No. 18-60868

IN THE

United States Court of Appeals

FOR THE FIFTH CIRCUIT

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients; SACHEEN CARR-ELLIS, M.D., M.P.H., on behalf of herself and her patients,

Plaintiffs-Appellees,

v.

THOMAS E. DOBBS, M.D., M.P.H., in his official capacity as State Health Officer of the Mississippi Department of Health; KENNETH CLEVELAND, M.D., in his official capacity as Executive Director of the Mississippi State Board of Medical Licensure,

Defendants-Appellants.

On Appeal from the United States District Court for the Southern District of Mississippi, Northern Division (Hon. Carlton W. Reeves)
No. 3:18-cv-171

BRIEF OF SOCIETY FOR MATERNAL-FETAL MEDICINE AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that—in addition to the persons and entities listed in the appellees' Certificate of Interested Persons—the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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IDENTITY AND INTEREST OF *AMICUS CURIAE*[1]

Founded in 1977, the Society for Maternal-Fetal Medicine ("SMFM") is the medical professional society for obstetricians who have additional training in the area of high-risk, complicated pregnancies. Representing over 4,000 members who care for high-risk pregnant women, SMFM supports the clinical practice of maternal-fetal medicine by providing education, promoting research, and engaging in advocacy to reduce disparities and optimize the health of high-risk pregnant women and their babies. SMFM and its members are dedicated to optimizing maternal and child outcomes and assuring that medically appropriate treatment options are available is critically important. SMFM has advocated at the state and federal level to ensure that high-risk women can make informed, reproductive health decisions in consultation with her healthcare provider and have access to the full spectrum of reproductive health services.

[1] Pursuant to Federal Rule of Appellate Procedure 29, undersigned counsel for SMFM 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 SMFM, their members, or their counsel, contributed money intended to fund the preparation of submission of this *amicus* brief. All parties have consented to SMFM filing this *amicus* brief in this litigation.

SUMMARY OF ARGUMENT

Mississippi House Bill 1510[2] (the "Ban"), if implemented, will infringe a woman's constitutional right to have an abortion prior to viability. Since 1973, the Supreme Court has recognized that a woman has the sole right to choose to terminate her pregnancy at any point prior to viability. During this time, the State's interests are insufficient to interfere with a woman's right to choose abortion care. Said another way, no state interest is sufficient to justify a ban on abortion prior to viability. Despite this well settled precedent, the State believes it can nonetheless effectively ban all abortions in Mississippi after 15 weeks from the last menstrual period ("LMP").[3] Because the Ban usurps a woman's fundamental right to choose to terminate a pre-viable pregnancy, it is unconstitutional. This is where the analysis should end.

Instead, Mississippi ignores this precedent prohibiting pre-viability bans and attempts to justify the Ban by introducing a newly framed state interest: preventing fetal pain in fetuses with a gestational age between 15 and 20 weeks LMP. Yet, it is well established and widely-accepted within the medical community that a fetus is not capable of perceiving pain prior to 26 weeks LMP. To dispute this, the State

[2] ROA.762-773.
[3] For clarity, the Ban prohibits abortion at 15 weeks 0 days LMP, not 15 completed weeks LMP.

relies on an alleged expert witness whose testimony consists of an outlier opinion based on unsound arguments and not subject to peer review.

In addition, if the Ban goes into effect, Mississippi women will be subjected to greater risks than they would be if they were able to access legal abortion care. Carrying a pregnancy to term and giving birth is far more dangerous for a woman's health and exposes her to a greater risk of maternal mortality. For women living with degenerative health conditions, they will have no choice but to carry their pregnancy to term, as the narrow medical emergency exception will not protect them.

The Ban will thus place physicians in an ethically untenable position; unless the Ban's narrow exceptions apply, a pregnant woman cannot receive an abortion even if her physician decides that it is in the patient's best interests. Physicians will be forced to choose between obeying the law and their ethical duty to administer the medically appropriate care women may require.

Accordingly, while none of the State's interests could justify the Ban under controlling law, the purported facts the State presents to support its interests are simply wrong. Because the Ban prohibits a woman from making the ultimate decision about whether to continue her pregnancy before viability, this Court should affirm the District Court's decision to permanently enjoin the Ban.

