IN THE SUPREME COURT FOR THE STATE OF NORTH DAKOTA
CASE NO. 20240291

ACCESS INDEPENDENT HEALTH SERVICES, INC., d/b/a Red River Women's Clinic; KATHRYN L. EGGLESTON on behalf of herself and her patients; ANA TOBIASZ, on behalf of herself and her patients; ERICA HOFLAND, on behalf of herself and her patients; and COLLETTE LESSARD, on behalf of herself and her patients,

Plaintiff–Appellees,

vs.

DREW H. WRIGLEY, in his official capacity as Attorney general for the State of North Dakota,

Defendant–Appellant,

and

KIMBERLEE JO HEGVIK, in her official capacity as the State's Attorney for Cass County; JULIE LAWYER, in her official capacity as the State's Attorney for Burleigh County; AMANDA ENGLESTAD, in her official capacity as the State's Attorney for Stark County; and HALEY WAMSTAD, in her official capacity as the State's Attorney for Grand Forks County,

Defendants.

BRIEF OF *AMICI CURIAE* THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, SOCIETY FOR MATERNAL-FETAL MEDICINE, AND SOCIETY OF FAMILY PLANNING

IN SUPPORT OF PLAINTIFF–APPELLEES AND AFFIRMANCE OF JUDGMENT BELOW

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STATEMENT OF INTEREST AND IDENTITY

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

[¶2] Founded in 1977, the Society for Maternal-Fetal Medicine (SMFM) is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM represents more than 7,000 members who care for high-risk pregnant people and provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

[¶3] The Society of Family Planning (SFP) is a leading source for abortion and contraception science. It represents more than 1,800 clinicians and scholars who advance just and equitable abortion and contraception informed by science. SFP works to build a diverse, equitable, inclusive, and multidisciplinary community of scholars and partners engaged in the science and medicine of abortion and contraception. It seeks to support the production and resourcing of research primed for impact, ensure clinical care is evidence-informed and person-centered through guidance, medical

education, and other activities, and develop leaders in abortion and contraception to transform the health care system.

STATEMENT OF AUTHORSHIP AND SUPPORT

[¶4] Pursuant to North Dakota Rule of Appellate Procedure 29(a)(4)(D), Democracy Forward Foundation attorneys Anne Swift and Carrie Flaxman affirm that they authored this brief with assistance from Molly Meegan of ACOG. No other party, party's counsel, or other person contributed money to support the preparation or submission of this brief.

SUMMARY

[¶5] The District Court's judgment should be affirmed. Longstanding principles of medical ethics and patient autonomy, together with the complexities inherent in providing care to pregnant patients, require that clinicians be permitted to use their medical judgment—honed through years of medical education, training, and experience—to provide evidence-based care that is consistent with clinical guidance and responsive to patients' individualized needs. That care may be an abortion.

[¶6] Because Senate Bill 2150 ("S.B. 2150," the "Amended Abortion Ban," or the "Ban") subjects North Dakota clinicians caring for pregnant patients to vague, unworkable, and inappropriate standards, it puts those clinicians at risk of arbitrary or discriminatory prosecution and will thus reduce the availability of OB-GYN care statewide, including for patients who never seek an abortion. North Dakotans who experience discrimination due to race or ethnicity, have low incomes, and/or who live in rural areas will suffer the most.[1]

[1] *See, e.g.*, Juanita Chinn et al., *Health Equity Among Black Women in the United States*, 30 J. Women's Health 212, 215 (2021), https://tinyurl.com/4pzmma4m.

ARGUMENT

I. S.B. 2150 Forces Clinicians to Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law.

[¶7] Abortion bans, including S.B. 2150, intrude upon the patient-physician relationship and violate long-established and widely accepted principles of medical ethics.

A. Abortion Bans Like S.B. 2150 Undermine the Patient-Physician Relationship and Prevent Physicians from Providing Evidence-Based Medicine to Their Patients.

[¶8] The foundation of medical practice is the patient-physician relationship. ACOG's *Code of Professional Ethics* states that "the welfare of the patient must form the basis of all medical judgments" and that OB-GYN's should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[2] Likewise, the American Medical Association's ("AMA") *Code of Medical Ethics* places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[3]

[¶9] Laws should not interfere with the ability of clinicians to offer appropriate treatment options to their patients, nor with the ability of patients to obtain care. Were the Amended Abortion Ban allowed to take effect, it would do just that, interfering with the patient-clinician relationship by forcing clinicians to weigh their patients' needs for life- and health-saving care against their own fear of loss of licensure, criminal prosecution, imprisonment, and other potential penalties.

