EXHIBIT A
Brief of American College of Obstetricians and Gynecologists as *Amicus Curiae* in Support of Plaintiff-Appellee

No. 17-2879

IN THE

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

FREDERICK W. HOPKINS,

Plaintiff-Appellee,

v.

LARRY JEGLEY, *et al.*,

Defendants-Appellants.

On Appeal from the United States District Court
for the Eastern District of Arkansas (Hon. Kristine Baker)

BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFF-APPELLEE AND AFFIRMANCE

Janice M. Mac Avoy
(Eighth Circuit admission pending)
Andrew B. Cashmore
Kira M. Whitacre
FRIED, FRANK, HARRIS, SHRIVER
& JACOBSON LLP
Counsel for Amicus Curiae *American College of Obstetricians and Gynecologists*
One New York Plaza
New York, New York 10004
212-859-8000

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, *Amicus Curiae* American College of Obstetricians and Gynecologists certifies that it is not a corporation that issues shares to the public.

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IDENTITY AND INTEREST OF *AMICUS CURIAE*

The American College of Obstetricians and Gynecologists ("ACOG") submits this brief *amicus curiae* in support of the Plaintiffs-Appellee.[1] ACOG is a national non-profit educational and professional organization that works to promote the advancement of women's health through continuing medical education, practice, research, and advocacy. With more than 58,000 members, including 275 obstetrician-gynecologists in Arkansas, ACOG is the leading organization of women's health care providers.

ACOG is dedicated to continuously improving all aspects of healthcare for women, establishing and maintaining the highest possible standards for education and clinical practice, promoting high ethical standards, publishing evidence-based practice guidelines, encouraging contributions to medical and scientific literature, and increasing awareness among its members and the public about the changing issues facing women's healthcare. ACOG's work has often been cited by federal

[1] Pursuant to Federal Rule of Appellate Procedure 29, undersigned counsel for ACOG certify that: no party's counsel authored this *amicus* brief in whole or in part; no party or party's counsel contributed money that was intended to fund preparing or submitting this *amicus* brief; and no person or entity, other than ACOG, its members, or its counsel, contributed money intended to fund the preparation of submission of this *amicus* brief.

courts, including the Supreme Court of the United States, as authoritative medical data.[2]

ACOG continues to affirm the legal right of a woman to obtain an abortion and believes women's decisions about whether to have an abortion should be made in consultation with their health care providers and without undue interference by outside parties.[3] While ACOG recognizes and respects that individuals may be personally opposed to abortion, outside parties, including legislators, must not assert their own personal beliefs in a way that compromises patients' access to care.[4] Therefore, it is ACOG's position that laws regulating medical care that

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[2] *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing ACOG's *amicus* brief in assessing disputed admitting privileges and surgical center requirements); *Hodgson v. Minn.*, 497 U.S. 417, 454 n. 38 (1990) (citing ACOG's *amicus* brief in assessing disputed parental notification requirement); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 916-17 (9th Cir. 2014) (citing ACOG and the American Medical Association's *amicus* brief as further support for a particular medical regimen), *cert. denied*, 135 S. Ct. 870 (2014); *Stuart v. Camnitz*, 774 F.3d 238, 251-52, 254, 255 (4th Cir. 2014) (citing ACOG and the AMA's *amicus* brief in assessing how an ultrasound requirement exceeded the bounds of traditional informed consent and interfered with physicians' medical judgment), *cert. denied*, 135 S. Ct. 2838 (2015).

[3] ACOG, *College Statement of Policy*, *Abortion Policy*, (Jan. 1993, re-aff'd 2014) ("Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties.").

[4] *See Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016); ACOG, *College Statement of Policy*, *Abortion Policy*, (Jan. 1993, re-aff'd 2014).

unduly interfere with a physician's ability to act in the best interest of his or her patient should be struck down.

