

No. 23-0629

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IN THE SUPREME COURT OF TEXAS

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STATE OF TEXAS, *et al.*,  
*Appellants*

v.

AMANDA ZURAWSKI, *et al.*  
*Appellees.*

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On Direct Appeal from the 353rd Judicial District of Travis County, Texas  
Cause No. D-1-GN-23-000968

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**BRIEF FOR *AMICUS CURIAE* PHYSICIANS FOR HUMAN RIGHTS  
IN SUPPORT OF APPELLEES**

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Gerson H. Smoger (TX Bar 00786920)  
Counsel of Record  
SMOGER AND ASSOCIATES PC  
4228 Hallmark Drive  
Dallas, Texas 75229-2847  
Telephone: (972) 243-5297  
Email: Gerson@texasinjurlaw.com

Payal Shah\*  
Christian M. De Vos\*  
PHYSICIANS FOR HUMAN RIGHTS  
256 W 38th Street, 9th Floor  
New York, NY 10018  
Tel: (646) 564-3720  
pshah@phr.org  
cdevos@phr.org

Janice Mac Avoy\*  
FRIED, FRANK, HARRIS, SHRIVER &  
JACOBSON LLP  
One New York Plaza  
New York, NY 10004  
Tel: (212) 859-8000  
Janice.MacAvoy@friedfrank.com

*\*Admitted Pro Hac Vice*

Counsel for *Amicus Curiae* Physicians for Human Rights  
(Additional Counsel listed on Signature Pages)

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## INTEREST OF AMICUS CURIAE<sup>1</sup>

For more than thirty-five years, Physicians for Human Rights (“PHR”) has used science and medicine to document and call attention to severe human rights violations around the world. PHR, which has shared in the Nobel Peace Prize, utilizes its expertise to investigate and speak out against attacks on healthcare workers and healthcare, prevent torture, document mass atrocities, and bring accountability to those who violate human rights.

Through PHR’s longstanding efforts to address human rights violations, PHR has developed an extensive network of partnerships with clinicians throughout the United States, and particularly within the state of Texas. In fact, PHR has eighty-nine clinician partners in Texas, including clinicians at many of the main academic medical centers, six student chapters at undergraduate and graduate schools, and one human rights clinic at Baylor College of Medicine. PHR’s clinician partners, including those in Texas, are deeply committed to ensuring respect for human rights for their patients and have expertise in conducting forensic medical examinations for survivors of human rights violations, including torture, and researching the impacts of national policies on patient health and rights.

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<sup>1</sup> Counsel for *amicus curiae* state that no counsel for a party authored this brief in whole or in part and that no person other than *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief. *See* Tex. R. App. P. 11.

Since the Supreme Court of the United States reversed *Roe v. Wade*<sup>2</sup> in *Dobbs v. Jackson Women’s Health Organization*, 597 U.S. \_\_\_, (2022) [hereinafter *Dobbs*], PHR has been conducting rigorous and ongoing research to understand the impacts of newly enacted state-level abortion bans on healthcare providers and hospitals, particularly in states with restrictive abortion legislation like Texas.<sup>3</sup> It is PHR’s belief that the combination of our expertise, extensive clinician network, and well-documented research, makes us uniquely positioned to present guidance to this Court and submit this amicus brief to share the results of our research.

PHR’s research supports the conclusion of the lower court—the inclusion of non-medical terminology in the Texas statutes, alongside severe civil and criminal penalties for performing abortions, leads to confusion, fear, and, ultimately, a chilling effect on the provision of medically necessary obstetric care, including abortion. Therefore, PHR presents this brief to explain why the clarification issued by the lower court is critical to ensuring that physicians can maintain medical standards of care and adhere to their professional ethical principles—including acting in a manner consistent with patients’ rights—for the ultimate benefit of their patients and the citizens of Texas.

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<sup>2</sup> 410 U.S. 113 (1973) [hereinafter *Roe*].

<sup>3</sup> See, e.g., Int’l Dual Loyalty Working Grp., Physicians for Hum. Rts. & Univ. of Cape Town, Health Sci. Fac., *Dual Loyalty & Human Rights In Health Professional Practice* (2002), <https://phr.org/wp-content/uploads/2003/03/dualloyalties-2002-report.pdf> [hereinafter “Proposed Guidelines”].

## SUMMARY OF THE LAWS AT ISSUE

Although Plaintiffs/Appellees’ brief outlines the Texas abortion-related statutes of concern, along with their corresponding medical exceptions in detail, PHR provides the below summary of Texas’s abortion bans and medical exceptions, which are critical to PHR’s analysis in addressing Plaintiffs/Appellees’ narrow suit for “equitable relief for the small subset of patients who require abortion to preserve their lives and their health” (Plaintiff/Appellees’ Response Brief at 2).

Pursuant to the 2021 Human Life Protection Act, Tex. Health & Safety Code §§ 170A.001-.007 (“HLPa” or “Trigger Ban”), “[a] person may not knowingly perform, induce, or attempt an abortion.”<sup>4</sup> Excluded from the definition of abortion are “act[s] [] done with the intent to: (A) save the life or preserve the health of an unborn child; (B) remove a dead, unborn child whose death was caused by spontaneous abortion; or (C) remove an ectopic pregnancy.”<sup>5</sup>

The HLPa contains the following list of medical exceptions:

(1) the person performing, inducing, or attempting the abortion is a licensed physician; (2) in the exercise of *reasonable medical judgment*, the pregnant female on whom the abortion is performed, induced, or attempted has a *life-threatening physical condition aggravated by, caused by, or arising* from a pregnancy that places the female at *risk of death* or poses a *serious risk of substantial impairment of a major bodily function* unless the abortion is performed or induced; and (3) the person performs, induces, or attempts the abortion in a manner that, in the exercise

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<sup>4</sup> Tex. Health & Safety Code Ann. §170A.002(a).

<sup>5</sup> Tex. Health & Safety Code Ann. § 245.002(1).

*of reasonable medical judgment, provides the best opportunity for the unborn child to survive unless, in the reasonable medical judgment, that manner would create: (A) a greater risk of the pregnant female’s death; or (B) a serious risk of substantial impairment of a major bodily function of the pregnant female.*<sup>6</sup>

Performing an abortion in violation of the HLPAs carries criminal penalties of a felony of the first or second degree which can result in imprisonment or a jail term of 5 to 99 years,<sup>7</sup> civil penalties “of not less than \$100,000 for each violation,”<sup>8</sup> and potential disciplinary action by the relevant licensing agencies.<sup>9</sup> This law became effective 30 days after the Supreme Court overturned *Roe v. Wade* in *Dobbs*.<sup>10</sup>

The Texas Heartbeat Act, Tex. Health & Safety Code §§ 171.201-.212 (“S.B. 8”) provides that “a physician may not knowingly perform or induce an abortion on a pregnant woman if the physician detected a fetal heartbeat for the unborn child as required by Section 171.203 or failed to perform a test to detect a fetal heartbeat.”<sup>11</sup> Like the HLPAs, the Heartbeat Act “do[es] not apply if a physician believes a medical emergency exists.”<sup>12</sup> A “medical emergency” is defined as “a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as

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<sup>6</sup> Tex. Health & Safety Code Ann. § 170A.002(b) (emphasis added).

<sup>7</sup> Tex. Health & Safety Code Ann. § 170A.004, Tex. Health & Safety Code Ann. § 170A.004.

<sup>8</sup> Tex. Health & Safety Code Ann. § 170A.005.

<sup>9</sup> Tex. Health & Safety Code Ann. § 170A.007.

<sup>10</sup> *Whole Woman’s Health et al. v. Paxton*, No. 22-0527 (Tex. July 1, 2022), <https://search.txcourts.gov/SearchMedia.aspx?MediaVersionID=a42fe4bc-32e8-454c-81e3-0d315e7dae77&coa=cossup&DT=STAY%20ORDER%20ISSUED&MediaID=efa47a15-2086-4525-9f8f-73ff4bad423b> (order granting stay).

<sup>11</sup> Tex. Health & Safety Code Ann. § 171.204(a).

<sup>12</sup> Tex. Health & Safety Code Ann. § 171.205(a).

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.”<sup>13</sup>

S.B.8 empowers private citizens to seek *\$10,000* in damages if it is found that someone either provided an abortion after approximately six weeks, or facilitated one. “Facilitating” an abortion broadly and ambiguously includes counseling a pregnant person, funding an abortion, or even providing a pregnant person with a ride to an abortion clinic.<sup>14</sup>

### **SUMMARY OF ARGUMENT**

The District Court’s guidance on Texas’s medical exceptions is necessary to enable clinicians to act in accordance with their professional ethics and avoid injury to their patients and themselves. Notably, Texas’s post-2021 abortion bans have called into question whether clinicians’ good faith medical judgment—which reflects a nuanced assessment based on a physician’s deep clinical experience, robust training, and analysis of both medical ethics and patient preference that an abortion is medically indicated—is sufficient to provide an abortion without risk of significant civil or criminal penalties. By introducing non-medical terminology and opening up clinicians to lawsuits and prosecution, the existing medical exceptions have created a chilling effect that is unworkable in practice.

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<sup>13</sup> Tex. Health & Safety Code Ann. § 171.002(3).

<sup>14</sup> Tex. Health & Safety Code Ann. §§ 171.207–08.

Instead, physicians face an impossible choice of either following the law or violating their medical, ethical, and human rights obligations, while also possibly harming their pregnant patients. The difficulties of this choice are only exacerbated by the harsh civil, criminal, and professional penalties a clinician may face for violating the law and place them in a “double bind” where they may face a medical malpractice suit if they follow the law.

Meanwhile, research, including studies conducted by PHR, reveals that the uncertainty created by the medical exceptions have delayed necessary medical care, including life- and health-preserving abortions, resulting in adverse health or death for pregnant patients. Patients in desperate and urgent need of healthcare may be forced to make long distance and dangerous journeys for treatment. Women diagnosed with fatal fetal impairments may be forced to continue their pregnancies, adversely impacting their physical and mental health and amounting to torture and cruel, inhuman, and degrading treatment. All the while, physicians often feel unable to give their pregnant patients the essential information they need to save their lives or preserve their health.

The devastating results for the citizens of Texas will only continue to escalate with time. In Texas and nationally, maternal mortality and morbidity are increasing to record levels and will continue to increase. The same is true of infant mortality. Meanwhile, OBGYNs are leaving the state and it is not likely they will be replaced.

OBGYN medical school enrollment is declining, particularly in states with abortion bans. As a result, many areas of Texas have already become “maternity care deserts” with the situation only to worsen in the years to come, especially if this court overturns the District Court’s guidance.

## ARGUMENT

### I. THE MEDICAL EXCEPTIONS TO TEXAS’S ABORTION BANS ARE UNWORKABLE FOR PRACTICING CLINICIANS

Texas has been classified as having some of the most restrictive laws on abortion, along with some of the most extensive civil and criminal penalties.<sup>15</sup> The state claims that these abortion bans are not draconian because they contain limited but “clear”<sup>16</sup> medical exceptions. But that could not be further from the truth. While Texas’s medical exceptions purport to leave discretion to physicians, like the exceptions in similarly restrictive states,<sup>17</sup> Texas’s exceptions provide no actionable medical guidance and “use definitions that are vague, narrow, and non-clinical, and

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<sup>15</sup> See Guttmacher Inst., *Interactive Map: US Abortion Policies and Access After Roe* (Nov. 14, 2023), <https://states.guttmacher.org/policies/texas/abortion-policies>.

<sup>16</sup> Defendant/Appellants’ Brief at 9.

