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NO. 22-CI-03225

JEFFERSON CIRCUIT COURT
DIVISION THREE (3)
HON. MITCH PERRY

EMW WOMEN'S SURGICAL CENTER, P.S.C. *et. al.* PLAINTIFFS

v.

DANIEL CAMERON, *et al.* DEFENDANTS

NOTICE

Please take notice that on Monday, July 25, 2022 at 9:45 a.m., *amici curiae* The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and the Society for Maternal-Fetal Medicine ("SMFM") (collectively, "*amici*"), will appear and move this Court for leave to submit the attached brief as *amici curiae*. The conference call-in number is 1-774-220-4000, ID 595-4919#.

MOTION BY THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE*

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and the Society for Maternal-Fetal Medicine ("SMFM") respectfully move this Court for leave to submit the enclosed brief as *amici curiae*. In support of this motion, movants state as follows:

1. 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.

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2. 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]

3. 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. 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.

4. 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.[2]

5. 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

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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*, 136 S. Ct. 2292 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue).

[2] *See, e.g.*, *Birchfield v. North Dakota*, 579 U.S. 438 (2016) (citing AMA research on blood-alcohol levels that constitute drunk driving); *Graham v. Florida*, 560 U.S. 48 (2010) (citing AMA brief as medical authority on juvenile development); *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (citing AMA brief in assessing patient privacy).

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members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

6. Movants respectfully request that this Court grant it leave to file the enclosed *amici curiae* brief, which provides scientific and medical authority regarding (i) the safe and routine nature of abortion care; (ii) the threat posed to Kentuckians' health by the laws at issue in this case; and (iii) the inconsistency of such laws with longstanding principles of medical ethics and practice.

7. Movants do not seek to participate in oral argument.

DATE: July 18, 2022

Respectfully submitted,

/s/ Michael P. Abate

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CERTIFICATE OF SERVICE

I certify that on July 18, 2022, I served a copy of the foregoing through the Court's electronic filing system which effectuates service upon all counsel of record.

/s/ Michael P. Abate

Michael P. Abate

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BRIEF OF *AMICI CURIAE* IN SUPPORT OF PLAINTIFF'S MOTION FOR RESTRAINING ORDER AND TEMPORARY INJUNCTION

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TABLE OF AUTHORITIES

CASES

Page(s)

Dobbs v. Jackson Women's Health Organization,
597 U.S. __ (2022)....................3

Gonzales v. Carhart,
550 U.S. 124 (2007)....................1

Hodgson v. Minnesota,
497 U.S. 417 (1990)....................1

June Medical Services, LLC v. Russo,
140 S. Ct. 2103 (2020)....................1

Roe v. Wade,
410 U.S. 113 (1973)....................3

Simopoulos v. Virginia,
462 U.S. 506 (1983)....................1

Stenberg v. Carhart,
530 U.S. 914 (2000)....................1

Whole Woman's Health v. Hellerstedt,
579 U.S. 582 (2016)....................1

STATUTES

Ky. Rev. Stat. Ann. § 311.772....................3, 7

Ky. Rev. Stat. Ann. § 311.990....................8

Ky. Rev. Stat. Ann. § 311.7701-7711....................3, 4

Ky. Rev. Stat. Ann. § 311.7702....................7

Ky. Rev. Stat. Ann. § 311.7705....................8

Ky. Rev. Stat. Ann. § 311.7706....................8

Ky. Rev. Stat. Ann. § 532.060....................8

Ky. Rev. Stat. Ann. § 534.030....................8

BRF : 000004 of 000037

OTHER AUTHORITIES

ACOG, *Abortion Policy* (revised and approved May 2022), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy 4

ACOG, Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* (Sept. 2021), https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2021/09/pharmacologic-stepwise-multimodal-approach-for-postpartum-pain-management 16

ACOG, *Code of Professional Ethics* (Dec. 2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf?la=en&hash=CC213370E1EFDCD3E81242D8384BE4AB 22, 25

ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* (Dec. 2007, reaffirmed 2016) 24

ACOG, Committee Opinion No. 651, *Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign* (Dec. 2015), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/12/menstruation-in-girls-and-adolescents-using-the-menstrual-cycle-as-a-vital-sign 9

ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/12/increasing-access-to-abortion 13

ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology 25

ACOG, *Facts Are Important: Understanding Ectopic Pregnancy*, https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy (last visited July 17, 2022) 18

ACOG Guide to Language and Abortion (Mar. 2022), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/publications/abortion-language-guide.pdf?la=en&hash=EDDEB0D9B24B7427A8F52378FA72E092 8

ACOG, Obstetric Care Consensus, *Placenta Accreta Spectrum* (July 2012, reaff'd 2021), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2018/12/placenta-accreta-spectrum 16

E06B0994-3CF0-4F46-B2FB-EE1F6D67CF6C : 000009 of 000043

BRF : 000005 of 000037

Filed 22-CI-003225 07/18/2022 David L. Nicholson, Jefferson Circuit Clerk

ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* (Mar. 2014, reaff'd 2016), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery 16

