STATE OF WISCONSIN CIRCUIT COURT DANE COUNTY

JOSH KAUL, in his official capacity as Attorney General, et al.,

Plaintiffs,

v.

JOEL URMANSKI, et al.,

Defendants.

No. 2022CV001594

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, WISCONSIN MEDICAL SOCIETY, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF PLAINTIFFS

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INTEREST OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit membership organization of more than 60,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all women and people in need of obstetric and gynecologic care; 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 patients and their families and communities. ACOG's Wisconsin Section has over 600 members 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, which recognize ACOG as a leading provider of authoritative scientific data regarding childbirth and abortion.[1]

The American Medical Association (AMA) is the nation's largest professional association of physicians, residents, and medical students. 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 AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in all fields of medical specialization and in every state. The AMA's publications and *amicus* briefs

[1] *See, e.g.*, *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2132 (2020); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-36 (2000); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983).

have been cited by many courts, including the U.S. Supreme Court.[2]

The Wisconsin Medical Society (WisMed) is the largest professional association of physicians, residents, and medical students in Wisconsin. Its mission is to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment.

The AMA and WisMed each join this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

The Society for Maternal-Fetal Medicine (SMFM) is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 5,500 members, including 98 professionals who live and practice in Wisconsin, caring for high-risk pregnant people. SMFM 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 high-risk pregnancies. SMFM's *amicus* briefs also have been cited by multiple courts.[3]

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 whose policies represent the education, training,

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[2] *See, e.g.*, *Ferguson v. City of Charleston*, 532 U.S. 67, 78, 81, 84 n.23 (2001); *Stenberg*, 530 U.S. at 934-36; *Vacco v. Quill*, 521 U.S. 793, 800 n.6 (1997); *Sullivan v. Zebley*, 493 U.S. 521, 534 n.13, 536 n.17, 541 n.22 (1990); *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

[3] *See, e.g.*, *Mayor of Baltimore v. Azar*, 973 F.3d 258, 285 & n.19 (4th Cir. 2020).

and experience of the vast majority of clinicians in this country. *Amici* believe that laws that criminalize and effectively ban abortion are not based on any medical or scientific rationale. Those laws also threaten the health of pregnant patients; disproportionately harm patients of color, patients in rural settings, and patients with low incomes; and profoundly interfere with the patient-physician relationship and undermine longstanding principles of medical ethics. As the AMA has recognized, "healthcare, including reproductive health services, like contraception and abortion, is a human right."[4]

Wisconsin currently has laws governing abortion that directly conflict with each other:

On one hand, Wisconsin Statute § 940.04 (originally enacted in 1849) bans abortion and imposes criminal penalties on individuals who provide abortions unless it "[i]s necessary . . . to save the life of the mother."[5] The law does not include any exceptions for threats to the patient's health, rape, incest, or fetal abnormalities.

On the other hand, since 1973 the Wisconsin Legislature has enacted several statutes that regulate abortion as a lawful medical procedure.[6] Wisconsin Statute § 940.15, enacted in 1985, permits abortion up to the point of fetal "viability," with exceptions to "preserve the life or health of the woman." Wisconsin Statute § 253.107 prohibits abortion after 20 weeks except in a "medical emergency."

Amici oppose the near-total abortion ban in Section 940.04 (the 1849 law) because it jeopardizes the health and safety of pregnant people in Wisconsin and places extreme burdens and risks on providers of essential reproductive health care, without a valid medical justification.

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4 AMA, *Preserving Access to Reproductive Health Service* (2022), https://bit.ly/3JPSd3y.

5 Wis. Stat. § 940.04(1), (5).

6 *See, e.g.*, Wis. Stat. § 253.095(2).

ARGUMENT

I. Abortion Is A Safe, Common, And Essential Component Of Health Care

The medical community recognizes that abortion is a safe, common, and essential component of reproductive health care.[7] In 2020, over 930,000 abortions were performed nationwide.[8] More than 6,000 abortions were performed in Wisconsin.[9] Approximately one-quarter of American women have an abortion before age 45.[10]

The medical evidence conclusively demonstrates that abortion is very safe.[11] Complication rates are extremely low, averaging around 2%, and most complications are minor and easily treatable.[12] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances.[13] The risk of death is even rarer. Nationally, fewer than one in 100,000

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[7] *See, e.g.*, Eds. of the *New England Journal of Medicine*, ACOG, 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); SMFM, *Access to Abortion Services* (2020).

[8] Rachel K. 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).

[9] Wis. Dep't of Health Servs., *Reported Induced Abortions in Wisconsin, 2020*, 6 tbl 3 (May 2020), https://bit.ly/3kz2bxi (*Abortions in Wisconsin*).

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

[11] *See, e.g.*, Nat'l Acads. of Scis., Eng'g, Med., *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.").