<sup>17</sup> The abortion bans in Texas are substantially similar to those in Louisiana (La. Stat. Ann. § 14:87.1 & § 14:1061.1 (2022)) and Oklahoma (Okla. Stat. Ann. § 63-1-745.1 - .11 (2022)), which both have complete bans on abortions with limited exceptions for threats to a pregnant patient’s life. If an abortion is performed that is not within the limited exceptions, clinicians in Louisiana and Oklahoma face criminal and civil penalties. Further, both states also include waiting periods and counseling requirements before an abortion can be obtained. As such, the negative outcomes observed in both Louisiana and Oklahoma in various studies and reports demonstrate the pervasive adverse effects likely to occur under the current Texas statutory regime. Notably, Oklahoma’s Supreme Court held on exactly this ground that its pre-*Roe* ban could not be enforced to prevent physicians from providing life and health preserving abortions. *Okla. Call for Reprod. Just. v. Drummond*, 526 P.3d 1123, 1130-32 (Okla. 2023) (per curiam).

effectively remove the ability of health care providers to best manage the care of pregnant people.”<sup>18</sup> Indeed, as Plaintiff/Appellees’ Brief describes, Texas “doctors are frightened” and “[i]t is the blind leading the blind on the ground.” 3.RR.453.<sup>19</sup>

Significantly, under this restrictive and uncertain landscape, physicians are unable to determine whether their good faith assessment of medical need is sufficient to legally provide the medically necessary care.<sup>20</sup> Prior to the passage of S.B. 8 in 2021, Texas physicians were able to make good faith determinations about whether abortion care was necessary based upon an individualized assessment of a pregnant patient’s medical needs, as well as by using their medical knowledge and experience—all while adhering to their extensive obligations as medical professionals.<sup>21</sup> Subsequent to the enactment of the HLP and S.B.8, that is no

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<sup>18</sup> See Mabel Felix, Laurie Sobel & Alina Salganicoff, *A Review of Exceptions in State Abortion Bans: Implications for the Provision of Abortion Services*, KFF (May 18, 2023), <https://www.kff.org/womens-health-policy/issue-brief/a-review-of-exceptions-in-state-abortion-bans-implications-for-the-provision-of-abortion-services/>; PHR et al., *Letter re: Urgent Appeal: Human rights crisis following the United States Supreme Court decision in Dobbs v. Jackson Women’s Health Org.*, at 6, ¶ 9 (Mar. 2, 2023), [https://www.globaljusticecenter.net/wp-content/uploads/2023/06/UNSpecialProceduresLetter\\_AbortionRightsUS.pdf](https://www.globaljusticecenter.net/wp-content/uploads/2023/06/UNSpecialProceduresLetter_AbortionRightsUS.pdf) [hereinafter “PHR Joint Briefing Paper”].

<sup>19</sup> Plaintiffs/Appellees’ Response Br. at 2.

<sup>20</sup> While Texas passed a 2023 statute to create an affirmative defense in certain cases for abortion provided when a patient experiences preterm premature rupture of membranes and ectopic pregnancy, as Appellees’ Response Brief argues, this only shifts the burden to the defendant to prove the defense and ultimately only serves to cause further confusion. H.B. 3058, Act of May 28, 2023, 88th Leg., R.S. (Tex. 2023); Plaintiff/Appellees’ Response Brief at 6.

<sup>21</sup> Proposed Guidelines, *supra* note 3, at 16; PHR Joint Briefing Paper, *supra* note 18, at 21 & n.130, ¶ 36; Working Group on discrimination against women and girls in law and practice, *Women’s Autonomy, Equality and Reproductive Health in International Human Rights: Between Recognition, Backlash and Regressive Trends* (Oct. 2017), <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf>.

longer the case. Now, Texas physicians must continue to adhere to their medical and ethical obligations while also navigating the threat of severe penalties if a court ultimately determines that they did not comply with the law. Clearly, the statutory exceptions are unworkable. To make Texas’s medical exceptions workable, Plaintiffs/Appellees initiated suit and the lower court issued its clarification.

One reason that the guidance is “difficult to implement in practice” is “because [the statutes’] terms do not necessarily correspond with medical diagnoses and exclude certain health-threatening conditions.”<sup>22</sup> Instead of making sound decisions based on experience and their advanced medical training, even when faced with the sudden onset of symptoms, the state’s medical exceptions deprive healthcare providers of *any* actionable medical guidance to determine the validity of their “belief,” “reasonable medical judgment,” assessment of “risk,” or what the “best opportunity” is. As a result, experienced physicians “report that the restrictive legal landscape means that they are generally unsure if and when medically necessary, and even lifesaving, abortions are legal.”<sup>23</sup>

Further, the fear of criminal and civil liability within the current statutory framework is devastating. “Providing an abortion—even one [physicians] believe

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<sup>22</sup> PHR Joint Briefing Paper, *supra* note 18, at 6, ¶ 9 (alteration added).

<sup>23</sup> *Id.*.

complies with the law—exposes [Plaintiffs/Appellees] to criminal and civil liability, including life imprisonment, crippling fines, and license revocation.”<sup>24</sup>

Evidence from other states with similarly stringent abortion bans and medical exceptions also confirms that the “[f]ear of punishment aligned with lack of clarity on how [abortion laws] will be enforced . . . can lead to devastating consequences” for clinicians” amid this lack of clarity.<sup>25</sup> A survey of thirty-seven hospitals in states with abortion bans showed a thorough inability to translate statutory language into usable medical guidance.<sup>26</sup> Twenty-eight of the institutions surveyed offered guidance which merely mimicked the language of the state’s abortion bans or offered no guidance at all.<sup>27</sup> Other institutions required physicians to call an office phone number or send an email to a specific address—both of which demonstrate a complete lack of understanding of the time-sensitive nature of many necessary

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<sup>24</sup> Appellee Br. at 19-20.

<sup>25</sup> Christian De Vos et al., *No One Could Say: Accessing Emergency Obstetrics Information as a Prospective Prenatal Patient in Post-Roe Oklahoma*, PHR, at 1-2 (Apr. 25, 2023), <https://phr.org/wp-content/uploads/2023/04/Oklahoma-Abortion-Ban-Report-2023.pdf> [hereinafter “PHR Oklahoma Report”]; PHR et al., *Legal Retrogression and the Harms of Louisiana’s Near Total Abortion Bans: A Report to the Human Rights Committee 139 Session*, at 2 (Sept. 12, 2023), [https://phr.org/wp-content/uploads/2023/10/ICCPR-LA-FF-Shadow-Report\\_Final.pdf](https://phr.org/wp-content/uploads/2023/10/ICCPR-LA-FF-Shadow-Report_Final.pdf) [hereinafter “PHR Louisiana Report”]; Piper Hutchinson, *Doctors spell out their opposition to Louisiana’s abortion law*, Louisiana Illuminator (July 6, 2022), <https://lailluminator.com/2022/07/06/doctors-spell-out-their-opposition-to-louisianas-abortion-law/>.

<sup>26</sup> Caroline Kitchener & Dan Diamond, *Faced with abortion bans, doctors beg hospitals for help with key decisions*, Wash. Post, Nov. 1, 2023, <https://www.washingtonpost.com/politics/2023/10/28/abortion-bans-medical-exceptions/>.

<sup>27</sup> *Id.*

procedures.<sup>28</sup> The nine institutions that attempted to provide physicians with *some* guidance on their state laws' medical exceptions only provided carefully scripted answers advising physicians to exercise caution.<sup>29</sup>

These findings are also consistent with PHR's own research in Oklahoma, which at the time of PHR's study had three overlapping abortion bans similar to Texas. Of the thirty-four hospitals that responded to PHR, not a *single* hospital could articulate clear, consistent policies for emergency obstetric care that enabled clinicians to make decisions based on their clinical judgment and pregnant patients' needs.<sup>30</sup>

## **II. THE UNWORKABILITY OF TEXAS'S MEDICAL EXCEPTIONS TO ITS ABORTION BANS RENDERS PHYSICIANS UNABLE TO UPHOLD THEIR CORE ETHICAL OBLIGATIONS**

Texas's medical exceptions give physicians the Hobson's choice of "dual loyalty"<sup>31</sup>—that is, a situation where physicians are unable to fully comply with both the law and their ethical obligations as medical practitioners. In many situations, a physician is ethically obligated to perform an abortion, and yet it is entirely unclear whether the demanding requirements and non-medical criteria set forth by the statutory medical exceptions would permit it. To the extent such conflicts of interest

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<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> PHR Oklahoma Report, *supra* note 25, at 12.

<sup>31</sup> Proposed Guidelines, *supra* note 3, at 16.

arise, physicians are forced to balance the competing state demands, including civil or criminal sanctions, against their medical obligations as physicians, along with complying with at minimum the Code of Ethics of the American Congress of Obstetricians and Gynecologists (“ACOG”), which states that treatment decisions should be resolved “in accordance with the best interest of the patient, respecting a [person’s] autonomy to make health care decisions.”<sup>32</sup> But Texas law mandates otherwise—that the physicians’ first obligation is to comply with Texas’s statutes. At times, it is impossible to do both. The combination of the nonmedical language describing exceptions to abortion bans and the corresponding harsh civil and criminal penalties “only sow more fear and confusion and potentially make clinicians reluctant to take steps to provide necessary medical care to patients.”<sup>33</sup>

The Texas abortion bans and medical exceptions prevent physicians from complying with four widely-recognized principles essential to the provision of quality medical care: (i) beneficence, or the duty to provide beneficial care to their patients; (ii) nonmaleficence, or “do no harm”; (iii) respect for patient autonomy; and (iv) justice or fair distribution of benefits and burdens.<sup>34</sup> Ethical codes from the AMA and other medical associations affirm that respect for these ethical principles

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<sup>32</sup> ACOG, *Code of Professional Ethics*, III(1) at 3 (Dec. 2018), <https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf> [hereinafter “ACOG, *Code of Professional Ethics*”].

<sup>33</sup> PHR Oklahoma Report, *supra* note 25, at 4.

<sup>34</sup> Proposed Guidelines, *supra* note 3, at 16.

requires physicians to act in accordance with patients' human rights, including by avoiding complicity in torture, discrimination, or the denial of autonomy.<sup>35</sup> The predictable results are ominous: 1) necessary medical care, including life- and health-preserving abortions, may be delayed, resulting in adverse health or death for pregnant patients; 2) patients in desperate and urgent need of healthcare may be forced to make long distance and dangerous journeys for treatment; 3) women diagnosed with fatal fetal impairments may be forced to continue their pregnancies while experiencing devastating risks to their physical and mental health; and 4) physicians all the while are encumbered from giving their pregnant patients essential information to save their lives or preserve their health. All of this will be discussed below.

**A. The abortion bans and medical exceptions force physicians to delay or withhold necessary medical care, thereby violating the immutable ethical principles of beneficence and nonmaleficence.**

Texas's medical exceptions can prevent physicians from complying with their ethical obligations of beneficence and nonmaleficence. Physicians assume a fundamental duty to serve the best interests of their patients, and the welfare of their patients should form the basis of any physician's medical judgments.<sup>36</sup> Beneficence

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<sup>35</sup> See Proposed Guidelines, *supra* note 3, at 19.

