No. 19-1392

In the Supreme Court of the United States

THOMAS E. DOBBS, M.D., M.P.H., IN HIS OFFICIAL CAPACITY AS STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, ET AL.,
Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF *AMICI CURIAE* ROBIN PIERUCCI, M.D. AND LIFE LEGAL DEFENSE FOUNDATION IN SUPPORT OF PETITIONERS

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INTEREST OF AMICI[1]

Amica Robin Pierucci, M.D., has been a practicing neonatologist for over twenty years. She also has a master's degree in bioethics and completed the National Catholic Bioethics Center ethics certificate course. In addition to her full-time clinical duties within the neonatal intensive care unit of a large regional medical center, Dr. Pierucci remains active in perinatal palliative care, and ongoing performance improvement projects. She has multiple publications in peer and non-peer reviewed journals and has spoken around the country on multiple perinatal and ethical topics. As an expert in caring for extremely young premature babies, Dr. Pierucci understands that medical science provides only limited ability to determine neonatal survival and that such a determination is best made by trained and experienced neonatologists, not abortion providers.

Dr. Pierucci contests the disconnect between two standards of care that are allowed under current law: the same patient that neonatologists such as herself are ethically, medically, and legally responsible to treat, obstetricians can legally abort. As a non-lawyer, Dr. Pierucci offers no opinions on the legal and constitutional matters addressed in

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[1] This brief was wholly authored by counsel for amici Robin Pierucci, M.D. and Life Legal Defense Foundation. No party or counsel for any party made any financial contribution toward the preparation or submission of the brief. Counsel of record for the parties have filed blanket letters of consent for amicus briefs.

this brief, but she knows, as a biological fact, that a unique human with DNA that is different from both genetic parents is alive from conception. Though human beings look different at different stages of development (e.g., embryo, fetus, neonate, toddler, adolescent, adult, elderly), we are always human beings. Because we are always human beings, doctors always have the obligation to provide the best care possible, and the state will always have an equal obligation to safeguard all its members.

Amicus Life Legal Defense Foundation is a California non-profit 501(c)(3) public interest legal and educational organization that works to assist and support those who advocate in defense of life. Its missions is to give innocent and helpless human beings of any age, particularly unborn children, a trained and committed defense against the threat of death, and to support their advocates in the nation's courtrooms. Life Legal Defense Foundation follows the science in recognizing that life begins at the moment of conception and does not end until natural death. We litigate cases to protect human life, from preborn babies targeted by a billion-dollar abortion industry to the elderly, disabled, and medically vulnerable denied life-sustaining care.

Life Legal Defense Foundation sees in the present case an opportunity for this Court to right a 48-year-old wrong: the stripping from states of their authority to protect the lives of innocent human beings within their borders.

SUMMARY OF THE ARGUMENT

The Fifth Circuit held that the State of Mississippi's Gestational Age Act was an unconstitutional ban on pre-viability abortions, based on Supreme Court precedent in *Planned Parenthood v. Casey,* 505 U.S. 833 (1992). Pet. App. 13a. The lower court noted that, although viability "may differ with each pregnancy" and is dependent on a variety of factors, nonetheless "viability is the critical point." *Id*. at 12a & n. 34 (quoting *Colautti v. Franklin*, 439 U.S. 379, 388-89 (1979)). Because of this Court's precedents, the Fifth Circuit was forced to adhere to a legal framework this Court has never explained.

This Court first bestowed constitutional significance on the concept of viability in its abortion jurisprudence in 1973, at which time it stated, "Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." *Roe v. Wade*, 410 U.S. 113, 160 (1973). Within two decades, that already generous window has shifted by several weeks.[2]

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[2] *See, e.g., Isaacson v. Horne*, 716 F.3d 1213, 1233 (9th Cir. 2013) (Kleinfeld, J., concurring) ("Viability is the 'critical fact' that controls constitutionality. That is an odd rule, because viability changes as medicine changes. As *Planned Parenthood v. Casey* noted, between *Roe v. Wade* in 1973 and the time *Casey* was decided in 1992, viability dropped from 28 weeks to 23 or 24 weeks, because medical science became more effective at preserving the lives of premature babies.")

More importantly, as this brief will demonstrate, viability outside the womb depends on a variety of external and subjective factors, including individual physicians' competence, continuing education in neonatal medicine, personal and institutional philosophies of the provision of life-sustaining medical interventions, and physician attitudes toward disabilities and societal challenges.

Amici join Petitioner Dobbs in urging this Court to revisit the doctrine of viability and clarify that the State's interest in preserving the life of human beings in the womb is not contingent on the entirely unrelated question of the possible medical outcomes if the mother went into labor and delivered the child prematurely.

ARGUMENT

I. THE VIABILITY BENCHMARK WITH *ROE* CONFLICTS WITH THIS COURT'S DETERMINATION THAT THERE IS AN UNQUALIFIED COMPELLING STATE INTEREST IN PRESERVING HUMAN LIFE.

In *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990), this Court found that the state not only has an interest in protecting an individual's right to life, but also has "an interest in life" itself. *Id.* at 281. This holding was consistent with the Court's finding in *Roe v. Wade* that the state has an

"important and legitimate interest in protecting the potentiality of human life." *Roe*, 410 U.S. at 162. In both cases, the state's interest in life and in protecting human life were weighed against an individual's constitutional rights (right to due process and right to privacy, respectively).

But the similarity in the decisions ends there. In *Roe,* this Court determined that the state's interest in the protection of human life became compelling at viability, relying on the fetus' "capability of *meaningful life* outside the mother's womb." *Id.* at 163 (emphasis added). By contrast, in *Cruzan* this Court rejected the idea of "meaningful life," holding that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan*, 497 U.S. at 282; *Washington v. Glucksberg*, 521 U.S. 702, 729 (1997) (quoting *Cruzan* and holding that the state "has an *unqualified* interest in the preservation of human life") (emphasis added). *See also Britell v. United States*, 372 F.3d 1370, 1383 (Fed. Cir. 2004) ("It is not the role of the courts to draw lines as to which fetal abnormalities or birth defects are so severe as to negate the state's otherwise legitimate interest in the fetus' potential life."); *State v. Final Exit Network, Inc.*, 889 N.W.2d 296, 305-06 (Minn. Ct. App. 2016) ("The state has a compelling interest in the preservation of D.D.'s life, and the prevention of her suicide, regardless of her incurable [non-viable] condition.")