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[2] ACOG, *ACOG Code of Professional Ethics* (Dec. 2018), https://tinyurl.com/2h37zjkh.

[3] Am. Med. Ass'n, Op. 1.1.1, *Patient-Physician Relationships*, https://tinyurl.com/y5mf23yv.

B. Abortion Bans Like S.B. 2150 Violate the Principles of Beneficence and Non-Maleficence.

[¶10] Beneficence, the obligation to promote the well-being of others, and non-maleficence, the obligation to do no harm and cause no injury, have been cornerstones of the medical profession for nearly 2500 years.[4] Both principles arise from the foundational ethical principle that the welfare of the patient forms the basis of all medical decision-making.[5] Clinicians respect these ethical duties by providing patient-centered, evidence-based care; sharing information with patients about risks, benefits, and options; and, ultimately, empowering patients to obtain care informed by both medical science and their individual lived experiences.

[¶11] Abortion bans like S.B. 2150 compromise these principles and practices by pitting clinicians' interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the clinician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the clinician to provide, or refer the patient for, that care. By preventing clinicians from providing necessary treatment and exposing them to significant penalties if they do, abortion bans like S.B. 2150 place clinicians in the ethical dilemma of choosing between providing the best available medical care and minimizing their own risk of substantial penalties, including imprisonment and the loss of their licenses and livelihoods. Forcing clinicians to choose

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[4] ACOG, Comm. Op. No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaff'd 2019), https://tinyurl.com/4x38bysr.

[5] ACOG, *ACOG Code of Professional Ethics*, *supra* note 3.

between the possible loss of their ability to practice medicine and their ability to provide scientific, ethical, and high-quality health care challenges the very core of the Hippocratic Oath: "Do no harm."

C. Abortion Bans Violate the Ethical Principles of Respect for Patient Autonomy.

[¶12] Another core principle of medical practice is patient autonomy—the respect for patients' control over their bodies and right to a meaningful choice when making medical decisions.[6] Patient autonomy revolves around self-determination, which in turn is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[7] Abortion bans deny patients the right to make their own choices about health care and inhibit the ability of clinicians to provide care in a manner that respects and safeguards their patients' autonomy.

[¶13] By removing clinicians' ability to respect patient autonomy, laws like S.B. 2150 harm both the ethical practice of medicine and patient health and safety. Preventing clinicians from utilizing their extensive training to safely perform a routine procedure where a patient has made an informed decision that the procedure is in their own best interest harms the integrity of the medical profession.

II. The Ban and Its Exceptions Force Clinicians to Determine Whether to Provide Abortion Care Based On Indiscernible, Unworkable Standards That Deter Clinicians From Providing Necessary Medical Care, Discourage Future Clinicians From Studying and Training in North Dakota, and Disproportionately Affect Vulnerable Populations

[¶14] S.B. 2150 and its exceptions for death or serious health risk (the "Serious Health Risk Exception") or, in the first six weeks of pregnancies, pregnancies caused by sexual violence (the "Sex Offenses Exception"), force clinicians to determine whether they may legally provide abortion

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[6] *Id.*

[7] ACOG, Comm. Op. No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstetrics & Gynecology e34 (2021), https://tinyurl.com/4cm5nhwp.

care based on indiscernible standards that are, as a practical matter, impossible to apply. These legal uncertainties increase the risk to clinicians and, as a result, deter them from providing necessary care to pregnant patients. The Ban will therefore reduce the care available to all North Dakotans, regardless of whether they seek abortions. Already vulnerable North Dakotans will suffer the most.

A. The Serious Health Risk Exception is Vague and Impossible to Apply.

[¶15] The Serious Health Risk Exception applies to abortions "deemed necessary based on reasonable medical judgment which was intended to prevent the death or a serious health risk to the pregnant female." S.B. 2150 § 1. "Reasonable medical judgment" is defined as "a medical judgment that would be made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." *Id.* § 1(4). But the Ban fails to explain where or how a physician should know what the "reasonable medical judgment" of a "reasonably prudent physician" in a particular circumstance would dictate. Likewise, the Ban describes a "serious health risk" as

> a condition that, in reasonable medical judgment, complicates the medical condition of the pregnant woman so that it necessitates an abortion to prevent substantial physical impairment of a major bodily function, not including any psychological or emotional condition.

Id. § 1(5). But the Ban does not define "major bodily function" apart from stating that the term does not include any psychological or emotional conditions.

