IN THE

United States Court of Appeals

FOR THE ELEVENTH CIRCUIT

SISTERSONG WOMEN OF COLOR REPRODUCTIVE JUSTICE COLLECTIVE, *et al.*,

Plaintiffs-Appellees,

v.

BRIAN KEMP, GOVERNOR OF THE STATE OF GEORGIA, IN HIS OFFICIAL CAPACITY, *et al.*,

Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Georgia
Honorable Steve C. Jones
Case No. 1:19-cv-02973

BRIEF FOR *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES (LISTED ON INSIDE COVER)

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**Not admitted in the Eleventh Circuit.*

THE AMERICAN ACADEMY OF FAMILY PHYSICIANS,
THE AMERICAN ACADEMY OF PEDIATRICS,
THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS,
THE AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS,
THE AMERICAN COLLEGE OF PHYSICIANS,
THE AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY,
THE AMERICAN MEDICAL ASSOCIATION,
THE AMERICAN PSYCHIATRIC ASSOCIATION,
THE AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE,
THE AMERICAN UROGYNECOLOGIC SOCIETY,
THE MEDICAL ASSOCIATION OF GEORGIA,
NURSE PRACTITIONERS IN WOMEN'S HEALTH,
THE SOCIETY FOR MATERNAL-FETAL MEDICINE,
THE SOCIETY OF FAMILY PLANNING,
THE SOCIETY OF GYNECOLOGIC ONCOLOGY,
THE SOCIETY OF GYNECOLOGIC SURGEONS, AND
THE SOCIETY OF OB/GYN HOSPITALISTS

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to Eleventh Circuit Rule 26.1, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Osteopathic Obstetricians and Gynecologists, the American College of Physicians, the American Gynecological and Obstetrical Society, the American Medical Association, the American Psychiatric Association, the American Society for Reproductive Medicine, the American Urogynecologic Society, the Medical Association of Georgia, Nurse Practitioners in Women's Health, the Society for Maternal-Fetal Medicine, the Society of Family Planning, the Society of Gynecologic Oncology, the Society of Gynecologic Surgeons, and the Society of OB/GYN Hospitalists (collectively, "*amici*" or "*amici curiae*") make the following disclosure:

Amici curiae are not aware of any trial judges, attorneys, persons, associations of persons, firms, partnerships, or corporations that have an interest in the outcome of this matter, other than those already identified in this brief or the other briefs filed with the Court.

Amici curiae are not subsidiaries or affiliates of any publicly owned corporation and are not aware of any publicly owned corporation, not a party to this appeal, having a financial interest in the outcome of this case.

Dated: February 23, 2021

s/ Janice Mac Avoy
Janice Mac Avoy

Counsel for Amici Curiae *the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Osteopathic Obstetricians and Gynecologists, the American College of Physicians, the American Gynecological and Obstetrical Society, the American Medical Association, the American Psychiatric Association, the American Society for Reproductive Medicine, the American Urogynecologic Society, the Medical Association of Georgia, Nurse Practitioners in Women's Health, the Society for Maternal-Fetal Medicine, the Society of Family Planning, the Society of Gynecologic Oncology, the Society of Gynecologic Surgeons, and the Society of OB/GYN Hospitalists*

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IDENTITY AND INTEREST OF *AMICI CURIAE*[1]

Amici, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists ("ACOG"), the American College of Osteopathic Obstetricians and Gynecologists, the American College of Physicians, the American Gynecological and Obstetrical Society, the American Medical Association ("AMA"), the American Psychiatric Association ("APA"), the American Society for Reproductive Medicine, the American Urogynecologic Society, the Medical Association of Georgia, Nurse Practitioners in Women's Health, the Society for Maternal-Fetal Medicine ("SMFM"), the Society of Family Planning, the Society of Gynecologic Oncology, the Society of Gynecologic Surgeons, and the Society of OB/GYN Hospitalists, are major local and national organizations representing physicians and other medical professionals who serve patients in Georgia and beyond. Collectively, these groups count hundreds-of-thousands of medical professionals amongst their membership. Among other things, *amici* advocate for patients and practitioners,

[1] Pursuant to Federal Rule of Appellate Procedure 29, undersigned counsel for *amici curiae* certify that no counsel for a party authored this brief in whole or in part. No party or counsel for a party contributed money that was intended to fund preparing or submitting this brief. No person or entity—other than *amici curiae*, their members, or their counsel—contributed money that was intended to fund preparing or submitting this brief. All parties consent to the filing of this brief.

educate the public and others about reproductive health, and work to advance the ethical practice of medicine.

Amici are dedicated to ensuring access to the full spectrum of safe and appropriate healthcare. *Amici* work to preserve the sanctity of the patient-physician relationship and believe that patients, in consultation with their healthcare providers, should determine the appropriate course of medical care, based on the patient's own individualized needs, medical history, and preferences, without undue interference from third parties. As such, *amici* oppose any law that substitutes the whims of state lawmakers for the learned and considered decisions made by patients after informed discussions with their medical professionals and/or places their members at risk of criminal liability without fully and fairly informing those members of the behaviors that could violate the law.