SUMMARY OF ARGUMENT

Ark. Code Ann. § 20-16-1803 (the "D&E Ban" or the "Ban") criminalizes the safest and most common method of second-trimester abortion, dilation and evacuation ("D&E") in Arkansas. D&E accounts for all second-trimester abortions in Arkansas and nationwide is the most common method of abortion provided beginning early in the second trimester.

The State suggests that under the D&E Ban, physicians can still perform D&E so long as they first perform an additional procedure to attempt to cause fetal demise. This is a false choice, however. There is no guarantee that any fetal demise procedure will be successful, meaning that no physician can attempt D&E without risking either being unable to complete the procedure—which puts the patient's health at risk—or being subject to civil liability and criminal penalties associated with a Class D felony under Arkansas law. ACOG is not aware of any physician in Arkansas willing to perform D&E if the Ban goes into effect, rendering second-trimester abortions effectively unavailable for all women who require it.

The Ban is also untenable from a medical perspective. Attempting fetal demise in the early stages of the second trimester, when most second-trimester

abortions are performed, is inadequately studied and can present extreme health risks. The procedures used to attempt fetal demise are not medically appropriate for every patient, and, in all cases, create health risks to the woman. Indeed, ACOG is not aware of a single study that supports the State's contention that first inducing fetal demise makes D&E safer. The only other second-trimester abortion method, medical induction, is not performed in Arkansas. As a result, the Ban has the practical effect of eliminating all second-trimester abortions in Arkansas. Because of the health risks associated with attempting fetal demise procedures in the early second trimester and the unavailability of medical induction, the District Court issued a preliminary injunction against the Ban.

Moreover, the Ban interferes with the physician-patient relationship by placing physicians in the ethically untenable position of either (i) denying access to D&E, or (ii) violating the law and risking criminal and civil penalties. Because the D&E Ban effectively eliminates access to the safest and most common method of second-trimester abortion in Arkansas, increases health risks for all women who seek second-trimester abortion, does nothing to protect or advance patient health, and unduly interferes with the physician-patient relationship, the Court should affirm the District Court's decision to enjoin the Ban.

ARGUMENT

I. The Ban Criminalizes the Safest and Most Common Method of Second-Trimester Abortion in Arkansas

A. D&E Is the Safest and Most Common Method of Second-Trimester Abortion in Arkansas

In performing D&E, a physician first dilates a patient's cervix and then evacuates the uterus by removing tissue through the cervix and vagina. D&E was developed in the 1970s as a safer alternative to other methods of abortion used at that time, including medical induction.[5] Today, one hundred percent of second-trimester abortions in Arkansas are performed using D&E.[6]

Medical induction is far less commonly used to perform second-trimester abortions, and involves the administration of drugs to induce contractions and cause a woman to undergo labor.[7] Medical induction also requires a physician to use osmotic cervical dilators to dilate the cervix 24 hours before labor is induced.[8] Because of the complications associated with labor, medical induction occurs in a

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[5] ACOG, Practice Bulletin No. 135, *Second Trimester Abortion*, 121 Obstetrics & Gynecology 1394, 1395 (2013).

[6] Center for Health Statistics, Arkansas Department of Health, *Induced Abortions by Probable Post-Fertilization (PPF) and Type of Procedure Arkansas Occurrences – 2016*, (May 30, 2017).

[7] ACOG, s*upra*, note 5, at 1395-96. Second-trimester abortion can also be effected by hysterectomy or hysterotomy, but these methods pose much higher risks of complication than D&E and medical abortion and will only be used if the latter two methods fail. *Id.* at 1396.