Limiting a state's ability to protect human lives to only those lives deemed "meaningful" because the arbitrary benchmark of viability has been reached is in direct conflict with this Court's 1990 holding in *Cruzan,* affirmed in *Glucksberg*, that a state need not qualify its interest in the preservation of human life before acting.

At issue in *Glucksberg* was the constitutionality of a Washington State law prohibiting assisting suicide. Plaintiffs challenged the law in reliance on *Casey*'s substantive due process reasoning, which placed "the most intimate and personal choices a person may make in a lifetime," those decisions "central to personal dignity and autonomy," beyond the reach of state regulation. 521 U.S. at 726 (quoting *Casey*, 505 U.S. at 851).

However, this Court declined to extend *Casey*'s amorphous holding to assisted suicide and medical decision-making about end-of-life care. The Court thus avoided the burden it took on in the area of abortion of first creating a framework limiting the ability of states to protect human life from deliberate destruction, and then spending decades refining and re-interpreting its own handiwork and specialized terminology (e.g., "viability," "large fraction," "substantial obstacle"), unmoored from the text of the Constitution.

This Court should overrule *Roe* and *Casey* and restore consistency to its decisions allowing states to protect human life regardless of the "meaningfulness" of that life as measured by judge-made standards.

II. THERE IS NO "POINT" IN PREGNANCY AT WHICH VIABILITY "OCCURS."

In *Roe*, this Court established viability as the "point" at which the state's interest in protecting human life becomes compelling, allowing the state to prohibit abortion. The Court defined its concept of viable as "potentially able to live outside the mother's womb, albeit with artificial aid." *Roe*, 410 U.S. at 160. This Court has *never* attempted to elaborate on why a child's ability or inability to survive outside the womb in the case of a premature delivery has any bearing on the state's interest in protecting the child from being killed inside the womb.

In *Roe*, the Court could not locate the so-called "point" of viability more precisely than to say that it is "usually placed about seven months (28 weeks) but may occur earlier, even at 24 weeks." *Id*. Thus, even as first enunciated by this Court, the "point" when viability "occurred" ranged across 10% of a full-term 40-week pregnancy.[3]

A few years later, this Court acknowledged that multiple factors go into the assessment of viability including "fetal weight, based on an inexact estimate of the size and condition of the uterus; the woman's general health and nutrition; *the quality of the available medical facilities*; and

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[3] Pregnancy is commonly dated from the onset of the mother's last menstrual period (LMP), approximately two weeks before conception. All gestational ages described in this brief are dated from LMP.

other factors." *Colautti*, 439 U.S. at 395-96 (emphasis added). In other words, there is no "point" of viability in pregnancy generally, or even in any particular pregnancy.

It gets worse. *Colautti* assigned the role of assessing the viability of the fetus to the "responsible attending physician," i.e., the abortion provider. However, to the extent any given abortion provider has relevant[4] specialized training, such training would be in obstetrics, not neonatology.

Abortion providers are unlikely to stay current on medical advancements for infant survival. The largest abortion provider networks, Planned Parenthood Federation of America and the National Abortion Federation, offer continuing medical education on clinical abortion procedure but not on infant viability.[5] The American College of Obstetrics and Gynecology follows the same pattern, focusing its continuing education offerings related to abortion on maternal care, not infant

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[4] Relevant as opposed to irrelevant specialized training in, e.g., radiology or ophthalmology. Cf. *June Medical Servs. L. L. C. et al. v. Russo*. 140 S. Ct. 2103, 2156 (2020) (abortion provider "hired a radiologist and ophthalmologist to do abortions").

[5] Among abortion providers, infant survival is a "complication" to be carefully avoided. *See, e.g.*, Liz Jeffries & Rick Edmonds, *Abortion: The Dreaded Complication*, THE PHILADELPHIA INQUIRER, Aug. 2, 1981, available at https://digitalcollections.library.cmu.edu/awweb/awarchive?type=file&item=693589.

viability.[6] *Neonatologists, not obstetricians, are the experts in viability*.

Unsurprisingly, the presence or absence of relevant specialized training makes a noticeable difference in how physicians practice as well. A 2015 study by the Indiana University School of Medicine found that obstetricians and neonatologists approach patient consultations in drastically different ways. Obstetricians tend to discuss topics like maternal health risks, while neonatologists focus on post-birth complications and treatment options for the baby.[7] Moreover, better survival rates for pre-mature babies are found when there is a health care team, treating and interacting with both mother and child, rather than a single physician.

Injecting further subjectivity into the viability calculus is the fact that a physician's personal philosophy and attitude regarding the provision of life-sustaining medical interventions impacts the actual survival rate of an infant. Study after study throughout the world has shown that offering immediate life-sustaining treatment to preemies is the largest modifiable factor affecting infant survival.[8]

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[6] American College of Obstetrics and Gynecology, Education and Professional Development Opportunities, https://www.acog.org/education-and-events/cme-program. (last visited July 22, 2021).

[7] B. Tucker Edmonds, F. McKenzie, et al., *Comparing Obstetricians' and Neonatologists' Approaches to Periviable Counseling,* 35 J. Perinatology 344 (May 2015).

