

No. 17-51060

IN THE
United States Court of Appeals
FOR THE FIFTH CIRCUIT

WHOLE WOMAN'S HEALTH, On Behalf of Itself, Its Staff, Physicians and Patients; PLANNED PARENTHOOD CENTER FOR CHOICE, On Behalf of Itself, Its Staff, Physicians, and Patients; PLANNED PARENTHOOD OF GREATER TEXAS SURGICAL HEALTH SERVICES, On Behalf of Itself, Its Staff, Physicians, and Patients; PLANNED PARENTHOOD SOUTH TEXAS SURGICAL CENTER, On Behalf of Itself, Its Staff, Physicians, and Patients; ALAMO CITY SURGERY CENTER, P.L.L.C., On Behalf of Itself, Its Staff, Physicians, and Patients, doing business as Alamo Women's Reproductive Services; SOUTHWESTERN WOMEN'S SURGERY CENTER,

(Caption Continued on the Reverse)

*Appeal from the United States District Court
for the Western District of Texas
No. 1:17-cv-690*

***EN BANC BRIEF OF AMERICAN COLLEGE OF
OBSTETRICIANS AND GYNECOLOGISTS AND
THE AMERICAN MEDICAL ASSOCIATION AS
AMICI CURIAE IN SUPPORT OF
PLAINTIFFS-APPELLEES AND AFFIRMANCE***

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Plaintiffs-Appellees,

v.

KEN PAXTON, Attorney General of Texas, In His Official Capacity; SHAREN
WILSON, Criminal District Attorney for Tarrant County, In Her Official Capacity;
BARRY JOHNSON, Criminal District Attorney for McLennan County, In His
Official Capacity,

Defendants-Appellants.

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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<i>Planned Parenthood Fed’n v. Ashcroft</i> , 320 F. Supp. 2d 957 (N.D. Cal. 2004), <i>rev’d on other grounds by</i> <i>Gonzales v. Carhart</i> , 550 U.S. 124 (2007)	19
<i>Topalian v. Ehrman</i> , 954 F.2d 1125 (5th Cir. 1992)	19
<i>Tradewinds Envtl. Restoration, Inc. v. St. Tammany Park, LLC</i> , 578 F.3d 255 (5th Cir. 2009)	19
<i>Whole Woman’s Health v. Paxton</i> , 2020 U.S. App. LEXIS 32326 (5th Cir. 2020)	11
 Statutes	
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TEXAS HEALTH & SAFETY CODE ANN. §§ 171.011	20
TEXAS HEALTH & SAFETY CODE ANN. §§ 171.012	20
TEXAS HEALTH & SAFETY CODE ANN. § 171.044	16
TEXAS HEALTH & SAFETY CODE ANN. § 171.152	2
TEXAS INSURANCE CODE § 1218.002	21
TEXAS INSURANCE CODE § 1218.004	21
TEXAS INSURANCE CODE § 1696.002	21
 Other Authorities	
ACOG, Committee Opinion No. 700, <i>Methods for Estimating the Due</i> <i>Date</i> , (May 2017).	10
ACOG, Committee Opinion No. 390, <i>Ethical Decision Making in</i> <i>Obstetrics & Gynecology</i> (Dec. 2007, re-aff’d 2016)	24, 25

ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*,
 136(6) *Obstet. & Gynecol.* e107 (Dec. 2020).....22

ACOG, Facts are Important: Fetal Pain,
<https://www.acog.org/advocacy/facts-are-important/fetal-pain> 16, 17

ACOG, *Frequently Asked Questions Special Procedures* (May 2015),
<https://www.acog.org/Patients/FAQs/Induced-Abortion>5

ACOG, Joint Statement on Abortion Access During the COVID-19
 Outbreak (Mar. 2020), <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak>22

ACOG, Practice Bulletin No. 135, *Second Trimester Abortion*,
 121 *Obstetrics & Gynecology* 134 (2013, re-aff'd 2019).....*passim*

ACOG, *Statement of Policy, Global Women’s Health and Rights* (July
 2012, amended and re-aff'd July 2018),
<https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2018/global-womens-health-and-rights>23

ACOG, Wisconsin Section, *20-Week Abortion Ban Legislation*,
https://images.magnetmail.net/images/clients/ACOG/attach/WI_IssuePaper20WeekAbortionBan_updated.pdf 16

AMA, *Code of Medical Ethics*, Opinion 1.1.1, Patient-Physician
 Relationships, <https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships>.....24

AMA, *Code of Medical Ethics*, Opinion 1.1.3, *Patient Rights*,
<https://www.ama-assn.org/delivering-care/ethics/patient-rights>24

AMA, *Code of Medical Ethics*, Opinion 2.1.1, Informed Consent,
<https://www.ama-assn.org/delivering-care/ethics/informed-consent>26

AMA, *Principles of Medical Ethics*, (June 2001).....24

A.M. Autry et al., *A Comparison of Medical Induction and Dilatation
 and Evacuation for Second-Trimester Abortion*, 187 *Am. J.
 Obstetrics & Gynecology* 393 (2002)5

C. Barbieri et. al, *Sonographic Measurement of the Umbilical Cord Area and the Diameters of its Vessels During Pregnancy*, 32(3) J. Obstet. & Gynaecol. 230 (2012)13

Brief for the Attorneys General of the States of Louisiana, et al. as *Amici Curiae* Supporting Appellants, *Whole Woman’s Health, et al., v. Paxton, et al.*, (No. 17-51060) (Dec. 11, 2020)19

Emma Carpenter, et al., *Texas’ Executive Order during COVID-19 Increased Barriers for Patients Seeking Abortion Care*, Tex. Policy Evaluation Project (Jan. 2021).....21

Gillian Dean et al., *Safety of Digoxin for Fetal Demise Before Second-Trimester Abortion by Dilation and Evacuation*, 85 Contraception 144 (2012).....7, 8

Lorenzo Fabrizi, *A Shift in Sensory Processing that Enables the Developing Human Brain to Discriminate Touch from Pain*, 21 Current Biology 1552 (2011).....17