<sup>36</sup> Am. College of Emergency Physicians, *Policy Statement Code of Ethics*, II.B.1, at 6 (Oct. 2023), <https://www.acep.org/siteassets/new-pdfs/policy-statements/code-of-ethics-for-emergency-physicians.pdf>; ACOG, *Code of Professional Ethics*, I(1), at 2.

requires physicians “to place patients’ welfare above the physician’s own self-interest or obligations to others.”<sup>37</sup> Relatedly, nonmaleficence requires physicians to “do no harm” and seeks to ensure that a patient will be no worse off physically, emotionally, or otherwise after treatment than before.<sup>38</sup>

Abiding by these ethical principles is impossible under Texas’s current statutory framework. Experience and research confirms that fear of punishment has caused and will continue to cause delayed or denied medical care for ill pregnant patients. As a result, physicians are prevented from fulfilling their beneficence and nonmaleficence obligations by delaying measures necessary to help or even save their pregnant patients.<sup>39</sup>

A Texas OBGYN shared the following experience about trying to perform a medically indicated abortion after S.B.8 was enacted:

For the patients that we do have, who maybe come in as inevitable [abortions], we sit and we wait until they get infected or have some other reason that will allow us to intervene. So, it definitely, like knowing that the inevitable conclusion to this story will be a pregnancy loss, it’s hard

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<sup>37</sup> AMA, *Ethics Opinion 1.1.1 - Patient-Physician Relationships*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships>.

<sup>38</sup> Jacob P. Olejarczyk & Michael Young, *Patient Rights and Ethics* (Nov. 28, 2022), <https://www.ncbi.nlm.nih.gov/books/NBK538279/#:~:text=In%20healthcare%2C%20justice%20refers%20explicitly,be%20treated%20fairly%20and%20equitably>.

<sup>39</sup> Whitney Arey et al., *A Preview of the Dangerous Future of Abortion Bans — Texas Senate Bill 8*, 387:5 New Eng. J. Med. 388, 389 (2022), <https://www.nejm.org/doi/full/10.1056/NEJMp2207423> [hereinafter “Arey et al., *A Preview of the Dangerous Future*”].

that you have to then wait for them to then develop a complication like infection in order to do anything.<sup>40</sup>

Research performed by the Texas Policy Evaluation Project (the “Texas PEP”) following the enactment of S.B.8. revealed that, in multiple cases, physicians in Texas sent patients home because they interpreted the law as prohibiting an early intervention, only to have patients return with signs of potentially deadly sepsis.<sup>41</sup> An OBGYN interviewed by Texas PEP “recalled only one patient who was able to obtain an abortion at their hospital under S.B.8’s maternal health exemption, because her severe cardiac condition had progressed to the point that she was admitted to the intensive care unit.”<sup>42</sup>

Other Texas physicians have faced situations similar to the following woman pregnant with twins:

They watched her for 24–48 hours. She chose to leave [that hospital], then ruptured from twin A, then came directly to [our] hospital. Twin A was dead. [I] delivered that one, but then twin B is still alive. Never mind that the placenta of twin A is still in situ, essentially a wick for bacteria and infection—I’m forced to watch her for the next 24 hours until she gets febrile to [102.2 degrees

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<sup>40</sup> Whitney Arey et al. *Abortion Access and Medically Complex Pregnancies Before and After Texas Senate Bill 8*. 141:5 *Obstetrics & Gynecology* 995, 1000 (May 2023). [https://journals.lww.com/greenjournal/fulltext/2023/05000/abortion\\_access\\_and\\_medically\\_complex\\_pregnancies.20.aspx](https://journals.lww.com/greenjournal/fulltext/2023/05000/abortion_access_and_medically_complex_pregnancies.20.aspx) [hereinafter “Arey et al., *Abortion Access*”] (alteration added).

<sup>41</sup> Daniel Grossman et al., *Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision*, Texas PEP, at 7 (May 2023), <https://sites.utexas.edu/txpep/files/2023/05/ANSIRH-Care-Post-Roe-Report-Embargoed-until-15-May-23.pdf>.

<sup>42</sup> Arey et al., *A Preview of the Dangerous Future*, *supra* note 39, at 389.

Fahrenheit], tachycardic to the 120s, literally septic before I can start the process of induction.<sup>43</sup>

Another respondent was advised to try multiple interventions to avoid performing an abortion on a patient who had second trimester bleeding and pre-viable pre-labor rupture of membranes:

Even with her septic, it was an attempt at an induction first, which we know is substandard care. After essentially failing her induction, she's having fevers in the 103–104 range. I called the [maternal fetal medicine] staff that was on, and that initial recommendation was still not termination. It was hysterectomy. I've never done that and that morbidity is going to be insane. Then, I had to call the division director, and their recommendation was actually a high dose oxytocin induction and to avoid a termination.<sup>44</sup>

The patient eventually “expelled” the pregnancy, but the delays in care resulted in her needing a dilation and curettage procedure, losing three liters of blood, and being intubated in the intensive care unit.<sup>45</sup>

Additionally, the confusion surrounding which procedures are legal has caused unintended consequences to reproductive healthcare as a whole. For example, at least one hospital in Texas no longer offers treatment for ectopic pregnancies implanted in cesarean scars—a life-threatening condition—even though

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<sup>43</sup> Arey et al., *Abortion Access*, *supra* note 40, at 999-1001.

<sup>44</sup> Arey et al., *Abortion Access*, *supra* note 40, at 1001.

<sup>45</sup> *Id.*

the Society for Maternal-Fetal Medicine has strongly recommended that ectopic pregnancies be managed with surgical or medical treatment.<sup>46</sup>

Physician plaintiff Dr. Damla Karsan, who has practiced obstetrics and gynecology in Houston for over two decades, testified that the shift in Texas’s abortion care has led to a situation where a pregnant patient facing emergent medical conditions will nevertheless be denied an abortion.<sup>47</sup> As another OBGYN in Texas described her frustration: “It’s almost like we’re just rolling the dice on someone’s life.... I don’t know what I should do if I had a patient that died and it was like, this didn’t have to happen.”<sup>48</sup> Dr. Elissa Serapio, an Edinburg, Texas OBGYN, explained that her “colleagues were forced to watch their patients’ health deteriorate before providing abortions due to the narrow exceptions for legal abortion where the ‘life of the mother’ is at risk.”<sup>49</sup> In the words of another Texas maternal fetal

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<sup>46</sup> Arey et al., *A Preview of the Dangerous Future*, *supra* note 39, at 389 & n.4 (citing Russell Miller et al., *Society for Maternal-Fetal Medicine (SMFM) consult series #49: Cesarean scar pregnancy*, 222 Am. J. Obstet. Gynecol. B2-B14 (May 2020)).

<sup>47</sup> Pls.’ Sec. Am. Verified Pet. ¶¶ 371-378, *Zurawski et al. v. Texas*, No. D-1-GN-23-000968 (353rd Dist. Ct., Travis County, Tex. Nov. 14, 2023), <https://reproductiverights.org/wp-content/uploads/2023/11/Second-Amended-Verified-Petition.pdf> [hereinafter “*Zurawski*, Pls.’ Sec. Am. Ver. Pet.”]. Dr. Karsan has also raised concerns about how fear of retaliation has led to the silencing of clinicians, stating that she and “her colleagues fear that prosecutors and politicians will target them personally and threaten the state funding of the hospitals where they work if they provide abortion care to pregnant people with emergent medical conditions.” *Id.* ¶ 375; Ctr. for Reprod. Rights (“CRR”), *The Plaintiffs and Their Stories: Zurawski v. State of Texas*, (Nov. 14, 2023), <https://reproductiverights.org/zurawski-v-texas-plaintiffs-stories-remarks/> [hereinafter “CRR, *The Plaintiffs and Their Stories*”].

<sup>48</sup> See Charlie McCann, *Abortion bans in America are corroding some doctors’ souls*, *Economist* (Oct. 6, 2023), <https://www.economist.com/1843/2023/10/06/abortion-bans-in-america-are-corroding-some-doctors-souls>.

<sup>49</sup> PHR Joint Briefing Paper, *supra* note 18, at 6, ¶ 7

medicine specialist, “people have to be on death’s door to qualify” for medical exceptions to Texas’s abortion bans.<sup>50</sup>

The experience of Texas clinicians aligns with clinicians in Louisiana, where PHR’s research with partner organizations has found that life- and health-preserving abortion procedures are often unreasonably delayed or denied, resulting in devastating harm to patients. In one Louisiana case, a patient was already “very sick” with “heart problems and kidney failure and was on dialysis” when she got pregnant.<sup>51</sup> Despite understanding how risky her pregnancy was, “both the cardiologist and nephrologist would not write in the chart that they thought that the patient was at risk of dying because they knew what the implications of that would be, and they didn’t want their name on the chart.”<sup>52</sup> After the patient was hospitalized, she was finally transferred to another state to receive the abortion care she desperately needed.<sup>53</sup> After a Louisiana woman’s water broke at 16-weeks, her doctor advised that the proper medical treatment was an abortion but the hospital’s legal department “intervened and she was instead forced to labor and deliver her pregnancy” which resulted in “substantial hemorrhaging, one of the leading drivers of maternal mortality in Louisiana.”<sup>54</sup>

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<sup>50</sup> Arey et al., *A Preview of the Dangerous Future*, *supra* note 39, at 389.

<sup>51</sup> PHR Louisiana Report, *supra* note 25, at 7.

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> PHR Louisiana Report, *supra* note 25, at 8.

Aa a Louisiana physician shared:

I review every death of a pregnant or postpartum woman. And it's horrendous. It's horrible, like the worst several hours of any day. And I know because...when you're in the emergency department, you see the downstream effects of a whole lot of things. Any barrier in access to a woman at the most vulnerable time of her life, which it truly is for most, means more people suffer and more people die. It's just plain and simple.<sup>55</sup>

(Statistics show the physician is correct—Louisiana has one of the highest maternal mortality rates in the United States.<sup>56</sup>)

PHR's Oklahoma research shows similar devastating consequences. When Jaci Statton, an Oklahoma woman, sought treatment for a cancerous molar pregnancy, the hospital staff refused to perform an abortion “until she became much sicker.”<sup>57</sup> The hospital staff also shockingly recommended that Ms. Statton “sit in the parking lot” until something else happened, because they could not help her unless she was “crashing in front of [them] or [her] blood pressure [went] so high that [she was] fixing to have a heart attack.”<sup>58</sup>

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<sup>55</sup> PHR Louisiana Report, *supra* note 25, at 8-9.

<sup>56</sup> Rosemary Westwood, *Bleeding and in pain, she couldn't get to 2 Louisiana ERs to answer: Is it a miscarriage?*, NPR (Dec. 29, 2022), <https://www.npr.org/sections/health-shots/2022/12/29/1143823727/bleeding-and-in-pain-she-couldnt-get-2-louisiana-ers-to-answer-is-it-a-miscarria> (citing <https://www.cdc.gov/nchs/maternal-mortality/mmr-2018-2020-state-data.pdf>).

<sup>57</sup> Selena Simmons-Duffin, *In Oklahoma, a woman was told to wait until she's 'crashing' for abortion care*, NPR (Apr. 25, 2023), [<sup>58</sup> \*Id.\*](https://www.npr.org/sections/health-shots/2023/04/25/1171851775/oklahoma-woman-abortion-ban-study-shows-confusion-at-hospitals;Zurawski, Pls.' Sec. Am. Ver. Pet. ¶ 530, supra note 47.</a></p></div><div data-bbox=)

The confusion surrounding a permissible abortion under the unworkable medical exceptions has far-reaching impacts even beyond the practice of OBGYN. Jennifer Griggs, a Professor in the University of Michigan’s Department of Internal Medicine, Hematology & Oncology Division, shared the impact of abortion bans on women’s access to healthcare more broadly—even non-reproductive care. She described how the legal landscape post-*Dobbs* leaves pregnant patients and their clinicians in an untenable situation, risking the life of a pregnant patient by delaying treatment for a wide range of health conditions.<sup>59</sup> For example, Dr. Griggs reported that anti-abortion laws challenge doctors’ ability to provide cancer treatment in a timely manner because treatments such as chemotherapy and radiation can harm a fetus, particularly during early pregnancy.<sup>60</sup> Furthermore, laws that restrict women’s termination options can force physicians to delay cancer treatments until later in pregnancy, which can be dangerous for the mother.<sup>61</sup> These types of delays can put a patient’s life at risk.<sup>62</sup> But as a result of the statutory bans, even medical practitioners in other fields fear being arrested for prescribing medication that could be unsafe during pregnancy, or for advising a patient to undergo treatment that could end a pregnancy.<sup>63</sup>

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<sup>59</sup> PHR Joint Briefing Paper, *supra* note 18, at 8-9, ¶ 15.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> PHR Joint Briefing Paper, *supra* note 18, at 13 & n.79, ¶ 24.

