No. 20-5969

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

MEMPHIS CENTER FOR REPRODUCTIVE HEALTH; PLANNED PARENTHOOD OF TENNESSEE AND NORTH MISSISSIPPI; KNOXVILLE CENTER FOR REPRODUCTIVE HEALTH; FEMHEALTH USA, INC.; DR. KIMBERLY LOONEY; DR. NIKKI ZITE,
Plaintiffs-Appellees

v.

HERBERT H. SLATERY, III; LISA PIERCEY, M.D.; RENE SAUNDERS, M.D.; W. REEVES JOHNSON, JR., M.D.; HONORABLE AMY P. WEIRICH; GLENN R. FUNK; CHARME P. ALLEN; TOM P. THOMPSON, JR.,
Defendants-Appellants

On Appeal from the United States District Court for the
Middle District of Tennessee
(No. 3:20-cv-00501)

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

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Sixth Circuit Rule 26.1, the American College of Obstetricians and Gynecologists and The Society for Maternal-Fetal Medicine, *amici curiae*, make the following disclosure:

Neither the American College of Obstetricians and Gynecologists nor The Society for Maternal-Fetal Medicine is a subsidiary or affiliate of a publicly owned corporation. Neither the American College of Obstetricians and Gynecologists nor The Society for Maternal-Fetal Medicine is aware of any publicly owned corporation, not a party to this appeal, having a financial interest in the outcome.

Dated: December 22, 2020

/s/ Janice Mac Avoy
Janice Mac Avoy

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

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IDENTITY AND INTEREST OF *AMICI CURIAE*[1]

The American College of Obstetricians and Gynecologists ("ACOG") and The Society for Maternal-Fetal Medicine ("SMFM") are major medical organizations representing physicians and other clinicians who serve patients in Tennessee and nationwide.

ACOG is the nation's leading group of physicians providing health care for women. With more than 60,000 members—representing more than 90% of all obstetricians-gynecologists in the United States—ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of changing issues facing women's health care. ACOG is committed to defending the right of physicians to practice the full scope of obstetrics and gynecology and to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion, for all women.

[1] Pursuant to Federal Rule of Appellate Procedure 29, undersigned counsel for ACOG and SMFM certify that no counsel for a party authored this brief in whole or in part. No party or counsel for a party contributed money that was intended to fund preparing or submitting this brief. No person or entity—other than *amici curiae*, their members, or their counsel—contributed money that was intended to fund preparing or submitting this brief. All parties consent to the filing of this brief.

The Society for Maternal-Fetal Medicine ("SMFM") is a non-profit, membership organization based in Washington, D.C. With more than 5,000 physicians, scientists, and women's health professionals around the world, the Society supports the clinical practice of maternal-fetal medicine by providing education, promoting research and engaging in advocacy to optimize the health of high-risk pregnant women and their babies.

SUMMARY OF ARGUMENT

Tennessee Code §§ 39-15-216 (the "Cascading Bans") and 39-15-217 (the "Reason Bans") (together with the Cascading Bans, the "Bans") effectively eviscerate the constitutional right to terminate pregnancy. Since 1973, the Supreme Court has recognized that the right to terminate pregnancy prior to viability is protected by the Constitution of the United States. Under well-settled law, there is no state interest that is legally sufficient to justify an absolute ban on abortion prior to viability.

The State of Tennessee (the "State") nonetheless seeks to impose criminal penalties on medical professionals providing essential medical care and to restrict the right of pregnant people to receive constitutionally protected abortion care. The State offers two reasons why it should not be subject to the law as interpreted for more than four decades. First, through the Cascading Bans, the State contends it can prohibit pre-viability abortions beginning at just 6 weeks of gestation because the State asserts, incorrectly, that a "fetal heartbeat" is detectable at that stage. Second, through the Reason Bans, the State says it should be allowed to ban pre-viability abortions to the extent a physician knows they are being sought because of the fetus' sex, race, or potential Down syndrome diagnosis. Because there is undisputed medical consensus that a fetus at 6 weeks of gestation is *months*

away from viability, and because the Bans seek to prohibit pre-viability abortions, they are plainly unconstitutional.