Aileen M. Gariepy et al., *Transvaginal Administration of Intraamniotic Digoxin Prior to Dilation and Evacuation*, 87 Contraception 76 (2013)8, 9

Vinta Goyal et al., *Factors associated with abortion at 12 or more weeks gestation after implementation of a restrictive Texas law*, 102(5) Contraception 314 (2020)21

David A. Grimes et al., *Feticidal Digoxin Injection Before Dilation and Evacuation Abortion Evidence and Ethics*, 85 Contraception 140 (2012)7, 9, 10

Rebecca Jackson et al., *Digoxin to Facilitate Late Second-Trimester Abortion: A Randomized, Masked, Placebo Controlled Trial*, 97 Obstetrics & Gynecology 471 (2001)11,

Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Institute (2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>20

Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947 (2005)*passim*

Expert Report of Colleen Ann Malloy, M.D. (Sept. 20, 2017) 18

Keith L. Moore, et al., *The Developing Human Clinically Oriented Embryology* (Elsevier, 10th ed. 2016) 10

National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, at 2-18, <https://doi.org/10.17226/24950> (2018) 6

Maureen Paul et al., *Management of Unintended and Abnormal Pregnancy* (M. Paul et al. eds., 1st ed. 2009) 8

Record on Appeal.....*passim*

Danielle Roncari et al., *Inflammation or Injection at the Time of Second Trimester Induced Abortion*, 87 *Contraception* 67 (2013)..... 7

Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice* (Mar. 2010) 16, 16

Anna K. Sfakianaki et al., *Potassium Chloride-Induced Fetal Demise*, 33 *Journal of Ultrasound in Medicine* 2 (2014)..... 11

Society of Family Planning, *Induction of Fetal Demise Before Abortion*, 81 *Contraception* 462 (2010)*passim*

Society for Maternal-Fetal Medicine, *Access to Abortion Services*, (Dec. 2017, re-aff'd June 2020), [https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_\(2020\).pdf](https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf) 22

Supplemental Brief of the Appellants, *Whole Woman’s Health, et al., v. Paxton, et al.*, No. 17-51060 (5th Cir. Dec. 2, 2020)..... 6, 9, 15

Texas Health and Human Services, *2019 Complications of Induced Terminations of Pregnancy*, <https://hhs.texas.gov/sites/default/files/documents/about-hhs/records-statistics/research-statistics/itop/2019/2019-itop-complications.xlsx> 6

Texas Health and Human Services, *2019 Induced Terminations of Pregnancy by Facility and Procedure (Excel)*, <https://hhs.texas.gov/sites/default/files/documents/about-hhs/records-statistics/research-statistics/itop/2019/2019-itop-facility-procedure.xlsx>6

Texas Policy Evaluation Project, *Texas Women’s Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options*, (Nov. 2015), <https://www.ibisreproductivehealth.org/publications/texas-women%E2%80%99s-experiences-attempting-self-induced-abortion-face-dwindling-options>23

Kristina Tocce et al., *Umbilical Cord Transection to Induce Fetal Demise Prior to Second-Trimester D&E Abortion*, 88 *Contraception* 712 (2013) 14, 15

Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) *Obstetrics & Gynecology* 175 (2015)5

Kari White, et al., *Research Brief: The Potential Impacts of Texas’ Executive Order on Patients’ Access to Abortion Care*, Tex. Policy Evaluation Project (Mar. 2020).....21

Kari White, et al., *Research Letter: Changes in Abortion in Texas Following an Executive Order Ban During the Coronavirus Pandemic*, *JAMA* (Jan. 4, 2021) (published online)22

IDENTITY AND INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists (“ACOG”) and the American Medical Association (the “AMA”) submit this brief *amici curiae* in support of the Plaintiffs-Appellees.¹

ACOG is the nation’s leading group of physicians providing health care for women. With more than 60,000 members—representing more than 90% of all obstetricians-gynecologists in the United States—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 changing issues facing women’s health care. ACOG is committed to defending the right of physicians to practice the full scope of obstetrics and gynecology and to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion, for all women.

The AMA is the largest professional association of physicians, residents, and medical students in the United States. The AMA’s objectives are to promote the

¹ Pursuant to [Federal Rule of Appellate Procedure 29](#), undersigned counsel for ACOG and the AMA certify that: no party’s counsel authored this *amici* brief in whole or in part; no party or party’s counsel contributed money that was intended to fund preparing or submitting this *amici* brief; and no person or entity, other than ACOG or the AMA, their members, or their counsel, contributed money intended to fund the preparation of submission of this *amici* brief. All parties have consented to ACOG and the AMA filing this *amici* brief in this litigation.

science and art of medicine and the betterment of public health. It works relentlessly to advance important issues that protect patients and physicians, and it publishes the *Code of Medical Ethics*, the most comprehensive code of ethical medical conduct in the world. The AMA's members practice in all fields of medical specialization and in every state, including Texas.

SUMMARY OF ARGUMENT

Texas Health and Safety Code § 171.152 (the “D&E Ban”) criminalizes the safest and most common method of second-trimester abortion after approximately 15 weeks of gestation—dilation and evacuation (“D&E”)—in Texas. D&E accounts for a significant percentage of second-trimester abortions in Texas and is one of the most common methods of abortion provided in the state beginning early in the second trimester.

The State suggests that under the D&E Ban, physicians can still perform D&E so long as they first perform an additional procedure to attempt to cause fetal demise. But this is a false choice. There is no guarantee that any fetal demise procedure will be successful, meaning that no physician can attempt D&E without risking either being unable to complete the procedure—which puts the patient's health at risk—or being subject to criminal penalties under Texas law. If the D&E Ban goes into effect, women in Texas will be significantly harmed.

The State's suggested workaround of first attempting fetal demise is medically untenable, because those procedures cannot be performed on all patients and have been inadequately studied during the time in which most second-trimester abortions occur. All of the fetal demise procedures introduce risks, some of which can even be life-threatening, to which patients would not otherwise be exposed. Indeed, *amici* are not aware of a single study that supports the State's contention that first inducing fetal demise makes D&E safer. For these and other reasons, the District Court permanently enjoined enforcement of the D&E Ban.

