No. 19-1392

IN THE
Supreme Court of the United States

THOMAS E. DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, ET AL.,
Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF ABORTION CARE NETWORK, BIXBY CENTER FOR GLOBAL REPRODUCTIVE HEALTH, MEDICAL STUDENTS FOR CHOICE, NATIONAL ABORTION FEDERATION, PHYSICIANS FOR REPRODUCTIVE HEALTH & PLANNED PARENTHOOD FEDERATION OF AMERICA INC. AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

Elizabeth R. Moulton
ORRICK HERRINGTON & SUTCLIFFE LLP
405 Howard Street
San Francisco, CA 94105

E. Joshua Rosenkranz
Counsel of Record
Jennifer Keighley
Rachel G. Shalev
ORRICK, HERRINGTON & SUTCLIFFE LLP
51 West 52nd Street
New York, NY 10019
(212) 506-5000
jrosenkranz@orrick.com

Counsel for Amici Curiae

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

INTEREST OF AMICI CURIAE[1]

Abortion Care Network is the national membership association for community-based independent abortion care clinics, which collectively provide the majority of abortion care in the United States, serving three out of every five people who have an abortion. By supporting independent clinics, ACN works to ensure that every person can access dignified, expert abortion care.

Bixby Center for Global Reproductive Health at University of California, San Francisco integrates research, training, clinical care, and advocacy to advance reproductive autonomy, equitable and compassionate care, and reproductive and sexual health worldwide. It is a multidisciplinary group of over 200 people with physicians, nurses, advanced practice clinicians, social scientists, clinical researchers, and staff that span UCSF schools and departments.

Medical Students for Choice was founded by medical students in 1993 in response to the lack of abortion education in their medical training. Its 220 chapters around the world work to ensure that medical students and trainees are educated about all aspects of reproductive health care, including abortion.

---

[1] The parties have consented to the filing of this amicus brief. No counsel for a party authored the brief in whole or in part. No party, counsel for a party, or any person other than amici curiae and their counsel made a monetary contribution intended to fund the preparation or submission of the brief.

National Abortion Federation is the professional association of abortion providers. NAF's mission is to unite, represent, serve, and support abortion providers in delivering patient-centered, evidence-based care. NAF members include individuals, private and non-profit clinics, Planned Parenthood affiliates, women's health centers, physician's offices, and hospitals.

Physicians for Reproductive Health is a doctor-led non-profit whose mission is to assure meaningful access to comprehensive reproductive health care, including abortion. Since its founding in 1992, PRH has been comprised of a network of nationally recognized medical experts in abortion, contraception, and health care access.

Planned Parenthood Federation of America, Inc. is the leading provider of sexual and reproductive health care services in the United States, delivering services through more than 600 health centers operated by 49 affiliates. For over one hundred years, Planned Parenthood has advocated for access to health care services, provided comprehensive, medically accurate sexual and reproductive health education, and offered the full range of sexual and reproductive health care services, including abortion. One in five women in the United States has chosen Planned Parenthood's expert care at least once.

INTRODUCTION AND SUMMARY OF ARGUMENT

Mississippi asks this Court to overrule decades of precedent and permit states to ban abortion. Its case

rests on (among other errors) fundamental misconceptions about abortion care. This brief corrects those misconceptions by offering firsthand accounts from the health care professionals who provide that care.[2] Physicians, clinic administrators, and medical students describe, in their own words, (1) why abortion is vital to the health and wellbeing of all people who are pregnant or could become pregnant; (2) how it is profoundly ethical, patient-centered medical care that they provide with the utmost integrity and compassion; and (3) the grave consequences of banning abortion before viability.

ARGUMENT

I. Abortion Care Is The Model Of Ethical Care.

Mississippi's attack on abortion rests on the fundamentally flawed notion that it is "demeaning to the medical profession," Petrs. Br. 7 (quoting App. 66a-67a), and that banning abortion "protect[s] the integrity and ethics of the medical profession," Petrs. Br. 41 (quotation marks and citation omitted). The medical professionals who actually provide abortion know that, in fact, it is profoundly ethical medical care, and that the integrity of the medical profession is furthered by affording all pregnant people safe and needed medical care, including abortion.

---

[2] The narratives come from interviews conducted by amici counsel. All providers reviewed and approved their narratives. The opinions expressed are the providers' own and are not necessarily shared by the institutions for which they work.

As the accounts below illustrate, these professionals provide abortion because they know it is critical to people's health and wellbeing and makes it possible for them to live out their own vision of a good, dignified life. In other words, they know that having an abortion is among "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, [and] central to the liberty protected by the Fourteenth Amendment." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992).

Providers know, too, that abortion care stands at the vanguard of the medical profession's efforts to make care more compassionate and patient-centered. For many, the close connections they form with their patients inspire them to keep providing abortion, despite all the obstacles standing in the way. It is care they feel called to offer and are proud to provide.