I. THE STATE'S ALLEGED INTERESTS ARE LEGALLY IMMATERIAL BECAUSE STATES CANNOT BAN ABORTION PRIOR TO VIABILITY

It is well settled constitutional precedent, confirmed by the Supreme Court just a few years ago, that a State may not interfere with a woman's right to an abortion prior to viability.[4] The only controlling issue before the court is whether the Ban unconstitutionally interferes with that right. All other arguments that the State presents are legally immaterial and are a mere distraction.

It is abundantly clear that the Ban unconstitutionally prohibits abortion prior to viability. A fetus is only viable if there is a reasonable likelihood that it will be able to survive for a sustained period of time outside the womb.[5] Even without knowing the precise moment of viability, the scientific community agrees viability at 15 weeks LMP is not possible. In fact, not a single fetus delivered prior to 22 weeks LMP has ever survived.[6]

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[4] *See Roe v. Wade*, 410 U.S. 113, 163-64 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992); *Stenberg v. Carhart*, 530 U.S. 914, 920-21 (2000); *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2299 (2016).

[5] *Colautti v. Franklin*, 439 U.S. 379, 388 (1979).

[6] Matthew A. Rysavy et al., *Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants*, 372 N Engl J Med 1801 (2015); *see also* Later Abortion Initiative, Ibis Reproductive Health, *The Science of "Viability"* (Apr. 2018), *available at:* http://www.laterabortion.org/sites/default/files/lai_factsheet_viability.pdf (*last visited* Mar. 20, 2019).

The American College of Obstetricians and Gynecologists ("ACOG") and SMFM define the period of periviable delivery between approximately 20 and 25 weeks LMP. Even then, a fetus delivered between 22 and 23 weeks LMP require extraordinary life-saving intervention. A fetus of this age has a survival rate of only 5-6% and in almost all cases, *still* result in death.[7] Prior to 22 weeks LMP, life-saving intervention is not even medically possible; the lungs, arteries, and veins are too underdeveloped to allow for oxygenation and the skin is too weak to maintain body temperature.

If implemented, the Ban would prohibit abortions after 15 weeks LMP, more many weeks many weeks before viability is possible. For this reason, the Ban is not a permissible regulation, but rather a restriction on pre-viability abortions and is unconstitutional on these grounds alone.

II. SCIENTIFIC EVIDENCE SHOWS THAT A FETUS CANNOT EXPERIENCE PAIN PRIOR TO 24 WEEKS OF GESTATION

Based on long-standing Supreme Court precedent, the Court's analysis should start and end with the question of viability.[8] However, because the State cannot ignore that the Ban is a pre-viability prohibition on abortion, the State

[7] ACOG & SMFM, *Obstetric Care Consensus*, 130 Obstetrics & Gynecology e187, e188 (2017).

[8] *See Roe v. Wade*, 410 U.S. 113, 163-64 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992); *Stenberg v. Carhart*, 530 U.S. 914, 920-21 (2000); *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2299 (2016).

instead attempts to persuade the Court that the threshold question should be based on the ill-founded concept of fetal pain, an unsupported view on maternal health, and a distorted opinion on medical ethics. Nonetheless, the State's arguments still fail.

A. A Fetus Lacks the Capacity to Experience Pain During the Period in which Abortions are Currently Legal in Mississippi

The widely-accepted scientific consensus in the medical community is that the human fetus: (1) does not develop the necessary fetal brain connections required to perceive pain before at least 24 weeks of gestation, and (2) does not develop the capacity required for conscious perception of pain until at least the third trimester. This conclusion has been published, peer-reviewed, and re-affirmed many times, including by a group of experts at the University of California, San Francisco in 2005,[9] the Royal College of Obstetricians and

[9] Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947, 952 (Aug. 24/31 2005) (concluding that a human fetus probably does not have the capacity to experience pain until 29 weeks of gestation at the earliest).