Contrary to the State's assertion, the D&E Ban's requirement of fetal demise before D&E is not justified by a State interest in protecting a fetus from pain. It is well-established and widely accepted within the medical community that a fetus is not capable of perceiving pain at the gestational ages for which abortion is legal in Texas. The State's arguments are supported only by cherry-picked outliers in the medical literature and are at odds with the scientific community's consensus.

Finally, the D&E Ban interferes with the patient-physician relationship and places physicians in an ethically untenable position of either (i) denying access to D&E, or (ii) violating the law and risking criminal penalties. Because the D&E Ban restricts access to the safest and the most common method of second-trimester abortion in Texas after approximately 15 weeks of gestation, increases health risks for all Texas women for whom D&E is medically appropriate, does nothing to

protect or advance patient health, and unduly interferes with the patient-physician relationship, the Court should affirm the District Court’s decision to permanently enjoin the D&E Ban.

ARGUMENT

I. The D&E Ban Criminalizes the Safest and Most Common Method of Second-Trimester Abortion in Texas After Approximately 15 Weeks of Gestation

A. D&E Is the Safest and Most Common Method of Second-Trimester Abortion in Texas After Approximately 15 Weeks of Gestation

Some women, in consultation with their physicians and for various reasons, obtain abortions in the second trimester.² The vast majority of such procedures after 15 weeks are performed with the D&E method. To perform D&E, a physician dilates a patient’s cervix and evacuates the uterus by removing tissue through the cervix and vagina. D&E was developed in the 1970s as a safer alternative to other methods of abortion.

² ACOG, Practice Bulletin No. 135, *Second Trimester Abortion*, 121 *Obstetrics & Gynecology* 1394, 1394 (2013, re-aff’d 2019) (“Circumstances that can lead to second-trimester abortion include delays in suspecting and testing for pregnancy, delay in obtaining insurance or other funding, and delay in obtaining referral, as well as difficulties in locating and traveling to a provider...[Further,] [t]he identification of major anatomic or genetic anomalies in the fetus through screening and diagnostic testing most commonly occurs in the second trimester,” and such conditions include “preeclampsia and preterm premature rupture of membranes.”).

More than four decades of data demonstrate that D&E is the safest method of abortion starting early in the second trimester.³ It results in fewer medical complications than other abortion procedures, such as medical induction.⁴ Whereas medical induction involves the administration of drugs to induce contractions and cause a woman to undergo labor,⁵ D&E involves the administration of few drugs and does not require hospitalization, which allows more physicians to provide it and makes it more affordable for women.⁶ Major complications arise in less than one percent of D&E procedures.⁷ The procedure can also be completed in approximately ten minutes.⁸ For these reasons, D&E

³ *Id.*

⁴ Although medical induction is generally safe, it does involve risks and side effects that D&E does not, such as a risk of uterine rupture, a rare but potentially life-threatening condition, and a retained placenta, a condition which can cause hemorrhaging and requires a surgical intervention. *See* ACOG, *supra* note 2, at 1397-98; A.M. Autry et al., *A Comparison of Medical Induction and Dilation and Evacuation for Second-Trimester Abortion*, 187 *Am. J. Obstetrics & Gynecology* 393, 396 (2002). Because of the complications associated with labor, medical induction occurs in a hospital or hospital-like facility. ACOG, *Frequently Asked Questions Special Procedures* (May 2015), <https://www.acog.org/Patients/FAQs/Induced-Abortion>.

⁵ *See* ACOG, *supra* note 2, at 1395-96; ACOG, *Frequently Asked Questions*, *supra* note 4.

⁶ *See* ACOG, *supra* note 2, at 1398.

⁷ Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) *Obstetrics & Gynecology* 175, 181 (2015).

⁸ [ROA.1601](#).

constitutes the overwhelming majority of abortions in the United States starting early in the second trimester.⁹

B. It Is Medically Inappropriate to Require Physicians to Attempt Fetal Demise

The State’s mandate that physicians cause fetal demise before performing D&E would impose additional and serious health risks to patients without *any* counterbalancing medical benefit at the relevant gestational ages.¹⁰ The State argues that physicians can induce fetal demise by digoxin injection, potassium chloride injection, or “umbilical cord transection.” As discussed below, all of

⁹ National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States*, at 2-18, <https://doi.org/10.17226/24950> (2018) (“D&E is usually the medically preferred method of abortions at 14 weeks’ gestation or later. The alternative—induction—is more painful, slower, and more expensive.”). Medical induction is far less commonly used to perform second-trimester abortions in Texas and nationwide. Texas Health and Human Services, *2019 Induced Terminations of Pregnancy by Facility and Procedure (Excel)*, <https://hhs.texas.gov/sites/default/files/documents/about-hhs/records-statistics/research-statistics/itop/2019/2019-itop-facility-procedure.xlsx> (not listing medical induction as an abortion procedure used in Texas or on Texas residents and identifying only 0.15% of procedures as “Other/Not Stated”); *see also* [ROA.2035](#) (testimony of Dr. Bhavik Kumar) (noting that patients ultimately opted for D&E instead of medical induction because of the inaccessibility of medical induction services in Texas).

¹⁰ While the State alleges that there were no complications arising from induced fetal demise by digoxin from 2012 to 2017, App. Supp. Br. at 14, complications are not reported on such a granular level. For example, government statistics report complication type, but not the precise cause of complications. *See, e.g.*, Texas Health and Human Services, *2019 Complications of Induced Terminations of Pregnancy*, <https://hhs.texas.gov/sites/default/files/documents/about-hhs/records-statistics/research-statistics/itop/2019/2019-itop-complications.xlsx>.

these procedures impose additional risks even when not justified by countervailing benefits. And *amici* are not aware of any medical literature that concludes attempting fetal demise enhances the safety of D&E.¹¹ To the contrary, the procedures are contraindicated for certain patient groups, and are associated with increased risks including infection, uterine perforation, and extramural delivery.¹² Far from advancing women’s health, the D&E Ban is a medically inappropriate, politically-generated proscription against the safest method of abortion.