[8] *See*, e.g., C. H. Backes et al., *Outcomes Following a Comprehensive Versus a Selective Approach for Infants*

Compare, for example, the difference in survival rates between two American neonatal facilities that work with extremely pre-term births. At the University of Iowa, physicians default to immediate, active medical treatment for all pre-term infants starting at 22 weeks' gestation. These physicians have long seen over a 60% survival rate for babies in the 22-week category. Physicians at the University directly credit their default-to-treatment strategy for the high survival rate.[9] By contrast, Providence Women and Children's Services of Oregon has a very different rate of survival for 22-week births. The physicians there have a facility-wide policy to not provide care for

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Born at 22 Weeks of Gestation, 39 J. Perinatology 39, 45 (2019) (hospital that routinely provided prenatal corticosteroid administration, neonatal resuscitation, and intensive care had substantially higher survival rates [53 percent] than the hospital that only selectively provided such care [8 percent]); J. Lorenz, *Management decisions in extremely premature infants*, 8 Seminars in Neonatology 475 (Dec. 2003), available at https://www.sciencedirect.com/science/article/abs/pii/S1084275603001180 ("There is significant variability between developed nations in the survival of extremely premature infants among cohorts born within perinatal tertiary care centres. This is, at least to some degree, the result of differences in the aggressiveness of obstetrical and neonatal management at these gestational ages.")

[9] Keith Barrington, *Active intervention at 22 weeks' gestation, is it futile?,* Neonatal Research Blog (Oct. 29, 2018), available at https://neonatalresearch.org/2018/10/29/active-intervention-at-22-weeks-gestation-isit-futile/; P. Watkins, J. Dagle, et al., *Outcomes at 18 to 22 Months of Corrected Age for Infants Born at 22 to 25 Weeks of Gestation in a Center Practicing Active Management,* 217 J. Pediatrics 52 (Feb. 2020).

any 22-week births, regardless of the parents' wishes, and thus they have a 0% survival rate. Moreover, because the success of treatment rate is also dependent on the experience of doctors, Providence has a much lower survival rate for 23-week births, as well – only 21%, compared to the national average of 38%.[10]

Clearly, the willingness of a neonatologists to provide active care to a baby after birth is a large factor in the child's chance of survival. The philosophy of defaulting against care lowers the survival rate, even for those children who *do* receive care. Conversely, when a facility defaults to immediate active medical intervention, survival rates of all treated neonates increase.[11]

The decision for or against medical care for premature babies is also shaped by attitudes toward disability. A November 2019 report from the National Council on Disability found:

> [m]any healthcare providers critically undervalue life with a disability. Providers often perceive people with disabilities to have a low quality of life when, in reality, most report a high quality of life and level of happiness, especially when they have access to sufficient healthcare services and supports. This misperception has negatively

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[10] Patrick J. Marmion, *Periviability and the 'god committee,'* 106 Acta Paediatrica 857 (Jun. 2017).

[11] M. A. Rysavy, A. Das, S. R. Hintz, J. B. Stoll, B. R. Vohr, et al., *Between-hospital variation in treatment and outcomes in extremely preterm infants*, 372 New Engl. J. Med. 1801 (2015).

> influenced physicians' medical futility decisions and resulted in the withdrawal of necessary medical care from people with disabilities.[12]

Such biases play a large role in setting institutional policies concerning whether to default against care in dealing with premature newborns, where there is an incorrect presumption that most if not all survivors will have severe disabilities. [13] In discussing treatment decisions with parents, doctors may use the word *futile* as code to mean that the survival of the baby is not worth the cost of the treatment. [14] Though various studies have shown that, when adjusted for future life expectancy, costs for NICU treatments are one-twentieth to one-tenth the costs of treatments for adult ICU patients,[15] some researchers and doctors are reluctant to allow that the quality of life obtained is worth the treatment costs. In doing so, a circular dynamic is established where anticipated poor prognoses lead to denial of medical care, which in turn leads to poor outcomes and low survival

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[12] National Counsel on Disability, *Medical Futility and Disability Bias*, Bioethics and Disability Series at 10 (Nov. 2019).

[13] P. Watkins, J. Dagle, et al., *Outcomes at 18 to 22 Months of Corrected Age for Infants Born at 22 to 25 Weeks of Gestation in a Center Practicing Active Management*, 217 J. Pediatrics 52 (Feb 2020). *See also* Patrick J. Marmion, *Decreasing disabilities by letting babies die*, 33 Issues in Law and Medicine 209 (Nov 2018).

[14] Barrington, *supra* n.9.

[15] Marmion, *supra,* n.10.

rates, reinforcing the data underlying the original poor prognosis.

The same circularity can manifest itself with regard to social conditions. In 2018, the University of Texas released a report of the disparity between infant mortality rates from zip code to zip code.[16] Though Texas had an infant mortality rate lower than the national average, troubling findings were uncovered when some zip codes were shown to have disparities as high as 12 times the rates of neighboring zip codes.[17] While all races had areas of high infant mortality, Black mothers had the highest rates of infant mortality overall.[18]

Even when a mother lives in a locale flooded with medical resources, a child's chance of survival can decrease if none of the local hospitals have enough experience in saving the lives of extremely premature babies. While generally speaking, the availability of a NICU in a geographical area increases chances of survival, when NICUs become more commonplace, each unit may see fewer individual cases of periviable births each year and, thus, have less experience in successfully treating these babies.[19] This can then perpetuate the myth that active treatment is "futile," which may indurate a physician's incorrect assumption that a

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[16] E. Nehme, et al., *Infant mortality in communities across Texas*, The University of Texas (2012).
[17] *Id.* at 7.
[18] *Id.* at 12.
[19] R. Patel, M. Rysavy, et al., *Survival of Infants Born at Periviable Gestational Ages*, 44 Clinics in Perinatology 287 (Jun. 2017).

child of a certain age or weight is simply non-viable.

In sum, this Court's assumption in *Roe*, *Colautti*, and *Casey* that there is a "point" in pregnancy when viability "occurs" is mistaken. Viability is a prediction, not a point. Even if there were such a point, it would be impossible for most doctors, especially abortion providers who rarely provide care for even uncomplicated pregnancies, to determine when it has been reached. Viability depends on myriad factors that vary and fluctuate both before *and after* birth, from the physical to the philosophical, from the personal to the institutional to the systemic.