SUMMARY OF ARGUMENT

Georgia House Bill 481 (the "Ban") effectively eviscerates the constitutional right to abortion, and the District Court was correct to strike it down. Since 1973—for almost fifty years—the Supreme Court has recognized that the right to terminate pregnancy prior to viability is protected by the Constitution of the United States. Under well-settled, decades-old law, there is no state interest that is legally sufficient to justify an absolute ban on abortion prior to viability. The State of Georgia (the "State") nonetheless enacted legislation that would impose such a ban.

For example, the Ban imposes criminal penalties on medical professionals providing abortion care, based on the State's incorrect contention that it can prohibit pre-viability abortions beginning at just six weeks of gestation because a "human heartbeat" is detectable at that stage. Leaving aside that a "human heartbeat" is not detectable at six weeks' gestation, the Ban is plainly unconstitutional because a fetus at six weeks of gestation is *months* away from viability, and it is unconstitutional to prohibit pre-viability abortions. This is supported by undisputed medical consensus.

The State also champions its Ban as protecting maternal health. As leading medical experts, we can assure the Court that the Ban does not protect maternal health. Rather, it severely restricts access, especially for vulnerable groups, to one

of the safest medical procedures currently available. Carrying a pregnancy to term and giving birth carries a far greater risk to a patient's health and life than abortion care. Further, the Ban's narrow exception for medical emergencies does not cover many situations where pregnancy endangers a patient's health and life. Under the Ban, a patient living with health conditions that will complicate pregnancy and jeopardize health will have no choice but to carry the pregnancy to term.

Additionally, the Ban creates legal and ethical challenges for physicians treating patients in Georgia—indeed, forcing them to practice under threat of criminal sanction. Because it lacks reasonable exceptions to address situations where the life and health of pregnant patients is at risk, the Ban places physicians in an ethically untenable position: having to navigate a conflict between providing necessary, appropriate medical care and complying with the law. Moreover, the Ban frustrates physicians' ability to adhere to ethical principles by redefining the term "natural person" throughout Georgia's civil and criminal code provisions to include "an unborn child," defined as a fetus "at any stage of development" (the "Personhood Definition"). The Personhood Definition creates a new standard of care in which physicians will need to consider the interests of both a fetus "at any stage of development" and the patient. With no further guidance, physicians will have no clear understanding of which treatment options are legally permissible, and which could expose them to criminal liability without determining whether a

given patient is pregnant, and evaluating what effect, if any, a given medical treatment would have on that patient's fetus.

The Supreme Court has consistently made clear that there is *no* state interest sufficient to justify a pre-viability ban, and as a factual matter, the State's proffered interests offer no compelling reasons to disturb that law. The State is factually incorrect regarding the role of the fetal heartbeat in a viability analysis, and maternal health and safety—as well as the ethics and integrity of the medical community—are significantly undermined by the Ban. Because the Ban prohibits a patient from making the ultimate decision about whether to continue pregnancy before viability, this Court should affirm the District Court's decision.

ARGUMENT

I. THE STATE HAS UNLAWFULLY BANNED PRE-VIABILITY ABORTION

The "most central principle of *Roe v. Wade*" is that a patient has the right to "terminate her pregnancy before viability"[2] and that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure."[3] Indeed, "viability marks the earliest point at which the State's interest

[2] *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2135 (2020) (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 871 (1992)).
[3] *Casey*, 505 U.S. at 846.

in fetal life is constitutionally adequate to justify" restrictions on abortion.[4] Therefore, analyzing the constitutionality of the Ban begins and ends with the question of viability.

According to the Supreme Court, a fetus is viable when there is a reasonable likelihood that it will be able to survive for a sustained period of time outside of the womb.[5] As the District Court correctly recognized, even adopting the State's proffered and incorrect view of viability, the Ban prohibits pre-viability abortions by more than 13 weeks.[6] On that basis alone, the Ban fails to comply with

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[4] *Id.* at 860 ("The soundness or unsoundness of that constitutional judgment in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity can somehow be enhanced in the future. Whenever it may occur, the attainment of viability may continue to serve as the critical fact, just as it has done since *Roe* was decided; which is to say that no change in *Roe's* factual underpinning has left its central holding obsolete, and none supports an argument for overruling it.").

[5] *Colautti v. Franklin*, 439 U.S. 379, 388–89 (1979); *Casey*, 505 U.S. at 870 ("[Viability is] the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb.") (citing *Roe v. Wade*, 410 U.S. 113, 163 (1973)).

