IN THE SUPREME COURT OF THE STATE OF GEORGIA

Case No. S25A0300

STATE OF GEORGIA

Defendant-Appellant,

v.

SISTERSONG WOMEN OF COLOR REPRODUCTIVE JUSTICE COLLECTIVE, *et al.*,

Plaintiffs-Appellees.

On Appeal from the Superior Court of Fulton County, Georgia
Superior Court Case 2022CV367796

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, SOCIETY FOR MATERNAL-FETAL MEDICINE, AND THE GEORGIA OBSTETRICAL AND GYNECOLOGICAL SOCIETY IN SUPPORT OF PLAINTIFFS-APPELLEES

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STATEMENT OF INTEREST

Amici are major national and local organizations representing medical professionals who serve patients in Georgia and beyond. These groups are dedicated to ensuring access to the full spectrum of safe and appropriate health care, and work to preserve the patient-clinician relationship.

Representing more than 62,000 board-certified OB/GYNs in the United States, the American College of Obstetricians and Gynecologists ("ACOG") is the nation's premier professional membership organization of obstetrician-gynecologists dedicated to providing access to high-quality, safe, and equitable obstetric and gynecologic care. ACOG 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 issues facing reproductive health care. ACOG is committed to ensuring access for all people to the full spectrum of evidence-based, quality reproductive health care, including abortion care, and is a leader in the effort to confront the maternal mortality crisis in the United States.

ACOG's Georgia Section has over 1,600 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.

Founded in 1977, the Society for Maternal-Fetal Medicine ("SMFM") is a medical professional society for maternal-fetal medicine subspecialists, who

are obstetricians with additional training in high-risk pregnancies. SMFM represents more than 7,000 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.

The Georgia Obstetrical and Gynecological Society ("GOGS") has more than 950 members throughout Georgia and has been active since 1951. GOGS is committed to patient-centered, compassionate, evidence-based health care. GOGS opposes civil and criminal penalties for clinicians who provide such care and also opposes any legislation that undermines the patient-physician relationship and the practice of medicine.

SUMMARY OF ARGUMENT

The Living Infants Fairness and Equality Act (the "LIFE Act") undermines access to abortion care in Georgia without basis in medical science and without regard to the safety and well-being of pregnant people. Specifically, the LIFE Act, among other things, criminalizes abortion care occurring after embryonic cardiac activity, which the legislation characterizes as a "detectable human heartbeat," and which the State earmarks at six weeks of gestation.[1] Even accepting this premise, which is not based on scientific consensus or medical terminology, the LIFE Act impedes access to safe and effective health care for many Georgians, which is a violation of their fundamental right to bodily autonomy under the Georgia Constitution.

Abortion care is one of the safest health care services in modern medicine. Yet, the LIFE Act creates barriers to abortion care in Georgia. At six weeks of gestation, many people are unaware of a pregnancy and even if they are aware, they may nevertheless be unable to access abortion care within the permitted timeframe. A variety of personal factors impact a person's detection of their pregnancy. Moreover, even if a person becomes aware of their

[1] It is clinically inaccurate to use the word "heartbeat" to describe the sound that can be heard on an ultrasound in very early pregnancy. *See ACOG Guide to Language and Abortion* (Oct. 2024). For purposes of this *amicus* brief, *amici* assume that the LIFE Act prohibits abortion care at approximately six weeks of gestation, even though it is the medical opinion of *amici* that only embryonic cardiac activity exists at six weeks of gestation, and not a "detectable human heartbeat."

pregnancy within six weeks of gestation, a number of reasons such as lack of financial resources, inability to travel to a reproductive care facility, and unrelated Georgia laws make it extremely difficult to obtain abortion care within that time frame. For pregnant patients from communities of color or with fewer financial resources, the obstacles to obtaining abortion care are even greater. As discussed *infra*, since the LIFE Act was enacted two years ago, the number of patients needing to travel outside of Georgia to receive abortion care has skyrocketed, with 36 times as many patients traveling for care than prior to enactment.

The LIFE Act drafters intentionally created obstacles to receiving abortion care; unless and until a narrow statutory exception applies, the LIFE Act essentially requires many Georgians to carry their pregnancies to term if they cannot access abortion care outside of the state. Evidence-based medical research shows that continuing a pregnancy to term and giving birth carries greater risks to a person's health and life than obtaining an abortion—a routine and essential health care service. As leading medical experts, *amici* can state definitively that the LIFE Act does not protect maternal health. This is further confirmed by recent events: two Georgians made national news in 2024 when they died from complications of pregnancy – preventable tragedies that indirectly stemmed from the patients not receiving abortion care due to the impact of the LIFE Act.

Many Georgians will have no choice but to face these risks, because the LIFE Act's narrow exceptions, including the purported "medical emergency" exception, do not cover all situations where abortion care may be necessary. A "medical emergency" by its nature cannot be effectively defined by a third party that is not in the exam room faced with an actual patient. Clinicians regularly confront complex and nuanced medical situations, and there "is no one-size fits all law that can take every individual, family, or medical condition into account, making legislative interference in the practice of medicine incredibly dangerous."[2] Under the LIFE Act, a person living with health conditions that will complicate a pregnancy or be complicated by a pregnancy may have no choice but to continue the pregnancy to term, jeopardizing the person's health in violation of rights protected by the Georgia Constitution.