Gynecologists ("RCOG") in March 2010,[10] and by researchers from the University of Siena in Siena, Italy, in 2012.[11]

The ability to perceive pain is precluded by human physical development prior to 24 weeks of gestation (26 weeks LMP). A fetus does not develop the neural connections necessary to transmit signals from peripheral sensory nerves to the brain until at least 24 weeks of gestation.[12] Moreover, prior to that time, the fetal brain lacks the ability to transmit or process those signals, because the structures of the brain that facilitate those functions have not yet developed.[13]

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[10] RCOG, *Fetal Awareness: Review of Research and Recommendations for Practice*, at 11 (Mar. 2010) (concluding that "[t]he lack of cortical connections before 24 weeks … implies that pain is not possible until after 24 weeks" and "[e]ven after 24 weeks of gestation, there is continuing development and elaboration of intracortical networks") [hereinafter *Fetal Awareness*].

[11] Carlo V. Bellieni & Giuseppe Buonocore, *Is Fetal Pain A Real Evidence?*, 25 J. Maternal-Fetal & Neonatal Med. 1203, 1205 (2012) ("Our data show that there is consistent evidence of the possibility for the fetus to experience pain in the third trimester, and this evidence is weaker before this date and null in the first half of pregnancy.").

[12] RCOG, *Fetal Awareness*, at 11; Lee et al., 294 JAMA at 949-50; *see also* ACOG, Wisconsin Section, *20-Week Abortion Ban Legislation*, at 1 https://images.magnetmail.net/images/clients/ACOG/attach/WI_IssuePaper20WeekAbortionBan_updated.pdf.

[13] RCOG, *Fetal Awareness*, at 11 ("Connections from the periphery to the cortex are not intact before 24 weeks of gestation."); Stuart W.G. Derbyshire et al., *Can Fetuses Feel Pain?*, 332 BMJ 909, 912 (Apr. 15, 2006) (stating that the "neuroanatomical system for pain can be considered complete by 26 weeks' gestation").

Simply put, a fetus does not have the physiological capacity to perceive pain until at least 24 weeks of gestation.[14]

A fetus's perception of pain is further limited by cognitive development. Perception of pain involves more than just the mechanical transmission and reception of signals within the brain; it is "an emotional and psychological experience that requires conscious recognition of a noxious stimulus."[15] The capacity for such conscious recognition does not develop until the third trimester at the earliest, long after the point at which Mississippi prohibits abortion under current law.[16] Indeed, evidence suggests that the neural circuitry necessary to distinguish touch from "nociception" (i.e., painful touch) does not develop until 35-37 weeks of gestation, which is even later in the third trimester.[17]

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[14] RCOG, *Fetal Awareness*, at 9; *see also* ACOG, *Facts are Important, Fetal Pain*, (July 2013).

[15] Susan J. Lee et al., 294 JAMA at 952; *see also* Derbyshire, 332 BMJ at 912 ("A developed neuroanatomical system is necessary but not sufficient for pain experience."); RCOG, *Fetal Awareness*, at 6 (discussing definition of pain).

[16] Lee et al., 294 JAMA at 947, 952; Bellieni & Buonocore, 25 J. Maternal-Fetal & Neonatal Med. at 1205; *see also* RCOG, *Fetal Awareness*, at 11 ("[T]he fetus is sedated by the physical environment of the womb and usually does not awaken before birth."); Derbyshire, 332 BMJ at 911 (concluding that "it is not possible for a fetus to experience pain"). Under Mississippi law, an abortion may not be performed if it is determined that the probable gestational age of the fetus is twenty weeks or greater. MISS. CODE ANN. § 41-41-137 (2014).

[17] Lorenzo Fabrizi et al., *A Shift in Sensory Processing that Enables the Developing Human Brain to Discriminate Touch from Pain*, 21 Current Biology 1552, 1552 (Sept. 27, 2011) (concluding that "specific neural circuits necessary for discrimination between touch and nociception emerge from 35-37 weeks gestation in the human brain").

B. The State's Argument on Fetal Pain Early in the Second Trimester is Based on Bad Science

The State's supposed support for the Ban is based on the testimony of one alleged expert who mistakenly, and without any peer reviewed evidence, asserts that fetuses are capable of experiencing pain during the time when abortion is permissible in Mississippi. The scientific community has rejected this argument. Specifically, RCOG and the Journal of the American Medical Association ("JAMA"), two leading experts in the scientific community on this topic, and ACOG, whose work has been consistently viewed as authoritative by the Supreme Court and various federal circuit courts,[18] agree that pain perception is nonexistent until late in the third trimester when the human fetus develops the required fetal brain connections necessary to perceive pain.

