UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

REPRODUCTIVE HEALTH SERVICES OF PLANNED PARENTHOOD OF THE ST. LOUIS REGION, et al.,
Plaintiffs-Appellees,

v.

GOVERNOR MICHAEL L. PARSON, et al.,
Defendants-Appellants.

On Appeals from the United States District Court
for the Western District of Missouri, No. 2:19-cv-4155-HFS
Before the Honorable Howard F. Sachs

BRIEF FOR AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY, AND SOCIETY FOR MATERNAL FETAL MEDICINE AS AMICI CURIAE IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Eighth Circuit Rule 26.1A, American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians, American College of Osteopathic Obstetricians and Gynecologists, American Society for Reproductive Medicine, American College of Physicians, North American Society for Pediatric and Adolescent Gynecology, and Society for Maternal Fetal Medicine state that they are nonprofit organizations with no parent corporations or publicly traded stock.

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INTEREST OF AMICI CURIAE[1]

American College of Obstetricians and Gynecologists (ACOG), American Medical Association (AMA), American Academy of Family Physicians (AAFP), American College of Osteopathic Obstetricians and Gynecologists (ACOOG), American College of Physicians (ACP), American Society for Reproductive Medicine (ASRM), North American Society for Pediatric and Adolescent Gynecology (NASPAG), and Society for Maternal Fetal Medicine (SMFM) (together, Amici) submit this brief in support of the Plaintiffs-Appellees.

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, including obstetrician-gynecologists in Missouri—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 changing issues facing women's health care. ACOG is committed to defending the right of physicians to practice the full scope of obstetrics and gynecology and to ensuring access to the full spectrum of evidence-

[1] The parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part, and no party or person other than Amici, their members, and their counsel contributed money towards the preparation or filing of this brief.

based quality reproductive health care, including abortion, for all women. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care. ACOG's work has been cited frequently by the Supreme Court and other federal courts seeking authoritative medical data regarding the provision of women's health care, including childbirth and abortion.[2]

AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups, seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy-making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state, including Missouri.

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[2] *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing ACOG, AMA, and AAFP's brief for academic hospital admitting requirements, medical procedure mortality rate data, and treatment procedures after a miscarriage); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG's brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG's brief in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG publication in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions).

AAFP is the national medical specialty society representing family physicians. Founded in 1947, its 134,600 members are physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and serving the needs of its members with professionalism and creativity.

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.

ACP is the largest medical specialty organization in the U.S. and has members in more than 145 countries worldwide. ACP membership includes 159,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ASRM is a multidisciplinary not-for-profit organization dedicated to the advancement of the science and practice of reproductive medicine. Its members include approximately 8,000 professionals. ASRM accomplishes its mission through the pursuit of excellence in education and research and through advocacy on behalf of patients, physicians, and affiliated healthcare providers.

NASPAG is dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth. NASPAG conducts and encourages multidisciplinary and inter-professional programs of medical education and research in the field and advocates for the reproductive well-being of children and adolescents and the provision of unrestricted, unbiased, and evidence-based medical practice.

SMFM, founded in 1977, is the medical professional society for obstetricians who have additional training in the area of high-risk, complicated pregnancies. Representing over 4,000 members, SMFM supports the clinical practice of maternal-fetal medicine by providing education, promoting research, and engaging in advocacy to reduce disparities and optimize the health of high-risk pregnant women and their babies. SMFM and its members are dedicated to ensuring that medically appropriate treatment options are available for high-risk women.

SUMMARY OF ARGUMENT

Missouri's attempt to outlaw nearly all abortions after 8, 14, 18, and 20 weeks of pregnancy, as well as pre-viability abortions sought "solely because" of a diagnosis of or test result indicating Down syndrome, is fundamentally at odds with the provision of safe and essential health care, medical ethics, and well-settled constitutional law. Contrary to the assertions made by the Missouri legislature and Defendants-Appellants, there is no medical justification for Missouri House Bill 126 ("H.B. 126" or "the Bill"). Instead, H.B. 126 threatens the health and safety of women. The Bill impermissibly intrudes into the patient-physician relationship by limiting a physician's ability to perform the medical treatment that she and her patient decide is best for the patient's particular circumstances and medical interests. The Bill also undermines longstanding principles of medical ethics and places physicians in the untenable position of choosing between providing care consistent with their best medical judgment and ethical obligations *or* risking their license and criminal sanction.

