

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT
No. 18-35926

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PLANNED PARENTHOOD OF THE GREAT :
NORTHWEST AND THE HAWAIIAN :
ISLANDS, :

Plaintiff-Appellant, :

v. :

LAWRENCE GARTH WASDEN, in his :
official capacity as the Idaho Attorney General, :
et al., :

Defendants-Appellees, :

-----x

On Appeal from the
United States District
Court for the District of
Idaho (Boise)

Civil Action No. 1:18-cv-
00319-DCN

**MOTION FOR LEAVE TO FILE BRIEF OF *AMICI CURIAE* THE
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AND THE AMERICAN MEDICAL ASSOCIATION
IN SUPPORT OF PLAINTIFF-APPELLANT AND REVERSAL**

Pursuant to Rule 29 of the Federal Rules of Appellate Procedure, *amici curiae*, the American College of Obstetricians and Gynecologists (“ACOG”) and the American Medical Association (“AMA”), respectfully request leave to file the attached Brief in Support of Plaintiff-Appellant and Reversal.

Amici curiae are leading medical organizations representing physicians in the United States. ACOG is the premier professional membership organization of obstetricians and gynecologists, representing more than 90% of board-certified obstetrician-gynecologists in the United States and having more than 59,000

members dedicated to providing health care unique to women. AMA is the largest professional association of physicians, residents, and medical students in the United States.

This case involves a challenge to the Abortion Complications Reporting Act, Idaho Code §§ 39-9501 *et seq.*, and amendments to Idaho Code § 54-1413(1) and § 54-1814(25) (“the Act”), which create medically unsupported reporting requirements for physicians that threaten the reproductive rights of Idaho women. *Amici curiae* have a strong interest in the disposition of this case because the Act compels speech in violation of physicians’ First Amendment rights, threatens physicians with medical license suspension and criminal sanctions, and obstructs access to critical reproductive care and endangers the health and well-being of Idaho women. *See* Fed. R. App. P. 29(a)(3)(A).

The attached brief will assist the Court in evaluating the medical, scientific, and public health consequences of the Act. *Amici curiae* are leading medical authorities, and the attached brief offers evidence-based information that will assist this Court in evaluating the Act. In particular, the brief provides information and context on how the Act jeopardizes public health by creating a public misconception, with no scientific or medical basis, that abortion is unsafe or causally associated with cancer or mental health conditions, chills safe health care by threatening physicians with license suspension and criminal sanctions, and

compels speech by forcing physicians to report “complications” without regard for their professional judgment. *See* Fed. R. App. P. 29(a)(3)(B).

Amici curiae contacted the parties to obtain consent to file the attached brief. Plaintiff-Appellant consented. Defendants-Appellees¹ have not. ACOG and AMA have previously participated as *amici curiae* in reproductive health matters throughout the country, including in the Ninth Circuit and the United States Supreme Court. *See, e.g., Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905 (9th Cir. 2014) (citing brief submitted by ACOG and AMA as further support for a particular medical regimen), *cert. denied*, 135 S. Ct. 870 (2014); *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (citing *amici* brief submitted by ACOG, AMA, and other medical associations in assessing admitting privileges and surgical center requirements). ACOG’s work and *amicus* briefs have been cited by numerous courts seeking authoritative medical data regarding women’s health and reproductive health care, including childbirth and abortion.² The AMA’s

¹ We understand that all Defendants-Appellees are represented by the Idaho Attorney General’s office.

² *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 928, 932–36 (2000) (relying on ACOG’s *amicus* brief and referring to ACOG as among the “significant medical authority” supporting the comparative safety of the abortion procedure at issue, including in comparison with childbirth); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG and other medical organizations’ brief in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG publications in discussing “accepted medical standards” for the provision of obstetric-gynecologic

publications have been relied upon by numerous courts as authority on a variety of medical issues.³

Accordingly, *amici curiae* respectfully request leave to file the attached Brief of the American College of Obstetricians and Gynecologists and the

services, including abortions); *see also Gonzales v. Carhart*, 550 U.S. 124, 170–71, 175–78, 180 (2007) (Ginsburg, J., dissenting) (citing repeatedly to the ACOG’s *amicus* brief and ACOG’s congressional submissions regarding abortion procedures); *Greenville Women’s Clinic v. Bryant*, 222 F.3d 157, 168 (4th Cir. 2000) (extensively discussing ACOG’s guidelines).