Despite this scientific consensus, the State's purported expert nonetheless attempts to attack the opinions set forth by RCOG, JAMA, and ACOG. However, at the most basic level, the State's expert misconstrues the fundamental principle

[18] *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing *amici* brief submitted by ACOG, the AMA, and other medical associations in assessing disputed admitting privileges and surgical center requirements); *Hodgson v. Minnesota*, 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 AMA's *amici* brief as further support for a particular medical regimen); *Stuart v. Camnitz*, 774 F.3d 238, 251-52, 254, 255 (4th Cir. 2014) (citing ACOG and the AMA's *amici* brief in assessing how an ultrasound requirement exceeded the bounds of traditional informed consent and interfered with physicians' medical judgment).

required to understand the development of pain perception: she equates "pain" to reflexes and hormonal responses.[19] While fetal development prior to 20 weeks LMP may be sufficient to generate reflexive behaviors and hormonal responses, this development is not sufficient to support pain awareness.[20] As reported by JAMA, pain is a subjective sensory and emotional experience that requires the presence of consciousness to permit recognition of a stimulus as unpleasant, a fact conceded by the State's alleged expert.[21]

Nonetheless, the State's expert fails to fully acknowledge the difference between responses to nociceptive stimuli and pain perception. As RCOG has stated, while a fetus may have the ability to respond to noxious stimuli, this does not mean the response necessarily demonstrates a perception of "pain."[22] In order to perceive pain, there must be cortical recognition of a stimulus.[23] The State's expert disagrees and assumes that pain perception exists even in the absence of cortical connections.[24] She contends that the functions required to detect and

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[19] *See* ROA.776.
[20] *See* RCOG, *Fetal Awareness*, at 7.
[21] Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947, 948 (Aug. 24/31 2005). ROA.779, 783, 787-88. ("What is *not* universally accepted is at what point in development the ability to detect and respond to pain becomes psychologically and emotionally meaningful…i.e., whether a fetus is capable of suffering.").
[22] RCOG, Fetal Awareness, at 7.
[23] *Id.* at 11.
[24] *See* ROA.781.

respond to pain are in place by 8 to 10 weeks of human development.[25] But again, as the scientific community has re-affirmed, for pain perception to exist, the cortex must be functional in order for there to be cognitive awareness of a stimulus.[26] As reported in JAMA, this development occurs late in the third trimester.[27] Any brain development short of cortical function will not allow for pain perception.

The State's expert also erroneously concluded, without support, that fetal pain must exist because medications used to relieve pain, such as anesthesia and analgesia, are used during fetal surgeries, simply ignoring the many other reasons these medications are appropriate during fetal surgery.[28] Anesthesia and analgesia may serve purposes unrelated to pain reduction, including: (1) maintaining physical stability during a procedure; (2) improving surgical access to the fetus and to prevent contractions and placental separation; (3) preventing hormonal stress responses associated with poor surgical outcomes; and (4) preventing possible adverse effects on long-term neurodevelopment.[29] Thus, the use of fetal anesthesia or analgesia in no way suggests, let alone proves, fetal pain.[30]

In sum, while the State's purported expert claims that her opinion on fetal pain is supported by an "extensive and diverse body of data," that opinion has

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[25] ROA.779.
[26] RCOG, Fetal Awareness, at 7.
[27] *See* Lee et al., 294 JAMA at 949.
[28] ROA.786.
[29] *See* Lee et al., 294 JAMA at 951.
[30] *Id.* at 952.

never been published, let alone peer reviewed.[31] In fact, not a single article that she cited reached the same conclusion as she did.[32] Her opinion is an outlier.[33] The State is left with only faulty arguments to support its alleged interest in preventing fetal pain in fetuses of certain gestational ages.

III. THE BAN ENDANGERS WOMEN'S HEALTH BY RESTRICTING ACCESS TO MEDICALLY NECESSARY ABORTIONS

Abortion is one of the safest medical procedures available to women. Yet, in enacting the Ban, the Legislature distorts a single study to conclude that abortions carry risks to the maternal patient after 15 weeks LMP.[34] This cherry-picked argument ignores both the rest of that study's findings and the conclusions of the broader scientific and medical community. The State's belief that it is

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[31] ROA.785.

[32] *See* ROA.781.

