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SUPREME COURT OF TEXAS
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No. 23-0629

In the Supreme Court of Texas

STATE OF TEXAS ET AL.,

Defendants-Appellants,

v.

AMANDA ZURAWSKI ET AL.,

Plaintiffs-Appellees.

On Direct Appeal from the
353rd Judicial District Court of Travis County

Brief of *Amici Curiae* American College of Obstetricians and Gynecologists, American Medical Association, and Other Medical Organizations

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IDENTITY AND INTEREST OF *AMICI CURIAE*[1]

Amici curiae are leading medical societies representing physicians, and other clinicians who serve patients in Texas and nationwide:

The **American College of Obstetricians and Gynecologists (ACOG)** is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. With more than 62,000 members, ACOG maintains the highest standards of clinical practice and continuing education of its members; strongly advocates for equitable, exceptional, and respectful care for all women and people in need of obstetric and gynecologic care; promotes patient education; and increases awareness among its members and the public of critical issues facing patients and their families and communities. ACOG has appeared as *amicus curiae* in courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, which recognize ACOG as a leading provider of authoritative scientific data regarding childbirth and

[1] Pursuant to Rule 11(c) of the Texas Rules of Appellate Procedure, *Amici* confirm that no person or entity other than *Amici* made a monetary contribution to the preparation or filing of this brief.

abortion.[2]

Because ensuring access to the full spectrum of essential reproductive health care is critical to ACOG's mission and the health of our communities, ACOG opposes political and ideological interference into the practice of medicine and encourages approaches to policy issues that steer clear of such interference. ACOG's Statement of Policy on Legislative Interference acknowledges that while the "government serves a valuable role in the protection of public health and safety and the provision of essential health services," "[l]aws and regulations that veer from these functions and unduly interfere with patient-physician relationships are not appropriate."[3]

The **American Medical Association (AMA)** is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician

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[2] *See, e.g.*, *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *see also Gonzales v. Carhart*, 550 U.S. 124, 170- 171, 175-178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's brief and congressional submissions regarding abortion procedure).

[3] Am. Coll. of Obstetricians and Gynecologists, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, ACOG (last amended 2021), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship.

groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state. The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

Founded in 1947, the **American Academy of Family Physicians (AAFP)** is one of the largest national medical organizations, representing 129,600 family physicians and medical students nationwide. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and by supporting its members in providing continuous comprehensive health care to all.

Founded in 1974, the **Association of Black Cardiologists (ABC)** is a nonprofit organization dedicated to promoting the prevention and treatment of cardiovascular diseases and achieve health equity for all peoples through the elimination of disparities in patients' outcomes. For almost 50 years, the ABC has championed the fight for health equity such that all people can live long and healthy

lives. As part of these efforts, the ABC has dedicated a long-term focus on cardiovascular disease in women and the policies impacting women's health. More recent efforts have included strategies and solutions to address the Black maternal morbidity and mortality crisis through the ABC's signature campaign "We Are The Faces of Black Maternal Health" (wearethefaces.abcardio.org). The recent loss of broad protections on reproductive and contraceptive health including medically indicated life-saving termination of pregnancy will have a real impact on the maternal mortality rate. The ABC will continue to advocate for equitable health care and strongly oppose any efforts that impede access to comprehensive reproductive healthcare for patients or interfere in the relationship between a person and their physicians and/or healthcare professional.

The **American College of Chest Physicians (CHEST)** is a global leader in pulmonary, critical care, and sleep medicine. Established in 1935, CHEST supports more than 21,000 clinicians through education, research, and advocacy. CHEST members care for all patients who enter the ICU, including those with pregnancy complications, and must rely on their and their colleagues' medical judgment to act in the best interest of their patients to prevent and address life-threatening infections, such as sepsis.

The **American College of Physicians (ACP)** is the largest medical specialty organization and the second largest physician membership society in the United

States. ACP members include 161,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

The **American College of Preventive Medicine (ACPM)** is a 501c3 non-profit medical specialty society representing more than 2,000 physicians, dedicated to the practice of preventive medicine; improving the health and quality of life of individuals, families, communities, and populations through disease prevention and health promotion. ACPM supports our physician members in ensuring the reproductive health needs of their patient populations.

The **American Medical Women's Association (AMWA)** is the oldest multi-specialty organization for women in medicine. Founded in 1915, AMWA's mission is to advance women in medicine, advocate for equity, and ensure excellence in health care. This is achieved by providing and developing programs in advocacy, leadership, education, and mentoring. AMWA and its members are dedicated to ensuring excellence in clinical care for all Americans.

The **American Society for Reproductive Medicine (ASRM)** is a multidisciplinary not-for-profit organization dedicated to the advancement of the science and practice of reproductive medicine. Its members include approximately

8,000 professionals. ASRM accomplishes its mission through the pursuit of excellence in education and research and through advocacy on behalf of patients, physicians, and affiliated health care providers.

The **National Association of Nurse Practitioners in Women's Health (NPWH)** is the professional community for Women's Health Nurse Practitioners and other advanced practice registered nurses who provide women's and gender-related healthcare. We set a standard of excellence by generating, translating, and promoting the latest research and evidence-based clinical guidance, providing high-quality continuing education, and advocating for patients, providers, and the WHNP profession. Its mission includes protecting and promoting a woman and all individuals' rights to make their own choices regarding their health and well-being within the context of their lived experience and their personal, religious, cultural, and family beliefs.

The **Society for Maternal-Fetal Medicine (SMFM)** is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 6,500 members caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically

appropriate treatment options are available for individuals experiencing high-risk pregnancies.

These organizations collectively represent hundreds of thousands of medical practitioners in Texas and across the country, with deep expertise in both medical research and the treatment of patients in real-world settings. Ensuring robust access to evidence-based health care and promoting health care policy that improves patient health are central to *Amici's* missions. *Amici curiae* believe that all patients are entitled to prompt, complete, and unbiased health care that is medically and scientifically sound.

INTRODUCTION

The District Court orders should be affirmed to protect the ability of Texas clinicians to provide critical care to pregnant patients in medically complex cases. As *Amici* describe below, clinicians must be able to exercise their discretion to care for patients experiencing medically complex and nuanced conditions in order to protect them from negative health outcomes. Unfortunately, as the testimony in this case shows, the Texas abortion bans ("the Bans")[4] are deterring Texas clinicians from providing, and their patients from receiving, critically necessary abortions, even when that care is essential to protect those patients' lives and health. The Bans

[4] This case concerns (1) the historical ban at issue in *Roe v. Wade*, 410 U.S. 113 (1973) (Tex. Rev. Civ. Stats. Ann. arts. 4512.1–6; 1925 Tex. Penal Code arts. 1191–96) (the "pre-*Roe* Ban"); (2) Tex. Health & Safety Code §§ 170A.001–.007 (the "Trigger Ban"); and (3) Tex. Health & Safety Code §§ 171.201–.212 ("S.B. 8") (collectively the "Bans").

also threaten longstanding principles of medical ethics and patient autonomy and are further exacerbating Texas' shortage of medical professionals capable of providing obstetrics and gynecology ("OB-GYN") care. This will leave countless Texans—whether or not they ever seek abortions—without access to quality OB-GYN care. The Texans who are suffering the most are those who experience discrimination due to race or ethnicity, have low incomes, and/or who live in rural areas—individuals who already face inequities in the health care system. As a result, reversing the District Court will lead to a predictable increase of maternal mortality, already at a crisis rate, particularly for Texans of color.[5]

ARGUMENT

I. Clinicians Must Be Able to Provide Abortions Where Indicated for Pregnant Patients Experiencing Health- or Life-Threatening Medical Conditions.