³ The Supreme Court has repeatedly relied on and cited to the *AMA Code of Medical Ethics* as guidance. *National Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 592–93 (2012) (Ginsburg, J., concurring in part, dissenting in part); *Baze v. Rees*, 553 U.S. 35, 64, 112 (2008) (Alito, J., concurring & Breyer, J., concurring); *Ferguson v. City of Charleston*, 532 U.S. 67, 81 (2001); *Vacco v. Quill*, 521 U.S. 793, 800 n.6, 801 (1997); *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); *Rust v. Sullivan*, 500 U.S. 173, 214 (1991) (Blackmun, J., dissenting); *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 288, 308 (1990) (O’Connor, J., concurring & Brennan, J., dissenting); *Bates v. State Bar of Ariz.*, 433 U.S. 350, 369 n.20 (1977); *Roe v. Wade*, 410 U.S. 113, 144 n.39 (1973); *Lilly v. Commissioner*, 343 U.S. 90, 97 n.9 (1952).

American Medical Association as *Amici Curiae* in Support of Plaintiff-Appellant
and Reversal.

Dated: December 17, 2018
New York, N.Y.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 17th day of December, 2018, I electronically filed the foregoing Motion for Leave to File Brief of *Amici Curiae* the American College of Obstetricians and Gynecologists and the American Medical Association in Support of Plaintiff-Appellant and Reversal with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

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No. 18-35926

United States Court of Appeals
for the
Ninth Circuit

PLANNED PARENTHOOD OF THE GREAT NORTHWEST
AND THE HAWAIIAN ISLANDS,

Plaintiff-Appellant,

– v. –

LAWRENCE GARTH WASDEN, in his official capacity as the Idaho Attorney General;
JAN M. BENNETTS, in her official capacity as the Ada County Prosecuting Attorney;
GRANT P. LOEBS, in his official capacity as the Twin Falls County Prosecuting Attorney;
IDAHO STATE BOARD OF MEDICINE, individual members in their official capacities;
IDAHO STATE BOARD OF NURSING, the individual members in their official capacities;
RUSSELL S. BARON, in his official capacity as Director of the Idaho Department of
Health and Welfare; DANIEL BOWEN, in his official capacity as a member of the
Idaho Code Commission; ANDREW DOMAN, in his official capacity as a member
of the Idaho Code Commission; JILL S. HOLINKA, in her official capacity as a
member of the Idaho Code Commission,

Defendants-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO (BOISE)
DISTRICT COURT CASE NO. 1:18-CV-00319-DCN

**BRIEF FOR *AMICI CURIAE* AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS AND THE
AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF
PLAINTIFF-APPELLANT IN SUPPORT OF REVERSAL**

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CORPORATE DISCLOSURE STATEMENT PURSUANT TO FRAP 26.1

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure, *amici curiae*, the American College of Obstetricians and Gynecologists and the American Medical Association, state that they are non-profit organizations, with no parent corporations or publicly traded stock, and no publicly held company has 10% or greater ownership in *amici*.

STATEMENT REGARDING CONSENT TO FILE AND AUTHORSHIP

Defendants-Appellants have not consented to the filing of this brief. As such, Plaintiff-Appellant has filed this brief attached to a Motion for Leave to File Brief of *Amici Curiae* the American College of Obstetricians and Gynecologists and the American Medical Association in Support of Plaintiff-Appellant and Reversal.

No counsel for a party authored this brief in whole or in part, and no counsel for a party, nor any person other than the *amici curiae*, its members, or its counsel, contributed money that was intended to fund the preparation or submission of this brief. *See* Fed. R. App. P. 29(a)(4)(E).

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STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici Curiae the American College of Obstetricians and Gynecologists (“ACOG”) and the American Medical Association (“AMA”) submit this brief in support of Planned Parenthood of the Great Northwest and the Hawaiian Islands (“Plaintiff-Appellant” or “PPGNHI”).

With more than 58,000 members representing more than 90% of all board-certified obstetricians and gynecologists in the nation, ACOG is the premier professional membership organization of obstetricians and gynecologists and others dedicated to the improvement of women’s health. ACOG develops and publishes evidence-based practice guidelines, maintains the highest standards for continuing medical education, promotes high ethical standards in the practice of medicine, and fosters contributions to medical and scientific literature across all mediums and for all aspects of women’s health.

