No. 12-1168

IN THE

Supreme Court of the United States

ELEANOR MCCULLEN, *et al.*,
Petitioners,

v.

MARTHA COAKLEY, ATTORNEY GENERAL OF MASSACHUSETTS, *et al.*,
Respondents.

On a Writ of Certiorari To the United States Court of Appeals For The First Circuit

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND MASSACHUSETTS MEDICAL SOCIETY IN SUPPORT OF RESPONDENTS

DANA A. JUPITER
SIDLEY AUSTIN LLP
787 Seventh Avenue
New York, NY 10019
(212) 839-5300

JACK R. BIERIG*
TACY F. FLINT
SIDLEY AUSTIN LLP
One South Dearborn Street
Chicago, Illinois 60603
(312) 853-7000
jbierig@sidley.com

Counsel for Amici Curiae

*Counsel of Record

November 22, 2013

TABLE OF CONTENTS

TABLE OF CONTENTS—continued

TABLE OF AUTHORITIES

CASES Page

STATUTES

SCHOLARLY AUTHORITIES

TABLE OF AUTHORITIES—continued

TABLE OF AUTHORITIES—continued

TABLE OF AUTHORITIES—continued

TABLE OF AUTHORITIES—continued

TABLE OF AUTHORITIES—continued

TABLE OF AUTHORITIES—continued

TABLE OF AUTHORITIES—continued

OTHER AUTHORITIES

TABLE OF AUTHORITIES—continued

TABLE OF AUTHORITIES—continued

INTERESTS OF *AMICI CURIAE*[1]

Amici are private, voluntary, nonprofit organizations of physicians dedicated to promoting the public welfare through the maintenance of the highest professional standards and the provision of quality health care. *Amicus* American College of Obstetricians and Gynecologists (ACOG) has been the nation's leading group of professionals providing health care to women for more than 60 years; its more than 55,000 members represent over 90 percent of American board-certified obstetricians and gynecologists.

Amicus the American Medical Association (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 its House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty area and in every state, including Massachusetts.

The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the

---

[1] Pursuant to Supreme Court Rule 37.6, *amici curiae* state that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amici curiae* and their counsel, made any monetary contribution toward the preparation and submission of this brief. Pursuant to Rule 37.3, petitioners and respondents have consented to the filing of this *amici curiae* brief in letters enclosed with this brief.

American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

Amicus Massachusetts Medical Society (MMS) was founded in 1781 as a statewide professional association committed to advancing medical knowledge, developing and maintaining the highest professional and ethical standards of medical practice and health care, and promoting medical institutions. MMS is the oldest continuously operating medical society in the United States; its nearly 25,000 members include physicians practicing in all areas of medicine throughout the Commonwealth.

The Massachusetts statute regulates conduct that has an immediate and evident effect on the health and welfare of patients treated at reproductive health care facilities by members of ACOG, AMA, and MMS (collectively, the "medical associations") and other physicians. Similarly, the conduct regulated by the statute directly and adversely affects the ability of physicians and other medical providers to treat their patients. As associations of physicians, including physicians who provide reproductive health care in Massachusetts, the medical associations have a direct interest in ensuring that women have safe, unhindered access to essential reproductive health and other medical services. Moreover, the medical associations can offer knowledge of the conditions and circumstances of providing health care that will be useful to the Court's analysis.

SUMMARY OF ARGUMENT

This case calls on the Court to decide whether the challenged Massachusetts statute, Mass. Gen. Laws ch. 266, § 120E½(b) (the "Act"), is a permissible time-place-manner regulation. The Court must accordingly assess whether the statute is "justified without reference to the content of the regulated speech," "narrowly tailored to serve a significant government interest," and "leave[s] open ample alternative channels for communication of the information." *Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989) (quoting *Clark v. Cmty. for Creative Non-Violence*, 468 U.S. 288, 293 (1984)) (internal quotation marks omitted). The medical associations agree with respondents that the statute fully satisfies each of these criteria.

The Massachusetts legislature determined, after hearing extensive testimony documenting years of experiences by patients, clinicians, and law enforcement, that the fixed buffer zone provided for in the challenged statute was necessary to ensure safe, unhindered access to reproductive health facilities in that state. *See* Resp. Br. 1-14. As the testimony before the legislature showed, police and others could not, as a "practical matter," preserve access to reproductive health clinics by other means—through the state's previous floating buffer zone law, which had proved essentially unenforceable; through the use of targeted injunctions; or through more general criminal laws against assault, disturbing the peace, and the like. J.A. 12, 16-18, 20-22, 67-70, 77-79, 122-23; *see also* Resp. Br. 3-10 (summarizing evidence). While the State had attempted each of those measures, each had failed. In the legislature's judgment, a different form of protection was "necessary for the immediate

preservation of the public safety." Mass. St. 2007, c. 155. Accordingly, in 2007, the Massachusetts legislature enacted the challenged law in an effort to "increase forthwith public safety at reproductive health care facilities." *Id.*

There can be no doubt that the protection of public health and safety is a compelling interest that States are uniquely situated to advance. Indeed, promotion of health and safety "is unquestionably at the core of the State's police power." *Kelley v. Johnson*, 425 U.S. 238, 247 (1976); *see also Hillsborough Cty. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985). Notably, petitioners make no effort to dispute that the interests the Massachusetts legislature sought to serve through the challenged Act are compelling. *See* Pet. Br. 35, 45.

Instead, petitioners and their *amici* argue that the Act advances those concededly "legitimate" state interests improperly. Pet. Br. 45. In particular, petitioners and their *amici* contend that the Act is not content-neutral because it applies only to stand-alone reproductive health facilities, while the important state interests that the law was enacted to serve apply, in petitioners' view, to patients at all types of healthcare facilities and to "every building in the State that hosts any activity that might occasion protest or comment." *Id.* at 21-27; *see also* Bioethics Defense Fund Br. 7, 9, 11, 13, 17; Democrats for Life Br. 17; Eagle Forum Br. 4-5. Petitioners further argue that the Act is not narrowly tailored because, according to petitioners, "the interests in public safety and access are already amply served by" other, generally applicable state and federal laws. Pet. Br. 36. Finally, although petitioners have not argued as much, their *amici* contend that the Act actually undermines the state interest in health and safety

because, according to *amici*, it limits patients' ability to obtain supposedly relevant information from protesters, and "there is no other source of neutral information about abortion readily available to women who visit reproductive health facilities in Massachusetts." Women Who Attest Br. 21; *see also* Bioethics Defense Fund Br. 18.

