at 463-484; Tracey & Mantyh, *The Cerebral Signature for Pain Perception and Its Modulation*, 55 Neuron 377 (2007); Key, *Why Fish Do Not Feel Pain*, 3 Animal Sentience 1 (2016).

four weeks gestation.[21] The scientific evidence therefore demonstrates that an asserted concern about "fetal pain" should have no place in determining the constitutionality of the Ban or the understanding of viability.

III. THE BAN WILL HARM, NOT IMPROVE, PREGNANT PATIENTS' HEALTH

The State's health justifications for the Ban equally defy medical consensus. The Ban bars the provision of abortions after fifteen weeks of pregnancy with only narrowly defined exceptions for medical emergencies and severe fetal abnormalities. Miss. Code § 41-41-191(3)(h) & (j); (4)(a) (2018). Physicians and other clinicians could have their professional licenses suspended or revoked for providing an abortion in contravention of the Ban. *Id.* § 41-41-191(6). This Ban—an unconstitutional pre-viability ban on abortion—would cause severe and detrimental physical and psychological health consequences for pregnant patients.

A. The Ban Will Endanger The Physical And Psychological Health Of Pregnant Patients

While individuals who need an abortion want to obtain one as early as they can, there are a variety of reasons some patients may require a pre-viability abortion after the first trimester. Tens of thousands of abortions nationwide are performed at or after 14 weeks' gestation.[22] Because more than 45% of pregnancies in

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[21] Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice*, vii, 8-9 (Mar. 2010); SMFM et al., *SMFM Consult Series #59: The use of analgesia and anesthesia for maternal-fetal procedures*, Am. J. Obstetrics & Gynecology 4-5 (2021).

[22] CDC, *Abortion Surveillance–United States* (Nov. 27, 2020).

the United States are unplanned, and because many medical conditions—including irregular periods—may mask a pregnancy, many women do not discover they are pregnant for several weeks.[23] In fact, one study found that approximately half of those who obtain abortions in their second trimester do so because delays in suspecting and testing for pregnancy caused them to miss the opportunity for an earlier abortion.[24]

After patients become aware of their pregnancies, they may need time to consult with family or health professionals. It often takes time before patients who have decided they need to end their pregnancy can access abortion care given the host of logistical and financial barriers many face, including paying for the procedure, and organizing transportation, accommodation, childcare, and time off from work. Women who have abortions later in pregnancy have been found to "have had difficulty finding an abortion provider," "live farther from the clinic," "be less educated," "have had difficulty arranging transportation," "be unsure of their last menstrual period," and "experience fewer pregnancy symptoms."[25] One recent study found that women receiving first-trimester abortions were delayed in doing so for a variety of reasons: 36.5% due to travel and procedure costs, 37.8% due to not recognizing the pregnancy, 20.3% due to insurance problems, and 19.9% due

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[23] Guttmacher Inst., *Unintended Pregnancy in The United States* (Jan. 2019); Boonstra et al., Guttmacher Inst., *Abortion in Women's Lives* 29 (2006).

[24] Drey et al., *Risk Factors Associated with Presenting for Abortion in the Second Trimester*, 107 Obstetrics & Gynecology 128 (Jan. 2006).

[25] *Id.* at 128.

to not knowing where to find abortion care.[26] Even greater proportions of women needing second-trimester abortions faced these obstacles.[27] These hurdles are accentuated by the fact that in several states—including Mississippi—there is presently only one clinic providing abortions.

The Ban dangerously limits the ability of women at or near fifteen weeks' gestation to obtain the health care they need: some will be forced to travel outside the State to obtain an abortion; others will attempt self-induced abortion; and others still will be forced to carry their pregnancy to term. Each of these outcomes increases the likelihood of negative consequences to a woman's physical and psychological health that could be avoided if care were available.[28]

For instance, being forced to travel outside the State needlessly delays the abortion to later in pregnancy. Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication—a risk increased further still by continuing a pregnancy to term.[29] The Ban will also increase the possibility that women may attempt self-induced abortions through harmful or unsafe methods.[30] Stud-

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[26] Udapdhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014).

[27] *Id.*

[28] *See, e.g.*, ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020).

[29] Upadhyay et al., 125 Obstetrics & Gynecology at 181.