[33] The State's expert's opinions are themselves inconsistent. The State's alleged expert was deposed in a recent medical malpractice action as an alleged expert witness and opined that human fetuses can begin to perceive pain starting at eight weeks LMP. Disclosure of Expert Witness, *Elderkin, v. Greater New Haven OB-GYN Grp., P.C.*, No. NNH-CV-15-6056190-S (Conn. Super. Ct. Oct. 19, 2016). Following the opposing party's motion to preclude her testimony on the grounds that it lacked support, as evidenced by her admissions in the deposition, the plaintiffs removed her as one of their expert witnesses before the motion to preclude was ruled on. Plaintiffs' Witness List, *Elderkin, v. Greater New Haven OB-GYN Grp., P.C.*, No. NNH-CV-15-6056190-S (Conn. Super. Ct. Jan. 26, 2018).

[34] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstet. & Gynecol. 729 (Apr. 2004).

protecting women is unfounded and in fact would have the opposite effect -- it would *endanger* women's health and safety to ban abortion after 15 weeks.

A. The State Mistakenly Asserts that the Ban Protects Women from Physical Risks that Allegedly Arise From Abortion Care Post-15 Weeks LMP

Longstanding research has demonstrated that abortion is one of the safest procedures in modern medicine, regardless of whether the abortion is induced by medication or procedure.[35] This has been demonstrated time and time again by randomized controlled trials, large retrospective cohort studies, patient and provider surveys, systematic reviews, and epidemiological studies examining abortion care. For example, in a 2014 study, of the 1,000 women with pregnancies at various stages who received an abortion, approximately 95% of women experienced no complications.[36] In fact, abortion is so safe that there is a greater risk of mortality associated with colonoscopies, plastic surgery, dental procedures, and adult tonsillectomy than there is with abortion.[37]

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[35] *See* Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States* 10 (The National Academies Press 2018); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215, 215 (Feb. 2012); David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140 Annals Internal Med. 620, 623 (Apr. 20, 2004).

[36] Warren M. Hern, *Fetal Diagnostic Indications for Second and Third Trimester Outpatient Pregnancy Termination*, 34 Prenatal Diagnosis 438, 439 (2014).

[37] Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States* 75 (The National Academies Press 2018).

Statistically, there is a greater risk of maternal mortality in carrying a pregnancy to term as compared to receiving abortion care. As even the study relied on by the State points out, "[l]egal induced abortion-related deaths occur only rarely."[38] In the 25 years following the legalization of abortion, the risk of death from legal abortion declined dramatically by 85% (from 4.1% to 0.6%) with most of the decline occurring in the first three years.[39] From 1998 to 2005, the mortality rate related to abortions was reported to be 0.6 deaths per 100,000 procedures, whereas the mortality rate associated with live births during that same time period was 8.8 deaths per 100,000 live births.[40]

Finally, medical evidence demonstrates that carrying a pregnancy to term and giving birth is far riskier to a woman's health than an abortion. While risks related to abortion-related maternal mortality may get more complicated as the pregnancy advances, serious risks from abortions at all gestational ages are extremely rare and these risks do not approach the threshold of risks associated

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[38] Bartlett et al., 103 Obstet. & Gynecol. at 736.

[39] *Id.* at 733; *see also* Elizabeth G. Raymond, et al., *Mortality of Induced Abortion, Other Outpatient Surgical Procedures, and Common Activities in the United States*, 90 Contraception 476, 478-79 (July 18, 2014) (finding that the rate of death from legal abortion in the United States between 2000-2009 was 0.7 deaths per 1,000 procedures, and cautioning that this rate may substantially understate the safety of the majority of abortions, as this study included data for abortion performed at a late gestation age, when abortions are much rarer but more risky).

[40] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215, 216 (Feb. 2012).

with carrying a pregnancy to term.[41] In a 1998 to 2001 study, *all* studied maternal complications were found to be more common in women who gave birth as compared to women who received abortion care.[42] These complications ranged from moderate to potentially life-threatening, and included anemia, hypertensive disorders, pelvic or perineal trauma, mental health conditions, obstetric infections, postpartum hemorrhage, antepartum hemorrhage, asthma, and excessive vomiting.[43] The occurrence of complications related to carrying a pregnancy to term only lends credence to the widely-accepted consensus in the medical community that abortions are one of the least risky procedures.

