Nos. 21-463 & 21-588

IN THE SUPREME COURT OF THE UNITED STATES

WHOLE WOMEN'S HEALTH, *ET AL.*,

Petitioners,

v.

AUSTIN REEVE-JACKSON, JUDGE, DISTRICT COURT OF TEXAS, 114TH DISTRICT, *ET AL.*,

Respondents.

UNITED STATES OF AMERICA,

Petitioner,

v.

THE STATE OF TEXAS, *ET AL.*,

Respondents.

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

BRIEF FOR TEXAS MEDICAL ASSOCIATION AS *AMICUS CURIE* IN SUPPORT OF PETITIONERS

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**Application for Admission Pending*

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INTEREST OF *AMICUS CURIAE*

The Texas Medical Association (TMA) is the nation's largest and one of the oldest state medical societies. It represents the voice of more than 55,000 physician and medical student members committed to improving the health of all Texans. TMA's vision is to improve the health of all Texans, and it does so by supporting its mission—standing up for physicians by providing distinctive solutions to the challenges they encounter in the care of patients. TMA has an interest in the United States' application and underlying case because they substantially impact Texas' physicians.[1]

TMA's membership is divided on the issue of what the general rule of law should be with respect to the gestation period for a lawful abortion. However, as demonstrated by TMA's policies, TMA's members are united in their opposition against unreasonable interference in the physician-patient relationship with respect to virtually all medical treatments and against subjecting physicians to frivolous lawsuits. TMA's policies are adopted by TMA's House of Delegates—physicians who represent members' interests statewide. Here are a few of those policies, in relevant part, for reference[2]:

1. *Policy No. 10.002 Abortion*: TMA recognizes abortion as a legal and time-sensitive medical procedure, and the performance of abortion must be based upon early and accurate diagnosis of pregnancy; informed and nonjudgmental

[1] In accordance with Sup. Ct. R. 37.6, TMA states that no party's counsel authored this brief, in whole or in part, and no party or party's counsel contributed money to fund the preparation or submission of this brief.

[2] *See also* TMA Policy No. 10.003 Patient Autonomy and Accuracy of Information in Informed Consent for Abortion; Policy No. 245.003 Professional Freedom Erosion; Policy No. 250.002 Ethical Practice of Medicine for Physicians Participating in the Women's Health Program; and Policy No. 250.003 Limiting Physician and Patient Conversations, available at https://www.texmed.org/Policy/Index/.

counseling; prompt referral to skillful and understanding personnel working in a good facility; reasonable cost; and professional follow up.

2. *Policy No. 170.007 Professional Liability: Professional Liability*: To ensure access to medical care for Texans, TMA will continue efforts to . . . reduce or limit frivolous professional liability claims...

3. *Policy No. 245.020 Physicians Retaining Autonomous Clinical Decision-Making Authority*: TMA 1) opposes policy that prohibits physicians from following best practice guidelines as developed by their various specialty societies… and 3) opposes any policy that hinders the autonomous clinical decision-making authority of a physician or prevents a physician from providing evidence-based, empathic, and comprehensive treatment options to a patient.

4. *Policy No. 245.021 Patient-Doctor Privileged Communication*: TMA (1) opposes efforts by the Texas Legislature to insert itself into the patient-physician relationship in any way that interferes with the free and full disclosure of health care information in the best interests of the patient, and (2) reaffirms its support of the free exchange of professional information in the patient-physician relationship as privileged and worthy of the highest professional protection.

Accordingly, consistent with TMA's policies, TMA presents this *amicus curiae* brief in support of the United States.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

TMA submits this brief to supplement the United States' argument on standing to enjoin the State of Texas, including its officers, officials, agents, employees, and any other persons or entities acting on its behalf, and private parties seeking to enforce S.B. 8 to prevent harm to the "general welfare" and "public at large." *In re Deb*, 158 U.S. 564, 584, 586 (1895). Despite the State's contention otherwise, the federal government's standing is not limited to statutory authorization. "The United States … has in many cases been allowed to file suits in this and other courts against States … with or without specific authorization from

Congress." *U.S. v. Mississippi*, 380 U.S. 128, 140 (1965) (citing case examples). To hold contrary would diminish the powers of the courts to protect the people of this country against deprivation and destruction by the States of their federally guaranteed rights. *Id.* at 141.