1. *Injecting Digoxin*

To attempt to cause fetal demise by injecting digoxin, a physician injects the drug directly into the fetus or, if that is not possible, into the amniotic fluid. Intrafetal injections are more effective at causing demise than intraamniotic

¹¹ ACOG, *supra* note 2, at 1396; *see also* Society of Family Planning, *Induction of Fetal Demise Before Abortion*, 81 *Contraception* 462, 463 (2010) (“Although numerous methods have been used over the years to achieve fetal demise, data remain scarce documenting the effect of these techniques upon the safety of the abortion itself.”); David A. Grimes et al., *Feticidal Digoxin Injection Before Dilation and Evacuation Abortion Evidence and Ethics*, 85 *Contraception* 140, 140 (2012) (noting that while some physicians claim fetal demise makes D&E easier, there is no evidence to support this hypothesis); Danielle Roncari et al., *Inflammation or Injection at the Time of Second Trimester Induced Abortion*, 87 *Contraception* 67, 67 (2013) (noting that the usefulness of induced fetal demise remains unknown).

¹² Roncari, *supra* note 11; *see also* Gillian Dean et al., *Safety of Digoxin for Fetal Demise Before Second-Trimester Abortion by Dilation and Evacuation*, 85 *Contraception* 144, 148 (2012) (finding that digoxin before D&E is associated with increased rates of spontaneous abortion and recommending that digoxin injections not be administered prior to D&E).

injections, but are more difficult to administer—especially at earlier gestations—because a physician must use a spinal needle under ultrasound guidance to inject the drug through the patient’s abdomen, vaginal wall, or vagina and cervix.

Injecting digoxin does not render the D&E Ban appropriate because, among other things, digoxin is not medically appropriate for all women. The procedure is contraindicated for women who are obese,¹³ or who have anatomical variations such as a long cervix or fibroids. Digoxin injections also pose health risks, including infection, for all women.¹⁴ Further, the drug may be accidentally absorbed into a woman’s circulation, resulting in toxicity or causing consumptive coagulopathy, a condition affecting the blood’s ability to clot.¹⁵

Moreover, digoxin does not cause fetal demise in all cases.¹⁶ Consistent with accepted medical studies, experts in this case testified that digoxin injections

¹³ Aileen M. Gariepy et al., *Transvaginal Administration of Intraamniotic Digoxin Prior to Dilation and Evacuation*, 87 *Contraception* 76, 76 (2013) (finding that when digoxin is injected under a transabdominal approach, it is difficult for the physician to accomplish on obese patients).

¹⁴ ACOG, *supra* note 2, at 1396 (noting that a retrospective cohort study reported increased odds of infection after digoxin use); *see also* Dean *supra* note 12 (finding infection to be a primary outcome of their retrospective cohort study on digoxin use to induce fetal demise prior to D&E); Maureen Paul et al., *Management of Unintended and Abnormal Pregnancy* (M. Paul et al. eds., 1st ed. 2009), at 168 (“Any procedure associated with transabdominal needle placement into the uterine cavity can result in maternal infection.”).

¹⁵ *See* SFP, *supra* note 11, at 463, 469.

¹⁶ *See, e.g., id.* at 467 (reporting that in a retrospective cohort study, there was an eight percent failure rate among women who received intra-amniotic digoxin and a four percent failure rate among women who received various doses of intrafetal

have a five to ten percent failure rate.¹⁷ The State argues that physicians can cure this by administering a second dose of digoxin should the first dose fail.¹⁸

However, *amici* are unaware of any reported studies about the risks to women of using multiple digoxin injections should a first dose fail.¹⁹

Requiring a digoxin injection would create another, de facto waiting period because even successful digoxin injections can take up to 24 hours to cause fetal demise. Because overnight dilation is not an essential part of D&E before approximately 18 weeks of gestation, D&E is typically a one-day procedure. A woman required to receive a digoxin injection would thus have to go to an additional appointment at a clinic in advance of her abortion, unless she would have otherwise already required advance dilation. The D&E Ban would thus create an additional barrier to abortion for Texas women, who already must make

digoxin); Grimes, *supra* note 11, at 140 (“[D]igoxin injection may fail to achieve its primary objective: from zero percent to seventy percent of first injections are unsuccessful in causing fetal demise, depending on dose and route of administration.”); Gariepy, *supra* note 13 (finding in a prospective study, digoxin administration was unsuccessful in eight percent of participants).

¹⁷ See *id.*; [ROA.1935-36](#) (testimony of Dr. Mark D. Nichols); [ROA.2099](#) (testimony of Dr. Robin Wallace); [ROA.2214-15](#) (testimony of Dr. Amna Dermish); [ROA.2779](#) (testimony of Dr. Eduardo Aquino).

¹⁸ App. Supp. Br. at 13.

¹⁹ Physicians who refuse to administer multiple digoxin injections before it is adequately studied will have no good choices, as they will either need to perform D&E without first inducing fetal demise in violation of the D&E Ban, refuse to perform the abortion altogether, or recommend one of the other two fetal demise procedures that are not available in Texas and cause further delay and expense for patients. See [ROA.1938](#) (testimony of Dr. Nichols).

multiple trips to a clinic to obtain an abortion, and whose ability to access abortion has already been seriously curtailed by clinic closures and various state restrictions on abortions.

Further, digoxin injections are more difficult to administer in the early stages of the second trimester, when most D&Es occur, due to the small size of the fetus.²⁰ In addition, it is widely recognized that a fetus changes rapidly from one week to the next and that determining gestational age is vital for the timing of appropriate care.²¹ Therefore, a digoxin injection administered before 18 weeks, whether by one week or three weeks, does not necessarily carry the same risk/benefit analysis as digoxin injections administered after 18 weeks. Likewise, risks inherent to abortion care vary based on gestational age. *Amici* are not aware of any reported studies that show the effects of the drug before 18 weeks, making it impossible for physicians to determine whether the procedure is appropriate or safe for patients in that stage of pregnancy. Physicians should not have to perform, and patients should not have to experience, medically unnecessary procedures with unknown risks, complication rates, and efficacy.²²

²⁰ D&E procedures are common beginning at 15 weeks.