Finally, the LIFE Act creates legal and ethical challenges for clinicians treating patients in Georgia. Once a pregnancy progresses beyond the legal time period contemplated by the LIFE Act, unless an exception applies, clinicians cannot administer abortion care in Georgia without potential criminal punishment, even if such care is the most medically appropriate course of action. And, given the limited, vague, and unworkable aspects of the

[2] ACOG, *Understanding Medical Emergency Exceptions in Abortion Bans and Restrictions* (Aug. 2022), https://www.acog.org/news/news-articles/2022/08/understanding-medical-emergency-exceptions-in-abortion-bans-restrictions.

LIFE Act's exceptions, clinicians will only further be deterred from providing abortion care, as violations of the LIFE Act are punishable by a term of imprisonment. Thus, the LIFE Act places clinicians in an ethically untenable position: having to navigate a conflict between providing appropriate medical care and complying with the law.

For all these reasons, and those further discussed herein, *amici* respectfully submit that this Court affirm the order of the Superior Court of Georgia.

ARGUMENT

I. THE LIFE ACT LACKS A SCIENTIFIC BASIS TO LIMIT ACCESS TO SAFE MEDICAL CARE

The LIFE Act's abortion care restrictions are not based on science. The LIFE Act bans abortion care after a "detectable human heartbeat," which the State sets at six weeks of gestation. However, at this stage, there is no heart, as the term is understood in medicine, and the tissue that might become the heart is far from fully formed. In banning abortion care, the LIFE Act prohibits a safe and effective medical service and does so without medical or scientific justification.

A. The LIFE Act Lacks Medical Justification

The LIFE Act is not grounded in science and lacks a medical justification for restricting abortion care in Georgia. Specifically, the LIFE Act prohibits abortion care when an "unborn child has been determined...to have a

detectable human heartbeat...."[3] The LIFE Act defines "detectable human heartbeat" to mean "embryonic or fetal cardiac activity or the steady and repetitive rhythmic contraction of the heart within the gestational sac."[4] From these statements, *amici* understand that the State's definition of "detectable human heartbeat" includes the embryonic cardiac activity that occurs as a result of electrical flickering of a portion of the embryonic tissue, which the State posits as detectable at approximately six weeks of gestation. However, this definition is inconsistent with longstanding scientific consensus. While embryonic cardiac activity can signal that an early pregnancy may continue to develop, it 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.

Fetal cardiac development, like all gestational development, is a gradual process that continues through a pregnancy. As a matter of medical science, a true fetal heartbeat, as distinct from embryonic cardiac activity, exists only after the chambers of the heart develop, which typically occurs after 10 weeks.[5] Until the chambers of the heart develop, it is not accurate to characterize any

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[3] O.C.G.A. § 16–12–141(b).

[4] *Id.* at 141(a)(2).

[5] *See Fetal Development*, Mount Sinai (Aug. 2023), https://www.mountsinai.org/health-library/special-topic/fetal-development; *FAQs: Pregnancy*, Mass. Gen. Hosp. (Feb. 2023), https://www.massgeneral.org/obgyn/patient-resources/pregnancy-and-parenting/faq; *Abortion: A Women's Right to Know*, Ga. Dep't. of Pub. Health (Aug. 2022). (noting that a fetal heartbeat can be detected starting at 12 weeks of gestation).

audible cardiac activity as a heartbeat. Thus, the medical evidence contradicts the State's purported interest in restricting abortion care once a heartbeat is detected, and the LIFE Act contains no medical-based justification for eliminating safe and effective health care at six weeks of gestation.

B. Abortion Care is Safe and Effective Health Care

As recognized widely by the medical community, abortion is a safe, essential part of comprehensive health care, and just like any other safe and effective medical intervention, it must be available equitably to all people.[6] Randomized controlled trials, large retrospective cohort studies, patient and clinician surveys, systematic reviews, and epidemiological studies examining abortion care consistently demonstrate that abortion is extremely safe, regardless of whether the abortion is induced by medication or procedure.[7]

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[6] *See, e.g.*, ACOG, *Statement on the Decision in* Dobbs v. Jackson (Jun. 24, 2022); ACOG, *Abortion Policy* (revised and approved May 2022); ACOG, Committee Opinion No. 815, *Increasing Access to Abortion,* 136:6 Obstetrics & Gynecology e107, e107–08 (Dec. 2020); Editors of the New England Journal of Medicine et al., *The Dangerous Threat to Roe v. Wade*, 381 New Eng. J. Med. 979, 979 (2019) ("Access to legal and safe pregnancy termination ... is essential to the public health of [pregnant patients] everywhere."); American Medical Association ("AMA"), *Principles of Medical Ethics*, *Chapter 4*: *Genetics & Reproductive Medicine*, § 4.2.7 (last visited Jan. 2025); Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119:2 Obstetrics & Gynecology 215, 216 (Feb. 2012) (finding that the risk of death is 14 times higher with childbirth than with abortion); Grimes & Creinin, *Induced Abortion: An Overview for Internists*, 140:8 Annals of Internal Med. 620 (Apr. 2004).