[8] ACOG, *Frequently Asked Questions Special Procedures*, (May 2015), https://www.acog.org/Patients/FAQs/Induced-Abortion.

hospital or hospital-like facility, rather than an outpatient clinic.[9] The procedure can involve significant pain, requiring medication and anesthesia, and can last from 12 hours to several days.[10] Women who undergo medical induction often receive treatment in maternity wards, alongside women who are delivering babies. Such an environment may be very difficult for women who are terminating wanted pregnancies for medical reasons, and may expose women to hospital staff with a strong moral antipathy to abortion.[11]

Although medical induction is generally safe, it does involve risks, including uterine rupture, a rare but potentially life-threatening condition that can be especially problematic for women who have had multiple previous cesarean deliveries.[12] Another risk, in approximately five percent to ten percent of procedures, is retained placenta, a condition which can cause hemorrhage and requires a surgical procedure to remedy.[13] In addition, some medical inductions

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[9] *See id.*

[10] *See* ACOG, s*upra*, note 5, at 1395-96; ACOG, *Frequently Asked Questions Special Procedures*, (May 2015), https://www.acog.org/Patients/FAQs/Induced-Abortion. *See also* MAUREEN PAUL ET AL., MANAGEMENT OF UNINTENDED AND ABNORMAL PREGNANCY, 159 (M. Paul et al. eds., 1st ed. 2009).

[11] MAUREEN PAUL ET AL., s*upra*, note 10, at 159.

[12] ACOG, *supra*, note 5, at 1397.

[13] *See id.* at 1398; A.M. Autry et al., *A Comparison of Medical Induction and Dilation and Evacuation for Second-Trimester Abortion*, 187 Am. J. Obstetrics & Gynecology 393, 396 (2002).

fail.[14] If medical induction results in an incomplete abortion, D&E would be necessary but effectively unavailable in Arkansas because of the Ban.

More than four decades of data demonstrate that D&E is the safest method of abortion starting early in the second trimester.[15] It results in fewer medical complications than medical induction—in fact, major complications arise in less than one percent of D&E procedures.[16] D&E constitutes the overwhelming majority of abortions in the United States starting early in the second trimester.

D&E can be completed in approximately 30 minutes and is performed in outpatient, rather than hospital, settings.[17] Ensuring access to D&E is especially significant in Arkansas, where virtually all abortions occur in clinical settings.[18] Because D&E involves the administration of fewer drugs and does not require

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[14] *See* ACOG, *supra*, note 5, at 1396; A.M. Autry et al., *supra*, note 13, at 395 (reporting that medical induction failed for 11 study participants who had to then undergo D&E).

[15] ACOG, *supra*, note 5, at 1395.

[16] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstetrics & Gynecology 175, 181 (2015).

[17] ACOG, *Frequently Asked Questions Special Procedures*, (May 2015), https://www.acog.org/Patients/FAQs/Induced-Abortion; MAUREEN PAUL ET AL., s*upra*, note 10, at 158-59. In Arkansas, D&E typically is a one-day procedure from 14.0 to 17.6 weeks LMP.

[18] *Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1035 (E.D. Ark. 2017) ("There are only two entities providing abortion care in Arkansas: Little Rock Family Planning Services, which provides abortions through 21.6 LMP, and Planned Parenthood Great Plains, which provides only medication abortion through 10 weeks LMP in Little Rock and Fayetteville, Arkansas. If hospitals in Arkansas are providing any abortion care, it is in only rare circumstances.") (citations omitted).

hospitalization, more physicians are able to provide it and it is more affordable for women.[19]

B. It Is Medically Inappropriate to Require Physicians to Attempt Fetal Demise

The State suggests that D&E could still be available under the Ban so long as fetal demise is first induced through one of three ways: digoxin injection, potassium chloride injection, or umbilical cord transection. As discussed below, each procedure poses health risks above and beyond those associated with standalone D&E, and none offer any counterbalancing medical benefit. ACOG is not aware of any evidence that suggests that attempting fetal demise enhances the safety of D&E.[20] To the contrary, each procedure is contraindicated for certain groups of patients, and some studies have shown that attempting fetal demise can result in labor and extramural delivery.[21] Far from advancing women's health, the

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[19] *See* ACOG, *supra*, note 5, at 1398.

