No. 20-6267

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRISTOL REGIONAL WOMEN'S CENTER, P.C., ET AL.,
Plaintiffs-Appellees,

v.

HERBERT H. SLATERY III, ET AL.,
Defendants-Appellants.

On Appeal from the United States District Court
for the Middle District of Tennessee, No. 3:15-CV-00705
Before the Honorable Bernard A. Friedman

BRIEF FOR AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN PSYCHIATRIC ASSOCIATION, NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY, SOCIETY OF FAMILY PLANNING, SOCIETY OF GYNECOLOGIC SURGEONS, AND SOCIETY OF OB/GYN HOSPITALISTS IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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April 8, 2021

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

Disclosure of Corporate Affiliations and Financial Interest

Sixth Circuit
Case Number: 20-6267 Case Name: Bristol Regional Women's Ctr v. Slatery

Name of counsel: Kimberly Parker, Emily L. Stark, L. Alyssa Chen, and Amy Lishinski

Pursuant to 6th Cir. R. 26.1, Amici Curiae American College of OB/GYNs, et al.
Name of Party

makes the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

No

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

No

CERTIFICATE OF SERVICE

I certify that on April 8, 2021 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by placing a true and correct copy in the United States mail, postage prepaid, to their address of record.

s/ Kimberly Parker

This statement is filed twice: when the appeal is initially opened and later, in the principal briefs, immediately preceding the table of contents. See 6th Cir. R. 26.1 on page 2 of this form.

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INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG"), the American Academy of Pediatrics ("AAP"), the American College of Osteopathic Obstetricians and Gynecologists ("ACOOG"), the American Psychiatric Association ("APA"), the North American Society for Pediatric and Adolescent Gynecology ("NASPAG"), Society of Family Planning ("SFP"), the Society of Gynecologic Surgeons ("SGS"), and the Society of OB/GYN Hospitalists ("SOGH") submit this brief as *amici curiae* in support of the Plaintiffs-Appellees.[1]

The **ACOG** is the nation's leading group of physicians providing health care for women. With more than 60,000 members—representing more than 90% of all obstetricians-gynecologists in the United States—ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum

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[1] The parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2). Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), undersigned counsel for amici curiae certify that: (1) no counsel for a party authored this brief, in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity—other than amici curiae, their members, and their counsel—contributed money intended to fund the preparation or submission of this brief.

of evidence-based quality reproductive health care, including abortion care, for all women.

The **AAP** is a nonprofit professional organization founded in 1930 dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Its membership is comprised of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. AAP has become a powerful voice for child and adolescent health through education, research, advocacy, and the provision of expert advice. AAP has worked with the federal and state governments, health care providers, and parents on behalf of America's families to ensure the availability of safe and effective reproductive health services.

The **ACOOG** is a non-profit, non-partisan organization committed to excellence in women's health representing over 2,500 providers. ACOOG educates and supports osteopathic physicians to improve the quality of life for women by promoting programs that are innovative, visionary, inclusive, and socially relevant. ACOOG is likewise committed to the physical, emotional, and spiritual health of women.

The **APA** is a nonprofit organization representing over 37,400 physicians who specialize in the practice of psychiatry. APA members engage in research into and education about diagnosis and treatment of mental health and substance

use disorders, and are front-line physicians treating patients who experience mental health and/or substance use disorders.

The **NASPAG** is dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth. With its diverse membership including gynecologists, adolescent medicine specialists, pediatric endocrinologists, and other medical specialties, NASPAG's focus is to serve and be recognized as the lead provider in pediatric and adolescent gynecology ("PAG") education, research, and clinical care; conduct and encourage multidisciplinary and inter-professional programs of medical education and research in the field of PAG; and advocate for the reproductive well-being of children and adolescents and the provision of unrestricted, unbiased, and evidence-based practice of PAG.