[7] *See* National Academies of Sciences, Engineering and Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (Mar. 2018); Aiken et al., *Safety and Effectiveness of Self-Managed Medication Abortion Provided Using Online Telemedicine in the United States: A Population-Based Study*, 10:100200 Lancet

Complication rates from abortion care are extremely low, averaging around 2%, and most complications are minor and easily treatable.[8] Research shows that "adverse events are rare for later first trimester abortion."[9] Given that patients seek abortion care for a wide range of reasons and that care is highly safe and effective, it is unsurprising that it is a common medical procedure: in 2023, over 1,035,000 abortions were performed nationwide.[10]

Moreover, several comprehensive studies make clear that there are no significant risks of psychological harm from the provision of abortion care.[11] In fact, the Turnaway Study, a landmark research project reviewing the effects of unwanted pregnancy, found that people who are denied abortion care consistently have worse physical and mental health outcomes than those who seek and receive them.[12] Relatedly, a recent analysis of national survey data

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Reg'l Health 1, 6 (June 2022); Raymond & Grimes, *supra note* 6; Grimes & Creinin, *supra* note 6, at 623.

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

9 Kapp et al., *Medical Abortion in the Late First Trimester: A Systematic Review*, 99:2 Contraception 77, 77 (Feb. 2019).

10 Maddow-Zimet & Gibson, *Despite Bans, Number of Abortions in the United States Increased in 2023*, Guttmacher Inst. (Mar. 2024), https://www.guttmacher.org/2024/03/despite-bans-number-abortions-united-states-increased-2023.

11 Major et al., *Report of the APA Task Force on Mental Health and Abortion*, at 4 (2008); American Psychological Association, *Position Statement on Abortion* (July 2018); Rocca et al., *Emotions and Decision Rightness Over Five Years Following an Abortion: An Examination of Decision Difficulty and Abortion Stigma*, 248 Soc. Sci. & Med. 1, 1–2 (Jan. 2020).

12 *Turnaway Study*: *The Mental Health Impact of Receiving vs. Being Denied a Wanted Abortion*, U.C. San Francisco 1, 3 (July 2018).

conducted by researchers at the Johns Hopkins Bloomberg School of Public Health found a small but significantly greater increase in self-reported anxiety and depression symptoms among respondents in states that banned abortion care post-*Dobbs*, compared to those in states that did not enact bans.[13]

II. THE LIFE ACT RESTRICTS ABORTION ACCESS IN GEORGIA WITHOUT MEDICAL JUSTIFICATION

The LIFE Act impairs access to abortion care in Georgia because within the imposed six-week legal time period, many people are unaware that they are pregnant and even if they are aware, several personal and government-imposed factors may delay a person from seeking abortion care within that time period. People with fewer financial resources, people of color, and people who live in care deserts or rural areas with limited access to care are likely to face even greater challenges in accessing abortion care within six weeks of gestation. As a result of the extremely short period of time in which abortion care is legal in Georgia under the LIFE Act, abortion care will be even more challenging to access within the state.

A. People May Not Know They Are Pregnant at Six Weeks of Gestation

The most common sign of a potential pregnancy is a missed period; until then, most people (particularly those who are not planning a pregnancy) will

[13] Thronburg et al., *Anxiety and Depression Symptoms After the* Dobbs *Abortion Decision*, 331(4) JAMA 294 (Jan. 2024).

have no reason to suspect they are pregnant.[14] A person's menstrual cycle is typically about four weeks long, although many people have longer or irregular cycles. Even if a person experiences highly regular cycles, they would already be four weeks pregnant, as measured from the last menstrual period, when they first have reason to suspect they may be pregnant. The LIFE Act prohibits abortion just two weeks later. Before six weeks of gestation, clinicians cannot always confirm an intrauterine pregnancy via ultrasound and therefore in some cases, may not be able to offer abortion care.[15]

Many people experience irregular menstrual cycles due to factors including stress, obesity, smoking, ovarian and adrenal tumors, exercise-induced amenorrhea, eating disorders, and endocrine conditions, such as polycystic ovary syndrome, thyroid dysfunction, and premature ovarian failure.[16] Moreover, young adolescents, within the first few years of menstrual life, may have irregular menstrual cycles or longer menstrual cycles of six

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[14] Administering a home pregnancy test too early in a person's pregnancy may result in a false negative result because the hormone a person's body produces during pregnancy, human chorionic gonadotrophin, may not yet be at a detectable level to trigger a positive test result. *Pregnancy*, U.S. Food & Drug Admin. (Apr. 2019), https://www.fda.gov/medical-devices/home-use-tests/pregnancy.

[15] Heller & Cameron, *Termination of Pregnancy at Very Early Gestation Without Visible Yolk Sac on Ultrasound*, 41 J. Fam. Planning & Reprod. Health Care 90, 90–91 (Sept. 2014).