ACOG Practice Bulletin No. 162: *Prenatal Diagnostic Testing for Genetic Disorders*, 127 Obstetrics & Gynecology 108 (May 2016)....................24

ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2017/10/postpartum-hemorrhage....................16

ACOG Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/02/gestational-diabetes-mellitus 15

ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/09/prevention-and-management-of-obstetric-lacerations-at-vaginal-delivery 16

ACOG, Practice Bulletin No. 200, *Early Pregnancy Loss* (Nov. 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss....................11

ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (June 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/06/gestational-hypertension-and-preeclampsia 16

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............3, 4, 20

ACOG, *Statement of Policy: Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaffirmed and amended Aug. 2021), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship 22, 23

Allen, Rebecca H., et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625 (2013) 18

AMA, *Code of Medical Ethics*, https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-overview (visited July 17, 2022)....................22, 24, 25

E06B0994-3CF0-4F46-B2FB-EE1F6D67CF6C : 000010 of 000043

BRF : 000006 of 000037

Filed 22-CI-003225 07/18/2022 David L. Nicholson, Jefferson Circuit Clerk

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

AMA, *Principles of Medical Ethics* (rev. June 2001), https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics 24

American Society for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745 (2011) 6

ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6 (Dec. 2014) 6

Bae, Jinju, et. al., *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18 BMC Womens's Health 1 (2018) 9

Bearak, Jonathan, et. al., Guttmacher Institute, *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care* (updated Apr. 23, 2020), https://www.guttmacher.org/article/2020/04/covid-19-abortion-bans-would-greatly-increase-driving-distances-those-seeking-care 14

Biggs, M. Antonia, 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 (2017) 6, 16

Boonstra, Heather D., et al., Guttmacher Institute, *Abortion in Women's Lives* (May 2006), https://www.guttmacher.org/report/abortion-womens-lives 9

CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html 21

Cortes-Hernandez, J., et al., Clinical *Predictors of Fetal and Maternal Outcome* in *Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643 (2002) 17

Dennis, Amanda, et al., *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141 (2015) 18

Drey, Eleanor, et al., *Risk Factors Associated With Presenting for Abortion in the Second Trimester*, 107 Obstetrics & Gynecology 128 (Jan. 2006) 10

Editors of the *New England Journal of Medicine,* the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) 4

E06B0994-3CF0-4F46-B2FB-EE1F6D67CF6C : 000011 of 000043

BRF : 000007 of 000037

Filed 22-CI-003225 07/18/2022 David L. Nicholson, Jefferson Circuit Clerk

FDA, *Pregnancy* (Apr. 29, 2019), https://www.fda.gov/medical-devices/home-use-tests/pregnancy 10

Fong, Katherine W., et al., *Detection of Fetal Structural Abnormalities with US During Early Pregnancy*, 24 RadioGraphics 157 (Jan.-Feb. 2004) 12

Gadsby, Roger, et al., *A Prospective Study of Nausea and Vomiting During Pregnancy*, 43 Brit. J. of Gen. Prac. 245 (June 1993) 9

Grazer, Frederick M. & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436 (2000) 6

Greene, Michael F. & Jeffrey L. Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184 (2004) 17

Grossman, Daniel., et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, 92 Contraception 360 (2015) 15

Guttmacher Institute, Fact Sheet, *Unintended Pregnancy in the United States* (Jan. 2019), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states 9

Guttmacher Institute, *State Facts About Abortion: Kentucky* (June 2022), https://www.guttmacher.org/sites/default/files/factsheet/sfaa-ky.pdf 21

Heller, Rebecca & Sharon Cameron, *Termination of Pregnancy at Very Early Gestation Without Visible Yolk Sac on Ultrasound*, 41 J. Fam. Plann. Reprod. Health Care 90 (2015) 10

Jerman, Jenna, et al., Guttmacher Institute, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf 20

Jones, Bonnie Scott, et al., *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623 (2009) 14

Jones, Rachel K., et al., Guttmacher Institute, *Abortion Incidence and Service Availability in the United States, 2017* (2019), https://www.guttmacher.org/—report/abortion-incidence-service-availability-us-2017 14

Jones, Rachel K., et al., Guttmacher Institute, *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), https://www.guttmacher.org/—print/article/2022/06/long-term-decline-us-abortions-reverses-showing-rising-need-abortion-supreme-court 4

Filed 22-CI-003225 07/18/2022 David L. Nicholson, Jefferson Circuit Clerk

E06B0994-3CF0-4F46-B2FB-EE1F6D67CF6C : 000012 of 000043

BRF : 000008 of 000037

Filed 22-CI-003225 07/18/2022 David L. Nicholson, Jefferson Circuit Clerk

Jones, Rachel K., et al., Guttmacher Institute, *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022), https://www.guttmacher.org/print/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions 5

Jones, Rachel K. & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904 (2017) 4