For the above reasons and those discussed below, Amici, who are major medical organizations representing physicians and other clinicians who serve patients in Missouri and nationwide, urge the Court to affirm the district court's injunction.

ARGUMENT

I. THE BANS WILL HARM, NOT IMPROVE, WOMEN'S HEALTH

H.B. 126 includes four separate gestational age bans (collectively, the "Gestational Age Bans") prohibiting abortions at or after 8, 14, 18, and 20 weeks after the first day of a patient's last menstrual period ("LMP")[3] with only a single, narrowly-defined exception for medical emergencies.[4] Physicians and other clinicians would be found guilty of a class-B felony and risk the loss of their professional license for providing an abortion in contravention of the Gestational Age Bans' limits.[5] H.B. 126 also prohibits pre-viability abortions at any stage of pregnancy where a physician "knows" a patient is seeking an abortion "solely because" of a "prenatal diagnosis, test, or screening" indicating Down syndrome (the "Reason Ban").[6]

As the Plaintiffs-Appellees capably explain, both categories of bans represent unconstitutional pre-viability restrictions on abortion.[7] Amici weigh in to explain that while the Bans are couched in concern for women's health, in

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[3] Mo. Rev. Stat. §§ 188.056 (the "8-week ban"), 188.057 (the "14-week ban"), 188.058 (the "18-week ban"), 188.375 (the "20-week ban").

[4] *Id.* § 188.015(7).

[5] *See, e.g.*, *id.* § 188.056.1.

[6] *Id.* §§ 188.038.2, 188.038.3.

[7] Appellees' Brief 12-34.

reality, they would engender severe and detrimental physical and psychological health consequences for women.

A. Abortion Is A Safe, Common, And Essential Component Of Women's Healthcare

The overwhelming weight of medical evidence conclusively demonstrates that abortion is an extremely safe, common medical procedure.[8] In 2017, there were over 860,000 abortions performed nationwide,[9] including roughly 4,710 in Missouri.[10] Approximately one quarter of American women will have an abortion before the age of 45.[11]

Abortion is already one of the safest medical procedures performed in the United States. Complication rates from abortion are extremely low, averaging around 2%, and most complications are relatively minor and easily treatable.[12]

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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) ("*Safety and Quality of Abortion Care*") ("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.").

[9] Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, at 7 (2019).

[10] Guttmacher Inst., *State Facts About Abortion: Missouri* (2020).

[11] Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).

[12] *See, e.g.*, Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (finding 2.1% abortion-related complication rate); *Safety and Quality of Abortion Care*, *supra* note 8, at 60.

Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[13] The risk of death from an abortion is even rarer. Nationally, fewer than one in 100,000 patients die from an abortion-related complication.[14] In contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[15] In the United States, 90% of abortions occur within the first trimester, where the risk of complications is especially low.[16] Advances in medical science have expanded safe options for pregnancy termination. For example, medical abortion, which involves the use of medication rather than a clinical procedure, is a safe and effective option for women who seek termination of a first-trimester pregnancy.[17]

In addition to the limited physical risks of obtaining an abortion, medical research demonstrates that abortion does not negatively affect women's mental health or psychological well-being. Recent long-term studies have found that women who receive wanted abortions had "similar or better mental health

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[13] White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015).

[14] Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 Obstetrics & Gynecology 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

[15] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

[16] Guttmacher Inst., *Induced Abortion in the United States* 2 (Sept. 2019).

[17] *Safety and Quality of Abortion Care*, *supra* note 8, at 51-55 (discussing efficacy of medication abortion).

outcomes than those who were denied a wanted abortion," and that receiving an abortion did not increase the likelihood for women of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to carry an unwanted pregnancy to term.[18]

Moreover, access to abortion remains essential for women's overall health and well-being. One recent study noted that a full 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[19] Many women have written eloquently about the impact of access to safe, legal abortion on their personal and professional lives.[20]

As a safe, common medical procedure, the medical community recognizes abortion as an "essential" component of women's health care.[21]

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[18] 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).