[16] Attia et al., *The Impact of Irregular Menstruation on Health: A Review of the Literature*, 15:11 Cureus 1, 1–3 (Nov. 2023); ACOG, Committee Opinion No. 651, *Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign*, at 3 (Dec. 2015, re-aff'd 2025).

weeks or more.[17] Other people experience menorrhagia, or bleeding during their menstrual cycle,[18] which can be mistaken for a period and may lead a person to believe they did not miss a period when they are actually pregnant. Because a missed period tends to be the most definitive signal of potential pregnancy before testing, people who experience irregular menstrual cycles and bleeding would have no reason to suspect pregnancy before six weeks.[19] As such, many people who experience irregular menstrual cycle activity may be foreclosed from accessing abortion care in Georgia.

Moreover, about one in two pregnancies in America are unplanned.[20] Given this fact, almost half of pregnant people may not immediately consider other potential symptoms of early pregnancy, such as nausea or vomiting, to be indicative of pregnancy.[21] Some people also may never experience nausea or vomiting before six weeks of gestation (or at all).[22] One study found that one in three people learn they are pregnant only after six weeks of gestation,

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17 Harrison et al., *The Normal Menstrual Cycle*, NASPAG Essentials of Pediatric & Adolescent Gynecology at 68 (June 2024).

18 *Menstrual Disorders*, Mount Sinai (last visited Jan. 2025), https://www.mountsinai.org/health-library/report/menstrual-disorders.

19 Indeed, other than a missed period, pregnancy symptoms differ and are not always predictable. Sayle et al., *A Prospective Study of the Onset of Symptoms of Pregnancy*, 55 J. Clinical Epidemiology 676, 676 (July 2002).

20 *Unintended Pregnancy*, Ctr. for Disease Control (May 2024).

21 Finer & Zolna, *Declines in Unintended Pregnancy in the United States, 2008 - 2011*, 374 N. Eng. J. Med. 843, 843 (Mar. 2016).

22 *See* Zhang et al., *Risk Factors of Prolonged Nausea and Vomiting During Pregnancy*, 13 Risk Mgmt. & Healthcare Pol'y 2645, 2645 (Nov. 2020) (finding that nausea and vomiting typically start at 5 or 6 gestational weeks).

and later confirmation of pregnancy is more common among people of color, young people, and those living with food insecurity.[23] Therefore, people who mistake pregnancy symptoms for any other condition or do not experience these ancillary symptoms until after six weeks of gestation are unable to obtain abortion care in Georgia, unless a narrow exception under the LIFE Act applies.

B. Pre-existing Barriers and Laws Additionally Hinder Access to Abortion Care

Even if a person detects their pregnancy within six weeks of gestation, unrelated, pre-existing obstacles and state laws may nevertheless create challenges to accessing abortion care before the LIFE Act bans such care.

First, there are very few providers left in Georgia who offer abortion care. As of 2020, 95% of Georgia counties had no abortion provider.[24] More than half of all Georgians live in one of those counties and would need to travel beyond their county borders to obtain abortion care.[25]

Second, Georgia law creates financial barriers to abortion care. For example, Georgia forbids the use of state funding for abortion care, with only narrow exceptions where the person's life is at risk, or the pregnancy results

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[23] Ralph et al., *Home Pregnancy Test Use and Timing of Pregnancy Confirmation Among People Seeking Health Care*, 107 Contraception 10, 15–16 (Mar. 2022).

[24] Jones et al., *Abortion Incidence and Service Availability in the United States, 2020*, 54 Perspectives on Sexual & Reprod. Health 128, 135 (Nov. 2022).

[25] *Id.*

from rape or incest.[26] Similarly, Georgia law forbids private health insurance plans offered through the state exchange under the Patient Protection and Affordable Care Act from covering abortion care in any way.[27] Patients needing abortion care are typically disproportionately low-income and will therefore require time to raise, if they even can, the money needed to pay for abortion care themselves.[28]

Third, pre-existing Georgia laws restrict access for patients needing abortion care. For example, Georgia law requires that people undergo government-scripted counseling and then wait 24 hours before obtaining abortion care.[29] Georgia minors are subjected to parental notification requirements before they obtain abortion care unless they obtain a judicial bypass, with only a limited exception in a case of "medical emergency."[30] Obtaining a judicial bypass can delay access to abortion care for up to four

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[26] Georgia implements these restrictions through Georgia Community Health Department manuals. *See, e.g.*, *Feminist Women's Health Ctr. v. Burgess*, 651 S.E.2d 36, 37 (Ga. 2007) (noting that the State will reimburse abortion care received by eligible persons only "if the life of the mother would be endangered if the fetus were carried to term or if the mother was a victim of rape or incest").

[27] O.C.G.A. § 33–24–59.17.

[28] People with incomes less than 200 percent below the poverty level experience an abortion rate six times that of people with incomes more than 200 percent above the poverty level. Harned & Fuentes, *Abortion Out of Reach: The Exacerbation of Wealth Disparities After Dobbs v. Jackson Women's Health Organization*, Guttmacher Inst. (Jan. 2023), https://www.guttmacher.org/article/2023/01/abortion-out-reach-exacerbation-wealth-disparities-after-dobbs-v-jackson-womens.

[29] O.C.G.A. § 31–9A–3(1).

[30] O.C.G.A. §§ 15–11–682(a)(1), 15–11–684, 15–11–686.

weeks.[31] These restrictions already foreclose abortion care for untold numbers of Georgians with no medical justification, and the LIFE Act will only further limit the practical ability of people to access abortion care.