Abortion is an essential component of reproductive health care. One-quarter of all women of reproductive age in the United States will have an abortion in their lifetime.[6] People access abortion care for a myriad of reasons,

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[5] Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department*, *2006–2016*, 2 J. Am. Coll. Emergency Physicians Open e12549, 6-8 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8571073/pdf/EMP2-2-e12549.pdf; Juanita Chinn et al., *Health Equity Among Black Women in the United States*, 30 J. Women's Health 212, 215 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8020496/pdf/jwh.2020.8868.pdf

[6] Guttmacher Inst. *Induced Abortion in the United* States (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states. The National Academies of Sciences has found that restrictions on abortion harm patients' health and well-being, making care less safe. Nat. Acads. of Scis., Eng'g, and Med., *The Safety and Quality*

including personal circumstance, in cases of rape and incest, in connection with early pregnancy loss, and in the event of a wide range of obstetric complications. Abortion is not only common, but also incredibly safe.[7]

Pregnancy and birth can create significant health risks, which can lead to negative outcomes for pregnant patients.[8] It is essential to the life and health of patients experiencing medical complications during pregnancy that abortion is available as a possible treatment. Because of the complexities inherent in providing care to pregnant patients, including in emergency situations, clinicians must be permitted to use their medical judgment—honed through years or decades of medical education, training, and experience—to provide evidence-based care that is consistent with clinical guidance and responsive to their patients' individualized needs, including abortions.

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of Abortion Care in the United States 10 (2018), https://www.ncbi.nlm.nih.gov/books/NBK507236/pdf/Bookshelf_NBK507236.pdf.

[7] *See, e.g., id*. ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective. Serious complications are rare."); *see also* Eds. of the New Eng. J. of Med. et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979, 979 (2019), https://www.nejm.org/doi/pdf/10.1056/NEJMe1910174 ("Access to legal and safe pregnancy termination … is essential to the public health of women everywhere."); Am. Coll. of Obstetricians and Gynecologists, *Abortion Policy*, ACOG (last rev. May 2022), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy; Soc'y for Maternal-Fetal Med., Access to Abortion Services (June 2020), https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf.

[8] Pregnancy is fourteen-times more dangerous than abortion. *E.g.,* Am. Coll. of Obstetricians and Gynecologists, *Abortion Access Fact Sheet*, ACOG, https://www.acog.org/advocacy/abortion-is-essential/come-prepared/abortion-access-fact-sheet.

For pregnant patients, nuanced and complex medical conditions are frequent and can be dangerous. Some of the complex medical diagnoses pregnant patients face include, but are not limited to:

- **Premature pre-labor rupture of membranes ("PPROM")**, where the amniotic sac ruptures, prior to viability, potentially leading to serious maternal infection and sepsis;[9]

- **Miscarriage** or early pregnancy loss ("EPL"), which is extremely common, occurring in approximately 10% of clinically recognized pregnancies.[10] Patients seek hospital-based care with miscarriage-related concerns hundreds of thousands of times each year.[11] A miscarriage may put a patient at risk of excessive blood loss and serious infection as long as the products of conception remain in the uterus, or may involve a pregnancy that will not continue but in which embryonic or fetal cardiac activity is observed;[12]

- **Excessive bleeding**, which can be caused by placenta accreta spectrum and other conditions;[13]

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[9] Am. Coll. of Obstetrics and Gynecology, *ACOG Practice Bulletin No. 217, Prelabor Rupture of Membranes* e80, e80 (Mar. 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/03/prelabor-rupture-of-membranes.

[10] Am. Coll. of Obstetrics and Gynecology, *ACOG Practice Bulletin No. 200*, *Early Pregnancy Loss* e197, e197 (Nov. 2018, *reaff'd* 2021), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss.

[11] Carolyn A. Miller et al., *Patient Experiences With Miscarriage Management in the Emergency and Ambulatory Settings*, 134 Obstetrics & Gynecology 1285, 1285 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6882532/pdf/ong-134-1285.pdf (noting that "[p]atients with concerns about a potential miscarriage . . . present for care in [EDs] at a rate of approximately 500,000 each year in the United States"); Benson, *supra* note 5, at 8 (finding that "EPL-related care accounts for > 900,000 ED visits in the United States each year").

[12] Am. Coll. of Obstetrics and Gynecology, *ACOG Practice Bulletin No. 200, Early Pregnancy Loss*, *supra* note 10.

[13] *See* Am. Coll. of Obstetricians and Gynecologists, *FAQs: Bleeding During Pregnancy*, ACOG (Aug. 2022), https://www.acog.org/womens-health/faqs/bleeding-during-

- **Gestational hypertension and preeclampsia** (high blood pressure), which complicate 2–8% of pregnancies globally and are one of the leading causes of maternal mortality deaths around the world.[14]

- **Placental abruption**, which is when the placenta separates from the inner wall of the uterus, causing serious and potentially uncontrollable bleeding. It is the cause of stillbirth in up to 10% of cases and can result in serious complications for the pregnant person, such as cardiac arrest or kidney failure.[15]

A number of other serious medical conditions can jeopardize a pregnant patient's health. These include, but are not limited to: Alport syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve that can occur in patients with no history of cardiac symptoms), lupus (a connective tissue disorder that may suddenly worsen during pregnancy and lead to blood clots and other serious complications),

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pregnancy; Am. Coll. of Obstetricians and Gynecologists, *ACOG Obstetric Care Consensus No. 7, Placenta Accreta Spectrum* (Dec. 2018, *reaff'd* 2021), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2018/12/placenta-accreta-spectrum.

[14] *ACOG Practice Bulletin No. 222, Gestational Hypertension and Preeclampsia,* 135 Obstetrics & Gynecology e237, e237 (June 2020), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/06/gestational-hypertension-and-preeclampsia; *see also United States v. Idaho,* 623 F. Supp. 3d 1096, 1104 (D. Idaho 2022), *reconsideration denied* 2023 WL 3284977 (D. Idaho May 4, 2023), *appeal filed* Case No. 22-35440 (9th Cir. June 28, 2023) (discussing situations in which high blood pressure or preeclampsia might occur).