[19] Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS ONE 1, 7 (2015).

[20] *See, e.g.*, Brief for Michele Coleman Mayes [et al.] and 365 Other Legal Professionals Who Have Exercised Their Constitutional Right to an Abortion as Amici Curiae Supporting Petitioners, *June Medical Servs. v. Gee*, No. 18-1323 (U.S. Dec. 2, 2019) (discussing how amici benefitted in their personal and professional lives from being able to access an abortion when needed).

[21] *See, e.g.*, Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the *New England Journal of Medicine* along with "several key organizations in obstetrics, gynecology, and maternal-fetal medicine" including the American

B. The Bans Will Endanger Women's Physical And Psychological Health

H.B. 126 takes the drastic step of banning abortion as early as eight weeks' gestational age. Given that more than 45% of pregnancies in the United States are unplanned, and considering that many medical conditions, including irregular periods, may hide a pregnancy, many women may not even discover they are pregnant before the cutoffs imposed by the Gestational Age Bans.[22] Even where women become aware of their pregnancies, it may take time before patients can access abortion care, which may cause them to hit the Bill's various pre-viability gestational age limits. The fact that just one clinic providing abortions currently remains open in Missouri means that many women will contend with a host of significant logistical and financial barriers, including paying for the procedure, and organizing transportation, accommodation, and childcare as needed. Neighboring states have already reported an "influx" of patients from Missouri traveling to seek

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Board of Obstetrics and Gynecology, that "[a]ccess to legal and safe pregnancy termination … is essential to the public health of women everywhere"); ACOG, *Abortion Policy*; Soc'y for Maternal-Fetal Med., *Access to Pregnancy Termination Services* (2017).

[22] Guttmacher Inst., *Unintended Pregnancy in the United States* (Jan. 2019) (noting that approximately 45% of pregnancies in the U.S. are unplanned); Guttmacher Inst., *Abortion in Women's Lives* 29 (2006) (noting impact of irregular periods on detecting pregnancy in early stages).

abortions given the lack of access within the state.[23] The Bill would effectively criminalize the vast majority of abortions sought in Missouri because many patients will be unable to terminate their pregnancies before the arbitrary cutoffs imposed by the law.

Pre-viability restrictions on abortion typically increase the likelihood that women will delay the procedure until a later gestational period in order to travel outside the state, will attempt to self-induce abortions through potentially harmful methods, or will ultimately be unable to obtain abortions at all, forcing them to carry an unwanted pregnancy to term.[24] Each of these outcomes increases the likelihood of negative consequences to a woman's physical and psychological health that could be avoided if abortion services were available.[25] For instance, though the risk of complications overall remains exceedingly low, delaying the procedure increases medical risks to the patient because the chance of a major complication is higher in the second trimester than in the first.[26] Studies have

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[23] *See, e.g.*, Weber, *What the Possible End of Abortions in Missouri Means for Neighboring States*, KAISER HEALTH NEWS (May 28, 2019) (noting that physicians in Kansas and Illinois already provide abortions to an "influx" of patients from Missouri after several Missouri abortion clinics closed down).

[24] *See, e.g.*, Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

[25] *See, e.g.*, ACOG, *Committee Opinion No. 613, Increasing Access to Abortion* (Nov. 2014, reaffirmed 2019).

[26] Upadhyay et al., *supra* note 12, at 181.

found that women are more likely to self-induce abortions where they face barriers to reproductive services, and methods of self-induction outside medical abortion may rely on harmful tactics such as herbal or homeopathic remedies, getting punched in the abdomen, using alcohol or illicit drugs, or taking hormonal pills.[27] Finally, evidence suggests that women are more likely to experience short-term psychological issues when *denied* an abortion. For example, women denied abortions because of gestational age bans are more likely to report short-term symptoms of anxiety than those women who received an abortion.[28] Accordingly, pre-viability restrictions on abortion, such as those at issue here, are detrimental to women's physical and psychological health and well-being.[29]

C. There Is No Health Or Safety Justification For The Gestational Age Bans

The State's attempts to justify the Gestational Age Bans as a means of "protecting and promoting" women's health and well-being is neither credible nor persuasive.[30] The State asserts that "abortion at any stage of development involves serious risks of grave physical and psychological harms" yet fails to cite a single

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[27] Grossman et al., Tex. Pol'y Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015).