**B. Clarification of Texas’s medical exceptions is essential to fulfill clinicians’ ethical obligation of justice and to act in accordance with their patients’ recognized human rights.**

A part of every physician’s ethical obligation is to act in accordance with the principle of justice. This requires “[f]airness in deciding competing claims, often to resources, but also to human rights and laws or social policy.”<sup>64</sup> In other words, physicians must not only exercise their clinical discretion to do what is medically prudent for their patients, but they are also bound to follow professional codes of ethics and essential human rights guarantees.

Numerous professional associations have ethical codes that affirm the centrality of human rights and professional obligations in the practice of medicine, finding particularly that the protection of human rights is broadly within the scope of a physician’s professional duty.<sup>65</sup> For instance, Principle I of the AMA Code of Ethics affirms that, “[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”<sup>66</sup> Principle IV states that “a physician shall respect the rights of patients . . . and shall safeguard patient confidences and privacy within the constraints of the law.”<sup>67</sup> Ethical opinions issued by the AMA further prohibit clinician involvement in numerous violations of

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<sup>64</sup> Proposed Guidelines, *supra* note 3, at 16.

<sup>65</sup> Proposed Guidelines, *supra* note 3, at 19.

<sup>66</sup> AMA, *Code of Medical Ethics*, Principle I (June 2001), <https://code-medical-ethics.ama-assn.org/principles> [hereinafter “AMA Principles”].

<sup>67</sup> *Id.*, Principle IV.

human rights, including torture.<sup>68</sup> Similarly, the Code of Professional Ethics of the American College of Obstetricians and Gynecologists recognizes that “[t]he welfare of the patient (beneficence) is central to all considerations in the patient–physician relationship. Included in this relationship is the obligation of physicians to respect the rights of patients....”<sup>69</sup>

Respect for human rights requires both attending clinicians and governments—including state-level governments—to ensure access to abortion to preserve the life and health of a pregnant patient. Indeed, the United States has ratified the International Covenant on Civil and Political Rights (“ICCPR”), the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (“CAT”), and the International Convention on the Elimination of All Forms of Racial Discrimination (“ICERD”) to “respect and protect” the rights enshrined therein.<sup>70</sup> These treaties protect, among other fundamental rights, the right

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<sup>68</sup> AMA, *Ethics Opinion 9.7.5 - Torture*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/torture>; see also, United Nations (“U.N.”), G.A. Res. 37/194, *The Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (Dec. 18, 1982), <https://www.ohchr.org/en/instruments-mechanisms/instruments/principles-medical-ethics-relevant-role-health-personnel>, and particularly Principle 2, which states: “It is a gross contravention of medical ethics... for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment . . . .”

<sup>69</sup> ACOG, *Code of Professional Ethics*, *supra* note 32, at 1.

<sup>70</sup> PHR Joint Briefing Paper, *supra* note 18, at 31, ¶ 55-56; U.N., G.A. Res. 2200a (XXI), *International Covenant on Civil and Political Rights* (ICCPR) (Dec. 16, 1996), <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-civil-and-political-rights>; U.N., G.A. Res. 39/46, *Convention Against Torture and Other Cruel, Inhuman or*

to life, privacy and autonomy, to be free from torture and other cruel, inhuman, or degrading treatment or punishment (“ill treatment”), equality and non-discrimination, and to seek, receive, and impart information.<sup>71</sup> The UN bodies that monitor these treaties have clarified that where state parties adopt restrictive abortion laws with unworkable medical exceptions that lead to the denial of abortion when necessary to prevent death or health risks, this constitutes a violation of human rights.<sup>72</sup> The obligation flows to all levels of government, including state governments.<sup>73</sup> This means that where Texas’s laws are resulting in physicians denying patients abortions to save their lives and health due to fear of prosecution,

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*Degrading Treatment or Punishment* (CAT) (Dec. 10, 1984), <https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-against-torture-and-other-cruel-inhuman-or-degrading>; U.N., G.A. Res. 2106 (XX), *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) (Dec. 21, 1965), <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-convention-elimination-all-forms-racial>.

<sup>71</sup> PHR Joint Briefing Paper, *supra* note 18, at 31-32, ¶ 58.

<sup>72</sup> *See, e.g., Mellet. v. Ireland*, U.N. Doc. CCPR/C/116/D/2324/2013, at 16, ¶ 7.7 (Nov. 17, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/257/18/PDF/G1625718.pdf?OpenElement>; *Whelan v. Ireland*, U.N. Doc. CCPR/ C/119/D/2425/2014, at 14, ¶ 7.9 (July 11, 2017), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/187/77/PDF/G1718777.pdf?OpenElement>; *K.L. v. Peru*, U.N. Doc. CCPR/C/85/D/1153/2003, at 4, ¶¶ 2.1, 2.3 (Nov. 22, 2005), <https://documents-dds-ny.un.org/doc/UNDOC/DER/G05/451/53/PDF/G0545153.pdf?OpenElement>; CAT Committee, *Concluding observations: Ireland*, U.N. Doc. CAT/C/IRL/CO/1, at 4, ¶ 26 (June 17, 2011), [https://digitallibrary.un.org/nanna/record/706554/files/CAT\\_C\\_IRL\\_CO\\_1-EN.pdf?withWatermark=0&withMetadata=0&version=1&registerDownload=1](https://digitallibrary.un.org/nanna/record/706554/files/CAT_C_IRL_CO_1-EN.pdf?withWatermark=0&withMetadata=0&version=1&registerDownload=1).

<sup>73</sup> Human Rights Committee (HRC), *General Comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, U.N. Doc. CCPR/C/21/Rev.1/Add.13, at 2, ¶ 4 (May 26, 2004), [https://digitallibrary.un.org/nanna/record/533996/files/CCPR\\_C\\_21\\_Rev.1\\_Add.13-EN.pdf?withWatermark=0&withMetadata=0&version=1&registerDownload=1](https://digitallibrary.un.org/nanna/record/533996/files/CCPR_C_21_Rev.1_Add.13-EN.pdf?withWatermark=0&withMetadata=0&version=1&registerDownload=1).

the state must act to address this fear and ensure medically-necessary abortions are accessible.

The U.N. Human Rights Committee (“HRC”) has also recognized that under the right to life, protected by Article 6 of the ICCPR,<sup>74</sup> state parties’ “restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering....”<sup>75</sup> The HRC has consistently criticized laws that effectively restrict abortion where a woman’s life or health is in danger,<sup>76</sup> making clear that a state’s failure to address preventable maternal mortality—including where it results from restrictions on abortions—

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<sup>74</sup> ICCPR, *supra* note 70, Part III, article 6(1).

<sup>75</sup> PHR, *Submission to the Human Rights Committee (CCPR) on the United States of America, Fifth Periodic Report, 139<sup>th</sup> Session*, at 13 (Aug. 2023), [https://phr.org/wp-content/uploads/2023/10/PHR-CCPR-Submission-for-the-USA\\_final.pdf](https://phr.org/wp-content/uploads/2023/10/PHR-CCPR-Submission-for-the-USA_final.pdf) [hereinafter PHR Human Rights Committee Letter].

<sup>76</sup> HRC, *Concluding Observations: Chile*, at 3, ¶ 8, U.N. Doc. CCPR/C/CHL/CO/5 (May 18, 2007), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G07/419/97/PDF/G0741997.pdf?OpenElement>; HRC, *Concluding Observations: Madagascar*, at 3, ¶ 14, U.N. Doc. CCPR/C/MDG/CO/3 (May 18, 2007), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G07/419/59/PDF/G0741959.pdf?OpenElement>; HRC, *Concluding Observations: Panama*, at 2, ¶ 9, U.N. Doc. CCPR/C/PAN/CO/3 (Apr. 17, 2008), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G08/411/62/PDF/G0841162.pdf?OpenElement>; HRC, *Concluding Observations: Ireland*, at 3, ¶ 9, U.N. Doc. CCPR/C/IRL/CO/4 (Aug. 19, 2014), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/141/79/PDF/G1414179.pdf?OpenElement>; HRC, *Concluding Observations: UK & Northern Ireland*, at 8, ¶ 17, U.N. Doc. CCPR/C/GBR/CO/7 (Aug. 17, 2015), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G15/182/29/PDF/G1518229.pdf?OpenElement>; HRC, *Concluding Observations: Poland*, at 4-5, ¶¶ 23-24, U.N. Doc. CCRR/C/POL/CO/7 (Nov. 23, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/260/78/PDF/G1626078.pdf?OpenElement>.

violates pregnant individuals' right to life.<sup>77</sup> Indeed, in 2023, the HRC expressed its concern at the “profound impact” of post-*Dobbs* abortion legislation, and called on the United States to “redouble its efforts to prevent and combat maternal mortality and morbidity....”<sup>78</sup> The HRC has both found: 1) violations of Article 17 of the ICCPR in several cases where laws have led to patients being denied abortions necessary to prevent severe risks to their health;<sup>79</sup> and 2) violations of human rights protected under the ICCPR, including the rights to life and privacy, where pregnant women have been forced to travel in order to access medically necessary abortions.<sup>80</sup> For example, the HRC held Ireland accountable for numerous human rights violations under the ICCPR when Amanda Mellet, who was pregnant with a fetus with impairments not compatible with life, was legally denied an abortion and forced

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<sup>77</sup> HRC, *Concluding Observations: Mali*, at 4, ¶ 14, U.N. Doc. CCPR/CO/77/MLI (Apr. 16, 2003), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G03/413/09/PDF/G0341309.pdf?OpenElement>; HRC, *Concluding Observations: Ecuador*, at 2, ¶ 11, U.N. Doc. CCPR/C/79/Add.92 (Aug. 18, 1998), <https://icj2.wpenginepowered.com/wp-content/uploads/2006/09/Concluding-Observations-CCPR-Ecuador-1998-eng.pdf>.

<sup>78</sup> HRC, *Concluding observations on the fifth periodic report of the United States of America*, at 7, ¶¶ 27-29, U.N. Doc. CCPR/C/USA/CO/5 (Nov. 3, 2023), [https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FUSA%2FCO%2F5&Lang=en](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FUSA%2FCO%2F5&Lang=en).

<sup>79</sup> See also, *Mellet. v. Ireland*, U.N. Doc. CCPR/C/116/D/2324/2013, at 16, ¶ 7.7 (Nov. 17, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/257/18/PDF/G1625718.pdf?OpenElement>; *Whelan v. Ireland*, U.N. Doc. CCPR/ C/119/D/2425/2014, at 14, ¶ 7.9 (July 11, 2017), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/187/77/PDF/G1718777.pdf?OpenElement..>

<sup>80</sup> See also, *Mellet. v. Ireland*, U.N. Doc. CCPR/C/116/D/2324/2013, at 16, ¶ 7.7 (Nov. 17, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/257/18/PDF/G1625718.pdf?OpenElement>; *Whelan v. Ireland*, U.N. Doc. CCPR/ C/119/D/2425/2014, at 14, ¶ 7.9 (July 11, 2017), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/187/77/PDF/G1718777.pdf?OpenElement>.

to travel to the United Kingdom to receive care.<sup>81</sup> This decision was affirmed in the case of *Whelan v. Ireland*.<sup>82</sup>

Faced with life-threatening medical conditions and the lack of options in their home state, pregnant women have routinely been forced to travel to other states far from their homes in order to receive medically necessary care. Kailee DeSpain of central Texas had to drive ten hours to New Mexico for an abortion for a nonviable pregnancy because her doctors in Texas would not provide one.<sup>83</sup> Another Texan, who was diagnosed with a rupture of membranes before fetal viability, was “angry and sad” to learn that she had to travel outside of Texas for abortion care because of S.B.8.<sup>84</sup> “I knew how dangerous it was for me to get on a plane and go get an abortion but I knew that it was still the safer option for me than sitting in Texas and waiting, and I could potentially get sicker.”<sup>85</sup> The same patient reported that her obstetrician told her, “[i]f you labor on the plane, leave the placenta inside of you.