If the enforcement of S.B. 8 is not enjoined, in addition to the harm identified by the federal government, it will also result in the continued following harm to the general welfare: (1) unreasonably interfering in the physician-patient relationship, hurting the ability for physicians to provide quality healthcare; (2) causing medical residents to seek out-of-state training programs to meet their training requirements, which threatens Texas' already critical physician shortage; and (3) interfering with physicians' due process rights and abusing the court system with frivolous lawsuits.

For example, the vague restrictions in S.B. 8 chill important conversations between physicians and their patients about medical care due to the potential of violating S.B. 8. *See, e.g.*, Tex. Health & Safety Code § 171.208(a)(2)-(3). The vague "conduct that aids or abets" language of S.B. 8 is deterring physician communications with pregnant patients diagnosed with certain conditions, such as cancer or Adult Congenital Heart Disease. Physicians are directed by recognized national standards to have conversations about the potential impact of a disease or a recommended treatment on the patient's pregnancy. Many times, these conversations involve the risk of a negative outcome on the patient's pregnancy. These conversations might factor into a patient's decision to pursue an abortion in violation of S.B. 8. Physicians

are concerned these medically appropriate conversations would subject them to a lawsuit under the new law.

Similarly, it is standard practice for obstetricians to offer genetic testing and counseling for their pregnant patients. Under S.B. 8, physicians are concerned the language "conduct that aids or abets" does not provide clear guidance on whether they are restricted from providing these services if a patient ultimately pursues an abortion in violation of the law after the testing and/or counseling. *Id.*

Further, national medical ethics standards direct physicians to engage in these conversations with patients. *See, e.g.*, American Medical Association (AMA) Code of Medical Ethics, Opinions 1.1.3 & 2.1.1. These standards also recognize, and studies support, the positive health benefits of unrestricted, confidential dialogue between physicians and patients, including better patient health outcomes and establishing effective treatment plans. Attempting to comply with the vague restrictions in S.B. 8 puts physicians directly in conflict with providing quality medical care.

Also, because of S.B. 8's restrictions, medical residents are expected to seek training out of state to meet certain medical accreditation requirements. This is troublesome because Texas is facing a critical physician shortage that sources report may continue to grow in the next decade.[3] Studies show that medical residents are more likely to take physician positions in the state where they completed their

[3] Tex. Health and Human Services Commission, Department of State Health Services, Texas Physician Supply and Demand Projections, 2018-2032 (May 2020), available at https://www.dshs.state.tx.us/legislative/2020-Reports/TexasPhysicianSupplyDemandProjections-2018-2032.pdf.

residency program.[4] TMA has also received feedback that S.B. 8's restrictions will make it harder for schools to recruit medical students, further exacerbating the physician shortage in this state.

Additionally, S.B. 8 violates due process requirements and threatens to overload the court systems. The law fails to clearly outline what conduct (or intended conduct) constitutes a violation of the law. *See e.g.*, Tex. Health & Safety Code §§ 171.208(a)(2)-(3) ("engages [or intends to engage in] conduct that aids or abets") & 171.205 ("medical emergency" exception). This due process violation interferes in the physician-patient relationship by causing confusion concerning what a physician can or cannot counsel the physician's patient on. *See Pacific Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 44 (1991) ("Due process requires that a State provide meaningful standards to help guide the application of its laws." Otherwise "such standards are void for vagueness" and should be enjoined). This is especially troubling because it puts physicians at odds with nationally recognized standards of medical care, increasing the risk of a lawsuit for a violation of those standards.