A. The decision to provide and obtain an abortion is deeply ethical.

Providers know that abortion is vital to people's health and makes it possible for their patients to live dignified lives of their own choosing. Simply put, they provide that care because their patients need it. For them, it would be unethical *not* to provide it.

* * *

Bhavik Kumar, M.D., M.P.H.

Dr. Kumar provides abortion, gynecological, and primary care in Texas. He attended medical school at

Texas Tech University and completed his residency in family medicine at Montefiore Medical Center in New York.

Growing up in Texas, as a brown, gay, undocumented immigrant, I quickly learned that there are systems of oppression that keep certain people in power and allow them to control the trajectory of other people's lives. I also saw firsthand how the lack of access to accurate and comprehensive sex education in Texas contributed to unwanted pregnancies. At the same time, I observed how critically important access to abortion was for my friends, family, and community members—it provided them with the ability to have autonomy over their own lives and to reach their full potential.

When I was in medical school, I got involved with Medical Students for Choice and learned about the shortage of providers, particularly in the South and Midwest, and how difficult it is to recruit new physicians to provide this care in hostile states. I thought about all the people I knew who had benefited so much from being able to access abortion, and I wondered, who is going to be left in Texas to provide patients with the care that they need after the current providers retired? Nobody, I worried.

Patients' stories are what drive me to continue doing this work, despite the hostility that I face. I develop a sacred relationship with patients. They often share with me intimate details of their lives that they might not tell anybody else, ever. It's so valuable to be able to provide this service to patients, and to help them obtain the care that they need when they are

often at their most vulnerable. If I'm not helping patients, providing them with the care that I've been trained to provide, who am I? It's what gives my life meaning.

* * *

Like Dr. Kumar, the close connection Dr. Dermish forms with her patients drives her to provide this much-needed care.

* * *

Amna Dermish, M.D.

Dr. Dermish provides abortion, gynecological, and primary care in Texas. She attended medical school at the University of Colorado, completed her residency in obstetrics and gynecology at Pennsylvania Hospital in Philadelphia, and completed a fellowship in family planning at the University of Utah.

Our patients are 100% the reason I come to work every day. It's the conversations with patients that give my work so much meaning. It's every time a patient holds my hand or gives me a hug and thanks me for the care I've provided.

Patients often share deeply personal and private information with me. They will explain to me their reasons for getting an abortion. Sometimes it's because of a concern about a medical complication. Sometimes it's because they are worried about the status of their relationship and don't want to parent alone. Sometimes it's because they don't feel like they

can have another child on top of the children they're already parenting. And sometimes they will explain just how vulnerable they're feeling, expressing concerns about how other people will judge their decision to obtain an abortion. Part of my role as an abortion provider is to give people the space to have that kind of open conversation with me, and to make sure they know that I understand their reasoning and validate and support their decision-making, whether it's to have an abortion or to carry the pregnancy to term.

It is a privilege and responsibility to have these kinds of intimate interactions with patients. And it's a privilege to hear back from some patients years later about the positive impact that being able to determine whether or when to have a child had on their lives. I remember one person who came back to our health center a couple of years after her abortion to tell me how her abortion had allowed her to graduate from college and fulfill her dreams for herself. That was a special day.

* * *

The connection providers form with their patients often isn't limited to counseling and exam rooms. Providers are members of their communities, and their patients are their children's teachers, fellow members of mom groups, and spouses' co-workers. That community link is often an important part of why they work in abortion care in the first place.

* * *

Lori Williams, M.S.N., A.P.R.N.

Ms. Williams is the clinical director and nurse practitioner at Little Rock Family Planning Services in Arkansas.

For me, abortion care is natural. It is a calling. It is my passion. People in the abortion community—people who feel just as passionately about their work as I do—have said to me, "You've chosen such a hard place to provide this care. You could do this in places where it wouldn't be so stressful and difficult. Why Arkansas?" But I always knew that I needed to do this work in Arkansas. And I still feel that way. This is my home. This is where I live. This is where I am raising my children. This is where I need to be. The women of Arkansas need this care and I'm proud and honored to provide it.

* * *

Medical students currently training to provide abortion feel the same call to serve their communities. A medical student in Mississippi reports:

> I'm committed to providing abortion care in Mississippi. I have lived here for nearly a decade. I want to use my skills here and help the people I see every day. People's lives are at risk if abortions are not available.

Similarly, Harvard Medical School student Mugdha Mokashi plans to provide care in Alabama when she completes her training:

> I want to provide abortion care in Alabama because it is where I grew up and where I consider home. There are so few providers in Alabama, and I feel like I could make such a meaningful contribution to patients in my home state.

Some providers have themselves had abortions—an experience that further helps them understand and connect with their patients.