[30] *See, e.g.*, Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (2019) (noting a rise

ies have found that women are more likely to self-induce abortions where they face barriers to reproductive services, and methods of self-induction outside safe medical abortion (i.e., abortion by pill) may rely on harmful tactics such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills.[31]

Those patients who do not—or cannot—obtain an abortion due to the Ban will be forced to carry a pregnancy to term—an outcome with significantly greater risk to maternal health and mortality. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[32] and maternal mortality rates have increased staggeringly since then.[33] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[34] A woman's risk of death associated with childbirth is accordingly approximately 14 times higher than any risk of death from an abortion.[35]

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in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

[31] Grossman et al., Tex. Pol'y Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015).

[32] Raymond & Grimes, 119 Obstetrics & Gynecology at 216.

[33] MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6% increase in maternal mortality rates between 2000 and 2014).

[34] Raymond & Grimes, 119 Obstetrics & Gynecology at 216.

[35] *Id.*

In addition to much greater maternal mortality, continued pregnancy and childbirth also entail other substantial health risks for women. Even an uncomplicated pregnancy causes significant stress on the body and involves physiological and anatomical changes. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or cause new conditions. For example, approximately 6 to 7% of pregnancies are complicated by gestational diabetes mellitus, a condition in which carbohydrate intolerance develops during pregnancy and which frequently leads to maternal and fetal complications, including developing diabetes later in life.[36] Another complication is preeclampsia, a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in blood pressure swings, liver issues, and seizures, among other conditions.[37] Labor and delivery are likewise not without significant risk, including that of hemorrhage, placenta accreta spectrum, hysterectomy, cervical laceration, and debilitating postpartum pain, among others.[38] Approximately one in three women who give birth in the United States do so by cesarean delivery, a major procedure that carries in-

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[36] ACOG Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018).

[37] ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (Dec. 2018).

[38] ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017); ACOG Obstetric Care Consensus, *Placenta Accreta Spectrum* (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* (Sept. 2021).

creased risk of complications.[39] Finally, evidence suggests that women denied abortions because of gestational age limits are more likely to experience negative psychological health outcomes—such as anxiety, lower self-esteem, and lower life satisfaction—than those women who obtained a needed abortion.[40] Accordingly, as a medical and scientific matter, the fifteen-week ban is detrimental to women's physical and psychological health and well-being.[41]

B. There Is No Health Or Safety Justification For The Fifteen-Week Ban

Similar to its disregard of the greater risks of forcing patients to continue a pregnancy, the State's affirmative attempt to justify the Ban as a means of "protecting the health of women" is scientifically baseless. Pet. Br. 7-8; Miss. Code § 41-41-191. In enacting the Ban, the Legislature relied on a single study to conclude that abortion "carries significant physical and psychological risks to the maternal patient." Pet. Br. 8.; Miss. Code § 41-41-191. But the State ignores the rest of that study's findings—which show that, although the risks of abortion marginally increase as pregnancy progresses, abortion is exceedingly safe throughout pregnancy and comparatively safer than

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[39] CDC, National Vital Statistics Reports Vol. 70, No. 2, *Births: Final Data for 2019* (2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* (Mar. 2014, reaff'd 2016).

[40] Biggs et al., 74 JAMA Psychiatry at 172.

[41] *Safety and Quality of Abortion Care* at 74 (noting that the greatest threats to the safety and quality of abortion in the U.S. are unnecessary regulations that restrict access to abortion).

continued pregnancy and childbirth[42]—as well as the conclusions of the broader scientific and medical community, and decades of clinical experience.

Contrary to the State's assertion, the overwhelming weight of medical consensus finds induced abortion is one of the least risky procedures in modern medicine and is several times safer than the only alternative—carrying a pregnancy to term and giving birth.[43] Moreover, every complication associated with abortion, including anemia, hypertensive disorders, and pelvic and perineal trauma is "more common among women having live births than among those having abortions."[44]

As discussed above (*see supra* pp.17), although the risk of complications does increase somewhat as pregnancy progresses, the absolute risk of complications associated with an abortion remains exceedingly low across all gestational ages and methods.[45] There are a variety of reasons why abortion carries a comparatively greater risk of complications as pregnancy progresses, including that abortions in the second trimester typical-

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[42] Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729 (2004).