AMA is the largest professional association of physicians, residents, and medical students in the United States. Through medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in AMA’s policy making process. AMA’s objectives are to promote the science and art of medicine and the betterment of public health. Further, AMA advocates that scientific knowledge, data, and research will be protected and freely disseminated in accordance with the

First Amendment to the United States Constitution.

ACOG and AMA recognize that abortion is an essential health care service and oppose laws affecting health care that are unsupported by scientific evidence and that are not necessary to achieve an important public health objective.

SUMMARY OF ARGUMENT

Amici are leading medical organizations representing physicians in the United States.¹ AMA is the largest professional association of physicians, residents, and medical students in the country, and ACOG is the nation's leading organization of physicians who provide health services unique to women. *Amici* are dedicated to health care, research, and evidence-based health policy. *Amici* are committed to improving the health of women and to preserving access to health care.

The Abortion Complications Reporting Act, Idaho Code §§ 39-9501 *et seq.*, and amendments to Idaho Code § 54-1413(1) and § 54-1814(25) (“the Act”) is at fundamental odds with these principles. The Act is medically and scientifically

¹ Courts, including the U.S. Supreme Court, frequently rely on submissions by *amici* as authoritative sources of medical information, including on issues concerning abortion care. *See, e.g., Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing *amici* brief submitted by ACOG, AMA, and other medical associations in assessing disputed admitting privileges and surgical center requirements); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 916–17 (9th Cir. 2014) (citing brief submitted by ACOG and AMA as further support for a particular medical regimen), *cert. denied*, 135 S. Ct. 870 (2014).

unsound. It is vague and forces abortion providers to report, among other things, breast cancer, mental health issues, and failure to appear for a follow-up appointment as “complications” of a very safe, well-studied procedure, creating a public misconception that abortion is unsafe or causally associated with incidents of cancer or mental health conditions. In fact, abortion is one of the safest medical procedures performed in the United States. Medically, it is safer than carrying a pregnancy to term and significantly safer than childbirth. The Act chills this safe medical care by threatening physicians with license suspension and criminal sanctions, obstructing access to critical reproductive care and endangering the health and well-being of women in Idaho. Lastly, by forcing physicians to report 37 “complications” that are not based in medical science but are, according to the Idaho Legislature, “abnormal or [] deviant process[es] or event[s] arising from the performance or completion of an abortion,”² the Act compels speech in violation of physicians’ First Amendment rights.

For these and the reasons outlined below, *amici* oppose the Act and support Plaintiff-Appellant.

ARGUMENT

The Act’s medically unsupported requirements threaten the reproductive rights of Idaho women. By mandating that physicians report various

² I.C. § 39-9503(2).

“complications” that are in no way causally linked to abortion or actual “complications” at all, the Act adds unfounded barriers that prevent women from obtaining the reproductive health care they need. The Act should be enjoined.

I. Abortion Is an Extremely Safe Medical Procedure.

Legal abortion is an extremely safe and well-studied procedure. The risk of death resulting from an abortion has been exceptionally low—no more than a fraction of a percent—for decades.³ Abortion care creates little to no increased risk of future pregnancy problems,⁴ and no increased risk of cancer,⁵ including breast cancer.⁶ Even minor complications from the procedure are very rare,⁷ making

³ Tara C. Jatlaoui et al., Ctrs. Disease Control and Prevention, *Abortion Surveillance—United States, 2015*, 1, 5, 45 tbl.23 (2018) (finding that between 1978 and 2014, the national mortality rate ranged from 0.52 per 100,000 (or 0.00052%) to 0.78 per 100,000 (or 0.00078%)); *see also* Elizabeth G. Raymond et al., *Mortality of induced abortion, other outpatient surgical procedures and common activities in the United States*, 90 *Contraception* 476 (2014) (finding the U.S. mortality rate for abortions was comparable to or lower than that of plastic surgery and dental procedures).

⁴ Nat’l Academies of Sciences, Eng’g, and Med., *The Safety and Quality of Abortion Care in the United States* 133–47 (2018).

⁵ Alan Guttmacher Inst., *Fact Sheet: Induced Abortion in the United States, 2018*, available at <https://www.guttmacher.org/fact-sheet/induced-abortion-united-states> (“no indication that abortion is a risk factor for other cancers”).

⁶ ACOG Comm. Op. No. 434, *Induced Abortion and Breast Cancer Risk*, June 2009.