The **SFP** is the source for science on abortion and contraception. SFP represents approximately 1000 scholars and academic clinicians united by a shared interest in advancing the science and clinical care of family planning. The pillars of SFP's strategic plan are: 1) building and supporting a multidisciplinary community of scholars and partners who have a shared focused on the science and clinical care of family planning, 2) supporting the production of research primed for impact, 3) advancing the delivery of clinical care based on the best available

evidence, and 4) driving the uptake of family planning evidence into policy and practice.

The **SGS** is comprised of over 400 physicians representing both private practice and academic faculty—all involved in teaching and the practice of advanced gynecologic surgery. The mission of the SGS is to promote excellence in gynecologic surgery through acquisition of knowledge and improvement of skills, advancement of basic and clinical research, and professional and public education.

The **SOGH** is a rapidly growing group of physicians, midwives, nurses and other individuals in the healthcare field who support the OB/GYN Hospitalist model. SOGH is dedicated to improving outcomes for hospitalist women and supporting those who share this mission. SOGH's vision is to shape the future of OB/GYN by establishing the hospitalist model as the care standard and the Society values excellence, collaboration, leadership, quality and community.

Amici oppose medically unnecessary laws or restrictions that serve to delay or prevent care.

INTRODUCTION

Because it impermissibly obstructs patients' ability to access abortion care safely and in a timely manner according to their treating physician's best medical judgment, the mandatory waiting period of Tennessee Code Ann. § 39-15-202(a)-

(h) (the "Act") was correctly held unconstitutional. The Act requires patients seeking an abortion to, prior to the procedure, receive certain information in person from a physician, and then to wait at least 48 hours after receiving the information (which in practice results in significant delay, sometimes as much as two to four weeks).

Access to abortion care is already very limited in Tennessee, and the medically unnecessary requirements of the Act will further restrict the availability of abortion care in Tennessee and make access to such care impossible for some patients. In Tennessee, there are only eight clinics in four cities that provide abortion care, meaning many patients are forced to travel great distances to seek an abortion. It is unduly burdensome to further require patients to spend additional time—including time away from work and/or their families—and to shoulder the increased financial burdens, to take a second, medically unnecessary trip to their clinician. With access to abortion already limited, the Act's additional unnecessary burdens pose grave threats to patients' health and welfare.

The burdens imposed by the Act are particularly acute for low-income women, who comprise the majority of patients seeking abortions in Tennessee. As the District Court noted, "75% of women seeking abortions are poor or low income," and "the overwhelming majority of women seeking an abortion in

Tennessee are already mothers and are either poor or near low-income."[2] Low-income women are more likely to work jobs with inflexible leave and to lack the job security and childcare coverage to be able to miss work, engage in long-distance travel, and/or stay in the vicinity of the providing facility for the time period necessary to satisfy the Act's waiting period and secure a second appointment. Similarly, the Act's 48-hour waiting period exacerbates existing burdens for adolescents in Tennessee[3] who may likewise lack resources (financial or otherwise) to access abortion care. In addition to the costs of travel, childcare, missed work or school, and other logistical expenses,[4] the Act results in patients paying higher prices for the procedure itself because the waiting period imposes

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[2] Opinion, R.275, PageID#6578 (citing testimony of Sheila Katz, Ph.D).

[3] In Tennessee, adolescents under the age of 18 seeking abortion care generally must obtain parental consent or, in the alternative, a judicial bypass (a court order determining that the adolescent is mature enough to make the decision to have an abortion and that it is in the adolescent's best interest not to inform their parents). *See* Tenn. Code Ann. §§ 37-10-303 to 308 (Juveniles); American Acad. of Pediatrics, *The Adolescent's Right to Confidential Care When Considering Abortion* 4 (Feb. 2017), https://bit.ly/3wGDRLV. Although an adolescent may obtain a judicial bypass, this causes "further delays in access to medical treatment (from 4 days to several weeks)." American Acad. of Pediatrics, *The Adolescent's Right to Confidential Care When Considering Abortion* 6-7. The Act's waiting period accordingly further compounds the delay in abortion care already imposed on many adolescents.