III. ATTACHING CONSTITUTIONAL SIGNIFICANCE TO VIABILITY IS ILLOGICAL.

Why is any of this relevant to the case at issue? Mississippi's Gestational Age Act bans almost all abortions after 15 weeks' gestation. Petitioners have never suggested that an unborn child at 15 weeks' gestation is capable of sustained survival outside the womb under any circumstances, so why does uncertainty about the "point" of viability matter?

It matters because this Court has built a constitutional framework on an illogical and imaginary premise, undeserving of the benefit of *stare decisis*.

As noted above, this Court's explanation in *Roe* of the significance of the non-existent "point" of viability consisted simply of restating the definition of viability. *Colautti*, in turn, took the significance

of viability as a given, with no further attempt at explaining the logic behind it. Rather, *Colautti* emphasized that, because the point of viability (i.e., "a reasonable probability of the fetus' sustained survival outside the womb") is specific to each pregnancy and can be determined only by the attending physician, "neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability -- be it *weeks of gestation* or fetal weight or any other single factor -- as the determinant of when the State has a compelling interest in the life or health of the fetus." *Colautti,* 439 U.S. at 388-89 (emphasis added).

As the years rolled by, dissenting justices continued to point out the illogic of attaching constitutional significance to viability, e.g.,

> The governmental interest at issue is in protecting those who will be citizens if their lives are not ended in the womb. The substantiality of this interest is in no way dependent on the probability that the fetus may be capable of surviving outside the womb at any given point in its development, as the possibility of fetal survival is contingent on the state of medical practice and technology, factors that are in essence morally and constitutionally irrelevant. The State's interest is in the fetus as an entity in itself, and the character of this entity does not change at the point of viability under conventional medical wisdom. Accordingly, the State's interest, if compelling after

> viability, is equally compelling before viability.

Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 795 (1986) (White, J., dissenting). *See also*, *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 461 (1983) (O'Connor, J., dissenting) ("The choice of viability as the point at which the state interest in *potential* life becomes compelling is no less arbitrary than choosing any point before viability or any point afterward.")

However, the plurality in *Casey*, relying on *stare decisis*, reaffirmed the Court's commitment to the constitutional significance of viability, even while acknowledging that its original judgment might have been unsound:

> [V]iability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions. The soundness *or unsoundness* of that constitutional judgment in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity can somehow be enhanced in the future.

Casey, 505 U.S. at 860 (emphasis added). In affirming "*Roe*'s central holding," the *Casey*

plurality also restated *Roe*'s utterly false premise that viability "occurs" at a "point" or "moment" in pregnancy, and not just some point, but at a *medically discernible* point or moment.

The *Casey* plurality made a self-conscious attempt to explain the reasoning behind the viability standard:

> The second reason is that the concept of viability, as we noted in *Roe*, is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman.[20]

Casey, 505 U.S. at 870. However, as Justice Scalia pointed out,

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[20] This Court also half-heartedly offered a third justification for drawing a line a viability: "The viability line also has, as a practical matter, an element of fairness. In some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child." *Casey*, 505 U.S. at 870. However, given government data showing that over 90% of abortions are performed in the first trimester and over 98% by 20 weeks of pregnancy (CDC, *Abortion Surveillance – Findings and Reports* (2016), available at https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm), laches could be said, as a matter of fairness, to come into play well before viability.

> [t]he arbitrariness of the viability line is confirmed by the Court's inability to offer any justification for it beyond the conclusory assertion that it is only at that point that the unborn child's life "can in reason and all fairness" be thought to override the interests of the mother. . . . Precisely why is it that, at the magical second when machines currently in use (though not necessarily available to the particular woman) are able to keep an unborn child alive apart from its mother, the creature is suddenly able (under our Constitution) to be protected by law, whereas before that magical second it was not? That makes no more sense than according infants legal protection only after the point when they can feed themselves.

Id. at 989, n.5 (Scalia, J., concurring and dissenting).[21]

With unconscious irony, the *Casey* plurality distinguished the freedom of legislatures to "draw lines which appear arbitrary without the necessity of offering a justification" from its own duty to justify its line-drawing. *Id.* at 870. But no legal scholar has found this Court's justification

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[21] A closer analogy than Justice Scalia's might be found in the concept of "pool safe," defined as the stage of development at which a child has a reasonable chance of survival if he or she accidentally falls into a swimming pool. Analogizing to viability, the state may act to protect the life of a pool-safe child, but may not act to protect a child who is not pool safe from being held face down in a bucket of water until dead.

persuasive, much less compelling.[22] This Court's fictitious "point of viability" line has less justification than Mississippi's line of 15 weeks, based as the latter is on the science of fetal development, preservation of maternal health, and protection of medical ethics. *Compare* Pet. Cert. at 15-20 (examining viability standard) *with id.* at 20-26 (justification for 15-week abortion limit).

IV. ATTACHING CONSTITUTIONAL SIGNIFICANCE TO VIABILITY IS UNWORKABLE.

In further justification of its decision to impose constitutional weight on the concept of viability, the *Casey* plurality asserted, "Liberty must not be extinguished for want of a line that is clear," and "there is no line other than viability which is more workable." *Casey*, 505 U.S. at 869-70.

This Court has never revoked or modified *Colautti*'s holding that an abortion ban based on gestational age is impermissible, and that determination of viability must be left to the judgment of the "responsible attending" abortion provider. The district court below affirmed this

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[22] *See*, e.g., Paul Benjamin Linton and Maura K. Quinlan, *Does Stare Decisis Preclude Reconsideration of Roe v. Wade? A Critique of Planned Parenthood v. Casey*, 70 Case W. Res. L. Rev. 283 (2019), available at https://scholarlycommons.law.case.edu/caselrev/vol70/iss2/9 for a detailed critique of the viability standard.

point: "Viability is not the same for every pregnancy. It is a determination that must be made by a trained medical professional on a case-by-case basis." Pet. App. 44a.

