STATE OF SOUTH CAROLINA **RICHLAND COUNTY** PLANNED PARENTHOOD SOUTH ATLANTIC, on behalf of itself, its patients, and physicians and staff, *et al.*, *Plaintiffs*, v. SOUTH CAROLINA, *et al.*, *Defendants.*	**IN THE COURT OF COMMON PLEAS** **FOR THE FIFTH JUDICIAL CIRCUIT** C/A No.: 2022-CP-4003569

BRIEF OF AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND PRELIMINARY INJUNCTION

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INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and the Society for Maternal-Fetal Medicine ("SMFM") submit this *amicus curiae* brief in support of Plaintiffs.

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 South Carolina Section has over 900 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).

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 South Carolina 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;

(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

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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.

individualized care but also to the fabric of our communities and the integrity of our health care infrastructure."[3]

On February 18, 2021, South Carolina's legislature passed Senate Bill 1, 124th Gen. Assemb., Reg. Sess. (S.C. 2021) (hereinafter the "Six-Week Ban") which, among other things, bans abortion after the detection of embryonic cardiac activity—as early as approximately six weeks of pregnancy—with limited exceptions, including for medical emergencies, rape, and incest.[4] The Six-Week Ban had been enjoined in federal court as unconstitutional since its passage, but *amici* understand the Ban has now gone into effect in the wake of *Dobbs v. Jackson Women's Health Org.*, 597 U.S. __ (2022).[5] *Amici* oppose the Six-Week Ban because it would—without any valid medical justification—jeopardize the health and safety of pregnant people in South Carolina and place extreme burdens and risks upon providers of essential reproductive health care.

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[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* S.C. Code § 44-41-680.

[5] *See* Order Granting Mot. to Stay & Staying Preliminary Injunction, *Planned Parenthood et al. v. Wilson*, 3:21-cv-00508 (June 27, 2022).

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.[6] Abortion is a common medical procedure. In 2020, over 930,000 abortions were performed nationwide,[7] including roughly 5,468 in South Carolina.[8] Approximately one quarter of American women have an abortion before the age of 45.[9]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[10] Complication rates from abortion are extremely low, averaging

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[6] *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.

[7] 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).

[8] South Carolina Department of Health And Environmental Control, *A Public Report Providing Statistics Compiled from All Abortions Reported to DHEC* (2020), https://scdhec.gov/sites/default/files/media/document/2020-Abortion_SC-Report.pdf.

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

[10] *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.").

around 2%, and most complications are minor and easily treatable.[11] And as even the South Carolina Department of Health and Environmental Control recognizes, "[s]erious problems with legal abortions are rare."[12] Major complications from abortion occur in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[13] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[14] By contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[15] In fact, abortion is so safe that there is a greater risk of complications or

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[11] *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.

[12] South Carolina Department of Health and Environmental Control, *Risks of Abortion* (2019), https://scdhec.gov/risks-abortion.

[13] 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 South Carolina 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); Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

[14] *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).

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

mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[16]

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.[17] One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[18]

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[16] 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*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl. 15 (2021) (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).

[17] 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).

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

II. Despite the Safe and Routine Nature of Abortions, South Carolina's Ban Would Prohibit the Majority of Abortions with No Medical Justification

The Six-Week Ban would—without any valid medical justification—jeopardize the health and safety of pregnant people in South Carolina and place extreme burdens and risks upon providers of essential reproductive health care by criminalizing the majority of abortions in the state. The Six-Week Ban criminalizes providing abortions (i) without determining whether there is a detectable "fetal heartbeat"[19]; or (ii) after a "fetal heartbeat" has been detected.[20] There are narrow exceptions to each prohibition, as addressed *infra* Part III.B.