Finally, as another example of the harm caused by S.B. 8, it purports to allow almost any individual or entity to file a lawsuit for an alleged violation of the law without any actualized, individual injury. Tex. Health & Safety Code § 171.208 (a). This attempts to unconstitutionally circumvent well-established standing principles required by state and federal courts and flood the U.S. court system with baseless,

[4] AAMC, Report on Residents, Table C6: Physician Retention in State of Residency, by State (2008), available at https://www.aamc.org/data-reports/students-residents/interactive-data/table-c6-physician-retention-state-residency-training-state.

costly litigation. *See Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 150, 158 (2014) (discussing the injury-in-fact standard for standing); *Spokeo, Inc. v. Robins*, 578 U.S. 330, 136 S.Ct. 1540, 1548 (2016) ("For an injury to be 'particularized,' it must affect the plaintiff in a personal and individual way."); *Heckman v. Williamson County*, 369 S.W.3d 137, 155 (Tex. 2012) ("After all, our Constitution opens the courthouse doors only to those who have or are suffering an injury. As for the injury itself, it must be concrete and particularized, actual or imminent, not hypothetical.") (internal citations omitted). Of course, the provision awarding a prevailing plaintiff attorneys' fees and a *minimum* of $10,000 in damages, while simultaneously ensuring a prevailing defendant cannot recover attorneys' fees, is grossly unfair and serves as a cordial invitation to open the proverbial floodgates to frivolous suits. Tex. Health & Safety Code § 171.208(b) & (c).

For all of these reasons and those others herein discussed, the federal government has standing to bring this case and enjoin the State, including its officers, officials, agents, employees, and any other persons or entities acting on its behalf, and private parties from enforcing S.B. 8 to prevent further harm to the general welfare of Americans.

ARGUMENT

TMA offers this brief in support of the United States' and specifically supplements the basis for standing under *In re Deb* and the harm to the "general welfare" and "public at large" that will result from failure to permit the United States to enjoin the State of Texas, including its officers, officials, agents, employees, and any other persons or entities acting on its behalf, and the millions of private parties

purportedly granted standing under S.B. 8 to enforce the law. *In re Deb*, 158 U.S. at 584.

I. *In re Deb* Supports Standing for the United States to Prevent Harm to the General Welfare and Public at Large.

This Court recognized in *In re Deb* the important duty the United States is tasked with, to "promote the interest of all," which "to prevent the wrongdoing of one resulting in injury to the general welfare, is often sufficient to give standing in court." *Id.* Despite the State's contentions otherwise, this duty is not restricted to statute. "The United States … has in many cases been allowed to file suits in this and other courts against States … with or without specific authorization from Congress." *Mississippi*, 380 U.S. at 140 (citing case examples). Indeed this concept dates back to "ratifying the Constitution, [where] the States consented to suits brought by … the Federal Government[,] … entrusted with the duty "take Care that the Laws be faithfully executed." *Chao v. Virginia Dep't of Transp.*, 291 F.3d 276, 281-282 (4th Cir. 2002) (citing U.S. Const., Art. II, § 3). These principles authorize the United States to seek to enjoin the State of Texas, including its officers, officials, agents, employees, and any other persons or entities acting on its behalf, and private individuals seeking to enforce S.B. 8. To hold contrary would "diminish the powers of the courts to protect the people of this country against deprivation and destruction by the States of their federally guaranteed rights." *Mississippi*, 380 U.S. at 141.

II. Failure to Grant Standing to the United States to Protect the Welfare of the Public Will Continue to Allow S.B. 8 to Cause Substantial and Irreparable Injuries.

In addition to the harm identified by the federal government, failure to enjoin S.B. 8 will continue to result in the following serious, irreparable injuries: (1) unreasonably interfering in the physician-patient relationship, hurting the ability for physicians to provide quality healthcare; (2) causing medical residents to seek out-of-state training programs to meet their training requirements, which threatens to exacerbate Texas' physician shortage; and (3) interfering with physicians' due process rights and abusing the court system with frivolous lawsuits.

A. S.B. 8 is Chilling Essential Communications in the Physician-Patient Relationship.

TMA has received alarming reports that the vague language in S.B. 8 is chilling critical healthcare communications between physicians and patients due to confusion surrounding what actions or intended actions are actually prohibited. These reports include concerns with the following S.B. 8 phrases: (1) "knowingly engaging in conduct that aids and abets the performance or inducement of an abortion"; (2) "intend[ing] to engage" in such conduct; and (3) a "medical emergency." Tex. Health & Safety Code §§ 171.208(a)(2)-(3) & 171.205. Some examples of these concerns include:

1. Upon information and belief, an entire OB/GYN Department was told they could not discuss abortion with a patient in any regard after cardiac activity was detected for fear it would violate the "conduct that aids or abets" provisions of S.B. 8.