The State attempts to justify the Bans by claiming they protect fetal and maternal health. They do not, and in fact, do the opposite. The Bans severely restrict access, especially for vulnerable groups, to one of the safest courses of medical care currently available. Carrying a pregnancy to term and giving birth carries a far greater risk to a woman's health and life than abortion care. Further, the Bans incorporate only a narrow exception for medical emergencies that does not cover many situations where a woman's health and life are endangered by pregnancy. Under the Bans, a woman living with health conditions that will complicate her pregnancy will have no choice but to carry the pregnancy to term, even if it is dangerous to her health. Likewise, the Bans provide *no* exception for a woman who receives a negative fetal diagnosis during pregnancy, meaning a woman may be forced to carry an embryo or fetus with life-limiting conditions (including lethal fetal conditions as well as others for which there is little or no prospect of long-term survival outside the womb without severe morbidity or extremely poor quality of life, and for which there is no cure).[2]

[2] ACOG, Committee Opinion No. 786, *Perinatal Palliative Care*, 134(3) Obstet. & Gynecol. e84, e84 (Sept. 2019).

Given the lack of reasonable exceptions to address the life and health of women, the Bans place physicians in an ethically impossible position. The Bans effectively dictate that in many, many cases, a pregnant woman would not be able to receive abortion care even when she and her physician believe that such care is in her medical best interests. Additionally, the Reason Bans would prevent care if the physician knows that the woman is seeking an abortion because of the fetus' sex, race, or potential Down syndrome diagnosis and would punish physicians with criminal penalties if such a procedure is nonetheless performed. The Reason Bans therefore chill the free flow of information between patients and doctors—both because doctors have incentives to insulate themselves from knowing their patients' motivations, and because patients could lose their right to abortion care if they share too much information with their doctors. This outcome compromises the efficacy of medical care available in the State.

The law is clear that there can be *no* state interest sufficient to justify a pre-viability ban, and as a factual matter, the State's proffered interests offer no compelling reasons to disturb that law. The State is factually incorrect regarding the role of the fetal heartbeat in a viability analysis, and maternal health and safety—as well as the ethics and integrity of the medical community—are significantly *undermined* by the Bans. Because the Bans prohibit 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 enjoin them.

ARGUMENT

I. THE STATE HAS UNLAWFULLY BANNED ABORTION PRE-VIABILITY

Whether the Bans are constitutional begins and ends with the question of viability.[3] The "most central principle of *Roe v. Wade*" is that a woman has the right to "terminate her pregnancy before viability"[4] and that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure."[5] Indeed, "viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify" restrictions on abortion.[6]

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[3] "Viability" is generally known as that time when a given fetus can meaningfully survive outside its mother's womb. *See Roe v. Wade*, 410 U.S. 113, 163–64 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) (plurality opinion); *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, 2300 (2016).

[4] *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2135 (2020) (quoting *Casey*, 505 U.S. at 871).

[5] *Casey*, 505 U.S. at 846.

[6] *Id.* at 860 ("The soundness or unsoundness of that constitutional judgment in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity can somehow be enhanced in the future. Whenever it may occur, the attainment of viability may continue to serve as the critical fact, just as it has done since *Roe* was decided; which is to say that no change in *Roe's* factual

As the District Court correctly recognized, the Bans inherently prohibit pre-viability abortions given that Tennessee already has laws prohibiting post-viability abortions that are not at issue here. Therefore, the narrow question before this Court is whether the State's blanket prohibitions against pre-viability abortion are sustainable. They are not.

According to the Supreme Court, a fetus is viable when there is a reasonable likelihood that it will be able to survive for a sustained period of time outside of the womb.[7] The State seeks to ban abortion at gestational ages before any fetus could survive outside the womb.[8] If implemented, the Bans would prohibit pre-viability abortions as early as three-and-a-half months before viability would be even a possibility.

It is important to note that viability cannot be measured by exclusive reference to any one factor—including gestational age. Instead, an assessment of viability is a case-by-case determination that includes the general health of the

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underpinning has left its central holding obsolete, and none supports an argument for overruling it.").

[7] *Colautti v. Franklin*, 439 U.S. 379, 388–89 (1979); *Casey*, 505 U.S. at 870 ("[Viability is] the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb.") (citing *Roe*, 410 U.S. at 163).