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

[13] Kari 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 nearly 40% of all abortions in Wisconsin obtained by Wisconsin residents and about half of abortions nationwide. Elizabeth G. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013) (addressing rates at which major complication occur for medication

patients die from an abortion-related complication.[14] By contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[15] Abortion is so safe that there is a greater risk of complications or mortality for wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[16] And the rate of abortion-related complications remains low later in pregnancy. For example, starting at 14 weeks gestational age, the predominant method of abortion is dilation and evacuation, which is a safe and routine procedure.[17]

Abortion poses no significant risks to mental health or psychological well-being. People who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and receiving an abortion does not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal

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abortion); *Abortions in Wisconsin* 11 tbl. 11 (data on Wisconsin medication abortions obtained by Wisconsin residents, category labeled "Chemically induced"); Rachel K. Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

[14] *See* Katherine Kortsmit et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Abortion Surveillance – United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl. 15 (2021) (Kortsmit) (finding mortality rate from 0.00041% to 0.00078% for approximately five-year periods from 1978 to 2014); Suzanne 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] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012) (Raymond & Grimes).

[16] Advancing New Standards in Reproductive Health, *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); Am. Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011) (33% of colonoscopies result in minor complications); Frederick M. Grazer & Rudolph H. 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 29 tbl. 15 (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in the years 2013-2018).

[17] ACOG, Practice Bulletin No. 135, *Second Trimester Abortion*, 121 Obstetrics & Gynecology 1394, 1394 (2013, reaff'd 2021).

ideation compared to those who were forced to continue a pregnancy.[18] One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[19]

II. Statutes That Ban Abortion Harm Pregnant Patients' Health

Statutes like Section 940.04 that effectively ban abortion cause severe physical and psychological health consequences for pregnant patients desiring an abortion. The limited exception in Section 940.04—allowing an abortion only when "necessary . . . to save" the patient's life—is insufficient to protect the health of pregnant patients.

A. Statutes That Ban Abortion Endanger The Physical And Psychological Health Of Pregnant Patients

Criminalizing safe abortions will result in delays in obtaining abortions, increased use of unsafe self-managed abortion methods, and an increased likelihood that patients will be forced to continue pregnancies to term. All of these consequences entail significant health risks.

Typically, many delays in seeking an abortion are caused by a lack of information about where to find abortion care.[20] The need to travel out of state and consider various states' criminal and civil penalties likely will further increase confusion about where to find needed health care. In addition, almost one-third of delays are caused by travel and procedure costs.[21]

By eliminating licensed abortion clinics and imposing a near-total ban on abortion, Section 940.04 will increase these costs. A 2021 analysis found that closing Wisconsin's abortion clinics would result in a 171% increase in the average required travel distance for Wisconsinites seeking

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

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

[20] Ushma D. 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).

[21] *Id.*

abortions.[22] Longer travel distances mean higher travel costs, which can cause a patient to delay a needed abortion until later in a pregnancy. Although the risk of complications from abortions overall remains exceedingly low—especially compared to the health risks of carrying a pregnancy to term—increasing gestational age increases the chance of a major complication.[23] Abortions at later gestational ages also are typically more expensive.[24]

By removing access to safe, legal abortion, Section 940.04 also increases the possibility that a pregnant patient will attempt a self-managed abortion through a harmful or unsafe method.[25] Studies have found that people are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-management may rely on harmful tactics such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or dangerously misusing hormonal pills, rather than using FDA-approved abortion medication, which is a safe way to self-manage abortion.[26]

Patients who do not, or cannot, obtain an abortion because of Section 940.04 will be forced to continue a pregnancy to term—an outcome with significant health risks. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[27] and rates have sharply increased since then.[28] In contrast, the mortality rate associated with abortions

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[22] Guttmacher Inst., *If* Roe v. Wade *Falls: Travel Distance for People Seeking Abortion* (June 23, 2022), https://bit.ly/3DUckfY (on average, Wisconsin abortion clinic closures would increase abortion-seeking Wisconsinites' driving distance from 34 miles to 91 miles).

[23] *Incidence of Visits* 181.

[24] Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

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

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

[27] Raymond & Grimes 216.

[28] Marian F. 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).

performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures, meaning that a pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[29]

Continued pregnancy and childbirth also entail other substantial health risks. Even an uncomplicated pregnancy causes significant stress on the body. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or lead to newly arising health issues. Sickle-cell disease can worsen during pregnancy, leading to severe anemia and vaso-occlusive crisis, a condition resulting in significant pain.[30] Pregnant patients with inherited thrombophilia, which can be undetected until a triggering event such as pregnancy, have a high risk of developing life-threatening blood clots.[31] Pregnancy can exacerbate asthma, making it a life-threatening condition.[32] Approximately 6-7% of pregnancies are complicated by gestational diabetes mellitus, which frequently leads to maternal and fetal complications, including developing diabetes later in life.[33] And preeclampsia, a relatively common complication, is a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in fluctuating blood pressure, heart disease, liver issues, seizures, and death.[34]

Labor and delivery likewise carry significant risks. These include hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs when the placenta is unable to detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum

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29 Raymond & Grimes 216.