Kashyap, Namrata, et al., *Early Detection of Fetal Malformation, a Long Distance Yet to Cover! Present Status and Potential of First Trimester Ultrasonography in Detection of Fetal Congenital Malformation in a Developing Country: Experience at a Tertiary Care Centre in India*, 2015 Journal of Pregnancy 1 (2015) 12

Kentucky Department for Public Health, *Annual Report 2021, Public Health Maternal Mortality Review, A Report of Data from Years 2013-2019* (Nov. 2020), https://chfs.ky.gov/agencies/dph/dmch/Documents/MMRAnnualReport.pdf 21

Kentucky Department for Public Health, Office of Vital Statistics, *Kentucky Annual Abortion Report for 2020*, https://chfs.ky.gov/agencies/dph/dehp/vsb/Forms/2020KYAbortionAnnualReport.pdf 4, 5, 10, 20

Kiely, David G., et al., *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management*, 6 Obstetric Med. 144 (2013) 17

Kortsmit, Katherine, et al., U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Abortion Surveillance—United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1 (2021) 5, 6, 10

MacDorman, Marian F., 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 (Sept. 22, 2021) 21

MacDorman, Marian F., et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016) 15

Mangla, Kimberly, et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019) 19

Martin, Joyce, et al., *Births: Final Data for 2019*, CDC-National Vital Statistics Reports, Vol. 70 (Mar. 23, 2021), https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-508.pdf 16

Matsuo, Koji, et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531 (2007) 17

Filed 22-CI-003225 07/18/2022 David L. Nicholson, Jefferson Circuit Clerk

E06B0994-3CF0-4F46-B2FB-EE1F6D67CF6C : 000013 of 000043

BRF : 000009 of 000037

National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* (2018), https://nap.national academies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states 5

Raymond, Elizabeth G. & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012) 5, 15

Raymond, Elizabeth G., et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26 (2013) 5

Rocca, Corinne H., et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS ONE 1 (2015) 6

Royal College of Obstetricians and Gynecologists, *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales* (May 2010), https://www.rcog.org.uk/media/21lfvl0e/terminationpregnancyreport18may2010.pdf. 11

Rydberg, Catharina & Katarina Tunon, *Detection of Fetal Abnormalities by Second-Trimester Ultrasound Screening in a Non-Selected Population*, 96 Acta Obstetricia Gynecologica Scandinavica 176 (Nov. 22, 2016) 12

Society for Maternal-Fetal Medicine, *Access to Pregnancy Termination Services* (2017), https://s3.amazonaws.com/cdn.smfm.org/media/1269/Access_to_Pregnancy_Termination_Services.pdf 4, 11

Stout, Karen K. & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552 (May 2007) 17

United States Census Bureau, *2019 Poverty Rate in the United States* (Sept. 17, 2020), https://www.census.gov/library/visualizations/interactive/2019-poverty-rate.html 21

Upadhyay, Ushma D., et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687 (Sept. 2014) 13, 14

Upadhyay, Ushma D., et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015) 5, 14

White, Kari, et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422 (2015) 5

Zane, Suzanne, et al., *Abortion-Related Mortality in the United States,* 1998-2010, 126 Obstetrics & Gynecology 258 (2015) 5

E06B0994-3CF0-4F46-B2FB-EE1F6D67CF6C : 000014 of 000043

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E06B0994-3CF0-4F46-B2FB-EE1F6D67CF6C : 000015 of 000043

INTEREST OF AMICI CURIAE

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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's Kentucky Section has over 600 members living and practicing in the state who, together with their patients, are directly affected by laws restricting access to abortion care and other reproductive health 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]

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[1] *See, e.g.*, *June Med. 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).

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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. 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 in Kentucky and 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;

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(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), Kentucky intends to enforce KRS 311.772, which imposes criminal penalties on individuals who provide abortions.[4] This statute was designed to become effective upon the reversal of *Roe v. Wade*,[5] and therefore is colloquially known as the "Trigger Ban."[6] Kentucky also or in the alternative intends to enforce KRS 311.7701 to -11, which imposes criminal penalties on individuals who

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[2] AMA, *Press Release: AMA bolsters opposition to wider criminalization of reproductive health* (June 14, 2022).

[3] ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference* (July 7, 2022).

[4] Ky. Rev. Stat. Ann. ("KRS") § 311.772 (West).

[5] 410 U.S. 113 (1973).

[6] *Amici* understand that Kentucky asserts the Trigger Ban is effective in light of the Supreme Court's June 24, 2022 decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. __, No. 19-1392 (2022). Alternatively, it may become effective once the U.S. Supreme Court transmits a certified copy of the judgment and opinion. Compl. ¶ 28.

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provide abortions after embryonic cardiac activity becomes detectable, which generally occurs around the sixth week of pregnancy (the "Six-Week Ban").[7]

Collectively and individually, the Kentucky Bans would—without any valid medical justification—jeopardize the health and safety of pregnant people in Kentucky and place extreme burdens and risks upon providers of essential reproductive health care. *Amici* oppose such laws.

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.[8] Abortion is a common medical procedure. In 2020, over 930,000 abortions were performed nationwide,[9] including roughly 4,100 in Kentucky.[10] Approximately one quarter of American women have an abortion before the age of 45.[11]

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[7] KRS § 311.7701-11.