The Ban defines "fetal heartbeat" to mean "cardiac activity, or the steady and repetitive rhythmic contraction of the fetal heart, within the gestational sac,"[21] and the legislature made a finding that "a fetal heartbeat begins at a biologically identifiable moment in time, normally when the fetal heart is formed in the gestational sac."[22] From these statements, *amici* understand that South Carolina 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, this is inconsistent with the medical community's understanding of when during gestation a heartbeat becomes detectable. As a matter of medical science, a true fetal heartbeat exists only after the chambers

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19 Sec. 44-41-650.

20 Sec. 44-41-680.

21 Sec. 44-41-610.

22 Sec. 2(5)-(6).

of the heart have been developed and can be detected via ultrasound, which typically occurs around 17-20 weeks' gestation.[23]

Despite its misuse of medical terminology, *amici* understand that the legislature's goal is to prohibit abortion after approximately six weeks' gestation. Although this purportedly allows individuals to seek an abortion before approximately six weeks' gestation, in practice, due to the ways in which pregnancy symptoms are observed and challenges in seeking care, the Six-Week Ban will likely prevent many pregnant patients in South Carolina who want an abortion from obtaining one. This is because, 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;[24] 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,[25] many pregnant patients may not consider other potential

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

[24] 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, reaff'd 2020).

[25] 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).

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.[26]

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 decision about whether to continue the pregnancy before the six weeks' gestation mark.[27] 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.[28] 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.[29]

For all of these reasons, the majority of abortions provided in South Carolina—and nationwide—are performed after six weeks' gestational age. In 2020, approximately 55.5% of abortions provided in South Carolina were performed after six weeks' gestation.[30] The Six-Week Ban thus has the effect of criminalizing the majority of abortions provided in the State.

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

[27] 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*, https://www.fda.gov/medical-devices/home-use-tests/pregnancy (Apr. 29, 2019).

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

[29] 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).

[30] South Carolina Department of Health and Environmental Control, *A Public Report Providing Statistics Compiled from All Abortions Reported to DHEC*, *supra* note 8.

South Carolina's deprivation of essential health care is based on flawed legislative findings that "a fetal heartbeat is a key medical predictor" that a fetus "will reach live birth" and that pregnant women can "know[] the likelihood of the human fetus surviving to full-term birth based upon the presence of a fetal heartbeat."[31] However, while embryonic cardiac activity can signal that an early pregnancy may continue to develop (as opposed to end in a spontaneous abortion or miscarriage),[32] 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.

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

The Six-Week Ban states that "the State of South Carolina has legitimate interests from the outset of a pregnancy in protecting the health of the pregnant woman and the life of the unborn child who may be born,"[33] but the Ban is not medically justified in light of those asserted interests. To the contrary, the Ban will harm the health of pregnant individuals in South Carolina, and the idea of protecting embryonic development or fetuses from the onset of fetal cardiac activity creates arbitrary, medically unjustified, and conflicting responsibilities for medical providers (as described further *infra* Part V).

The Six-Week Ban 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

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31 Sec. 2(5), 2(8).

32 ACOG, Practice Bulletin No. 200, *Early Pregnancy Loss* (Nov. 2018).

33 S.B. 1 Sec. 2.

earlier the abortion is performed—the Six-Week Ban 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.[34] 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.[35]

The Six-Week Ban has limited health-related exceptions for abortions "designed or intended to prevent the death of the pregnant woman or to prevent the serious risk of a substantial and irreversible impairment of a major bodily function of the pregnant woman,"[36] in the case of an abortion performed after embryonic cardiac activity is detected; or in the case of a "medical emergency" in the case of an abortion performed without first determining whether fetal cardiac activity is detectable.[37] 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 not fall within the narrow exceptions, as described *infra* Part III.B. The Six-Week Ban also excepts abortions after a fetal heartbeat is detected (1) if the pregnancy is the result of rape or incest and the physician that performs the abortion reports the allegation

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34 The safety of medication abortion is well established. *See supra* note 13.