⁷ Kari White et al., *Complications from first-trimester aspiration abortion: A systematic review of the literature*, 92 *Contraception* 422, 434, 435 tbl.7 (2015); *see also* Ushma D. Upadhyay et al., *Incidence of Emergency*

abortion as safe as or safer than many routine outpatient procedures, such as colonoscopies.⁸ Yet providers of other routine outpatient procedures are not inundated with reporting requirements like those placed on abortion care providers.

The Act provides no medical benefit. First, Idaho has required that abortion complications be reported since 1977. Under I.C. § 39-261, abortion providers must report all induced abortions occurring within the state. To facilitate such reporting, the Idaho Department of Health and Welfare provides a form that must be completed for each induced abortion. The form requires attending physicians to report whether any of the five most frequent complications of an abortion occurred and provides space to list any additional complications.⁹ While the Act claims to “promote the health and safety of women by adding to the sum of medical and

Department Visits and Complications After Abortion, 125 *Obstetrics & Gynecology* 175 (2015) (finding that the risk of a major complication from a legal abortion was 0.23% and of any complication for which a patient sought (whether necessary or not) or received any medical care within six weeks was 2.1%).

⁸ White et al., *supra* note 7, at 436 (“[t]he percentage of complications [from first-trimester aspiration abortion] is comparable to other common office-based procedures, like vasectomy, and lower than that reported for [routine procedures], such as colonoscopy”); *see also Whole Woman’s Health*, 136 S. Ct. at 2315 (citing brief submitted by major medical organizations, including ACOG and AMA).

⁹ The five complications listed are hemorrhage, infection, uterine perforation, cervical laceration, and retained products. While the wording and categorization varies slightly, these are the same major complications studied in White et al. and Upadhyay et al., *supra* note 7.

public health knowledge through the compilation of relevant data,”¹⁰ I.C. § 39-261 already achieves this goal. This reveals the Act’s true purpose: to collect medically irrelevant information to artificially inflate the reported rate of alleged risks of an induced abortion.

Second, the data collected under the Act is itself unnecessary; abortion is one of the most well-studied medical procedures in the United States, and further reporting requirements will add nothing new to the medical literature regarding this safe procedure. The conclusion of the National Academies of Sciences, Engineering, and Medicine’s 2018 comprehensive review of induced abortion literature could not be clearer:

The committee’s overarching task was to assess the safety and quality of abortion care in the United States. . . . The committee concludes that legal abortions are safe and effective. . . .

The committee did not identify gaps in research that raise concerns about these conclusions and does not offer recommendations for specific actions to be taken by policy makers, health care providers, and others.¹¹

The safety of legal abortion stands in contrast to the risks of childbirth.¹²

¹⁰ I.C. § 39-9502(2).

¹¹ Nat’l Academies of Sciences, Eng’g, and Med., *supra* note 4, at 167.

¹² *Id.* at 75 tbl.2–4; ACOG Comm. Op. No. 613, *Increasing Access to Abortion*, Nov. 2014 (citing Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216 (2012)).

Women in the United States are 14 times more likely to die in childbirth than as a result of a legal abortion.¹³ Women in Idaho are more likely to die from childbirth than women in the United States generally,¹⁴ and Idaho women are 39 times more likely to die in childbirth than as a result of a legal abortion.¹⁵

II. The Law Is Not Based in Medical Science.

Many of the Act's unnecessary, irrational, and onerous reporting requirements have no basis in medical science. The reporting erroneously undermines the fact—established by rigorous, peer-reviewed medical literature—that abortion is incredibly safe and has low complication rates.¹⁶ The Act presumes medically inaccurate relationships between abortion and dozens of medical conditions, such as breast cancer, creating the false impression among the public that abortion is unsafe. The Act's reports, which disregard accepted

¹³ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216 (2012).

¹⁴ Pl.'s Decl. of Sabina Holmquist ¶ 29.

¹⁵ There were 24.3 maternal deaths per 100,000 births in Idaho from 2005 to 2011. United Health Foundation, *America's Health Rankings*, 2018, available at https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality/state/ID (using data from the CDC WONDER Online Database, Mortality files). The national mortality rate for legal abortions from 2008 to 2014 is 0.62 per 100,000. Jatlaoui et al., *supra* note 3, at tbl. 23.

¹⁶ See ACOG Comm. Op. No. 613, *Increasing Access to Abortion*, Nov. 2014.

research protocols, will be useless for future scientific studies.¹⁷ The statute is not written to collect any reliable, scientific data, and it fails to advance medical science.