[15] *See United States v. Idaho*, 623 F. Supp. 3d at 1104 (discussing placental abruption complications); Am. Coll. of Obstetricians and Gynecologists et al., *ACOG Obstetric Care Consensus No. 10, Management of Stillbirth* (Mar. 2020, reaff'd 2021), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2020/03/management-of-stillbirth.

pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy), and diabetes (which can worsen to the point of causing blindness as a result of pregnancy).[16] Indeed, pregnancy imposes significant physiological changes on a person's body. "These changes can exacerbate underlying or preexisting conditions, like renal or cardiac disease, and can severely compromise health."[17]

Access to abortion is essential to patients experiencing these and other medical conditions. In treating those patients, medical professionals must be permitted to use their medical judgment acquired through years of medical education, training, and experience to provide evidence-based care that is consistent with clinical guidance and responsive to their patients'

[16] *See* Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531-32 (Feb. 2007), https://pubmed.ncbi.nlm.nih.gov/29492669/; Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955531/pdf/552.pdf; J. Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-647 (2002), https://tinyurl.com/v4bj4yv3; Robert Silver et al., Soc'y for Maternal-Fetal Med., *SMFM Consult Series #64: Systemic Lupus Erythematosus in Pregnancy* (Mar. 2023), https://www.smfm.org/publications/462-smfm-consult-series-64-systemic-lupus-erythematosus-in-pregnancy; David G. Kiely et al., *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management*, 6 Obstetric Med. 144, 146 (2013), https://tinyurl.com/4fx63rjc; Michael F. Greene & Jeffrey L. Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004), https://tinyurl.com/3z8tuzur; Am. Coll. of Obstetricians and Gynecologists et al., *ACOG Practice Bulletin No. 190, Gestational Diabetes Mellitus*, 131 Obstetrics & Gynecology e49, e49 (Feb. 2018), https://pubmed.ncbi.nlm.nih.gov/29370047/; Am. Coll. of Obstetricians and Gynecologists et al., *ACOG Practice Bulletin No. 222, Gestational Hypertension and Preeclampsia, supra* note 14, at e239.

[17] Am. Coll. of Obstetricians and Gynecologists, *Abortion Can Be Medically Necessary*, ACOG, https://www.acog.org/news/news-releases/2019/09/abortion-can-be-medically-necessary

individualized needs.

Importantly, for pregnant patients who face medical conditions threatening their health or life, timing in accessing treatment is essential. Rapid treatment improves patient outcomes, while delays increase the risk of complications, permanent injury, or death.[18] Approximately four in five pregnancy-related deaths nationwide are preventable;[19] any deterrent to providing life-saving care promptly could have a dire impact on the patient. For all these reasons, clinicians must be able to use their judgment to provide critical abortions, without delay or threat of criminal or civil prosecution, to patients who need them to preserve their life or health.

II. The Abortion Bans Are Preventing Clinicians from Providing Necessary Care to Pregnant Texans.

The Bans are forcing clinicians to withhold medically appropriate abortion care or risk prosecution or loss of their livelihoods, resulting in pregnant patients, like the Patient-Plaintiffs in this case, being unable to access care when faced with dangerous health conditions.

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[18] *See*, *e.g.*, Robert W. Neumar, *The Zerhouni Challenge: Defining the Fundamental Hypothesis of Emergency Care Research*, 49 Annals Emergency Med. 696, 697 (2007), https://www.annemergmed.com/article/S0196-0644(07)00212-0/fulltext.

[19] Ctrs. For Disease Control and Prevention, *Four in 5 Pregnancy-related Deaths in the U.S. are Preventable*, CDC (Sept. 19, 2022), https://www.cdc.gov/media/releases/2022/p0919-pregnancy-relateddeaths.html.

A. The Bans Deter Clinicians from Providing Medically Necessary Care.

Exposing Texas clinicians to civil and criminal liability under Texas' abortion statutes is chilling the provision of essential health care to Texans. Any clinician considering terminating a pregnancy—even where necessary in their judgment to save the life or health of the pregnant patient—will have to consider the possible consequences of that care: that they may be indicted by a state official who disagrees with the exercise of their judgment; that they would bear the cost of retaining counsel and defending against the indictment; and that they would risk loss of their medical license, livelihood, and reputation—and even face life in prison—if a jury decides they were incorrect in their medical judgment. Even if they are not prosecuted, they could face disciplinary action from state officials, and risk losing their license and livelihoods if their decision to provide care is second-guessed or replaced by the judgment of state officials with no training or expertise.

As a result, the Bans have created a chilling effect on care in Texas.[20] The testimony in this case, from experts on both sides, makes this clear. For example, Defendants' expert Dr. Ingrid Skop admitted that doctors were "confused" and "frightened," stating "[i]t is the blind leading the blind on the ground."[21] Physician-Plaintiff Dr. Damla Karsan worried that "the penalties are extremely severe … they're criminal, not just civil, including up to 99 years in prison, losing my medical license and my livelihood and the career I love, and six-figure fines."[22] When it comes to care for her patients, Dr. Karsan feels like her "hands are tied" because she cannot provide the care indicated by her training and experience, a situation that is "gut-wrenching" because it prevents her from "tak[ing] the best care of [her] patients

[20] After the filing of this case, the legislature apparently acknowledged some of the harms of the Bans by amending one of them to create a limited affirmative defense for "medical treatment" provided to pregnant Texans with preterm premature rupture of membranes ("PPROM"). H.B. 3058, 88th Reg. Sess. (Tex. 2023). The bill also created an affirmative defense for "ectopic pregnancy at any location," though ectopic pregnancy is already excluded from Texas's definition of abortion applicable to the abortion bans. Tex. Health & Safety Code § 245.002(1), (4-a). Not only is that amendment insufficient to protect patients for the reasons highlighted in Plaintiffs' brief, Appellee's Br. at 5-6, but singling out one medical condition and not giving clinicians discretion to provide needed care for other conditions suggests that Texas intends *not* to protect the health of pregnant patients with other conditions. Texas' reply brief concedes as much, noting: "Texas has rationally balanced its interest in protecting unborn children against its interest in protecting pregnant women from death or impairment of a severe bodily function." Appellant's Reply Br. at 21. For this reason*, Amicus ACOG* believes it is impossible to provide a list of medical emergencies sufficient to address the many nuanced and complex situations that arise on a regular basis during pregnancy, and misguided attempts to create such a list leads to danger for many patients. Whether care should be provided should be left to the trained judgment of a clinician in consultation with their patient.

[21] 2 R.R. at 28 (internal quotations omitted).

[22] 2 R.R. at 172.

[she] possibly can."[23] Reports indicate that other Texas clinicians are in a similar situation.[24]

Research conducted since the implementation of the Bans has confirmed the sentiment is shared widely and that there is a pervasive "climate of fear" among the Texas medical community.[25] A recent national survey conducted by the Kaiser Family Foundation found that "68% of OB-GYNs said that the *Dobbs* "ruling has worsened their ability to manage pregnancy-related emergencies."[26] Almost 40% of

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[23] 2 R.R. at 178.