* * *

Ying Zhang, M.D.

Dr. Zhang provides full-spectrum family care, including primary care, obstetrics, family planning, and abortion in Seattle, Washington.

I provide full-spectrum primary care. That includes taking care of babies, children, adults, and older people. And it includes taking care of people who are pregnant and want to be pregnant, and people who are pregnant and don't want to be pregnant. With that perspective, it's easy for me to see that abortion care should be a regular part of health care. It is care that people need to live their fullest and best lives.

In fact, it was care that both my mother and I needed and received. It changed the trajectory of both of our lives. Having had that experience has helped me empathize with patients. I understand there are so many reasons why some chose to keep pregnancies, and some chose to have an abortion. I am fortunate that I have the training to help and support patients

no matter what they decide is best for them, their health, their families, and their futures.

* * *

Many providers are parents, too, just like their patients—a factor that plays into the decisions to have and provide abortions.

* * *

Ghazaleh Moayedi, D.O., M.P.H.

Dr. Moayedi is an OB-GYN and complex family planning specialist. She received her medical degree from Texas College of Osteopathic Medicine and provides abortion care in Texas and Oklahoma.

Many of the people I take care of are already parents. They both love and have compassion for their pregnancies and know they can't continue them. That love and compassion is what drives them to choose abortion. Our patients are moms and we are moms, too. We do this work out of a deep love for kids, for families, and for communities. Abortion care is part of supporting thriving families and communities.

* * *

All providers overcome enormous obstacles to provide abortion care, including onerous and medically unnecessary regulations, hostility, harassment, and other outrageously unethical behavior. For some, those obstacles also include outright racism. Dr. DeShawn Taylor, perhaps the first Black woman to

own an abortion clinic in the United States, describes her experience.

* * *

DeShawn Taylor, M.D., M.Sc., FACOG

Dr. Taylor is an OB-GYN, clinical professor, and reproductive rights advocate who founded and owns Desert Star Family Planning clinic in Phoenix, Arizona. She received a medical degree from UCLA and completed postgraduate training in obstetrics and gynecology at King/Drew Medical Center in Los Angeles and a fellowship in family planning at the University of Southern California, where she also received a master's degree.

I have a trifecta of triggers for harassment: I'm Black, a woman, and I provide abortion care. Those are three ways that I am walking through the world and monitoring my spaces. I don't get called just "a baby-killer," I'm "a n****r baby-killer." I'm accused of "committing Black genocide." Those aren't things white abortion providers have yelled at them. And so, my level of vigilance is significantly heightened. But people need abortions, so I do what needs to be done to make sure abortion care is available to them.

* * *

No one should have to endure the harassment that Dr. Taylor and other providers face, but they persevere because they are devoted to providing the care their patients want and need.

B. Abortion care elevates the medical profession.

Abortion care is among the most compassionate, ethical forms of medical care available. As Dr. Moayedi observes, "abortion providers are at the cutting edge of ethical health care in this country. Our work happens at the intersection of racial, social, gender, economic, disability, and immigration justice. Being an abortion provider means being fluent in understanding those intersections of oppression." Dr. Colleen McNicholas agrees.

* * *

Colleen McNicholas, D.O., M.S.

Dr. McNicholas completed a residency and fellowship in OB-GYN at Washington University in St. Louis School of Medicine. Following a decade in academic medicine, she became the Chief Medical Officer of Planned Parenthood of the St. Louis Region. She currently provides abortion in Missouri, Illinois, and Oklahoma.

The medical profession as a whole is trying to move toward a more patient-centered approach, an intersectional understanding that takes account of the many factors that affect health and wellbeing. Abortion care is well ahead of most other areas of medicine in making that move.

My ethical responsibility and the responsibility of people who care for pregnant people is to fully see the

person standing in front of us. That means understanding not only their health status but also the social situation around them—what is the context in which this person needs or wants to be or not to be pregnant? At the same time, providers have to trust that patients are truly the experts in their own lives. We are here to provide technical, medical information, and to talk about safety and risk. But ultimately, we have placed the patient at the center of their care. We trust that they know what is best for them and their family.

* * *

Unfortunately, the high standard of care and compassion abortion providers show often stands in stark contrast to how some health care professionals treat their patients. A medical student in Louisiana and an abortion provider in Colorado describe the disparity.

* * *

Jessica Mecklosky

Ms. Mecklosky is a medical student in Louisiana.

As a doctor, you are there to help the patient with whatever they need. Here, I have seen anti-abortion doctors criticizing their patients, withholding information, and treating sexual assault victims with disrespect and without sympathy. For example, I have seen doctors fail to give information about birth control when discharging new mothers—even though this is a national standard of care. I saw several doc-

tors who were totally unfamiliar with the judicial bypass procedure for a minor to obtain an abortion. I observed doctors deny knowing the location of the only abortion clinic in New Orleans. These patients desperately need accurate information about their reproductive health, from sex education to abortion counselling, and they aren't getting it.