As demonstrated above, viability is not a line, or a point, or a moment in a pregnancy. Much less is it a line, point, or moment discernible by human or medical skill. Viability is less "workable," and certainly gives less notice, than a limit on abortion stated in weeks of gestational age justified by factors such as anatomical development, the capability of feeling pain, or the presence of a detectable heartbeat. And indeed, late-term abortion providers use gestational age, not viability, to advertise their services. Amici are unaware of any abortion provider offering abortion "up to viability" or "prior to viability" or "post-viability only for maternal health indications." *See, e.g.*, https://www.abortionclinics.com/clinic-category/ late-abortion-clinics/ (last visited July 19, 2021) (late-term abortions advertised as "up to" and "beyond" 25 or 27 or 32 weeks' gestation). Abortion providers do not claim for themselves the ability to assess viability that this Court entrusted to them in *Colautti*.[23]

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[23] Even if abortion providers possessed such skills of prognostication, there is nevertheless no call for them, even in states that try to place limits on post-viability abortions. As with the assessment of viability, the Court entrusted to the "appropriate medical judgment" of the "responsible physician" the assessment of a wide-ranging list of considerations ("emotional, psychological, familial") that states must allow as justifications for a post-viability abortion. *Roe*, 410 U.S. at 164-65; *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

Viability as determined by the abortion provider is a "workable" standard only in the sense that a state abortion restriction anchored in viability as assessed by the abortionist is unenforceable, and thus does not give rise to difficult cases. It "works" for the abortion industry, but not for the state trying to protect unborn children.

V. THIS COURT MADE VIABILITY THE TIPPING POINT IN A BALANCING OF IMPONDERABLE VALUES.

In his concurrence in *June Medical Services, L.L.C. v. Russo*, 140 S. Ct. 2103 (2020), the Chief Justice wrote:

> In this context, courts applying a balancing test would be asked in essence to weigh the State's interests in "protecting the potentiality of human life" and the health of the woman, on the one hand, against the woman's liberty interest in defining her "own concept of existence, of meaning, of the universe, and of the mystery of human life" on the other. There is no plausible sense in which anyone, let alone this Court, could objectively assign weight to such imponderable values and no meaningful way to compare them if there were . . . . Pretending that we could pull that off would require us to act as legislators, not judges, and would result in nothing other than an

> "unanalyzed exercise of judicial will" in the guise of a "neutral utilitarian calculus."

June Medical Services, 140 S. Ct. at 2136 (Roberts, C.J. concurring) (quoting *Roe*, 410 U.S. at 162, and *Casey*, 505 U.S. at 851).

The context of the Chief Justice's statement was whether *Casey*'s "undue burden standard requires court to weigh the law's asserted benefits against the burdens it imposes on abortion access." *Id*. (internal quotations and citations omitted). But the Chief Justice's observations stand as an indictment of both *Roe* and *Casey* at their core.

In both *Roe* and *Casey*, the Court used the imaginary "point" of viability as a tipping point in a "grand balancing" (*Id*. at 2135; quotation marks omitted) of imponderable values of human life and liberty, among others. *See, e.g*., *Roe*, 401 U.S. at 165 ("This holding, we feel, is consistent with the relative weights of the respective interests involved, with the lessons and examples of medical and legal history, with the lenity of the common law, and with the demands of the profound problems of the present day"); *Casey*, 505 U.S. at 846 (plurality) ("Before viability the State's interests are not strong enough to support a prohibition of abortion"); *Id*. at 871 ("The *Roe* Court recognized the State's 'important and legitimate interest in protecting the potentiality of human life.' The weight to be given this state interest, not the strength of the woman's interest, was the difficult question faced in *Roe*.")

In *Roe* and *Casey*, this Court called the mythical "point" of viability into service specifically

and consciously to accomplish its goal of deciding as judges, once and for all, matters that the Chief Justice correctly stated should be left to the legislative process.

VI. THIS COURT'S LINE-DRAWING WOULD BE BETTER EMPLOYED IN DETERMINING THE POINT AT WHICH THE STATE *MUST* PROTECT A CHILD IN THE WOMB.

As discussed *infra*, this Court has never adequately explained why viability is of constitutional significance. In *Roe*, this Court declared,

> With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. *This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb.* State regulation protective of fetal life after viability thus has both logical and biological justifications. If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother.

Roe, 410 U.S. at 163-64 (emphasis added). Of this particular passage, one commentator noted, "[T]he

Court's defense seems to mistake a definition for a syllogism."[24]

A very different "logical and biological" conclusion about constitutional rights could be drawn from the definition of viability:

> After viability, when a human being is capable of meaningful life outside the mother's womb, the State *must*, consistent with its obligations under the Fourteenth Amendment, protect this human from being deliberately killed to the same extent it protects older human beings.

Such a conclusion is at least as, and likely more, plausible than *Roe*'s declaration that only after the unborn child could survive outside the womb, a state may, or may not, prohibit his or her deliberate destruction, subject to broad exceptions effectively gutting even this limited permission.

The decades following Roe have seen a near-universal rejection of this Court's reasoning (if not the result) in *Roe* and *Casey* finding a right to abortion somewhere in the Constitution.[25]

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[24] John Hart Ely, *The Wages of Crying Wolf: A Comment on* Roe v. Wade, 82 Yale L. J. 920, 924 (1973). *See also id.* at 924 n.40 ("This line is drawn beyond quickening, beyond the point where any religion has assumed that life begins, beyond the time when abortion is a simple procedure, and beyond the point when most physicians and nurses will feel the procedure is victimless.")

[25] A former clerk for Justice Blackmun relates an anecdote concerning the draft decision in *Roe* circulated among the justices. A clerk for one of the other justices, noting the length

Additionally, the Court's decision to use viability as a line of demarcation is, as shown above, indefensible. On top of these errors, many legal scholars have also rejected this Court's holding that the unborn are not persons under the Fourteenth Amendment. *See, e.g.*, Joshua J. Craddock, Protecting Prenatal Persons: Does the Fourteenth Amendment Prohibit Abortion? 40 Harv. J. L. & Pub. Policy 539 (2017).[26]

These scholars recognize that establishing the principle of Fourteenth Amendment personhood for the unborn does not dictate a single, judicially-imposed result for all states, all statutes, or all pregnancies. Paulsen, at 70 ("That the word 'person,' as used in the Constitution in the Fifth and Fourteenth Amendments, is broad enough to embrace living but unborn humans does not itself say anything specific about what the precise legal regime must be with respect to abortion"); Finnis, *Born and Unborn: Answering Objections to Constitutional Personhood*, First Things, April 9,

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of the draft, called Blackmun's chambers "to ask where he should look for the crux of its legal analysis." He was directed to a particular section, but some minutes later he called again. "'I read what you suggested' he said. 'So where's the analysis?'" Edward Lazarus, *Closed Chambers* 366 (1998).