[8] *See, e.g.*, Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine 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); ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference*, *supra* note 3.

[9] 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).

[10] KY Dept. for Pub. Health, Office of Vital Statistics, *Kentucky Annual Abortion Report for 2020*, at 2 ("*Kentucky Annual Abortion Report for 2020*"). https://chfs.ky.gov/agencies/dph/dehp/vsb/Forms/2020KYAbortionAnnualReport.pdf (last visited June 28, 2022).

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

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The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[12] Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and easily treatable.[13] 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.[14] Only 0.73% of abortions in Kentucky in 2020 resulted in any type of complication.[15] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[16] By contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[17] In fact, abortion is so

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[12] *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.").

[13] *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*, *supra* note 12 at 55, 60.

[14] 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 all abortions in Kentucky and 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); *Kentucky Annual Abortion Report for 2020*, *supra* note 10 at 12 (number of Kentucky medication abortions, category labeled "medical non-surgical"); Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

[15] *Kentucky Annual Abortion Report for 2020*, *supra* note 10 at 12.

[16] *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).

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

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safe that there is a greater risk of complications or mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[18]

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.[19] One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[20]

II. Despite the Safe and Routine Nature of Abortions, Kentucky's Trigger Ban and Six-Week Ban Effectively Prohibit All Abortions with No Medical Justification

Collectively and individually, the Trigger Ban and the Six-Week Ban would—without any valid medical justification—jeopardize the health and safety of pregnant people in Kentucky and place extreme burdens and risks upon providers of essential reproductive health care by criminalizing nearly all abortions. The State purports to justify at least the Six-Week Ban by citing the State's "interests from the outset of the pregnancy in protecting the health of the

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[18] ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014); American Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011); Grazer & de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000); Kortsmit et al., *Abortion Surveillance—United States, 2019*, *supra* note 16 at 29 tbl. 15.

[19] 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).

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

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woman and the life of an unborn human individual who may be born,"[21] but the Bans are not medically justified in light of those asserted interests. To the contrary, the Bans will harm the health of pregnant individuals in Kentucky, as described *infra* Part III, and the idea of protecting embryonic development or fetuses beginning with fertilization creates arbitrary, medically unjustified, and conflicting responsibilities for medical providers, see *infra* Parts II.C, III.B.

A. *The Trigger Ban Criminalizes Providing Abortion Care at any Point After Fertilization*

The Trigger Ban effects a near-total prohibition against any and all abortion care. The Trigger Ban subjects clinicians to criminal penalties (imprisonment and a fine) for, *inter alia*, performing procedures and prescribing medication "with the specific intent of causing or abetting the termination of the life of an unborn human being."[22] "Unborn human being" covers the time period "from fertilization to full gestation and childbirth."[23]

There are only two narrow exceptions to this otherwise complete ban on all abortion care: (1) procedures that are "necessary in reasonable medical judgment to prevent the death or substantial risk of death due to a physical condition, or to prevent the serious, permanent impairment of a life-sustaining organ of a pregnant woman;"[24] or (2) "[m]edical treatment" resulting "in the accidental or unintentional injury or death to the unborn human being."[25]

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[21] KRS § 311.7702(8).

[22] *Id.* § 311.772(3).

[23] *Id.* § 331.772(1)(c).

[24] *Id.* § 331.772(4)(a). This exception also directs that "the physician shall make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of the unborn human being in a manner consistent with reasonable medical practice."

[25] *Id.* § 331.772(4)(b).

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Because of the criminal penalties and extremely narrow exceptions, the Trigger Ban functions as a near-absolute ban on abortion services.

B. *The Six-Week Ban Criminalizes Providing Abortion Care Where There Is Detectable Cardiac Activity, Which has the Effect of Prohibiting the Majority of Abortions*

In addition to the Trigger Ban, Kentucky law also independently bans abortion after approximately six weeks' gestational age. The Six-Week Ban subjects clinicians to criminal penalties (imprisonment and a fine[26]) for performing an abortion (1) if the clinician did not first attempt to determine whether there is a "fetal heartbeat," except in the case of a medical emergency;[27] or (2) after a "fetal heartbeat" has been detected,[28] unless the procedure is "designed or intended to prevent the death" or "substantial and irreversible impairment of a major bodily function of the pregnant woman."[29] The Trigger Ban reflects a misunderstanding by the legislature of key medical issues and terminology. *Amici* understand that Kentucky believes its definition of "fetal heartbeat" includes the embryonic cardiac activity that occurs as a result of electrical flickering of a portion of the embryonic tissue, which typically is detectable at approximately six weeks' gestation. However, as a matter of medical science, a true fetal heartbeat exists only after the chambers of the heart have been developed and can be detected via ultrasound, which typically occurs around 17-20 weeks' gestation.[30]

In addition, although the ban purports to allow individuals to seek an abortion before approximately six weeks' gestation, in practice, due to the ways in which pregnancy symptoms

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[26] *Id.* §§ 311.990(23); 532.060(2)(d); 534.030(1).