* * *

Kristina Tocce, M.D., M.P.H.

Dr. Tocce is Vice President and Medical Director for Planned Parenthood of the Rocky Mountains. She obtained her medical degree from Albert Einstein College of Medicine and completed her OB-GYN residency at Mount Sinai School of Medicine in New York, where she also taught. She completed her master's degree and family planning fellowship at the University of Colorado.

I can't tell you how many patients I have had who were against abortion until they needed one. They say, "I never thought I would be here. Thank you for being so compassionate. I was so afraid of being judged because I never supported this care before." I appreciate that. "Of course we'll take care of you," I tell them. We take care of everyone, and without judgment.

* * *

Given that, nothing strikes abortion providers as more outrageous than Mississippi's contention that

abortion care is "demeaning to the medical profession." Petrs. Br. 37 (quotation marks and citation omitted). Dr. Yashica Robinson shares her reaction below.

* * *

Yashica Robinson, M.D.

Dr. Robinson is an OB-GYN who provides abortion in addition to routine obstetric and gynecological services in Alabama. She attended medical school at Morehouse School of Medicine and completed her residency at the University of Alabama at Birmingham.

As an abortion provider, I strive for integrity and to maintain the ethics of the profession. That means providing patients the care that they need. Like many abortion providers, that is one of the reasons I fight to provide this care. It is unethical to withhold care that a patient needs, sometimes so desperately. That is especially true with patients who have the fewest financial resources, the least amount of social support, and very little meaningful access to health care in general. They are the ones most affected by restrictions on abortion.

We sometimes have medical trainees come to our clinic who have reservations about providing abortion care. But when they step into our clinic, they change their minds. They see that some patients are very young. Some are in the state foster-care system. Some have survived sexual assault and become pregnant. Sometimes it's all of these things. The trainees see

what these patients have to go through—state-mandated judicial bypass if neither parent is available or willing to consent; the 48-hour waiting period the law requires all patients endure; having to travel long distances. It is one thing after another, adding up to mounting costs, distress, and delays that sometimes push people further into pregnancy before they are able to actually have the abortion procedure.

Seeing patients and all the hoops they are forced to jump through and how desperately they want and need our services changes those trainees' hearts and minds. They see that it would be cruel *not* to provide our services.

II. It Is Critical That Abortion Be Available Beyond The First Few Weeks Of Pregnancy.

When Mississippi isn't urging this Court to permit states to ban abortion entirely, it is defending its 15-week ban on the ground that it does not ban *all* previability abortions. Petrs. Br. 46-48. People who want abortions, the state says, can simply get them earlier in pregnancy. Petrs. Br. 47-48. But as abortion providers like Dr. Moayedi know, "There are about a million reasons patients don't get abortions earlier." "Blaming patients," as Dr. Tocce puts it, "isn't just wrong; it ignores reality."

Dr. Kumar explains that, while patients having abortions after 15 weeks are "fewer in number," they are usually the "most complex and compelling cases." Research shows that more than half of the people seeking second-trimester abortions do not realize they are pregnant until after the first trimester. Resps. Br.

30. And as Dr. Kumar observes, these second-trimester patients are often "people with low incomes, and/or people of color who had more barriers and hurdles that they needed to overcome to get to the health center. We prioritize getting these patients the care that they need because we don't want to be adding any additional barriers."

Those barriers and hurdles work together to delay patients from accessing abortion care earlier. Dr. Taylor explains that "many people getting abortions at 15 weeks don't get them earlier because they don't have access to a clinic close to where they live. Even just getting a ride can be incredibly difficult and can push things down the road."

Targeted restrictions on abortion providers passed by states have severely limited the number of providers by making it too expensive or difficult to stay open. Those medically unnecessary regulations—including mandatory waiting periods and multi-visit requirements—also make it more difficult for those who need to travel to get abortion care. Marva Sadler, the senior director of clinical services at Whole Woman's Health in Texas, reports: "Scheduling those visits can be a nightmare. Patients have to arrange for time off from their jobs, childcare, transportation, everything."

The same is true in Mississippi. A medical student there, who is training to become an abortion provider and works as a volunteer escort at Respondent Jackson Women's Health Organization, reports:

> Let's say you live in the Delta, a low-resource area. And maybe you already have kids so you have to find someone to sit for them. Then you have to find a way to get all the way to Jackson. You have to get off of work. You have to find a way to pay for the overnight stay somewhere because it's just as expensive to drive back and forth in your car—that is, if you have one. It's just one thing on top of another. I can't imagine how people swing it half the time.