[26] *See also* John D. Gorby, *The "Right" to an Abortion, the Scope of Fourteenth Amendment "Personhood," and the Supreme Court's Birth Requirement*, 4 S. Ill. U. L.J. 1 (1979); Charles I. Lugosi, *Conforming to the Rule of Law: When Person and Human Being Finally Mean the Same Thing in Fourteenth Amendment Jurisprudence*, 22 Issues L. & Med. 119 (2007); Michael Stokes Paulsen, *The Plausibility of Personhood*, 74 Ohio St. L.J. 13 (2013).

2021 (the place of the unborn in any "rationally defensible scheme of justice . . , given their situation and circumstances, is not simple but ought not to be denied by simply conferring on those in a position to destroy them the lawful authority to do so.")

Without excluding other outcomes, recognition that the unborn are persons under the Fourteenth Amendment should at least suffice to end our national scandal of legally unrestricted abortions at any gestation. Under the current abortion framework, even in those states that choose to make some effort to protect children capable of "meaningful life outside the mother's womb," abortion providers at most have to fill out some paperwork documenting which of the many justifications falling under "maternal health" could be applicable to the particular patient.[27]

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[27] While this Court did not include fetal abnormality as a type of "maternal health" abortion, it is the most common justification publicly raised by abortion advocates for not restricting second and third trimester abortions. However, fetal abnormality is present in only a small percentage of later abortions. *See e.g.*, Mary Duenwald, "Possible Ban on Abortion Technique Leaves Doctors Uneasy," *New York Times*, April 22, 2003 (https://www.nytimes.com/2003/04/22/health/possible-ban-on-abortion-technique-leaves-doctors-uneasy.html) ("[B]oth sides acknowledge that abortions done late in the second trimester, no matter how they are conducted, are most often performed to end healthy pregnancies because the woman arrived relatively late to her decision to abort. A Guttmacher study from 1987 indicates that only 2 percent of abortions done after 16 weeks of pregnancy are done because of fetal abnormalities").

Whatever abortion restrictions may (or may not) exist on paper, because of the flexibility of this Court's jurisprudence, abortion providers across the country advertise their services for later abortions: beyond 20 weeks, beyond 24 weeks, beyond 28 weeks, beyond 32 weeks. *See* Appendix. The audience for these advertisements and websites is not doctors who have unexpectedly diagnosed a dangerous condition in a pregnant woman. These advertisements are direct-to-consumer marketing of *Roe*- and *Casey*-sanctioned abortions indistinguishable from infanticide.

CONCLUSION

Mississippi's 15-week abortion restriction is well-supported by the state's compelling interest in the preservation of human life. Additionally, the viability threshold for a compelling state interest in preserving human life, created by this Court in 1973, should be abandoned in favor of the medically updated and philosophically consistent standard of an "unqualified" interest in protecting life that this Court upheld in the 1990 case of *Cruzan*. This Court should grant overrule *Roe* and *Casey* and recognize the right and responsibility of states to protect the lives of unborn human beings.

Respectfully submitted,

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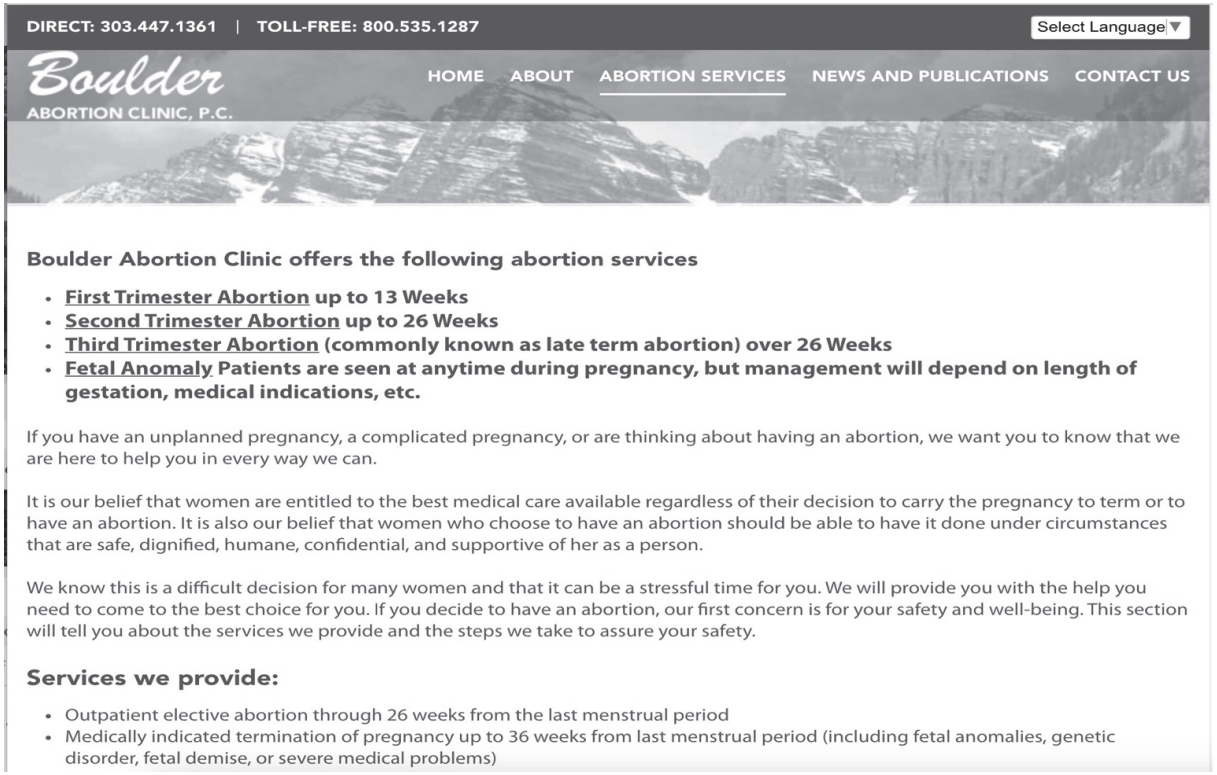
Counsel for Amici Curiae