B. The State Mistakenly Asserts that the Ban Protects Women from Psychological Risks that Allegedly Arise From Abortion Care Post-15 Weeks LMP

"Arguments that abortion causes women emotional harm, and that women come to regret abortions they decided to have, are used to … advance legislation restricting access to abortion."[44] Here, the State has tried to do just that. The State alleges that abortions carry significant psychological risks after 15 weeks LMP, but neither the Legislature, in enacting the Ban, nor the State, in this litigation, cite a single source for this proposition. This is not surprising. In 2008, the American

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[41] ACOG, Committee Opinion No. 613, *Increasing Access to Abortion*, at 2 (Nov. 2014, re-aff'd 2017); Raymond & Grimes, 119 Obstet. & Gynecol. at 217.
[42] Raymond & Grimes, 119 Obstet. & Gynecol. at 217.
[43] *Id.*
[44] Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to in the United States: A Longitudinal Study*, 10(7) PLOS ONE 1, 10 (July 8, 2015).

Psychological Association (the "APA") concluded that no sufficient evidence existed to support a claim that an observed association between abortion history and mental health is caused by abortion *per se*.[45]

To the contrary, the APA found that the best prediction of a woman's mental health after an abortion is the status of her mental health before she received an abortion.[46] Negative post-abortion psychological experiences can result from a variety of pre-abortion circumstances, including: (1) preexisting conditions, such as poverty; (2) life circumstances, such as exposure to violence or sexual abuse; and (3) personality characteristics, such as low perceived social support or low self-esteem.[47]

Similarly, researchers at the Johns Hopkins Bloomberg School of Public Health concluded that "the highest-quality research available does not support the hypothesis that abortion leads to long-term mental health problems" and noted that most of the studies reviewed had neutral findings suggesting few, if any, differences between women who had abortions and their respective comparison groups in terms of mental health issues.[48]

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[45] Brenda Major et al., *Report of the APA Task Force on Mental Health and Abortion*, at 91-2 (2008), *available at* http://www.apa.org/pi/*women*/programs/abortion/mental-health.pdf.
[46] *Id.* at 4, 92.
[47] *Id.* at 92.
[48] Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 448-49 (July 2, 2008).

In fact, a 2015 study found that 95% of the women participants felt that receiving an abortion was the right decision.[49] Moreover, of the 5% who stated that they regretted their decision, 89% confirmed that having an abortion was still the right decision for them.[50] This proved to be true regardless of whether the woman obtained the abortion earlier or later in the pregnancy.[51] Another study found that women who receive a requested abortion are actually better able to maintain a positive future outlook and achieve their aspirational life plans than women who are denied abortion care and must carry an unwanted pregnancy to term.[52] However, women who are denied abortions have reported greater anxiety and depression symptoms, lower self-esteem, and lower life satisfaction,[53] thus directly contradicting the State's purported interest in enhancing maternal health with the Ban.

C. The "Medical Emergency" Exception to the Ban Does Not Adequately Protect Women's Health

Because the Ban would effectively eliminate abortions after 15 weeks LMP, women that require an abortion, especially those experiencing a high-risk

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[49] Rocca et al., 10(7) PLOS ONE at 10.
[50] *Id*.
[51] *Id.*
[52] Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC Women's Health 102 (2015).
[53] 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, 169 (Dec. 14, 2016, corrected Jan. 18, 2017).

pregnancy, will face significant challenges to their health that will unnecessarily compromise their quality of life and survival. Medical emergencies, as defined by the Ban, are limited to situations where an abortion is necessary (1) to preserve the life of a pregnant woman whose life is endangered by a physical disorder, illness, or injury or (2) to prevent substantial and irreversible impairment of a major bodily function.[54]

The medical emergency exception is extremely narrow. There are many medical conditions that develop during or are aggravated by pregnancy that may not manifest or require treatment until after 15 weeks LMP. For example, medical conditions that may arise after that point that do not arise to a "medical emergency" include: alport syndrome, a form of kidney inflammation;[55] valvular heart disease, the abnormal closure of a heart valve that can occur in women with no history of cardiac symptoms;[56] lupus, a connective tissue disorder that may suddenly worsen during pregnancy and lead to fatal blood clots and other serious complications;[57] and severe pulmonary hypertension, which involves increased pressure within the lung's circulation system and can escalate in severity resulting

[54] ROA.767.
[55] Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstet. & Gynecol. 531, 531 (Feb. 2007).
[56] *See* Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart 552, 552 (May 2007).
[57] *See* J. Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-47 (2002).

in seizures, heart failure, renal failure, liver disease, blood clotting disorders, and death.[58] Any of these conditions can progress and become more serious or lead to additional health risks if abortion care is not available.