When coupled with the restrictions Georgians already face, the LIFE Act can create an insurmountable barrier to abortion care. Even for people who can confirm pregnancy before six weeks of gestation, it is often difficult or impossible to access care in Georgia within that window. During this short time, a person must (1) decide whether to continue the pregnancy; (2) notify parents or obtain a judicial bypass if the person is a minor; (3) schedule an appointment with one of the few clinicians who provide abortion care in the state; and (4) navigate restrictive Georgia laws, including the 24-hour waiting period. Many people will need to gather resources to pay for the abortion and its related costs, arrange transportation, and take time off from work and obtain childcare. Less time to finalize these arrangements means that more people will be foreclosed from obtaining care.

The LIFE Act has unsurprisingly forced many Georgians to seek abortion care out of state. However, traveling out of state is not a viable option for all. For some people, the logistical and financial burden of traveling out of

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[31] American Academy of Pediatrics Committee on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 139:2 Pediatrics 1, 6–7 (Feb. 2017); Ralph et al., *Reasons for and Logistical Burdens of Judicial Bypass for Abortion in Illinois*, 68 J. Adolescent Health 71, 75 (Jan. 2021).

state for abortion care is far greater than obtaining the same care in Georgia. Traveling longer distances equates to increased financial burdens, absences from work, and difficulties in finding and paying for childcare.[32] This is likely to result in substantial delay, which may further increase costs and may subject the person to a more involved procedure that could have otherwise been avoided. Moreover, the need to travel out of state and consider various states' individual criminal and/or civil penalties related to abortion care is likely to cause increased delay and confusion.[33] This is especially true in light of the current uncertainty of abortion care access in several states across the country, including those that border Georgia.

C. The LIFE Act Exacerbates Barriers Faced by Marginalized Communities

The effects of the LIFE Act are not felt equally, as people with fewer financial resources, people of color and people who live in care deserts or rural areas with limited access to care are disproportionately burdened by

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[32] Wasser et al., *Catastrophic Health Expenditures for In-State and Out-of-State Abortion Care*, 7:11 JAMA Network Open, at 1, 2 (Nov. 2024); *see also* Ogbu-Nwobodo et al., *Mental Health Implications of Abortion Restrictions for Historically Marginalized Populations*, 387:17 New Engl. J. Med. 1613, 1614 (Oct. 2022) (noting that traveling across state lines for abortion care is especially difficult for low-income individuals, the LGBTQ+ community, and people with serious mental health conditions).

[33] *See* Forouzan et al., *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care*, Guttmacher Inst. (Dec. 2023), https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care.

restrictions on abortion care.[34] For these individuals, receiving abortion care services may already be challenging for a number of reasons, including reduced access to insurance coverage, lower employment rates, and lengthy distances from medical centers.[35] Given that 75% of abortion care patients are low-income, the LIFE Act is particularly devasting for Georgians who are least able to access medical care and who have the least amount of resources to navigate the statute's restrictions before six weeks of gestation.[36] Those who are denied abortion care are more likely to experience downward economic mobility, with Black women especially impacted by poorer labor market outcomes.[37] By severely shortening the timeframe in which a pregnant person can seek abortion care, the LIFE Act serves to unjustly punish already vulnerable communities.

III. THE LIFE ACT MAY HARM PREGNANT PEOPLES' HEALTH

For Georgians who cannot access abortion care within the short timeframe contemplated by the LIFE Act and face obstacles in accessing

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[34] Kozhimannil et al., Abor*tion Access as a Racial Justice Issue*, 387:17 New Engl. J. Med. 1537, 1537 (Oct. 2022).

[35] *Id.* at 1538; *see also* Ogbu-Nwobodo et al., *supra note* 32.

[36] Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst. (May 2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014.

[37] *See* Mahoney, *The Economic and Workforce Impact of Restrictive Abortion Laws,* Inst. for Women's Policy Research 1, 19–20 (Oct. 2024); *see also* Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions*, 108:3 Am. J. Pub. Health 411, 411–12 (Mar. 2018).

abortion care outside of the state, they will have no choice but to continue their pregnancy to term, unless one of the three limited exceptions to the LIFE Act applies. The LIFE Act puts Georgians at greater health risks, including death. As further discussed herein, recent reporting on two Georgians who died as an indirect result of the LIFE Act's restrictions illustrates the real impacts faced by pregnant patients who cannot access appropriate abortion care, even when such care is medically required and elected by the patient. The "medical emergency" exception to the LIFE Act offers little support and help, as the exception is narrow and unworkable, and the vast number of Georgians are unlikely to fall within its confines.[38]

A. People Face Greater Risks When Forced to Continue a Pregnancy to Term

Continuing a pregnancy carries a greater risk of death and health complications than obtaining an abortion.

First, U.S. and Georgia-specific statistics illustrate that patients who undergo a live birth face a significant risk of maternal mortality. The risk of death associated with childbirth in the U.S. is approximately 14 times higher than the risk associated with getting an abortion.[39] The U.S. has the highest

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[38] The LIFE Act also authorizes an abortion (1) when a pregnancy is the result of rape or incest and an official report alleging the offense has been reported, or (2) if a physician determines that the pregnancy is medically futile. O.C.G.A. §§ 16–12–141(b)(1), (3). Both of these exceptions are limited and narrow and are inapplicable to many Georgians seeking abortion care.