[24] *See, e.g.*, Erin Coulehan, *A Sneaky Bill May Soften Texas Abortion Ban*, Glamour (Aug. 31, 2023), https://www.glamour.com/story/hb3058-bill-may-soften-texas-abortion-ban ("'So what we've been seeing is women suffering long term consequences because of the complete inability to perform modern medical interventions because of a politically-motivated piece of legislation.'"); Eleanor Klibanoff, *Doctors Report Compromising Care Out of Fear of Texas Abortion Law*, Tex. Tribune (June 23, 2022), https://www.texastribune.org/2022/06/23/texas-abortion-law-doctors-delay-care/
("'We know in the post-Roe landscape, physicians and institutions are going to have really diverse interpretations of narrow exemptions,'" Arey said. "'And this is going to compromise pregnant people's ability to get evidence-based health care and support from the health care provider that they need.'"); *id*. ("'Physicians have said that they don't feel like they can offer the standard medical interventions that are the standard of care across the United States…'"); Sophie Novack, *"You Know What? I'm Not Doing This Anymore."*, Slate (Mar. 21, 2023), https://slate.com/news-and-politics/2023/03/texas-abortion-law-doctors-nurses-care-supreme-court.html; ("'At the end of the day, I just want to take care of my patients and provide the best care for them. And this is just another layer that makes you question what you're doing.'"); Sara Hutchinson, *Abortion Laws Stand Between Pregnant Texans and the Care They Need*, Tex. Observer (Mar. 23, 2023), https://www.texasobserver.org/abortion-laws-pregnancy-loss-healthcare/ ("'Before, if someone needed a [medically necessary] abortion, a doctor would just provide it; we never heard about it,'" she said. "'But now, with routine cases that are not ethical issues, doctors feel like they need to check all the boxes to make sure that they are not going to get sued or lose their license.'").

[25] Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans—Texas Senate Bill 8*, 387 N. Eng. J. Med. 388, 389 (2022), https://www.nejm.org/doi/pdf/10.1056/NEJMp2207423?articleTools=true.

[26] Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After Dobbs*, KFF (June 21, 2023), https://www.kff.org/womens-health-policy/report/a-national-survey-of-obgyns-experiences-after-dobbs/.

OB-GYNs feel constrained in "their ability to provide care for miscarriages and other pregnancy-related medical emergencies since the Dobbs decision."[27] And over half of clinicians (55%) practicing in states like Texas where abortion is banned say their ability to practice within the standard of care has been hindered. [28]

As a result, clinicians have been forced to rely on "expectant management," otherwise known as the "wait and see" approach, rather than providing an abortion when it is medically indicated. When caring for a patient suffering from a medical condition, clinicians are forced to ignore their judgment and—directly contrary to their training, ethical obligations and clinical guidance— withhold treatment until a patient's condition deteriorates before providing the clinically indicated termination of pregnancy. The results are devastating: A recent study found that "expectant management of obstetrical complications in the previable period was associated with significant maternal morbidity."[29] Moreover, state-mandated "[e]xpectant management resulted in 57% of patients having a serious maternal morbidity

[27] *Id*.
[28] *Id*.
[29] Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 Am. J. of Obstetrics & Gynecology 648, 649 (July 4, 2022), https://www.ajog.org/article/S0002-9378(22)00536-1/fulltext.

compared with 33% who elected immediate pregnancy interruption under similar clinical circumstances reported in states without such legislation."[30]

Nor are hospitals able to provide the guidance clinicians need to resolve the difficult choices they face every day in trying to treat pregnant patients experiencing complications. According to a recent study by the Physicians for Human Rights ("PHR"), the Oklahoma Call for Reproductive Justice, and the Center for Reproductive Rights, not a single hospital in Oklahoma articulated a clear or consistent policy for emergency care under a state abortion ban. [31] Almost 65% of hospitals "were unable to provide information about procedures, policies, or support provided to doctors…when the clinical decision is that it is necessary to terminate a pregnancy."[32] Another recent analysis found the same: public hospitals in states with abortion bans "have failed to provide specific guidance or policies to help doctors navigate high-stakes decisions over how to interpret new abortion bans."[33]

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[30] *Id*. The study also documented a significant increase in maternal morbidity among patients with preterm labor who would have been promptly offered induction abortions before the law but, due to fear regarding the law, were not offered such treatment until their physicians determined that an emergent condition posed "an immediate threat to maternal life." *Id*. The study followed patients with premature preterm rupture of the membranes and pregnancy tissue prolapsed into the vagina. Among these patients, 43% experienced maternal morbidity such as infection or hemorrhage; 32% required intensive care admission, dilation and curettage, or readmission; and one patient required a hysterectomy. *Id*.

[31] Physicians for Human Rights et al., *No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-*Roe *Oklahoma* 22 (2023), https://phr.org/wp-content/uploads/2023/04/Oklahoma-Abortion-Ban-Report-2023.pdf.

[32] *Id*. at 13.

[33] Caroline Kitchener & Dan Diamond, *Faced with Abortion Bans, Doctors Beg Hospitals for Help with Key Decisions*, Wash. Post (last updated Nov. 1, 2023), https://www.washingtonpost.com/politics/2023/10/28/abortion-bans-medical-exceptions/.

Defendants' expert Dr. Skop does not disagree that Texas physicians have not been providing abortion in cases where it is medically indicated. She blames the resulting gaps in care not on the Bans, but on physicians and on medical societies like *Amici*, stating "[t]he law is quite clear. The fault lies with the physicians [who] are not being given guidance by the organizations that usually will give them guidance, the medical societies and the hospital societies."[34] She is wrong—the Bans are at fault here. Clinicians should not have to decide between risking criminal prosecution or their patients' health, nor should they have to guess whether their conduct could put them into legal jeopardy. Texas clinicians, confused by the Bans and trying to understand how Defendants and other state officials will, in retrospect, judge the decisions they make in providing care to patients experiencing pregnancy complications, are not to blame. Nor are the medical societies like *Amici* at fault—giving legal advice to clinicians is not within the scope of their role, and they cannot change the fact that clinicians are being placed in legal jeopardy when their judgment can be second-guessed by elected officials or even private citizens with no connection to a particular case. Even if the medical societies provided guidance, there is no guarantee state officials would agree with that guidance, leaving clinicians who follow it still open to the real possibility of civil and criminal liability. Because clinicians are not able to rely on their own judgment without facing the

[34] 3 R.R. at 404.

potential for life-changing criminal prosecutions and draconian civil penalties, the Bans inevitably and predictably are placing the lives and health of pregnant Texans at risk.