A. There Is No Causal Link between Abortion and Subsequent Development of Breast Cancer.

The statute requires abortion providers to report the “[s]ubsequent development of breast cancer” as a complication of abortion, even though the medical community agrees there is no causal link between abortion and the risk of developing breast cancer.¹⁸ Early studies suggesting a link between induced abortion and an increased breast cancer risk were found to be “methodologically flawed.”¹⁹ Rigorous studies in the early 2000s demonstrated “no causal relationship between induced abortion and a subsequent increase in breast cancer risk.”²⁰ Across the board, medical, public health, and cancer organizations deny

¹⁷ Pl.’s Decl. of Ushma Upadhyay ¶ 14 (“the Act’s classification system is irrational and cannot and will not facilitate reliable scientific studies or research. The reports required under the Act (and the resulting data the Department must make publicly available) will be useless and unusable for evidence-based scientific research.”). In the abortion field, studies should follow individual patients over a defined period of time or use comprehensive medical record data to fully assess the safety of the procedure. *Id.* at ¶ 18.

¹⁸ Nat’l Academies of Sciences, Eng’g, and Med., *supra* note 4, at 148–49.

¹⁹ ACOG Comm. Op. No. 434, *supra* note 6.

²⁰ *Id.*

any link between induced abortions and the development of breast cancer.²¹

Rather than advance medical science, the Act's reporting requirements will only scare women into believing, based on misleading data gathered by the State, that an abortion will increase their likelihood of later developing breast cancer. There is no public health justification for reports by abortion providers about breast cancer in women who have had abortions, because there is a complete lack of evidence that abortions cause this medical condition.

B. Women Who Undergo Abortions Do Not Have Increased Mental Health Conditions.

Requiring a provider to report “any psychological or emotional condition reported by the patient” as a complication of abortion, creates another false relationship. Women are no more likely—and in fact less likely—to experience

²¹ Am. Pub. Health Ass'n, *Restricted Access to Abortion Violates Human Rights, Precludes Reproductive Justice, and Demands Public Health Intervention*, Nov. 3, 2015, available at <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/04/11/24/restricted-access-to-abortion-violates-human-rights> (“There is no association between abortion and breast cancer.”); Nat'l Breast Cancer Coal., *Abortion and Breast Cancer Risk: Position Statement*, June 2011, available at <http://www.breastcancerdeadline2020.org/breast-cancer-information/breast-cancer-information-and-positions/abortion-and-breast-cancer.pdf> (“Based on overwhelming scientific evidence, NBCC does not support any public policy efforts that imply such a link exists.”); Nat'l Cancer Inst., Nat'l Inst. of Health, *Abortion, Miscarriage, and Breast Cancer Risk: 2003 Workshop*, Jan. 12, 2010, available at <https://www.cancer.gov/types/breast/abortion-miscarriage-risk#summary-report> (“They concluded that having an abortion or miscarriage does not increase a woman's subsequent risk of developing breast cancer.”).

mental health issues after obtaining an abortion than having carried an unwanted pregnancy to term.²² All pregnancies involve risks of both physical and psychological complications.²³ Some of these risks can be fatal, while others, such as depression, persist even after childbirth.²⁴ The risks associated with unwanted pregnancies are particularly troubling. Women who undergo unintended childbirth experience increased risk of maternal depression,²⁵ and unwanted births carry increased risks of congenital anomalies, premature delivery, and low birth

²² See Nat'l Collaborating Centre for Mental Health, Acad. Med. Royal C., *Induced abortion and mental health: A systematic review of the mental health outcomes of induced abortion, including their prevalence and associated factors* 120–26, Dec. 2011, available at https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf; Trine Munk-Olsen et al., *Induced First Trimester Abortion and Risk of Mental Disorder*, 364 NEW ENG. J. MED. 332, 332 (2011); Brenda Major et al., *Abortion and Mental Health: Evaluating the Evidence*, 64 AMERICAN PSYCHOLOGIST 863, 863 (2009); Am. Psychol. Ass'n, *Report of the APA Task Force on Mental Health and Abortion* 92, 2008, available at <https://www.apa.org/pi/women/programs/abortion/mental-health.pdf>.

²³ See World Health Org., *Managing Complications in Pregnancy and Childbirth: A Guide for Midwives and Doctors* (2d ed. 2017), available at http://whqlibdoc.who.int/publications/2007/9241545879_eng.pdf.

²⁴ See *id.* at C-13.

²⁵ M. Antonia 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, 171 (2017).

weight.²⁶ Carrying an unwanted pregnancy to term can be, and often is, dangerous for women's health.