[4] COVID has exacerbated many of these issues. Declaration of Kimberly Looney, R.232-5, PageID#5880, ¶22 ("The COVID-19 pandemic has only exacerbated these obstacles for patients seeking abortion care.").

additional operational and logistical costs on clinics.[5] The increased cost of the procedure and the expenses and logistical roadblocks attendant to the waiting period are undue and substantial burdens likely to prevent some patients from accessing abortion care altogether.

Amici, who are major medical organizations representing the nation's leading physicians and other clinicians, are opposed to measures that unnecessarily burden pregnant patients' health care—particularly where, as here, such measures create substantial and often insurmountable obstacles to care and when the measures have zero scientific or medical benefit. Amici are also uniquely qualified to assist the Court in assessing the health risks of the increased delay imposed by the Act as well as its overly narrow medical emergency exception. For the above reasons and those discussed herein, Amici urge the Court to affirm the District Court's ruling holding the Act unconstitutional.

ARGUMENT

I. THE ACT IMPOSES IMPERMISSIBLE BURDENS ON PATIENTS SEEKING ABORTION CARE

The medical community—including Amici—recognizes abortion as an essential component of health care.[6] While the Act requires a 48-hour waiting

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[5] *See* Opinion, R.275, PageID#6545, n.20 (describing price increases in the wake of the Tennessee Law).

[6] *See, e.g.*, Amici Brief for American College of Obstetricians and Gynecologists, American Medical Association, and Other Nationwide Organizations of Medical

period, its real-world consequences lead to far greater delay. Given factors such as the limited number of physicians providing abortion care and the logistical difficulties (particularly for low-income patients) in arranging a visit to a clinic providing abortion care, the Act has caused substantial delays. "[S]ince [the Act] has been in effect, wait times for abortion appointments have increased significantly," "the gestational age at which abortions are performed has increased, including an increase in second trimester abortions," and "the number of medication abortions has decreased."[7] The Act's mandatory waiting period thus substantially delays abortion care, which increases medical risk and violates a patient's right to receive treatment consistent with the best available medical evidence and their physician's professional medical judgment.

Professionals Opposing Petition for Writ of Mandamus 5, *In re Abbott*, No. 20-50264 (5th Cir. Apr. 2, 2020) ("Abortion is an essential component of comprehensive health care."); ACOG, *Abortion Policy* (Nov. 2020) ("Induced abortion is an essential component of women's health care."), https://bit.ly/3doQFgZ; Society for Maternal-Fetal Medicine, *Access to Abortion Services* (June 2020) (recognizing abortion as a "critical health care service"), https://bit.ly/3fyxwfe.

[7] Opinion, R.275, PageID#6630-6631. The District Court found "clear evidence that patients in Tennessee must wait significantly longer than 48 hours." *Id.*, PageID#6630.

A. The Act's Waiting Period Is Unconstitutional Because It Subjects Patients to Increased Medical Risk and Limits Abortion Care Options

The Act burdens pregnant patients by increasing the probability of health complications. Although abortion is one of the safest medical procedures,[8] delaying abortion care increases the associated medical risks.

1. The Act's Mandatory Waiting Period Increases Medical Risk

Medical evidence dictates that, once a patient has decided to have an abortion, it is critical to move forward with the procedure as soon as possible. Although abortion is a very safe medical procedure, abortion-related mortality increases exponentially with each week of gestation.[9] There is an "inherently greater technical complexity to later abortions related to the anatomical and

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[8] *See, e.g.*, National Academies of Sciences, Engineering, & Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (2018) ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E or induction—are safe and effective. Serious complications are rare."), https://bit.ly/2R0mhSC.