B. The Bans Prevent Patients from Receiving Medically Necessary Care.

Patients are suffering as a result, as the testimony of the Patient-Plaintiffs showed in this case. Lead plaintiff Amanda Zurawski suffered from previable premature rupture of the membranes—but because the threat to her life was not sufficiently acute, she was sent home for expectant management.[35] At just 18 weeks, her water broke.[36] Although her doctors knew that the fetus could not survive and that she would inevitably develop a dangerous infection, they believed that Texas' law prohibited them from terminating the doomed pregnancy until she was "'sick enough that [her] life was at risk.'"[37] Three days later, "'she went downhill very, very fast[,]'" her fever spiking "'in a matter of maybe five minutes.'"[38] As a result of this delay, she became septic and nearly died from the infection, and her uterus and fallopian tubes were heavily scarred as a result of the infection, permanently

[35] Pls.' First Am. Verified Pet. ¶¶ 11–29.
[36] Elizabeth Cohen & John Bonifield, *Texas Woman Almost Dies Because She Couldn't Get an Abortion*, CNN (Nov. 16, 2022), https://www.cnn. com/2022/11/16/health/abortion-texas-sepsis/index.html.
[37] *Id*.
[38] *Id*.

impacting her fertility and making it challenging (if not impossible) for her to become pregnant in the future.[39]

Other patients are being forced to face the continued health risks posed by pregnancy even in the face of pregnancies that will not result in a sustained life because of a tragic fetal condition. For example, Patient-Plaintiff, Dr. Austin Dennard, was unable to obtain care in Texas and was forced to travel out of the state to receive an abortion for a nonviable pregnancy.[40] Her fetus was diagnosed with anencephaly, a deadly condition where the fetus does not develop a fully formed skull or brain.[41] She recalled her experience as one where she felt her "pregnancy was not [her] own, that it belonged to the State."[42] She felt abandoned by the State, which she felt put her physical and emotional health at risk for a fetus that was not going to survive.[43]

Plaintiffs' case includes evidence of similar situations befalling a dozen Texan patients,[44] and many other Texans have faced similar emergencies.[45] As long as the

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[39] Pls.' First Am. Verified Pet., *supra* note 35,. ¶¶ 25–29.
[40] *Id.* ¶¶ 59-60.
[41] *Id.* ¶ 57.
[42] 3 R.R. at 379.
[43] *Id*.
[44] *See* Appellees' Br. at 10-13. Last week, seven additional plaintiffs joined the case, bringing the total number to 22, including two physicians. Eleanor Klibanoff, *More Women Join Lawsuit Challenging Texas' Abortion Laws*, Tex. Tribune (Nov. 14, 2023), https://www.texastribune.org/2023/11/14/texas-abortion-laws-lawsuit/
[45] *See* María Méndez, *Texas Laws Say Treatments for Miscarriages, Ectopic Pregnancies Remain Legal but Leave Lots of Space for Confusion*, Tex. Tribune (July 20, 2022), https://www.texastribune.org/2022/07/20/texas-abortion-law-miscarriages-ectopic-pregnancies/;

Bans remain in effect, Texas patients will continue to suffer from their deterrent effects. The District Court orders should be affirmed so that clinicians can provide, and patients can obtain, necessary health care before they suffer further harm.

III. The Bans Are Forcing Clinicians to Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law.

Abortion bans, such as the ones at issue in this case, intrude upon the patient-physician relationship and violate long-established—and widely accepted—principles of medical ethics, including beneficence, non-maleficence, and respect for patient autonomy.

A. The Bans Undermine the Patient-Physician Relationship and Prevent Physicians from Providing Evidence-Based Medicine to Their Patients.

The foundation of medical practice is the patient-physician relationship. ACOG's *Code of Professional Ethics* states that "the welfare of the patient must form the basis of all medical judgments" and that OB-GYN's should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[46] Likewise, the American Medical Association's ("AMA") *Code of*

Danielle Campoamor, *Post-Roe, Doctors are Delaying Care for Pregnancy Complications*, Today (July 22, 2022), https://www.today.com/health/post-roe-doctors-are-delaying-care-pregnancy-complications-rcna38796.

[46] Am. Coll. of Obstetricians and Gynecologists, *Code of Professional Ethics* 2 (Dec. 2018), https://tinyurl.com/2h37zjkh.

Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[47]

Laws should not interfere with the ability of clinicians to offer appropriate treatment options to their patients, nor with the ability of patients to obtain the best care for themselves. That should always be the case in medicine, but particularly so when providing care to patients facing complex medical conditions that may require rapid treatment. Yet, interfering with the provision of medical care is precisely what the Bans do. The Bans force clinicians to weigh their patients' need for health- and life-saving care against the threat of criminal prosecution, imprisonment, loss of licensure and other potential penalties when they are later second-guessed by others. The Bans are therefore interfering in the patient-clinician relationship throughout Texas, preventing clinicians from providing evidence-based, standard of care medicine.

B. The Bans Violate the Principles of Beneficence and Non-Maleficence.

Beneficence, the obligation to promote the well-being of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2500 years ago.[48] Both of these principles arise from the foundational ethical principle

[47] Am. Med. Ass'n, *Code of Medical Ethics Opinion 1.1.1*, https://tinyurl.com/y5mf23yv.
[48] Am. Med. Ass'n, *Principles of Medical Ethics*, AMA (rev. June 2001), https://code-medical-ethics.ama-assn.org/principles; Am. Coll. of Obstetricians and Gynecologists, *Committee*

that the welfare of the patient forms the basis of all medical decision-making.[49] Obstetricians, gynecologists, and other clinicians caring for patients respect these ethical duties by providing patient-centered, evidence-based care, sharing information with patients about risks, benefits, and options, and ultimately empowering patients to obtain care informed by both medical science and their individual lived experiences.

The Bans compromise these principles and practices by pitting clinicians' interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the clinician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the clinician to provide, or refer the patient for, that care. However, the Bans prevent clinicians from providing necessary treatment and expose them to significant penalties if they do so. The Bans, therefore, place clinicians in the ethical dilemma of choosing between providing the best available medical care, thus risking substantial penalties including loss of their freedom and livelihoods, or protecting themselves, thus putting patients' health at risk. This decision, between possible loss of the ability to practice medicine

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Opinion No. 390, Ethical Decision Making in Obstetrics and Gynecology 1, 3 (Dec. 2007, reaff'd 2016), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2007/12/ethical-decision-making-in-obstetrics-and-gynecology.

[49] Am. Coll. of Obstetricians and Gynecologists, *Code of Professional Ethics*, *supra* note 46; Am. Med. Ass'n, *Code of Medical Ethics Opinion 1.1.1*., *supra* note 47, and accompanying text.

and the practice of scientific, ethical, high-quality health care, challenges the very core of the Hippocratic Oath: "Do no harm."

C. The Bans Violates the Ethical Principles of Respect for Patient Autonomy.

Another core principle of medical practice is patient autonomy—the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[50] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[51] The Bans deny patients the right to make their own choices about health care and inhibit the ability of clinicians to provide care in a manner that respects and safeguards their patients' autonomy.

By removing clinicians' ability to respect patient autonomy, the Bans harm both the ethical practice of medicine and patient health and safety. The integrity of the medical profession is not protected by preventing clinicians from utilizing their extensive training and sound medical evidence to safely perform a routine procedure that a patient has made an informed decision is in their own best interest when facing a condition that threatens their life or health. Instead, the medical profession's

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[50] *See* Am. Coll. of Obstetricians and Gynecologists, *Code of Professional Ethics*, *supra* note 46, at 1 ("[R]espect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental.").