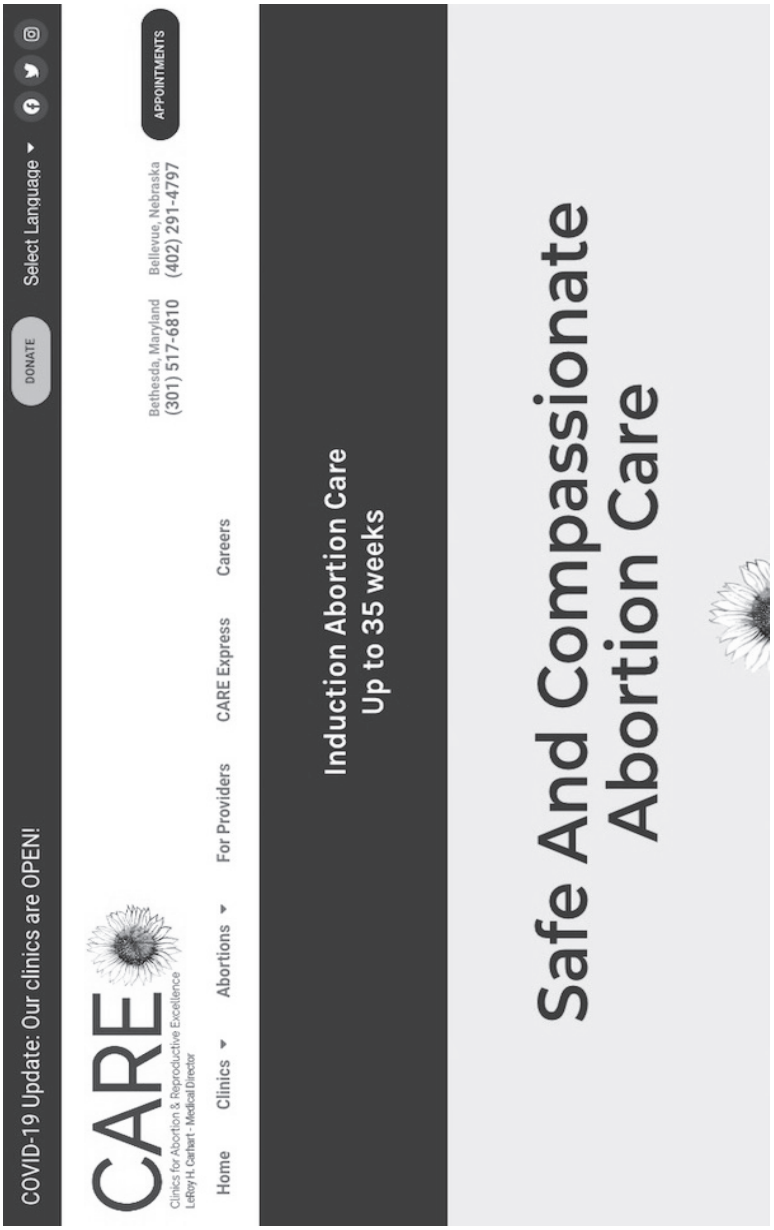
July 27, 2021

APPENDIX



https://www.drhern.com/abortion-services/

https://abortionclinics.org/third-trimester-surgical-abortions/



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LeRoy H. Carhart - Medical Director

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INDUCTION ABORTION CARE

FACTS ABOUT INDUCTION PROCEDURE (24 Weeks And Later)

This is typically a 3 day procedure, in some instances it can take 4 days, depending on your medical history. First, an ultrasound will be done. This is done by passing a microphone-like instrument over your abdomen (belly) which measures the size of your pregnancy. The final decision as to whether the induction can be done will depend on your medical history, physical exam, lab tests, and the doctor's evaluation. On the first day the cervix is slowly opened with cervical dilators, each one slightly bigger than the last. When the cervix is as open as possible, small sponges (laminaria) that take up water from your body will be placed; they swell and continue to open the cervix overnight. The next morning the laminaria are removed and new laminaria are placed. This is repeated as needed until the cervix is adequately open. The induction abortion ends with the start of labor and delivery of a stillborn.

IMPORTANT

Birth control: You can become pregnant again right after your pregnancy ends. To avoid any unwanted or unplanned pregnancy start using birth control immediately.

*We strongly suggest planning an extra day with your visit with us. Sometimes an extra day for dilation is needed for later abortions.

https://fpamg.com/service/late-term-abortion-services/

Late-Term Abortion Services

FPA Medical → Services → Late-Term Abortion Services

Abortion up to 24 weeks

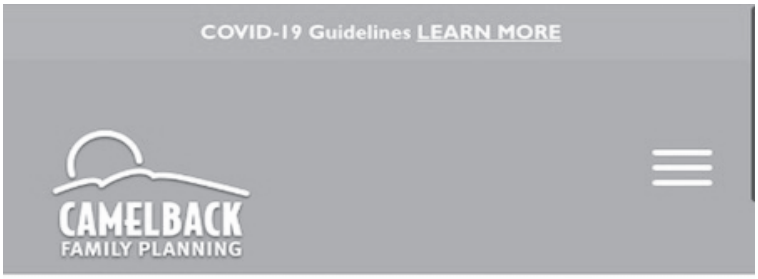
On the first day dilators will be placed in the cervix to gently and slowly open the cervix overnight. You will return the next day to have the procedure. This is the safest and most comfortable way to perform a *surgical abortion after 14 weeks*.