[8] *See, e.g.*, ACOG, *Extremely Preterm Birth, Frequently Asked Questions: What are the health outcomes for extremely preterm babies?*, https://www.acog.org/womens-health/faqs/extremely-preterm-birth (last accessed Dec. 17, 2020); ACOG & SMFM, *Periviable Birth*, 130(4) Obstet. & Gynecol. e187, e188 (Oct. 2017).

woman and fetus, fetal weight, gestational age, and available life-sustaining medical treatments.[9] Viability of any particular pregnancy must be determined on a case-by-case basis by the treating physician.[10]

Ignoring these medical facts, the State points to a supposed "fetal heartbeat" in an attempt to support an inference of "viability" with respect to the Bans it seeks to justify here. The State's assertion is not scientifically or medically accurate. At the early stages of pregnancy, what the State calls a "fetal heartbeat" is instead an electrically induced flickering of a portion of fetal tissue where the heart has not yet developed.[11] Even setting the State's medically inaccurate explanation aside, the Cascading Bans still fail to pass constitutional muster because the State has

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[9] *Colautti*, 439 U.S. at 388–89 ("Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability -- be it weeks of gestation or fetal weight or any other single factor -- as the determinant of when the State has a compelling interest in the life or health of the fetus.").

[10] *Id.* ("[V]iability is reached when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support.").

[11] At the early stages of pregnancy, no cardiac activity is audible—any such activity is visible only and can be seen on an ultrasound—and the tissue that will become the heart is far from fully formed. At 6 weeks of gestation, fetal development has not even begun; the fertilized egg is developing into an embryo. Even with ultrasound technology, the embryo is not immediately visible. Shuchi K. Rodgers et al., *Normal and Abnormal US Findings in Early First-Trimester Pregnancy: Review of the Society of Radiologists in Ultrasound 2012 Consensus Panel Recommendations*, 35 RadioGraphics 2135, 2137 (2015). It can be observed only at around 6 weeks of gestation, at which time it measures 1 to 2 millimeters, the size of a green pea. *Id.*

not—and consistent with current science cannot—show that this electrically induced flickering has any bearing whatsoever on the question of viability.

The Reason Bans are unconstitutional under the same analysis: they seek to ban abortion prior to viability. Viability does not depend on the race, sex, or diagnosis of a fetus or the reason that a person may seek to terminate a pregnancy. The Supreme Court has long held that states cannot infringe upon a woman's right to seek pre-viability abortion care and Tennessee should not be permitted to do so here.[12]

Because the State's Bans unquestionably seek to regulate pre-viability abortion, they are facially unconstitutional.

II. THE BANS PROHIBIT NEARLY ALL ABORTIONS IN TENNESSEE

A. Many People May Not Know They Are Pregnant at 6 Weeks of Gestation

At 6 weeks of gestation, many people may not be aware that they are pregnant. The most common sign of a potential pregnancy is a missed period; until then, most women will have no reason to suspect they are pregnant.[13] A woman's

[12] *Casey*, 505 U.S. at 860 ("[T]he attainment of viability may continue to serve as the critical fact.").

[13] Administrating a home pregnancy test too early in a woman's menstrual cycle or too close to the time a woman became pregnant may result in a false negative result, because the hormone a woman's body produces when she becomes pregnant, human chorionic gonadotrophin, may not yet be at a detectable level to

menstrual cycle is typically four weeks long. Thus, even a woman with highly regular cycles would be four weeks pregnant, as measured from the last menstrual period, on the day when her missed period occurs. The Bans begin prohibiting abortion just two weeks later. At this time, procedural abortion care may not always be feasible, as the location of the pregnancy must usually be confirmed prior to administering abortion care to ensure it is within the uterus, as opposed to being an ectopic pregnancy.[14] Further, an ultrasound administered before 6 weeks of gestation may not yet reveal definitive signs of pregnancy.[15] Therefore, even if a woman knows she is pregnant and obtains an appointment for an abortion within 6 weeks of gestation, it may not be possible to access abortion care when a doctor cannot determine the physical location of the pregnancy.

On the other hand, for the many women who experience irregular cycles, the Bans may prohibit abortion before they can confirm pregnancy. Stress, obesity, smoking, and other factors may influence the menstrual cycle and have been associated with irregularities.[16] Further, some women may experience

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trigger a positive test result. *Pregnancy*, U.S. FOOD & DRUG ADMINISTRATION (Apr. 29, 2019), https://www.fda.gov/medical-devices/home-use-tests/pregnancy.