²¹ ACOG, Committee Opinion No. 700, *Methods for Estimating the Due Date*, at 2 (May 2017); Keith L. Moore, et al., *The Developing Human Clinically Oriented Embryology* 92 (Elsevier, 10th ed. 2016).

²² Grimes, *supra* note 11, at 142 (“The risk/benefit equation argues against routine feticidal digoxin injection[F]eticidal injection of digoxin should be offered only in the context of a formal research study.”).

Finally, the medical evidence contradicts the claim, asserted in the dissent to the panel opinion, that the vast majority of women prefer a digoxin injection before the abortion procedure.²³ Medical evidence does not suggest that the overwhelming majority of women prefer receiving a digoxin injection (or any other procedure) prior to receiving abortion care for the sole purpose of causing fetal demise. The study relied upon by the dissent found that while 92% of eligible subjects preferred a digoxin injection prior to an abortion, women expressed this preference for a variety of reasons, many of which were unrelated to causing fetal demise.²⁴ Among the subset of these women who would opt for a digoxin injection in the future, only 35% expressed a desire for fetal death, while 48% believed the injection would make the D&E procedure easier or less painful.²⁵ For this reason, the study concluded that its findings should not stand for the principle that women prefer a digoxin injection prior to receiving abortion care.²⁶ Indeed,

²³ *Whole Woman's Health v. Paxton*, [2020 U.S. App. LEXIS 32326](#), at *35 (5th Cir. 2020) (Willett, J., dissenting).

²⁴ Rebecca Jackson et al., *Digoxin to Facilitate Late Second-Trimester Abortion: A Randomized, Masked, Placebo Controlled Trial*, 97 *Obstetrics & Gynecology* 471, 474 (2001) [hereinafter the "Jackson Study"]; Anna K. Sfakianaki et al., *Potassium Chloride-Induced Fetal Demise*, 33 *Journal of Ultrasound in Medicine* 2 (2014).

²⁵ Jackson Study, *supra* note 24, at 474.

²⁶ *Id.* at 475 ("Those results should be interpreted cautiously because only patients who were willing to accept digoxin entered the trial. Further study is needed to determine whether patients would truly prefer digoxin, even if it does not decrease procedure time, difficulty, or pain.").

published research has recognized the flaws in the Jackson study.²⁷ A careful review of the medical literature thus contradicts the claim that a majority of women prefer fetal death by digoxin.

2. *Injecting Potassium Chloride*

To attempt to cause fetal demise by injecting potassium chloride, a physician must inject potassium chloride directly into a fetal heart using a spinal needle under the guidance of an advanced ultrasound machine. Injecting potassium chloride is not meaningfully available in Texas: it carries substantial health risks, must be performed in a hospital setting by physicians with specialized training, and is very difficult to administer.

Potassium chloride injections are much more difficult and risky to administer than digoxin injections. During the second trimester, the fetal heart is smaller than a dime. Successfully injecting potassium chloride is very challenging, even for physicians trained to do so. Training in the safe administration of potassium chloride is not part of standard ob-gyn curricula, and, as a result, few physicians are qualified to perform the procedure.

²⁷ SFP, *supra* note 11, at 464 (noting that the Jackson Study is “limited” because many of the women mistakenly “believed the injection might make their abortion safer” and “the social acceptability of a positive response may have skewed the results”).

Potassium chloride injections also may pose severe risks to women's health. For example, incorrectly-administered injections can cause infection of varying degrees or cardiac arrest.²⁸ Due to such risks, physicians must rely on advanced ultrasound technology that is typically available only in hospitals. The procedure is rarely used outside the maternal-fetal medicine context because clinics are generally unable to afford such equipment, few physicians are trained to inject potassium chloride, and the injections carry high risks for patients.

3. *“Umbilical Cord Transection”*

To attempt to cause fetal demise by umbilical cord transection, a physician tries to sever the umbilical cord by inserting a suction tube or other instrument, such as forceps, into the uterus to rupture the amniotic membrane and, if possible, grasping the umbilical cord to sever it. This is not a viable method of fetal demise prior to a D&E. Attempting to sever an umbilical cord is technically challenging, rarely used, and unpredictable. The initial act of rupturing the amniotic membrane causes amniotic fluid to drain, which immediately causes the uterus to compress. This makes it difficult to identify the cord, which at 17 weeks of gestation is only about 8.5 millimeters in diameter, less than half the diameter of a dime,²⁹ and

²⁸ SFP, *supra* note 11, at 468-69 (noting that potassium chloride injections have caused maternal cardiac arrest and infection).

²⁹ C. Barbieri et. al, *Sonographic Measurement of the Umbilical Cord Area and the Diameters of its Vessels During Pregnancy*, 32(3) J. Obstet. & Gynaecol. 230, 233 (2012).

increases the likelihood that the physician's instruments will injure the patient. Additionally, the procedure's success depends in large part on the placement of the umbilical cord inside the uterus. If the fetus blocks the umbilical cord, the physician may determine that it is too difficult and risky to proceed.

Attempting to transect the umbilical cord involves inherent risks that D&E does not. If a physician begins the procedure but ultimately determines that transection is not possible, the patient is left with a ruptured amniotic membrane, creating a high risk of infection and serious harm to the patient. The procedure can also cause blood loss, placental separation, contractions, infection, and can increase the risk of uterine perforation.³⁰

Like injection-based methods of attempting to cause fetal demise, attempting to sever an umbilical cord is more difficult to perform in the earlier stages of pregnancy and has barely been researched.³¹ *Amici* are not aware of any studies regarding attempted transection in the early weeks of the second trimester. *Amici* are aware of only one study on transection later in the second trimester, and that study is problematic because it followed only two providers in a single setting and

³⁰ Kristina Tocce et al., *Umbilical Cord Transection to Induce Fetal Demise Prior to Second-Trimester D&E Abortion*, 88 *Contraception* 712, 714 (2013).

³¹ SFP, *supra* note 11, at 463, 466 (noting that umbilical cord transection has not been investigated rigorously nor described recently in the medical literature as a technique before abortion).

therefore is not generalizable.³² It also lacked a control group and did not evaluate how much time or how many attempts it took those physicians to successfully complete the procedures.³³

The State also alleges that physicians could utilize a suction technique to cause fetal demise in abortions that occur before seventeen weeks of gestation.³⁴ However, suction is not medically appropriate for all patients. The D&E Ban would prevent physicians from utilizing the safest and most appropriate procedure for their patients.