[6] *See* Doc 149 at 28, *SisterSong Women of Color Reproductive Justice Collective v. Kemp*, No. 19-cv-02973 (N.D. Ga. July 13, 2020) ("Applying Plaintiffs' proffered facts, Section 4 would prohibit abortions as early as 6 weeks lmp—roughly eighteen weeks before viability occurs. Applying the State Defendants' proffered facts, Section 4 would prohibit abortions at approximately 6-7 weeks lmp—roughly thirteen or fourteen weeks before viability occurs. Thus, under either party's version of the facts, it is indisputable that Section 4 prohibits abortions at a pre-viability point in pregnancy.").

mandatory Supreme Court precedent, and as the District Court properly held, it must be struck down.

II. THE BAN PROHIBITS NEARLY ALL ABORTIONS IN GEORGIA

The Ban effectively prohibits nearly all abortions in Georgia by outlawing abortion starting at just six weeks of gestation. At this point, patients may not be aware that they are pregnant. Moreover, numerous practical considerations prevent even patients who know they are pregnant from accessing abortion care before six weeks. The State adds obstacles of its own, including restrictions that make it more difficult for patients to pay for abortion care, government-mandated counseling, and a waiting period.

A. Patients May Not Know They Are Pregnant at Six Weeks of Gestation

The Ban takes effect around six weeks of gestation. Many patients, however, may not be aware that they are pregnant at that early stage. Indeed, the overwhelming majority of abortions in Georgia take place after six weeks of gestation.[7] The most common sign of a potential pregnancy is a missed period;

[7] The District Court found that in 2018, "approximately 87% of induced abortions in Georgia took place at or after six completed weeks of pregnancy." Doc 149 at 8, *SisterSong Women of Color Reproductive Justice Collective v. Kemp*, No. 19-cv-02973 (N.D. Ga. July 13, 2020).

until then, most patients (particularly those who are not planning a pregnancy) will have no reason to suspect they are pregnant.[8]

A patient's menstrual cycle is typically four weeks long. For many adolescent patients, it may be longer, as it is possible for the cycle to be six weeks or longer in early menstrual life.[9] Thus, even a patient with highly regular cycles would be four weeks pregnant, as measured from the last menstrual period, when they first have reason to suspect they may be pregnant. The Ban prohibits abortion just two weeks later. At only six weeks it may well be impossible for a physician to administer abortion care because they would typically have to confirm the location of the pregnancy to ensure it is within the uterus, as opposed to being an ectopic pregnancy.[10] Further, an ultrasound administered before six weeks of

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[8] Administering a home pregnancy test too early in a patient's menstrual cycle or too close to the time a patient became pregnant may result in a false negative result, because the hormone a patient's body produces when they become pregnant, human chorionic gonadotrophin, may not yet be at a detectable level to trigger a positive test result. *Pregnancy*, U.S. Food & Drug Administration (Apr. 29, 2019), https://www.fda.gov/medical-devices/home-use-tests/pregnancy.

[9] AAP Committee on Adolescence and ACOG Committee on Adolescent Health Care, *Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign*, 118(5) PEDIATRICS 2245, 2246–2247 (Nov. 2006).

[10] E. Steve Lichtenberg and Maureen Paul, *Surgical abortion prior to 7 weeks of gestation*, 88 Contraception 1, 11–12 (Mar. 2013). An ectopic pregnancy occurs when a fertilized egg grows outside of the uterus. Almost all ectopic pregnancies occur in a fallopian tube. ACOG, *Ectopic Pregnancy: Frequently Asked Questions*, https://www.acog.org/womens-health/faqs/ectopic-pregnancy (last visited Feb. 17, 2021).

gestation may not yet reveal definitive signs of pregnancy.[11] Therefore, even if a patient confirms a pregnancy and is able to obtain an appointment for an abortion within six weeks of gestation, abortion care may not be possible.

That is the scenario for the rare person who can confirm a pregnancy and get to a doctor before six weeks have passed. But the more common scenario concerns most patients who will not be able to confirm pregnancy. Many patients experience irregular menstrual cycles due to factors including stress, obesity, smoking, endocrine conditions, such as polycystic ovary syndrome, thyroid dysfunction, premature ovarian failure, exercise-induced amenorrhea, eating disorders, and ovarian and adrenal tumors.[12] Moreover, young adolescents, within the first few years of their period, may have irregular menstrual cycles or longer menstrual cycles that may be six weeks or more. Other patients experience metrorrhagia, or bleeding during their menstrual cycle, which can be mistaken for a period and may lead a patient to believe they did not miss a period when they are actually pregnant. Because a missed period tends to be the most definitive signal

[11] Rebecca Heller and Sharon Cameron, *Termination of pregnancy at very early gestation without visible yolk sac on ultrasound*, 41(2) J. Fam. Plann. Reprod. Health Care 90, 90–91 (2015).
[12] Jinju Bae et al., *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18:36 BMC Women's Health 1, 1 (2018); AAP Committee on Adolescence and ACOG Committee on Adolescent Health Care, 118(5) PEDIATRICS at 2246–47.

of pregnancy before testing, patients who experience irregular menstrual cycles and bleeding would have no reason to suspect pregnancy before six weeks.[13] Under the Ban, patients who experience irregular menstrual cycle activity would be completely foreclosed from accessing abortion care unless they somehow realize they are pregnant before the six week gestational cutoff.