[14] E. Steve Lichtenberg & Maureen Paul, *Surgical abortion prior to 7 weeks of gestation*, 88 Contraception 1, 11–12 (July 2013).

[15] Rebecca Heller and Sharon Cameron, *Termination of pregnancy at very early gestation without visible yolk sac on ultrasound*, 41(2) J. Fam. Plann. Reprod. Health Care 90, 90–91 (2015).

[16] Jinju Bae et al., *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18:36 BMC Women's Health 1, 1 (2018).

metrorrhagia, or bleeding during their menstrual cycle, which can be mistaken for a period and may lead a woman to believe she did not miss a period when she actually is pregnant. Other than a missed period, there is often no reason to suspect pregnancy at early stages. Pregnancy symptoms differ and are not always predictable.[17] Further, because about 45% of pregnancies in the U.S. are unplanned, women may not immediately consider a symptom of early pregnancy, such as nausea or vomiting, to be indicative of pregnancy.[18] Under the Bans, women may be completely foreclosed from accessing abortion care because they do not realize they are pregnant.

For all of those reasons, many women will first identify pregnancy symptoms close to or after 6 weeks of gestation. In one study, the average number of days from the last menstrual period to the onset of nausea and vomiting was 39 days, roughly 7.5 weeks.[19] Of course, some women may also never experience nausea or vomiting. Women who mistake pregnancy symptoms as something else until after 6 weeks of gestation pass will have no choice but to carry their pregnancies to term in Tennessee if the Bans are permitted to stand.

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[17] Amy E. Sayle et al., *A Prospective Study of the Onset of Symptoms of Pregnancy*, 55 Journal of Clinical Epidemiology 676, 676 (2002).
[18] Lawrence B. Finer et al., *Declines in Unintended Pregnancy in the United States, 2008 - 2011*, 374 N. Engl. J. Med. 843, 843 (Mar. 3, 2016).
[19] Roger Gadsby et al., *A prospective study of nausea and vomiting during pregnancy*, 43(371) Brit. J. of Gen. Prac. 245, 245 (June 1993).

B. A Woman's Practical Ability to Receive Abortion Care is Effectively Eliminated by the Bans

Even those women who are able to confirm their pregnancies before 6 weeks of gestation will find it nearly impossible to receive abortion before the Bans prohibit it. Tennessee women may face delays in obtaining abortion care for a number of reasons, including miscalculation of the length of the pregnancy, reluctance to tell a partner or parents about a pregnancy, time needed to decide how to resolve the pregnancy, and the number and location of abortion providers.[20] Indeed, 96% of Tennessee counties lack abortion providers and 63% of Tennessee women live in those counties.[21] The COVID-19 pandemic multiplies the logistical issues that women seeking abortion care face because they may experience limited access to service providers or be less willing to seek care in light of the significant risks associated with entering public locations, including doctors' offices.[22] Further complicating access to abortion during the ongoing public health crisis is Tennessee's law prohibiting telemedicine for abortion care.[23]

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[20] *See* Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103(4) Obstet. & Gynecol. 729, 735 (Apr. 2004).
[21] Guttmacher Institute, *State Facts About Abortion: Tennessee* (2020), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-tennessee.
[22] ACOG, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.
[23] Tenn. Code Ann. § 63-6-241.

In addition, Tennessee law erects more barriers that a woman seeking abortion care must overcome. For example, abortion patients are disproportionately low-income, and they need time to raise necessary funds for an abortion because Tennessee law forbids the use of state funds for abortion care, with only narrow exceptions.[24] Tennessee law also forbids coverage of abortion care in any health care plan offered through the state exchange under the Patient Protection and Affordable Care Act.[25] Minors also face delays in seeking abortion due to Tennessee laws requiring written, signed consent of a parent prior to receiving abortion care, with only a narrow "medical emergency" exception.[26] Yet another Tennessee statute requires written, signed consent and state-mandated counseling.[27]

Together with the practical and legal obstacles Tennessee women already face, the Bans effectively prevent access to abortion care even for the few women who can confirm pregnancy before 6 weeks of gestation. For example, a woman who learns of her pregnancy at 5 weeks of gestation will only have a single week to obtain abortion care. During this short time, a woman in Tennessee must (1)