II. Scientific Evidence Establishes that a Fetus Cannot Experience Pain Prior to 24 Weeks of Gestation

A. The Human Fetus Does Not Have the Capacity to Experience Pain During the Period in which Abortions Are Legal in Texas

The scientific community has soundly rejected the State's argument that a fetus can feel pain during the time abortion is permissible in Texas. At present, the widely-accepted scientific consensus is that (1) the human fetus does not develop the physical ability to perceive pain before at least 24 weeks, as even the basic anatomical structures necessary for transmission of signals from peripheral neural receptors to the brain have not yet developed; and (2) the capacity for conscious perception of pain does not develop until at least the third trimester, months after

³² Tocce, *supra* note 30, at 712.

³³ *Id.*

³⁴ App. Supp. Br. at 10-11.

abortion is no longer available under Texas law.³⁵ This conclusion has been re-affirmed many times, including by ACOG and the Royal College of Obstetricians and Gynaecologists.³⁶

A fetus does not develop the connections necessary to transmit signals from peripheral sensory nerves to the brain until at least 24 weeks of gestation.³⁷

Moreover, the fetal brain lacks the ability to transmit or process those signals, because the structures of the brain that permit those functions do not develop until at least 24 weeks of gestation.³⁸ As a result, a fetus does not have the physiological capacity to perceive pain until *at least* 24 weeks of gestation, at which point abortion is already prohibited under Texas law.³⁹

³⁵ [TEX. HEALTH & SAFETY CODE ANN. § 171.044.](#)

³⁶ Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice* 11 (Mar. 2010) [hereinafter RCOG] (“The lack of cortical connections before 24 weeks ... implies that pain is not possible until after 24 weeks” and “[e]ven after 24 weeks, there is continuing development and elaboration of intracortical networks”); *see also* Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947, 52 (2005) (concluding after review of available peer-reviewed journals analyzing fetal pain that a human fetus probably does not have the capacity to experience pain until 29 weeks of gestation at the earliest).

³⁷ ACOG, Wisconsin Section, *20-Week Abortion Ban Legislation*, 1, https://images.magnetmail.net/images/clients/ACOG/attach/WI_IssuePaper20WeekAbortionBan_updated.pdf; *see also* ACOG, *Facts are Important: Fetal Pain*, <https://www.acog.org/advocacy/facts-are-important/fetal-pain> (last visited Jan. 3, 2021).

³⁸ RCOG, *supra* note 36, at 11 (“Connections from the periphery to the cortex are not intact before 24 weeks of gestation.”).

³⁹ RCOG, *supra* note 36, at 11 (“The lack of cortical connections before 24 weeks ... implies that pain is not possible until after 24 weeks.”).

The perception of pain requires more than just the mechanical transmission and reception of signals within the brain; it is “an emotional and psychological experience that requires conscious recognition of a noxious stimulus.”⁴⁰ The capacity for such conscious recognition does not develop until the third trimester at the earliest, months after the point in which abortions are no longer permitted under Texas law.⁴¹ Indeed, there is good evidence that the neural circuitry necessary to distinguish touch from “nociception” (i.e., painful touch) does not develop until 35-37 weeks of gestation, which is late in the third trimester.⁴²

B. The State Fails to Cite Credible Scientific Evidence of Fetal Pain Early in the Second Trimester

The State argues that the D&E Ban is justified in part by its interest in prohibiting a procedure that, according to the State, has the potential to cause fetal pain. This stated interest is unfounded. There is no credible scientific evidence that fetuses can feel pain before 24 weeks of gestation.

The State bases its argument on the testimony of its alleged expert, Dr. Malloy, whose practice does not involve the study of fetal pain. Dr. Malloy is

⁴⁰ Lee, *supra* note 36, at 952; *see also* RCOG, *supra* note 36, at 6, 10 (discussing definition of pain); ACOG, *Facts*, *supra* note 37.

⁴¹ Lee, *supra* note 36, at 947, 952; *see also* RCOG, *supra* note 36, at 11 (“[T]he fetus is sedated by the physical environment of the womb and usually does not awaken before birth.”).

⁴² Lorenzo Fabrizi, *A Shift in Sensory Processing that Enables the Developing Human Brain to Discriminate Touch from Pain*, 21 *Current Biology* 1552, 1552 (2011); *see also* Lee, *supra* note 36, at 950.

Board Certified in neonatal-perinatal medicine and pediatrics, not gynecology or obstetrics.⁴³ She has no experience studying fetal development, and she has never treated fetuses previability, including performing surgery or other procedures.⁴⁴ She has never published a peer-reviewed article concerning fetal pain.⁴⁵

As a result, Dr. Malloy bases her opinions on fetal pain largely from her care of prematurely-delivered infants.⁴⁶ But Dr. Malloy conceded that she is not aware of any studies or articles that conclude that a pre-22 week fetus would feel pain in the same way that a premature infant would.⁴⁷ To the contrary, she conceded that there are numerous articles and studies (including materials that she relied on in completing her expert report) that contradict this assumption.⁴⁸

Because Dr. Malloy was unable to rely on her own experience concerning fetal pain, she relied on cherry-picked articles and researchers, including Dr. K.S. Anand, who Dr. Malloy characterized as the “guru” of the fetal pain rhetoric that has been adopted by the State.⁴⁹ Like Dr. Malloy, Dr. Anand has not conducted any primary research on pain perception: he is “a pediatrician who has conducted

⁴³ See Expert Report of Colleen Ann Malloy, M.D. at 8 (Sept. 20, 2017).

⁴⁴ See [ROA.2818](#), [2840](#).

⁴⁵ [ROA.2859](#).

⁴⁶ [ROA.2829](#).

⁴⁷ [ROA.2846](#).

⁴⁸ [ROA.2850](#); see Lee, *supra* note 36, at 947.