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<sup>81</sup> *Mellet. v. Ireland*, U.N. Doc. CCPR/C/116/D/2324/2013, at 16, ¶¶ 7.7-7.10 (Nov. 17, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/257/18/PDF/G1625718.pdf?OpenElement>.

<sup>82</sup> *Whelan v. Ireland*, U.N. Doc. CCPR/C/119/D/2425/2014, at 14, ¶ 7.9 (July 11, 2017), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/187/77/PDF/G1718777.pdf?OpenElement>.

<sup>83</sup> Elizabeth Cohen & Danielle Herman, *Why a Woman’s Doctor Warned Her Not to Get Pregnant in Texas*, CNN (Sept. 10, 2022), <https://www.cnn.com/2022/09/09/health/abortion-restrictions-texas/index.html>.

<sup>84</sup> Arey et al., *A Preview of the Dangerous Future*, *supra* note 39, at 389.

<sup>85</sup> *Id.*

You're going to have to deal with a 19-week fetus outside of your body until you land.”<sup>86</sup>

These accounts align with the experience of several of the patient plaintiffs in this matter. For example, after learning that her baby would not survive birth and continuing her pregnancy might cause a potentially fatal condition, Jessica Bernardo traveled to Seattle to obtain an abortion after her doctor's request to the hospital's ethics committee for an exception was denied.<sup>87</sup> After Dr. Austin Dennard learned that her fetus had no chance of survival due to anencephaly and that her pregnancy posed severe health risks, she was forced to travel out of state to obtain an abortion.<sup>88</sup>

Other accounts from around the country also substantiate that pregnant women who clinicians have determined are facing life-threatening complications requiring abortion for survival, including in cases of ectopic pregnancy, are being forced to “travel hundreds of miles to a different state for a lifesaving abortion” due to fear of legal penalties and confusion about whether clinicians' good faith determination of medical necessity is sufficient to counter this risk.<sup>89</sup> “Dr. Lisa Harris

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<sup>86</sup> Arey et al., *A Preview of the Dangerous Future*, *supra* note 39, at 389.

<sup>87</sup> Zurawski, Pls.' Sec. Am. Ver. Pet. ¶¶ 141-152, *supra* note 47; CRR, *The Plaintiffs and Their Stories*, *supra* note 47.

<sup>88</sup> Zurawski, Pls.' Sec. Am. Ver. Pet. ¶¶ 53-60, *supra* note 47; CRR, *The Plaintiffs and Their Stories*, *supra* note 47.

<sup>89</sup> PHR Joint Briefing Paper, *supra* note 18, at 7, ¶ 10; *see also id.* at 5, ¶ 6 (“Dr. Lisa Harris ... described how a patient treated at her institution for ectopic pregnancy—a life-threatening condition . . . [which] . . . requires an abortion—had to travel from her home state, Ohio, to Michigan because she could not find a doctor willing to treat her in Ohio after their six-week abortion ban came into effect.”).

... described how a patient treated at her institution for ectopic pregnancy—a life-threatening condition ... [which] ... requires an abortion—had to travel from her home state, Ohio, to Michigan because she could not find a doctor willing to treat her in Ohio after their six-week abortion ban came into effect.”<sup>90</sup>

However, not everyone has the funds and ability to travel for an abortion. All too often, individuals of lower income or from marginalized groups are simply unable to travel due to costs or heightened risks of criminalization.<sup>91</sup> These pregnant patients have no option to legally access an abortion should physicians in Texas deny care, raising concerns that abortion bans are resulting in violations of patients’ right to non-discrimination and equality. Indeed, with respect to the United States, independent U.N. human rights experts have expressed concern that “women and girls from marginalized communities, racial and ethnic minorities, migrants, women and girls with disabilities, or living on low incomes, in abusive relationships or in rural areas,” are disproportionately impacted by the laws adopted post-*Dobbs*.<sup>92</sup> The

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<sup>90</sup> PHR Joint Briefing Paper, *supra* note 18, at 7, ¶ 10; *see also id.* at 5, ¶ 6.

<sup>91</sup> PHR Louisiana Report, *supra* note 25, at 10-11.

<sup>92</sup> Press Release, U.N., *United States: Abortion bans put millions of women and girls at risk, UN experts say* (June 2, 2023), <https://www.ohchr.org/en/press-releases/2023/06/united-states-abortion-bans-put-millions-women-and-girls-risk-un-experts-say>; *see also*, CERD, *Concluding observations on the combined tenth to twelfth periodic report of the United States of America*, at 8-9, ¶¶ 35-36, U.N. Doc. CERD/C/USA/CO/10-12 (Sept. 21, 2022), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G22/495/96/PDF/G2249596.pdf?OpenElement> (in its 2022 review of the United States, expressing ““deep[] concern[]” that the changing restrictions surrounding abortion care would result in a “profound disparate impact on the sexual and reproductive health and rights of racial and ethnic minorities, in particular, those with low incomes.”) The impact of these bans is felt more intensely by “those [who] are Black . . . Indigenous . . . low income,” because “[t]hese communities already experience poor maternal and reproductive health outcomes,

impact on these communities will be especially devastating because these groups also already experience health disparities that lead to poorer health outcomes, including disproportionately high rates of maternal mortality and morbidity.<sup>93</sup>

A heartbreaking example of someone who could not afford to travel to another state is Mayron Hollis, a resident of Tennessee. Hollis learned that her pregnancy was “endangering her life,” prompting her to seek an abortion, the appropriate medical treatment for her condition.<sup>94</sup> Nonetheless, after being denied treatment in her own state and unable to travel elsewhere, “Hollis was forced to endure a dangerous pregnancy and birth, where she ultimately suffered severe hemorrhaging and lost her uterus, destroying her ability to give birth to any more children.”<sup>95</sup>

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[ ] are subjected to structural racial bias and discrimination,” and more commonly live in “communities where they have OB deserts.” PHR Louisiana Report, *supra* note 25, at 10.

<sup>93</sup> See, e.g., Emily Petersen et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, 68 *Morbidity & Mortality Weekly Report*, at (2019), 423–429, at 424 (between 2011 and 2015 Indigenous women had the second highest rate of pregnancy-related deaths),

<https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6818e1-H.pdf>; Lindsay Johnson, *The Disparate Impact of Texas’ Abortion Ban on Low-Income and Rural Women*, *Georgetown Law Journal on Poverty Law and Policy* (Feb. 24, 2022), [https://www.law.georgetown.edu/poverty-journal/blog/the-disparate-impact-of-texas-abortion-ban-on-low-income-and-rural-women/#:~:text=In%20examining%20the%20disparate%20effects,rural%20areas%20of%20the%20state%20\(rural%20and%20low-income%20women\).](https://www.law.georgetown.edu/poverty-journal/blog/the-disparate-impact-of-texas-abortion-ban-on-low-income-and-rural-women/#:~:text=In%20examining%20the%20disparate%20effects,rural%20areas%20of%20the%20state%20(rural%20and%20low-income%20women).)

<sup>94</sup> Payal Shah & Akila Radhakrishnan, *It’s Time to Call Abortion Bans What They Are—Torture and Cruelty*, *The Nation* (June 9, 2023), <https://www.thenation.com/article/society/abortion-bans-torture-cruelty/>.

<sup>95</sup> *Id.*

**C. Denial of abortion due to unworkable medical exceptions leads to foreseeable severe physical and mental suffering, which constitutes a violation of the right to be free from torture and ill-treatment.**

In addition to the general prohibition on the violation of patients' rights, medical ethics codes often specifically call on physicians to act in accordance with patients' rights to be free from torture and ill-treatment. Under medical ethics, clinicians are required to act in accordance with a state's obligations to prevent torture and ill-treatment, which is defined under the ICCPR and CAT.<sup>96</sup>

The CAT Committee, which monitors compliance with CAT, has recognized that the denial of abortion care in certain cases “can result in ‘physical and mental suffering so severe in pain and intensity as to amount to torture,’ a view echoed by the former Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.”<sup>97</sup> In particular, the HRC has repeatedly recognized that women and girls have experienced ill-treatment by the state in cases where they were forced to continue a pregnancy even after receiving news that their fetus would not survive pregnancy or sustain life outside of the womb.<sup>98</sup> As these UN bodies have

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<sup>96</sup>See PHR Louisiana Report, *supra* note 25, at 12 (“Human rights bodies have unambiguously and repeatedly affirmed that people who are denied access to abortion care . . . may endure severe anguish, and mental and physical suffering reaching the minimum level of severity necessary to engage the absolute prohibition of torture and other ill-treatment.”).

<sup>97</sup> PHR Joint Briefing Paper, *supra* note 18, at 33-34, ¶ 61; HRC, *Concluding Observations: Poland*, at 4-5, ¶¶ 23-24, U.N. Doc. CCRR/C/POL/CO/7 (Nov. 23, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/260/78/PDF/G1626078.pdf?OpenElement>.

<sup>98</sup> *K.L. v. Peru*, U.N. Doc. CCPR/C/85/D/1153/2003, at 9-10, ¶¶ 6.3 (Nov. 22, 2005), <https://documents-dds-ny.un.org/doc/UNDOC/DER/G05/451/53/PDF/G0545153.pdf?OpenElement>; *Mellet. v. Ireland*,

recognized, mandating the continuation of a pregnancy involving fatal fetal impairment can cause severe physical and mental anguish, thereby constituting torture and ill-treatment.

Texas’s abortion laws interfere with pregnant patients’ rights to be free from torture and cruel, inhuman and degrading treatment, by mandating them to continue pregnancies that will cause foreseeable physical and mental anguish. The risk of severe penalties and confusion results in physicians feeling unable to do anything but watch their patients undergo the agony of continuing a pregnancy despite the fetus having no chance of survival. As a result, pregnant women in Texas may be subjected to severe mental and physical pain that constitutes torture and cruel, inhuman or degrading treatment.<sup>99</sup>

Unfortunately, examples of this occurring in Texas and elsewhere are all too numerous. Too often, ‘worried that the presence of a fetal heartbeat meant treating [a patient] might run afoul of new restrictions on abortion,’<sup>100</sup> clinicians have felt that the state required them to just watch as their patients suffered. As Dr. Serapio

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U.N. Doc. CCPR/C/116/D/2324/2013, at 16, ¶ 7.7 (Nov. 17, 2016), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/257/18/PDF/G1625718.pdf?OpenElement>; *Whelan v. Ireland*, U.N. Doc. CCPR/ C/119/D/2425/2014, at 14, ¶ 7.9 (July 11, 2017), <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G17/187/77/PDF/G1718777.pdf?OpenElement>.

<sup>99</sup> Arey et al., *A Preview of the Dangerous Future*, *supra* note 39, at 389; Arey et al., *Abortion Access*, *supra* note 40, at 1002 (“I sometimes think I spend more time as a psychiatrist than I do as an [OBGYN]. The toll that that takes on the patient, the toll it takes on their families, and I’ve seen countless relationships that have been destroyed by the stress and anxiety of having to keep a pregnancy when they would not have chosen to do so under any other circumstance.”).