Approximately 45% of pregnancies in the United States are unplanned. Given this fact, almost half of pregnant patients may not immediately consider other potential symptoms of early pregnancy, such as nausea or vomiting, to be indicative of pregnancy.[14] And of course, some patients may never experience nausea or vomiting before six weeks (or at all). For example, in one study, the average number of days from the last menstrual period to the onset of nausea and vomiting was 39 days, roughly 5.5 weeks.[15] Therefore, patients who mistake pregnancy symptoms as something else or do not experience these ancillary symptoms until after six weeks of gestation will have no choice but to carry their pregnancies to term in Georgia if the Ban goes into effect.

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[13] Indeed, other than a missed period, pregnancy symptoms differ and are not always predictable. Amy E. Sayle et al., *A Prospective Study of the Onset of Symptoms of Pregnancy*, 55 J. of Clinical Epidemiology 676, 676 (2002).
[14] Lawrence B. Finer and Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008 - 2011*, 374 N. Eng. J. Med. 843, 843 (Mar. 3, 2016).
[15] Roger Gadsby et al., *A prospective study of nausea and vomiting during pregnancy*, 43(371) Brit. J. of Gen. Prac. 245, 245 (June 1993).

B. Other Georgia Laws that Hinder Access to Abortion Care Make it Practically Impossible to Obtain Abortion Care Before Six Weeks of Gestation

Georgia patients have extremely limited access to abortion care given that, as of 2017, an astounding 95% of Georgia counties have no abortion provider.[16] More than half of all Georgia patients live in a county with no provider and would need to travel beyond their county borders to receive abortion care.[17]

Further, Georgia law creates financial barriers to abortion care. For example, Georgia forbids the use of state funding for abortion care, with only narrow exceptions where the patient's life is at risk, or if the pregnancy results from rape or incest.[18] Similarly, Georgia law forbids private health insurance plans offered through the state exchange under the Patient Protection and Affordable Care Act from covering abortion care in any way.[19] Abortion patients are disproportionately low-income and will therefore require time to raise the hundreds of dollars needed to pay for abortion care themselves.

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[16] Guttmacher Institute, *State Facts About Abortion: Georgia* (2021), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-georgia#.
[17] *Id*.
[18] Georgia implements these restrictions through Georgia Community Health Department manuals. *See, e.g.*, *Feminist Women's Health Ctr. v. Burgess*, 651 S.E.2d 36, 37 (Ga. 2007) (citing several Georgia Department of Health *Policies and Procedures* manuals noting that the State will reimburse abortion care received by eligible patients only "if the life of the [patient] would be endangered if the fetus were carried to term or if the [patient] was a victim of rape or incest").
[19] Ga. Code Ann. § 33-24-59.17 (2020).

In addition to the limited access to service providers and financial barriers imposed by the State, Georgia law throws other roadblocks in front of patients seeking abortion care. For example, Georgia requires that patients undergo government-scripted counseling and then wait 24 hours before obtaining abortion care.[20] Georgia minors are subjected to parental notification requirements, unless they obtain a judicial bypass, before abortion care may be provided, with only a narrow "medical emergency" exception.[21] Several studies highlight the correlation between parental involvement laws and an increase in abortion care after six weeks.[22] Similarly, in some cases, obtaining a judicial bypass can delay access to abortion care of up to four weeks.[23]

These state-imposed obstacles already foreclose abortion care for untold numbers of Georgia patients, and the pre-viability Ban will practically eliminate the right to exercise autonomous decision-making authority over whether to obtain pre-viability abortion care for many more. Yet state-imposed obstacles do not end

[20] Ga. Code Ann. § 31-9A-3.
[21] Ga. Code Ann. §§ 15-11-682, 15-11-684, 15-11-686.
[22] AAP Committee on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 139(2) PEDIATRICS 1, 5 (Feb. 2017) (noting that in one study, second-trimester abortion rates among 17-year old adolescents increased by 21% following the enactment of a parental involvement law).
[23] *Id*. at 6–7 (noting delays ranging from 4 days to several weeks); Lauren J. Ralph, et al., *Reasons for and Logistical Burdens of Judicial Bypass for Abortion in Illinois*, 68 Journal of Adolescent Health 71, 75 (2021) (finding an average delay of 6.4 days).

the story. For example, the COVID-19 pandemic has multiplied the impediments that patients face in seeking abortion care. Travel, quarantine, and social distancing requirements limit access by restricting the number of appointments. Fewer medical professionals are available during the pandemic. Indeed, the pandemic puts significant pressure on patients as they decide whether to seek care in the first place, as they must balance the benefits of seeking necessary care with the significant risks associated with entering public locations, including medical facilities.[24]

Together with the practical and legal obstacles Georgia patients already face, the Ban effectively prevents access to abortion care even for patients who can confirm pregnancy before six weeks of gestation. During this short time, a patient in Georgia must (1) make a decision about whether to continue or terminate pregnancy; (2) notify parents or obtain a judicial bypass if the patient is a minor; (3) schedule an appointment with one of the few clinicians who provide abortion in the state, or another available clinician out of state; and (4) navigate the series of obstacles Georgia laws erect, including the 24-hour waiting period. Many patients will need to gather resources to pay for the abortion and its related costs, arrange transportation to the facility, and take time off from work and obtain childcare.