Contrary to these arguments, the Act not only is content-neutral, but also is narrowly tailored to promote—and does effectively promote—the fundamental State interest in public health and safety. The challenged statute was enacted to address a problem that is unique to the areas outside the entrances to reproductive health care facilities. Moreover, as the medical associations show below, the numerous institutional obstacles to obtaining reproductive health services, and the unparalleled importance of receiving such services without delay, further justify the State's decision to focus the law's protections on reproductive health facilities in order to serve the significant government interest in ensuring women's unencumbered and safe access to vital health care.

The reproductive health clinics that are the subject of the challenged statute provide a wide array of essential health services to thousands of women every year. Access to such services is, for many women, already limited by distance, cost, and other factors—and encountering harassment when entering clinics imposes yet another barrier that restricts women's ability to obtain needed health services promptly and safely. Yet delay in seeking reproductive health services leads to significantly worse patient outcomes. In particular, induced abortion is safest when provided early in pregnancy. Other reproductive health care is likewise most effective when delivered promptly. Accordingly, ensuring that

women are able to access such services as promptly as possible is uniquely important in this context. Moreover, experiencing the type of stress that protesters' harassment causes just before a procedure increases the risk of adverse results. The Act's focus on ensuring that women are not compelled to delay or even forgo reproductive health care, and ensuring that they are not harassed or intimidated immediately before undergoing medical procedures, is narrowly tailored to advance this essential state interest.

Furthermore, the contention of petitioners and their *amici* that the Act undermines health and safety by preventing petitioners and others from providing supposedly essential information to patients entering reproductive health care facilities—in particular, information that patients supposedly will not otherwise receive—is simply mistaken. The medical professionals who provide induced abortions and other reproductive health services have ethical and legal obligations to ensure that their patients give fully and accurately informed consent before any procedure is performed. Clinicians thus provide accurate, comprehensive information regarding the medical risks and benefits of induced abortion, and other reproductive health care, as well as information about alternatives. Moreover, much of the information that petitioners' *amici* suggest is provided to women only by protesters is in fact medically inaccurate and highly misleading. There is thus no basis for overturning the statute on the ground that it will ensure the availability of such information to women seeking reproductive health care.

Because the challenged law enables respondents to ensure safe access, unhindered by harassment, to reproductive health care facilities, and thus enables

medical providers to offer timely treatment, as well as comprehensive, accurate, and relevant medical information, the statute should be upheld and the decision below affirmed. As noted above, the interests at stake here are "unquestionably at the core" of the Massachusetts legislature's power to protect Massachusetts citizens. *Kelley*, 425 U.S. at 247. For that reason, this Court has traditionally granted States "'great latitude … to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons.'" *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996) (quoting *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 756 (1985)). This case should be no different. The legislative judgment encapsulated in the Act should not be disturbed.

ARGUMENT

I. THE ACT IS CONTENT-NEUTRAL AND NARROWLY TAILORED TO PROMOTE THE IMPORTANT STATE INTEREST IN PUBLIC HEALTH AND SAFETY.

A. The Reproductive Health Facilities At Issue Provide Essential Services That Many Women Struggle To Access.

The reproductive health facilities subject to the Act's protections play an essential and unique role in promoting women's health. The facilities at issue in this case provide a wide range of medical services to tens of thousands of patients every year, including breast and cervical cancer screening, infertility services, family planning, screening and treatment for sexually transmitted infections, abortions, and full gynecological services. J.A. 14, 18, 61, 77. More than two-thirds of patient visits are for preventative

health care.[2] J.A. 61, 77. The services provided by these reproductive health care facilities are essential to women's health and welfare.

For many women, the physicians and other medical providers who offer essential services at reproductive health care facilities act as the patient's primary—and sometimes only—connection to medical care.[3] This is particularly true for women who lack insurance. Among the uninsured, fully half of women visiting reproductive health clinics used the clinic as their only source of medical care. Frost, *Specialized Family Planning Clinics*, *supra.*

However, many women struggle to access reproductive health care facilities for a number of reasons.[4] Nationally, many women must travel

---

[2] In 2011, the latest year for which data is available, Planned Parenthood Affiliate Health Centers provided nearly 11 million medical services for nearly three million people. *2011-2012 Annual Report on Planned Parenthood Federation of America and Related Organizations* 4-5, *available at* http://issuu.com/actionfund/docs/ppfa_ar_2012_121812_vf/1 (last visited Nov. 20, 2013). Of the many, essential health services provided by Planned Parenthood Affiliate Health Centers, only 3 percent of those services were abortions. *Id.*

[3] Jennifer J. Frost et al., *Specialized Family Planning Clinics in the United States: Why Women Choose Them and Their Role in Meeting Women's Health Care Needs*, 22 Women's Health Issues e519 (2012); *see also, e.g.*, Jennifer J. Frost, *U.S. Women's Use of Sexual and Reproductive Health Services: Trends, Sources of Care and Factors Associated with Use, 1995-2010*, at 32 (May 2013), *available at* http://www.guttmacher.org/pubs/sources-of-care-2013.pdf ("In 2006-2010, a majority (63%) of women who visited a publicly funded clinic for one or more family planning services in the prior year reported that the clinic was their usual source for medical care.").

[4] *See, e.g.*, Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. Health

significant distances to access reproductive health services—and particularly induced abortion. In 2008, 87% of counties lacked a reproductive health care facility that provided induced abortions, and 35% of women aged 15-44 lived in those counties.[5] The number of abortion providers has been steadily declining since 1982. Jones & Kooistra, *supra*, at 41. Ninety-seven percent of all nonmetropolitan counties have no abortion services.[6] Nonhospital abortion providers estimate that 19% of their patients travel 50-100 miles, and 8% travel more than 100 miles.[7]

The need to travel long distances leads to delay in obtaining services.[8] The difficulty in accessing abortion providers is particularly problematic for vulnerable populations. *See* Dehlendorf & Weitz, *supra*, at 417 ("The effect of limited access to abortion services results in significant consequences for some

---

Care Poor Underserv. 415, 416 (2011) (explaining that poor and minority women experience significant barriers to accessing needed reproductive health services, including travel, time, lack of financial support for abortion care, and lack abortion services); Martin Donohoe, *Increase in Obstacles to Abortion: The American Perspective in 2004*, 60 J. Am. Med. Women's Ass'n 16, 18-22 (2005).