[39] ACOG, Committee Opinion No. 815, *supra* note 6, at e108.

maternal mortality ratio among developed countries and is only one of two countries worldwide to have experienced a significant increase in maternal mortality rates since 2000.[40]

There has been a significant rise in the maternal mortality rates in states that have implemented abortion care restrictions within the past twenty years, with a disproportionate increase for Black and Indigenous individuals.[41] Research has shown that "[s]tates with the most severe abortion restrictions tend to have the poorest maternal and neonatal health outcomes."[42] In Georgia, the maternal mortality rate is ***nearly twice*** the national rate.[43] The state is consistently ranked as having one of the highest maternal mortality rates in the country.[44] The mortality rate is far worse for Black individuals in Georgia, who are three times more likely to die from a pregnancy-related cause

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40 Fink et al., *Trends in Maternal Mortality and Severe Maternal Morbidity During Delivery-Related Hospitalizations in the United States, 2008 to 2021*, Obstetrics and Gynecology 1, 2 (June 2023); Wang et al., *Maternal Mortality in the United States: Trends and Opportunities for Prevention*, 74 Annual Review Med. 199, 200 (Jan. 2023).

41 Keegan et al., *Trauma of Abortion Restrictions and Forced Pregnancy: Urgent Implications for Acute Care Surgeons*, Trauma Surgery & Acute Care Open 2–3 (Jan. 2023).

42 Byron et al., *Health Equity in a Post 'Roe Versus Wade' America*, 14:12 Cureus 1, 3 (Dec. 2022).

43 Hernandez et al., *Maternal Health Equity in Georgia: A Delphi Consensus Approach to Definition and Research Priorities*, 23:596 BMC Pub. Health 1, 2 (Mar. 2023).

44 *Id.*

than white individuals.[45] It is expected that maternal mortality rates will only increase as additional prohibitions like the LIFE Act are placed on abortion care.[46]

Second, patients who carry a pregnancy to term may face serious health risks that could otherwise be avoided with abortion care. While abortion-related risks may become greater as pregnancy advances, serious risk from abortion care at all gestational ages is extremely rare and does not approach the threshold of risk associated with carrying a pregnancy to term.[47] In a 1998 to 2005 study, researchers determined that moderate and life-threatening pregnancy and birth-related complications (such as anemia, hypertensive disorders, mental health conditions, obstetric infections, asthma, and postpartum hemorrhage) were more common in people who gave birth than in those who received abortion care.[48]

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45 *Maternal Mortality Report 2018-2020 Data,* Ga. Dep't of Pub. Health (June 2023); Hernandez et al., *supra* note 43.

46 *See* Kheyfets et al., *The Impact of Hostile Abortion Legislation on the United States Maternal Mortality Crisis: A Call for Increased Abortion Education*, 11 Frontiers Pub. Health 1, 2 (Dec. 2023).

47 ACOG, Committee Opinion No. 815, *supra* note 6, at e108; Ranji et al., *Key Facts on Abortion in the United States*, KFF (Jun. 2024), https://www.kff.org/womens-health-policy/issue-brief/key-facts-on-abortion-in-the-united-states/#How-safe-are-abortions.

48 Raymond & Grimes, *supra* note 6, at 216–17 & Fig. 1.; *see also* Stevenson et al., *Comparing Mortality Risk of Induced Abortion with Mortality Risk of Staying Pregnant*, 127 Contraception 1, 2 (Oct. 2023) (In a 2013 to 2017 study, staying pregnant was found to be 32-35 times deadlier than induced abortion).

In addition, pregnancy can also exacerbate or complicate pre-existing medical conditions that frequently (and sometimes severely) worsen with pregnancy. For example, approximately 7-8% of pregnancies are complicated by gestational diabetes mellitus, a condition that frequently leads to maternal and fetal complications, including developing diabetes later in life. [49] 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. [50] Further, some pregnant people may develop placenta accreta, where the placenta grows too deeply into the uterine wall, which makes them more likely to require a hysterectomy and experience greater rates of maternal morbidity and mortality. [51] Even if a pregnant person develops none of these conditions, pregnancy alone causes significant stress on the body and involves physiological and anatomical changes. Labor and

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[49] *Percentage of Mothers with Gestational Diabetes, by Maternal Age – National Vital Statistics System, United States, 2016 and 2021*, Ctr. for Disease Control (Jan. 2023).

[50] ACOG, *FAQs*: *Preeclampsia and High Blood Pressure During Pregnancy* (last reviewed Jan. 2025), https://www.acog.org/womens-health/faqs/preeclampsia-and-high-blood-pressure-during-pregnancy.

[51] ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum*, 136 Obstetrics & Gynecology e259, e259 (Dec. 2018).

delivery likewise carry significant risks, including hemorrhage, hysterectomy, cervical laceration, and debilitating postpartum pain.[52]

When abortion care is medically appropriate and desired, the patient should not be required to continue a pregnancy to term, which may subject them to serious or fatal health risks.