[24] ACOG, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020), https://www.acog.org/news/news-releases/2020/03/joint-statement-on-abortion-access-during-the-covid-19-outbreak.

Less time means that more patients will fail in their endeavors to comply with the law while still obtaining care. The Ban will undoubtedly prevent virtually all access to abortion care for low-income patients who already struggle to access medical care and have the fewest resources.

Research shows that, where abortion access is limited, increased numbers of patients may resort to unsafe means to end unwanted pregnancies, including self-inflicted abdominal and bodily trauma or ingesting dangerous chemicals.[25] The Ban deprives Georgia patients of their Constitutional rights and places them in this unfortunate position—having to choose between following the law and obtaining safe care.

III. THE BAN ENDANGERS PATIENTS' HEALTH BY RESTRICTING ACCESS TO ABORTION

Abortion is one of the safest medical procedures available to patients, as widely acknowledged by the medical community and recognized by the Supreme Court of the United States.[26] The State is disingenuous when it claims that its Ban

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[25] ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, 136(6) Obstet. & Gynecol. e107, e108 (Dec. 2020); SMFM, *Access to Abortion Services*, at 1 (Dec. 2017, re-aff'd June 2020), https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf.

[26] *See, e.g.*, ACOG, Committee Opinion No. 815, at e108; *June Med. Servs. L.L.C.*, 140 S. Ct. at 2122 (noting that "abortions are so safe," and as a result, providers would be unlikely to admit patients to a hospital) (citing *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2313 (2016)); ACOG, *Induced Abortion, FAQ: What*

would promote maternal health; all it really does is effectively (and illegally) outlaw a highly safe procedure.[27]

A. Abortion Is One of the Safest Forms of Medical Care

Study after study demonstrates that abortion care is one of the safest procedures in modern medicine, regardless of whether the abortion is induced by medication or procedure.[28] This has been demonstrated time and time again by randomized controlled trials, large retrospective cohort studies, patient and provider surveys, systematic reviews, and epidemiological studies examining abortion care. For example, one study found that 98.7% of patients who received a first-trimester aspiration abortion and 94.8% of patients who received a medical abortion experienced *no* related complications.[29] In fact, abortion is so safe that

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is a first-trimester abortion? (May 2015), https://www.acog.org/womens-health/faqs/induced-abortion; Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstet. & Gynecol. 215, 215 (Feb. 2012); David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140(8) Annals Internal Med. 620, 621, 623 (Apr. 20, 2004).

[27] Brief of State Defendants-Appellants at 24, 29, 40, *SisterSong Women of Color Reproductive Justice Collective v. Kemp*, No. 20-13024 (11th Cir. Oct. 19, 2020).

[28] *See* Report by Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States*, 10 (National Academies Press 2018); Raymond & Grimes, 119(2) Obstet. & Gynecol. at 215; Grimes & Creinin, 140(8) Annals Internal Med. at 623.

[29] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstet. & Gynecol. 175, 181 (Jan. 2015).

there is a greater risk of mortality associated with colonoscopy, plastic surgery, dental procedures, and even adult tonsillectomy than there is with abortion.[30]

Nor are there significant risks of psychological harm resulting from abortion care. Comprehensive reviews of the scientific evidence by the APA and the Academy of Royal Medical Colleges in the United Kingdom establish that there is no causal association between abortion and adverse mental health outcomes.[31] The 2008 APA Task Force Report, in particular, found that "[t]he best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy."[32] And

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[30] Report by Committee on Reproductive Health Services, at 75.

[31] Brenda Major et al., *Report of the APA Task Force on Mental Health and Abortion*, at 4 (2008), http://www.apa.org/pi/women/programs/abortion/mental-health.pdf [hereinafter "APA Task Force Report"]; Academy of Medical Royal Colleges, by National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence an Associated Factors* 8 (Dec. 2011), https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf. The APA Task Force Report found that factors associated with "negative psychological responses following first-trimester abortions" include "perceptions of stigma, need for secrecy, and low or anticipated social support for the abortion decision; a prior history of mental health problems; personality factors . . .; and characteristics of the particular pregnancy." APA Task Force Report at 4. The APA Task Force Report stated that these factors "also predict negative psychological reactions to other types of stressful life events, including childbirth." *Id.*

[32] APA Task Force Report, at 4.

the 2018 Position Statement on Abortion of the APA notes that "available evidence does not support that having an abortion is associated with an increase in depressive, anxiety, or post-traumatic stress symptoms."[33]