[5] Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Persp. on Sexual & Reprod. Health 41, 46, 49 (2011).

[6] Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—And the Women They Serve—Pay the Price*, 16 Guttmacher Pol'y Rev. 7, 10 (2013) [hereinafter Gold & Nash, *TRAP Laws*].

[7] ACOG Comm. on Health Care for Underserved Women, Comm. Opinion No. 429, *Health Disparities for Rural Women* 2 (Mar. 2009).

[8] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstet. Gynecol. 729, 735 (2004).

women, including women in vulnerable populations having abortions at later gestational ages.") (footnote omitted).

Lack of financial support poses another significant barrier to women's access to abortion services.[9] Pursuant to the Hyde Amendment, federal Medicaid and Medicare funds may not be used for an abortion except to preserve a woman's life or in the case of rape or incest, Donohoe, *supra*, at 18, and only seventeen states allow Medicaid funds to be used for medically necessary abortions.[10] Women at all income levels face other significant barriers, such as work

---

[9] *See, e.g.*, Rachel K. Jones et al., *At What Cost?: Payment for Abortion Care by U.S. Women*, 23 Women's Health Issues e173 (2013) ("[A]bortion patients are confronted with substantial financial burdens in order to pay for the[ir] procedures," and such financial obstacles "may also influence at what stage in the pregnancy [a woman is] able to" seek an abortion); Donohoe, *supra*, at 18-19 (discussing cost of abortion procedures and lack of insurance coverage as significant barriers to abortion).

[10] Guttmacher Inst., *State Funding of Abortion Under Medicaid, State Policies in Brief* (Oct. 1, 2013), *available at* http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf; *see also* Jones & Kooistra, *supra*, at 50. Even in states where the state Medicaid program does cover abortion care for poor women, women still encounter obstacles in getting the state to pay for the procedure, because of, for example, difficulties negotiating the application process and difficulty locating a provider who accepts the state Medicaid payment for the necessary procedure; therefore, state funding under Medicaid does not necessarily resolve the significant delays caused by financial barriers to abortion services. *See, e.g.*, Diana Green Foster et al., *Predictors of Delay in Each Step Leading to an Abortion*, 77 Contraception 289, 292 (2008) (discussing factors associated with delay in abortion care based on study of women seeking second-trimester abortions in California); *see also* Jones et al., *supra* (discussing the numerous barriers to funding that exist even in the states where Medicaid does cover abortion services).

and scheduling problems, pressures from partners and family, distance from a provider, gestational limits, and increasing legal constraints on the circumstances under which abortions may be performed.[11]

Protests outside reproductive health care facilities impose an additional constraint on women's access to the critical health care services provided by those clinics. To be sure, some protesters are peaceful and neither harass nor create stress for patients visiting reproductive health facilities. However, the record in this case leaves no doubt that many patients in Massachusetts *did* face harassment when entering clinics before the challenged Act was put in place. *See* Resp. Br. 2-5, 6-12 (summarizing evidence of harassment and intimidation of patients entering reproductive health clinics before the current law was enacted). And the record here is hardly unique. In 2000, 82% of facilities providing 400 or more abortions per year experienced some type of harassment. Jones & Kooistra, *supra*, at 41. In 2008, the percentage of such providers reporting some type of antiabortion harassment increased to 89%, *id.* at 48, and the National Abortion Federal (NAF) reported 12,503 incidents of facility picketing alone.[12] Anti-

---

[11] Jones & Kooistra, *supra*, at 47-48; Stanley K. Henshaw, *Factors Hindering Access to Abortion Services*, 27 Fam. Plan. Persp. 54, 59 (1995);*see also* Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, Am. J. Pub. Health e1, e3 (published online ahead of print Aug. 15, 2013); Donohoe, *supra*, at 18-22; Lawrence B. Finer & Stanley K. Henshaw, *Abortion Incidence and Services in the United States in 2000*, 35 Persp. on Sexual & Reprod. Health 6, 13-14 (2003); Gold & Nash, *TRAP Laws*, *supra*, at 7.

[12] Diana Green Foster et al., *Effect of Abortion Protesters on Women's Emotional Response to Abortion*, 87 Contraception 81, 81 (2013) [hereinafter Foster et al., *Effect of Abortion Protesters*].

abortion violence has increased 21% from 1991 to 2012.[13]

Harassment or hindrances at the entrance to abortion clinics—no matter what the viewpoint of those protesting—has real, clinical consequences for patients. Women who encounter protesters may delay treatment or avoid seeking treatment altogether. *See, e.g.*, Russo et al., *supra*, at 565 ("Patients travel further to receive services in less harassed locations, sometimes delaying their procedures in order to avoid harassment."). That harassment outside reproductive health care facilities causes women to delay, or even forgo, obtaining necessary health services is clear from the evidence in the record. *See* J.A. 41, 51, 88-89 (describing women who delay procedures or opt not to enter facilities in order to avoid facing protesters); *see also id.* at 75 ("[W]ithout unfettered and reasonable access to these health services, … many women were being intimidated from having those services provided in an appropriate manner."); *infra* Section I.B.

Harassment by protesters outside of reproductive health care facilities reduces women's access to services for the additional reason that harassment by protesters reduces the number of medical professionals willing to work in reproductive health care facilities.[14] In addition to driving experienced medical

---

[13] Jennifer A. Russo et al., *Antiabortion Violence in the United States*, 86 Contraception 562, 565 (2012); *see also* J.A. 14-15, 18, 21, 54, 61-62, 68-72, 77-78, 84-88 (describing the frequency of antiabortion activities outside reproductive health care facilities).

[14] *See* Henshaw, *supra*, at 59 (11% of nonhospital providers reported that physician shortages and other staffing problems reduced their ability to provide abortion services); Russo et al., *supra*, at 565; Jones & Kooistra, *supra*, at 49; Deborah Epstein,

providers out of the practice, harassment and intimidation may discourage younger medical providers from entering the field, thereby further reducing the availability of abortion services.[15] Further reductions in the number of reproductive health providers will make access to all forms of reproductive health services all the more costly and burdensome for patients. And, as the record in this case shows, there have been no comparable protest activities—nor any resulting discouragement of providers—outside any other form of health care facility in Massachusetts. *See* Resp. Br. 2 n.1, 29-30.