Amy Hagstrom Miller, who oversees clinics in states that are both hostile to and more supportive of abortion, has special insight into how medically irrelevant external factors—especially government-imposed barriers—delay patients' access to care. She compares the access picture in Maryland versus Texas even before Senate Bill 8 (SB8), discussed *infra* § III, virtually banned abortion in Texas.

* * *

Amy Hagstrom Miller

Ms. Miller is the President and CEO of Whole Woman's Health and President of Whole Woman's Health Alliance, which together operate clinics in Texas, Maryland, Virginia, Indiana, and Minnesota. She has been involved with the provision of abortion care for over 30 years.

How people obtain abortions in this country is day and night depending on where they live, even though the abortion procedure and safety outcomes are the

same everywhere. In some states, government-imposed barriers make it exceedingly difficult for people to access abortion and delay their care. In states where Medicaid and private insurance do not cover abortion, where patients must make two trips to the abortion facility (and in some cases are mandated by the state to meet with the same physician at those two visits), and where few clinics remain because of state restrictions, patients are more likely to be pushed into the second trimester. And for some patients, these state-imposed barriers make it impossible for them to access an abortion at all.

In our clinic in Fort Worth, Texas, for example, a patient usually must wait at least two to three weeks before she can obtain her first appointment. A patient is often further delayed as she attempts to gather the funds to pay for the abortion since she can use neither Medicaid nor insurance to cover the cost, as well as to pay for related travel expenses. And in a cruel cycle, the longer she is delayed in gathering funds, the harder it is for her to pay for the abortion because the cost increases with gestational age. But at our clinic in Baltimore, Maryland, many patients can get an appointment for the very next day, and funding is usually not a barrier given Medicaid and private insurance coverage. It's no surprise that we perform a lot more second-trimester abortions in Fort Worth than we do in Baltimore. The state itself is at fault for delaying patients into the second trimester.

* * *

Dr. Moayedi agrees that lack of access is the biggest obstacle and identifies other reasons why her patients are sometimes delayed in obtaining abortions.

* * *

Dr. Moayedi (continued from Section I.A)

The biggest obstacle is a lack of access to abortion clinics. In Texas, there are far more places that deceive people about how far along they are and what their options are than there are facilities providing abortion care.

Next, sex education is wholly lacking in Texas. Texas children are only taught about abstinence, so our communities aren't getting educated on how they can get pregnant, how to prevent pregnancy, and how to detect pregnancy. I've cared for a patient coming in at 32 weeks pregnant, who for months took a combination of medications to combat various pregnancy symptoms because she didn't realize she was pregnant. By that time it was too late for her to have an abortion. That is not a failure on her part. That is a failure of our education system and our communities.

Some people also need time to process their emotions and figure out what they want to do once they learn they are pregnant. They often want to talk to their partners, parents, siblings, kids, clergy, and other doctors before they come to us.

Life circumstances also change. I take care of so many people who thought they were in loving, supportive relationships until they became pregnant.

People who had been planning to continue a pregnancy with a loving partner suddenly find themselves without a spouse, a house, and a way to take care of themselves.

And, of course, there is a small but important percentage of people who are waiting on a diagnosis. A medical condition might change or be gravely affected by pregnancy. We might not find out until well after 15 weeks that a pregnancy has a severe medical condition.

III. Banning Abortion Causes Serious Harm.

Mississippi claims that *Roe v. Wade*, 410 U.S. 113 (1973), has "inflicted significant" and "profound damage." Petrs. Br. 3, 14. To the contrary, overruling *Roe* would cause grave harm—and not just to the people who wish to end pregnancies.

A. Providers have already seen the damage abortion restrictions and bans do.

It does not take a crystal ball to forecast the consequences of allowing states to ban abortion. Providers have already seen what happens when access is severely restricted or abortion is even temporarily outlawed. For instance, early in the COVID-19 pandemic, several states halted abortion care, based on various pretextual reasons. And now, with SB8, Texas has banned abortion at approximately six weeks after the first day of the person's last period—which is just two weeks after a missed period for a person who has a perfectly regular menstrual cycle. Both have given

providers a heartbreaking glimpse into a future without *Roe*. Dr. Kumar describes his experience.

* * *

Dr. Kumar (continued from Section I.A)

When Texas banned abortion in the spring of 2020, claiming falsely that abortion was a non-essential service, our clinic was forced to shut down four different times. I remember one patient who came to our clinic four times—we had to turn her away twice because of court orders that were issued while she was in our waiting room. I had patients who had to travel, in the middle of a pandemic, to as far as Chicago or Colorado, to access the care that we could have provided right here. And I had other patients who didn't have the means or ability to travel out of state. Many of those patients, most of whom had low incomes and were people of color, were likely forced to carry pregnancies to term. I think a lot about those patients—forced to carry to term a pregnancy they didn't want, and then forced to give birth at the height of the pandemic in Texas—and I think about the trauma of it all. Why are we imposing this unnecessary trauma on people as they try to access a service that is already so stigmatized?

