No. 19-2690

# UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

LITTLE ROCK FAMILY PLANNING SERVICES, et al.,

*Plaintiffs-Appellees*,

v.

LESLIE RUTLEDGE, in her official capacity as Attorney General of the State of Arkansas, et al.,

*Defendants-Appellants.*

On Appeal from the United States District Court for Eastern District of Arkansas, Case No. 4:19-cv-00449-KGB, Hon. Kristine G. Baker

## BRIEF OF AMICI CURIAE SOCIETY FOR MATERNAL-FETAL MEDICINE AND AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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## INTEREST OF AMICI CURIAE

The Society for Maternal-Fetal Medicine ("SMFM" or "the Society") and the American College of Obstetricians and Gynecologists ("ACOG" or "the College") submit this *amici curiae* brief in support of the Plaintiffs-Appellees. All relevant parties consent to the filing of this brief.[1]

**SMFM** is a non-profit, membership organization dedicated to the optimization of pregnancy and perinatal outcomes. SMFM supports the clinical practice of maternal-fetal medicine, including by providing education, promoting research, and engaging in advocacy to optimize the health of high-risk pregnant women and their children, and is dedicated to expanding the delivery of quality tools and mentorship resources to drive best practices in maternal-fetal medicine.

The bulk of SMFM's members are maternal-fetal medicine subspecialists, Obstetrician and Gynecologist ("OB-GYN") physicians that have completed additional years of education and training to become high-risk pregnancy experts with highly advanced knowledge and training in medical, surgical, obstetrical, fetal, and genetic complications of pregnancy.

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[1] Pursuant to Federal Rule of Appellate Procedure 29, undersigned counsel for SMFM and ACOG certify that: no party's counsel authored this *amici curiae* brief in whole or in part; no party or party's counsel contributed money that was intended to fund preparing or submitting this *amici curiae* brief; and no person or entity, other than SMFM and ACOG, their members, or their counsel, contributed money intended to fund the preparation or submission of this *amici curiae* brief.

The Society's interest in this case stems from the scientific and medical expertise of its members and their desire to protect the integrity of evidence-based medicine. SMFM is further interested in this case because of its opposition to legislation and policies that compromise the patient-physician relationship by limiting a health care professional's ability to counsel women and/or provide medically appropriate treatment, as well as the interests of maternal-fetal medicine subspecialists ("MFMs") to pursue their calling. SMFM supports a woman's right to access the full spectrum of reproductive health services, including pregnancy termination.[2] SMFM and its members are dedicated to optimizing maternal and child outcomes, and assuring that medically appropriate options and personnel are available to women with high-risk pregnancies is critically important.[3]

**ACOG** is a national non-profit educational and professional organization that works to promote the advancement of women's health through continuing medical education, practice, research, and advocacy. With more than 58,000 members, ACOG is the leading organization of women's health care physicians and partners. ACOG is dedicated to continuously improving all aspects of health care for women, establishing and maintaining the highest possible standards for

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[2] Society for Maternal-Fetal Medicine, *Access to Pregnancy Termination Services* (Dec. 2017) ("SMFM Position Statement"), https://www.smfm.org/advocacy/positions (last accessed Sept. 8, 2019).

[3] *Id.*



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education and clinical practice, promoting high ethical standards, publishing evidence-based practice guidelines, encouraging contributions to medical and scientific literature, and increasing awareness among its members and the public about the changing issues facing women's healthcare.

ACOG opposes laws regulating medical care that unduly interfere with the patient-physician relationship or patient care absent a substantial public health justification.[4] ACOG recognizes that abortion is "an essential component of women's health care," that "[l]ike all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties," and that "[l]ike all patients, women obtaining abortions are entitled to privacy, dignity, respect and support."[5] ACOG opposes legislation that "weakens the patient-physician relationship" and prevents

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[4] ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (Reaffirmed July 2016) ("ACOG Leg. Policy Statement"), https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Legislative-Interference (last accessed Dec. 8, 2019) ("Laws that veer from these functions and unduly interfere with patient-physician relationships are not appropriate. Absent a substantial public health justification, government should not interfere with individual patient-physician encounters.").

[5] ACOG, Statement of Policy, *Abortion Policy* (Nov. 2014), ("ACOG Abortion Policy Statement") https://www.acog.org/Clinical-Guidance-and-Publications/Statements-of-Policy/Abortion-Policy?IsMobileSet=false.