[27] *Id.* § 311.7705.

[28] *Id.* § 311.7706(1).

[29] *Id.* § 311.7706(2)(a).

[30] *See ACOG Guide to Language and Abortion* 1 (Mar. 2022).

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are observed and challenges in seeking care, the Six-Week Ban will prevent many pregnant patients who want an abortion from obtaining one.

First, many people do not know they are pregnant by six weeks' gestational age, or only learn they are pregnant shortly before that window closes. The gestational age of a pregnancy is measured in weeks from the first day of a person's last menstrual period. The average menstrual cycle is four-weeks long, which means that at six weeks' gestation, a person would be only two weeks from their missed period. And, for a variety of reasons—including stress, obesity, thyroid dysfunction, and premature ovarian failure—many people experience irregular menstrual cycles, and adolescents may have cycles that are six weeks or longer in early menstrual life;[31] under these circumstances, people might not even notice a missed period before six weeks have passed. Further, because nearly half of pregnancies in the United States are unplanned,[32] many pregnant patients may not consider other potential symptoms—such as nausea or vomiting—to indicate pregnancy; other pregnant patients may simply not experience these symptoms at all before five or six weeks.[33]

Even if a person suspects they may be pregnant before six weeks pass, many people are unable to see a physician to confirm their pregnancy, let alone make a thoughtful, informed

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[31] Bae et al., *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18 BMC Women's Health 1, 1 (2018); ACOG, Committee Opinion No. 651, *Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign* 2 (Dec. 2015).

[32] Guttmacher Inst., Fact Sheet, *Unintended Pregnancy in the United States* (Jan. 2019); Boonstra et al., Guttmacher Inst., *Abortion in Women's Lives* 29 (May 2006).

[33] Gadsby et al., *A Prospective Study of Nausea and Vomiting During Pregnancy*, 43 Brit. J. of Gen. Prac. 245, 246 (June 1993).

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decision about whether to continue the pregnancy before the six weeks' gestation mark.[34] It often takes time before patients who have decided they need to end their pregnancy can access abortion care given the logistical and financial barriers many face, including health center wait times as well as organizing funds, transportation, accommodation, childcare, and time off from work.[35] Moreover, before six weeks' gestation, physicians cannot always confirm an intrauterine pregnancy via ultrasound and therefore in some cases, may not be able to offer an abortion.[36]

For all of these reasons, the majority of abortions provided in Kentucky—and nationwide—are performed after six weeks' gestational age. In 2020, approximately two-thirds of abortions provided in Kentucky were performed after six weeks' gestation.[37] The Six-Week Ban thus has the effect of criminalizing the majority of abortions provided in the State.

Because of its criminal penalties and extremely narrow exceptions, combined with the fact that many individuals do not know they are pregnant and cannot access reproductive health care before six weeks' gestation, the Six-Week Ban, like the Trigger Ban, functions as a near-absolute ban on abortion services.

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[34] Administering a home pregnancy test too early in a patient's menstrual cycle or too close to the time a patient became pregnant may result in a false negative result. FDA, *Pregnancy* (Apr. 29, 2019).

[35] *Cf.* Drey et al., *Risk Factors Associated With Presenting for Abortion in the Second Trimester*, 107 Obstetrics & Gynecology 128, 130 (Jan. 2006).

[36] Heller & Cameron, *Termination of Pregnancy at Very Early Gestation Without Visible Yolk Sac on Ultrasound*, 41 J. Fam. Plann. Reprod. Health Care 90, 90-91 (2015).

[37] *Kentucky Annual Abortion Report for 2020*, *supra* note 10 at 7. Nationwide, as well, the majority of abortions occur after six weeks' gestation. *See* Kortsmit et al., *Abortion Surveillance—United States, 2019*, *supra* note 16 at 24 tbl. 10.

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C. *Neither the Trigger Ban nor the Six-Week Ban Allow Sufficient Time for Patients and Clinicians to Consult Regarding Potential Risks Involving the Fetus*

The Trigger Ban's prohibition on abortion at any stage post-fertilization by definition does not permit patients to consult with their clinicians about the risks of continuing a pregnancy that may not be viable or that involves genetic, chromosomal, or other issues that may affect the likelihood of survival of a fetus or child after birth.[38] With respect to the Six-Week Ban, the Kentucky legislature's claim that embryonic cardiac activity is a "key medical predictor that an unborn human individual will reach live birth," is inconsistent with scientific understanding and medical practice. While embryonic cardiac activity can signal that an early pregnancy may continue to develop (as opposed to end in a spontaneous abortion or miscarriage),[39] embryonic cardiac activity is a scientifically arbitrary point in pregnancy. It does not by itself indicate whether a pregnancy will develop normally or end in a live birth, and it certainly is not a sign of fetal viability.