B. The "Medical Emergency" Exception to the LIFE ACT Does Not Adequately Protect a Person's Health

Georgians who require an abortion, particularly those experiencing high-risk pregnancies, may face significant challenges under the LIFE Act that harm their health and well-being. The LIFE Act limits a "medical emergency" to a situation where "an abortion is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function of the . . . woman."[53]

The State's narrow definition of a "medical emergency" is an unworkable framework, inconsistent with standards of care, that fails to account for the many nuanced situations faced by clinicians in diagnosing and administering care. For example, the definition fails to consider that people may experience

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[52] *See* ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage*, 130:4 Obstetrics & Gynecology e168 (Oct. 2017); ACOG, Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, 132:3 Obstetrics & Gynecology e87 (Sept. 2018); ACOG, *Clinical Consensus No. 1, Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management*, 138:3 Obstetrics & Gynecology e507 (Sept. 2021).

[53] O.C.G.A. § 16–12–141(a)(3).

medical conditions that have a significant impact on a person's health, but which may not rise to the level of a "medical emergency" until well after six weeks of gestation. Such medical conditions include: Alport syndrome (a form of kidney inflammation);[54] valvular heart disease (abnormal leakage or partial closure of a heart valve that can occur in people with no history of cardiac symptoms);[55] lupus (an autoimmune disorder that may suddenly worsen during pregnancy and lead to fatal blood clots and other serious complications);[56] and pulmonary hypertension (increased pressure within the lung's circulation system that can escalate in severity).[57]

Moreover, the mental health carve-out from the "medical emergency" exception ignores that an abortion can be necessary to protect the psychiatric well-being of a pregnant person. Pregnancy can create or exacerbate psychiatric symptoms, such as anxiety and depression, and by restricting the "medical emergency" exception to physical conditions, the legislature has

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[54] *See* Brunini et al., *Alport Syndrome and Pregnancy: A Case Series and Literature Review*, 297 Archives of Gynecology & Obstetrics 1421, 1430 (June 2018).

[55] *See* Lin & Carbajal, *Pregnancy and Valvular Heart Disease*, Critical Heart Condition in Pregnancy 61, 61–71 (2024).

[56] *See* Zucci et al., *Pregnancy in Systemic Lupus Erythematosus*, 37:4 Best Practice & Rsch. Clinical Rheumatology 1, 3 (Dec. 2023).

[57] *See* Maligireddy et al., *Maternal and Fetal Outcomes in Pulmonary Hypertension During Pregnancy: A Contemporary Nationwide Analysis*, 221 Am. J. Cardiology 113, 117–18 (June 2024).

removed therapeutic abortion care as an effective treatment for those suffering from life-threatening mental health emergencies.[58]

The State's "medical emergency" definition also fails to consider complications that present danger to maternal health that can affect fetal development and survival. For example, if a person experiences premature rupture of membranes and infection, preeclampsia, placental abruption, and/or placenta accreta, that person may be at risk of extensive blood loss, stroke, and/or septic shock, and it may be impossible for the fetus to survive. In this way, the LIFE Act runs counter to its purported intent to save lives, because it may lead to death for pregnant people and the fetuses they carry.

Equally concerning, the "medical emergency" definition is too vague to give patients or clinicians workable guidance about whether procedures are permitted or prohibited.[59] Recent reporting shows that at least one Georgian tragically died because of confusion as to whether her health deteriorated to a

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[58] Schetter & Tanner, *Anxiety, Depression and Stress in Pregnancy: Implications for Mothers, Children, Research, and Practice*, 25:2 Current Op. Psychiatry 141, 142 (Mar. 2012); *See* Wang & Weiss, *Post-Dobbs Psychiatric Exceptions in Abortion-Restricting States*, 75 Law & Psychiatry 710, 712 (2024).

[59] The same is true for determining when pregnancies may be "medically futile." O.C.G.A. § 16-12-141(b)(3). The State defines this narrow exception as when a fetus has a condition "that is incompatible with sustaining life after birth." *Id.* § 16-12-141(a)(4). But clinicians are left with no guidance on whether this means the baby must be predicted to die immediately, in the near term, or at some other future point. Instead of recognizing that clinicians must make such determinations of futility on a case-by-case basis, legislators require clinicians to make decisions without clear guidance and in fear that their own medical judgment may be second-guessed down the line.

point by which an exception to the LIFE Act applied.[60] In another case, a pregnant Georgian died after not seeking abortion care out of fear of potential prosecution based on the LIFE Act.[61] The LIFE Act and its vague "medical emergency" exception create dangerous confusion for clinicians and patients alike. These situations are exemplary of the nuanced situations not contemplated by the LIFE Act and illustrate why a "medical emergency" cannot be effectively or accurately defined in legislation.

Further, the LIFE Act creates uncertainty as to the extent of miscarriage management that is permissible. The statute fails to protect clinicians who must use their medical judgment to determine the best treatment plan and provide care in the moment. Miscarriages (where cardiac activity may still be detectible) are commonly treated via uterine aspiration, which is the same procedure as that used for the majority of abortions (other than medication abortions).[62] The LIFE Act permits removal of a "dead unborn child," but it

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60 *See* Kavitha Surana, *Abortion Bans Have Delayed Emergency Medical Care. In Georgia, Experts Say This Mother's Death Was Preventable*, ProPublica (Sept. 2024), https://www.propublica.org/article/georgia-abortion-ban-amber-thurman-death.