⁴⁹ [ROA.2823](#).

research on pain in general, focusing primarily on infants.”⁵⁰ Due to his lack of credibility, Dr. Anand’s purported expertise regarding fetal pain perception has been soundly rejected by federal courts.⁵¹ It is, therefore, not surprising that federal courts have also rejected Dr. Malloy’s unsupported opinions on fetal pain.⁵²

Amici States, led by Louisiana, point to allegedly “new research” to rebut the widely-accepted medical consensus that a fetus cannot feel pain before 24 weeks.⁵³ This argument is misguided. The proffered literature is not “new research,” as it does not supply new data. It merely relies on research published prior to the trial in this case. That aside, evidence “not presented at trial cannot be asserted on appeal.”⁵⁴

In short, the State is unable to provide credible evidence to support its assertion that a fetus is capable of feeling pain early in the second trimester.

⁵⁰ *Planned Parenthood Fed’n v. Ashcroft*, [320 F. Supp. 2d 957, 999](#) (N.D. Cal. 2004), *rev’d on other grounds by Gonzales v. Carhart*, [550 U.S. 124](#) (2007).

⁵¹ *Id.* at 999-1000 (declining to give Dr. Anand’s testimony any weight greater than that of others who have reviewed the scientific literature and reached different conclusions).

⁵² *See, e.g., EMW Women’s Surgical Ctr., P.S.C. v. Meier*, [373 F. Supp. 3d 807, 822-24](#) (W.D. Ky. 2019) (rejecting Dr. Malloy’s testimony that a fetus can “certainly” feel pain by 22 weeks, and possibly as early as 15 weeks, and relying on “extensive studies” by reputable medial organizations, including ACOG and RCOG, to conclude that “it is very unlikely that a fetus can feel pain before 24 weeks.”), *aff’d* [960 F.3d 785](#) (6th Cir. 2020).

⁵³ Br. of States as *Amici Curiae*, at 22.

⁵⁴ *Tradewinds Envntl. Restoration, Inc. v. St. Tammany Park, LLC*, [578 F.3d 255, 262](#) (5th Cir. 2009) (quoting *Topalian v. Ehrman*, [954 F.2d 1125, 1131](#) n. 10 (5th Cir. 1992)).

III. The D&E Ban Will Limit Access to D&E In Texas

The D&E Ban may cause many physicians in Texas to stop offering D&E services. Three abortion providers, in this case alone, testified that they will stop performing second-trimester D&E if they are required to ensure fetal demise beforehand. Because it is unknown how many more physicians will cease to offer D&E and since medical induction is not commonly performed in Texas, the D&E Ban will significantly compromise access to second-trimester abortion care. Even if physicians continue to provide D&E, the Ban requires them to force all their patients to submit to additional fetal demise procedures even when contraindicated or in the absence of countervailing benefit.

The many delays women in Texas already face make accessing abortion before 15 weeks no easy feat. To start, many women face delays as a result of the distances they must travel to an abortion clinic, as 96% of Texas counties lack such a facility.⁵⁵ This is particularly burdensome on women who need to make multiple visits to a clinic. After women receive a mandatory ultrasound and state-mandated counselling, women in Texas already need to wait 24 hours before receiving abortion care in order to comply with Texas law.⁵⁶ Under the D&E Ban, because

⁵⁵ Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Institute, at 18 (2019), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.

⁵⁶ [TEX. HEALTH & SAFETY CODE ANN. §§ 171.011-0.12.](#)

causing fetal demise by digoxin injection can take up to 24 hours, a woman could be required to then make an additional trip to complete the D&E, totaling three separate trips. This is particularly burdensome on abortion patients who are disproportionately low income and women of color⁵⁷ and can rarely rely on public funds or private insurance to cover expenses associated with abortion care.⁵⁸

The COVID-19 pandemic only increases the delays women already face, as women may be less willing to seek care in light of the significant risks associated with entering public locations or may experience limited access to service providers. These obstacles are not just hypothetical: in early 2020, Texas abortion providers were required to suspend services and cancel hundreds of scheduled appointments to comply with the governor's executive order canceling all surgeries and procedures except in limited circumstances.⁵⁹ Closures like this can force many women to travel over 200 miles to the nearest facility.⁶⁰ In fact, one study

⁵⁷ Vinta Goyal et al., *Factors associated with abortion at 12 or more weeks gestation after implementation of a restrictive Texas law*, 102(5) *Contraception* 314 (2020).

⁵⁸ 1 TEXAS ADMINISTRATIVE CODE § 354.1167 (noting that reimbursement for abortion care is available only when the pregnancy would have endangered the patient's life, or when the pregnancy is the result of rape or incest); TEXAS INSURANCE CODE §§ 1218.002, 1218.004; [TEX. INS. CODE § 1696.002](#).

⁵⁹ Kari White, et al., *Research Brief: The Potential Impacts of Texas' Executive Order on Patients' Access to Abortion Care*, Tex. Policy Evaluation Project, at 1 (Mar. 2020).

⁶⁰ *Id.* at 1; see also Emma Carpenter, et al., *Texas' Executive Order during COVID-19 Increased Barriers for Patients Seeking Abortion Care*, Tex. Policy Evaluation Project (Jan. 2021) (describing increased delays, costs, and difficulties

found a 38% decrease in the number of abortions provided in Texas from April 2019 to April 2020.⁶¹ *Amici* strongly oppose such responses to COVID-19 because they deny women access to an “essential component of comprehensive health care.”⁶²

The logistical delays imposed by Texas law, coupled with the delays caused by the ongoing pandemic, may force patients to delay abortion care even further into the second trimester, when the D&E Ban would severely restrict access to abortion services. Research shows that, where abortion access is limited, women may resort to unsafe means to end unwanted pregnancies, including self-inflicted abdominal and bodily trauma, ingesting dangerous chemicals, and relying on unqualified or predatory abortion providers.⁶³ This is a significant concern in Texas, where a higher percentage of women attempt self-induced abortion than do

associated with seeking abortion care during the pandemic, which in some instances completely precluded individuals from receiving appropriate care).

⁶¹ Kari White, et al., *Research Letter: Changes in Abortion in Texas Following an Executive Order Ban During the Coronavirus Pandemic*, JAMA (Jan. 4, 2021) (published online).