Statistically, carrying a pregnancy to term is far riskier than abortion care. The risk of death associated with childbirth is approximately 14-times higher than that associated with abortion.[34] This is particularly concerning given that the maternal death rate in Georgia has skyrocketed, especially for patients of color. Black patients in Georgia are more than twice as likely to die in childbirth than white patients in Georgia and six times more than white patients nationally.[35] And white patients in Georgia are more than twice as likely to die in childbirth than white patients nationally.[36] Indeed, as of 2017, Georgia ranked a dismal 48th in the United States for maternal mortality.[37]

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[33] APA, *Position Statement on Abortion*, at 1 (July 2018), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Abortion.pdf.
[34] ACOG, Committee Opinion No. 815, at e108 (citing Raymond & Grimes, 119(2) Obstet. & Gynecol. at 215).
[35] *When the State Fails: Maternal Mortality & Racial Disparity in Georgia*, Yale Global Health Justice Partnership, at 5–6, https://law.yale.edu/sites/default/files/area/center/ghjp/documents/ghjp_2018_when_the_state_fails-_maternal_mortality_racial_disparity_in_georgiarev.pdf.
[36] *Id*.
[37] *Id*. at 6.

While the risk related to abortion may become greater as the pregnancy advances, serious risk from abortion at all gestational ages is extremely rare and does not approach the threshold of risk associated with carrying a pregnancy to term.[38] In a 1998 to 2001 study, *all* studied maternal complications were found to be more common in patients who gave birth as compared to patients who received abortion care.[39] These complications ranged from moderate to potentially life-threatening, including anemia, hypertensive disorders, pelvic or perineal trauma, mental health conditions, obstetric infections, postpartum hemorrhage, antepartum hemorrhage, asthma, and excessive vomiting.[40] The occurrence of complications related to carrying a pregnancy to term only lends credence to the widely-accepted consensus in the medical community that abortion is an extremely safe medical procedure.

B. The "Medical Emergency" Exception to the Ban Does Not Adequately Protect Patient Health

Georgia patients who require an abortion, particularly those experiencing high-risk pregnancies, will face significant challenges under the Ban that will unnecessarily compromise their quality of life and likelihood of survival. The Ban

[38] ACOG, Committee Opinion No. 815, at e108; Raymond & Grimes, 119(2) Obstet. & Gynecol. at 217.
[39] Raymond & Grimes, 119(2) Obstet. & Gynecol. at 216–17 & Fig. 1.
[40] *Id.*

limits a "medical emergency" to a situation where "an abortion is necessary in order to prevent the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function of the . . . woman."[41]

This extremely narrow medical emergency "exception" fails to account for many situations where a physician diagnoses a condition that either compromises the patient's health, or the fetus's health. First, a patient may experience medical conditions that may not rise to a "medical emergency" and may not manifest or require treatment until after six weeks of gestation. For example, medical conditions that may arise after that point but may not always rise to a "medical emergency" include: Alport syndrome (a form of kidney inflammation);[42] valvular heart disease (abnormal leakage or partial closure of a heart valve that can occur in patients with no history of cardiac symptoms);[43] lupus (an autoimmune disorder that may suddenly worsen during pregnancy and lead to fatal blood clots and other

[41] Ga. Code Ann. § 16-12-141(a)(3).
[42] *See* Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109(2) Obstet. & Gynecol. 531, 531 (Feb. 2007).
[43] *See* Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93(5) Heart 552, 552 (May 2007).

serious complications);[44] and pulmonary hypertension (increased pressure within the lung's circulation system that can escalate in severity).[45]

Under these circumstances, physicians will be forced to withhold medically appropriate abortion care and compromise their patients' health so as not to risk prosecution. After six weeks of gestation, a patient will be universally required by law to carry a pregnancy to term in circumstances where a medical condition poses serious but not yet life threatening health risks. This is true even if a physician has consulted with their patient and conducted the necessary individualized analysis based on the patient's health, potential risks, and other variables, that abortion care is in the patient's best interest. In foreclosing abortion in these instances, the State is replacing the good faith judgment of a physician (in consultation with the patient) with the whim of the State. In doing so, the State unjustifiably puts its pregnant citizens in danger by denying appropriate care in all cases unless a condition deteriorates so severely that a "medical emergency" arises and an abortion becomes immediately necessary.

Moreover, various complications that present danger to maternal health can directly affect fetal development and survival. For example, if a patient

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[44] *See* J. Cortés-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41(6) Rheumatology 643, 646–47 (2002).

[45] *See* David G. Kiely et al., *Pregnancy and pulmonary hypertension: a practical approach to management*, 6(4) Obstet. Med. 144, 144, 153 (2013).

experiences premature rupture of membranes and infection, preeclampsia, placental abruption, and/or placenta accrete, that patient may be at risk of extensive blood loss, stroke, and/or septic shock, all of which would negatively impact the fetus.