[20] *Id.* at 1396; *see also* Society of Family Planning, *Induction of Fetal Demise Before Abortion*, 81 Contraception 462, 463 (2010) ("Although numerous methods have been used over the years to achieve fetal demise, data remain scarce documenting the effect of these techniques upon the safety of the abortion itself."); David A. Grimes et al., *Feticidal Digoxin Injection Before Dilation and Evacuation Abortion Evidence and Ethics*, 85 Contraception 140, 140 (2012) (noting that while some physicians claim fetal demise makes D&E easier, there is no evidence to support this hypothesis); Danielle Roncari et al., *Inflammation or Injection at the Time of Second Trimester Induced Abortion*, 87 Contraception 67, 67 (2013) (noting that the usefulness of induced fetal demise remains unknown).

[21] Danielle Roncari et al., *supra*, note 20, at 68; *see also* Gillian Dean et al., *Safety of Digoxin for Fetal Demise Before Second-Trimester Abortion by Dilation and Evacuation*, 85 Contraception 144, 148 (2012) (finding that digoxin before D&E is

D&E Ban prevents physicians in Arkansas from offering the safest method of abortion.

1. *Digoxin Injection*

To attempt fetal demise by digoxin injection, a physician attempts to inject the drug digoxin directly into the fetus or, if that is not possible, into the amniotic fluid. Digoxin injections are difficult to administer successfully, as a physician must use a spinal needle under ultrasound guidance to inject the drug through the patient's abdomen, vaginal wall, or vagina and cervix.

Digoxin injections do not cause fetal demise in all cases,[22] and ACOG is unaware of any evidence-based guidelines regarding administration of repeat injections of digoxin. Nor are there any reported studies about the benefits or risks to women of using multiple digoxin injections should a first dose fail.

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associated with increased rates of spontaneous abortion and recommending that digoxin injections not be administered prior to D&E).

[22] *See, e.g.*, Society of Family Planning, *supra*, note 20, at 467 (reporting that in a retrospective cohort study, there was an eight percent failure rate among women who received intra-amniotic digoxin and a four percent failure rate among women who received various doses of intrafetal digoxin); David A. Grimes et al., *supra*, note 20, at 140 ("[D]igoxin injection may fail to achieve its primary objective: from zero percent to seventy percent of first injections are unsuccessful in causing fetal demise, depending on dose and route of administration."); Aileen M. Gariepy et al., *Transvaginal Administration of Intraamniotic Digoxin Prior to Dilation and Evacuation*, 87 Contraception 76 (2013) (finding in a prospective study, digoxin administration was unsuccessful in eight percent of participants).

Even when successful, digoxin works slowly and can take up to 24 hours to cause fetal demise. Because overnight dilation is not part of D&E in the early weeks of the second trimester, when most D&Es take place, and it is often not part of D&E later in the second trimester, D&E in Arkansas is typically a one-day procedure. A woman required to receive digoxin injections would thus have to make an additional trip in advance of her abortion, unless she is already having osmotic dilators placed in her cervix the day before the evacuation. Further, digoxin injections are more difficult to administer in the early stages of pregnancy due to the small size of the fetus. This is a significant consideration in light of the fact that most second-trimester abortions occur in the early weeks of the second trimester. ACOG is not aware of any reported studies that show the effects of the drug prior to 18 weeks, making it impossible for physicians to determine whether the procedure is appropriate or safe for patients in that stage of pregnancy.

It is highly inappropriate to require physicians to perform a procedure that is medically unnecessary and for which the risks, complication rates, and efficacy are unknown.[23]

Additionally, digoxin injections are contraindicated for certain groups of women. For example, digoxin injections are not medically appropriate for women

[23] David A. Grimes et al., *supra*, note 20, at 142 ("The risk/benefit equation argues against routine feticidal digoxin injection. . . . [F]eticidal injection of digoxin should be offered only in the context of a formal research study.").

who are obese,[24] or who have anatomical variations such as a long cervix or fibroids. Further, accidental absorption of the drug into a woman's circulation can result in toxicity or can cause consumptive coagulopathy, a condition affecting the blood's ability to clot.[25] Digoxin injections also pose risks for women who do not fall into any of these patient groups, including infection that can create risks to their health.[26]

2. *Potassium Chloride Injection*

To cause fetal demise by potassium chloride, a physician uses a spinal needle to inject potassium chloride directly into a fetal heart under the guidance of an advanced ultrasound machine. Attempting fetal demise by potassium chloride is an unfeasible procedure in Arkansas: it carries extreme health risks, must be administered by physicians who have received specialized training, is very difficult to administer, and is effectively unavailable in Arkansas.