In sum, harassment at the entrance to reproductive health facilities—regardless of the content of any message sought to be communicated to patients—not only imposes an obstacle to women's ability to access both reproductive and other health care, but also exacerbates other existing constraints on women's access to reproductive health care. Because these access problems are unique to reproductive health facilities, the Act's focus on reproductive health facilities is entirely appropriate.

B. Prompt And Unhindered Access To Reproductive Health Services Is Critical To Promoting Women's Health.

It is incontrovertible that earlier treatment is better for patient health and welfare. Induced abortion is one of the *least* risky procedures in modern medicine. Bartlett et al., *supra*, at 734-36.

Will Violence End Patients' Access to Abortion?, 76 Med. Econ. 51, 52-54 (1999).

[15] David A. Grimes, *Clinicians Who Provide Abortions: The Thinning Ranks*, 80 Obstet. & Gynec. 719, 721 (1992); *see also* Jones & Kooistra, *supra*, at 46; Finer & Henshaw, *supra*, at 13-14.

Less than 0.3% of abortion patients in the United States experience a complication that requires hospitalization, and well-accepted statistics show that an induced abortion is far safer than carrying a pregnancy to term and giving birth.[16] However, induced abortion is safest and has the lowest risk of complications when performed early in a pregnancy.[17]

From the medical point of view, once a woman has made the decision to have an abortion, the sooner the procedure is performed the better, as "[the] risk of death increase[s] *exponentially* with increasing gestational age." Bartlett et al., *supra*, at 731 (emphasis added). For each additional week of gestation, there is a 38% increase in risk of death, *id.*, and most abortion-related mortalities could be prevented if women obtained their abortions prior to 8 weeks of pregnancy. Dehlendorf & Weitz, *supra*, at 417. Accordingly, "*there are significant health conse-*

---

[16] Gold & Nash, *TRAP Laws*, *supra*, at 7; Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215, 215 (2012). The mortality rate for all legal, induced abortions performed from 1998 to 2005 was 0.6 per 100,000 procedures, whereas the mortality rate for live birth during that same time period was 8.8 deaths per 100,000 births—approximately 14 times higher than that associated with abortion. *Id.* at 216; *see also* Bartlett et al., *supra*, at 734 ("In the 25 years following the legalization of abortion in 1973 the risk of death from legal abortion declined dramatically by 85%, from 4.1 to 0.6.") (citation omitted). The risk of dying from a legal abortion in the first trimester—when almost nine in 10 abortions in the United States are performed—is no more than four in a million. Gold & Nash, *TRAP Laws*, *supra*, at 7.

[17] Dehlendorf & Weitz, *supra*, at 417; Gold & Nash, *TRAP Laws*, *supra*, at 7.

quences for delayed access to care."[18] *Id.* (emphasis added).

The importance of prompt access to care is by no means limited to abortion. Other reproductive health services are likewise safer and more effective if delivered promptly. For example, early and regular prenatal care is a well-accepted strategy for improving health outcomes of pregnancy for mothers and infants.[19] Regular screenings for breast cancer and cervical cancer are essential to maximizing the likelihood of detecting the disease early when treatment options are greater and survival rates are significantly improved.[20] Delay resulting from patient

---

[18] An unwanted delay between the abortion decision and the abortion procedure can also have adverse health consequences, because such delay is a significant source of distress for many women. Jocelyn A. Handy, *Psychological and Social Aspects of Induced Abortion*, 21 Brit. J. Clin. Psychol. 29, 37 (1982).

[19] *See, e.g.*, Reagan G. Cox et al., *Prenatal Care Utilization in Mississippi: Racial Disparities and Implications for Unfavorable Birth Outcomes*, 15 Matern. Child Health J. 931, 931, 934-36 (2011); Sarah Partridge et al., *Inadequate Prenatal Care Utilization and Risks of Infant Mortality and Poor Birth Outcome: A Retrospective Analysis of 28,729,765 U.S. Deliveries over 8 Years*, 29 Am. J. Perinatol. 787, 789-93 (2012).

[20] *See, e.g.*, ACOG Comm. on Practice Bulletins-Gynecology, ACOG Practice Bulletin No. 122, *Breast Cancer Screening* (Aug. 2011); Lynn A. Gloeckler Ries et al., SEER Survival Monograph, *Cancer Survival Among Adults: U.S. SEER Program, 1988-2011*, *Patient and Tumor Characteristics* 102-04, 114-16 (2007) (showing significant differences in 5-year relative survival rates for female breast cancer and cervical cancer by stage at time of diagnosis), ACOG Comm. on Practice Bulletins-Gynecology, ACOG Practice Bulletin No. 131, *Screening for Cervical Cancer* (Nov. 2012) ("approximately 60% of diagnoses of cervical cancer are a result of inadequate screening"); Bengt Andrae et al., *Screening and Cervical Cancer Cure: Population Based Cohort Study*, 344 BMJ e900 (Mar. 1, 2012).

or provider fear of encountering harassment outside of reproductive health care facilities causes worse outcomes in each of these situations.

Moreover, an increased likelihood of delay is not the only adverse effect of harassment at the entrance to reproductive health facilities. As the record in this case reflects, the harassment that patients in Massachusetts endured before the challenged law was enacted gave rise to substantial stress for patients. *E.g.*, J.A. 21-22, 41, 51. The stress caused by confronting harassment simply compounds the stress that already exists for patients facing the emotional complexities of an unwanted pregnancy or the need for medical treatment.[21] Research shows that direct physical approaches—*i.e.*, "being stopped by protesters"—increases the risk of stress for patients "compared to seeing protesters only." Foster et al., *Effect of Abortion Protesters*, *supra*, at 86. For patients who are already in a state of emotional vulnerability, harassment in the form of close physical proximity outside a reproductive health care facility can have a profound negative effect on patients' psychological and physiological health.[22]

---

[21] *See, e.g.*, Nancy E. Adler et al., *Psychological Factors in Abortion*, 47 Am. Psychologist, 1194, 1197 (1992); *see also, e.g.*, J.A. 86.