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[24] Tenn. Code Ann. § 9-4-5116.
[25] Tenn. Code Ann. § 56-26-134; Chris Butler, *TennCare Releases Abortion Statistics*, THE TENNESSEE STAR (Sep. 11, 2018), https://tennesseestar.com/2018/09/11/tenncare-releases-abortion-statistics/ (noting that Tennessee's Medicaid program covered only six abortions in 2017).
[26] Tenn. Code Ann. § 37-10-303(a).
[27] Tenn. Code Ann. § 39-15-202.

make a decision about whether to continue or terminate her pregnancy; (2) schedule an appointment with one of the few clinicians who provide abortion in the state, or another available clinician out of state; and (3) navigate the series of obstacles Tennessee laws erect in her path. Furthermore, many women will need to gather resources to pay for the abortion and its related costs, arrange transportation to the health care facility, take time off work, and possibly arrange for childcare during appointments, all on an expedited basis. The Bans will undoubtedly prevent virtually all access to abortion care for low-income women who already struggle to access medical care and who have the fewest resources to navigate the Bans' restrictions.

Research shows that, where abortion access is limited, women may resort to unsafe means to end unwanted pregnancies, including self-inflicted abdominal and bodily trauma, ingesting dangerous chemicals, and relying on unqualified or predatory abortion providers.[28] It is unconstitutional to put Tennessee women in this position.

[28] ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, 136(6) Obstet. & Gynecol. e107, e108 (Dec. 2020); SMFM, *Access to Abortion Services*, at 1 (Dec. 2017, re-aff'd June 2020), https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf.

III. THE BANS ENDANGER WOMEN'S HEALTH BY RESTRICTING ACCESS TO ABORTION

Abortion is one of the safest medical procedures available to women, as widely acknowledged by the medical community and recognized by the Supreme Court of the United States.[29] Yet the Bans' legislative findings purport to conclude—without any citation to authority—that abortion care increases risks to maternal health. This is untrue. The State's assertion that it is protecting women is incorrect; the Bans have the opposite effect—they *endanger* women's health and safety by prohibiting abortion.

A. Abortion Is One of the Safest Forms of Medical Care

Longstanding research has demonstrated that abortion care is one of the safest procedures in modern medicine, regardless of whether the abortion is induced by medication or procedure.[30] This has been demonstrated time and time

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[29] *See, e.g.*, ACOG, Committee Opinion No. 815, at e108; *June Med. Servs. L.L.C.*, 140 S. Ct. at 2122 (noting that "abortions are so safe," and as a result, providers would be unlikely to admit patients to a hospital) (citing *Whole Woman's Health*, 136 S. Ct. at 2313); ACOG, *Induced Abortion, FAQ: What is a first-trimester abortion?* (May 2015), https://www.acog.org/womens-health/faqs/induced-abortion; Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstet. & Gynecol. 215, 215 (Feb. 2012); David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140(8) Annals Internal Med. 620, 621, 623 (Apr. 20, 2004).

[30] *See* Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States*, at 10 (The National Academies Press 2018), https://www.nap.edu/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-

again by randomized controlled trials, large retrospective cohort studies, patient and provider surveys, systematic reviews, and epidemiological studies examining abortion care. For example, one study found that 98.7% of women who received a first-trimester aspiration abortion and 94.8% of women who received a medical abortion experienced no related complications.[31] In fact, abortion is so safe that there is a greater risk of mortality associated with colonoscopies, plastic surgery, dental procedures, and even adult tonsillectomy than there is with abortion.[32]

Statistically, there are far greater risks in carrying a pregnancy to term as compared to receiving abortion care. The risk of death associated with childbirth is approximately 14 times higher than that with abortion.[33] While risks related to abortion may become greater 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 with carrying a pregnancy to term.[34] In a 1998 to 2001 study, *all* studied maternal complications were found to be more common in

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united-states; Raymond & Grimes, 119(2) Obstet. & Gynecol. at 215; Grimes & Creinin, 140(8) Annals Internal Med. at 623.

[31] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstet. & Gynecol. 175, 181 (Jan. 2015).

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

[33] ACOG, Committee Opinion No. 815, at e108 (citing Raymond & Grimes, 119(2) Obstet. & Gynecol. at 216).