[9] *See* ACOG, *Second Trimester Abortion*, Practice Bulletin No. 135, 121 Obstetrics & Gynecology 1394, 1397 (2013); Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 729 (2004) ("The risk of death increased exponentially by 38% for each additional week of gestation. Compared to women whose abortions were performed at or before 8 weeks of gestation, women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes.").

physiologic changes that occur as pregnancy advances."[10] Accordingly, "[a]s the number of weeks increases, the invasiveness of the required procedure and the need for deeper levels of sedation also increase."[11] Postponing an abortion procedure may carry particular risks for patients with certain common medical conditions—including hypertension, heart issues, or multiple prior uterine surgeries.[12]

2. The Act's Mandatory Waiting Period Limits Abortion Care Options

The Act's waiting period can cause patients to become ineligible for a first-trimester medication abortion, which is safer and less complex than procedures

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[10] *See* Bartlett, 103 Obstetrics & Gynecology at 735.

[11] *See* National Academies of Sciences, Engineering, & Medicine, *The Safety and Quality of Abortion in the United States* 10, *supra* note 8.

[12] *See* Society of Family Planning, *First-Trimester Abortion in Women with Medical Conditions*, 86 Contraception 622, 623 (2012) ("For women with medical problems, avoiding delays is particularly important because their condition may deteriorate with advancing pregnancy. For example, pregnancy-related physiological changes such as increased maternal blood volume and cardiac output begin in the middle of the first trimester of pregnancy, with associated cardiac risks that peak by the end of the second trimester."); Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 217 (2012) ("Many dangerous pregnancy-related complications such as pregnancy-induced hypertension and placental abnormalities manifest themselves in late pregnancy; early abortion avoids these hazards."); Frick et al., *Effect of Prior Cesarean Delivery on Risk of Second-Trimester Surgical Abortion Complication*s, 115 Obstetrics & Gynecology 760, 763 (2010) (finding that "[a] history of more than one cesarean delivery was associated with the greatest risk of major complication" for second-trimester surgical abortions).

available later in pregnancy. There are two general methods of abortion: medication or procedural. A medication abortion involves taking certain medications to induce an abortion.[13] A first-trimester medication abortion can be safely completed at home, while a second-trimester medication abortion is typically performed by a health care professional and may involve regional anesthesia.[14] A procedural abortion involves a surgery to remove the pregnancy and includes local or general anesthesia.[15] A first-trimester procedural abortion may be completed in one day, but a second-trimester procedural abortion may require more than one visit.[16]

In Tennessee, a medication abortion is available only in the first trimester up to around 10 weeks after the first day of a patient's last menstrual period ("LMP").[17] As a result, any patient who chooses to have an abortion beyond that

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[13] *See* ACOG, *Medication Abortion Up to 70 Days of Gestation*, Practice Bulletin No. 225, at e35 (Oct. 2020), https://bit.ly/3dtGdVo; ACOG, *Induced Abortion FAQs,* https://bit.ly/3dq96BP (visited Apr. 8, 2021).

[14] *See* ACOG, *Induced Abortion FAQs*, *supra* note 13.

[15] *See id.*

[16] *See* ACOG, *Second Trimester Abortion*, 121 Obstetrics & Gynecology at 1395.

[17] Opinion, R.275, PageID#6631; *cf.* ACOG, *Second Trimester Abortion*, 121 Obstetrics & Gynecology at 1395 ("In many areas of the United States, women have limited access to second-trimester abortion, in general, and may not have the option to choose between D&E and medical abortion.").

point must have a procedural abortion.[18] Many patients may prefer a medication abortion to a procedural abortion for a variety of reasons.[19] For example, some patients wish to avoid a procedural intervention, including the bodily invasiveness, or perceive medication abortion as safer, more natural, and private compared to a procedural abortion.[20] For patients with certain medical conditions, such as uterine fibroids or congenital uterine anomalies, a medication abortion is the medically indicated option.[21] For patients with history of sexual trauma, procedural abortion may be retraumatizing. The Act's mandatory waiting period forecloses the medication abortion option for patients who have decided that an abortion is the right decision for them but are close to the cutoff.