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

36 Sec. 44-41-680(B)(3); 44-41-690(A).

37 Sec. 44-41-660.

of rape or incest to the sheriff in the county in which the abortion was performed;[38] and (2) in the case of a fetal anomaly, which is narrowly defined as "incompatible with sustaining life after birth."[39] These exceptions are also problematic, as described *infra* Part III.B.

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

Criminalizing safe abortions provided by a licensed clinician in the State of South Carolina will likely result in delays 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.[40] 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.[41] As of June 2022, South Carolinians receiving an abortion before 14 weeks' gestation had to travel an average of 74 miles one-way, with that distance increasing to 102 miles one-way for those receiving an abortion before 20 weeks' gestation.[42] With no in-state abortion providers, those distances and associated procedure costs for South Carolinians seeking abortion will very likely increase. And these distances will likely increase even further in light of similar bans going into effect in neighboring states, including Georgia and Tennessee. Though the risk

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38 Sec. 44-41-680(B)(1)-(2); Sec. 44-41-680(C).

39 Sec. 44-41-680(B)(4); Sec. 44-41-430(5).

40 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).

41 *Id.*

42 Guttmacher Inst., *Interactive Map: US Abortion Policies and Access After Roe*, https://states.guttmacher.org/policies/south-carolina/abortion-statistics (last accessed July 20, 2022).

of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication.[43] Moreover, abortions at later gestational ages are typically more expensive, further increasing the barriers to obtaining care.[44]

By removing access to safe, legal abortion, the Ban will also increase the possibility that a pregnant patient will attempt self-managed abortions through harmful or unsafe methods.[45] 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.[46]

Those patients who do not, or cannot, obtain an abortion due to the Ban 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,[47] and rates have sharply increased since

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[43] Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, *supra* note 11, at 181.

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

[45] *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).

[46] Grossman et al., Tex. Pol'y Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, 92 Contraception 360 (2015).

[47] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 15, at 216.

then.[48] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[49] A pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[50]

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.[51] 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.[52]

Labor and delivery are likewise not without significant risk, including those of hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that causes the placenta to not detach at childbirth), hysterectomy, cervical laceration, and debilitating

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[48] 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).

[49] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 15, at 216.

[50] *Id.*

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

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

postpartum pain, among others.[53] 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.[54]

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.[55]

B. *The Narrow Exceptions to the Ban Do Not Adequately Protect Patients' Health and Create Problematic Standards for Physicians To Apply*

The Ban's narrow health-related exceptions 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 major bodily function, 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

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[53] 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).

[54] 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).

[55] 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 17, at 172.

the point of causing blindness as a result of pregnancy).[56] Further, the Ban does not take 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.

The Ban and its narrow 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).[57] The Ban does not clearly state that miscarriage management is permissible or protect clinicians that must use their medical judgment to determine the best

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[56] *See* Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 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).

[57] 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).

treatment plan and provide care in the moment. As another example, the Ban does not 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.[58] The lack of clarity with respect to the Ban's scope creates 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 Ban's exceptions are equally problematic. For example, "psychological or emotional conditions" are explicitly carved out of the definition of "medical emergency" and other health-related exceptions are limited to death and "irreversible impairment of a major bodily function"—the Six-Week Ban accordingly fails to take into account mental health issues that can put a pregnant patient's health and life at risk.

In addition, physicians who perform abortions pursuant to the health-related exceptions are required to make and keep specific documentation, including memorializing the rationale for performing an abortion pursuant to certain exceptions. Such rationales 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 exception for "fetal anomalies" depends on the legislature's standards for what constitutes a qualifying anomaly. That definition is very narrow and may exclude a wide range of fetal anomalies that are serious, but not necessarily fatal. The limited nature of this exception intrudes on physicians' judgment and the patient-physician relationship.

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[58] ACOG, *Facts Are Important: Understanding Ectopic Pregnancy*, https://www.acog.org/advocacy/facts-are-important/understanding-ectopic-pregnancy (last visited July 5, 2022).