But that trauma is continuing. On September 1, 2021, SB8 went into effect. I can now no longer provide abortions to patients who have cardiac motion present on an ultrasound, which can be even days before six weeks past their last period—which is less than two weeks after a missed period (if the patient

has regular periods, which many do not) and long before many patients even realize they are pregnant. It's an effective ban on most abortions in the state.

It's devastating to have to turn away so many patients and tell them that we can't provide them with the care that they need. I will usually perform between 20 and 30 abortions per day, but the day after the ban took effect, I was able to provide care to only three patients. I had to turn away other patients and tell them that their only option is to travel to another state. Just like with the COVID ban, I am fearful that many of our patients, particularly people with low incomes and patients of color, won't be able to get care out of state and will be forced to carry pregnancies to term. I am so worried about what this means for the physical and mental health of Texans.

* * *

Amy Hagstrom Miller (continued from Section II)

Abortion is now almost entirely inaccessible in Texas. Based on our prior experience, we know that the majority of patients will not be able to travel out of state due to their work, school, family, or childcare responsibilities and the high costs. Travel is particularly difficult, if not impossible, for our patients in the Rio Grande Valley, many of whom cannot travel out of state for fear of being deported. One patient told our staff she was unable to travel out of state and would instead try to obtain pills from Mexico.

* * *

Dr. Dermish (continued from Section I.A)

The COVID shutdown was awful—our staff had to call patient after patient to cancel their appointments. We had to rotate staff through that job because it was simply too heartbreaking for them to continue telling patients that they couldn't get the care that they needed. And after SB8 went into effect, we're going through this heartbreaking process yet again. But this time it's even worse because there's no end in sight. Just today, I had to turn away several patients who were too far along to obtain an abortion in Texas, including a patient who was less than six weeks pregnant. One curled up into a fetal position and started bawling hysterically. The others reacted more calmly but with no less devastation. I'm already dreading tomorrow, where I will yet again be forced to inflict pain on my patients as I deny them the care they need.

* * *

Providers in states that stayed open during the COVID shutdowns and are dealing with the ramifications of SB8 have also seen a frightening preview of a post-*Roe* world as they struggle to deal with an influx of those patients who are able to make it to another state to obtain care. Dr. Tocce recounts her experience in Colorado.

* * *

Dr. Tocce (continued from Section I.B)

In April 2020, after Texas banned abortion, our clinic in Colorado saw a massive increase in patients

from Texas. Patients were literally fleeing the state to obtain the care they needed, in some cases driving 12 hours each way. "My state does not care about me," they told us.

Patients were terrified on their way to us. Many—in particular patients of color and patients I perceived to be undocumented—not only had to get time off work, find a ride, coordinate childcare, and arrange for housing and food while on the road. They were also petrified that they would be stopped by the police on their long drives. And they were traveling during the height of a pandemic when people weren't even supposed to leave the house.

Every appointment was filled. We had to double-book some appointments and backlog others. Patients were so appreciative that they were able to obtain the care they needed that they sobbed in gratitude. But I think about the patients who couldn't reach us, who couldn't get together everything it takes to get to us. I fear what happened to them.

Now we are seeing this again as a result of SB8 in Texas. This time there is not an expiration date to an executive order; it is simply the state of health care in Texas today. Over the past two weeks, we have seen so many individuals from Texas. I am incredibly thankful to be able to provide care to patients who are able to travel to us and we are trying our best to accommodate as many of those patients as we can. But again, for every patient that reaches us, I worry about how many are not able to. Individuals of means will always find a way to obtain abortion care; SB8 is absolutely devastating to those who cannot. They are

forced to pursue a path in life that they did not choose; they may suffer from serious medical impacts of pregnancy as well. This is unacceptable medically and perpetuates racism and poverty.

* * *

Before SB8, Lori Williams in Arkansas described the COVID-shutdown deluge of patients as "the most difficult thing I've faced in 20 years." Like Dr. Tocce in Colorado, Williams and her team are again dealing with a flood of new patients. She discusses the challenges her patients face and her concerns for them.

* * *

Lori Williams (continued from Section I.A)

We're already starting to see patients from Texas. Women of means are the ones we're seeing first; they've been able to figure it out. But for others, it may take weeks to even make a plan. Some of them are hoping that if they wait, care will become available again in Texas. Others haven't been able to find someone who can drive them the five, six, or seven hours one-way across state lines. Arkansas's 72-hour waiting period is another barrier. People are calling us and saying, "Maybe I could get there once, but there's no way I can get there twice. There's no way I can take off work twice, find childcare twice, and get a ride twice." As a result of that, we're expecting a surge of second-trimester procedures.