[51] Am. Coll. of Obstetricians and Gynecologists, *Committee Opinion No. 819, Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstetrics & Gynecology e34 (Feb. 2021), https://tinyurl.com/586yd45x; Am. Med. Ass'n, *Code of Medical Ethics Opinion 2.1.1, Informed Consent* (last modified 2017), https://tinyurl.com/5ya59kaa.

integrity is safeguarded when clinicians are permitted to exercise their duty to care for patients based on their professional judgment and to ultimately respect patients' autonomy to make decisions about their own bodies and health.[52]

IV. The Abortion Bans Are Diminishing the Availability of OB-GYN Care to All Texas Residents.

Even before the Bans took effect, Texas was experiencing an alarming shortage of OB-GYN care.[53] Absent an influx of qualified medical professionals, this shortage is expected to worsen over time, leaving countless Texans without access to OB-GYN care even if they never seek an abortion.[54] The Bans are exacerbating that trend, dissuading medical professionals—including physicians, physician's assistants, nurse practitioners, registered nurses, nursing assistants, midwives, and other professionals—from practicing in the state. Further, the Bans are deterring medical students and residents from choosing Texas institutions for their training, which will further limit the pipeline of physicians needed to provide everyday care in Texas.[55] This will harm the Texas medical community and all Texans by further diminishing the availability of quality OB-GYN care in Texas.

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[52] Am. Med. Ass'n, *Patient Rights, Code of Medical Ethics Opinion 1.1.3* (last modified 2017), https://tinyurl.com/29y6mezd.
[53] Tex. Health and Hum. Servs., *Physician Supply and Demand Projections 2021-2032* 2 (May 2022), https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/Physician-Supply-and-Demand-Projections-2021-2032.pdf.
[54] *Id*.
[55] James Pollard, *Medical Students Worry About Where to Train as Several States Enact Abortion Restrictions*, PBS (Oct. 19, 2022), https://www.pbs.org/newshour/health/medical-students-worry-about-where-to-train-as-several-states-enact-abortion-restrictions.

A. The Shortage of OB-GYN in Texas Will Continue to Worsen Without an Influx of Medical Professionals Qualified to Provide OB-GYN Care.

According to the Texas Department of Health and Human Services, Texas already did not have enough OB-GYNs to meet the need for care among Texas residents, even before the Bans took effect.[56] As of 2018 (according to the most recent Department data), there were 3,096 OB-GYNs in Texas—approximately 10 percent fewer than the number needed to meet Texas' demand for OB-GYN care.[57] There is only one OB-GYN for every approximately 5,500 female residents in Texas.[58] Approximately 58 percent of Texas counties—148 counties total— have no OB-GYN at all, according to the most recent available data.[59]

A recent report from the March of Dimes has similarly found that 46 percent of counties in Texas were defined as "maternity care deserts," compared to 32.6 percent nationally.[60] Maternity care deserts are defined as "counties in which access to maternity health care services is limited or absent, either through lack of services

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[56] Tex. Health and Hum. Servs., *Physician Supply and Demand Projections 2021-2032*, *supra* note 53.
[57] Tex. Health and Hum. Servs., *Physician Supply and Demand Projections, 2018-2032* 12 (May 2020), https://www.dshs.texas.gov/sites/default/files/legislative/2020-Reports/TexasPhysicianSupplyDemandProjections-2018-2032.pdf.
[58] *See* Tex. Health and Hum. Servs., *Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 1* 22 (Apr. 2018), https://www.dshs.texas.gov/sites/default/files/mch/epi/docs/01-Regional-Analysis-of-Maternal-and-Infant-Health-in-Texas_PHR-1.pdf.
[59] *Id*.
[60] March of Dimes, *Where You Live Matters: Maternity Care in Texas* 1 (2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Texas.pdf.

or barriers to a woman's ability to access that care within counties."[61] In Texas, pregnant patients living in maternity care deserts have to travel 4.5 times farther in comparison to pregnant patients living near full-access maternity care.[62] Greater distance to maternity care can create a greater risk of maternal morbidity and adverse infant outcomes.[63]

The problem is most apparent in Texas' rural communities. More than half of Texas physicians practice in Texas' five most populous counties, even though only 44 percent of Texas' population resides in those counties.[64] Due in large part to the shortage of medical professionals, hospitals in rural Texas are closing at an alarming rate: since 2010, 27 rural hospitals have closed temporarily or permanently, and among the 158 remaining rural hospitals, only 66 offer labor and delivery services.[65]

The Texas Department of Health and Human Services has estimated that, without an increase in the number of medical students training in Texas, this deficit will continue to worsen over time: "[W]ithout any action to increase physicians in

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[61] March of Dimes, *Maternity Care Desert* (last updated Oct. 2022), https://www.marchofdimes.org/peristats/data?top=23.
[62] *Id*.
[63] *Id*.
[64] N. Tex. Reg'l Extension Ctr., *The Physician Workforce in Texas* 3 (Apr. 2015), https://dfwhcfoundation.org/wp-content/uploads/2015/04/mhaNTREC2015studyfinal.pdf. The most recent available data demonstrates that OB-GYN density in urban counties (19.4 OB-GYNs per 100,000 female residents) is more than twice as high as that in rural counties (9.1 OB-GYNs per 100,000 female residents). Tex. Health and Hum. Servs., Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 1, supra note 58, at 22.
[65] Tex. Org. of Rural & Cmty. Hosps. (TORCH), *Ten Things to Know About Texas Rural Hospitals* (revised Nov. 2021), https://www.torchnet.org/uploads/1/1/9/5/119501126/torch_25_things_fact_sheet.pdf.

Texas, the gaps between supply and demand will widen between 2022 and 2032."[66] With more than 30 percent of Texas' OB-GYNs at or nearing retirement age, recruiting the next generation of Texas OB-GYNs is critical to ensuring the availability of quality OB-GYN care for all Texans.[67] Encouraging prospective OB-GYNs to train in Texas is critical in addressing Texas' OB-GYN shortage as, on average, 57.1 percent of medical residents ultimately practice in the state where they complete their residencies.[68] The Department has estimated that, to meet the demand for OB-GYNs in Texas by 2032, there would need to be an annual increase of 13 new in-state OB-GYN residency positions, or alternatively, an annual increase of 33 graduates from each of Texas' sixteen medical schools.[69]

In short, Texas needs many more clinicians to provide OB-GYN care, not fewer, to ensure that Texans who need that care can lead healthy lives and have healthy pregnancies. Lack of access to OB-GYN health care is devastating to all Texans, not just those seeking abortions.

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[66] Tex. Health and Hum. Servs., *Physician Supply and Demand Projections 2021-2032*, *supra* note 53.
[67] Ass'n Am. Med. Colleges, *Texas Physician Workforce Profile* (2021), https://www.aamc.org/media/58336/download.
[68] Ass'n Am. Med. Colleges, *Report on Residencies, Executive Summary* 4 (Nov. 2021), https://www.aamc.org/media/57601/download?attachment.
[69] *Id*. at 14, 15.

B. The Bans Discourage Medical Professionals and Students Seeking Careers in Reproductive Health from Practicing in Texas and Deprive Texas-Based Residency Programs of the Ability to Offer Full Scope of Required Training.