[43] *Id.* at 729; *see also supra* notes 8-14 and accompanying text.

[44] Raymond & Grimes, 119 Obstetrics & Gynecology at 216-217; *see also* Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089, 1092 (2008) ("Rates of anemia, hypertensive disorders of pregnancy, pelvic and perineal trauma, excessive vomiting, and postpartum hemorrhage each occurred more frequently in women who had a live birth or stillbirth.").

[45] *See supra* notes 8-14 and accompanying text.

ly require more involved procedures and more sedation than procedures in the first trimester.[46]

The medical community has not, however, recommended any pre-viability limits—rather, it has recommended, as the study the State relies on explains, "increased access to surgical and nonsurgical abortion services" as they "may increase the proportion of abortions performed at lower-risk, early gestational ages."[47] This conclusion is consistent with a recent study published by the National Academies of Medicine, Engineering, and Science showing that the greatest threats to the safety and quality of abortion in the United States are unnecessary government regulations that restrict access to abortion.[48]

Similarly, there is no support for the State's proposition that abortion "carries significant … psychological risks." Pet. Br. 7-8 (quotation marks omitted); Miss. Code § 41-41-191. In fact, the "highest-quality research available does *not* support the hypothesis that abortion leads to long-term mental health problems."[49] In the context of unplanned pregnancies, high-quality recent studies have found no long-term difference in the risk of

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[46] *Safety and Quality of Abortion Care* at 10.

[47] Bartlett et al., 103 Obstetrics & Gynecology at 736; *see also* ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020).

[48] *Safety and Quality of Abortion Care.*

[49] Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 448-449 (July 2008) (emphasis added); *see also* Biggs et al., *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*, 105 Am. J. Pub. Health 2257, 2561 (2015) (finding that obtaining an abortion does not correlate with higher rates of diagnoses of mental health disorders).

experiencing symptoms of posttraumatic stress, depression, or anxiety, or of experiencing lower self-esteem or life satisfaction between women who have abortions and those who carry their pregnancy to term.[50] Instead, evidence indicates that being denied a wanted abortion can have a *detrimental* impact on women's mental health.[51] In short, contrary to the State's claim, the fifteen-week ban will not advance or protect women's health; rather it will cause physical and psychological harm for pregnant women. The State's claim that the Ban promotes the health of pregnant women is simply without legitimate scientific basis.

C. The Narrow Medical Emergency Exception Does Not Adequately Protect Patients' Health

Under the Ban, a physician may perform an abortion after fifteen weeks only in cases involving a "medical emergency" or "severe fetal abnormality." Miss. Code § 41-41-191. The Ban narrowly defines a "medical emergency" as a condition when "an abortion is necessary to preserve the life of the pregnant woman" or when pregnancy will create a "serious risk of substantial and irreversible impairment of a major bodily func-

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[50] Biggs et al., 74 JAMA Psychiatry at 177.

[51] *Id.* at 172 (finding that a week after seeking an abortion, women denied abortion because of gestational age limits are significantly more likely to report symptoms of anxiety than women who receive an abortion); *id.* (finding that depression and anxiety in women who had abortions declined following the abortion, but that in women who were denied abortions and subsequently gave birth those symptoms remained); Biggs et al., *Does Abortion Reduce Self-Esteem and Life Satisfaction?*, 23 Quality of Life Research 2505 (2014) (finding that women who received an abortion experienced higher self-esteem than women who were denied an abortion).

tion." *Id.* This accordingly forecloses an abortion for women who might face serious medical complications that, while posing grave risks to their health, are not urgent or extreme enough in the State's narrow view to fall within the Act's medical emergency exception.

There are a significant number of serious medical conditions that may not qualify as a "medical emergency" under the Ban's narrow definition but would nevertheless jeopardize a patient's health. These include, but are not limited to: Alport syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve that can occur in patients with no history of cardiac symptoms), lupus (a connective tissue disorder that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy), and diabetes (which can worsen to the point of causing blindness as a result of pregnancy).[52] The Ban also makes no exception for women who may have experienced conditions constituting a "medical emergency" in previous pregnancies and now seek to terminate a subsequent pregnancy to avoid future life-threatening complications. Moreover, the Ban makes no allowances for mental health issues that might put a woman's health and life

[52] *See* Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 2007); Stout & Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-647 (2002); Kiely et al., *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013); Greene & Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

at risk if the pregnancy is not terminated.[53] Any of these conditions can progress and become more serious or lead to additional health risks if abortion care is not available.

