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KANAWHA COUNTY CIRCUIT COURT

IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

WOMEN'S HEALTH CENTER OF WEST VIRGINIA, ***on behalf of itself, its staff, its physicians, and its patients*****; DR. JOHN DOE,** ***on behalf of himself and his patients*****; DEBRA BEATTY; DANIELLE MANESS, and KATIE QUIÑONEZ,**

Plaintiffs,

Civil Action No. 22-C-556
Honorable Judge Tera L. Salango

v.

CHARLES T. MILLER, ***in his official capacity as Prosecuting Attorney of Kanawha County*****; and PATRICK MORRISEY,** ***in his official capacity as Attorney General of West Virginia*****,**

Defendants.

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

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Amici Curiae the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and the Society for Maternal-Fetal Medicine ("SMFM") respectfully request leave to file this proposed Brief of *Amici Curiae* in Support of Plaintiff's Motion for a Preliminary Injunction.

INTEREST OF *AMICI CURIAE*

ACOG is the nation's leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG has appeared as *amicus curiae* in courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.[1]

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

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[1] *See, e.g.*, *June Medical Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *see also Gonzales v. Carhart*, 550 U.S. 124, 170-171, 175-178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's brief and congressional submissions regarding abortion procedure).

physicians, residents, and medical students are represented in the AMA's policymaking process. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state. The AMA's publications and amicus curiae briefs have been cited in cases implicating a variety of medical questions in courts across the U.S., including the U.S. Supreme Court.

SMFM, founded in 1977, is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM represents more than 5,500 members who care for high-risk pregnant people and provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

INTRODUCTION AND SUMMARY OF ARGUMENT

Abortion is an essential part of comprehensive health care. When abortion is legal, it is safe. *Amici curiae* are leading medical societies representing physicians, nurses, and other clinicians who serve patients nationwide, and whose policies represent the education, training, and experience of the vast majority of clinicians in this country. *Amici*'s position is that state laws that criminalize and effectively ban abortion:

(1) are not based on any medical or scientific rationale;

(2) threaten the health of pregnant patients;

(3) disproportionately harm patients of color, patients in rural settings, and patients with low income; and

(4) impermissibly interfere with the patient-physician relationship and undermine longstanding principles of medical ethics.

As the AMA has recently recognized, "it is a violation of human rights when government intrudes into medicine and impedes access to safe, evidence-based reproductive health services, including abortion and contraception."[2] ACOG, the AMA, SMFM, and approximately 75 other health care organizations agree that "[a]bortion care is safe and essential reproductive health care. Keeping the patient–clinician relationship safe and private is essential not only to quality individualized care but also to the fabric of our communities and the integrity of our health care infrastructure."[3]

In the wake of *Dobbs v. Jackson Women's Health Org.*, 597 U.S. ___ (2022), West Virginia now intends to enforce W. Va. Code § 61-2-8, enacted in 1882, which imposes criminal penalties on individuals who provide abortions except when provided "in good faith, with the intention of saving the life of [the] woman or child." *Amici* oppose this abortion ban because it would—without any valid medical justification—jeopardize the health and safety of pregnant people in West Virginia and place extreme burdens and risks upon providers of essential reproductive health care.

ARGUMENT

I. Abortion Is a Safe, Common, and Essential Component of Health Care

The medical community recognizes abortion as a safe and essential component of reproductive health care.[4] Abortion is a common medical procedure. In 2020, over 930,000

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[2] AMA, *Press Release: AMA bolsters opposition to wider criminalization of reproductive health* (June 14, 2022), https://www.ama-assn.org/press-center/press-releases/ama-bolsters-opposition-wider-criminalization-reproductive-health.

[3] ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference* (July 7, 2022), https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizations-release-joint-statement-in-opposition-to-legislative-interference.

[4] *See, e.g., id.*; Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med.

abortions were performed nationwide.[5] Approximately one quarter of American women have an abortion before the age of 45.[6]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[7] Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and easily treatable.[8] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[9] The risk of death from an abortion is even rarer:

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979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine that "[a]ccess to legal and safe pregnancy termination ... is essential to the public health of women everywhere"); ACOG, *Abortion Policy* (revised and approved May 2022); Soc'y for Maternal-Fetal Med., *Access to Pregnancy Termination Services* (2017).

[5] Jones et al., Guttmacher Inst., *Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court is Poised to Overturn* Roe v. Wade (June 15, 2022).