[22] *See* Catherine Cozzarelli & Brenda Major, *The Effects of Anti-Abortion Demonstrators and Pro-Choice Escorts on Women's Psychological Responses to Abortion*, 13 J. Soc. Clin. Psychol. 404, 406 (1994) ("anti-abortion demonstrators have a visible adverse impact on women entering picketed clinics," and "some women show obvious signs of psychological stress (including sweating, palpitations, anger, crying, or hyperventilation) after being subjected to anti-abortion demonstrators"); *see also* Warren M. Hern, *Proxemics: The Application of Theory to Conflict Arising From Antiabortion Demonstrations*, 12 Population & Env't 379, 380 (1991) (patients who encountered "even

Such stress-related symptoms complicate medical procedures and increase the attendant risks. *See Hern*, *supra*, at 380. "In general, high preoperative fear or stress is predictive of a variety of poorer outcomes, including greater pain, longer hospital stays, more postoperative complications, and poorer treatment compliance." Janice K. Kiecolt-Glaser et al., *Psychological Influences on Surgical Recovery: Perspectives From Psychoneuroimmunology*, 53 Am. Psychologist 1209, 1214 (1998). If a patient becomes agitated before or during an induced abortion, "she could easily experience serious complications of the abortion that would be extremely unlikely under

---

a few picketers …. would enter the clinic's waiting room crying[,] shaking from fear and anger," and demonstrating clear signs of "psychophysiological stress").

Amicus Cato Institute's claim that women seeking abortions are not upset by protesters, Cato Institute Br. 16, is not supported by the sole article it cites, Foster et al., *Effect of Abortion Protesters*, *supra*, which only considered the continued effects of protesters on women one week after they obtained abortions. *Id.* at 82. The Foster article did not address the emotional impact of protesters on women immediately prior to, or at the time of, the procedure and, more importantly, as the authors explicitly noted, the Foster study did not include women who were so upset by the protesters that they left the facility without receiving the health services they sought to obtain. *Id.* at 86.

That *amicus* Cato Institute's claim is a fallacy is further demonstrated by the accounts of the medical providers who have comforted and counseled patients who arrive at the facilities distraught, scared and even panicked, as a result of their encounters with protesters. *See, e.g.*, J.A. 14 (clinic director describing patients "becom[ing] panicked while attempting to avoid the protesters"); *id.* at 85 (volunteer describing patients being "terrified to even walk into the clinic"); *id.* at 86 (similar).

other circumstances." Hern, *supra*, at 381.[23] Additionally, research has shown that the upsetting experience of encountering harassment from protesters is correlated to increased levels of depression 30 minutes after an abortion; "the more intense the antiabortion activity outside the clinic when a woman tried to enter, the more depressed she was post-abortion."[24]

C. The Challenged Fixed Buffer Zone Protects Patients From The Adverse Effects Of Harassment Without Regard To The Content Of Protesters' Speech.

By protecting patients' safe access, unhindered by harassment, to reproductive health facilities, the Act serves both to reduce the likelihood that patients will delay or forgo treatment, and to reduce the adverse effects on patients from the stress of direct physical confrontation by protesters. Moreover, it does so

---

[23] Some of these complications stem from the use of anesthesia. Patients exhibiting signs of heightened anxiety often require higher levels of sedation, and increasing the level of sedation in turn increases the risk of the surgery. *See* Kiecolt-Glaser et al., *supra*, at 1214; Janice Abbott & Paul Abbott, *Psychological and Cardiovascular Predictors of Anaesthesia Induction, Operative and Post-operative Complications in Minor Gynaecological Surgery*, 34 Brit. J. Clin. Psychologist 613, 621-22 (1995) ("[A] person's pre-operative emotional, cognitive and cardiovascular state influences the induction of anaesthesia, operative problems and short-term recovery …. High levels of heart rate and blood pressure immediately prior to the induction of anaesthesia is a clinically undesirable state which determines induction, operative and post-operative outcomes.").

[24] Catherine Cozzarelli & Brenda Major, *The Impact of AntiAbortion Activities on Women Seeking Abortions in The New Civil War: The Psychology, Culture and Politics* 81, 93 (Linda J. Beckman & S. Marie Harvey eds., 1998).

without regard to the content of anyone's speech, and without unduly burdening speech.

As respondents have demonstrated, the Massachusetts legislature designed the challenged Act not to regulate speech related to abortion, but to confront a particular problem of conduct: harassment and obstruction centered around the entrances to reproductive health clinics. Resp. Br. 12-15. Both the record in this case and the medical literature collected above make clear that that is a unique problem—one that does not apply in other medical contexts. Moreover, the significance of harassment at the clinic door is greater for reproductive health than many other medical facilities in two ways: Timely access to care is particularly essential to patient health, and harassment or obstruction at the clinic door creates particularly adverse effects, in the sphere of reproductive health. The Massachusetts legislature's focus on reproductive health clinics is thus entirely appropriate, and does not convert the content-neutral terms of the statute into a *de facto* content-based restriction. *See, e.g.*, *Ward*, 491 U.S. at 791 ("The government's purpose is the controlling consideration. A regulation that serves purposes unrelated to the content of expression is deemed neutral, even if it has an incidental effect on some speakers or messages but not others."); *Burson v. Freeman*, 504 U.S. 191, 207 (1992) (plurality) ("The First Amendment does not require States to regulate for problems that do not exist.").

Moreover, the statute is narrowly tailored to promote the State's substantial interest in health and safety. Patients who desire to communicate with protesters remain free to do so outside the buffer zone or in any other context. At the same time, the Act's fixed buffer zone protects those most vulnerable

patients whose health would be adversely affected by being subjected to harassment in the immediate vicinity of clinic entrances, or who would delay or forgo treatment in order to avoid such harassment. As noted above, harassment through direct physical approaches—of the sort that occurred under the prior Massachusetts law providing for floating buffer zones, *e.g.*, J.A. 41, 51, 86, 123—is more likely to cause harmful stress to patients. By contrast, the presence of protesters, such as those located outside the fixed buffer zone under the current Act, is less likely to do so. *See* p. 16-17, *supra*. The Act reflects the Massachusetts legislature's considered judgment—supported by decades of experience—that *only* a fixed buffer zone can effectively increase public safety at reproductive health facilities and mitigate the adverse effects of harassment at clinic entrances on patients while respecting the right of protesters to communicate their message, whatever it may be. The Act is thus narrowly tailored to promote the important state interest of patient health and safety. *See Ward*, 491 U.S. at 799 ("[T]he requirement of narrow tailoring is satisfied 'so long as the … regulation promotes a substantial government interest that would be achieved less effectively absent the regulation.'") (omission in original) (quoting *United States v. Albertini*, 472 U.S. 675, 689 (1985)).