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a patient from receiving counsel or treatment "according to the best available medical evidence and the physician's professional medical judgment."[6]

Federal courts, including the Supreme Court of the United States, frequently cite ACOG's work as authoritative medical data regarding women's health care.[7]

## INTRODUCTION AND SUMMARY OF ARGUMENT

The availability of safe, legal abortion is an essential component of women's[8] health care.[9] Like all medical matters, decisions regarding abortion should be made by patients in consultation with their physicians and other health care professionals and without undue interference by outside parties. Physicians and other medical professionals who provide safe, effective, and necessary medical

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[6] *Supra* note 4, ACOG Leg. Policy Statement.

[7] *See, e.g., Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing ACOG's *amicus* brief in assessing disputed admitting privileges and surgical center requirements); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG's *amicus* brief in assessing disputed parental notification requirement); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 916-17 (9th Cir. 2014) (citing ACOG and the American Medical Association's ("AMA") *amicus* brief as further support for a particular medical regimen), cert denied 574 U.S. 1060 (2014); *Stuart v. Camnitz*, 774 F.3d 238, 251-52, 254, 255 (4th Cir 2014) (citing ACOG and the AMA's *amicus* brief in assessing how an ultrasound requirement exceeded the bounds of traditional informed consent and interfered with physician's medical judgment), cert denied, 135 S. Ct. 2838 (2015).

[8] *Amici* use the term "women" throughout this brief, but recognize that transgender and non-binary individuals can become pregnant and would be affected by the Acts. The positions taken by *amici* in this brief are meant to encompass such persons.

[9] *See supra* note 5, ACOG Abortion Policy Statement.

care should not face criminal sanction. But, this is what the State of Arkansas seeks to do through 2019 Arkansas Acts 493, 619, and 700.

By effectively banning all abortions in Arkansas after 18 weeks from the last menstrual period ("LMP") (the "Gestational Age Ban"), banning all abortions sought "solely on the basis of" a diagnosis of or test result indicating Down syndrome or "[a]ny other reason to believe" that a fetus has Down syndrome (the "Reason Ban"), and prohibiting physicians from performing abortions unless they are board-certified or board-eligible in obstetrics and gynecology (the "Ob-Gyn Requirement"), the Arkansas Acts threaten the health and safety of women. The Acts also violate well-settled constitutional law. The Gestational Age Ban and Reason Ban both ban abortions pre-viability without justification. And, the Ob-Gyn Requirement is a restriction on a woman's ability to access abortion care without any medical justification. Collectively and separately, the Acts substantially interfere with the quality of medical care available to women seeking abortions within Arkansas without any—let alone a substantial or meaningful—health benefit.

Further, the Acts undermine core longstanding principles of medical ethics. Defining a patient's course of treatment according to vague political—rather than medical—considerations would force doctors into an ethical conundrum: if the law is permitted to stand, physicians who sought to practice consistent with their best

medical judgment and ethical obligations could be put in a position where they risked their license and/or criminal sanction. The State's attempt to defend the Acts on the basis of promoting the integrity and ethics of the medical profession is, accordingly, without merit.

There is simply no medical basis or other public health benefit to burdening a woman's right to obtain reproductive health care or a physician's ability to practice medicine consistent with his or her ethical obligations. Accordingly, the Court should affirm the decision below.

## ARGUMENT

### I. The Gestational Age Ban and Reason Ban Unconstitutionally Ban Abortions Prior to Viability

The U.S. Constitution indisputably protects a woman's right to terminate a pregnancy prior to viability. A fetus is only viable if there is a reasonable likelihood that it will be able to survive for a sustained period of time outside of a woman's uterus.[10] There is no specific gestation age that ensures viability and viability often depends on the characteristics of an individual pregnancy.[11] That

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[10] *Supra* note 5, ACOG Abortion Policy Statement.

[11] Kaiser Family Foundation, *Abortions Later in Pregnancy*, available at https://www.kff.org/womens-health-policy/fact-sheet/abortions-later-in-pregnancy/ (last accessed Dec. 30, 2019).

said, the consensus of the medical and scientific community is that viability—sustained survival outside the womb—at 18 weeks LMP is not possible.[12]

The Gestational Age Ban and the Reason Ban would prohibit a woman from choosing an abortion before viability is possible and thus are unconstitutional on this ground alone.[13]

## II. All Three Acts Endanger Women's Health

The State's premise that the Acts promote safety for the patient is without merit and not supported by medical or scientific evidence. In fact, the laws would endanger, not promote, women's health and safety.