61 *See* Kavitha Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, ProPublica (Sept. 2024), https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia.

62 Allen et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40:4 Obstetrics & Gynecology Clinics N. Am. 625, 632 (2013); *see also* Keegan et al., *supra* note 41, at 2 (the "[m]edical and surgical management" of both induced abortions and miscarriages is identical).

does not state miscarriage management is permissible.[63] This means that pregnant people who are actively miscarrying may be denied care if any cardiac activity is still detectable.[64] Miscarriages can occur in much-wanted pregnancies, long after six weeks have elapsed, and require critical and often immediate intervention, but uncertainty among medical professionals as to the extent of care permissible under the statute may cause them to delay (or even withhold) essential care and may put pregnant people at risk.

IV. THE LIFE ACT MAY FORCE CLINICIANS TO DENY PATIENTS MEDICALLY NECESSARY CARE IN LIGHT OF POTENTIAL CRIMINAL PROSECUTION

The LIFE Act frustrates clinicians' abilities to exercise all reasonable means to ensure their patients receive the most appropriate and effective care and impedes adherence to the medical profession's ethical principles.[65]

Clinicians are required to abide by a number of ethical obligations. For example, beneficence requires clinicians to act in a way that is likely to benefit

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[63] O.C.G.A. § 16–12–141(a)(1)(A). A recent statement by the Georgia Department of Health addressing permissible care did little to clarify the statute's ambiguous language. *Notice to Health Care Providers Regarding Misinformation About Abortions in Georgia*, Ga. Dep't of Cmty. Health (Sept. 2024), https://dph.georgia.gov/document/document/notice-healthcare-providers-ga-law-09-25-2024/download.

[64] Felix, et al., *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (June 2024), https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortions-bans-implications-for-the-provision-of-abortion-services/.

[65] *See* ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 3 (Dec. 2007, re-aff'd 2019); *see also* AMA, *Principles of Medical Ethics, Chapter 1: Opinions on Patient-Physician Relationships* § 1.1.3(b) (last visited Jan. 2025).

patients[66] and non-maleficence directs clinicians to refrain from acting in ways that might harm patients, unless the harm is justified by concomitant benefits.[67] Yet under the LIFE Act, a clinician who believes abortion care is appropriate for a patient facing a medical condition after approximately six weeks of gestation is unable to provide safe and effective care until the patient's health deteriorates to a "medical emergency" (or another exception applies). The clinician is then required to report to the State the basis of their determination that a "medical emergency" existed, suggesting that the State may second-guess medical judgments.[68] Given that the State, may disagree with a clinician's judgment that an abortion was medically necessary, as defined under the LIFE Act, a clinician may be justifiably hesitant to provide such care.

Similarly, principles of patient autonomy recognize that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions.[69] Clinicians are obligated to honor and respect patient decisions about their care through patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make a decision informed by

66 ACOG, Committee Opinion No. 390, *supra* note 65, at 3–4.
67 *See id.*
68 O.C.G.A. § 31–9B–3(a)(2).
69 ACOG, Committee Opinion No. 390, *supra* note 65, at 3.

medical science and individual experiences.[70] The LIFE Act removes these meaningful choices from patients and their clinicians and replaces them with legislative prohibitions.

A clinician's ability to practice medicine in accordance with medical ethics is further complicated by the threat of criminal punishment. A clinician found guilty of violating the LIFE Act faces up to ten years in prison.[71] The LIFE Act's criminal sanctions effectively require clinicians not to provide care (unless such care is permissible under the narrow statutory scheme), even if doing so is consistent with sound medical judgment and their patients' wishes. This places clinicians in an ethically untenable position: (i) choosing to follow the law, or (ii) providing appropriate health care and risking criminal sanctions.[72]

Amici, along with many other medical organizations, oppose legislation that interferes with clinician judgment, intrudes on the patient-clinician

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70 SMFM Position Statement, *Access to Abortion Care*, at B7–B8 (July 2024), [hereinafter "SMFM Statement"] ("[P]hysicians have a professional responsibility to respect each individual's autonomy in decisions regarding pregnancy and to provide nonjudgmental care[.]").

71 O.C.G.A. § 16-12-140(b).

72 Clinicians must also face this impossible choice with the records access provision (O.C.G.A. § 16–12–141(f)), which requires health records of abortion patients to be available to state prosecutors. Clinicians must either violate their ethical obligation to keep medical records confidential, unless patients consent to providing access, or refuse and face potential criminal consequences.

relationship, and lacks scientific basis.[73] Medical "[d]ecisions must be left to patients in consultation with their trusted clinicians."[74]

CONCLUSION

For all the reasons stated above, the Court should affirm the order of the lower court.

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[73] *See, e.g.*, ACOG, *More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference* (July 2022); SMFM Statement, *supra* note 70, at B7.

[74] ACOG, *Abortion Bans are to Blame, Not Doctors* (Oct. 2024), https://www.acog.org/news/news-releases/2024/10/acog-abortion-bans-are-to-blame-not-doctors.

This submission does not exceed the word-count limit imposed by Rule 20.

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