II. CLINICAL PROVIDERS OF REPRODUCTIVE HEALTH SERVICES ARE ETHICALLY OBLIGATED TO, AND DO, PROVIDE COMPREHENSIVE AND ACCURATE INFORMATION REGARDING RISKS ASSOCIATED WITH, AND ALTERNATIVES TO, ABORTION.

Petitioners' *amici* contend that the Act does not promote women's health and safety—and, improb-

ably, that the Act undermines health and safety—because it reduces women's access to the supposedly "neutral information" about abortion that is allegedly provided only by protesters. Women Who Attest Br. 21; Bioethics Defense Fund Br. 18; Eagle Forum Br. 7-11. This contention is doubly incorrect. First, physicians are ethically obligated to—and do—ensure that their patients provide fully and comprehensively informed consent before undergoing any procedure, including induced abortion. And second, the "neutral" information to which petitioners' *amici* refer is not only not "neutral," but instead medically inaccurate and highly misleading. In short, petitioners' *amici*'s unsupported arguments do not diminish the important State interests served by the challenged law.

A. Informed Consent.

Reproductive health clinicians provide comprehensive and accurate medical information about induced abortion, as well as alternatives to abortion, to all patients before any procedure is performed. For example, ACOG's official policy is that "[a] pregnant woman should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion. The information conveyed should be appropriate to the duration of the pregnancy."[25] Assuring that

---

[25] ACOG, *College Statement of Policy: Abortion Policy* 2, ¶ 5 (reaffirmed July 2011); *see also, e.g.*, NAF, *2013 Clinical Policy Guidelines* 3 (2013), *available at* http://www.prochoice.org/pubs_research/publications/documents/2013NAFCPGsforweb.pdf ("Obtaining informed consent and assessing that the decision to have an abortion is made freely by the patient are essential parts of the abortion process."). NAF's 2013 Clinical Policy Guidelines likewise state: "The practitioner must ensure that appropriate personnel have a discussion with the patient in which accurate information is provided about the abortion

patients provide fully informed consent is one of physicians' most profound ethical obligations.[26] Moreover, the obligation to provide such information is mandated by statute or case law in every state.[27]

Accordingly, the medical providers who work at reproductive health care facilities thoroughly and accurately educate their patients about the risks and benefits of induced abortion, as well as its alternatives. Physicians and other clinicians are not advocates for abortion, *see, e.g.*, Pet. Br. 27-28; Women Who Attest Br. 11, 21-22, but medical professionals with legal and ethical obligations to ensure that their patients possess full and accurate knowledge of the risks from and alternatives to induced abortion and other reproductive health treatments.

There is thus no merit to petitioners' *amici*'s claim that "misrepresentations [are] often made to women seeking abortion who may be told that pregnancy termination is simply a matter of removing a 'clump

---

procedure and its alternatives, and the potential risks and benefits. The patient must have the opportunity to have any questions answered to her satisfaction prior to intervention." *Id.*

[26] *See* ACOG, *Code of Professional Ethics, Code of Conduct* ¶ 5 (July 2011), *available at* https://www.acog.org/~/media/Departments/National%20Officer%20Nominations%20Process/ACOGcode.pdf?dmc=1&ts=20120911T1242523048; NAF, *Ethical Principles for Abortion Care* 2 (2011), *available at* http://www.prochoice.org/pubs_research/publications/downloads/about_naf/NAF_Ethical%20_Principles.pdf; *see also* Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 Guttmacher Pol'y Rev. 6, 12 (2007).

[27] Chinue Turner Richardson & Elizabeth Nash, *Misinformed Consent: The Medical Accuracy of State-Developed Abortion Counseling Materials*, 9 Guttmacher Pol'y Rev. 6, 6 (2006).

of cells.'" Bioethics Defense Fund Br. 16 & n.15.[28] Similarly, petitioners' *amici*'s claim that "the last and perhaps only" chance for a woman to receive the information that petitioners and their *amici* seek to share, due to the lack of a "Woman's Right to Know" law in Massachusetts, is also unavailing. *Id.* at 18. To the contrary, a recent analysis of state-mandated "informed consent" materials from the 22 states that were identified as having such state-developed materials revealed that "although most of the information in the materials about abortion comports with recent scientific findings and the principles of informed consent, some content—specifically, that which is related to breast cancer, psychological impact, fetal pain and referrals for additional care—

---

[28] The only authority cited to support this unfounded assertion is an online article from 1990 wherein an individual woman is quoted as claiming that she was misled by an unidentified abortion counselor at an undisclosed location on an unknown date. *See* Monte Harris Liebman, *Fetal Development Information: An Essential Aspect of Informed Consent*, 3 Abortion Decision Making (1990), *available at* http://lifeissues.net/writers/air/air_vol3no1_1990.html. In fact, the woman's quotation is taken from a regional newspaper from *1977*, and relates to an alleged incident that occurred in *1974*. *See* Milton Rockmore, *Are You Sorry You Had An Abortion?*, St. Petersburg Indep., Sept. 5, 1977, at 15-A.

As discussed above, the medical providers at reproductive health care facilities are professionals who comply with their legal and ethical obligations to provide women with accurate information about the abortion procedure, any medically accepted alternatives that might be appropriate for the patient, and medically accurate information about potential risks and benefits of the abortion procedure and its alternatives. NAF, *Ethical Principles for Abortion Care*, *supra*, at 2. There is absolutely no evidence to support petitioners' *amici*'s meritless claim to the contrary.

is either misleading or altogether incorrect."[29] Accord-ingly, as leading organizations of medical profession-als, the medical associations adamantly oppose any legislatively mandated, procedure-specific informed consent requirements as improper interference with the confidential doctor-patient relationship, and unnecessary intrusions into personal medical decis-ions that delay care and interfere with a woman's ability to make a decision for herself, with the counsel of her health care provider. *See* ACOG, *Statement of Policy: Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013), *available at* http://www.acog.org/~/media/Statements%20of%2Policy/Public/2013LegislativeInterference.pdf; AMA, *H-5.989 Freedom of Communication Between Physicians and Patients*, *available at* http://www.ama-assn.org/resources/doc/PolicyFinder/policyfiles/HnE/H-5.989.HTM (last viewed Nov. 20, 2013); *see also* Steven E. Weinberger et al., *Legislative Inter-ference with the Patient-Physician Relationship*, 367 New Eng. J. Med. 1557 (2012) (five professional societies representing the majority of U.S. physicians providing clinical care declaring their opposition to such