⁶² ACOG, Joint Statement on Abortion Access During the COVID-19 Outbreak (Mar. 2020), <https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak>.

⁶³ ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, 136(6) *Obstet. & Gynecol.* e107, e108 (Dec. 2020); Society for Maternal-Fetal Medicine, *Access to Abortion Services*, at 1 (Dec. 2017, re-aff’d June 2020), [https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_\(2020\).pdf](https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf).

women nationally.⁶⁴ Even more women may consider or attempt self-induction if the D&E Ban goes into effect.⁶⁵

IV. The D&E Ban Places Physicians in an Ethically Compromising Position

ACOG and the AMA are committed to the right of every woman to access the “best available, scientifically based health care.”⁶⁶ For women who seek second-trimester abortion, the best available scientifically based health care includes D&E. The D&E Ban makes it illegal for physicians to act in accordance with their ethical obligations to their patients.

A. The Ethical Dilemma

To comply with the D&E Ban, physicians must either deny access to the safest and most common form of second-trimester abortion in Texas after approximately 15 weeks of gestation, or attempt to ensure fetal demise using understudied, unnecessary, and risk-increasing procedures. In some instances, physicians will determine that inducing fetal demise prior to D&E is medically

⁶⁴ Texas Policy Evaluation Project, *Texas Women’s Experiences Attempting Self-Induced Abortion in the Face of Dwindling Options*, at 1 (Nov. 2015), <https://www.ibisreproductivehealth.org/publications/texas-women%E2%80%99s-experiences-attempting-self-induced-abortion-face-dwindling-options>.

⁶⁵ *Id.* at 1.

⁶⁶ ACOG, *Statement of Policy, Global Women’s Health and Rights* (July 2012, amended and re-aff’ d July 2018), <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2018/global-womens-health-and-rights>.

inappropriate for a particular patient. In such cases, the physician would be forced to either deny the patient the safest procedure available or risk incurring criminal penalties for violating the law. In making this determination, the D&E Ban potentially creates an irreconcilable conflict between the physician's professional and ethical obligations.

Physicians are ethically required to exercise all reasonable means to ensure their patients receive the most appropriate and effective care.⁶⁷ These ethical obligations are expressed through the principles of beneficence, non-maleficence, and patient autonomy.⁶⁸ Beneficence requires physicians to act in a way that is likely to benefit patients.⁶⁹ Non-maleficence directs physicians to refrain from acting in ways that might harm patients unless the harm is justified by concomitant benefits.⁷⁰ If a physician determines that it is in a patient's best interest to undergo D&E without first attempting fetal demise but is nonetheless forced to impose the procedure, the Ban compromises that physician's ability to fulfill their duties of beneficence and non-maleficence.

⁶⁷ ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics & Gynecology*, at 1 (Dec. 2007, re-aff'd 2016); AMA, *Code of Medical Ethics*, Opinion 1.1.1, Patient-Physician Relationships, <https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships>.

⁶⁸ ACOG, *supra* note 67, at 1 (Dec. 2007, re-aff'd 2016); AMA, *Principles of Medical Ethics*, (June 2001).

⁶⁹ ACOG, *supra* note 67, at 3; AMA, *Code of Medical Ethics*, Opinion 1.1.3, *Patient Rights*, <https://www.ama-assn.org/delivering-care/ethics/patient-rights>.

⁷⁰ ACOG, *supra* note 67, at 3.

Autonomy recognizes that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions. The principle also requires physicians to honor and respect patient decisions about the course of their care.⁷¹ This principle illustrates the injustice of the D&E Ban, where the law would prevent a physician from offering a patient D&E, even though it may be the safest method available.

ACOG and the AMA recognize that attempting fetal demise may be appropriate in some cases for some patients. While some physicians may view fetal demise as beneficial to the performance of D&E in some circumstances for some patients, this approach has not been widely adopted throughout the medical community. The decision to attempt fetal demise is one that must be left to a physician's medical judgment based on each patient's circumstances. All three procedures that can be used to attempt fetal demise do not always work, are not appropriate for all patients, and pose health risks. It is, therefore, imperative that physicians be permitted to consider a patient's health to determine whether attempting fetal demise in a particular instance is safe and appropriate, as what is medically suitable for one patient may not be the best course of action for another.

⁷¹ *Id.*

B. The D&E Ban Improperly Intrudes Into
the Patient-Physician Relationship

The D&E Ban creates a dangerous precedent of empowering legislators to interfere with individualized medical determinations and care in ways that increase, rather than reduce, medical risks. Political considerations, especially those which have no scientific basis, should not restrict physicians' ability to exercise sound medical judgment and provide patients with a full range of safe and quality care.⁷²

CONCLUSION

For all of the reasons stated above, the D&E Ban should not be implemented. This Court should affirm the District Court's permanent injunction.

Dated: January 11, 2021

Respectfully submitted,

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⁷² AMA, *Code of Medical Ethics*, Opinion 2.1.1, Informed Consent, <https://www.ama-assn.org/delivering-care/ethics/informed-consent> (“Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care.”).

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*Not admitted in the Fifth Circuit.

CERTIFICATE OF SERVICE

I hereby certify that on January 11, 2021, I electronically filed a true and correct copy of the foregoing *Amici Curiae* Brief with the Clerk of the Court by using the appellate CM/ECF system, which will send notification of such filing to all registered users of the CM/ECF system.

Dated: January 11, 2021

/s/ Janice M. Mac Avoy
Janice M. Mac Avoy

CERTIFICATE OF COMPLIANCE

I hereby certify that (i) required privacy redactions have been made in compliance with Fifth Circuit Rule 25.2.13; (ii) the electronic submission is an exact copy of the paper document in compliance with Fifth Circuit Rule 25.2.1; and (iii) the document has been scanned with the most recent version of commercial virus-scanning software and was reported free of viruses.

I further certify that this brief complies with: (i) the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 6,441 words, excluding the parts of the brief exempted by Rule 32(f); and (ii) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Times New Roman) using Microsoft Word (the same program used to calculate the word count).

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/s/ Janice M. Mac Avoy
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