[28] Biggs et al., *Women's Mental Health*, *supra* note 18, at 172.

[29] *Safety and Quality of Abortion Care*, *supra* note 8, at 74 (noting that the greatest threats to the safety and quality of abortion in the U.S. are unnecessary regulations that restrict access to abortion).

[30] Appellants' Br. 45-46; Mo. Rev. Stat. §§ 188.026.2(33), 188.026.5(7).

empirical study that supports this conclusion and Amici are aware of none.[31] Like any medical or surgical procedure, abortion carries some possibility of complications. However, contrary to the State's assertion that there is "medical and scientific uncertainty in this area,"[32] the overwhelming weight of medical consensus finds induced abortion is one of the *least* risky procedures in modern medicine and is several times safer than the only alternative—carrying a pregnancy to term and giving birth.[33] The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[34] and maternal mortality rates have only increased since then.[35] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[36] A woman's risk of death associated with childbirth is accordingly approximately 14 times higher than any risk of death from an abortion.[37]

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[31] Appellants' Br. 45.

[32] *Id*.

[33] Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 729 (2004).

[34] Raymond & Grimes, *supra* note 15, at 216.

[35] MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6% increase in maternal mortality rates between 2000 and 2014).

[36] Raymond & Grimes, *supra* note 15, at 216.

[37] *Id*.

Appellants selectively cite from just one study to argue that the "risk of complications from surgical abortion increases exponentially with gestational age,"[38] omitting the study's own conclusion that surgical abortion is "one of the safest surgeries" performed in reproductive-age women, with a "low" risk of complications.[39] The State also fails to note that every complication associated with abortion, including anemia, hypertensive disorders such as preeclampsia, and pelvic and perineal trauma is "more common among women having live births than among those having abortions."[40]

As discussed above (*see supra* pp.7-9), though the risk of complications does increase somewhat with gestational age, the absolute risk of complications associated with an abortion remains exceedingly low across gestational ages and methods.[41] There are a variety of reasons why abortion at later gestational ages carries a greater risk of complications, including that abortions in the second trimester typically require more invasive procedures and more sedation than

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[38] Appellants' Br. 45; Diedrich & Steinauer, *Complications of Surgical Abortion*, 52 Clinical Obstetrics & Gynecology 205 (2009).

[39] Diedrich & Steinauer, *supra* note 38, at 205.

[40] Raymond & Grimes, *supra* note 15, at 216-217; *see also* Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089, 1092 (2008) ("Rates of anemia, hypertensive disorders of pregnancy, pelvic and perineal trauma, and postpartum hemorrhage each occurred more frequently in women who had a live birth or still birth.").

[41] *See supra* notes 12-17 and accompanying text.

procedures in the first trimester.[42] The medical community has not, however, recommended gestational age limits—rather, the medical community has recommended "increased access to surgical and nonsurgical abortion services" as they "may increase the proportion of abortions performed at lower-risk, early gestational ages."[43] This conclusion is consistent with a recent study published by the National Academies of Medicine, Engineering, and Science showing that the greatest threats to the safety and quality of abortion in the United States are unnecessary government regulations that restrict access to abortion.[44]

Similarly, the State cites no empirical evidence in support of its proposition that abortion carries "serious risks of grave … psychological harms."[45] Systematic reviews of the available literature have concluded that the "highest-quality research available does not support the hypothesis that abortion leads to long-term mental health problems."[46] In the context of unplanned pregnancies, recent studies have

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[42] *Safety and Quality of Abortion Care*, *supra* note 8, at 10.

[43] Bartlett et al., *supra* note 33, at 736; *see also* ACOG, *Committee Opinion No. 613*, *supra* note 25.

[44] *Safety and Quality of Abortion Care*, *supra* note 8.

[45] Appellants' Br. 45.