Furthermore, the Act's waiting period can push patients outside of the gestational period where any abortion is legally available, which creates additional health risks. First, when safe, legal abortion care is unavailable, patients may attempt to self-induce abortion without the care of a medical professional or seek

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[18] In Tennessee, only five providers in the entire state provide procedural abortions, and only two after 15 weeks LMP. *See Opinion*, R.275, PageID#6631.

[19] *See, e.g.*, ACOG, *Medication Abortion Up to 70 Days of Gestation*, at e32, *supra* note 13.

[20] *Id.*

[21] *See id.*

illegal and unsafe treatments.[22] Second, some patients may be forced to unwillingly carry a pregnancy to term. The risk of death from continuing a pregnancy through childbirth is approximately 14 times higher than that of abortion.[23] And the maternal mortality rate in Tennessee is three times higher for Black women.[24] Moreover, denial of a wanted abortion is associated with detrimental psychological consequences. Research shows that "[w]omen who are denied an abortion are more likely to initially experience higher levels of anxiety, lower life satisfaction and lower self-esteem compared with women who received an abortion."[25] Data also show that even years later, "women receiving wanted abortions had similar or better mental health outcomes than those who were denied

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[22] *See* Jones, et al., *Abortion Incidence and Service Availability in the United States*, *2017*, at 3, 8 (Sept. 2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest), https://bit.ly/3sKUDqx; Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, at 8 (May 2016) (noting that "self-induced abortion" "may have increased in recent years, particularly in restrictive states"), https://bit.ly/39BSohH; *see also* ACOG, *Decriminalization of Self-Induced Abortion* (Dec. 2017) ("In 2015, there were more than 700,000 Google searches for information regarding self-induced abortion in the United States, suggesting that many women at least consider this option."), https://bit.ly/2QYoTAq.

[23] Raymond & Grimes, 119 Obstetrics & Gynecology at 217 ("Legal abortion in the United States remains much safer than childbirth.").

[24] *See* Tenn. Dep't of Health, *Maternal Mortality Review*, https://bit.ly/3utnNep (visited Apr. 8, 2021).

[25] American Psychological Association, *Abortion and Mental Health* (2018), https://bit.ly/31EB7Af.

a wanted abortion."[26] This indicates that patients who are denied an abortion suffer more negative psychological consequences than patients who obtain desired abortion procedures.[27]

3. The Act's Narrowly Defined "Medical Emergency" Exception Compromises Patients' Health

The Act narrowly defines a "medical emergency" as a condition that necessitates an "immediate abortion of [a patient's] pregnancy to avert [their] death" or a "serious risk of substantial and irreversible impairment of major bodily function."[28] Under this exception, a physician may bypass the Act's waiting period only once a medical condition has so compromised a patient's health that they require an "immediate" abortion to avert death or a serious risk of substantial and irreversible impairment of a major bodily function. It accordingly forecloses an abortion for those patients who might face grave medical complications that, while posing substantial risks to their physical and mental health, are not yet urgent enough to fall within the Act's narrow exception. And because the Act's waiting

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[26] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169, 177 (2017).

[27] *See id.*

[28] Ten. Code Ann. § 39-15-202(f)(1).

period causes significant delays,[29] patients are exposed to these risks for far longer than 48 hours.

There are a significant number of serious medical conditions that may not qualify as a "medical emergency" under the Act's narrow definition but would nevertheless jeopardize a patient's health. Many patients who suffer from pre-existing physical health conditions, such as diabetes, lupus, cardiac conditions, pulmonary hypertension, or renal disease, experience severely exacerbated symptoms during pregnancy.[30] Other patients may have, in prior pregnancies, experienced conditions constituting a "medical emergency" and wish to avoid future life-threatening complications by terminating a subsequent unplanned pregnancy. Moreover, the Act does not clearly make allowances for mental health issues that might put a patient's health at risk.[31] In any of these circumstances, patients should not be forced to wait until a condition deteriorates to the point of a

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[29] Opinion, R.275, PageID#6630-6631.