Further, embryonic cardiac activity occurs too early in a pregnancy for patients to have undergone screening for genetic, chromosomal, or other issues that could detect potentially life-threatening fetal anomalies. Pregnant patients typically undergo ultrasound scans late in the first trimester and again in the second trimester to detect potential abnormalities.[40] One study concluded that 23% of major fetal anomalies were detected between 11 to 14 weeks of gestation

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[38] Soc'y for Maternal-Fetal Med., *Access to Pregnancy Termination Services*, *supra* note 8, at 1.

[39] ACOG, Practice Bulletin No. 200, *Early Pregnancy Loss* (Nov. 2018).

[40] Royal College of Obstetricians and Gynecologists, *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales* 11 (May 2010).

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and that 33.7% were detected in the second trimester.[41] Two additional studies found that in over half of the pregnancies studied, fetal malformations were not detected until the second trimester.[42] Major fetal anomalies are often incompatible with survival; a pregnant patient who cannot obtain abortion care under these circumstances can be forced to carry to term a fetus that has little or no life expectancy. Carrying such a pregnancy to term may present life-threatening or life-altering risks to the pregnant patient. Forcing abortions to occur before this screening occurs or not at all deprives patients of the opportunity to discuss these personal, complex, medical considerations with their clinicians and families and make informed decisions about their health and the health of their families.

III. By Prohibiting Abortions, the Bans Will Harm Pregnant Patients' Health

Either of Kentucky's bans would 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—the Trigger Ban and Six-Week ban will likely cause delays in obtaining an abortion. Second, pregnant individuals may be more likely to

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[41] Fong et al., *Detection of Fetal Structural Abnormalities with US During Early Pregnancy*, 24 RadioGraphics 157, 172-173 (Jan.-Feb. 2004).

[42] Kashyap et al., *Early Detection of Fetal Malformation, a Long Distance Yet to Cover! Present Status and Potential of First Trimester Ultrasonography in Detection of Fetal Congenital Malformation in a Developing Country: Experience at a Tertiary Care Centre in India*, 2015 Journal of Pregnancy 1, 6 (2015) (finding that, out of the total number of women with diagnosed fetal malformation, 65% presented before 20 weeks of gestation and of that, only 1.6% were diagnosed prior to 12 weeks of gestation); Rydberg & Tunon, *Detection of Fetal Abnormalities by Second-Trimester Ultrasound Screening in a Non-Selected Population*, 96 Acta Obstetricia Gynecologica Scandinavica 176, 176 (Nov. 22, 2016) (finding that half of the major structural malformations in otherwise normal fetuses were detected by routine ultrasound examination in the second trimester).

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attempt self-managed abortions using harmful or unsafe methods—that is, self-managed methods other than procuring appropriate medications through licensed providers.[43] 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.[44]

Both the Trigger Ban and Six-Week Ban have limited exceptions for abortions necessary to prevent a pregnant patient's death or permanent impairment to life-sustaining organs or bodily function (with respect to (1) the Trigger Ban and (2) the Six-Week Ban in the case of an abortion performed after embryonic cardiac activity is detected) or in the case of a "medical emergency" (with respect to the Six-Week Ban in the case of an abortion performed without determining whether fetal cardiac activity is detectable). But these narrow exceptions are vague and thus create risks for clinicians. Moreover, they are inadequate to protect the health of pregnant patients as they do not permit them to obtain an abortion in a wide range of circumstances that could risk substantial harm to patients and yet do fall within the narrow exceptions, as is described *infra* Part B.

A. *The Bans Will Endanger the Physical and Psychological Health of Pregnant Patients*

Criminalizing safe abortions provided by a licensed clinician in the State of Kentucky will likely result in delays in obtaining abortions. Typically, many delays in seeking an abortion

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[43] The safety of medication abortion is well established. *See supra* note 14.

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

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are caused by the patient's lack of information about where to find abortion care.[45] 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 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.[46] With no in-state abortion providers, the travel and procedure costs for Kentuckians seeking abortion will very likely increase. For example, a 2020 analysis demonstrated that the closure of Kentucky's abortion clinics would nearly double the average required travel distance for Kentuckians seeking an abortion.[47] This distance is likely even greater now in light of similar bans going into effect in neighboring states, including Tennessee and West Virginia. Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication.[48] Moreover, abortions at later gestational ages are typically more expensive, further increasing the barriers to obtaining care.[49]

By removing access to safe, legal abortion, the Bans will also increase the possibility that a pregnant patient will attempt self-managed abortions through harmful or unsafe methods.[50] Studies have found that women are more likely to self-manage abortions when they face barriers

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

[46] *Id.*

[47] Bearak et. al., Guttmacher Inst., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care* (updated Apr. 23, 2020).

[48] Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 13 at 181.

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

[50] *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).

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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.[51]

Those patients who do not, or cannot, obtain an abortion due to the Bans will be forced to continue a pregnancy to term—an outcome with significantly greater risks to the health and mortality of the pregnant individual. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[52] and rates have sharply increased since then.[53] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[54] A pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[55]

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

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[51] Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, 92 Contraception 360 (2015).

[52] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 17 at 216.

[53] 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).

[54] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 17 at 216.