The Texas Bans work directly against the state's urgent need for more OB-GYNs by discouraging medical professionals from practicing in Texas and compromising the ability of residency programs to offer full scope, required training in the state. Practicing OB-GYNs are reportedly leaving Texas for states where abortion remains legal.[70] Health care staffing firms report that OB-GYN candidates are declining employment opportunities in states with abortion bans, like Texas, where OB-GYN care is already a scarce resource.[71] For example, one recruiter working to fill a single maternal-fetal medicine job in Texas reportedly received rejections from multiple separate candidates, all of whom "expressed fear they could

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[70] *See* Alice Ollstein, *Abortion Doctors' Post-Roe Dilemma: Move, Stay, or Straddle State Lines*, Politico (June 29, 2022), https://www.politico.com/news/2022/06/29/abortion-doctors-post-roe-dilemma-move-stay-or-straddle-state-lines-00040660; *see also* Peter Holley, *Texas Abortion Doctors Face a Difficult Choice: To Flee or Not to Flee*, Tex. Monthly (May 9, 2022), https://www.texasmonthly.com/news-politics/texas-abortion-doctors-choose-flee-or-stay/; Shefali Luthra, *"We're Not Going to Win That Fight:" Bans on Abortion and Gender-Affirming Care Are Driving Doctors from Texas*, The 19th (June 21, 2023), https://19thnews.org/2023/06/abortion-gender-affirming-care-bans-doctors-leaving-texas/ ("I do want to do the best for my patients, and I need to work in an environment where I can provide patients with at least the standard of care,");Charlotte Scott, *Doctors Could Face Life in Jail, $100,000 Penalty for Providing Abortion Care*, Spectrum Local News (Aug. 25, 2022), https://tinyurl.com/yc3up2e2; Grace Benninghoff, *OB-GYN Residents are Required to Receive Clinical Abortion Training. They Can't Do That in Texas*, Tex. Monthly (May 23, 2023), https://www.texasmonthly.com/news-politics/abortion-training-ob-gyn-medical-residents-leaving-texas/; Mary Tuma, *Abortion Providers on Two Years of Texas Ban: 'We're Living in a Devastating Reality'*, The Guardian (Aug. 31, 2023), https://www.theguardian.com/world/2023/aug/31/texas-abortion-ban-senate-bill-8.

[71] *See* Tex. Health and Hum. Servs., *Physician Supply and Demand Projections 2021-2032*, *supra* note 53, at 1-2.

be fined or lose their license for doing their jobs."[72] Another recruiter reported that some prospective OB-GYN candidates "won't even consider opportunities in states with new or pending abortion bans."[73] The experience of a plaintiff in this case confirms this: Physician-Plaintiff Danielle Mathisen, an OB-GYN resident in Hawai'i, graduated from the University of Texas Southwestern Medical Center.[74] She would like to return to Texas, but the Bans deter her.[75] Dr. Mathisen says, "I know there are people in Texas that need the care that I know how to provide. But I cannot give it to them there."[76]

In addition to concerns about criminal and civil liability based on the practice of evidence-based medicine, the Bans are affecting medical and residency education in Texas. Indeed, the American Council on Graduate Medical Education has long required, and continues to require, training in abortion care as a core competency that must be taught in residency programs.[77] This training is necessary to ensure that OB-GYNs have the skills to properly manage miscarriages (i.e. spontaneous

[72] Christopher Rowland, *A Challenge for Antiabortion States: Doctors Reluctant to Work There,* Wash. Post (Aug. 6, 2022), https://www.washingtonpost.com/business/2022/08/06/abortion-maternity-health-obgyn/. (Quotation omitted.)
[73] *Id.*
[74] Pls.' First Am. Verified Pet., *supra* note 34, ¶ 332.
[75] *Id.* at ¶ 345; Klibanoff, *supra* note 44.
[76] Klibanoff, *supra* note 44.
[77] There is an exception for residents who opt out due to religious objections, which has existed in the same form for decades. Accreditation Council for Graduate Med. Educ., *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology Summary and Impact of Interim Requirement Revisions* (2022), https://www.acgme.org/globalassets/pfassets/reviewandcomment/220_obstetricsandgynecology_2022-06-24_impact.pdf.

abortion) and other pregnancy complications such as those identified above.[78] In Texas, however, with teaching hospitals chilled from providing medically necessary care, residents and students cannot receive the level of training and experience necessary to provide quality reproductive care to patients.[79] Residency programs in Texas must now send their trainees to other regions of the country to obtain required training because the Bans prevent the full scope of OB-GYN training from being provided in the state.

Recent data from the 2022-2023 residency application cycle shows that the total number of residency applications decreased nationwide since the *Dobbs* decision, with states that ban or severely restrict abortion seeing the greatest

[78] *See* Kavita Vinekar et al., *Project Implications of Overturning* Roe v. Wade *on Abortion Training in U.S. Obstetrics and Gynecology Residency Programs*, 140 Obstetrics & Gynecology 146, 148 (Aug. 2022), https://journals.lww.com/greenjournal/Fulltext/2022/08000/Projected_Implications_of_Overturning_Roe_v_Wade.3.aspx. Indeed, the Accreditation Council for Graduate Medical Education ("ACGME") requires OB-GYN residency programs to provide access to abortion training and, in states that restrict abortion, requires that OB-GYN residents have access to such training in another state.

[79] *See, e.g.*, Sara Hutchinson, *Post-Roe, Some Areas May Lose OB/GYNs If Medical Students Can't Get Training*, Wash. Post (Sept. 2, 2022), https://www.washingtonpost.com/education/2022/09/02/abortion-training-rural-areas/; Christopher Brown, *Abortion Ruling Pits State Bans Against OB-GYN Training Rules*, Bloomberg Law (June 27, 2022, https://news.bloomberglaw.com/health-law-and-business/abortion-ruling-pits-state-bans-against-ob-gyn-training-rules); Sara Hutchinson, *Abortion Bans Complicate Medical Training, Risk Worsening OB/GYN Shortages*, Wash. Post (Oct. 13, 2023), https://www.washingtonpost.com/education/2023/10/13/obgyn-training-abortion-restrictions/.

decreases in residency applications submitted by medical school graduates.[80] This is in contrast to the previous three application cycles, which saw increases in residency applications.[81] With respect to OB-GYN residencies specifically, the number of applicants in abortion-restricted states like Texas decreased by 10.5 percent, whereas applications in states where abortion is legal decreased by only 5.3 percent.[82] These post-*Dobbs* decreases in residency applications suggest that applicants "may be selectively reducing their [applications to] . . . states with more state-imposed restrictions on health care."[83] Similarly, a research team at Emory University surveyed 490 third- and fourth-year medical students applying across specialties throughout the country regarding their residency applications.[84] According to the study, 75% of those surveyed felt state abortion laws affected where they would apply for residency, with roughly 60% of medical students reporting they would not apply to states with restrictive laws.[85] Evidently, the Bans discourage medical professionals and trainees from practicing and training in Texas to the detriment of all Texans in need of OB-GYN care.