30 ACOG, Practice Bulletin No. 78, *Hemoglobinopathies in Pregnancy* (Jan. 2007, reaff'd 2021).

31 ACOG, Practice Bulletin No. 197, *Inherited Thrombophilias in Pregnancy* (July 2018, reaff'd 2022) (*Inherited Thrombophilias in Pregnancy*).

32 ACOG, Practice Bulletin No. 90, *Asthma in Pregnancy* (Feb. 2008, reaff'd 2020).

33 ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018, reaff'd 2019).

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

pain.[35] 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.[36]

Evidence also suggests that pregnant people denied abortions are more likely to experience negative psychological health outcomes—like anxiety, lower self-esteem, and lower life satisfaction—than those who obtained a needed abortion.[37]

B. The Ban's Limited Exception Will Not Adequately Protect Patients' Health

The sole exception in Section 940.04 is insufficient to protect the health of the pregnant patient. The exception allows for abortion if it "is necessary . . . to save the life of" the patient. The law does not define "necessary." The law does not include any exceptions for cases of threats to the patient's health, or for rape, incest, or fetal abnormalities.

Pregnancy can exacerbate existing health issues that do not necessarily or immediately lead to death, but nevertheless pose serious health risks. 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), and pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy).[38] Maternal mental health

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[35] ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017, reaff'd 2019); ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum* 1-2 (July 2012, reaff'd 2021) (*Placenta Accreta Spectrum*); ACOG, Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018, reaff'd 2022); ACOG, Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* 507 (Sept. 2021).

[36] CDC, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* (2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* 1-3 (Mar. 2014, reaff'd 2019).

[37] Biggs 172.

[38] *See* Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 2007); Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); J. Cortés-Hernández 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); David G. Kiely et al., *Pregnancy and*

issues also can put a pregnant patient's health and life at risk.[39] Additionally, sometimes patients seek abortion care because of significant medical issues that they experienced during prior pregnancies. If abortion care is unavailable, those prior conditions could progress or reoccur, endangering the health of the pregnant patient and directly affecting fetal development and survival. Examples include preeclampsia,[40] placental abruption (separation of the placenta from the uterine wall),[41] placenta accreta,[42] peripartum cardiomyopathy (enlargement of the heart in or after pregnancy),[43] and thrombophilia.[44]

The narrow exception in Section 940.04 allows abortion care solely when "necessary" to save the patient's life. Coupled as it is with the threat of criminal sanctions, this statute necessarily will chill the provision of critical medical care in the examples just described because doctors will be unsure when they will be able to provide needed abortions for their patients. 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 before they can seek abortion care. Further confusion will arise when doctors manage early pregnancy loss. For example, incomplete miscarriages are commonly treated via uterine aspiration, which is the same procedure used for most abortions (other than

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Pulmonary Hypertension: A Practical Approach to Management, 6 Obstetric Med. 144, 153 (2013); Michael F. Greene & Jeffrey L. Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

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

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

[41] ACOG, Obstetric Care Consensus No. 10, *Management of Stillbirth* 7, 11 (March 2009, reaff'd 2021).

[42] *Placenta Accreta Spectrum* 2.

[43] ACOG, Practice Bulletin No. 212, *Pregnancy and Heart Disease* (May 2019, reaff'd 2021).

[44] *See Inherited Thrombophilias in Pregnancy*.

medication abortions).[45] But Section 940.04 does not clearly state that miscarriage management is permissible.

Physicians should not be put in the impossible position of either letting a patient deteriorate until death is possible or facing potential criminal punishment for providing needed care consistent with their medical judgment but still potentially in contravention of Section 940.04. Indeed, that impossible choice could cause some physicians to second-guess the necessity of critical abortion care until it is too late to save the pregnant patient's life. The many examples just provided of the potential health problems faced by pregnant patients demonstrate why decisions about whether to continue a pregnancy are properly left to clinicians and patients, rather than legislators. Legislators are not and should not be in the exam room, and do not have the training or experience to exercise medical judgment to evaluate complex or developing situations and recommend a course of treatment. Section 940.04 indefensibly jeopardizes patients' health.

III. Laws That Ban Abortion Hurt Rural, Minority, And Poor Patients The Most

Abortion bans like the one in Section 940.04 disproportionately affect people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to policies that increase the inequities that already plague the nation's health care system.