[55] *Id.*

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leads to maternal and fetal complications, including developing diabetes later in life.[56] Preeclampsia, another relatively common complication, is a disorder associated with new-onset 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.[57]

Labor and delivery are likewise not without significant risk, including those of hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that can cause the placenta to not detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum pain, among others.[58] 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.[59]

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 an abortion.[60]

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

[57] ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (June 2020).

[58] 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).

[59] Martin et al., *Births: Final Data for 2019*, CDC-National Vital Statistics Reports, Vol. 70 (Mar. 23, 2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* (Mar. 2014, reaff'd 2016).

[60] 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 19 at 172.

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B. *The Narrow Exceptions to the Bans Do Not Adequately Protect Patients' Health*

The narrow maternal health-related exceptions of the Trigger Ban and Six-Week Ban are insufficient to protect the health of the pregnant patient. Pregnancy can exacerbate existing health issues that do not necessarily lead to death or permanent impairment of a life-sustaining organ, but nevertheless pose serious health risks for patients during pregnancy. Examples include: Alport Syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve), lupus (a connective tissue disease that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy), and diabetes (which can worsen to the point of causing blindness as a result of pregnancy).[61] Further, neither Ban takes into account whether patients experienced life-threatening or permanent impairment of a life-sustaining organ during prior pregnancies. Any of these prior conditions can progress or reoccur if abortion care is not available. Various complications that present danger to the health of the pregnant patient also can directly affect fetal development and survival. For example, if a patient experiences premature rupture of membranes and infection, preeclampsia, placental abruption, and/or placenta accreta, that patient may be at risk of extensive blood loss, stroke, and/or septic shock, all of which would negatively affect the fetus.

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

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The Kentucky Bans and their exceptions are too vague to give clinicians workable guidance about what procedures are permitted or prohibited, especially with respect to managing early pregnancy loss. For example, incomplete miscarriages are commonly treated via uterine aspiration, which is the same procedure as that used for the majority of abortions (other than medication abortions).[62] Neither of the Kentucky Bans clearly state that miscarriage management is permissible or protect clinicians that must use their medical judgment to determine the best treatment plan and provide care in the moment. As another example, neither Kentucky Ban contains an explicit exception for an ectopic pregnancy (which occurs when a fertilized egg grows outside the uterine cavity). Ectopic pregnancies can never be viable and must be treated urgently through medication or surgery.[63] The lack of clarity with respect to the Kentucky Bans is creating unacceptable barriers to care and unacceptable risks for physicians seeking to provide necessary, routine care in changing circumstances and real time.

Other elements of the Kentucky Bans' exceptions are equally problematic. For example, the Trigger Ban states that if the death or permanent impairment exception is applied, the physician must still "make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of the unborn human being in a manner consistent with reasonable medical practice." The Trigger Ban provides no guidance into how physicians are meant to undertake this analysis, leaving clinicians in the impossible position of providing care that can and will be second-guessed and disputed for ideological purposes.

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[62] Allen et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625, 632 (2013) (uterine aspiration is used for induced abortion and treatment of miscarriages); Dennis et al., *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141, 141, 143 (2015) (technical aspects of miscarriage management and induced abortion are the same).

[63] ACOG, *Facts Are Important: Understanding Ectopic Pregnancy*.

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In addition, by limiting its exception to only potentially fatal "physical condition[s]" and "permanent impairment of a life-sustaining organ," neither the Trigger Ban nor the Six-Week Ban take into account mental health issues that can put a pregnant patient's health and life at risk.[64]

Further, the Trigger Ban's exception for medical treatment that "results in the accidental or unintentional injury or death to the unborn human being" is a vague standard that could be easily second-guessed by the State, subjecting medical professionals, who are using their medical judgment and skills to treat patients in accordance with their training and ethical obligations, to liability.

The Six-Week Ban's exception for procedures where "the physician believes that a medical emergency exists that prevents compliance" with the prohibition on abortion creates a vague and confusing standard for physicians to attempt to apply because "medical emergency" is not and cannot reasonably be defined in legislation. The medical necessity of any particular medical procedure must, instead, be left to the discretion of physicians, in consultation with their patients wherever possible.

Also, both exceptions applicable to the Six-Week Ban require physicians to document their rationale for providing an abortion on the basis of the exception and retain those records for at least 7 years, indicating that the State is willing to second-guess medical judgments in a way that may expose physicians to substantial risk.

It is untenable to force pregnant patients to wait until their medical condition escalates to the point that an abortion is necessary to prevent death or permanent injury to a major bodily

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[64] *See, e.g.*, Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

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function or life-sustaining organ before being able to seek potentially life-saving medical care. Nor should physicians be put in the impossible position of either letting a patient deteriorate until one of these narrow exceptions is met or facing potential criminal punishment for providing medical care in contravention of the Bans. Indeed, that impossible choice could cause some physicians to second guess the necessity of critical abortion care until the pregnant patient has serious medical complications or it is too late to save the pregnant patient's life. The limited exceptions described here indefensibly jeopardize patients' health.