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[24] Aileen M. Gariepy et al., *Transvaginal Administration of Intraamnitoic Digoxin Prior to Dilation and Evacuation*, 87 Contraception 76, 76 (2013) (finding that when digoxin is injected under a transabodminal approach, it is difficult for the physician to accomplish on obese patients).

[25] *See* Society of Family Planning, *supra*, note 20, at 463, 469.

[26] ACOG, s*upra*, note 5, at 1396 (noting that a retrospective cohort study reported increased odds of infection after digoxin use); *see also* Gillian Dean et al., *Safety of Digoxin for Fetal Demise Before Second-Trimester Abortion by Dilation and Evacuation*, 85 Contraception 144, 145 (2012) (finding infection to be a primary outcome of their retrospective cohort study on digoxin use to induce fetal demise prior to D&E); MAUREEN PAUL ET AL., s*upra*, note 10, at 168 ("Any procedure associated with transabdominal needle placement into the uterine cavity can result in maternal infection.").

Potassium chloride injections are much more difficult and risky to administer than digoxin. During the second trimester, the fetal heart is smaller than a dime. Successfully injecting potassium chloride is very challenging to accomplish, even by trained physicians who undergo the necessary additional training. Potassium chloride training is not a part of standard ob-gyn curricula and, as a result, few physicians are qualified to offer the procedure.

Potassium chloride injections also pose risks that can be severe. For example, injections administered incorrectly can have a devastating impact on the woman's health, including infection of varying degrees or cardiac arrest.[27] Because of the risks associated with injecting potassium chloride into a woman's body, physicians must rely on advanced ultrasound technology that is typically available only in hospitals. By contrast, D&E can occur in outpatient settings. Because clinics are generally unable to afford the ultrasound equipment required to inject potassium chloride, few physicians are trained in its administration, and because injecting potassium chloride carries high risks for patients, it is a rarely used procedure.

[27] Society of Family Planning, *supra*, note 20, at 468-69 (noting that potassium chloride injections have caused maternal cardiac arrest and infection).

3. *Umbilical Cord Transection*

Attempting fetal demise by transecting the umbilical cord requires a physician to rupture the amniotic membrane by inserting a suction tube or other instrument, such as forceps, into the uterus to grasp the umbilical cord, if possible, and sever it. Cord transection is a technically challenging, rarely used, unpredictable procedure. First, rupturing the amniotic membrane causes amniotic fluid to drain. This immediately causes the uterus to compress, making it difficult to identify the cord and increasing the likelihood that the physician's instruments may injure the woman. Second, the procedure's success depends in large part on the placement of the umbilical cord. If the umbilical cord is blocked by the fetus, it may be difficult and risky for a physician to attempt to reach it.

Attempting to transect the umbilical cord involves inherent risks. If a physician begins the procedure but ultimately determines that transection is not possible, the patient is left with a ruptured amniotic membrane, creating a high risk of infection. The procedure can also create blood loss, placental separation, contractions, infection, and even uterine perforation.

Similar to induced fetal demise by injection, umbilical cord transection is more difficult to perform in the earlier stages of pregnancy and is hardly

researched.[28] ACOG is not aware of any studies regarding attempted transection in the early weeks of the second trimester. ACOG is aware of only one study on transection later in the second trimester, and reliance on that study is problematic. The study included procedures performed by only two providers in a single setting and therefore cannot be generalizable.[29] Moreover, it lacked a control group, and it did not evaluate how much time or how many passes it took to successfully grasp and transect the cord in the cases it considered.[30]

II. The Ban Places Physicians in an Ethically Compromising Position

ACOG is committed to the right of every woman to access the "best available, scientifically based health care."[31] For women who seek second-trimester abortion, the best available scientifically-based health care includes D&E.