<sup>100</sup> PHR Joint Briefing Paper, *supra* note 18, at 7, ¶ 10; *see also id.* at 5, ¶ 6.

explained, physicians in Texas have felt they are compelled to do nothing “even when there was a zero percent chance that the pregnancy in question could result in a live birth.”<sup>101</sup> The following paragraphs describe several accounts that implicate the right to freedom from torture and ill treatment.

Amanda Zurawski, a patient plaintiff in this case, explained to the Senate Judiciary Committee that she “dilated prematurely due to a condition known as cervical insufficiency” and quickly after her “membranes ruptured” and she was “told by multiple doctors that the loss of [her] daughter was inevitable.”<sup>102</sup> Despite confirming that her pregnancy was not viable, her physicians deprived her of the necessary care and advised her “there was nothing they could do.”<sup>103</sup> Her “doctors didn’t feel safe enough to intervene as long as” they could detect a heartbeat or “until I was sick enough for the ethics board at the hospital to consider my life at risk and permit the standard healthcare I needed at that point—an abortion.”<sup>104</sup> Therefore, Zurawski was forced to wait until she “developed sepsis—a condition in which bacteria in the blood develops into infection, with the ability to kill in under an

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<sup>101</sup> PHR Joint Briefing Paper, *supra* note 18, at 6, ¶ 7.

<sup>102</sup> *The Assault on Reproductive Rights in a Post-Dobbs America: Before the S. Judiciary Committee*, April 26, 2023 (Testimony of Amanda Zurawski), <https://www.judiciary.senate.gov/imo/media/doc/2023-04-26%20-%20Testimony%20-%20Zurawski.pdf>.

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

hour.”<sup>105</sup> Zurawski testified, that she “ha[s] been one of the first who was affected” but she is “certainly not the last.”<sup>106</sup>

Patient Plaintiff Kylie Beaton learned at 20 weeks pregnant that her baby had a condition in which the brain does not develop normally, and the head grows abnormally quickly.<sup>107</sup> The baby would barely survive past birth.<sup>108</sup> Nonetheless, Ms. Beaton was forced to continue her pregnancy, despite her pleas to be induced before the baby’s head grew to be too large to deliver vaginally.<sup>109</sup> At 35 weeks, experiencing severe abdominal pain, Ms. Beaton was rushed for an emergency Cesarean, and her baby died, as expected, four days after he was born.<sup>110</sup>

In addition, Houston patient Marlena Stell suffered a miscarriage and was forced to carry fetal remains for at least two weeks after her physician, instilled with fear by Texas’s anti-abortion laws, refused to perform a standard surgery to remove the remains.<sup>111</sup>

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<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Zurawski, Pls.’ Sec. Am. Ver. Pet.* ¶¶ 117-118, *supra* note 47; CRR, *The Plaintiffs and Their Stories*, *supra* note 47.

<sup>108</sup> *Zurawski, Pls.’ Sec. Am. Ver. Pet.* ¶ 118.

<sup>109</sup> *Id.* ¶¶ 118-119, 122.

<sup>110</sup> *Id.* ¶¶ 124-133.

<sup>111</sup> Elizabeth Cohen et al., *In some states, doctors weigh ‘ruinous’ litigation against proper care for women who have miscarriages*, CNN (July 20, 2022) <https://www.cnn.com/2022/07/20/health/doctors-weigh-litigation-miscarriage-care/index.html>

As a maternal-fetal medicine specialist in Texas described her experience counseling patients after S.B.8's enactment:

You really can barely imagine what it's like for a woman or a couple to be faced with a devastating diagnosis for the fetus that they've just learned about maybe days or weeks before. They have grappled with this terrible, heart-breaking decision. And then they're told by the doctor, 'Well, good luck to you. Jump on Google and see where you can find a place to get your termination.'<sup>112</sup>

Pregnant patients' stories from other states with similarly restrictive bans and ambiguous medical exceptions are illustrative of the pain Texas women will continue to face under these statutes. One example is Deborah Dorbert, a Florida resident, whose fetus was diagnosed with "Potter syndrome, a rare and lethal condition."<sup>113</sup> Although the state of Florida "has an exception for fatal fetal abnormalities," doctors refused to provide care because they detected a heartbeat.<sup>114</sup> Deborah was forced to "wait for labor to be induced at 37 weeks" and watch her baby struggle to breathe for 99 tortuous minutes.<sup>115</sup> As a result, Deborah "wrestl[es] with anxiety and depression" and has not been able to return to work.<sup>116</sup> Nancy

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<sup>112</sup> Arey et al., *Abortion Access*, *supra* note 40, at 1000.

<sup>113</sup> *Zurawski, Pls.' Sec. Am. Ver. Pet.*, *supra* note 47, ¶ 523; Frances Stead Sellers, Thomas Simonetti, & Maggie Penman, *The Short Life of Baby Milo*, Wash. Post (May 19, 2023), <https://www.washingtonpost.com/health/interactive/2023/florida-abortion-law-deborah-dorbert/>; Maya Yang, *Florida Couple Unable to Get Abortion Will See Baby Die After Delivery*, The Guardian (Feb. 18, 2023), <https://www.theguardian.com/world/2023/feb/18/florida-abortion-law-couple-birth>.

<sup>114</sup> Frances Stead Sellers, Thomas Simonetti, & Maggie Penman, *The Short Life of Baby Milo*, Wash. Post (May 19, 2023), <https://www.washingtonpost.com/health/interactive/2023/florida-abortion-law-deborah-dorbert/>

<sup>115</sup> *Id.*

<sup>116</sup> *Id.*

Davis, a Louisiana resident, “was [] 10 weeks pregnant” when her fetus was diagnosed with acrania, a rare and fatal condition in which the fetus does not develop a skull.<sup>117</sup> Though initially told she was a candidate for abortion in her home state based on a list of conditions that constituted a “medically futile” fetus, she was later informed that “in order to comply with the state’s trigger ban she would need to carry her pregnancy to term or travel to Florida.”<sup>118</sup>

In Wisconsin, hospital staff refused to “remove the fetal tissue for a patient with an incomplete miscarriage for fear that it would violate that state’s abortion ban.”<sup>119</sup> As a result of Wisconsin’s limited medical exceptions at the time, the patient “was left to bleed at home for more than 10 days” until she expelled the tissue.<sup>120</sup> Although she was lucky enough to survive, delaying miscarriage care “pose[s] serious risks to [pregnant person]’s health” because they “can lead to hemorrhaging and life-threatening sepsis, and can potentially impact future fertility.”<sup>121</sup> In addition to the physical trauma and pain, “[d]elayed care can also cause serious psychological

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<sup>117</sup> *Zurawski, Pls.’ Sec. Am. Ver. Pet.* ¶ 511, *supra* note 47; Ramon Antonio Vargas, *Louisiana Woman Carrying Unviable Fetus Forced to Travel to New York for Abortion*, *The Guardian* (Sept. 14, 2022), <https://www.theguardian.com/us-news/2022/sep/14/louisiana-woman-skull-less-fetus-new-york-abortion>.

<sup>118</sup> *Zurawski, Pls.’ Sec. Am. Ver. Pet.* ¶ 511, *supra* note 47; Ramon Antonio Vargas, *Louisiana Woman Carrying Unviable Fetus Forced to Travel to New York for Abortion*, *The Guardian* (Sept. 14, 2022), <https://www.theguardian.com/us-news/2022/sep/14/louisiana-woman-skull-less-fetus-new-york-abortion>.

<sup>119</sup> PHR Joint Briefing Paper, *supra* note 18, at 7, ¶ 11.

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*

suffering and trauma for women and families already dealing with pregnancy loss.”<sup>122</sup>

Jaci Statton of Oklahoma, discussed above, was informed by doctors that her pregnancy was not viable and that it could threaten her life if an abortion was not performed soon.<sup>123</sup> Nevertheless, three hospitals declined to provide her with treatment.<sup>124</sup> Her story reflects the result of unworkable medical exceptions—denial of compassionate care forced by fear. This reality was echoed in a study conducted by PHR and partners, where Oklahoma hospital staff struggled with how to respond to questions about the availability of abortion care in case of obstetric emergency; one Oklahoma hospital representative understood the law to mean that even in such a case, “a pregnant patient’s body” would be used “as an ‘incubator’ to carry the [fetus] as long as possible.”<sup>125</sup>

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<sup>122</sup> *Id.*

<sup>123</sup> Selena Simmons-Duffin, *In Oklahoma, a woman was told to wait until she’s ‘crashing’ for abortion care*, NPR (Apr. 25, 2023), <https://www.npr.org/sections/health-shots/2023/04/25/1171851775/oklahoma-woman-abortion-ban-study-shows-confusion-at-hospitals>; *Zurawski, Pls.’ Sec. Am. Ver. Pet.* ¶ 530, *supra* note 47; Pam Belluck, *Legal Actions Seek Guarantee of Abortion Access for Patients in Medical Emergencies*, N.Y. Times (Sept. 12, 2023), <https://www.nytimes.com/2023/09/12/health/abortion-rights-lawsuits.html>.

<sup>124</sup> Selena Simmons-Duffin, *In Oklahoma, a woman was told to wait until she’s ‘crashing’ for abortion care*, NPR (Apr. 25, 2023), <https://www.npr.org/sections/health-shots/2023/04/25/1171851775/oklahoma-woman-abortion-ban-study-shows-confusion-at-hospitals>; *Zurawski, Pls.’ Sec. Am. Ver. Pet.* ¶ 530, *supra* note 47; Pam Belluck, *Legal Actions Seek Guarantee of Abortion Access for Patients in Medical Emergencies*, N.Y. Times (Sept. 12, 2023), <https://www.nytimes.com/2023/09/12/health/abortion-rights-lawsuits.html>.

<sup>125</sup> PHR Oklahoma Report, *supra* note 25, at 16.

**D. Clinicians’ fear of civil, criminal, and professional penalties impacts their ability to share medical information with their patients as medical ethics requires, including the provision of critical counseling to avoid health risks from pregnancy complications.**

A common thread in the harrowing narratives from patients denied abortion care is the withholding of medical information by fearful physicians. The result is that the necessary and required flow of information between a physician and patient breaks down when the law restricts the medically necessary actions that a physician can take. Inevitably, statutory bans on treatment “undermine physicians’ ability to provide—and patients’ ability to access—accurate information from their trusted healthcare providers about safe, legal abortion.”<sup>126</sup>

Indeed, Texas medical exceptions often force “providers [to] withhold comprehensive, accurate, and evidence-based information on abortion services, fearing that providing such information will violate their state’s abortion laws” and, as a result, restrict the receipt of information that they are ethically bound to share with their patients.<sup>127</sup> For instance, physician Plaintiff Dr. Judy Levison, an obstetrician and gynecologist licensed in Texas and a professor at Baylor College of Medicine, who practiced in Texas for over twenty years, joined the case after experiencing how the state’s new abortion bans “chilled the provision of the standard

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<sup>126</sup> PHR Louisiana Report, *supra* note 25, at 9.

<sup>127</sup> *Id.*

of practice of obstetric care, including counseling patients about the options for genetic screening for chromosomal diagnoses or neural tube defects and the options for abortion if a lethal fetal diagnosis was found.”<sup>128</sup>

Indeed, a research survey conducted in Texas concluded that S.B.8 adversely affected the options physicians could offer, with participants indicating that “they were restricted from mentioning abortion as an option, whereas others informed patients about abortion with the caveat that it ‘...unfortunately [was] no longer an option in the state of Texas.’”<sup>129</sup> This is consistent with the experience of a Texas mother of four who was hospitalized for blood clots caused by her pregnancy. She asked five doctors to perform an abortion, each of whom refused to even discuss the possibility of abortion with her because of S.B.8.<sup>130</sup>

A 39-year-old woman who received the fetal diagnoses of spina bifida and trisomy 18 was “shocked” when her physician would not even inform her about termination options, stating “[w]hen you already have received news like that and can barely function, the thought of then having to do your own investigating to

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<sup>128</sup> *Zurawski, Pls.’ Sec. Am. Ver. Pet.* ¶¶ 380, 382, *supra* note 47; CRR, *The Plaintiffs and Their Stories*, *supra* note 47.