[30] For instance, lupus can suddenly worsen and lead to fatal blood clots or other serious complications. Similarly, pulmonary hypertension can escalate in severity, resulting in seizures, heart and renal failure, blood-clotting issues, and death. *See* Kiely, *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management* 6 Obstetric Med. 144, 153 (2013). Pre-existing diabetes can worsen to the point of causing blindness as a result of pregnancy. Greene & Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

[31] *See generally* Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019) (discussing the prevalence of maternal suicide and overdose).

"serious risk of substantial and irreversible … impairment" before being able to obtain potentially life-saving care.

B. The Act Impairs a Patient's Right to be Treated Consistent with the Best Available Medical Evidence and Their Physician's Professional Medical Judgment

Every patient has the "right to be counseled and treated by [their] physician according to the best available medical evidence and [their] physician's professional medical judgment."[32] Medical ethics require that the welfare of the patient form the basis of all medical decision-making.[33] As with other medical decisions, clinicians, in collaboration with their patients and in consideration of their patients' individual health needs, are best-suited to determine appropriate abortion treatment options.[34]

The Act intrudes on a patient's right to be treated according to the best available medical evidence and their physician's professional medical judgment by requiring physicians to substitute a legislative requirement for their own professional judgment as to when, and under what circumstances, their patient can choose to have an abortion. The Act forces a physician to prescribe a treatment

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[32] ACOG, *Legislative Interference with Patient Care, Medical Editions, and the Patient-Physician Relationship* (July 2019), https://bit.ly/3dsuG91.

[33] ACOG, *Code of Professional Ethics* 2 (Dec. 2018), https://bit.ly/31V3CtL.

[34] ACOG, *Abortion Policy*, *supra* note 6 ("[D]ecisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties.").

plan that, at best, may not be in the patient's best interest, and, at worst, could completely prevent the patient from accessing medically indicated treatment. Furthermore, the mandatory waiting period creates the harmful implication that the physician is not accepting of a patient's choice to have an abortion, which could result in the patient questioning her choice, doubting the physician-patient bond, and receiving negative health care experiences.[35] As a result, pregnant patients in Tennessee are burdened by their physicians' inability to provide medical treatment free from legislative interference.[36]

II. THE WAITING PERIOD IS NOT MEDICALLY NECESSARY

The waiting period is also entirely unnecessary. Amici oppose measures that interfere with the patient-provider relationship, absent scientific evidence that such measures medically benefit the patient. To the extent the Act purports to protect a patient's right to give informed consent, that justification fails. Informed consent is undeniably a vital prerequisite to any medical procedure, including

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[35] *Cf.* Birkhäuer et al., *Trust In The Health Care Professional And Health Outcome: A Meta-analysis* 1-2 (2017) ("From a clinical perspective, patients reported more beneficial health behaviours, less symptoms and higher quality of life and to be more satisfied with treatment when they had higher trust in their health care professional."), https://bit.ly/2Pt64ow.

[36] Laws should not interfere with the ability of physicians to determine appropriate courses of treatment. ACOG, *Legislative Interference with Patient Care, Medical Editions, and the Patient-Physician Relationship*, *supra* note 32; *see also* Weinberger et al., *Legislative Interference with the Patient-Physician Relationship*, 367 New Eng. J. Med. 1557 (2012) (generally discussing negative ramifications of inappropriate legislative interference in medicine).

abortions, but informed consent can be obtained in a single visit, as it is for all other medical care. The Act's mandatory waiting period thus provides no medical benefit and serves only to undermine medical care.