[34] ACOG, Committee Opinion No. 815, at e108; Raymond & Grimes, 119(2) Obstet. & Gynecol. at 217.

women who gave birth as compared to women who received abortion care.[35] 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.[36] The occurrence of complications related to carrying a pregnancy to term only lends credence to the widely-accepted consensus in the medical community that abortion is an extremely safe medical procedure.

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

Tennessee women who require an abortion, particularly those experiencing high-risk pregnancies, will face significant challenges to their health under the Bans that will unnecessarily compromise their quality of life and survival. "Medical emergencies," as defined by the Bans, are limited to situations where a condition endangers the life of a woman or a major bodily function.[37]

The medical emergency "exception" is extremely narrow. First, many maternal medical conditions meeting the State's definition of "medical emergency" will not manifest or require treatment until after 6 weeks of gestation. For example, medical conditions that may arise after that point but may not always

[35] Raymond & Grimes, 119(2) Obstet. & Gynecol. at 216–17 & Fig. 1.
[36] *Id.*
[37] Tenn. Code Ann. § 39-15-211(a)(3).

arise to a "medical emergency" include: alport syndrome (a form of kidney inflammation);[38] valvular heart disease (the abnormal closure of a heart valve that can occur in women with no history of cardiac symptoms);[39] lupus (a connective tissue disorder that may suddenly worsen during pregnancy and lead to fatal blood clots and other serious complications);[40] and severe pulmonary hypertension (increased pressure within the lung's circulation system that can escalate in severity resulting in seizures, heart failure, renal failure, liver disease, blood clotting disorders, and death).[41]

Under these circumstances, physicians will be forced to withhold medically appropriate abortion care in order to comply with the Bans. After 6 weeks of gestation, a woman will be universally required to carry a pregnancy to term in circumstances where a medical condition poses serious, but not yet urgent, health risks. This is true even if a physician concludes in consultation with a patient, and after conducting a highly individualized analysis based on that patient's health, potential risks, and other variables, that abortion care is in the patient's best

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[38] Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109(2) Obstet. & Gynecol. 531, 531 (Feb. 2007).
[39] *See* Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93(5) Heart 552, 552 (May 2007).
[40] *See* J. Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41(6) Rheumatology 643, 646–47 (2002).
[41] *See* David G. Kiely et al., *Pregnancy and pulmonary hypertension: a practical approach to management*, 6(4) Obstet. Med. 144, 144, 153 (2013).

interest. In foreclosing abortions in these instances, the State is replacing the good faith judgment of a physician (in consultation with the patient) with that of the State. In doing so, the State unjustifiably jeopardizes maternal health by delaying appropriate care in all cases until a condition deteriorates so severely that a "medical emergency" arises and an abortion becomes immediately necessary.

Moreover, various complications that present danger to maternal health can directly affect fetal development and survival. For example, if a woman experiences premature rupture of membranes and infection, preeclampsia, placental abruption, and/or placenta accrete, she may be at risk of extensive blood loss, stroke, and/or septic shock, all of which would negatively impact the fetus.

Additionally, other medical conditions unrelated to pregnancy may unexpectedly arise after 6 weeks of gestation and cause women to seek pregnancy termination. For example, women who learn after 6 weeks of gestation that they have cancer requiring radiation or chemotherapy may seek to terminate the pregnancy to avoid having the fetus die in utero due to exposure to toxic treatments. Similarly, women who have or develop mental health conditions may seek to terminate their pregnancies because of the risk of fetal complications these conditions or their treatment may impose, including pre-term birth, low birth weight, and intrauterine growth restriction, which are a leading cause of neonatal,

infant, and childhood morbidity, mortality, and neurodevelopmental impairments and disabilities.[42]

A woman faced with serious medical conditions should not be forced to carry a pregnancy to term because the condition does not rise to the level of a "medical emergency," nor should that woman be forced to wait to see if the condition will rise to the point of a "medical emergency."

C. The Bans' Restriction of Care In Light of A Fetal Diagnosis Further Endangers Maternal Health

Under the Bans, women are unable to seek abortion care in light of a fetal diagnosis, which almost always occurs post-6 weeks of gestation. Abortion care is sometimes required due to fetal congenital, chromosomal, and structural abnormalities.[43] Often times, these diagnoses are incompatible with survival; a woman who cannot obtain abortion care under those circumstances can be forced to carry a fetus to term—sometimes for months—that has little or no life expectancy. Carrying such a pregnancy to term may present life-threatening or life-altering risks to the pregnant woman.