2. Physicians are concerned whether they can discuss fetal aneuploidies with pregnant patients or those planning to conceive, in a nondirective, purely informational way based on the "engages in conduct that aids or abets"

language of S.B. 8. Current standard of care practice is to offer pregnant patients with a prenatal screening for fetal aneuploidy, which looks for the presence of an abnormal number of specific chromosome cells. These aneuploidies are associated with fetal anomalies (including some that are life-threatening to the embryo or patient), which could factor into a pregnant patient ultimately deciding to pursue an abortion.

3. Physicians also raised concerns about whether a physician who treats cancer can discuss treatment options for a pregnant patient diagnosed with cancer at eight weeks' gestation, when some of those life-saving treatment options might cause or require terminating the pregnancy or could cause fetal anomalies.

Another example TMA received is with the defined term "medical emergency," which is vague in the context of a pregnant patient diagnosed with cancer:

> [A] life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Id. at § 171.002(3). Cancer in a pregnant patient is not necessarily caused by or arising from the pregnancy, and the term "aggravated" is vague. It is also unclear at what point a "serious risk of substantial impairment of a major bodily function" or "danger of death" occurs for a pregnant patient who is battling cancer, and any delay in treatment might substantially increase a negative outcome for the health of the patient. Further, the "conduct that aids or abets" language is vague because it does not provide adequate guidance on whether discussing medical treatments for cancer that might have the side effect of negatively impacting the patient's pregnancy would place the physician in jeopardy of a lawsuit if the patient ultimately seeks an abortion with another physician in violation of S.B. 8.

There is strong public interest in maintaining confidential, open communication to encourage individuals to seek appropriate, quality care. Indeed,

federal and state law generally protect open dialogue between a physician and patient for the purpose of facilitating appropriate medical care. *See generally, e.g.*, *Nat'l Institute of Family and Life Advocates v. Becerra*, ---- U.S. ----, 138 S.Ct. 2631 (2018) (discussing free speech protections against content-based and content-neutral regulations); *see also In re Columbia Valley Reg'l Med. Ctr.*, 41 S.W.3d 797, 801 (Tex. App. 2001) ("The basis for the physician-patient and the mental health privileges, which includes…confidentiality…[is] to encourage the full communication necessary for effective treatment…. The…purpose is apparent: to allow for complete communication without fear of disclosure, so that the professional can effectively render services.") (internal quotations omitted).

Open communication in physician-patient counseling is also a pillar of providing ethical healthcare. The AMA, which provides ethical guidance to the nation's physicians, has issued several applicable opinions. For example, in relevant part, AMA Code of Medical Ethics Opinion 2.1.1 states:

> Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

And Opinion 1.1.3 states in relevant part:

> To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.

Studies also show honest and open dialogue between a physician and the physician's patient is necessary to achieve "the best outcome and patient satisfaction," and it is "essential for the effective delivery of healthcare."[5] Good physician-patient communication can also help ensure patients share important information necessary for an accurate diagnosis of their condition and for establishing an effective treatment plan. Therefore, it is crucial that enforcement of the law be enjoined to prevent the ongoing harm to patient care caused by S.B. 8's unreasonable interference in the physician-patient relationship.