<sup>129</sup> Arey et al., *Abortion Access*, *supra* note 40, at 998.

<sup>130</sup> Dr. Ghazaleh Moayedi & Whitney Arey, *Abortion bans threaten all Pregnancy Care*, Rewire News Group (Sept. 1, 2022), <https://rewirenewsgroup.com/2022/09/01/abortion-bans-threaten-all-pregnancy-care/>.

determine where to get this medical care and to arrange going out of state feels additionally overwhelming.”<sup>131</sup>

Once again, these types of experiences have unfortunately been replicated in other states with restrictive abortion laws. A healthcare provider in Louisiana explained the conundrum: “As a provider, I am supposed to counsel my patients on risks and benefits, alternatives, and help them navigate through making a decision. And I can’t do that...because it’s not allowable and I can go to jail.”<sup>132</sup>

As a result, many practitioners feel surveilled and left second-guessing every conversation they have with patients.<sup>133</sup> For example, in Arizona a provider suspended *legal* abortion services, “because, as a Black doctor, she felt particularly vulnerable to potential criminalization.”<sup>134</sup> Dr. Leilah Zahedi-Spung, a physician who moved to Colorado from Tennessee in the wake of its restrictive abortion laws, cited to her “relief” to be moving to a state “where I’m not under a microscope. That

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<sup>131</sup> Arey et al., *A Preview of the Dangerous Future*, *supra* note 39, at 389.

<sup>132</sup> PHR Louisiana Report, *supra* note 25, at 9 & n.61 (citing Law and Policy Guide: *The Right to Information on Abortion*, Ctr. for Reprod. Rts., <https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-the-right-to-information-on-abortion/>); PHR, *Human Rights Crisis: Abortion in the United States After Dobbs* (2023), [https://phr.org/wp-content/uploads/2023/04/4.13.23\\_UN\\_SR\\_briefingPaper\\_FINAL.pdf](https://phr.org/wp-content/uploads/2023/04/4.13.23_UN_SR_briefingPaper_FINAL.pdf)).

<sup>133</sup> PHR Joint Briefing Paper, *supra* note 18, at 16, ¶ 28.

<sup>134</sup> *Id.* at 13, ¶ 24.

someone isn't gonna turn me in to the cops, or show up at my house and arrest me for doing my job."<sup>135</sup>

Thus, the inevitable risk of lawsuits and prosecution has a chilling effect on patient-physician communications. Yet, this inhibition on communication is expressly contrary to multiple ethical guidelines that OBGYNs are bound to follow. The AMA Code of Medical Ethics states that “[e]xcept in emergency situations in which a patient is incapable of making an informed decision, withholding information without the patient’s knowledge or consent is ethically unacceptable.”<sup>136</sup> ACOG has recognized this principle while unequivocally opposing impediments to accessing abortion care because “any efforts interfering in this relationship harm the people seeking essential health care and those providing it.”<sup>137</sup> Finally, the American Academy of Family Physicians opposes legislation that infringes on the content or breadth of information exchanged within the patient-physician relationship and legislation that interferes with the provision of evidence-based medical care, either of which “can harm the health of the patient, the family, and the community.”<sup>138</sup>

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<sup>135</sup> Poppy Noor, *The doctors leaving anti-abortion states: ‘I couldn’t do my job at all’*, The Guardian (Oct. 26, 2022), <https://www.theguardian.com/world/2022/oct/26/us-abortion-ban-providers-doctors-leaving-states>. [hereinafter “Noor, *The doctors leaving*”].

<sup>136</sup> AMA, *Ethics Opinion 2.1.3 - Withholding Information from Patients*, <https://code-medical-ethics.ama-assn.org/ethics-opinions/withholding-information-patients>.

<sup>137</sup> *Abortion Policy: Statement of Policy*, ACOG, (May 2022), <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy>; see also PHR Oklahoma Report, *supra* note 25, at 20.

<sup>138</sup> PHR Oklahoma Report, *supra* note 25, at 20 & n.90 (citing Ada D. Stewart, American Academy of Family Physicians, *Testimony to the Hearing on Reproductive Care in a Post-Roe America*:

The bottom line is that honesty and credibility are paramount to the doctor-patient relationship, but the bans have significantly impacted the practice of medicine and physician-patient communications. Indeed, stripping physicians of medical discretion when making critical decisions prevents them from communicating with their patients in total candor in violation of their ethical guidelines and the health needs of their patients.

### **III. THE MEDICAL EXCEPTIONS TO TEXAS’S ABORTION BANS HAVE CAUSED SIGNIFICANT LEGAL INJURIES TO CLINICIANS AND OBGYNS IN PARTICULAR, WHICH MAY RESULT IN THEM NO LONGER BEING ABLE TO PRACTICE MEDICINE.**

Dr. Kylie Cooper, a maternal-fetal medicine specialist in Idaho (which has enacted a near-total ban on abortions), remarked about the *Dobbs* decision, “[m]y husband and I would talk about this every day. It was consuming us. What if I lost my license? What would happen to our kids if I went to jail? What about my guilt if I didn’t help a sick patient to my fullest ability?”<sup>139</sup> This is the sort of dilemma faced by physicians in Texas as a result of the state’s unworkable medical exceptions.

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*Barriers, Challenges, and Threats to Women’s Health, S. Comm. on Health Educ. Lab. & Pensions*, 117th Cong. 4 (Jul. 13, 2022), <https://www.aafp.org/dam/AAFP/documents/advocacy/prevention/women/TS-SenateHELP-PostRoe-071322.pdf>.

<sup>139</sup> Stacy Weiner, *The fallout of Dobbs on the field of OBGYN*, Ass’n of Am. Med. Colleges (Aug. 23, 2023), <https://www.aamc.org/news/fallout-dobbs-field-OBGYN>.

It is not possible to create a comprehensive list of conditions for which abortion is required.<sup>140</sup> These nuanced decisions are impossible to make in the absence of a clear, good faith standard, rendering physicians vulnerable to lawsuits or prosecution.<sup>141</sup> Physicians are required to decide, often in a matter of minutes, whether their pregnant patient has, according to the law, “a *life-threatening physical condition* aggravated by, caused by, or arising from a pregnancy that places the female at *risk of death* or *poses a serious risk of substantial impairment of a major bodily function* unless the abortion is performed or induced....”<sup>142</sup>

Equipped with only nonmedical statutory guidance, physicians are forced to make decisions that carry immense weight for their patients and themselves, while the penalties for making the “wrong” decision cannot be understated. Under the HLPAs, any individual who assists with an abortion, including not only the physician, but also the hospital administrative staff, nurses, and anesthesiologists assisting with the procedure, may face *up to 99 years in prison*.<sup>143</sup> Under S.B.8, private citizens are empowered to seek \$10,000 in damages if it is found that someone either

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<sup>140</sup> The American College of Obstetricians and Gynecologists considered, but decided against, providing a list of conditions considered to be medical emergencies within the purview of the medical exceptions, concluding that such a list would result in “more risk and more danger.” Caroline Kitchener & Dan Diamond, *Faced with abortion bans, doctors beg hospitals for help with key decisions*, Wash. Post, Nov. 1, 2023, <https://www.washingtonpost.com/politics/2023/10/28/abortion-bans-medical-exceptions/>.

<sup>141</sup> PHR Human Rights Committee Letter, *supra* note 75, at 11.

<sup>142</sup> Tex. Health & Safety Code Ann. § 170A.002(b)(2) (emphasis added).

<sup>143</sup> PHR Joint Briefing Paper, *supra* note 18, at 15, ¶ 27 (citing TX Code Ann. § 170A.004(b)).

provided an abortion after approximately six weeks, or facilitated one.<sup>144</sup> This is chilling. “Facilitat[ing]” an abortion broadly includes counseling a pregnant person, funding an abortion, or even providing a pregnant patient with a ride to an abortion clinic.<sup>145</sup> How many will trust their own judgment when the risk is so great to their colleagues and others around them?

Physicians also face the risk of losing their medical licenses<sup>146</sup> and the ability to practice medicine, as well as reputational harm, steep fines, and other professional penalties. Ultimately, physicians can lose the ability to support themselves—often after a decade or more of education.

Finally, the medical exceptions also subject physicians to potential legal injuries beyond those provided for by statute. This situation, recognized as the “Abortion Double Bind,” refers to when abortion bans trap clinicians between the risk of criminal penalty for ending a pregnancy that is not perilous enough to qualify for the state’s medical exceptions, and the risk of malpractice liability for not ending a pregnancy that is dangerous<sup>147</sup> and results in injuries or death to the pregnant patient

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<sup>144</sup> Dov Fox, *The Abortion Double Bind*, 113 Am. J. Publ. Health 1068-73, at 1070 (Oct. 1 2023), <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2023.307369?role=tab>. [hereinafter “Fox, *Abortion Double Bind*”].

<sup>145</sup> Fox, *Abortion Double Bind*, *supra* note 144, at 1070.

<sup>146</sup> Physicians who perform their ethical duties of providing necessary medical care to their patients may be subjected to professional disciplinary action by the relevant licensing agencies. Tex. Health & Safety Code Ann. §170A.007.

<sup>147</sup> See 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*, 78:4 Obstetrical & Gynecological Survey 194-196 (Apr. 2023),

argued to be preventable. As a result, physicians are faced with two draconian options: either leave their patients to suffer harm and risk civil liability or perform an abortion and risk criminal and civil prosecution.<sup>148</sup>

#### **IV. RESEARCH DEMONSTRATES THAT THE ALREADY ADVERSE EFFECTS OF THE TEXAS ABORTION REGIME WILL ONLY MULTIPLY WITH TIME**

Recent reports and studies from Texas and evidence from states with similarly restrictive abortion bans demonstrate that the aftermath has been staggering.<sup>149</sup> Indeed, medical research supports the inescapable conclusion that providing care to patients under the Texas abortion regime cannot be done in a way that is beneficial, either to patients or physicians.

The unworkability of the Texas laws has exacerbated maternal mortality and morbidity. The United States already has the highest maternal mortality rate of all high-income countries, and its maternal death rate has climbed from 20.1 deaths per

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[https://journals.lww.com/obgynsurvey/abstract/2023/04000/maternal\\_morbidity\\_and\\_fetal\\_outcomes\\_among.4.aspx](https://journals.lww.com/obgynsurvey/abstract/2023/04000/maternal_morbidity_and_fetal_outcomes_among.4.aspx); Fox, *Abortion Double Bind*, *supra* note 144, at 1068; *see also* Harris Meyer, *Malpractice Lawsuits Over Denied Abortion Care May Be on the Horizon*, KFF Health News (June 23, 2023), <https://kffhealthnews.org/news/article/malpractice-lawsuits-denied-abortion-care/>, but note the recently passed H.B. 3058.

<sup>148</sup> PHR Joint Briefing Paper, *supra* note 18, at 6, ¶ 8.

<sup>149</sup> The abortion bans in Texas are substantially similar to those in Louisiana and Oklahoma. Like Texas, both Louisiana's and Oklahoma's law operate as complete bans on abortions with limited exceptions for threats to the life of the pregnant person. If an abortion is performed and is not within the limited exceptions, clinicians in Louisiana and Oklahoma face criminal and civil penalties. Further, both states also include waiting periods and counseling requirements before a pregnant person can obtain an abortion. As such, the negative outcomes observed in both Louisiana and Oklahoma in various studies and reports is worth noting as it can be expected to occur or is already occurring in Texas.