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[42] *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(10) Arch Gen. Psych. 1012, 1012 (Oct. 2010).

[43] Royal College of Obstetricians and Gynecologists, *Termination of Pregnancy for Fetal Abnormality in England, Scotland and Wales*, 13–14 (May 2010).

Women typically undergo ultrasound scans late in the first trimester and again in the second trimester to detect potential abnormalities.[44] One study concluded that 23% of major fetal anomalies were detected between 11 to 14 weeks of gestation and that 33.7% were detected in the second-trimester.[45] Two additional studies found that in over half of the pregnancies studied, fetal malformations were detected in the second trimester.[46]

In these sensitive circumstances, women and their physicians must consider the options available and the best course of action, which in some instances is abortion care. Considerations must account for both fetal and maternal health, as any fetal intervention to treat a diagnosis affects a woman's bodily integrity.[47]

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[44] *Id.* at 11.

[45] Katherine W. Fong et al., *Detection of Fetal Structural Abnormalities with US During Early Pregnancy*, 24(1) RadioGraphics 157, 172–73 (Jan.-Feb. 2004).

[46] Namrata Kashyap et al., *Early Detection of Fetal Malformation, a Long Distance Yet to Cover! Present Status and Potential of First Trimester Ultrasonography in Detection of Fetal Congenital Malformation in a Developing Country: Experience at a Tertiary Care Centre in India*, 2015 Journal of Pregnancy 1, 6 (2015) (finding that, out of the total number of women with diagnosed fetal malformation, 65% presented before 20 weeks of gestation and of that, only 1.6% were diagnosed prior to 12 weeks of gestation); Catharina Rydberg & Katarina Tunon, *Detection of Fetal Abnormalities by Second-Trimester Ultrasound Screening in a Non-Selected Population*, 96(2) Acta. Obstet. Gynecol. Scand. 176, 176 (Nov. 22, 2016) (finding that half of the major structural malformations in otherwise normal fetuses were detected by routine ultrasound examination in the second trimester).

[47] *See* ACOG Committee on Ethics and American Academy of Pediatrics Committee on Bioethics, Committee Opinion No. 501, *Maternal-Fetal Intervention and Fetal Care Centers*, at 5 (Aug. 2011, re-aff'd 2017).

Under the Bans, women lose access to abortion care even if their doctors determine that it is the best course of action. In addition to prohibiting medically appropriate care, by restricting abortions even after a fetal diagnosis, the Bans cause additional severe emotional pain for women and their families.[48] This is especially true where a woman receives a fetal diagnosis post-6 weeks of gestation and will be forced to carry a pregnancy to term, even if she is carrying a fetus with a life-limiting diagnosis.

IV. THE BANS IMPINGE UPON THE INTEGRITY OF THE MEDICAL PROFESSION

A. The Bans Are Contrary To Bedrock Principles of Medical Ethics

The Bans undermine the ability of physicians to act in the best interest of their pregnant patients. If a woman's health is compromised, and if the probable gestation of the fetus is greater than 6 weeks or the woman expressed herself in a manner that could be deemed to violate the Reason Bans, the physician may only perform an abortion in a legislation-defined "medical emergency," even if the physician determines that an abortion is medically necessary. In these circumstances, physicians are put in a position of having to choose between

[48] ACOG, *ACOG Statement on Abortion Reason Bans* (Mar. 10, 2016), https://www.acog.org/news/news-releases/2016/03/acog-statement-on-abortion-reason-bans.

following the law and acting in accordance with medical ethics that prioritize patient wellbeing.