It is untenable to force a pregnant patient to wait until her medical condition escalates to the point that "an abortion is necessary to preserve [her] life" or her pregnancy creates "serious risk of substantial and irreversible impairment of a major bodily function" before being able to seek potentially life-saving care. Miss. Code § 41-41-191. Nor should physicians be put in the impossible position of either letting a patient deteriorate until one of these conditions is met or face possible loss of their medical licenses for performing an abortion in contravention of the Ban. In forcing physicians to wait until a patient is close enough to death that they will risk their license to practice medicine to save her life by providing needed abortion care, the State indefensibly jeopardizes patients' health.

D. The Ban Will Hurt Rural, Minority, And Poor Patients The Most

The Ban will disproportionality impact people of color, those living in rural areas, and those with limited economic resources. This is because, as a general matter, 75% of those seeking abortion are living at or below 200% of the federal poverty level, and the majority of patients seeking abortions identify as Black, Hispanic,

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[53] Miss. Code § 41-41-191 (2018) ("medical emergency" defined as when "life is endangered by a physical disorder, *physical* illness, or *physical* injury" (emphasis added)); *see also*, *e.g.*, Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

Asian, or Pacific Islander.[54] Similarly, traveling out of State for medical care is more difficult, if not impossible, for patients with limited means or geographic remoteness.

The inequities continue after an abortion is denied. As explained *supra* pp.18-20, forcing patients to continue pregnancy increases their risk of complications, and the risk of death associated with childbirth is approximately 14-times higher than that associated with abortion. Nationwide, Black women's pregnancy-related mortality rate is 3.2 times higher than that of white women, with significant disparities persisting even in areas with the lowest overall rates and among women with higher levels of education.[55] Indeed, Black women in Mississippi are nearly three times more likely to die from pregnancy-related causes than white women, making carrying an unwanted pregnancy to term disproportionately dangerous for them.[56] The Ban thus exacerbates inequities in women's health and health care, negatively affecting the most vulnerable Mississippians.

IV. THE BAN FORCES CLINICIANS TO MAKE AN IMPOSSIBLE CHOICE BETWEEN UPHOLDING THEIR ETHICAL OBLIGATIONS AND FOLLOWING THE LAW

Pre-viability abortion bans such as the one at issue in this case violate long-established—and widely accepted—principles of medical ethics and intrude upon

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[54] Jerman et al., Guttmacher Inst., *Characteristics of U.S. abortion patients in 2014 and changes since 2008* (2016).

[55] CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019).

[56] Mississippi State Department of Health, *Mississippi Maternal Mortality Report* (Apr. 2019).

the foundation of the patient-physician relationship: honest, open communication. Such bans require medical professionals to violate the age-old principles of beneficence, non-maleficence, and respect for patient autonomy in order to avoid negative personal and professional consequences such as having their licenses to practice medicine revoked. Miss. Code § 41-41-191(6). It is pre-viability abortion bans—not the ability to perform safe abortions before a fetus could ever survive outside the womb—that threaten the medical profession's integrity. *See* Pet. Br. 5 (framing the Ban as furthering Mississippi's interest in "protecting … the medical profession's integrity").

A. The Ban Undermines The Patient-Physician Relationship

Patient safety is of paramount importance to amici. While some regulation of medical practice is necessary to protect patient safety, legislation that substitutes lay lawmakers' views for a physician's expert medical judgment impermissibly interferes with the patient-physician relationship and poses grave dangers to patient well-being. ACOG's *Code of Professional Ethics* states that "the welfare of the patient must form the basis of all medical judgments" and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[57] Likewise, the AMA *Code of Medical Ethics* places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[58]

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[57] ACOG, *Code of Professional Ethics* 2 (Dec. 2018).