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

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

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

[9] White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015). This is also true for medication abortions. which account for about half of abortions nationwide. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013) (regarding major complication rates for medication abortion); Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

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

Similarly, there are no significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies have found that women who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and that receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to continue a pregnancy to term.[13] One recent study noted

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[10] *See* Kortsmit et al. U.S. Dep't of Health & Human Services, Centers for Disease Control and Prevention, *Abortion Surveillance—United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl. 15 (2021) (finding mortality rate from 0.00041% to 0.00078% for approximately five-year periods from 1978 to 2014); Zane et al., *Abortion-Related Mortality in the United States*, 1998-2010, 126 Obstetrics & Gynecology 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

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

[12] ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014) (2.1% of abortions result in minor or major complications—with 1.88% resulting in minor complications and 0.23% resulting in major complications—compared to 7% of wisdom-tooth extractions, 8-9% of tonsillectomies, and 29% of childbirths); American Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011) (33% of colonoscopies result in minor complications); Grazer & de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000) (mortality rate from liposuction in late 1990s was 20 per 100,000); Kortsmit et al., *Abortion Surveillance—United States, 2019*, *supra* note 10, at 29 tbl. 15 (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in the years 2013-2018).

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

that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[14]

II. Statutes that Effectively Prohibit Abortions Will Harm Pregnant Patients' Health

Statutes that ban abortions through criminal and/or civil penalties—even those with narrow health-related exceptions—will cause severe and detrimental physical and psychological health consequences for pregnant patients who want to obtain an abortion. First, while abortion is overall a safe medical procedure, the risk of complications and associated costs are lower the earlier the abortion is performed—and restrictive abortion statutes will likely cause delays in obtaining an abortion. Second, pregnant individuals may be more likely to attempt self-managed abortions using harmful or unsafe methods—that is, self-managed methods other than procuring appropriate medications through licensed providers.[15] Third, continuing a pregnancy to term presents higher risk to the health and mortality of the pregnant patient than obtaining a safe, legal abortion. Each of these outcomes increases the likelihood of negative consequences to the patient's physical and psychological health that could be avoided if abortion were available.[16]

As an initial matter, criminalizing or otherwise penalizing safe abortions provided by a licensed clinician will likely result in delays for pregnant patients in obtaining abortions. Typically, many delays in seeking an abortion are caused by the patient's lack of information about where to find abortion care.[17] The need to travel out of state and consider various states' individual criminal and/or civil penalties related to abortion is likely to further increase

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

[15] The safety of medication abortion is well established. *See supra* note 9.

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

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

confusion for patients about where they can find needed health care. In addition, almost a third of delays are caused by travel and procedure costs.[18] For pregnant patients in states that no longer have in-state abortion providers, the travel and procedure costs for those seeking abortion will likely increase—forcing patients to wait to obtain an abortion at an increased gestational age. Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication.[19] Moreover, abortions at later gestational ages are typically more expensive, further increasing the barriers to obtaining care.[20]

Second, by removing access to safe, legal abortion, statutes banning abortion will also increase the possibility that a pregnant patient will attempt self-managed abortions through harmful or unsafe methods.[21] Studies have found that women are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-management outside safe medical abortion (i.e., abortion by pill) may rely on harmful tactics such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills.[22]

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[18] *Id.*

[19] Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 8, at 181.

[20] Jones et al., *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

[21] *See, e.g.*, Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

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

Further, those patients who do not, or cannot, obtain an abortion due to abortion bans will be forced to continue a pregnancy to term—an outcome with significantly greater risk to the health of the pregnant individual and of mortality. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[23] and rates have sharply increased since then.[24] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[25] A pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[26]

Continued pregnancy and childbirth also entail other substantial health risks for the pregnant person. Even an uncomplicated pregnancy causes significant stress on the body and involves physiological and anatomical changes. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or cause new conditions. For example, approximately 6-7% of pregnancies are complicated by gestational diabetes mellitus, a condition which frequently leads to maternal and fetal complications, including developing diabetes later in life.[27] Preeclampsia, another relatively common complication, is a disorder associated with new-onset

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[23] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 11 at 216.

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

[25] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 11, at 216.

[26] *Id.*

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

hypertension that occurs most often after 20 weeks of gestation and can result in blood pressure swings, heart disease, liver issues, and seizures, among other conditions.[28]

Labor and delivery are likewise not without significant risk, including those of hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs when the placenta is unable to detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum pain, among others.[29] Approximately one in three people who give birth in the United States do so by cesarean delivery, a major surgical procedure that carries increased risk of complications.[30]

Evidence also suggests that pregnant people denied abortions because of gestational age limits are more likely to experience negative psychological health outcomes—such as anxiety, lower self-esteem, and lower life satisfaction—than those who obtained a needed abortion.[31]

III. Statutes that Ban Abortion Will Hurt Rural, Minority, and Poor Patients the Most

Statutes that effectively ban abortion will disproportionately impact people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to abortion policies that increase the inequities that already plague the health care system in this country.[32]

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

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

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

[31] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, *supra* note 13, at 172.

[32] ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference*, *supra* note 3.

In 2019, two-thirds of patients who obtained abortions in the United States identified as other than white.[33] Non-Hispanic Black women and Hispanic women received abortions at higher rates (i.e., more abortions per 100,000 women) than white women, as tracked by the CDC.[34] In addition, 75% of abortion patients nationwide are living at or below 200% of the federal poverty level.[35] Patients with limited means and patients living in geographically remote areas will be disproportionately affected by the closure of clinics, which requires them to travel longer distances (and pay higher associated costs) to obtain safe, legal abortions. These travel and procedure costs are compounded in states where other laws or regulations create substantial financial barriers to abortion care (e.g., lack of coverage under insurance policies).