---

[29] Richardson & Nash, *supra*, at 7; *see also* Heather Gould et al., *Predictors of Abortion Counseling Receipt and Helpfulness in the United States*, 23 Women's Health Issues e249, e254 (2013) ("[W]omen receiving care at the facilities required to implement the [state, mandated counseling] laws were significantly less likely to report finding counseling helpful[, which] suggests that these laws may reduce the quality of care or, at the very least, may be having a negative effect on some women's counseling experiences."); *id.* ("Laws requiring the provision of state-mandated, abortion-specific information beyond what is includ-ed under existing informed consent laws do not seem to be helpful to women presenting for abortion care.").

laws, which affect all physicians across different areas of specialization).

B. Petitioners' *Amici*'s Medically Inaccurate Assertions.

Additionally, much of the supposedly "neutral" information petitioners' *amici* argue will not be provided by clinicians is medically inaccurate and highly misleading. Thus, whatever supposed impact the challenged law may have on patients' access to such information from protesters does not undermine the important State interests in promoting health and safety served by the Act.

1. Induced Abortion Does Not Lead To Psychological Harms.

Petitioners' *amici* assert that there is a "direct correlation between a woman's history of abortion and her risk of anxiety, depression, suicide, drug dependence, and poor mental health," and claim that women who undergo induced abortions have a higher incidence of each of these psychological harms than either the general population or women who have a live birth. *See* Women Who Attest Br. 27 & n.14, 12 n.3; Eagle Forum Br. 8; Bioethics Defense Fund Br. 17 n.17. These claims are wholly unsupported by the scientific evidence.

In 2006, the American Psychological Association (APA) conducted its second comprehensive review of the existing scientific literature relating to psychological response after abortion, and concluded: "[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 preg-

nancy."[30] The APA Task Force further reported that, while "some women do experience sadness, grief, and feelings of loss following termination of a pregnancy, and some experience clinically significant disorders, including depression and anxiety," there is "*no evidence* sufficient to support the claim that an observed association between abortion history and mental health was caused by the abortion per se, as opposed to other factors." APA Task Force Report, *supra*, at 4 (emphasis added); *see also* Brenda Major et al., *Abortion and Mental Health: Evaluating the Evidence*, 64 Am. Psychologist 863, 885 (2009) ("2009 Update") (updating the APA Task Force Report and reaching the same conclusion: "the claim that observed associations between abortion history and a mental health problem are *caused by* the abortion per

---

[30] Brenda Major et al., *Report of the APA Task Force on Mental Health and Abortion* 4 (2008), *available at* http://www.apa.org/pi/women/programs/abortion/mental-health.pdf ("APA Task Force Report") (emphasis in original). The APA Task Force Report continues to stand as the benchmark review of this body of literature. Although a 2011 meta-analysis claimed to find flaws in the report's findings, Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199 Brit. J. Psychiatry 180, 180, 185 (2011), this meta-analysis itself has been resoundingly criticized by the scientific community. *See, e.g.*, Acad. of Med. Royal Colls., *Induced Abortion and Mental Health* 14 (Dec. 2011), *available at* http://www.nccmh.org.uk/reports/ABORTION_REPORT_WEB%20FINAL.pdf ("Academy of Medical Royal Colleges Report") (observing, with respect to the 2011 Coleman meta-analysis, that "[d]etails of the search strategy and the number of papers retrieved in the search were not provided, nor was it clear why certain papers and outcomes were excluded"; studies relied on were "not required to control for mental health problems prior to the abortion"; and "[p]revalence rates of mental health problems and factors associated with poorer outcomes were not included in the review and meta-analysis").

se, as opposed to other factors, is not supported by the existing evidence."). Subsequent reviews of available evidence have reached nearly identical conclusions.[31]

The authorities cited by petitioners' *amici* either do not support their medically inaccurate claims to the contrary, or report conclusions based on studies with numerous, significant methodological flaws. *See, e.g.*, APA Task Force Report, *supra*, at 22-24 (identifying "a number of methodological limitations [in the Reardon study cited by *amicus* Eagle Forum] that make it difficult to interpret the results," including "differential exclusion of women with subsequent abortions from the delivery group but not from the abortion group, a sampling strategy that both advantaged the delivery group and rendered generaliz-

---

[31] *See, e.g.*, Gail Erlick Robinson et al., *Is There an "Abortion Trauma Syndrome"? Critiquing the Evidence*, 17 Harv. Rev. Psychiatry 268, 276 (2009) ("The most well controlled studies continue to demonstrate that there is no convincing evidence that induced abortion of an unwanted pregnancy is per se a significant risk factor for psychiatric illness."); Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 448-49 (2008) (explaining that all of the studies finding a link between induced abortion and psychological harm suffered from "the most flawed methodology"); *see also* Julia R. Steinberg & Lawrence B. Finer, *Examining the Association of Abortion History and Current Mental Health: A Reanalysis of the National Comorbidity Survey Using a Common-Risk-Factors Model*, 72 Soc. Sci. & Med. 72, 79-80 (2011) [hereinafter, Steinberg & Finer, *Examining the Association*] (explaining that "what drives the relation between abortion and mental health is factors common among women having abortions and women with poor mental health," and that, when prior risk factors were controlled in a nationally representative sample of women, there was no significant relation between abortion and mental health disorders).

ability of the findings problematic; lack of basic demographic information known to be associated with mental health, including marital status and race; lack of information about previous reproductive history, lack of adequate assessment of prior mental health history, lack of adequate information about co-occurring risks (e.g., health status, violence exposure), lack of information about critical characteristics of the abortion decision context (e.g., whether the pregnancy was initially intended and terminated because of fetal anomalies), and inclusion of covariates across analyses and studies that varied for unspecified reasons.").[32]

Accordingly, petitioners' *amici*'s claim that women seeking abortions are misled and inadequately informed about the purported link between induced abortion and psychological harm is unavailing; the weight of the reliable scientific evidence conclusively demonstrates that there is *no causal connection* between abortion and psychological harm.