[58] AMA, *Code of Medical Ethics Opinion 1.1.1.*

The patient-physician relationship is critical for the provision of safe and quality medical care.[59] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests, and with the best available scientific evidence.[60] Amici oppose laws that threaten the patient-physician relationship absent a justifiable health reason. "Laws … that require physicians to give, or withhold, specific information when counseling patients, or that mandate which tests, procedures, treatment alternatives or medicines physicians can perform, prescribe, or administer are ill-advised."[61] Laws should not interfere with the ability of physicians to offer appropriate treatment options to their patients without regard for their own self-interests.

By prohibiting pre-viability abortions, the Ban interferes with the patient-physician relationship. For example, if a patient's health were compromised, but the fetus was at approximately fifteen-weeks LMP, the Ban would only allow a physician to perform an abortion if the threat to the patient's health rose to a legislatively defined "medical emergency," regardless of the

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[59] ACOG, *Statement of Policy*, *Legislative Interference with Patient Care*, *Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended August 2021) ("*ACOG, Legis. Policy Statement*").

[60] AMA, *Patient-Physician Relationships*, *Code of Medical Ethics Opinion 1.1.1* ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.").

[61] *ACOG, Legis. Policy Statement*, *supra* note 59.

overall medical advisability of the procedure or the desire of the patient. Miss. Code § 41-41-191(3). The Ban defines a qualifying "medical emergency" to mean that the pregnant patient's life must be "endangered by a physical disorder, physical illness, or physical injury … or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function." *Id.* (3)(j). A physician and patient together may conclude that an abortion was in the patient's best medical interests even though the risk posed by continuing the pregnancy does not rise to the level of immediately life threatening or risking substantial and irreversible physical impairment of a major bodily function. The Ban thus forces physicians to choose between the ethical practice of medicine or obeying the law.[62]

B. The Ban Violates The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the well-being of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2500 years ago.[63] Both of these principles arise from the foundation of medical ethics which

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[62] *Cf. AMA, Patient Rights, Code of Medical Ethics Opinion 1.1.3* ("Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.").

[63] AMA *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaff'd 2016).

requires that the welfare of the patient forms the basis of all medical decision-making.[64]

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make a decision informed by both medical science and their individual lived experiences.[65]

The fifteen-week ban compromises these principles and practices by pitting physicians' interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But the fifteen-week ban and its extremely narrow medical exception prohibits physicians from providing that treatment after fifteen weeks and exposes physicians to significant penalties if they do so. The fifteen-week ban therefore places physicians in the ethical dilemma of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This decision, between possible loss of the ability to practice medicine and the practice of scientific, ethical, high-

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[64] ACOG, *Code of Professional Ethics* 2 (Dec. 2018); AMA, *Code of Medical Ethics Opinion 1.1.1.*, *supra* note 58 and accompanying text.

[65] ACOG, Practice Bulletin No. 162: *Prenatal Diagnostic Testing for Genetic Disorders*, 127 Obstetrics & Gynecology e108 (May 2016).

quality health care is one that challenges the very core of the Hippocratic Oath: "Do no harm."

C. The Ban Violates The Ethical Principle Of Respect For Patient Autonomy

Another core principle of medical practice is patient autonomy—the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[66] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[67] The fifteen-week ban would deny patients the right to make their own choices about health care if they decide they need, for example, to seek a previability abortion after fifteen weeks.

By undermining the patient-physician relationship, violating the principles of beneficence and nonmaleficence, and threatening clinicians' ability to respect patient autonomy, the Ban harms both the ethical practice of medicine and patient health and safety. Therefore, contrary to the State's assertion (at 5) that the Ban will "protect[] … the medical profession's integrity," it will undermine the practice of medicine. The integrity of the medical profession is *not* protected by preventing physicians from utilizing their extensive training and reliance on medical evidence to safely perform a routine procedure that a patient has made an

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[66] ACOG, *Code of Professional Ethics* 1 (Dec. 2018) ("respect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental").

[67] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021); AMA, *Code of Medical Ethics Opinion 2.1.1*.

informed decision is in her own best interest. Instead, the medical profession's integrity is safeguarded when physicians are permitted to exercise their duty to counsel and care for patients based on "objective professional judgment" and ultimately respect patients' autonomy to make decisions about their own bodies and health.[68]

CONCLUSION

For the foregoing reasons, amici urge this Court to affirm the Fifth Circuit's decision.

Respectfully submitted.

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[68] AMA, *Patient Rights, Code of Medical Ethics Opinion 1.1.3.*