A mandatory waiting period for abortion is unnecessary because the informed consent process underlying all medical care is already designed to support well-informed patient decision-making. Informed consent, as a "practical application of the bioethics principle of respect for patient autonomy," is "one of the four pillars of principle-based medical ethics."[37] Ethical norms require "that an obstetrician-gynecologist gives the patient adequate, accurate, and understandable information" that "the patient has the ability to understand and reason through."[38] They further require that the patient "is free to ask questions and to make an intentional and voluntary choice, which may include refusal of care or treatment."[39] These standards governed care in Tennessee before and after passage of the Act and a mandatory delay does nothing to advance these principles.

The Act requires no additional counseling or medical care during the mandatory waiting period.[40] Nor does the Act require tests or other procedures

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[37] ACOG, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, Committee Opinion No. 819, at e35 (Feb. 2021), https://bit.ly/3sJhP8T.

[38] *Id.* at e34.

[39] *Id.*

[40] *See* Tenn. Code Ann. § 39-15-202(a)-(h).

that would necessitate a waiting period to collect and interpret results. The Act simply requires every Tennessee physician to instruct their patients to take a completely arbitrary and medically unnecessary amount of additional time to reconsider their decision, implicitly questioning the patient's ability to make an informed decision regarding whether abortion is the right decision for her. As the District Court explained, "[t]here is no indication in this record, or in the legislative history, that prior to [the law] taking effect abortion patients lacked the information or time necessary to make an informed, voluntary, and uncoerced decision."[41]

Given the clear lack of medical benefit, it is not surprising that Tennessee does not require a waiting period for any other medical procedure. The closest analogy is a 30-day period that Medicaid patients must wait before undergoing a sterilization procedure. As was explained at trial, however, this policy restricts only whether doctors may bill Medicaid for the procedure. It does not—in contrast to the law at issue here—prohibit the procedure itself or require a patient to undergo a forced delay in care.[42]

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[41] Opinion, R.275, PageID#6627.

[42] In any event, the sterilization waiting period interferes with patient autonomy. *See* ACOG, *Access to Postpartum Sterilization*, Committee Opinion No. 827, at e4 (Mar. 2021) ("Although the original intent was to protect the reproductive rights of individuals and prevent forced or coerced sterilizations, some have expressed concerns that failure to meet sterilization consent requirements has itself begun to restrict patient autonomy and has become a barrier to desired postpartum sterilization."), https://bit.ly/2Od3rXd; *see also* Borrero et al., *Medicaid Policy on*

There is no reason abortion should be singled out for an across-the-board, mandatory waiting period. A 2016 study measuring the decisional certainty of women who received abortions found that "the level of uncertainty in abortion decision making is comparable to or lower than other health decisions," including, for example, "levels observed in studies of men and women making decisions about reconstructive knee surgery."[43] The study concluded that "[t]he high levels of decisional certainty found in this study challenge the narrative that abortion decision making is exceptional compared to other healthcare decisions and requires additional protection such as laws mandating waiting periods."[44] Requiring a mandatory waiting period for all pregnant patients serves only to undermine patient autonomy and force physicians to question, or appear to question, their patients' well-informed decisions.

CONCLUSION

For the foregoing reasons, the District Court's decision should be affirmed.

Sterilization—Anachronistic or Still Relevant?, 310 New. Eng. J. Med. 102, 104 (2014) (arguing for imposition of "[m]easures to promote informed decision making regarding sterilization, rather than stringent and restrictive regulations").

[43] Ralph et al., *Measuring Decisional Certainty Among Women Seeking Abortion*, 95 Contraception 269, 269, 276 (2017).

[44] *Id.* at 269.

Respectfully submitted.

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April 8, 2021

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g)(1), the undersigned hereby certifies that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and Fed. R. App. P. 29(a)(5).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(a)(7)(B), the brief contains 4,573 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Office 365 in 14-point Times New Roman font. As permitted by Fed. R. App. P. 32(g)(1), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

/s/ Kimberly A. Parker
KIMBERLY A. PARKER

April 8, 2021

CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of April, 2021, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

/s/ Kimberly A. Parker
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