We're worried, too, about what will happen in Arkansas. Well-known anti-abortion legislators have already expressed a desire to pass something similar here as quickly as they can. It's very distressing and confusing to our patients.

* * *

Dr. McNicholas, whose clinic in Illinois already sees many patients from more restrictive states, also worries about their capacity to take on more:

> We are already seeing patients six days a week for nine hours a day. If we have to absorb even more patients from other states, that means longer delays. It is ironic that the politicians who are trying to restrict second-trimester abortion are the ones who will be responsible for pushing abortion later into gestation, including well into the second trimester.

Unfortunately, the COVID pandemic and SB8 aren't the only times patients have not been able to access abortion care in their home states (or regions). Among other restrictions, gestational limits similar to Mississippi's have made that experience all too common.

* * *

Dr. Dermish (continued from Section I.A)

Even before SB8 went into effect, I was routinely forced to turn away second-trimester patients who were too far along to access an abortion in Texas because of the state's gestational limit. There is this misconception that if abortion isn't available, people will just move forward and go on to have a beautiful family. I can tell you that when this option is taken away from patients, they do not respond with joy. They respond with anger, fear, and resignation.

For patients who are interested, we will refer them to an out-of-state provider. They usually don't have the resources to fly anywhere, so they are only interested in what's within driving distance. The closest option for patients in their second trimester is in Albuquerque. It's an 11-hour one-way drive from Austin.

Many patients are completely overwhelmed when I tell them that they can't obtain an abortion in Texas. Those are the patients I never hear back from, and who likely end up carrying to term. It's a lot for patients to process. And the exact same circumstances that have led them to be delayed in accessing care—financial hardship, lack of childcare, inflexible work schedules, lack of familial support—are exactly what will prevent them from getting to Albuquerque.

* * *

Dr. Tocce (in Colorado) shares the story of a patient she helped who would not be able to access care

if a law like Mississippi's abortion ban had been in place.

* * *

Dr. Tocce (continued from Section I.B)

I had a patient who was 13 years old and had been repeatedly sexually assaulted by her mother's boyfriend. She never even had her first menstrual period—she became pregnant as a result of sexual assault that had been going on since she was eight. By the time her mother figured out what was going on and brought her to us, the patient was just under 23 weeks pregnant.

They were an immigrant family who spoke only Spanish and had already been through so much: The mother had only just learned that her partner had been assaulting her daughter and they had to relocate to protect themselves. Here she was, this 13-year-old girl, wearing a Mickey Mouse sweatshirt. I can't imagine being in her situation and being told, "You must deliver this baby." I can't imagine looking her mother in the eye and telling her, "It's not allowed. She can't have an abortion." I can't even fathom it.

If we had to turn her away, I don't know how she and her family would have navigated the system and accessed care. Travelling was not possible for them—the family wouldn't have been able to coordinate finances and flights and get childcare for the other children. Fortunately, we in Colorado were able to take care of that patient. She had a tremendous road to emotional recovery ahead of her after that horrific

history of assault, but at least she was not forced to have a baby she could not care for.

B. Banning abortion perpetuates inequality and risks patient safety.

The prospect that this Court could permit states to ban abortion is "the scariest thing" medical student Mugdha Mokashi, who has already begun training to provide abortions, can imagine. She continues:

> It means that I won't be able to go home to Alabama and take care of the community I grew up in. It means that where someone resides will directly impact their ability to live their lives on their own terms. And it will deepen inequities in our society.

Amy Hagstrom Miller elaborates on the inequalities that will result:

> Access to safe abortion is a fundamental right that generations have been able to depend on in this country. Knowing that you could have an abortion if you needed one, even if you don't ultimately end up having one, has allowed generations of women to dream about their futures with true equality. It is devastating to think about what it would look like if that went away.

Some providers remember what it was like before *Roe*, and they fear what it will be like after.

Mona Reis

Ms. Reis founded the Presidential Women's Center in Palm Beach County, Florida, over 40 years ago. The day after Roe *was decided, she joined the University of Miami School of Medicine as a counselor to work in the first outpatient abortion clinic in Miami. She has been a leader in the movement for reproductive rights ever since.*

Growing up in the 1960s, I knew women who had to travel to other countries to have abortions. Those who couldn't afford to travel risked their lives being blindfolded on a street corner and taken to a secret location to have an abortion that may not even have been performed by a trained clinician. Their loved ones spent hours wondering if they were safe. They did not have access to any follow-up services, like counseling, and had to keep their abortions secret. The whole process was needlessly traumatic. A legal, accessible abortion provides protection for everyone—the patient, their family, and the providers.

We are about to put people into crisis—especially people with the least resources. I cannot believe this is still not settled, that women still don't have access to comprehensive health care. To me, it is the most fundamental right we have. Having an abortion can be one of the most important decisions a woman will ever make. So many times a patient says, "I never expected to become pregnant. I want to go to college." Or, "I'm in medical school and want to continue." Women have hopes and dreams. When women don't want to be pregnant and don't have the resources to

be parents, what kind of life is that for them? For their children?