Abortion, on the other hand, is extremely safe, and women who have abortions do not have an increased risk for psychiatric illness.²⁷ The strongest indicator of mental health status after an abortion is whether the patient has a history of mental health issues predating the procedure.²⁸ Mental health problems are not caused by abortion, but can be caused by other preexisting and concurrent risk factors, such as poverty, exposure to violence, drug use, and personality characteristics.²⁹ One recent five-year longitudinal study, the Turnaway Study, followed almost 1,000 women who sought abortions nationwide and found that

²⁶ A.P. Mohallajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal Outcomes*, 109 *Obstetrics & Gynecology* 678, 684 (2007).

²⁷ Nat'l Academies of Sciences, Eng'g, and Med., *supra* note 4, at 153 ("having an abortion does not increase a women's risk of . . . mental health disorders (depression, anxiety, and PTSD)."); Gail Erlick Robinson et al., *Is There an "Abortion Trauma Syndrome"? Critiquing the Evidence*, 17 *Harv. Rev. Psychiatry* 268, 276 (2009) ("To date, the published studies concluding that abortion causes psychiatric illness have numerous methodological problems; since their conclusions are questionable, they should not be used as a basis for public policy.").

²⁸ See Nat'l Collaborating Centre for Mental Health, *supra* note 22; Am. Psychol. Ass'n, *supra* note 22; Pl.'s Decl. of Sabina Holmquist ¶ 42 ("There is no reliable evidence that abortion 'creates' or 'causes' psychological or emotional problems that did not already exist prior to or would have arisen regardless of having had the procedure.").

²⁹ Major et al., *supra* note 22, at 869.

women who had an abortion had similar or even *better* mental health outcomes than those who were denied a wanted abortion.³⁰

Reports by abortion providers about mental health conditions perpetuates the inaccurate notion that abortions are harmful to women. There is no basis in public health to report this information.

C. Failure to Appear for Follow-Up Visits Is Not a “Complication” of an Abortion.

The Act requires abortion providers to report when patients do not return for a follow-up visit, even though this behavior is not a “complication” of abortion and should not be treated as such. Rather, it is a personal decision of a patient.³¹

Follow-up appointments are not medically necessary in all cases, and a patient may or may not be advised by a physician to return.³² Failure to appear at a follow-up

³⁰ Biggs et al., *supra* note 25, at 174 (“Women who were denied an abortion, in particular those who later miscarried or had an abortion elsewhere . . . had the most elevated levels of anxiety and the lowest self-esteem and life satisfaction 1 week after being denied an abortion, which quickly improved and approached levels similar to those in the other groups by 6 to 12 months.”); *see also* Pam Belluck, *Abortion Is Found to Have Little Effect on Women’s Mental Health*, N.Y. Times, Dec. 14, 2016, available at <https://www.nytimes.com/2016/12/14/health/abortion-mental-health.html>.

³¹ Pl.’s Decl. of Sabina Holmquist ¶ 52.

³² World Health Org., *Safe Abortion: Technical and Policy Guidance for Health Systems* 52 (2d ed. 2012) (“Following safe, induced abortion, post-abortion care may not require a follow-up visit if the woman has adequate information about when to seek care for complications and has received any needed supplies or information to meet her contraceptive needs.”).

appointment is often a sign that the patient is feeling well enough to continue her daily life and views another visit as pointless. That is the opposite of a complication. Failure to appear is wholly consistent with the medical fact that abortion is among the safest of procedures. Abortion patients “may return to their normal daily activities when they feel ready . . . generally within hours or 1–2 days following a first trimester abortion.”³³ There is no public health issue for the State to address when women choose not to come in for a follow-up appointment.

* * * * *

The state of Idaho does not have any legitimate public health reason to collect information regarding “complications” like breast cancer, mental health issues, failure to return for follow-up visits, or any other categories that have no basis in medical science or public health. Nor is there a basis to assume these conditions are “abnormal or [] deviant process[es] or event[s] arising from the performance or completion of an abortion.”³⁴ The Act imposes unnecessary reporting requirements on providers, and, in doing so, reveals the State’s intent to create a false impression that abortion is risky. Indeed, the State does not require

³³ Kathleen M. McIntosh et al., *Routine Aftercare and Contraception*, in *A Clinician’s Guide to Medical and Surgical Abortion* 188 (Maureen Paul, ed., 1999).