In Wisconsin, 34% of the Wisconsinites who obtained abortions in 2020 were Black and 12% were Hispanic.[46] According to 2021 data, 27.8% of Black Wisconsinites live in poverty, as do 18.6% of Hispanic Wisconsinites, while the poverty rate in Wisconsin is 10.9% overall.[47] In addition, 75% of abortion patients nationwide are living at or below 200% of the federal poverty

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45 Rebecca H. 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); Amanda 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).

46 *See Abortions in Wisconsin* 9 tbl 7.

47 Kaiser Family Foundation, *Poverty Rate by Race/Ethnicity* (2021), https://bit.ly/3QbzDoA.

level.[48] Patients with limited means and patients living in geographically remote areas will be disproportionately affected by Section 940.04, which will require them to travel longer distances (and pay higher associated costs) to obtain safe, legal abortions. These travel and procedure costs will be compounded by the fact that other Wisconsin laws create substantial financial barriers to abortion care, such as lack of coverage under insurance policies for public employees and health plans offered in the state's health exchange, except in cases of life endangerment, severely compromised health, or rape or incest.[49]

The inequities continue after an abortion is denied. Forcing patients to continue pregnancies increases their risk of complications.[50] Nationwide, Black patients' pregnancy-related mortality rate is at least 3.2 times higher than that of white patients, with significant disparities persisting even in areas with low overall mortality rates and among patients with higher levels of education.[51] Section 940.04 thus exacerbates health care inequities, disproportionately harming the most vulnerable Wisconsinites.

IV. Statutes That Ban Abortion Force Clinicians To Make An Impossible Choice Between Upholding Their Ethical Obligations And Following The Law

Abortion bans 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

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48 Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* 11 (2016).

49 Guttmacher Inst., *State Facts About Abortion: Wisconsin* (June 2022), https://bit.ly/3fkcOS1.

50 Raymond & Grimes 216.

51 Emily E. Petersen et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007-2016*, 68 Morbidity & Mortality Weekly Report 762, 763 (Sept. 6, 2019) (Black patients' pregnancy-related mortality rate is 3.2 times that of white patients); *see* Marian F. 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. 2021) (Black patients' pregnancy-related mortality rate is 3.55 times that of white patients).

medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. Statutes That Ban Abortion Undermine The Patient-Physician Relationship

The patient-physician relationship is critical for the provision of safe, quality medical care.[52] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests with the best available scientific evidence.[53] 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."[54] 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."[55]

Section 940.04 forces physicians to supplant their medical judgments regarding what is in patients' best interests with the Legislature's non-expert determination. 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 it is the medically appropriate course. Laws that ban abortion—such as Section 940.04, which bans abortion without exceptions for circumstances such as the mental health of the pregnant patient, rape and incest, or

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

[53] 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.").

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

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

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

Those laws also create inherent conflicts of interest. Physicians need to be able to offer appropriate treatment options without regard for their own self-interest.[56] Section 940.04 profoundly intrudes upon the patient-physician relationship by prohibiting physicians from performing abortions in many circumstances. Even if a patient's health were compromised, Section 940.04 would allow an abortion only in life-threatening circumstances, regardless of the overall medical advisability of the procedure or the patient's desires. A physician and patient together may conclude that an abortion is in the patient's best medical interests even though the risk posed by continuing the pregnancy does not yet rise to the standard in the law's exception. Wisconsin's ban thus forces physicians to choose between the ethical practice of medicine—counseling and acting in their patients' best interest—and obeying the law.[57]

B. Statutes That Ban Abortion Violate The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions.[58] Both principles arise from the foundation of medical ethics that requires patient welfare to form the basis of medical decision-making.

Physicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy

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56 *See Legis. Policy Statement.*

57 *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.").

58 AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481-82 (Dec. 2007, reaff'd 2016).

options, and ultimately empowering patients to make decisions informed by both medical science and their lived experiences.[59]

Section 940.04 pits physicians' interests against those of their patients. If a physician 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 Section 940.04, with its limited exception, prohibits physicians from providing that treatment and exposes physicians to criminal penalties if they do. It therefore places physicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

C. Statutes That Ban Abortion Violate The Ethical Principle Of Respect For Patient Autonomy

Finally, a core principle of medical practice is patient autonomy—respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[60] Patient autonomy revolves around self-determination, which is safeguarded by the ethical concept of informed consent and its rigorous application to patients' medical decisions.[61] Section 940.04 denies patients the right to make their own choices about health care if they decide they need to seek an abortion.

CONCLUSION

This Court should declare that Wisconsin Statute § 940.04 is unenforceable as applied to abortions.

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59 ACOG, *Code of Professional Ethics* 1-2 (Dec. 2018).

60 *Id.* at 1 (Dec. 2018) ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

61 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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