[¶16] During pregnancy, nuanced and complex medical conditions can be frequent, and may be urgent and even dangerous. Such conditions may pose a serious but uncertain risk to a pregnant person's health. Examples of the complex medical diagnoses pregnant patients can experience include

- **Preterm pre-labor rupture of membranes ("PPROM")**, where the amniotic sac ruptures before viability labor begins and before 37 weeks of pregnancy, potentially causing sepsis;

- **Miscarriage** or early pregnancy loss, which is extremely common and often risks excessive blood loss and serious infection while the products of conception remain in the uterus, even when embryonic or fetal cardiac activity is still present;
- **Hypertensive disorders of pregnancy, including preeclampsia**, which are leading causes of maternal mortality worldwide; and
- **Placental abruption**, where the placenta separates from the inner wall of the uterus and often causes serious complications for the pregnant person, such as cardiac arrest or kidney failure.[8]

Pregnancy may also prevent patients from accessing treatment for chronic or serious conditions, including cancer.[9] For some of these patients, an abortion might be the recommended medical care to preserve their health. It is difficult, if not impossible, for clinicians caring for pregnant patients to know whether treatment for a particular condition, at a particular moment in time, is necessary to prevent "death or a serious health risk."

[¶17] The Serious Health Risk exception is a vague standard that clinicians would struggle to apply in real-world medical scenarios where pregnant patients experience complications. That is particularly concerning in North Dakota, where "[w]omen with one or more chronic health

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[8] ACOG, Prac. Bull. No. 217, *Prelabor Rupture of Membranes* (Mar. 2020), https://tinyurl.com/2wmk3s63; ACOG, Prac. Bull. No. 200, *Early Pregnancy Loss* (Nov. 2018), https://tinyurl.com/34kesvyn; ACOG, Prac. Bull. No. 222, *Gestational Hypertension and Preeclampsia* (June 2020), https://tinyurl.com/3wpcduww; *United States v. Idaho*, 623 F. Supp. 3d 1096, 1104 (D. Idaho 2022) (discussing placental abruption complications).

[9] Nicole T. Christian & Virginia Borges, *What Dobbs Means for Patients with Breast Cancer*, 387 New Eng. J. Med. 766 (2022), https://tinyurl.com/y7nd86nt.

conditions have a 62% increased likelihood of having a preterm birth compared to those without any chronic health conditions."[10]

B. The Sex Offenses Exception Requires Clinicians to Make Unqualified Legal Assessments Based on Unavailable Evidence.

[¶18] The Sex Offenses Exception, meanwhile, excludes abortions that, "based on reasonable medical judgment[,] resulted from gross sexual imposition, sexual imposition, sexual abuse of a ward, or incest, as those offenses are defined in chapter 12.1-20. . . ." S.B. 2150 § l. Applying that Exception will be impossible for clinicians in practice. The statutory elements of these crimes would include knowledge of facts that a physician usually has no way of accessing or determining. For example, one provision requires that a perpetrator act with knowledge or "reasonable cause to believe that the victim is unaware that a sexual act is being committed" upon them. *See* N.D. Cent. Code §12.1-20-03. Clinicians also would have no way to know whether that pregnancy "resulted from" the crime at issue. Even if clinicians had access to the relevant facts, the overwhelming majority of clinicians are not lawyers, prosecutors, or judges, and thus cannot be expected to determine whether a specific crime occurred in order to provide care to patients under the Exception.

C. S.B. 2150 Pits Clinicians' Professional and Ethical Duties Against Their Risk of Licensure Penalties, Prosecution, and Imprisonment.

[¶19] More than half of clinicians practicing in states where abortion is banned say their ability to practice within the standard of care has been hindered.[11] Under abortion bans like North Dakota's, even if a clinician's medical expertise and considered judgment lead her to conclude that an abortion

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[10] Lucas Fontenot et al., *Where You Live Matters: Maternity Care in North Dakota*, March of Dimes (2023), https://tinyurl.com/ycywud7e.

[11] Brittni Frederiksen et al., *A National Survey of OBGYNs' Experiences After* Dobbs, KFF (June 21, 2023), https://tinyurl.com/keaj9mj3.

is necessary to prevent death or a serious health risk, the clinician will have to weigh the patients' need against a reasonable fear of indictment by a state official who disagrees with the clinician's exercise of judgment; the cost of counsel and defending against the indictment; and the potential professional licensure penalties, adverse impacts to the clinician's livelihood, and reputation—to say nothing of five years in prison.