In some cases, especially after 20 weeks, the surgical abortion may be done in a 3 step procedure in which dilators are placed on the first and second days and the procedure finished on the third day.

Surgical Abortion Follow-up Care

After your surgical abortion a follow-up visit is very important. You must come in for a post-procedure visit 2 to 3 weeks after the abortion. There is no charge for this visit.

https://www.camelbackfamilyplanning.com/surgical-abortion/



SURGICAL ABORTION 5 WEEKS UP TO 23.6 WEEKS

A surgical abortion is a simple, safe abortion procedure.

BEFORE YOUR SURGICAL ABORTION VISIT

- The day before your surgery appointment: Hydrate, drink plenty of fluids and water.
- Please take any prescription medication at the usual times.
- Your Surgical Abortion Visit
- The day of your surgery appointment: Do not eat anything for 6 hours before your appointment. You may have clear liquids (water, black coffee/tea, or soda) until 2 hours before your appointment time.
- Wear underwear (No Thong Style) that supports a pad and have pads at home.
- Wear LOOSE SHORTS, PAJAMA PANTS or a DRESS ONLY. NO Yoga pants, NO leggings, NO tights, NO skinny jeans.
- Plan to be in the office for approximately 2-4 hours if you are under 12 weeks.
- If you are between 12 and 17weeks, it is a one-day procedure, you will be in the office approximately 4 – 8 hours.
- After 17weeks, you will probably need 2 visits to the office that will be approximately 2 hours for the first and 4-6 hours for the second visit.
- You MUST have a driver take you home. Your driver MUST be with you when you check in and present a valid driver's license at check-in.
- All **abortion fees** for care must be paid IN FULL, prior to care being rendered. Payments can be made in person the day of your procedure, or here on our website. **https://www.camelbackfamilyplanning.com/pay-now/**
- We accept Cash, Visa, MasterCard, American Express, and Discover. Card-holder must be present with a government-issued photo ID and signature authorization card.

https://www.thewomenscenters.com/abortion-procedures/

HOME | ABORTION CARE | PREGNANCY OPTIONS | FINANCIAL ASSISTANCE | TAKE ACTION | CONTACT US | Select Language | Type Keyword:

The Women's Centers

Atlanta, GA (404)257-0057 | Cherry Hill, NJ (856)667-5910 | Delaware County, PA (610)874-4361 | Philadelphia, PA (215)574-3590 | Hartford, CT (860)525-1900

REQUEST AN APPOINTMENT

SECOND TRIMESTER ABORTION

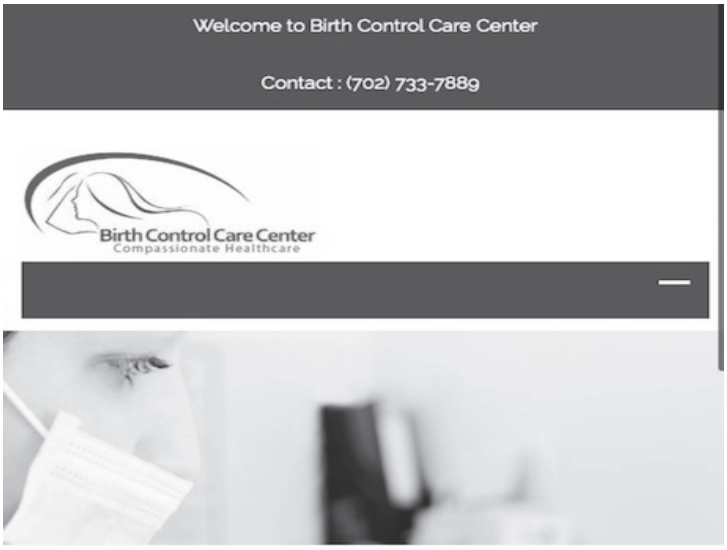
At our Centers, abortion procedures in the second trimester are generally performed between 12 and 24.6 weeks of pregnancy. Not all of our Centers offer abortion through 24 weeks, so please confirm with a patient advocate when you call to make your appointment.

During a second trimester procedure, your cervix needs to be dilated (opened) prior to the actual abortion procedure. Depending on your stage in pregnancy and your unique health history, this dilation may take anywhere from an hour up to overnight before your procedure. Most patients who are 17 weeks thru 24 weeks of pregnancy will require a two-day procedure.

Our compassionate staff will make sure your instructions are clear so that you understand how long you will be in our Center receiving care, and if you may need that extra day.

Anesthesia in the second trimester is done through IV sedation. IV sedation medications will reduce anxiety and pain and causes a depression of consciousness. Because these medications will make you drowsy and not alert, you are required to bring an escort who will register with you at the start of your appointment and assume responsibility for your safe delivery home after receiving the IV medications.

https://birthcontrolcarecenter.com/service/late-term-abortion-services/



Late-Term Abortion Services

Birth Control Care Center → Services → Late-Term Abortion Services

Abortion up to 24 weeks

On the first day dilators will be placed in the cervix to gently and slowly open the cervix overnight. You will return the next day to have the procedure. This is the safest and most comfortable way to perform a *surgical abortion after 14 weeks.*

In some cases, especially after 20 weeks, the surgical abortion may be done in a 3 step procedure in which dilators are placed on the first and second days and the procedure finished on the third day.

https://southwesternwomens.com/southwestern-womens-options-albuquerque-new-mexico/

Southwestern Women's
There are options.

Southwestern Women's Options

Abortions through 32 weeks
Abortions After 32 Weeks on a Case by Case Basis

Medical Abortion by Telemedicine – Abortion Pill by Mail
For Qualified New Mexico Patients

1st Trimester Medical and Surgical Abortions

2nd Trimester Abortions

Financial Counseling and Assistance

Fetal Indications Program

Contact Albuquerque Office

https://floridaabortion.com/services/second-trimester-abortions/abortions-over-20-weeks/