The inequities continue after an abortion is denied. As explained *supra* Part III, forcing patients to continue pregnancy increases their risk of complications, and the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion. Nationwide, Black patients' pregnancy-related mortality rate is 3.2 to 3.5 times higher than that of white patients, with significant disparities persisting even in areas with the lowest overall mortality rates and among patients with higher levels of education.[36] Statutes banning abortion thus exacerbate inequities in maternal health and reproductive health care, disproportionately harming the most vulnerable pregnant patients.

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[33] *See* Kortsmit et al., *Abortion Surveillance—United States, 2019*, 70 Morbidity & Mortality Weekly Rep. *supra* note 10, at 20 tbl. 6.

[34] *Id.*

[35] Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (2016).

[36] CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019) (3.2 times); MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 Am. J. Pub. Health 1673, 1676-1677 (Sept. 22, 2021) (3.55 times).

IV. Statutes Banning Abortion Force Clinicians To Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law

Statutes banning abortion violate long-established and widely accepted principles of medical ethics by: (1) substituting legislators' opinions for a physician's individualized patient-centered counseling and creating an inherent conflict of interest between patients and medical professionals; (2) asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. *Statutes Banning Abortion Undermine the Patient-Physician Relationship by Substituting Flawed Legislative Judgment for a Physician's Individualized Patient-Centered Counseling and by Creating Conflicts of Interest Between Physicians and their Patients*

The patient-physician relationship is critical for the provision of safe and quality medical care.[37] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests with the best available scientific evidence.[38] ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments," and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[39] Likewise, the AMA Code of Medical Ethics places on physicians the "ethical

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

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

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

responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[40] Statutes banning abortion force physicians to supplant their own medical judgments—and their patients' judgments—regarding what is in the patients' best interests with the legislature's non-expert decision regarding whether and when physicians may provide abortions.

As described above, abortions are safe, routine, and, for many patients, the best medical choice for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician's ability to provide an abortion where both the physician and patient conclude that is the medically appropriate course. Laws that have the effect of banning abortion in nearly all circumstances are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

Statutes banning abortion also create inherent conflicts of interest for physicians. Physicians need to be able to offer appropriate treatment options based on patients' individualized interests without regard for the physicians' own self-interest.[41] Statutes that prohibit physicians from performing abortions profoundly intrude upon the patient-physician relationship.[42] For example, a physician and patient together may conclude that an abortion is in the patient's best medical interests even though the abortion ban prohibits abortion under the patient's particular circumstances. The Ban thus forces physicians to choose between the ethical

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[40] AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1.*

[41] *See* ACOG, *Legis. Policy Statement, supra* note 37.

[42] ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference, supra* note 3.

practice of medicine—counseling and acting in their patients' best interest—and obeying the law.[43]

B. *Statutes Banning Abortion Violate the Principles of Beneficence and Non-Maleficence*

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2,500 years ago.[44] Both of these principles arise from the foundation of medical ethics which requires that the welfare of the patient forms the basis of all medical decision-making.[45]

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make a decision informed by both medical science and their individual lived experiences.[46]

Statutes banning abortion pit physicians' interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But abortion bans prohibit physicians from providing

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

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

[45] *See supra* notes 37-40 and accompanying text.

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

that treatment and may expose physicians to significant penalties if they do so. It therefore places physicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

C. *Statutes Banning Abortion Violate the Ethical Principle of Respect for Patient Autonomy*

Finally, a core principle of medical practice is patient autonomy—the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[47] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[48] Statutes banning abortion would deny patients the right to make their own choices about health care if they decide they need to seek an abortion.

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[47] ACOG, *Code of Professional Ethics*, *supra* note 39, at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

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

CONCLUSION

For the foregoing reasons, this Court should enjoin enforcement of W. Va. Code § 61-2-8.

RESPECTFULLY SUBMITTED this 14th day of July 2022.

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IN THE CIRCUIT COURT OF KANAWHA COUNTY, WEST VIRGINIA

WOMEN'S HEALTH CENTER OF WEST VIRGINIA, ***on behalf of itself, its staff, its physicians, and its patients*****; DR. JOHN DOE,** ***on behalf of himself and his patients*****; DEBRA BEATTY; DANIELLE MANESS, and KATIE QUIÑONEZ,**

Plaintiffs,

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v.

CHARLES T. MILLER, ***in his official capacity as Prosecuting Attorney of Kanawha County*****; and PATRICK MORRISEY,** ***in his official capacity as Attorney General of West Virginia*****,**

Defendants.

CERTIFICATE OF SERVICE

I, Anthony J. Majestro, the undersigned counsel, do certify that on July 14, 2022, I have served the **BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION** by depositing a true and correct copy of the same in the regular course of the U.S. Mail, postage prepaid, at the addresses set forth below:

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