D. Abortion Bans Like S.B. 2150 Prevent Clinicians From Providing Medically Necessary Care, with Devastating Consequences.

[¶20] For the reasons explained above, clinicians treating pregnant patients under abortion bans like S.B. 2150 are forced to ignore their medical and professional judgment and—directly contrary to their training, ethical obligations, and clinical guidance—withhold clinically indicated abortion care until patients' conditions deteriorate further. This will necessarily result in a "wait and see" approach, also known as "expectant management," which can have devastating results. A recent study found that "expectant management of obstetrical complications in the previable period was associated with significant maternal morbidity."[12] Moreover, state-mandated "[e]xpectant management resulted in 57% of patients having a serious maternal morbidity." For patients in states without abortion bans who obtained an abortion under similar circumstances, that number was 33%.[13]

[¶21] The same study documented a significant increase in maternal morbidity among patients with preterm labor who would have been promptly offered abortions absent a ban but, due to the

[12] Anjali Nambiar et al., *Maternal Morbidity and Fetal Outcomes Among Pregnant Women at 22 Weeks' Gestation or Less with Complications in 2 Texas Hospitals After Legislation on Abortion*, 227 Am. J. Obstetrics & Gynecology 648, 649 (2022), https://tinyurl.com/jr5d4mh9.

[13] *Id*.

law, were not offered care until their physicians determined there was an immediate threat to their life. For patients with either PPROM or pregnancy tissue prolapsed into the vagina, 43% experienced maternal morbidity such as infection or hemorrhage; 32% required intensive care admission, dilation and curettage, or readmission; and one patient required a hysterectomy.[14]

E. The Ban Will Deter Medical Professionals From Practicing, Studying, and Training in North Dakota.

[¶22] S.B. 2150 and its predecessor are already affecting medical and residency education in North Dakota. Even before passage of S.B. 2150, North Dakota faced a shortage of OB-GYN care.[15] Should the Amended Abortion Ban be permitted to take effect, it will exacerbate that problem. The evidence is clear: abortion bans discourage medical professionals and trainees from practicing and training in the relevant states. In a 2022 survey of third- and fourth-year U.S. medical students applying to residency programs, 57.9% of respondents were unlikely or very unlikely to apply to one or more residency programs located in a state with abortion restrictions.[16] An analysis of the 2023-2024 application cycle for medical residency programs by the Association of American

[14] *Id.*

[15] David Molmen et al., *Fifth Biennial Report: Health Issues for the State of North Dakota*, Univ. N.D. Sch. Med. & Health Scis., at xxi (2019), https://tinyurl.com/2fw8bff5 (reporting that "North Dakota has relatively fewer specialists than the Midwest or the rest of the United States in certain specialties, including obstetrics-gynecology").

[16] Ariana M. Traub et al., *How Dobbs May Influence the Geographic Distribution of Medical Trainees in the United States*, Health Educ. Behav. (2024).

Medical Colleges ("AAMC") found "continued disproportionate decreases in the number of applicants to programs in states with limits or restrictions [on abortion care]."[17]

F. North Dakotans in Rural Areas, of Color, and With Low Incomes Will be Disproportionately Impacted.

[¶23] Implementation of the Amended Abortion Ban would be especially devastating for marginalized populations, including patients living in rural areas, patients of color, and patients with low incomes. As a result of structural inequities and social determinants of health, these populations are already "more likely to face barriers in accessing routine health care services, including prenatal care," resulting in an increased risk of complex health issues during pregnancy.[18]

[¶24] North Dakota healthcare providers are "disproportionately located in the larger urbanized areas of the state," and a staggering 71.7% of counties in North Dakota are defined as maternity care deserts—compared to 32.6% nationwide.[19] As a result, "women in North Dakota have a very high vulnerability to adverse outcomes."[20] Black patients are particularly at risk, as they face a higher risk of death than any other racial group due causes including "historical exposure to racial trauma, discrimination, and marginalization; systemic barriers such as systematic racism and implicit bias

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[17] Kendal Orgera & Atul Grover, *States With Abortion Bans See Continued Decrease in U.S. MD Senior Residency Applicants*, AAMC (May 9, 2024), https://tinyurl.com/3czhkfwk.

[18] Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department, 2006–2016*, 2 J. Am. Coll. Emergency Physicians e12549 (2021), https://tinyurl.com/35nsjsjr.

[19] Fontenot et al., *supra* note 11.

[20] *Id.*

within the health care system; the possibility of being uninsured; reduced access to reproductive health care services; and socioeconomic factors."[21] Ensuring that North Dakotans can lead healthy lives and maintain healthy pregnancies requires more clinicians providing OB-GYN care, not fewer. Those who face the structural inequities detailed above suffer most.