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[12] ACOG, Obstetric Care Consensus, *Periviable Birth* (Oct. 2017), https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Periviable-Birth?IsMobileSet=false. A fetus delivered between 22 and 23 weeks requires extraordinary life-saving intervention and even with such intervention, has a survival rate of only 5-6%. Of the 5-6% that survive, significant morbidity is universal (98-100%). *Id.*; Tonse N.K. Raju, et al., *Periviable Birth*, 123 OBSTETRICS & GYNECOLOGY 1083, 1085 (May 2014) ("Infants born at 20 weeks and 21 weeks of gestation do not survive, irrespective of resuscitation efforts.").

[13] With regard to the Reason Ban, Down syndrome is typically diagnosed in a fetus between 10 and 14 weeks LMP, after a woman undergoes a chorionic villus samplings ("CVS") diagnostic procedure. Women can also receive a Down syndrome diagnosis after undergoing an amniocentesis, which is usually performed in the second trimester between 15 and 22 weeks of gestation. A study of patients in California revealed that screening in the first trimester identified 75.9% of all Down syndrome cases. Baer, et al., *Detection Rates for Aneuploidy by First-Trimester and Sequential Screening*, 126 OBSTETRICS & GYNECOLOGY 753, 755 (Oct. 2015).

### A. Abortion Is A Common and Extremely Safe Medical Procedure

Abortion has consistently been one of the safest medical procedures performed in the United States.[14] The risk of death resulting from an abortion has been exceptionally low for decades.[15] It is also extremely rare that an abortion will result in complications that require hospital admission.[16] Major complications from abortions are rare, occurring in less than one-fourth of one percent of procedures, making the procedure safer than the removal of wisdom teeth.[17] Abortions are also safer than adult tonsillectomies, colonoscopies, plastic surgery, and dental procedures.[18]

Abortion is far safer than carrying a pregnancy to term. Between 1998 and 2005, the pregnancy-associated mortality rate among women who delivered live

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[14] Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States* 74 (The National Academies Press 2018).

[15] Elizabeth G. Raymond, et al., *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215-29 (FEB. 2012).

[16] Ushma D. Upadhyay, et al., *Abortion-Related Emergency Department Visits in the United States: An Analysis of a National Emergency Department Sample*, BMC Medicine (2018).

[17] Bixby Center for Global Reproductive Health, *Abortion Restrictions Put Women's Health, Safety and Well-Being at Risk* 1; Upadhyay UD, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175-83 (Jan. 2015).

[18] *Supra* note 14, Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States* 74.



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neonates in the United States was 8.8 deaths per 100,000 live births.[19] The mortality rate related to legal induced abortion during that same interval was 0.6 deaths per 100,000 abortions.[20] While the maternal mortality rate in the United States has been rising, mortality from abortion is virtually non-existent.

In one study comparing physical health consequences after carrying a pregnancy to term and abortion, the women who gave birth reported potentially life-threatening complications, such as eclampsia and postpartum hemorrhage, whereas those having abortions did not.[21] Women who gave birth also reported the need to limit physical activity for a period of three times longer than that reported by women who received abortions.[22]

### B. The Gestational Age Ban Will Harm, Not Improve, Women's Health

The State's claim that the Gestational Age Ban will improve women's health is without merit. Amici describe below the State's error and distortion of the facts. The district court properly reached the factual conclusion that there was

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[19] *Supra* note 15, Raymond, et al. *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 216.

[20] *Id.* ("Thus, according to federal statistics, the risk of death associated with childbirth was approximately 14 times higher than that with abortion.").

[21] *Side Effects, Physical Health Consequences, and Mortality Associated With Abortion and Birth After an Unwanted Pregnancy*, https://www.ncbi.nlm.nih.gov/pubmed/26576470.

[22] *Id.*.



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insufficient evidence to support the Gestational Age Ban.[23] Amici write to highlight the medical and scientific inaccuracies in the State's claims.

### *1. The State Distorts the Medical Evidence it Purports to Rely On to Support the Gestational Age Ban*

The State claims that the Gestational Age Ban "responds to evidence linking increased maternal risk to increased gestational age and seeks to limit that risk." In referring to this alleged "evidence," the Gestational Age Ban states, "[a]ccording to a 2004 article, abortion can cause significant physical and psychological risks to the pregnant woman that increase with gestational age. Specifically, the relative physical and psychological risks escalate exponentially as gestational age increases in abortions performed after eight (8) weeks' gestation."[24] The State's position does not accurately reflect the state of medical and scientific evidence or the broad and overwhelming consensus of the medical and scientific communities as reflected in verifiable evidence: abortion is safe and the greatest threat to the safety of abortion is unnecessary restrictions on abortion.[25]

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[23] *See Little Rock Family Planning Services v. Rutledge*, 398 F. Supp. 3d 330 (E.D. Ark. 2019); *see also Whole Woman's Health*, 136 S.Ct. at 2310 (the "Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.") (emphasis omitted).