[46] Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 448-449 (July 2008); *see also* Biggs et al., *Mental Health Diagnoses 3 Years After Receiving or Being Denied an Abortion in the United States*, 105 Am. J. Pub. Health 2257, 2561 (2015) (finding that obtaining an abortion does not correlate with higher rates of diagnoses of mental health disorders).

found no difference in the risk of depression or other mental health problems between women who have abortions and women who carry their pregnancy to term.[47] In actuality, there is evidence that gestational age bans, like those at issue here, can lead to *detrimental* effects on women's mental health.[48] The limits established by H.B. 126 therefore are likely to engender more detrimental physical and psychological consequences for women, rather than benefit their health.

The Gestational Age Bans would do nothing to mitigate the already extremely low risk of complications associated with abortions. The State's misguided attempt to justify them on maternal health grounds is without basis.

D. The Narrow Medical Emergency Exception In The Gestational Age Bans Does Not Adequately Protect Women's Health

H.B. 126 narrowly defines a "medical emergency" as a condition that necessitates an "immediate" abortion to "avert the death of the pregnant woman" or a "serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman."[49] Under this exception, a physician may

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[47] Biggs et al., *Women's Mental Health*, *supra* note 18, at 177.

[48] *Id.* at 172 (noting that a week after seeking an abortion, women denied abortions because of gestational age limits are more likely to report symptoms of anxiety than women who receive an abortion); Biggs et al., *Does Abortion Reduce Self-Esteem and Life Satisfaction?*, 23 Quality of Life Research 2505 (2014) (finding that women who received an abortion experienced higher self-esteem in the short term than women denied an abortion); Biggs et al, *Women's Mental Health*, *supra* note 18, at 177.

[49] Mo. Rev. Stat. § 188.015(7).

perform an abortion outside of H.B. 126's gestational age limits only once a medical condition has so compromised a patient's health that she requires an "immediate" abortion to avert death. It accordingly forecloses an abortion for women who might face serious medical complications that, while posing grave risks to their physical and mental health, are not yet urgent enough to fall within the Bill's narrow exception.

There are a significant number of serious medical conditions that would not qualify as a "medical emergency" under the Bill's narrow definition but would nevertheless jeopardize a patient's health. Many such conditions may not arise or require intervention until later in pregnancy, including after 18 or 20 weeks LMP. 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.[50] Other women may experience conditions constituting a "medical emergency" in previous pregnancies, and wish to avoid future life-threatening complications by terminating

[50] For instance, lupus can suddenly worsen post-18 weeks LMP and lead to fatal blood clots or other serious complications. Similarly, pulmonary hypertension can escalate in severity post-18 weeks LMP, resulting in seizures, heart and renal failure, blood-clotting issues, and death. *See* Kiely et al., *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).

a subsequent unplanned pregnancy. Moreover, the Bill does not make any allowances for mental health issues that might put a woman's health at risk.[51]

In all these circumstances, women should not be forced to wait until a condition deteriorates to the point of a "serious risk of substantial and irreversible … impairment" before being able to seek potentially life-saving care. H.B. 126 also puts physicians in the impossible position of either letting a patient deteriorate until an "immediate" abortion is necessary because death or serious injury is imminent or face possible criminal prosecution and the loss of their medical license for performing an abortion in contravention of the Bans. This indefensibly jeopardizes patients' health.

II. MEDICAL CONSENSUS ESTABLISHES THAT PRE-VIABILITY ABORTION DOES NOT CAUSE FETAL PAIN

In asserting an interest in preventing "fetal pain," Missouri attempts to manufacture medical uncertainty where none exists.[52] The clearly established medical consensus is that fetal pain perception is not possible before *at least* 24 weeks LMP, which is well after the time when Plaintiff-Appellee Reproductive Health Services stops performing abortions.[53]

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[51] *See, e.g.*, Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

[52] *See* Appellants' Br. 14, 47-48.

[53] *See Reproductive Health Servs. of Planned Parenthood of St. Louis Region, Inc. v. Parson*, 389 F. Supp. 3d 631, 637 (W.D. Mo. 2019).