Finally, the Ban requires that physicians acting under the rape or incest exceptions report the rape or incest exception to the county sheriff. This requires pregnant patients to choose between accessing the abortion services they need and their ability to maintain privacy and control over the intensely personal decision of whether and how to report their assault. This may dissuade patients from seeking an abortion or endanger patients by forcing them to report an assault to law enforcement against their wishes.

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 impairment of a major bodily function 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 Ban. 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 Ban Will Hurt Rural, Minority, and Poor Patients the Most

The Ban 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.[59]

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

In South Carolina, 54% of patients who obtained abortions in 2019 were Black.[60] In addition, 75% of abortion patients nationwide have household incomes below 200% of the federal poverty level.[61] 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 South Carolina laws create substantial financial barriers to abortion care (e.g., limited coverage under insurance policies).[62] This impact of the Ban on low-income people will likely be particularly acute in South Carolina, where nearly 14% of the population lived below the poverty line as of 2019.[63]

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

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60 South Carolina Community Assessment Network, *Pregnancy (1990-2019)*, South Carolina Department of Health and Environmental Control, https://apps.dhec.sc.gov/Health/scan/scan/pregnancy/input.aspx.

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

62 *State Facts About Abortion: South Carolina*, Guttmacher Institute (Jun. 2022), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-south-carolina.

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

mortality rates and among women with higher levels of education.[64] Patients of color in South Carolina are nearly 2.4 times more likely to die from pregnancy-related causes than white patients,[65] making continuing an unwanted pregnancy to term disproportionately dangerous for them. The Ban thus exacerbates inequities in maternal health and reproductive health care, disproportionately harming the most vulnerable South Carolinians.

V. The Ban Forces Clinicians To Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law

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 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.

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64 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, 1676-77 (Sept. 22, 2021) (3.55 times).

65 South Carolina Maternal Morbidity and Mortality Review Committee, *Legislative Brief* (March 2021), https://scdhec.gov/sites/default/files/media/document/2021SCMMMRCLegislativeBrief.pdf.

A. *The Ban Undermines 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.[66] 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.[67] 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."[68] 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."[69]

The Ban, however, forces 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.

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66 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*").

67 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.").

68 ACOG, *Code of Professional Ethics* 2 (Dec. 2018).

69 AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1*.

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—are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

The Ban also creates 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.[70] Here, however, by prohibiting physicians from performing abortions, the Ban profoundly intrudes upon the patient-physician relationship. For example, if a patient's health were compromised, the Ban 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 Ban's exceptions. The Ban thus forces physicians to choose between the ethical practice of medicine—counseling and acting in their patients' best interest—and obeying the law.[71]

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[70] *See* ACOG, *Legis. Policy Statement*, supra note 66.

[71] *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.").

B. *The Ban Violates 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.[72] 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.[73]

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.[74]

The Ban pits 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 Ban, with its narrow medical exceptions, prohibits physicians from providing that treatment and expose physicians to significant penalties if they do so. The Ban therefore places physicians in the ethical impasse of choosing between providing the best

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[72] 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).

[73] *See supra* notes 66-69 and accompanying text.

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

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 Ban Violates 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.[75] 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.[76] The Ban 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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[75] ACOG, *Code of Professional Ethics*, *supra* note 68 at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

[76] 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 the Six-Week Ban.

DATE: July 20, 2022

Respectfully Submitted,

/s/ Randall S. Hiller

Randall S. Hiller (SC Bar No. 2513)
RANDALL S. HILLER, P.A.
850 B Wade Hampton Blvd.
Greenville, SC 29609
(864) 232-0026
rsh@rshpa.org

Kimberly A. Parker*
WILMER CUTLER PICKERING HALE AND DORR LLP
1875 Pennsylvania Avenue NW
Washington, D.C. 20006
(202) 663-6000
kimberly.parker@wilmerhale.com

Counsel for Amici Curiae *the American College of Obstetricians and Gynecologists, American Medical Association, and Society for Maternal-Fetal Medicine*

**Motion for admission pro hac vice to be filed*