[24] 2019 Ark. Act 493, 20-16-2002(a)(6)-(8).

[25] *Supra* note 14, Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States* 74.



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### *2. There is No Health or Safety Justification for the Gestational Age Ban*

As noted, abortion is an extremely safe medical procedure. While the risk of complications from abortion is incredibly low, the risk of complications does increase with gestational age. Yet, in all cases, adverse outcomes after abortions are extremely rare, even when an abortion is performed later in pregnancy.[26]

There are a variety factors that cause greater risk of complications for abortions performed later in pregnancy, as opposed to earlier. For example, as the number of weeks of gestation increase, the invasiveness of the required procedure and the need for deeper levels of sedation may also increase.[27] Moreover, the population of women having abortions later in pregnancy is also likely composed of a greater proportion of women with coexisting medical conditions, which puts them at a higher risk of complications.[28] These and other factors that might

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[26] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 736 (Apr. 2004); *supra* note 14, Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States*.

[27] *Supra* note 14, Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States,* 10.

[28] *See supra* note 15, Raymond, et al., *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 218. "[B]ecause comorbidities are sometimes the motivation of abortion, the underlying medical risk of patients undergoing abortion may be higher than that of other pregnant women. Women in good health may be more likely to choose to continue their pregnancies than those who are ill (selection bias termed the "healthy mother" effect)."



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increase the risk of abortion as gestational age increase do not warrant a gestational age ban on abortions.

On the contrary, the medical community recommends "increased access to surgical and nonsurgical abortion services" as they "may increase the proportion of abortions performed at lower-risk, early gestational ages."[29] It is the consensus of the medical community that unnecessary bans and restrictions on abortion access endanger women.[30] A recent study published by the National Academies of Medicine, Engineering and Science concluded that the greatest threats to the safety and quality of abortion in the United States are unnecessary regulations on abortion.[31] Accordingly, the Gestational Age Ban would not mitigate the rare risk of complications associated with abortions. Instead, it creates unnecessary medical

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[29] *See supra* note 26, Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 736 (Apr. 2004). The State and the Act are likely referencing this article in support of their claim that the Gestational Age Ban responds to evidence linking increased maternal risk to increased gestational age. However, Bartlett's 2004 article does not recommend decreasing the availability of legal abortions—it recommends increasing their availability.

[30] *Supra* note 14, Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States* 74; ACOG, Committee Opinion No. 613, *Increasing Access to Abortion* (Nov. 2014), available at https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Increasing-Access-to-Abortion?IsMobileSet=false.

[31] *Supra* note 14, Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States* 74.



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risks by forcing women to carry a pregnancy to term or resort to self-help in terminating their pregnancies.

The State also seeks to justify its Gestational Age Ban based on the proposition contained in the Act that "psychological risks escalate exponentially as gestational age increases in abortions performed after eight (8) weeks' gestation." There is no evidence for the State's assertion.

For women with an unplanned pregnancy, there is no difference in the risk of depression or other mental health problems between those who have an abortion and those who carry their pregnancy to term.[32]

Researchers at the Johns Hopkins Bloomberg School of Public Health concluded that "the highest-quality research available does not support the hypothesis that abortion leads to long-term mental health problems" and noted that most of the studies reviewed had neutral findings suggesting few, if any, differences between women who had abortions and their respective comparison groups in terms of mental health issues.[33] The American Psychological Association (the "APA") has concluded that the available evidence does not

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[32] ACOG, *Frequently Asked Questions: Induced Abortion*, available at https://www.acog.org/Patients/FAQs/Induced-Abortion.

[33] Vignetta E. Charles, et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 CONTRACEPTION 436, 448-49 (July 2008).

support a claim of an observed association between abortion history and mental health is caused by abortion *per se*.[34]

A 2015 study examined patient's emotional responses after receiving abortions.[35] The study found that nearly all of the participants felt that receiving an abortion was the right decision.[36] Another study found that women who are able to access abortion care are actually better able to maintain a positive future outlook and achieve their aspirational life plans than women who are denied abortion care and must carry an unwanted pregnancy to term.[37] Contrary to the State's attempt to persuade otherwise, evidence actually suggests that women who are denied abortion care have reported greater anxiety and depression symptoms, lower self-

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[34] Brenda Major, et al., *Report of the APA Task Force on Mental Health and Abortion*, at 91-92 (2008), available at http://www.apa.org/pi/women/programs/abortion/mental-health.pdf.