Simply put, there is no credible scientific evidence of fetal pain perception pre-viability. Appellants base their assertion on a single affidavit; in contrast, every major medical organization that has examined the issue of fetal pain and several peer-reviewed studies have reached the opposite conclusion, as demonstrated by Plaintiffs-Appellees in the record below.[54]

The medical consensus is that fetal pain perception is not possible before 24 weeks LMP because the circuitry required to experience pain is not developed in earlier gestations. Pain perception requires an intact neural pathway from the periphery of the body (the skin), through the spinal cord, into the thalamus (the gray matter in the brain that relays sensory signals) and on to region of the cerebral cortex.[55] These neural connections do not develop until after at least 24 weeks

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[54] *See* ACOG, *Facts Are Important—Fetal Pain* (July 2013); Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice* (Mar. 2010) (concluding fetal pain is not possible before 24 weeks gestation, based on expert panel review of over 50 papers in medical and scientific literature); Kostovic & Jovanov-Milosevic, *The Development of Cerebral Connections During the First 20-45 Weeks' Gestation*, 11 Seminars in Fetal & Neonatal Med. 415 (2006); Apkarian, et al., *Human Brain Mechanisms of Pain Perception and Regulation in Health and Disease*, 9 Eur. J. Pain 463 (2005); Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 J. Am. Med. Ass'n 947 (2005).

[55] *See, e.g.*, Apkarian et al., *supra* note 54, at 463-484; Tracey & Mantyh, *The Cerebral Signature for Pain Perception and Its Modulation*, 55 Neuron 377 (2007); Key, *Why Fish Do Not Feel Pain*, 3 Animal Sentience 1 (2016).

LMP, and the cerebral cortex does not fully mature until after birth.[56] Additionally, medical literature shows that a fetus likely cannot experience pain at any gestational age because it is kept in a sleep-like state by environmental factors in the uterus, including certain hormones and low oxygen levels.[57]

The suggestion that the use of fetal anesthesia during fetal surgery indicates an expectation of fetal pain perception is false. During fetal surgery, fetal anesthesia and analgesia are appropriate because they serve other purposes unrelated to pain reduction—particularly, inhibition of fetal movement and prevention of long-term developmental consequences from the hormonal and circulatory stress responses to surgery.[58] Whether fetal anesthesia is appropriate

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[56] Kosovic & Jovanov-Milosevic, 11 Seminars in Fetal & Neonatal Med. 415.

[57] *See* ACOG, *Facts Are Important—Fetal Pain*, *supra* note 54, at 10-11; Rigatto et al., *Fetal Breathing and Behavior Measured Through a Double-Wall Plexiglass Window in Sheep*, 61 J. Applied Physiol. 160 (1986); Derbyshire, *Can Fetuses Feel Pain?*, 332 BMJ 909 (2006); Mellor et al., *The Importance of 'Awareness' for Understanding Fetal Pain*, 49 Brain Research Reviews 455 (2005).

[58] Lee et al., *supra* note 54, at 951; Smith et al., *Pain and Stress in the Human Fetus*, 92 European J. Obstetrics & Gynecology and Reprod. Biology 161, 161, 165 (2000) (fetal anesthesia may be appropriate even before the "neuroanatomical pathways" necessary to feel pain begin to develop, because of hormonal and circulatory stress responses with "long-term neurodevelopmental sequelae" that can occur earlier, and which may be prevented by anesthesia).

during fetal surgery is thus a separate and distinct question from whether there is fetal pain perception.[59]

III. THE BANS INTRUDE ON THE PATIENT-PHYSICIAN RELATIONSHIP

Patient safety is of paramount importance to Amici. While some regulation of medical practice is necessary to protect patient safety, legislation that substitutes a political agenda for a physician's sound medical judgment impermissibly interferes with 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 obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[60]

The patient-physician relationship is critical for the provision of safe and quality medical care.[61] At the core of this relationship is the ability to speak frankly and confidentially about important issues and concerns. Amici oppose laws that unduly threaten the patient-physician relationship absent a justifiable public health reason. "Laws that require physicians to give, or withhold, specific

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[59] Lee et al., *supra* note 54, at 951.

[60] ACOG, *Code of Professional Ethics* 2 (Dec. 2018); *see also* AMA, *Code of Medical Ethics Opinion 1.1.1* (discussing physicians' "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others").