A. The Ethical Dilemma

To comply with the D&E Ban, physicians must either deny access to the safest and most common form of second-trimester abortion in Arkansas, or attempt one of three understudied or high-risk procedures to attempt to induce fetal demise,

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[28] Society of Family Planning, *supra*, note 20, at 463, 466 (noting that umbilical cord transection has not been investigated rigorously nor described recently in the medical literature as a technique before abortion).
[29] Kristina Tocce et al., *Umbilical Cord Transection to Induce Fetal Demise Prior to Second-Trimester D&E Abortion*, 88 Contraception 712 (2013).
[30] *Id.*
[31] ACOG, *Statement of Policy*, *Global Women's Health and Rights* (July 2012, re-aff'd), http://www.acog.org/-/media/Statements-of-policy/public/2012GlobalWmHlthRights.pdf.

regardless of whether doing so is deemed medically appropriate by the physician. The Ban conflicts with physicians' professional and ethical obligations to provide optimal and individualized care for each patient according to their professional judgment. If a physician determines that inducing fetal demise prior to D&E is medically inappropriate for a particular patient, the Ban would force the physician to either deny her the safest procedure available or risk incurring civil or criminal penalties for violating the law.

Physicians are ethically required to exercise all reasonable means to ensure that patients receive most appropriate care.[32] These ethical obligations are expressed through the principles of beneficence, non-maleficence, and patient autonomy.[33] Beneficence requires physicians to act in a way that is likely to benefit patients.[34] Non-maleficence directs physicians to refrain from acting in ways that might harm patients unless the harm is justified by concomitant benefits.[35] If a physician believes it is in a patient's best interest to undergo D&E

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[32] ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, at 1-2 (2011), https://www.acog.org/-/media/Departments/National-Officer-Nominations-Process/ACOGcode.pdf?dmc=1&ts=20180104T2059488380; *see also* American Medical Association, *Principles of Medical Ethics*, § 1.1.3(b) (2016).
[33] ACOG, *Ethical Decision Making in Obstetrics & Gynecology*, Committee Opinion No. 390, at 1 (Dec. 2007, re-aff'd 2016).
[34] *Id.* at 3.
[35] *Id.*

but is nonetheless forced to first attempt fetal demise, the physician cannot fulfill their duties of beneficence and non-maleficence.

Autonomy recognizes that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions. The principle also requires physicians to honor patient decisions about the course of their care.[36] The injustice of the Ban is all the more apparent in this context, where the law would prevent a physician from offering a patient D&E, even though it may be the safest method available.

ACOG recognizes that attempting fetal demise may be appropriate in some cases for some patients. However, the decision to attempt fetal demise is one that must be left to a physician's medical judgment based on each patient's circumstances. All three procedures that can be used to attempt fetal demise pose health risks, do not always work, and are not appropriate for all patients. It is imperative that physicians be permitted to consider a patient's health to determine whether attempting fetal demise in a particular instance is safe and appropriate. What a physician deems to be medically suitable for one patient will not always be the best course of action for another.

[36] *Id.*

B. Because of the Ban, No Physician in the State of Arkansas Will Perform D&E

Safe abortion care can exist only if women are able to access trained abortion providers.[37] In 2016, one hundred percent of second-trimester abortions in Arkansas were performed using D&E.[38] All of these abortions occurred at the only facility in Arkansas that offers second-trimester abortions, Little Rock Family Planning Services. Dr. Frederick Hopkins, who is a physician at the center and the plaintiff in this case, has stated that he will stop performing second-trimester D&E altogether due to the ethical and legal concerns created by the Ban. As a result, the Ban will effectively preclude all women in Arkansas from having access to second-trimester abortion.