* * *

Advances in medicine and technology may have made self-managed abortions less risky than they once were, but many providers still fear what pregnant people will do if abortion is outlawed and they cannot travel to obtain one. As Lori Williams says, "It's frightening to think what people will do if they are faced with a total inability to get care—particularly those patients who are in the second trimester. We are afraid of what people who are that desperate will do when they run out of options."

Dr. Kumar elaborates on his fears.

* * *

Dr. Kumar (continued from Section I.A)

Banning abortion doesn't mean that the need for abortion will stop. Real people will bear the consequences. Some patients who are early enough in pregnancy will access abortion pills online, and some patients with financial resources will travel out of state, but other desperate patients will turn to unsafe means, like unregulated providers or self-harm.

In countries where abortion is banned or restricted, we find higher maternal mortality rates and people accessing unregulated and, at times, unsafe abortions. We are already hearing from patients who are accessing pills, herbs, teas, and other alleged

treatments for abortion on their own, because of Texas SB8. The harsher the restriction and the longer it stays in place, the more common and dire these patient stories will become.

* * *

The medical student from Mississippi shares Dr. Kumar's fears:

> We know that in places where abortion is illegal abortions aren't less common, they are just less safe. Here in Mississippi, I had a patient at a free medical clinic where I volunteer say, "There better not be a baby in there because if there is, I'm going to drink some turpentine." People will do extreme things because they need to not be pregnant. That's understandable. If you come from a low-resource area, your option isn't going to be to go on the internet and buy abortion pills, your option is drink some bleach, which people do, or use a coat hanger, which people do.

C. Banning abortion hurts people who want to continue pregnancies.

The consequences of cutting off abortion access are not limited to people who wish to terminate pregnancies. "People don't realize that banning or restricting abortion care doesn't just impact abortion," Dr. Moayedi observes. "It impacts every aspect of pregnancy care."

Dr. Robinson agrees: "When you restrict abortion access, you end up with providers who aren't competent to provide that care in an emergency." In other words, even abortion bans that have exceptions to save lives risk those very lives. Dr. Taylor's experience bears that out.

Dr. Taylor (continued from Section I.A)

Abortion saves lives. I was brought in to care for a patient who was 22 weeks pregnant, had children at home, and was having heart failure. She was in the cardiac intensive care unit, and she was dying. I came in on a holiday weekend to do the abortion procedure. She had to have the procedure on a bypass machine. The procedure took five minutes. Right after, the cardiologist turned to me, in shock, and said, "Oh my god, she's already improving on cardiac indices." I simply replied, "That's what we do." The woman was out of the hospital three days later, back to her children.

There are people who believe it is God's will to let that woman die, that is, until it is *their* loved one in that position. Then, they want someone to have the skills to save them. But how does someone have those skills if they never have a chance to get them? The state talks about demeaning the medical profession. But what is the black eye on the profession? It's not giving that person the procedure she needs and letting her die.

* * *

Dr. Taylor's experience isn't unique, as Dr. Moayedi recounts below.

* * *

Dr. Moayedi (continued from Section I.A)

I was consulted on a case of a person who was 22 weeks pregnant with triplets. She already had children and this was a wanted pregnancy; she was not seeking an abortion. But she started to have serious pregnancy complications. She needed an abortion to save her life, and as she became sicker, she begged the hospital providers for one. But that hospital wouldn't perform an abortion.

Weeks later, the woman woke up in the ICU. She had lost all three babies and her limbs. The reason was tragic, but simple: She wasn't given a lifesaving abortion when she needed it. There were many reasons for that, but they all hinge on the restrictions on abortion in Texas at that time, which meant both that physicians lacked training in how to provide abortions and that physicians were confused about when those restrictions applied. So this mother of several children has become permanently disabled because of the impact abortion restrictions also have on people who want to continue pregnancies and be parents.

* * *

For the foregoing reasons and those in Respondents' brief, the Court should reaffirm "*Roe*'s essential holding" and prevent states like Mississippi from extinguishing "the right of the woman to choose to have an abortion before viability." *Casey*, 505 U.S. at 846.

CONCLUSION

The Court should affirm the judgment below.

Respectfully submitted,

Elizabeth R. Moulton
ORRICK, HERRINGTON & SUTCLIFFE LLP
405 Howard Street
San Francisco, CA 94105

E. Joshua Rosenkranz
Counsel of Record
Jennifer Keighley
Rachel G. Shalev
ORRICK, HERRINGTON & SUTCLIFFE LLP
51 West 52nd Street
New York, NY 10019
(212) 506-5000
jrosenkranz@orrick.com

September 20, 2021