[61] ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaffirmed July 2016) ("*ACOG, Legis. Policy Statement*").

information when counseling patients, or that mandate which tests, procedures, treatment alternatives or medicines physicians can perform, prescribe, or administer are ill-advised."[62] Laws should not interfere with the ability of physicians to determine appropriate courses of treatment and to discuss those options with their patients openly, honestly, and confidentially.[63] Indeed, the Reason Ban entirely fails to account for the extensive counseling provided to women who receive a prenatal Down syndrome diagnosis. After such an evaluation, women are often referred to a genetic counselor to receive in-depth, neutral, and supportive counseling to make informed choices given their particular circumstances.[64]

By criminalizing the performance of the vast majority of pre-viability abortions, H.B. 126 wrongfully intrudes on the patient-physician relationship. For example, the Gestational Age Bans and narrow medical exception may prohibit a physician from advising that an abortion is medically necessary and in the best

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[62] *Id.*

[63] *ACOG, Legis. Policy Statement*; *see also* Weinberger et al., *Legislative Interference with the Patient-Physician Relationship*, 367 New Eng. J. Med. 1557, 1557-1559 (2012) (generally discussing negative ramifications of inappropriate legislative interference in medicine).

[64] See National Society of Genetic Counselors, *Code of Ethics* (2017) (genetic counselors work to "[e]nable their clients to make informed decisions, free of coercion, by providing or illuminating the necessary facts, and clarifying the alternatives and anticipated consequences").

interest of the patient based on politically, rather than medically, determined gestational age limitations. Similarly, the Reason Ban jeopardizes open and honest conversation between a patient and her physician. On one end of the dialogue, it incentivizes patients not to be completely forthcoming and undermines the trust between the patient and her doctor. On the other end, the Reason Ban would cause physicians to worry about whether, and how, to ask questions that would ordinarily facilitate the provision of care. For example, if a patient mentions concern about the possibility of a Down syndrome diagnosis, the Reason Ban may prevent a physician from recommending or performing an abortion that the physician deems medically necessary and appropriate for reasons entirely unrelated to Down syndrome.

IV. THE BANS ARE CONTRARY TO CORE PRINCIPLES OF MEDICAL ETHICS AND PLACE PHYSICIANS IN ETHICALLY COMPROMISED POSITIONS

Contrary to Appellants' claims that the Bans would protect the integrity and public reputation of the medical profession, both the Gestational Age Bans and the Reason Ban violate long-established—and widely accepted—principles of medical ethics.[65] Missouri ostensibly believes that H.B. 126 is necessary to preserve the integrity of the medical profession by "regulating and restricting practices that might cause the medical profession or society as a whole to become insensitive,

[65] Appellants' Br. 31, 46.

even disdainful, to life."[66] In fact, the Bans would do the exact opposite, asking medical professionals to violate the age-old principles of beneficence, non-maleficence, and patient autonomy in order to avoid being criminalized, facing civil penalty, and license suspension.

A. The Bans Violate The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the well-being of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic tradition nearly 2500 years ago.[67] Both of these principles arise from the foundation of medical ethics which requires that the welfare of the patient form the basis of all medical decision-making.[68]

Obstetricians, gynecologists, and other clinicians providing abortion respect these ethical duties by providing patients with enough information to allow them to make fully informed decisions about pregnancy management or pre-viability termination. ACOG guidelines state that all physicians should offer prenatal

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[66] Mo. Rev. Stat. § 188.026.5(5).

[67] ACOG, *Committee Opinion No. 390, Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaffirmed 2019).

[68] ACOG, *Code of Professional Ethics*, *supra* note 60, at 2.

assessment and the option of pregnancy termination to their patients, among other options.[69]

H.B. 126 compromises these principles by pitting physicians' interests against those of their patients. The Gestational Age Bans make it a class-B felony to perform a pre-viability abortion at or after 8, 14, 18, and 20 weeks LMP.[70] Physicians who perform abortions in contravention of these limits would face up to 15 years imprisonment and risk the loss of their professional license.[71] Additionally, physicians who perform pre-viability abortions at any stage of a patient's pregnancy knowing that their patient is seeking the abortion "solely because" of a prenatal diagnosis indicating Down syndrome, face civil penalties, including the loss of their medical licenses.[72]

If a physician concludes that an abortion is medically necessary, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. But the Gestational Age Bans and their extremely narrow medical exception will do the opposite, either forcing physicians not to advise their patients that terminating their pregnancies is an option after 8 weeks or otherwise

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[69] ACOG, *Practice Bulletin No. 162: Prenatal Diagnostic Testing for Genetic Disorders*, 127 Obstetrics & Gynecology e108 (May 2016).