[35] Corinne H. Rocca, et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0128832.

[36] *Id.*

[37] Ushma D. Upadhyay, et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102 (Nov. 2015), available a https://bmcwomenshealth.biomedcentral.com/articles/10.1186/s12905-015-0259-1.



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esteem, and lower life satisfaction than those who are able to control their reproductive lives.[38]

There is no evidence to support the State's asserted interest in protecting women's psychological health; indeed, the evidence that does exist suggests that restrictions on abortion create risk of psychological harm.

#### *3. The Narrow Medical Emergency Exception in the Gestational Age Ban Does Not Adequately Protect Women's Health*

Medical emergencies, as defined by the Gestational Age Ban, are limited to situations where an abortion is necessary (1) to preserve the life of the pregnant woman whose life is endangered by a physical disorder, illness, or injury, or (2) to prevent a serious risk of substantial and irreversible impairment of major bodily function. Yet, some women who require an abortion face significant challenges to their health that will compromise their physical and mental health but do not fall within this exception, especially those experiencing a high-risk pregnancy.

Under the Act, physicians who render abortion care for women with medical complications that may not be universally considered a "serious risk of substantial and irreversible impairment of major bodily function" would face criminal

[38] 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, 169 (Dec. 2016, corrected Jan. 2017). In addition, women denied a wanted abortion are more likely to stay tethered to abusive partners. Advancing New Standards in Reproductive Health, *Turnaway Study*, available at https://www.ansirh.org/research/turnaway-study.

sanction and/or suspension or revocation of their medical license.[39] There are any number of serious medical conditions that some may not consider as presenting a "serious risk of substantial and irreversible impairment of a major bodily function." For example, pre-existing physical health conditions frequently worsen during a pregnancy, including lupus, cardiac conditions, renal disease, and even infectious diseases like influenza. In addition, many medical conditions that develop during pregnancy or are aggravated by pregnancy may not manifest or require treatment until after 18 weeks LMP. For example, lupus can suddenly worsen post-18 weeks LMP and lead to fatal blood clots and other serious complications.[40] A pregnant woman can also experience pulmonary hypertension post-18 weeks LMP, which involves increased pressure within the lung's circulation system and can escalate in severity, potentially resulting in seizures, heart failure, renal failure, liver disease, blood clotting disorders, and even death.[41] To protect their own health, women faced with these challenges need to be able to consult freely with their physician and to have the option to obtain abortion care,

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[39] 2019 Ark. Act 493, 20-16-2003(7).

[40] *See* J. Cortes-Hernandez et al., *Clinical Predictor of Fetal and maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 RHEUMATOLOGY 643, 646-47 (June 2002).

[41] *See* David G. Kiely et al., *Pregnancy and Pulmonary Hypertension: A Practical Approach to Management*, 6 OBSTET. MED. 144, 153 (2013).



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and women should not be forced to wait until a condition deteriorates to the point of a "serious risk" to seek a potentially life-saving procedure.

Moreover, women may experience medical conditions that have posed a "serious risk of substantial and irreversible impairment of major bodily function" in a previous pregnancy, and wish to avoid the life-threatening condition by terminating subsequent unplanned pregnancies. For example, women may be diagnosed with idiopathic thrombocytopenia during a pregnancy, an immune disorder that prevents the blood from clotting normally. This may cause intense, heavy bleeding during and after delivery. The women may also pass the condition on to their fetus. In such situations, a patient may wish to terminate a later pregnancy to avoid the risks associated with her condition, especially in conjunction with other medical factors. For example, the decision may be reached prior to the patient being in "imminent" danger from the condition, when the patient learns of the pregnancy or the risk of the condition after 18 weeks LMP, after learning of a Down syndrome diagnosis, or after learning of compounding risk factors. As every situation is unique for the risk factors specific to each



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patient,[42] the Acts would prohibit a woman from receiving an abortion despite the potential health risks of the pregnancy. Likewise, physicians that provide potentially life-saving abortion care should not face criminal sanction and/or suspension or revocation of their medical license

Additionally, the medical exception is limited to situations involving a "physical disorder, illness, or injury" or "impairment of a major bodily function." A "major bodily function" is defined as functions of the "immune system, normal cell growth, and digestive, bowl, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions."[43] Mental health illnesses are not encompassed by the medical exception and these can arise after 18 weeks LMP or worsen during a pregnancy.[44]

The Gestational Age Ban's narrow medical exception does not mitigate the obstacles erected by the Act that thwart the ability of a woman to choose

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[42] *See* SMFM, *Executive Summary: Reproductive Services for Women at High Risk for Maternal Mortality Workshop* (2019). "Risk assessment should include factors that can exacerbate or mediate the risk of pregnancy for a woman with one of these conditions, including the severity of the maternal or fetal condition, the woman's capacity to manage the condition, her desire to be pregnant, and the availability of obstetric care providers in her geographic area. The woman's tolerance of risk is also an important consideration that should provide the context for patient-centered, shared decision-making." *Id.*

[43] 2019 Ark. Act 493, 20-16-2003(6).