IV. The Bans Will Hurt Rural, Minority, and Poor Patients the Most

The Bans 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.[65]

In Kentucky, 34.5% of patients who obtained abortions in 2020 were Black and 7.5% were Hispanic.[66] In addition, 75% of abortion patients nationwide have household incomes below 200% of the federal poverty level.[67] 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 by the fact that other Kentucky laws create substantial financial barriers to abortion care (e.g., lack of coverage under insurance

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

[66] *Kentucky Annual Abortion Report for 2020*, *supra* note 10 at 5-6.

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

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policies).[68] This impact of the Bans on low-income people will likely be particularly acute in Kentucky, which had the fourth highest poverty rate in the United States as of 2019.[69]

The inequities continue after an abortion is denied. As explained *supra* Part III.A, 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 3.2-3.5 times higher than that of white patients, with significant disparities persisting even in areas with the lowest overall mortality rates and among women with higher levels of education.[70] Black patients in Kentucky are nearly two-and-a-half times more likely to die from pregnancy-related causes than white patients,[71] making continuing an unwanted pregnancy to term disproportionately dangerous for them. The Bans thus exacerbates inequities in maternal health and reproductive health care, disproportionately harming the most vulnerable Kentuckians.

V. <u>The Bans Force Clinicians To Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law</u>

Abortion bans such as the one at issue in this case 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

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[68] Guttmacher Inst., *State Facts About Abortion: Kentucky* (June 2022).

[69] United States Census Bureau, *2019 Poverty Rate in the United States* (Sept. 17, 2020).

[70] 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).

[71] KY Dept. for Pub. Health, *Annual Report 2021, Public Health Maternal Mortality Review, A Report of Data from Years 2013-2019*, at 5 (Nov. 2020), https://chfs.ky.gov/agencies/dph/dmch/Documents/MMRAnnualReport.pdf.

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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. *The Bans 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.[72] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests, and with the best available scientific evidence.[73] 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."[74] Likewise, the AMA Code of Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[75]

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

[73] 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.").

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

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

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The Bans, however, 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 available 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—including, but not limited to, those that ban abortion (i) before patients are even able to know they are pregnant, and (ii) without exceptions for circumstances like mental health of the pregnant patient and cases of rape and incest—are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

The Bans also create inherent conflicts of interest. Physicians need to be able to offer appropriate treatment options based on patients' individualized interests without regard for the physicians' own self interests.[76] Here, however, by prohibiting physicians from performing abortions, the Kentucky Bans profoundly intrude upon the patient-physician relationship. For example, if a patient's health were compromised, the Bans would only allow an abortion in the face of death or substantial and irreversible physical impairment of a major bodily function, regardless of the overall medical advisability of the procedure or the desire of the patient. A physician and patient together may conclude that an abortion was in the patient's best medical interests even though the risk posed by continuing the pregnancy does not rise to the standard set forth in the Bans' exceptions. The Bans thus force physicians to choose between the ethical

[76] *See* ACOG, *Legis. Policy Statement*, *supra* note 72.

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practice of medicine—counseling and acting in their patients' best interest—and obeying the law.[77]

B. *The Bans 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.[78] 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.[79]

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.[80]

The Kentucky Bans pit physicians' interest against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But the Bans, with their narrow medical exceptions,

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[77] *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.").

[78] 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).

[79] *See supra* notes 72-75 and accompanying text.

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

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prohibit physicians from providing that treatment and expose physicians to significant penalties if they do so. The Bans therefore place physicians in 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. *The Bans 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.[81] 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.[82] The Kentucky Bans would deny patients the right to make their own choices about health care if they decide they need to seek an abortion.

[81] ACOG, *Code of Professional Ethics*, *supra* note 74 at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

[82] 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.*

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CONCLUSION

For the foregoing reasons, this Court should enjoin enforcement of the Trigger Ban and the Six-Week Ban.

DATE: July 18, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on July 18, 2022, I served a copy of the foregoing through the Court's electronic filing system which effectuates service upon all counsel of record.

/s/ Michael P. Abate

Michael P. Abate

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NO. 22-CI-03225

JEFFERSON CIRCUIT COURT
DIVISION THREE (3)
HON. MITCH PERRY

EMW WOMEN'S SURGICAL CENTER, P.S.C. *et. al.* — **PLAINTIFFS**

v.

DANIEL CAMERON, *et al.* — **DEFENDANTS**

[PROPOSED] ORDER FOR LEAVE TO FILE BRIEF OF *AMICI CURIAE*

Amici Curiae the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and the Society for Maternal-Fetal Medicine ("SMFM") (collectively, "*Amici*"), filed a motion seeking leave to submit a brief in this matter. The Court having reviewed the submissions of the parties on the motion, and being otherwise sufficiently advised,

IT IS HEREBY ORDERED that the motion is GRANTED and the clerk shall file the brief tendered with Amici's motion in the court record.

____
HON. MITCH PERRY
JUDGE, JEFFERSON CIRCUIT COURT

____
DATED

TD : 000001 of 000002

Tendered by:

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