[70] Mo. Rev. Stat. §§ 188.056, 188.057, 188.058, 188.375.

[71] *See* Mo. Rev. Stat. § 188.056.1.

[72] *See* Mo. Rev. Stat. § 188.038.4.

exposing the physicians to criminal and civil penalties. Or, if a patient does seek an abortion, and the physician decides that the abortion is medically appropriate and necessary, the physician could be prevented from providing that care if the patient's initial reasons for seeking the abortion are ones that are proscribed by the Bill. Additionally, the Reason Ban may drive physicians to forego the provision of prenatal testing and counseling so that a possible Down's diagnosis does not become a reason for a patient to seek an abortion. It is a misperception that the Down's community would eventually disappear due to early prenatal screenings.[73] Indeed, the evidence shows that the rate of live births with Down syndrome has increased over the last decade despite the widespread availability of early detection.[74]

H.B. 126 therefore places physicians in the ethical dilemma of choosing between providing the best available medical care for their patients and risking substantial penalties *or* protecting their own careers and livelihoods.

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[73] *Down Syndrome*, Hearing Before the Subcomm. On Labor, Health and Human Services of the H. Comm. On Appropriations, 115th Cong. (Oct. 25, 2017) (statement of Dr. Joaquin M. Espinosa, Exec. Dir., Linda Crnic Institute for Down Syndrome).

[74] *Id.*

B. The Bans Violate The Ethical Principle Of Respect For Patient Autonomy

Alongside beneficence and non-maleficence, the other core principle of medical practice is patient autonomy—the recognition that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions.[75] Physicians must respect the right of individual patients to make their own choices about their health care.[76] 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.[77]

The Gestational Age Bans would violate patient autonomy by denying patients the right to make their own choices about health care if they choose, for example, to seek a pre-viability abortion after one of the applicable gestational age limits. Similarly, the Reason Ban would undermine the principle of patient autonomy by depriving patients of their ability to choose their own reasons for terminating a pregnancy. In doing so, the Reason Ban would invade patient privacy interests, impede patient self-determination, and restrict a woman's ability to obtain desired medical care. The right to privacy does not countenance official

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[75] ACOG, *Code of Professional Ethics*, *supra* note 60, at 1 ("respect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental").

[76] *Id.*

[77] ACOG, *Committee Opinion No. 439, Informed Consent* 2-3 (Aug. 2009, reaffirmed 2015).

interrogation of a woman's reasons for ending a pre-viability pregnancy and especially does not countenance prohibition of her seeking such a procedure because of politicians' disapproval of her reasons for doing so. Obstetricians and gynecologists and other clinicians providing abortion respect patient autonomy by providing their patients with information and guidance so that they are empowered to make informed and voluntary decisions. The Reason Ban would violate this principle by forcing physicians either to avoid offering prenatal counseling and testing so that the reason for an abortion is not questioned, or by preventing physicians from discussing abortion as an option when a potential Down syndrome diagnosis is at play. As a result, the Bans would increase the likelihood that patients are not given the proper information and guidance required to make their own decisions about their health care.

Through such restrictions on the ability of physicians to render care consistent with their patients' wishes, H.B. 126 acutely undermines physicians' ethical obligations. Amici oppose any laws which cause such grave ethical dilemmas and incentivize physicians to prioritize their professional security over the welfare of their patients through the provision of medical care that falls short of the accepted clinical standards.

Abortion is a safe, common, and necessary medical procedure.[78] Physicians should not face criminal liability for providing basic medical care that approximately one-quarter of all women will require in their lifetimes. Even more pressingly, physicians should not be made to choose between facing criminal liability or providing care consistent with their ethical duties and guidelines of good clinical practice.

CONCLUSION

For the foregoing reasons, Amici urge this Court to affirm the district court's decision.

Respectfully submitted,

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[78] *Supra* pp.7-9.

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)(i).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(f), the brief contains 6,497 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word for 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

January 22, 2020

CERTIFICATE OF SERVICE

I hereby certify that on this 22nd day of January 2020, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth 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.

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