[44] Kimberly Mangla, et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, AMERICAN JOURNAL OF OBSTETRICS & GYNECOLOGY 295 (Oct. 2019).



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appropriate healthcare in consultation with her physician. Indeed, the Acts would harm, not foster, health care for women.

### C. The Reason Ban Will Harm Women's Health

The Reason Ban will also harm women's health, as it prevents women from accessing abortion care if the physician has any reason to believe that the woman may be seeking the abortion because of a test result, diagnosis, or "any other reason to believe" that the fetus has Down syndrome. This law harms women's health. For example and as is discussed more fully below at Section III, a woman's physician may believe that an abortion is medically necessary, but under the Reason Ban, would be prevented from providing the necessary abortion care because of the Down syndrome diagnosis. Similarly, if a woman who has received a Down syndrome diagnosis desires an abortion for another reason, including to protect her own health, she will not be able to access this treatment if the physician disagrees with her motivation.



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### D. The Ob-Gyn Requirement is Medically Unnecessary and Would Harm Women's Health by Restricting the Pool of Physicians and Clinicians Qualified to Provide Abortion

A physician or other medical professional need not be a board-certified or board-eligible ob-gyn in order to safely provide abortion care.[45] There are any number of physicians and medical professionals (including family physicians, advanced practice clinicians, nurse-midwives, physician assistants, and nurse practitioners) that are not board-certified or board-eligible ob-gyns who provide

[45] Barbara Levy, et al., *Consensus Guidelines for Facilities Performing Outpatient Procedures*, 133 OBSTETRICS & GYNECOLOGY 255-60 (Feb. 2019), available at https://journals.lww.com/greenjournal/fulltext/2019/02000/Consensus_Guidelines_for_Facilities_Performing.4.aspx; World Health Organization, *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception*, available at https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=6D970BC5962BC3D71EFDC656108ABAB7?sequence=1; *Supra* note 30, ACOG, Committee Opinion No. 613, *Increasing Access to Abortion*.



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safe, effective abortion care.[46] Many rural communities in America depend upon non-ob-gyn medical professionals for abortion care. There is no evidence that the ob-gyn requirement provides any benefits for patients. A vigorous review of evidence by the National Partnership for Women & Families, American College of Obstetricians & Gynecologists, American College of Physicians, American Academy of Family Physicians, American College of Nurse Midwives, Nurse Practitioners in Women's Health, and the Society of Family Planning found that board certification is not required for provision of safe abortion care.[47] By attempting to restrict the provision of abortion to only a small category of medical professional who can provide such care, the State impermissibly burdens women's

[46] ACOG, Practice Bulletin, *Medical Management of First-Trimester Abortion* (March 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Medical-Management-of-First-Trimester-Abortion; World Health Organization, *Health Worker Roles in Providing Safe Abortion Care and Post-Abortion Contraception*, available at https://apps.who.int/iris/bitstream/handle/10665/181041/9789241549264_eng.pdf;jsessionid=6D970BC5962BC3D71EFDC656108ABAB7?sequence=1; Center for Reproductive Health Education in Family Medicine, *Family Medicine Residencies with Abortion Training*, (last accessed Dec. 16, 2019), https://rhedi.org/resources/residency-training/ ("A growing number of family medicine residencies now offer comprehensive training in abortion, including didactic and clinical training in contraception, pregnancy options counseling, hands-on abortion training, and pre- and post-abortion care.").

[47] *Supra* note 45, Levy, et al., *Consensus Guidelines for Facilities Performing Outpatient Procedures*.



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access to care. The Act would drastically reduce the number of providers offering abortion services.

## III. The Acts Undermine Medical Ethics and Erode Core Foundations of the Patient-Physician Relationship

### A. The Acts Undermine the Foundations of the Patient-Physician Relationship

The patient-physician relationship is essential to the provision of safe and quality medical care.[48] Physicians must be able to have open, honest, and confidential communications with their patients in order to determine appropriate treatment options and to counsel their patients according to the best currently available medical evidence and the physician's professional medical judgment.[49] When providing care to their patients, the welfare of a patient is central to the physician's considerations.[50] Physicians are ethically required to exercise all reasonable means to ensure that their patients receive the most appropriate and effective care.[51] These ethical obligations are expressed through the principles of beneficence and non-maleficence.[52] Beneficence requires physicians to act in a

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[48] *Supra* note 4, ACOG Leg. Policy Statement.