³⁴ I.C. § 39-9503(2).

the reporting of complications of any other medical procedure, including those with higher complication rates.

III. The Act Chills Safe Medical Care by Imposing Potential License Suspensions and Criminal Sanctions.

Providers of medical care should never be penalized for providing safe care. Yet if a physician violates the Act, the State Board of Medicine “may refuse licensure” to or otherwise discipline a physician³⁵ and could subject him or her to penalty of misdemeanor,³⁶ even though the Act does nothing to make care any safer and is at odds with accepted medical practice. The Act’s penalties are also concerning because the Act itself is vague—it fails to contain any time limitation on the reporting requirement or guidance or direction as to what constitutes “physical injuries”³⁷ or an “indirect” complication.³⁸ If the Act is permitted to

³⁵ I.C. § 54-1808 (“The board may refuse licensure if it finds that the applicant had engaged in conduct prohibited by section 54-1814, Idaho Code.”). *See* I.C. § 54-1814 (“Every person licensed to practice as a physician assistant or registered as an extern, intern or resident in this state is subject to discipline by the board pursuant to the procedures set forth in this chapter and the rules promulgated pursuant thereto upon any of the following ground: . . . (25) Failure to comply with the requirements of the abortion complications reporting act, chapter 95, title 39, Idaho Code.”).

³⁶ I.C. § 39-9506.

³⁷ I.C. § 39-9503(2)(q).

³⁸ I.C. §39-9504.

stand, the threat of license suspension and other sanctions will chill the provision of abortions, and Idaho women will struggle to access abortion care.

The Supreme Court has found that a statute that subjects doctors to strict civil and criminal liability based on diagnoses or determinations over which medical experts could disagree “could have a profound chilling effect on the willingness of physicians to perform abortions”³⁹ Other courts have found that the threat of suspension or loss of a medical license will do the same.⁴⁰

Abortion is one of the most common medical procedures in the United States, and yet it is performed at a comparatively small number of facilities. In 2014, 1,671 facilities performed an estimated 926,200 abortions.⁴¹ The number of abortion facilities decreased by 3% between 2011 and 2014, with a 7% drop in clinics providing abortions in western states.⁴²

³⁹ *Colautti v. Franklin*, 439 U.S. 379, 396 (1979).

⁴⁰ *Planned Parenthood of Central New Jersey v. Farmer*, 220 F.3d 127, 144–45 (3d Cir. 2000); *Planned Parenthood of the Heartland v. Heineman*, 724 F. Supp. 2d 1025, 1038–39 (D. Neb. 2010).

⁴¹ Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 *Perspectives on Sexual and Reproductive Health* 17 (2017).

⁴² *Id.* at 20.

Idaho is a predominantly rural state, and rural women face particularly high barriers to accessing abortion care.⁴³ In 2014, 90% of counties in the United States had no clinics that provided abortion care, and 39% of women of reproductive age in the United States lived in those counties.⁴⁴ Rural physicians in private practice are substantially less likely to perform abortions than urban physicians in private practice.⁴⁵ Due to the dearth of private physician providers and the smaller number of clinics, rural women are far more likely to need to travel long distances for abortion care.⁴⁶ The need to travel longer distances to reach abortion providers is associated with increased reliance on emergency room visits and fewer patient options regarding abortion procedures and pain management.⁴⁷ The National Academies of Sciences, Engineering, and Medicine's review of the evidence regarding the safety and efficacy of legal abortion concluded that many state regulations are barriers to quality abortion care because they limit women's access to trained providers.⁴⁸

⁴³ ACOG Comm. Op. No. 586, *Health Disparities in Rural Women*, Feb. 2014, at 2.

⁴⁴ Jones & Jerman, *supra* note 41, at 20.

⁴⁵ ACOG Comm. Op. No. 586, *supra* note 43, at 2.

⁴⁶ *Id.*

⁴⁷ Nat'l Academies of Sciences, Eng'g, and Med., *supra* note 4, at 115–16.

⁴⁸ *Id.* at 162–65.

Idaho women already have insufficient access to abortion providers; only 3 of Idaho's 44 counties have abortion providers. Women in most of Idaho live more than 100 miles from the nearest abortion provider.⁴⁹ Pocatello, Idaho is one of 27 cities nationwide identified as an "abortion desert" because its more than 50,000 residents live more than 100 miles from an abortion provider.⁵⁰ Idaho's women need more abortion providers, not threats directed at the providers they do have. The loss of any of the state's existing providers would substantially reduce Idaho women's already limited access to abortion.