B. S.B. 8 Threatens to Interfere with Texans' Access to Medical Care.

TMA received feedback that medical residents are expected to pursue their training out-of-state due to S.B. 8's restrictions. One reason for this is that the Accreditation Council for Graduate Medical Education (ACGME), which is the accrediting body for residency and fellowship training, has signaled it will not change its accreditation requirements for obstetrician residency. This will likely require residents to leave the state to meet the requirements for that training, as applicable. TMA also received concerns that S.B. 8's extreme, vague enforcement measures will interfere with Texas medical schools' recruiting efforts. This is extremely concerning, because the Department of State Health Services recently reported that Texas is facing a physician shortage—from 2018 to 2032, it projected that Texas' physician

[5] *See e.g.*, Fong J., et al., NCBI, *Doctor-Patient Communication: A* Review (Spring 2010), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/ (discussing the importance of physician counseling on positive patient outcomes); INST. FOR HEALTHCARE COMMUNICATION, *Impact of Communication in Healthcare* (July 2011), available at https://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/ (discussing a "wealth" of studies supporting the benefit of physician-patient communication).

shortage will increase from 6,218 full-time equivalent (FTE) positions to 10,330 FTE positions.[6] The effect of S.B. 8 on residents and medical students may exacerbate the shortage, particularly because studies show that residents are more likely to accept physician positions in the state where they are trained.[7]

C. S.B. 8 Threatens Due Process and Enables Abuse of the Court System.

S.B. 8's obscure restrictions continue to deprive physicians of due process. *See Haslip*, 499 U.S. at 44. "Due process requires that a State provide meaningful standards to help guide the application of its laws." *Id.* Here, the State has failed to meet this requirement. The prohibitions in S.B. 8, as demonstrated above, are vague and do not provide physicians with clear guidance on what actions or intended actions violate the law. This confusion puts physicians in jeopardy of violating nationally recognized standards of medical care, subjecting them to additional liability risks and threatening patient care.

For example, the American Heart Association and American College of Cardiology released nationally recognized guidelines on treating patients with Adult Congenital Heart Disease (ACHD). These guidelines, on the next page, expressly state a physician should discuss the option of terminating a pregnancy and obstetrical and fetal risks for women with ACHD:

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[6] Tex. Health and Human Services Commission, Department of State Health Services, Texas Physician Supply and Demand Projections, 2018-2032 (May 2020), available at https://www.dshs.state.tx.us/legislative/2020-Reports/TexasPhysicianSupplyDemandProjections-2018-2032.pdf.

[7] AAMC, Report on Residents, Table C6: Physician Retention in State of Residency, by State (2008), available at https://www.aamc.org/data-reports/students-residents/interactive-data/table-c6-physician-retention-state-residency-training-state.

Figure

3.13. Pregnancy, Reproduction, and Sexual Health

3.13.1. Pregnancy

Recommendations for Pregnancy
Referenced studies that support recommendations are summarized in Online Data Supplement 19.

COR	LOE	RECOMMENDATIONS
I	C-LD	1. Women with CHD should receive prepregnancy counseling with input from an ACHD cardiologist to determine maternal cardiac, obstetrical and fetal risks, and potential long-term risks to the mother (S3.13.1-1–S3.13.1-4).
I	C-LD	2. An individualized plan of care that addresses expectations and contingencies should be developed for and with women with CHD who are pregnant or who may become pregnant and shared with the patient and all caregivers (S3.13.1-2, S3.13.1-3).
I	B-NR	3. Women with CHD receiving chronic anticoagulation should be counseled, ideally before conception, on the risks and benefits of specific anticoagulants during pregnancy (S3.13.1-5, S3.13.1-6).
I	B-NR	4. Women with ACHD AP classification IB-D, IIA-D, and IIIA-D* should be managed collaboratively during pregnancy by ACHD cardiologists, obstetricians, and anesthesiologists experienced in ACHD (S3.13.1-2, S3.13.1-7, S3.13.1-8).
I	C-EO	5. In collaboration with an ACHD cardiologist to ensure accurate assessment of pregnancy risk, patients at high risk of maternal morbidity or mortality, including women with pulmonary arterial hypertension (PAH), Eisenmenger syndrome, severe systemic ventricular dysfunction, severe left-sided obstructive lesions, and/or ACHD AP classification ID, IID, IIID* should be counseled against becoming pregnant or be given the option of terminating pregnancy.
I	B-NR	6. Men and women of childbearing age with CHD should be counseled on the risk of CHD recurrence in offspring (S3.13.1-9).
IIa	B-NR	7. Exercise testing can be useful for risk assessment in women with ACHD AP classification IC-D, IIA-D, and IIIA-D* who are considering pregnancy (S3.13.1-10, S3.13.1-11).
IIa	B-NR	8. When either parent has CHD, it is reasonable to perform fetal echocardiography (S3.13.1-12, S3.13.1-13).