100,000 live births in 2019, to 23.8 in 2020, to 32.9 in 2021.<sup>150</sup> Additionally, for every person in the United States who dies as a consequence of pregnancy or childbirth, up to 70 suffer hemorrhages, organ failure or other significant complications, amounting for more than 1 percent of all births.<sup>151</sup>

Criminalizing these abortion bans coupled with the Texas refusal to provide any guidance regarding the law, has only worsened this epidemic. Across the United States, there have been numerous cases of pregnant patients who have suffered preventable trauma, including nearly dying, because physicians have either delayed providing abortion care or outright denied it.<sup>152</sup> A national study conducted in the wake of *Dobbs* found that “health care providers have seen increased morbidity, exacerbated pregnancy complications, an inability to provide time-sensitive care, and increased delays in obtaining care for patients in states with abortion bans.”<sup>153</sup> Findings from another study established that changes in practice “were associated

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<sup>150</sup> PHR Oklahoma Report, *supra* note 25, at 8.

<sup>151</sup> *Id.*

<sup>152</sup> PHR Human Rights Committee Letter, *supra* note 75, at 11 (citing *How post-Roe laws are obstructing clinical care*, UCSF (May 16, 2023), <https://www.ansirh.org/research/research/how-post-roe-laws-are-obstructing-clinical-care>; Daniel Grossman et al., *Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision*, Texas PEP, at 7 (May 2023), <https://sites.utexas.edu/txpep/files/2023/05/ANSIRH-Care-Post-Roe-Report-Embargoed-until-15-May-23.pdf>).

<sup>153</sup> PHR Human Rights Committee Letter, *supra* note 75, at 11.

with a doubling of severe morbidity for patients presenting with preterm pre-labor rupture of membranes and other complications before 22 weeks' gestation.”<sup>154</sup>

Recent studies in Texas demonstrate that the consequences of the abortion bans are no different from other states with similarly restrictive bans. After S.B.8 went into effect, researchers found that twice as many pregnant patients in two Dallas hospitals ended up in the intensive care unit for avoidable, life-threatening emergencies than would have before the Texas abortion bans.<sup>155</sup> There has also been a significant increase in maternal morbidity among patients with preterm labor who prior to the ban would have been promptly offered induction abortions, but due to fear regarding S.B. 8, these patients were not offered such treatment until their physicians determined that the condition posed “an immediate threat to maternal life.”<sup>156</sup> As a result, state-mandated expectant management under Texas’s abortion bans means a lapse of *nine days* on average between first diagnosis and the

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<sup>154</sup> Daniel Grossman et al., *Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision*, Texas PEP, at 17 (May 2023), <https://sites.utexas.edu/txpep/files/2023/05/ANSIRH-Care-Post-Roe-Report-Embargoed-until-15-May-23.pdf> (citing 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*, 227:4 Am. J. Obstet. Gynecol. 648-50.e1 (Oct. 2022), <https://pubmed.ncbi.nlm.nih.gov/35803323/>).

<sup>155</sup> 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*, 78:4 Obstetrical & Gynecological Survey 194-196 (Apr. 2023), [https://journals.lww.com/obgynsurvey/abstract/2023/04000/maternal\\_morbidity\\_and\\_fetal\\_outcomes\\_among.4.aspx](https://journals.lww.com/obgynsurvey/abstract/2023/04000/maternal_morbidity_and_fetal_outcomes_among.4.aspx); Fox, *Abortion Double Bind*, *supra* note 144, at 1070.

<sup>156</sup> 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*, 227:4 Am. J. Obstet. Gynecol. 648, 649 (Oct. 2022), <https://pubmed.ncbi.nlm.nih.gov/35803323/>.

development of “complications that qualified as an immediate threat to maternal life.”<sup>157</sup>

Effects of criminalizing medically necessary abortion care in these states include higher infant mortality rates as well as 34% higher death rates for women aged 15-44.<sup>158</sup> Overall, infant mortality rose in 2022 for the first time in *two decades*, with the rise most prominently seen in four states: Texas, Missouri, Georgia, and Iowa—all of which have instituted criminal abortion bans since the overturning of *Roe*.<sup>159</sup> These rates will undoubtedly worsen.

The chilling effects of the unworkable medical exceptions have trickled down into medical training and education. Medical schools in abortion-restrictive states are now limited in what they can teach about abortion care, negatively impacting the quality and comprehensiveness of the obstetrics specialty and causing medical students in the OBGYN field to study and eventually practice in less restrictive states. A survey of nearly 500 third- and fourth-year medical students showed that

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<sup>157</sup> *Id.*

<sup>158</sup> Jacqueline Howard, *Maternal and infant death rates are higher in states that ban or restrict abortion, report says*, CNN (Dec. 16, 2022), <https://www.cnn.com/2022/12/14/health/maternal-infant-death-abortion-access/index.html>; Eugene Declercq et al., *The U.S. Maternal Health Divide: The Limited Maternal Health Services and Worse Outcomes of States Proposing New Abortion Restrictions*, The Commonwealth Fund (Dec. 14, 2022), <https://www.commonwealthfund.org/publications/issue-briefs/2022/dec/us-maternal-health-divide-limited-services-worse-outcomes>.

<sup>159</sup> Aria Bendix, *Infant mortality rose in 2022 for the first time in two decades*, NBC News (Nov. 1, 2023), <https://www.nbcnews.com/health/health-news/infant-mortality-rose-2022-first-time-two-decades-rcna122995>.

nearly 60% of respondents with interests across specialties reported they were unlikely to apply for a residency in a state with abortion bans.<sup>160</sup>

Research affirms that states that restrict abortion also have fewer doctors providing care to pregnant people, creating “maternity care deserts.”<sup>161</sup> One of the reasons for this is that many OBGYNs have left restrictive states to avoid the high penalties for practicing what they believe to be necessary medicine. For example, Dr. Alireza Shamshirsaz shared that he felt forced to refuse to provide a selective, lifesaving abortion to a 21-week pregnant woman which caused him to move from his home in Houston to Boston, Massachusetts.<sup>162</sup> Similarly, Dr. Zahedi-Spung moved from Georgia, to Missouri, *then* to Tennessee, *and then* to Colorado—with each move prompted by newly passed abortion bans. After leaving Tennessee, she describes her “guilt” for “leaving patients in a community that I care about deeply,” but made clear she can no longer be a part of a “system that is making me harm people.”<sup>163</sup>

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<sup>160</sup> ACOG, *Issue Brief: Training and Workforce after Dobbs*, at 1 (Aug. 2023), [https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/training-after-dobbs\\_issue-brief.pdf](https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/training-after-dobbs_issue-brief.pdf).

<sup>161</sup> March of Dimes, *Where You Live Matters: Maternity Care Access in Texas* (2023), <https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Texas.pdf>.

<sup>162</sup> Noor, *The doctors leaving*, *supra* note 135.

<sup>163</sup> *Id.*

Another recent study found that OBGYN residency program applications have decreased by *ten percent* in states banning abortions.<sup>164</sup> While medical school graduates applying to residency positions decreased nationwide during the 2022-2023 application cycle, schools in those states with abortion bans felt a larger impact.<sup>165</sup> And, between 2022 and 2023, OBGYN had the second largest decrease in applications, second only to emergency medicine which was largely impacted by the COVID-19 pandemic.<sup>166</sup> As more than 44% of OBGYN residency programs are located in states that have banned or are likely to ban abortions, and as many medical residents choose to practice where they trained, existing divides in healthcare access will deepen.<sup>167</sup>

The overall effects have been borne out by medical studies. The difference in pregnancy outcomes in states with “extreme” abortion bans has been compared with outcomes in states without such bans. Those with such bans have a 32% lower rate

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<sup>164</sup> PHR Human Rights Committee Letter, *supra* note 75, at 12 & n.69 (citing Kendal Orgera et al., *Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women’s Health*, Ass’n of Am. Med. Colleges (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>).

<sup>165</sup> Kendal Orgera et al., *Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women’s Health*, Ass’n of Am. Med. Colleges (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>.

<sup>166</sup> *Id.*

<sup>167</sup> PHR Joint Briefing Paper, *supra* note 18, at 12, ¶ 21.

of obstetricians to births; a 62% higher proportion of individuals giving birth with no or late prenatal care; and 62% higher maternal death rates across all races.<sup>168</sup>

The result of all of this is that there is now a staffing shortage of physicians in states with restrictive abortion laws. This has led to not only the closure of dozens of abortion clinics nationwide, but hospitals in states with restrictive abortion laws—which need OBGYN practitioners the most—have also reported the closure of labor and delivery wards due to the inability to attract trained obstetricians and gynecologists.<sup>169</sup>

And as for Texas? A 2023 March of Dimes study found that 46.5% of counties in Texas are considered “maternity care deserts,” as compared to 32.6% in the United States as a whole.<sup>170</sup>

Moreover, if not corrected, the abortion bans and unworkable exceptions will undoubtedly increase maternal morbidity, infant mortality, and death rates for women aged 15-44, along with an accompanying decrease in the number of available

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<sup>168</sup> Callie Cox Bauer et al., *Turning Rage Into Action: Abortion Care and Residency Training in the United States*, J. Graduate Med. Educ. 291, 293 tbl. 1 (June 2023), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10286934/>.

<sup>169</sup> PHR Human Rights Committee Letter, *supra* note 75, at 12; *see also* Julie Rovner, *Abortion Bans are Driving Off Doctors and Closing Clinics, Putting Basic Health Care at Risk*, KFF Health News (May 24, 2023), <https://kffhealthnews.org/news/article/analysis-pro-life-movement-abortion-maternal-health-healthbent-column/> (“That means fewer doctors to perform critical preventive care like Pap smears and screenings for sexually transmitted infections, which can lead to infertility.”).

<sup>170</sup> March of Dimes, *Where You Live Matters: Maternity Care Access in Texas* (2023), <https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Texas.pdf>.

comprehensively trained medical professionals. The increased pain and resultant suffering of Texas citizens cannot be understated.

### CONCLUSION

The judgment of the district court should be affirmed.

Dated: November 22, 2023

Respectfully submitted,

/s/ Gerson H. Smoger

Gerson H. Smoger  
Counsel of Record  
Texas State Bar No. 00786920  
SMOGER AND ASSOCIATES PC  
4228 Hallmark Drive  
Dallas, Texas 75229-2847  
Tel: (972) 243-5297  
Gerson@texasinjurylaw.com

Payal Shah\*  
Christian M. De Vos\*  
PHYSICIANS FOR HUMAN  
RIGHTS  
256 W 38th Street, 9th Floor  
New York, NY 10018  
Tel: (646) 564-3720  
pshah@phr.org  
cdevos@phr.org

Janice Mac Avoy\*  
Laura Israel Sinrod\*  
Shira D. Sandler\*  
Charlotte D. Stewart\*  
Breanna Weber\*  
Jordan T. Pamlye\*  
FRIED, FRANK, HARRIS,  
SHRIVER & JACOBSON LLP  
One New York Plaza

New York, NY 10004  
Tel: (212) 859-8000  
Janice.MacAvoy@friedfrank.com  
*\*Admitted Pro Hac Vice*

Corinne R. Moini\*  
FRIED, FRANK, HARRIS,  
SHRIVER & JACOBSON LLP  
801 17th Street NW  
Washington, DC 20006  
Tel: (202) 639-7452  
Corinne.Moini@friedfrank.com

*Counsel for Amicus Curiae  
Physicians for Human Rights*

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Gerson H. Smoger  
Counsel of Record

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