Moreover, there is no medical benefit in penalizing what is safe.⁵¹ The Act's threat of loss of licensure and criminal penalties for providing safe medical care will only chill that care.

IV. The Act Compels Speech in Violation of Physicians' First Amendment Rights.

The speech compelled by the Act is content-based, and therefore the Act is subject to strict scrutiny. Thus, the Act is "presumptively unconstitutional . . .

⁴⁹ Alice F. Cartwright et al., *Identifying National Availability of Abortion Care and Distance from Major US Cities: Systematic Online Search*, 20 J. Med. Internet Res. e186, p.9 fig. 1 (2018).

⁵⁰ *Id.* at 8 tbl.3.

⁵¹ *See supra* Section I.

[and] justified only if the government proves that [the Act is] narrowly tailored to serve compelling state interests.”⁵² The Act fails on both counts.

Prior to the Act, physicians would report the complications required under I.C. § 39-261 as well as complications that they, in their professional judgment, viewed as medically necessary. Physicians’ reports contain their medical determinations of their patients’ conditions after an abortion procedure, and by forcing physicians to add certain misleading “complications” to these reports, the Act “alte[rs] the content of [the physicians’] speech.”⁵³ For example, as explained in Plaintiff-Appellant’s briefing, the Act requires physicians to report “normal side effects that are routine, minor and expected.”⁵⁴

Where government “polices the content of professional speech, it can fail to preserve an uninhibited marketplace of ideas in which truth will ultimately prevail.”⁵⁵ The Supreme Court has recognized that “[p]rofessionals might have a host of good-faith disagreements, both with each other and with the government,

⁵² *Nat’l Inst. of Family and Life Advocates v. Becerra*, 138 S. Ct. 2361, 2371, (2018) (citing *Reed v. Town of Gilbert*, 135 S. Ct. 2218, 2226 (2015)).

⁵³ *Id.* (internal citations omitted).

⁵⁴ Pl.’s Mem. Supp. Mot. Prelim. Inj., 8 (citing Decl. of Sabina Holmquist ¶ 33–34).

⁵⁵ *Becerra*, 138 S. Ct. at 2374 (internal quotation and citation marks omitted).

on many topics in their respective fields.”⁵⁶ Plaintiff-Appellant’s physicians must be allowed to exercise their medical judgment to determine when a “complication” is truly a complication. This is the only way to develop reliable data about abortion complications.

Instead, under the Act, physicians must report patient information that is “routine, minor and expected.” Under the Act, the government—not a medical association or other authority with health care expertise—dictates to physicians a list of “complications” and tells physicians they apply to abortion, notwithstanding physicians’ medical judgment.

The Act’s claimed purpose is to “promote the health and safety of women by adding to the sum of medical and public health knowledge through the compilation of relevant data.”⁵⁷ Yet forcing physicians to report “complications” they would otherwise not report risks poisoning the actual published reports in peer-reviewed literature about abortion safety and its low complication rates.⁵⁸ The State’s true interest is not in collecting relevant abortion data, but even if it were, there is no

⁵⁶ *Id.* at 2374–75 (listing doctors as its first example of professionals it has in mind and holding content-based speech regulations imposed on crisis pregnancy centers unconstitutional).

⁵⁷ I.C. § 39-9502(2).

⁵⁸ Pl.’s Decl. of Ushma Upadhyay ¶¶ 14, 18, 30; Pl.’s Decl. of Sabrina Holmquist ¶¶ 15, 56.

additional accurate data to collect. Physicians must not be required to report “complications” that do not exist, merely to advance the state’s political objectives.

V. Conclusion

For the foregoing reasons, this Court should reverse the decision of the District Court.

Dated: December 17, 2018

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

In accordance with Fed. R. App. P. 29(a)(5) and 32(a)(7), the undersigned certifies that this brief has been prepared in a proportionally spaced typeface, Times New Roman, in 14-point font. According to the word processing system used to prepare the brief, Microsoft Word 2010, it contains 4,527 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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CERTIFICATE OF SERVICE

I hereby certify that, on December 17, 2018, a true and correct copy of the foregoing Brief of the American College of Obstetricians and Gynecologists and the American Medical Association as *Amici Curiae* in Support of Plaintiff-Appellant was filed with the Clerk of the United States Court of Appeals for the Ninth Circuit via the Court's CM/ECF system. Counsel for all parties will be served electronically by the Court's CM/ECF system.

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