*See Tables 3 and 4 for the ACHD AP classification system.

It is unclear if S.B. 8's vague "conduct that aids or abets" language prohibits these discussions if doing so would lead to a patient seeking and obtaining an abortion in violation of the law. Yet, a physician might be subject to a lawsuit for failing to have these types of conversations with their patients as an expected standard of care practice. This concern is not hypothetical—suits have been filed (and won) where physicians failed to follow specialty guidelines or fully discuss the risks, benefits and alternative treatments in medical care.

Further, S.B 8 is resulting in, and threatens to continue to result in, abuse of the American court system due to an immeasurable number of frivolous lawsuits filed by individuals and entities with no legal standing. Under federal and state law,

regardless of the venue a would-be plaintiff files suit in, it is well-settled that the exercise of judicial power is restricted to litigants who can show, *inter alia*, an injury-in-fact, one that is "concrete and particularized"—the plaintiff must have a "personal stake in the outcome of the controversy." *Driehaus*, 573 U.S. at 150, 158 (citing the injury-in-fact standard for standing); *see also Robins*, 136 S.Ct. at 1548 ("For an injury to be 'particularized,' it must affect the plaintiff in a personal and individual way."); *Heckman*, 369 S.W.3d at 155 ("After all, our Constitution opens the courthouse doors only to those who have or are suffering an injury. As for the injury itself, it must be concrete and particularized, actual or imminent, not hypothetical.") (internal citations omitted).

Importantly, the statute itself does not create standing—the jurisdiction of the courts cannot be expanded by statute. *Robins*, 136 S.Ct. at 1547-1548 ("Injury in fact is a constitutional requirement, and '[i]t is settled that Congress cannot erase Article III's standing requirements by statutorily granting the right to sue to a plaintiff who would not otherwise have standing.'"); *Nephrology Leaders and Associates v. Am. Renal Associates, LLC*, 573 S.W.3d 912, 915 (Tex. App. 2019) ("But [a statute] cannot set a lower standard than set by the general doctrine of standing because courts' constitutional jurisdiction cannot be enlarged by statute"); *see also In re Lazy W. Dist. No. 1*, 493 S.W.3d 538, 544 (Tex. 2016) ("For the Legislature to attempt to authorize a court to act without subject matter jurisdiction would violate the constitutional separation of powers.").

Yet S.B. 8 claims to allow almost *any* person *anywhere* to file a lawsuit for an alleged violation of the statute. Tex. Health & Safety Code § 171.208 (a). But in almost all cases, such a plaintiff will have not been affected in a "personal and individualized way." *Robins*, 136 S.Ct. at 1548. These plaintiffs will have had no contact or other independent connection with the physician, the pregnant patient, or the patient's embryo at all. Thus, if the law is continued to be enforced, it will continue to unfairly force physicians to waste money and time defending such frivolous lawsuits—and it will continue to burden the courts with these cases.

This is especially concerning when the draconian fee-shifting design that awards a prevailing plaintiff its attorneys' fees while, conversely, prohibiting courts from awarding legal fees to a prevailing defendant, encourages potential plaintiffs (without standing) to place their bets on litigation with little to lose but much to gain. Prevailing plaintiffs are further enticed by a guaranteed award of a *minimum* of $10,000 in damages. Tex. Health & Safety Code § 171.208(b) & (c). Physicians will incur significant defense costs, including costs to retain counsel to respond to a complaint, engage in discovery, and file a motion to challenge standing in an ultimately baseless lawsuit, plus incur additional fees in the event of an appeal. This abuse of the civil litigation process cannot stand.

CONCLUSION AND PRAYER

For these reasons, TMA respectfully urges the Court to find that the United States may bring suit in federal court and obtain injunctive or declaratory relief

against the State, state court judges, state court clerks, other state officials, and all private parties to prohibit S.B. 8 from being enforced.

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Respectfully submitted,

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