[49] *Id.*

[50] ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, at 1-2 (July 2011).

[51] *Id.*

[52] *Id.*



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way that is likely to benefit patients.[53] Non-maleficence directs physicians to refrain from acting in ways that might harm patients unless the harm is justified by concomitant benefits.[54]

Legislating elements of patient care and counseling will drive a wedge between a patient and her physician when the legislation is not appropriately grounded and uses vague concepts like "serious risk." SMFM and ACOG oppose legislation that interferes with the patient-physician relationship or causes a physician to compromise his or her medical judgment about what information or treatment is in the best interests of the patient.[55] Amici also oppose any laws that expose physicians and other medical professionals who provide safe, effective, and necessary medical care to criminal sanction. The Acts restrict the ability of physicians to act in the best interest of their pregnant patients. This undermines the

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[53] ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 3 (Dec. 2007), available at https://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Ethics/co390.pdf?dmc=1&ts=20120305T0654106237.

[54] *Id.*

[55] *Supra* note 4, ACOG Leg. Policy Statement. "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." *Id.* Even if the laws that intrude on the physician-patient relationship are generally consistent with the clinical standard of care at the time of the their enactment, medical treatment protocols written into law can quickly become outdated as medical knowledge advances. *Id.*



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patient-physician relationship in a way that creates consequences far beyond the abortion decision.

The Gestational Age Ban and Reason Ban create an ethical dilemma for physicians treating pregnant women. If a physician determines, in his or her professional medical opinion, that an abortion is medical necessary and in the best interest of the patient, the principles of beneficence and non-maleficence direct the physician to perform or recommend the performance of that abortion. But the Gestational Age Ban and the narrow medical exception may prevent the physician from doing so, thereby preventing the physician from fulfilling his or her ethical duties to the patient. The Reason Ban may also prevent the physician from performing or recommending an abortion, if the patient requests an abortion because of a Down syndrome diagnosis, despite the physician's determination that an abortion is medically necessary and appropriate for reasons separate and apart from the Down syndrome diagnosis. In this situation, the patient's purpose in seeking the abortion may prevent the physician from providing that care.

The Reason Ban also inhibits open and honest conversation between a woman and her physician. It also creates obstacles to providing treatment in the best interests of the patient as it undermines the trust between a patient and her



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medical professional.[56] That trust is important not just in the context of considering abortion, but in all aspects of the patient's medical care.

### B. The Acts Are Contrary to Core Principles of Medical Ethics, Including Respect for Patient Autonomy

Patient autonomy is a fundamental concept in medical ethics recognizing that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions.[57] Physicians should respect the right of individual patients to make their own choices about their health care.[58]

By restricting the ability of women to receive abortion care, the Gestational Age Ban undermines patient autonomy and a woman's ability to make decisions about her medical care. There are a number of reasons that a woman may find it necessary to seek abortion care after 18 weeks LMP. For example, some pregnant women may not seek prenatal care until 18 weeks LMP or later for various reasons, including lack of insurance or funding, medical conditions or medications

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[56] The Reason Ban further fails to take into account the extensive counseling that is provided to women after receiving a Down syndrome diagnosis. After obtaining this diagnosis, women are often referred to a genetic counselor. Through interactions with a genetic counselor and her other physicians, she receives significant neutral and supportive counseling. *See* National Society of Genetic Counselors, *Code of Ethics*, available at https://www.nsgc.org/p/cm/ld/fid=12#section2, (last accessed Dec. 16, 2019) (genetic counselors work to "[e]nable their clients to make informed decisions, free of coercion, by providing or illuminating the necessary facts, and clarifying the alternatives and anticipated consequences")\.

[57] *Supra* note 50, ACOG, *Code of Professional Ethics*, at 1-2.

[58] *Id.* at 1.

that make menstruation irregular, or substance use disorders. Such women may not learn about physical or chromosomal anomalies in their fetus until after 18 weeks LMP. Moreover, some women develop conditions during pregnancy that could lead them to need abortion care later in pregnancy. If a woman wished to undergo an abortion procedure after 18 weeks LMP and prior to fetal viability, the Gestational Age Ban would deny her of her right as a patient to make her own choices about her healthcare.