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[80] Kendal Orgera et al., Ass'n Am. Med. Colls., *Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health Organization Decision* (Apr. 13, 2023), https://www.aamcresearchinstitute.org/our-work/data-snapshot/training-location-preferences-us-medical-school-graduates-post-dobbs-v-jackson-women-s-health.
[81] *Id.*
[82] *Id.*
[83] *Id.*
[84] Pollard, *supra* note 55.
[85] *Id.*

V. The Bans Are Having Devastating Consequences for Texas Patients Whether or Not They Require Abortions, Disproportionately Impacting Those Living in Rural Areas, People of Color and People with Low Incomes.

The impacts of the Bans are especially devastating for people and communities from marginalized populations, including patients living in rural areas, patients of color, and patients with low incomes. As a result of structural inequities and social determinants of health, these populations are "more likely to face barriers in accessing routine health care services, including prenatal care."[86]

This is especially true for rural Texans, where the burden of the deficit in OB-GYN care bears heavily. As discussed above, living in "maternity care deserts" with hospitals closing, rural Texans need more access to care, not less.[87] Similarly, Texans with low incomes and Texans of color face disproportionate harm from the Bans as pregnant patients of color or with fewer financial resources are also less likely to receive prenatal care, resulting in an increased risk for complex health issues occurring in pregnancy.[88]

Patients of color experience a higher rate of severe maternal mortality and are

[86] Benson et al., *supra* note 5, at 2.
[87] *See* Part IV, *supra* pp. 32-41.
[88] Benson, *supra* note 5, at 2; see also Chinn et al., *supra* note 5, at 215 (explaining that "Black women are at a disadvantage regarding the protective factor of the early initiation of prenatal care.").

more likely to die from pregnancy-related complications.[89] Maternal mortality, defined by the Centers for Disease Control and Prevention ("CDC") as "the death of a woman during pregnancy, at delivery, or soon after delivery[,]" is "a tragedy for her family and for society as a whole."[90] The United States maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births, a sharp increase from prior years.[91] Data shows that United States has a maternal mortality rate more than three times the rate of most other high-income countries,[92] and the maternal mortality rate in Texas is one of the highest in the United States.[93]

These rates are even higher for Black patients. The most recent Texas Department of Health and Human Services report found that in 2019, Black Texans were more than twice as likely as White Texans to die from pregnancy-related

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[89] Nat'l Inst. of Child Health and Hum. Dev., *Maternal Morbidity and Mortality* (last accessed Nov. 20, 2023), https://www.nichd.nih.gov/health/topics/factsheets/maternal-morbidity-mortality. *;* see also Chinn, *supra* note 5, at 215 (Black and Latina women "are at greater risk of poor pregnancy outcomes.").

[90] Ctrs. for Disease Control and Prevention, *Maternal Mortality*, CDC (last reviewed Apr. 26, 2023), https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html.

[90] Donna L. Hoyert, Ctrs. for Disease Control and Prevention, *Maternal Mortality Rates in the United States, 2021* (last reviewed Mar. 16, 2023), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm#:~:text=The%20increases%20from%202020%20to,(Figure%202%20and%20Table).

[91] *Id*.

[92] Munira Z. Gunja et al., The Commonwealth Fund, *The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison* (Dec. 1, 2022), https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison.

[93] Casey Leins, *States with the Highest Maternal Mortality Rates*, US News (June 12, 2019), https://www.usnews.com/news/best-states/articles/2019-06- 12/these-states-have-the-highest-maternal-mortality-rates (reporting that the maternal mortality rate in Texas was the sixth highest in the United States).

causes.[94] Most of these deaths were preventable.[95] Discrimination contributed to almost 17% of pregnancy-related deaths.[96] Black patients in Texas face inequities even in geographic areas with the lowest overall mortality rates and among patients with higher levels of education.[97] And, as a result of these inequities, Black patients are more likely to face "higher rates of preventable disease and chronic health conditions including diabetes, hypertension, and cardiovascular disease,"[98] all of which can contribute to complications during pregnancy.

Many of these patients face challenges when accessing reproductive care. For example, as a result of systemic inequities and barriers, Black patients have limited access to quality contraceptive care and counseling as compared to White patients.[99] A study showed that Black women enrolled in Medicaid were less likely than White

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[94] Tex. Health and Hum. Servs., *Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022*, App. E-1 (Dec. 2022, updated Oct. 2023), https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/2022-MMMRC-DSHS-Joint-Biennial-Report.pdf.

[95] Tex. Health and Hum. Servs., *Addendum - Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report 2022* (Oct. 25, 2023), Addendum-2022-MMMRC-DSHS-Joint-Biennial-Report.pdf (texas.gov)

[96] *Id*.

[97] Emily E. Petersen et al., Ctrs. for Disease Control & Prevention, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths — United States, 2007–2016* (Sept. 6, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm; Marian F. MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 111 Am. J. Pub. Health 1673, 1676–1677 (Sept. 22, 2021), https://ajph.aphapublications.org/doi/10.2105/AJPH.2021.30637.

[98] Nat'l P'ship for Women & Families, *Black Women's Maternal Health: A Multifaceted Approach to Addressing Persistent and Dire Health Disparities* 1 (Apr. 2018), https://nationalpartnership.org/wp-content/uploads/black-womens-maternal-health-2018.pdf.

[99] *Id*. at 2.

women to receive postpartum contraception.[100] Black patients face a higher risk of death than any other racial group due to a multitude of causes, including, but not limited to, "historical exposure to racial trauma, discrimination, and marginalization; systemic barriers such as systematic racism and implicit bias within the health care system; the possibility of being uninsured; reduced access to reproductive health care services; and socioeconomic factors."[101]

The Bans operate to deny care to patients who need abortions for health- or life-saving reasons. This only increases the already existing inequities of maternal health for communities of color and other marginalized communities. And as the OB-GYN desert in Texas worsens because of the Bans, those who face structural inequities to care will only suffer further.

CONCLUSION

For all the reasons stated above, the Court should confirm that the Bans do not prevent Texas clinicians from providing abortions where necessary in the clinician's judgment to preserve the health or life of pregnant Texans and affirm the District Court's orders in favor of Plaintiffs-Appellees.

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[100] *Id.*

[101] Anuli Njoku et al., *Listen to the Whispers Before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States*, 11 Healthcare 1, 1 (Feb. 3, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9914526/pdf/healthcare-11-00438.pdf.

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The undersigned counsel certifies that this petition complies with the typeface requirements of TEX. R. APP. P. 9.4(e), because it has been printed in a conventional typeface no smaller than 14-point except for footnotes, which are no smaller than 12-point. This document also complies with the word-count limitations of TEX. R. APP. P. 9.4(i), because it contains less than 15,000 words, excluding any parts exempted by TEX. R. APP. P. 9.4(i)(1).

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Claudia Center		ccenter@dredf.org	11/21/2023 7:53:56 PM	SENT

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Associated Case Party: Women Enabled International

Name	BarNumber	Email	TimestampSubmitted	Status
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