Additionally, other medical conditions unrelated to pregnancy may unexpectedly arise after six weeks of gestation and cause patients to seek pregnancy termination for their health. For example, patients who learn after six weeks of gestation that they have cancer requiring radiation or chemotherapy may seek to terminate the pregnancy to avoid having the fetus die in utero during treatment. But the Ban would prevent them from doing so.

A patient faced with a serious medical condition should not be forced to carry a pregnancy to term because the condition does not rise to the level of a "medical emergency," nor should that patient be forced to wait to see if the condition will rise to the point of a "medical emergency." The Ban creates exactly these situations.

IV. THE BAN IMPINGES UPON THE INTEGRITY OF THE MEDICAL PROFESSION

The Ban complicates physicians' abilities to act according to their ethical duties and in the best interests of their patients. The Personhood Definition further hamstrings physicians by criminalizing incidental impacts to fetuses in the provision of routine medical care, encouraging physicians to improperly weigh the

interests of fetuses, and delaying or denying necessary care to patients. Finally, the Ban intrudes upon the patient-physician relationship by attempting to replace physicians' judgment with the political preferences of State lawmakers.

A. The Ban Is Contrary to Bedrock Principles of Medical Ethics

The Ban undermines physicians' ability to act in the best interests of their patients. If a patient's health is compromised but the fetus is approximately six weeks of gestation and the Ban has taken effect, a physician may only perform an abortion in a legislatively defined "medical emergency," regardless of medical necessity. In these circumstances, physicians are put in a position of having to choose between following the law and acting in accordance with medical ethics that prioritize patient wellbeing. This is untenable.

The Ban frustrates physicians' abilities to exercise all reasonable means to ensure that their patients receive the most appropriate and effective care and impedes adherence to the profession's ethical principles of beneficence, non-maleficence, and patient autonomy.[46] Beneficence requires physicians to act in a way that is likely to benefit patients.[47] Non-maleficence directs physicians to

[46] ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 3–5 (Dec. 2007, re-aff'd 2016); *see also* AMA, *Principles of Medical Ethics, Chapter 1: Opinions on Patient-Physician Relationships*, § 1.1.3(b) (2016).
[47] ACOG, Committee Opinion No. 390, at 3–4.

refrain from acting in ways that might harm patients unless the harm is justified by concomitant benefits.[48] Yet under the Ban, a physician who believes abortion care is appropriate for a patient facing a medical condition after approximately the sixth week of gestation is unable to provide medically necessary care until the patient's health deteriorates to the point of a "medical emergency." This effectively prevents the physician from providing the best care possible; under the Ban, the physician must refuse to provide care unless or until the patient's health is so severely compromised that "an abortion is necessary in order to prevent the death of the woman or the substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[49] Given the State's narrow definition of a "medical emergency" and the lack of a scienter element for "medical emergency" determinations, a physician has no way of knowing whether their ultimate call, which involves a very subjective, complex analysis, will be deemed reasonable if it is later judged by a factfinder. Knowing they will likely face intense scrutiny in the future and potential criminal consequences, physicians may well be deterred from providing abortion care in situations where they are unsure whether a "medical emergency" occurred.

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[48] *Id.*

[49] Ga. Code Ann. § 16-12-141(a)(3).

Similarly, principles of patient autonomy recognize that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions.[50] Physicians must honor and respect patient decisions about the course of their care.[51] The Ban removes these meaningful choices from patients and their physicians and replaces them with a blanket legislative prohibition.

A physician's ability to practice medicine in accordance with bedrock principles of medical ethics may be complicated by the looming threat of potential criminal penalties applicable under the Ban. A physician found guilty of violating the Ban faces up to ten years in prison.[52] The Ban's criminal sanctions thus encourage physicians not to provide essential care, even if doing so is consistent with their patients' wishes and in their patients' medical interest.

B. The Personhood Definition of the Ban May Constrain Physicians From Providing Appropriate Medical Care

A physician's ability to adhere to the ethical principles of the medical profession is further frustrated by the Ban's unconstitutionally vague, medically inaccurate, and confusing definition of "natural person." As the District Court correctly observed, by redefining "natural person" throughout Georgia's civil and

[50] ACOG, Committee Opinion No. 390, at 3.
[51] SMFM, *Access to Abortion Services*, at 2 ("[P]hysicians have a professional responsibility to respect each individual's autonomy in decisions regarding pregnancy and to provide nonjudgmental care.").
[52] Ga. Code Ann. § 16-12-140.

criminal code to include "an unborn child," the State imposes a novel, complicated, and vague restriction on physicians.[53] Under the Ban, for example, physicians could face criminal penalties for any incidental impact on a fetus that arises during a patient's care, including not only in the administration of abortion care, but in the provision of any health care. In any action undertaken by a physician, whether medically appropriate or in furtherance of a patient's elected choice, the physician will need to consider the interests of both the patient and the fetus, whose medical needs can often be in direct conflict. In these circumstances—most obviously in the face of a cancer diagnosis—it may be impossible to provide medical care in the best interest of both the patient and the fetus, as well as to properly respect patient autonomy.