Additionally, other medical conditions unrelated to pregnancy may unexpectedly arise after 15 weeks LMP where a woman may wish to terminate a pregnancy. For example, women who learn after 15 weeks LMP that they have cancer requiring radiation or chemotherapy may choose to terminate the pregnancy to avoid having the fetus die in utero due to exposure to toxic treatments. Similarly, women who develop mental health conditions such as depression may wish to terminate their pregnancy because of the risk of fetal complications these conditions may impose, including pre-term birth, low birth weight, and intrauterine growth restriction, which are the leading causes of neonatal, infant, and childhood morbidity, mortality, and neurodevelopmental impairments and disabilities.[59] Because risky medical conditions may only arise or pose serious threats after 15 weeks LMP, the State's argument that women will have time to decide whether to obtain an abortion before the Ban takes effect is not realistic.[60]

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[58] *See* David G. Kiely et al., *Pregnancy and Pulmonary Hypertension: A Practical Approach to Management*, 6 Obstet. Med. 144, 153 (2013).

[59] *See* Nancy K. Grote et al., *A Meta-Analysis of Depression During Pregnancy and the Risk of Preterm Birth, Low Birth Weight, and Intrauterine Growth Restriction*, 67 Arch Gen. Psych. 1012 (2010).

[60] The State's argument also fails to consider that many women face delays in obtaining abortion care and may only have access to such care later in the

IV. THE BAN IMPINGES UPON THE INTEGRITY OF THE MEDICAL PROFESSION

A. The Ethical Dilemma

The Ban deprives physicians of the ability to act in the best interest of their pregnant patients. If a woman's health is compromised and if the probable gestational age of the fetus is greater than 15 weeks LMP, the woman's physician may only perform an abortion in a "medical emergency," even if the physician determines in his or her medical opinion that an abortion is medically necessary. In these circumstances, physicians will have to choose between following the law or adhering to their ethical responsibilities.

Physicians are ethically required to exercise all reasonable means to ensure that their patients receive the most appropriate and effective care.[61] These ethical

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pregnancy. Delays in obtaining abortion care can be attributable to the decreased number of abortion providers, decreased services offered by abortion providers, the failure to recognize a pregnancy, the miscalculation of the length of the pregnancy, the reluctance to tell a partner or parents about a pregnancy, the time needed to decide how to resolve the pregnancy, the time needed to make arrangements to obtain abortion care, such as transportation and money, and state laws, such as parental notification laws and mandatory waiting periods, that have been associated with second-trimester abortions. Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstet. & Gynecol. 729, 735 (Apr. 2004).

[61] ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, at 1-2 (July 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, Chapter 1: Opinions on Patient-Physician Relationships*, § 1.1.3(b) (2016).

obligations are expressed through the principles of beneficence, non-maleficence, and patient autonomy.[62] Beneficence requires physicians to act in a way that is likely to benefit patients.[63] Non-maleficence directs physicians to refrain from acting in ways that might harm patients unless the harm is justified by concomitant benefits.[64] If a physician determines that it is in a patient's best interest to receive abortion care to improve a woman's health after a fetus has a gestational age greater than 15 weeks LMP, the physician cannot fulfill his or her duties of beneficence and non-maleficence.

Patient autonomy recognizes that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions. It also requires physicians to honor and respect patient decisions about the course of their care.[65] This principle illustrates the injustice of the Ban, where the law would prevent a physician from offering a patient abortion care, even when a patient makes the meaningful choice that an abortion is in her best medical interest.

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[62] *See* ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, at 1-2; *see also* ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 3-5 (Dec. 2007, re-aff'd 2016).
[63] ACOG, Committee Opinion No. 390, at 3.
[64] *Id.*
[65] *See* ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, at 1.