The Reason Ban also undermines the principle of patient autonomy by depriving women of their ability to terminate a pregnancy solely based on their reason for doing so. The Reason Ban invades patient privacy interests and may restrict a woman's ability to obtain desired medical care because of the manner in which she expresses herself. Through restricting the ability of physicians to render care consistent with their patient's wishes, the Acts undermine physician ethics. Physicians and other medical professionals should be trusted counselors for their patients. Acts such as these that create conflicts between physicians and their patients erode foundational principles of medical ethics, the patient-physician relationship, and impede on core principles of patient autonomy.

### C. The Acts Chill Safe Medical Care by Imposing Potential Criminal Sanctions and License Suspensions

Physicians and other medical professionals should never be penalized for providing safe medical care to their patients. Yet if a physician is found to have

purposely or knowingly violated the Acts, the physician would be are guilty of a Class D felony.[59] The Arkansas State Medical Board may also suspend or revoke the physician's license.[60] These penalties are particularly concerning because the language of the Acts would pose insurmountable difficulties of interpretation. Both the language of the medical exception in the Gestational Age Ban and the concept of a "sole" reason in the Reason Ban are vague, subjective standards that do not provide guidance on when a physician would be guilty or not. For the reasons explained below, the Acts functionally create a substantial and unconstitutional impairment to the provision of abortions in Arkansas through imposing unreasonably vague and medically unnecessary criminal and professional restrictions on physicians.

The narrow medical exception in the Gestational Age Ban only allows abortions if there is a "serious risk of substantial and irreversible impairment of major bodily function." Predictions related to these risks are the subject of consultation between the physician and the patient and what the patient may view as "serious" and "substantial" may not be the same as the physician or the State

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[59] 2019 Ark. Act 493, 20-16-2006(a)(1); 2019 Ark. Act 691, 20-16-2004; 2019 Ark. Act 700, 20-16-605(b).

[60] 2019 Ark. Act 493, 20-16-2006(b); 2019 Ark. Act 691, 20-16-2005(a); 2019 Ark. Act 700, 20-16-605(b). Constitutional due process also protects against the State interfering with the liberty interest of physicians practicing their profession. Here, the Acts have no rational basis to interfere with that interest.

prosecutor.[61] These are not medically recognized or precise terms and there will be variances in what is considered "serious" by physicians as well as their patients.

Similarly, the concept of what is a "sole" reason in the Reason Ban has no medical basis. Medical decisions are made on a holistic basis, including not only the patient's unique physical attributes but also mental and emotional considerations. And the mental and emotional considerations attendant upon a Down syndrome diagnosis cannot be ignored when a woman seeks an abortion. As such factors will always have been taken into consideration, the language of the Reason Ban fails to have any meaning other than as a basis to threaten physicians meeting patient needs. The U.S. Constitution prohibits criminal statutes of this vague and confusing nature.[62] Compounding the constitutional problems, in this context, the vagueness and language problems coupled with the threat of license suspension and other sanctions would create a substantial chilling effect upon the provision of legal abortion in Arkansas, unconstitutionally burdening the right of a woman to terminate her pregnancy under the U.S. Constitution.

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[61] *See* SMFM, *Executive Summary: Reproductive Services for Women at High Risk for Maternal Mortality Workshop* (2019).

[62] The Government violates the Fifth Amendment's guarantee that "[n]o person shall . . . be deprived of life, liberty, or property, without due process of law" by taking away someone's life, liberty, or property under a criminal law "so vague that it fails to give ordinary people fair notice of the conduct it punishes, or so standardless that it invites arbitrary enforcement." *Johnson v. U.S.*, 135 S. Ct. 2551, 2556 (2015).



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## CONCLUSION

Amici offer this brief to validate fact-finding below and to enable a better understanding of the effects the Acts would have on women's health care and the practice of medicine.

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Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

This amicus curiae brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(a)(5) because it is 6,309 words, excluding the portions exempted by Federal Rule of Appellate Procedure 32(f), if applicable. The brief's type size and type face comply with Federal Rule of Appellate Procedure 32(a)(5) and (6) because it has been prepared in a proportionally-spaced typeface, including serifs, using Microsoft Word 2016 in Times New Roman 14-point font.

Pursuant to Eight Circuit Local Rule 28A(h)(2), I also certify that a virus detection program (Windows Defender Antivirus) was run on the file containing the electronic brief and no virus was detected.

Dated: January 7, 2020

s/ Roxann E. Henry
Roxann E. Henry

**CERTIFICATE OF SERVICE**

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit by using the CM/ECF system on January 7, 2020

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