In addition, the State provides no clarity on what actions by a physician could lead to criminal and civil liability. The Personhood Definition could change the application of hundreds of Georgia laws and result in unforeseeable,

[53] Doc 149 at 40, *SisterSong Women of Color Reproductive Justice Collective v. Kemp*, No. 19-cv-02973 (N.D. Ga. July 13, 2020) ("Under Section 3, medical professions would be charged with the care of *two* individual patients, whose medical needs might be in direct conflict with one another—necessitating an entirely new standard of care. That these highly sophisticated parties are currently litigating the meaning of 'unjustified risk of harm' or 'gross deviation from the standard of care' underscores that persons of common intelligence would be forced to guess what conduct might leave them open to criminal penalty.").

unintended, and even absurd consequences.[54] Consider a real world example: In August 2012, a 16-year-old pregnant patient died from complications due to acute leukemia after proper treatment was withheld.[55] The patient needed chemotherapy to treat the cancer, but her physicians withheld it out of fear of criminal prosecution because the Dominican Republic's constitution recognizes personhood from the moment of conception.[56] The government of the Dominican Republic delayed essential chemotherapy while determining whether she had a valid right to receive it.[57] By the time the government ultimately permitted treatment, the patient's health had deteriorated so substantially that she (and the fetus) died anyway.[58] In failing to provide physicians with fair notice of the type of conduct that is forbidden or required under state law, Georgia places physicians in vulnerable, ethically challenging positions that may discourage the administration of appropriate care, and leave Georgia patients in peril.

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[54] Rafael Romo, *Pregnant teen dies after abortion ban delays her chemo treatment for leukemia*, CNN (Aug. 18, 2012), https://www.cnn.com/2012/08/18/world/americas/dominican-republic-abortion/index.html; *see also* Center for Reproductive Rights, *Rights at Risk: The Truth About Prenatal Personhood* 10 (2012).
[55] *Id*.
[56] *Id*.
[57] *Id.*
[58] *Id.*

The State's unprecedented expansion of personhood rights to fetuses takes away the personhood rights of patients. It replaces the medical judgment of physicians who are best situated to determine the appropriate medical care for patients on a case-by-case basis and has the chilling potential to restrict access to health care.[59]

C. The Ban Improperly Intrudes Upon the Patient-Physician Relationship

Amici, along with many other medical organizations, oppose legislation that interferes with the physician-patient relationship and is not based upon scientific evidence.[60] The patient-physician relationship is the keystone of delivering appropriate medical care, and political considerations, especially those that have no scientific basis, should not restrict physicians' ability to exercise sound medical judgment and provide patients with a full range of safe and quality care.[61]

The Supreme Court has consistently held that laws regulating abortion care which unduly interfere with a physician's ability to act in the best interest of his or

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[59] *Abortion: Attempts to Ban Abortion*, ACLU, (last accessed Feb. 21, 2021) https://www.aclu.org/other/abortion-attempts-ban-abortion, ("[P]ersonhood laws would ban all abortions…would interfere with doctors' ability to treat life-threatening pregnancies . . . [and would] endanger a woman's health. . . . They are clearly a case of government overstepping its bounds.").

[60] *See, e.g.*, SMFM, *Access to Abortion Services*, at 1; ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, amended and re-aff'd July 2019).

[61] SMFM, *Access to Abortion Services*, at 1–2.

her patient should be struck down.[62] Here, the Ban goes beyond undue interference; it outright prohibits physicians from exercising sound medical judgment. It intrudes upon the patient-physician relationship and mandates an outcome—carrying an unwanted pregnancy to term—irrespective of whether that is the safest course of action and without considering the totality of other circumstances that factor into a course of care.

The Ban replaces a physician's judgment with the political preferences of State lawmakers, a dangerous standard that will only serve to interfere with individualized medical determinations and care in ways that increase, rather than reduce, medical risks.

CONCLUSION

For all the reasons stated above, the Ban should not be implemented and the Court should affirm the District Court's decision to enjoin the Ban.

[62] *See, e.g.*, *Casey*, 505 U.S. at 877–79; *see also June Med. Servs. L.L.C.*, 140 S. Ct. at 2132–33; *Whole Woman's Health*, 136 S. Ct. at 2312–13.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with: (i) the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) and 32(a)(7)(B) because it contains 6,486 words, excluding the parts of the brief exempted by Rule 32(f); and (ii) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Times New Roman) using Microsoft Word (the same program used to calculate the word count).

Dated: February 23, 2021

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CERTIFICATE OF SERVICE

I hereby certify that on February 23, 2021, I electronically filed a true and correct copy of the foregoing *Amicus Curiae* Brief with the Clerk of the Court by using the appellate CM/ECF system, which will send notification of such filing to all registered users of the CM/ECF system.

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