B. The Ban Improperly Intrudes Upon the Patient-Physician Relationship

SMFM opposes legislation that interferes with the physician-patient relationship and is not based upon scientific evidence. The patient-physician relationship is the keystone of delivering appropriate medical care, and political considerations, especially those that 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.

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.[66] The effect of the Ban would go beyond undue interference; it would outright prohibit physicians from exercising sound medical judgment. It would intrude upon the patient-physician relationship and mandate an outcome -- carrying an unwanted pregnancy to term -- irrespective of whether it is safe or the medically appropriate course of action.

The Ban replaces a physician's judgement with that of the Legislature, a dangerous standard that will only serve to interfere with individualized medical determinations and care in ways that increase, rather than reduce, medical risks.[67]

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

[67] *See* ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, at 1 (May 2013).

C. Notwithstanding the Ban's Exceptions, Abortion Care Will be Unavailable in Mississippi After 15 Weeks LMP

Since 1973, the Supreme Court has repeatedly affirmed that the Fourteenth Amendment protects a woman's right to abortion at the pre-viability stage of pregnancy.[68] The Ban flies in the face of that precedent and the statutory exception does absolutely nothing to save it.

Under the Ban, women seeking abortion care after 15 weeks would have no choice but to seek treatment outside of Mississippi or resort to measures outside of a medical setting. Historical data shows that where abortion access is limited, women often resort to alternative means to end an unwanted pregnancy, some of which can be unsafe, including self-inflicted abdominal and bodily trauma, ingestion of dangerous chemicals, and reliance on unqualified abortion providers.[69] Today, approximately 21 million women worldwide obtain unsafe abortions each year, and these unsafe abortions result in approximately 50,000 maternal deaths annually.[70] Banning abortion, as the State has done, does not prevent abortions. It simply makes them more unsafe, causing more harm to maternal health.

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[68] *See Roe v. Wade*, 410 U.S. 113, 163-64 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992); *Stenberg v. Carhart*, 530 U.S. 914, 920-21 (2000); *Gonzales v. Carhart*, 550 U.S. 124, 146 (2007); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2299 (2016).

[69] ACOG, Committee Opinion No. 613, *Increasing Access to Abortion*, at 2 (Nov. 2014, re-aff'd 2017).

[70] *Id.*

CONCLUSION

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

Dated: April 12, 2019

Respectfully submitted,

s/ Janice Mac Avoy

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CERTIFICATE OF SERVICE

I hereby certify that on April 12, 2019, I electronically filed a true and correct copy of the foregoing *Amicus Curiae* Brief with the Clerk of the Court by using the appellate CM/ECF system, which will send notification of such filing to all registered users of the CM/ECF system.

Dated: April 12, 2019

s/ Janice Mac Avoy
Janice M. Mac Avoy

CERTIFICATE OF COMPLIANCE

I hereby certify that (i) required privacy redactions have been made in compliance with Fifth Circuit Rule 25.2.13; (ii) the electronic submission is an exact copy of the paper document in compliance with Fifth Circuit Rule 25.2.1; and (iii) the document has been scanned with the most recent version of commercial virus-scanning software and was reported free of viruses.

I further certify that this brief complies with: (i) the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 5,776 words, excluding the parts of the brief exempted by Rule 32(f); and (ii) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Times New Roman) using Microsoft Word (the same program used to calculate the word count).

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April 15, 2019

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No. 18-60868
Jackson Women's Health Orgn, et al v. Thomas Dobbs, et al
USDC No. 3:18-CV-171

Dear Ms. Mac Avoy,

The following pertains to your brief electronically filed on April 12, 2019.

We filed your brief. However, you must make the following corrections within the next 14 days.

You need to correct or add:

Argument is not labeled (only the summary of argument is labeled), see FED. R. APP. P. 28(a)(8) and 5TH CIR. R. (28.3)(i).

You must electronically file a "Form for Appearance of Counsel" within 14 days from this date. You must name each party you represent, see FED. R. APP. P. 12(b) and 5TH CIR. R. 12 & 46.3. The form is available from the Fifth Circuit's website, www.ca5.uscourts.gov. If you fail to electronically file the form, the brief will be stricken and returned unfiled.

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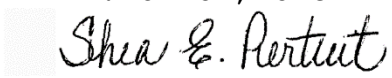

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