An additional concern is the risk that women will resort to measures outside of a medical setting to obtain an abortion. Historical data show that where access is limited, women often resort to unsafe means to end an unwanted pregnancy, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, and reliance on unqualified abortion providers.[39] Today, approximately

[37] ACOG, Committee Opinion No. 612, *Abortion Training and Education*, at 1 (Nov. 2014, re-aff'd 2017).
[38] Center for Health Statistics, Arkansas Department of Health, *Induced Abortions by Probable Post-Fertilization (PPF) and Type of Procedure Arkansas Occurrences – 2016*, (May 30, 2017).
[39] ACOG, Committee Opinion No. 613, *Increasing Access to Abortion*, at 2 (Nov. 2014, re-aff'd 2017).

21 million women worldwide obtain unsafe abortions each year, and they result in approximately 50,000 maternal deaths annually.[40]

ACOG opposes laws that interfere with patients' ability to be treated according to the best currently available medical evidence and physicians' medical judgment.[41] As the Supreme Court has consistently articulated, laws regulating abortion care that unduly interfere with a physician's ability to act in the best interest of his or her patient should be struck down.[42]

C. The D&E Ban Improperly Intrudes Into the Patient-Physician Relationship

The Ban creates a dangerous precedent for legislatures to inject political views into the patient-physician relationship by permitting legislators to determine which medical procedures they deem suitable for patients without a medical or

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[40] *Id.*

[41] ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, (May 2013).

> Laws should not interfere with the ability of physicians to determine appropriate treatment options and have open, honest, and confidential communications with their patients. Nor should laws interfere with the patient's right to be counseled by a physician according to the best currently available medical evidence and the physician's medical judgment. . . . Laws that require physicians to give, or withhold, specific information when counseling patients, or that mandate which tests, procedures, treatment alternatives or medicines physicians can perform, prescribe, or administer are ill-advised.

Id.

[42] *See Planned Parenthood v. Casey*, 505 U.S. 833 (1992); *see also Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

public health justification. Political considerations, especially those which have no scientific basis, should not restrict physicians' ability to exercise sound medical judgment and provide patients with a full range of safe and quality care.

CONCLUSION

For all of the reasons stated above, the Ban should not be implemented. This Court should affirm the District Court's injunction.

Dated: February 27, 2018

Respectfully submitted,

FRIED, FRANK, HARRIS, SHRIVER & JACOBSON LLP

s/ Andrew B. Cashmore

JANICE M. MAC AVOY (*Eighth Circuit admission pending)*
ANDREW B. CASHMORE
KIRA M. WHITACRE
One New York Plaza
New York, New York 10004
andrew.cashmore@friedfrank.com
(212) 859-8000
Counsel for Amicus Curiae American College of Obstetricians and Gynecologists

CERTIFICATE OF COMPLIANCE WITH TYPE FACE REQUIREMENTS, TYPE STYLE REQUIREMENTS, AND TYPE-VOLUME LIMITATIONS PURSUANT TO FED. R. APP. P. 32

I hereby certify that this brief complies with the typeface requirements of Federal Rules Appellate Procedure 32(a)(5) and the type styles requirements of Federal Rules of Appellate Procedure 32(a)(6) because it has been prepared in 14-point Times New Roman, a proportionally spaced typeface.

I further certify that this brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 32(a)(7)(B) and 29(a)(5) because it contains 4,363 words, excluding parts of the brief exempted under Rule 32(f), according to the count of Microsoft Word.

Dated: February 27, 2018

s/ Andrew B. Cashmore
ANDREW B. CASHMORE

CERTIFICATE OF COMPLIANCE WITH EIGHTH CIRCUIT RULE 28A(h)(2)

Pursuant to this Court's Rule 28A(h)(2), I hereby certify that the electronic version of this Brief of American College of Obstetricians and Gynecologists as *Amicus Curiae* in Support of Plaintiff-Appellee has been scanned for viruses and is virus-free.

Dated: February 27, 2018

s/ Andrew B. Cashmore
ANDREW B. CASHMORE