---

[32] For specific criticisms of the myriad methodological flaws in each of the other studies relied on by petitioners' *amici*, see Julia R. Steinberg & Lawrence B. Finer, *Coleman, Coyle, Shuping, and Rue Make False Statements and Draw Erroneous Conclusions in Analyses of Abortion and Mental Health Using the National Comorbidity Survey*, 46 J. Psychiatric Res. 407 (2012); Academy of Medical Royal Colleges Report, *supra*, at 14-15, 18, 47, 153; Trine Munk-Olson et al., *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 New Eng. J. Med. 332, 336-37 (2011); Steinberg & Finer, *Examining the Association*, *supra*; Robinson et al., *supra*, at 275-76; 2009 Update, *supra*, at 871-78; Charles et al., *supra*, at 442, 444, 448; APA Task Force Report, *supra*, at 22-29.

2. Induced Abortion Does Not Cause Subsequent Preterm Birth.

Petitioners' *amici* also claim that induced abortion correlates with an increased risk of subsequent preterm birth, and assert that this "medical risk" is not disclosed to women seeking abortions. Eagle Forum Br. 8-9; Bioethics Defense Fund Br. 17 n.17. However, the most recent evidence confirms that there is no significant risk of preterm birth after one abortion.[33] The sources cited by petitioners' *amici* either do not support their inaccurate claims,[34] or contain conclusions based on earlier studies with significant methodological flaws.[35]

---

[33] *See* R. Klemetti et al., *Birth Outcomes After Induced Abortion: A Nationwide Register-Based Study of First Births in Finland*, 27 Human Reprod. 3315, 3317 (2012) (reporting that, after adjusting for mothers' background characteristics, risks of preterm birth were seen only among mothers with three or more surgical, induced abortions); *see also* Clare Oliver-Williams et al., *Changes in Association Between Previous Therapeutic Abortion and Preterm Birth in Scotland, 1980 to 2008: A Historical Cohort Study* (July 2013), *available at* http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001481 (reporting no association between previous abortion and preterm birth from 2000 onwards).

[34] *See* Jay D. Iams et al., *Primary, Secondary, and Tertiary Interventions to Reduce the Morbidity and Mortality of Preterm Birth*, 371 The Lancet 164, 165 (2008), *cited in* Eagle Forum Br. 9; Hanes M. Swingle et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses*, 54 J. Reprod. Med. 95, 103 (2009), *cited in* Eagle Forum Br. 9.

[35] *See* John M. Thorp et al., *Long-Term Physical & Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 Obstet. & Gynecol. Surv. 67, 74 (2003), *cited in* Bioethics Defense Fund Br. 17 n.17; Inst. of Med., *Preterm Birth: Causes, Consequences, and Prevention* 519 (July 2006), *cited in* Eagle Forum Br. 9; *see also* Klemetti et al., *supra*, at 3318, 3319 (discussing pervasive methodological flaws in earlier

3. Well-Established Medical Evidence Proves That There Is No Causal Connection Between Induced Abortion And Breast Cancer Risk.

Finally, petitioners' *amicus* Eagle Forum Education & Legal Defense Fund asserts that induced abortions correlate with a "significantly increased breast-cancer risk," and claims that this is one of the "medical risks" that is not disclosed to women seeking an abortion. Eagle Forum Br. 8-9. Notably, Eagle Forum is alone in this assertion.

The purported correlation between induced abortions and breast cancer risk has been thoroughly debunked by mainstream medical authority; exhaustive research from leading medical organizations and specialists in cancer research has conclusively determined that there is *no link* between abortion and breast cancer.[36] Other reviews of the existing scientific literature have reached the same con-

---

studies); Carol J. Rowland et al., *Answering Questions about Long-Term Outcomes in Management of Unintended and Abnormal Pregnancy: Comprehensive Abortion Care* 252, 255-57 (Maureen Paul et al. eds., 2009) (discussing the numerous methodological flaws in the studies analyzed by Thorp, *supra*).

[36] *See, e.g.,* Nat'l Cancer Inst. (NCI), *Summary Report: Early Reproductive Events and Breast Cancer Workshop* (Mar. 4, 2003, updated Jan. 12, 2010), *available at* http://www.cancer.gov/cancertopics/causes/ere/workshop-report ("Induced abortion is not associated with an increase in breast cancer risk."); NCI, *Abortion, Miscarriage, and Breast Cancer Risk*, *available at* http://www.cancer.gov/cancertopics/factsheet/Risk/abortion-miscarriage (Jan. 12, 2010) ("[T]he evidence overall still does not support early termination of pregnancy as a cause of breast cancer.").

clusion.[37] *Amicus* Eagle Forum's claim to the contrary is entirely without merit.[38]

CONCLUSION

The medical associations and their members share respondents' interest in promoting safe, timely, and unhindered access to health care. The challenged Act is a content-neutral measure narrowly tailored to promote that goal. For the foregoing reasons, and for the reasons set forth in respondents' Brief, this Court should affirm the judgment.

Respectfully submitted,

DANA A. JUPITER
SIDLEY AUSTIN LLP
787 Seventh Avenue
New York, NY 10019
(212) 839-5300

JACK R. BIERIG*
TACY F. FLINT
SIDLEY AUSTIN LLP
One South Dearborn Street
Chicago, Illinois 60603
(312) 853-7000
jbierig@sidley.com

Counsel for Amici Curiae

November 22, 2013 *Counsel of Record

---

[37] *See, e.g.*, Valerie Beral et al., *Breast Cancer and Abortion: Collaborative Reanalysis of Data from 53 Epidemiological Studies, Including 83,000 Women With Breast Cancer From 16 Countries*, 363 The Lancet 1007, 1014 (2004) ("[T]he totality of the worldwide epidemiological evidence indicates that pregnancies ending as either spontaneous or induced abortions do not have adverse effects on women's subsequent risk of developing breast cancer.").

[38] Significantly, the sole authority cited for this purported correlation was not a study of abortion and does not support *amicus* Eagle Forum's medically inaccurate claim. *See* Kim E. Innes & Tim E. Byers, *First Pregnancy Characteristics & Subsequent Breast Cancer Risk Among Young Women,* 112 Int'l J. Cancer 306, 309 (2004).