III. The Amended Abortion Ban Also Prevents Clinicians From Providing Necessary Care By Banning Abortions Even When Psychological or Emotional Conditions Necessitate Such Care or Where There is Little to No Possibility of Fetal Survival.

[¶25] The Serious Health Risk Exception explicitly does not apply to a "psychological or emotional condition." Abortion may be appropriate care for pregnant patients suffering from pre-existing psychiatric disorders "severe enough to impair their ability to function and care for themselves or the fetus," such as mania, obsessive-compulsive disorder, or anorexia nervosa.[22]

[¶26] Abortion may also be necessary when carrying a pregnancy to term will implicate "substantial risks of future adverse psychiatric outcomes," such as for pregnant patients with a

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[21] Anuli Njoku et al., *Listen to the Whispers Before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States*, 11 Healthcare 1, 1 (2023), https://tinyurl.com/2un97szd.

[22] Nina V. Kraguljac et al., *Post-Roe v. Wade Psychiatry: Legal, Clinical, and Ethical Challenges in Psychiatry Under Abortion Bans*, Lancet Psychiatry (May 22, 2024). Appellants rely on statements made by the U.S. Department of Justice in *Moyle v. United States*, 603 U.S. 324 (2024). But that case is about what a federal statute requires of certain hospitals providing care to patients experiencing an "emergency medical condition," as defined in that statute, and is thus inapposite. Appellants rely on statements made by the U.S. Department of Justice in *Moyle v. United States*, 603 U.S. 324 (2024). But that case is about what a federal statute requires of certain hospitals

history of (1) severe antenatal or postpartum psychosis or depression, (2) prior suicide attempts attributed to pregnancy, (3) trauma-related disorders where a forced pregnancy would pose a substantial risk of exacerbating psychiatric symptoms, or (4) trauma-related disorders that could be exacerbated by the experience of childbirth.[23] Indeed, "[p]atients with a history of postpartum depression had a 20% to 25% risk for another depressive episode after a subsequent pregnancy," and "[i]ndividuals who have had postpartum psychosis, a life-threatening condition for the parent and newborn, have a recurrence risk of more than 50%."[24] With respect to pregnant patients suffering from a trauma-related disorder, the Sex Offenses Exception only applies during the first six weeks of pregnancy—when many individuals may not know they are pregnant or be able to access abortion care. Pregnant patients "giving birth to the child of a rapist" may "be subject to devastating levels of distress" warranting abortion long after the first six weeks of pregnancy.

[¶27] Second, even though carrying a pregnancy to term and experiencing childbirth both come with higher risks for morbidity and mortality than having an abortion, the Ban does not permit patients to end pregnancies where there is little to no possibility of fetal survival. Those conditions include neural tube defects (including anencephaly); certain trisomies (the presence of an extra chromosome); triploidy (the presence of an extra set of chromosomes); certain fetal gastric and cardiac conditions; and Potter Syndrome (where the fetus does not develop functional kidneys). In

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providing care to patients experiencing an "emergency medical condition," as defined in that statute, and is thus inapposite.

[23] *Id.*

[24] Katherine L. Wisner & Paul S. Appelbaum, *Abortion Restrictions and Mental Health*, 80 JAMA Psychiatry 285 (2023).

multifetal pregnancies, a fetal condition in one or more of the fetuses can lead to an emergent condition where selective abortion (sometimes called selective "fetal reduction" or "fetal termination") is necessary to give the pregnant person and the remaining fetus(es) the best chance of survival.[25]

CONCLUSION

[¶28] As long as the specter of the Amended Abortion Ban remains, it will risk the health and lives of pregnant patients and imperil OB-GYN care for all North Dakotans. The Court should affirm the District Judge's Conclusion and bar implementation of the Ban.

[25] ACOG, Prac. Bull. 231, *Multifetal Gestations Twins Triplet and Higher-Order Multifetal Pregnancies* (June 2021), https://tinyurl.com/3273769c.

CERTIFICATE OF COMPLIANCE

[¶29] Pursuant to Rule 32(d) of the North Dakota Rules of Appellate Procedure, the undersigned certifies that the foregoing Brief of Amici Curiae in Support of Plaintiff–Appellees was prepared in a proportionally spaced, 12-point type; is 18 pages in length; and complies with the page limitation applicable to amicus curiae briefs under Rule 29(a)(5) and Rule 32(a)(8)(B).

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