The Bans frustrate a physician's ability to exercise all reasonable means to ensure that their patients receive the most appropriate and effective care and impede adherence to the profession's ethical principles of beneficence, non-maleficence, and patient autonomy.[49] Beneficence requires physicians to act in a way that is likely to benefit patients.[50] Non-maleficence directs physicians to refrain from acting in ways that might harm patients unless the harm is justified by concomitant benefits.[51]

Yet, under the Bans, a physician who believes abortion care is appropriate for a woman facing a medical condition after the sixth week of gestation is unable to provide medically necessary care until the woman's health deteriorates to the point of a "medical emergency." This is in tension with a physician providing the best care possible, because, under the Bans, a physician is required to refuse to provide care unless, or until, the woman's health is so severely compromised that "immediate performance or inducement of an abortion" is required to prevent

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[49] ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 3–5 (Dec. 2007, re-aff'd 2016); *see also* American Medical Association, *Principles of Medical Ethics, Chapter 1: Opinions on Patient-Physician Relationships*, § 1.1.3(b) (2016).
[50] ACOG, Committee Opinion No. 390, at 3–4.
[51] *Id.*

death or "substantial and irreversible impairment of a major bodily function."[52] Given the State's narrow definition of a "medical emergency" and the lack of a scienter element for "medical emergency" determinations, a physician has no way of knowing whether their ultimate call, which involves a very subjective, complex analysis, will be deemed "reasonable" if it is later judged by a factfinder. Knowing they will likely face intense scrutiny in the future, physicians may be deterred from providing abortion care in situations where reasonable minds may differ as to whether a "medical emergency" occurred.

Similarly, patient autonomy recognizes that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions.[53] It also requires physicians to honor and respect patient decisions about the course of their care.[54] As a result of the Reason Bans, however, women may lose their right to choose abortion care purely because of the manner in which they express themselves. Physicians may be forced to refrain from performing medically appropriate abortion care in circumstances where, for example, a patient's chart, circumstances, or expressions suggest even the faintest desire to seek abortion care in light of the fetus' characteristics or potential for Down

[52] Tenn. Code Ann. § 39-15-211(a)(3).
[53] ACOG, Committee Opinion No. 390, at 3.
[54] SMFM, *Access to Abortion Services*, at 2 ("[P]hysicians have a professional responsibility to respect each individual's autonomy in decisions regarding pregnancy and to provide nonjudgmental care.").

syndrome diagnosis. Worse, to avoid being placed in an untenable position, physicians may also be less willing to provide standard medical care such as prenatal testing and counseling to ensure that a possible fetal Down syndrome diagnosis is not assumed to be the basis for seeking abortion care. This illustrates the perversity of the Bans, which would compromise a physician's ability to fulfill his or her duty to honor patient autonomy even when a patient makes the meaningful choice that an abortion is in her best medical interest.

A physician's ability to practice medicine in accordance with bedrock principles of medical ethics is incredibly compromised given the looming threat of potential criminal, monetary, and medical licensure penalties applicable under the Bans. A physician deemed to violate the Bans can be found guilty of a Class C felony and must report the charge to the board of medical examiners.[55] Simply put, to evade the harsh (even criminal) sanctions of the Bans, physicians are likely to be deterred from providing essential care even if it consistent with the patient's wishes and in her medical interest.

[55] Tenn. Code Ann. § 39-15-216(b)-(c), (g).

B. The Bans Improperly Intrude Upon the Patient-Physician Relationship

Amici, along with many other medical organizations, oppose legislation that interferes with the physician-patient relationship and is not based upon scientific evidence.[56] 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.[57]

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.[58] The effect of the Bans goes beyond undue interference; it outright prohibits physicians from exercising sound medical judgment. It intrudes upon the patient-physician relationship and mandates an outcome—carrying an unwanted pregnancy to term—irrespective of whether that is the safest course of action.

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[56] *See, e.g.*, SMFM, *Access to Abortion Services*, at 1; ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, amended and re-aff'd July 2019).
[57] SMFM, *Access to Abortion Services*, at 1–2.
[58] *See, e.g.*, *Casey*, 505 U.S. at 877–79; *see also June Med. Serv. L.L.C.*, 140 S. Ct. at 2132–33; *Whole Woman's Health*, 136 S. Ct. at 2312–13.

The Bans replace a physician's judgement with that of the State, a dangerous standard that will only serve to interfere with individualized medical determinations and care in ways that increase, rather than reduce, medical risks.

CONCLUSION

For all the reasons stated above, the Bans should not be implemented and the Court should affirm the District Court's decision to enjoin the Bans.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby 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 6,183 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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CERTIFICATE OF SERVICE

I hereby certify that on December 22, 2020, 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.

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