Nos. 21-463 & 21-588

IN THE

Supreme Court of the United States

WHOLE WOMAN'S HEALTH, ET AL.,
Petitioners,

v.

AUSTIN REEVE JACKSON, JUDGE, DISTRICT COURT OF TEXAS, 114TH DISTRICT, ET AL.,
Respondents.

THE UNITED STATES OF AMERICA,
Petitioner,

v.

THE STATE OF TEXAS, ET AL.,
Respondents.

ON WRIT OF CERTIORARI BEFORE JUDGMENT TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF LEADING MEDICAL ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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Tex. Health & Safety Code Ann. § 171.204(a) 11

Tex. Health & Safety Code Ann. § 171.205(a) 23

OTHER AUTHORITIES

ACOG Code of Professional Ethics, Ethical Foundations (2018) 20

ACOG, COMMITTEE OPINION NO. 385, THE LIMITS OF CONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE (2007, reaff'd 2016) 21

ACOG, COMMITTEE OPINION NO. 390, ETHICAL DECISION MAKING IN OBSTETRICS AND GYNECOLOGY (2007, reaff'd 2016) 21

ACOG, COMMITTEE OPINION NO. 651, MENSTRUATION IN GIRLS AND ADOLESCENTS: USING THE MENSTRUAL CYCLE AS A VITAL SIGN (2015, reaff'd 2020) 13

ACOG, COMMITTEE OPINION NO. 815, INCREASING ACCESS TO ABORTION (2020) 16

ACOG, COMMITTEE OPINION NO. 819, INFORMED CONSENT (2021) 21

ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, Statement of Policy (2013, reaff'd & amended 2021)................ 23

ACOG, PRACTICE BULLETIN*:* DIAGNOSIS OF ABNORMAL UTERINE BLEEDING IN REPRODUCTIVE-AGED WOMEN (July 2012), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2012/07/diagnosis-of-abnormal-uterine-bleeding-in-reproductive-aged-women... 13

ACOG, PRACTICE BULLETIN: EARLY PREGNANCY LOSS (November 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss. 12, 22

American College of Emergency Physicians, Code of Ethics for Emergency Physicians........... 21

American Medical Association, Code of Medical Ethics, Principles of Medical Ethics VIII (2001) 20, 21, 24

Bhagwan Satiani et al., *A Critical Deficit of OBGYN Surgeons in the U.S. by 2030*, 2 SCI. RES. 95 (2011) 24

Casey Leins, *States with the Highest Maternal Mortality Rates*, US News, June 12, 2019, https://www.usnews.com/news/best-states/articles/2019-06-12/these-states-have-the-highest-maternal-mortality-rates........17

Craig P. Griebel et al., *Management of Spontaneous Abortion*, 72 AM. FAM. PHYSICIAN 1243 (2005)..22

DONNA HOYERT, NAT'L CTR. HEALTH STAT., MATERNAL MORTALITY RATES IN THE UNITED STATES, 2019 (2021)................................18

Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215 (2012)...17

HEATHER D. BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES (2006).........15

JENNA JERMAN ET AL., GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008 (2016)...18

Jinju Bae et al., *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18 BMC WOMEN'S HEALTH 1 (2018)...13

Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 CONTRACEPTION 422 (2015) 14

LIZA FUENTES ET AL., TEX. POL'Y EVALUATION PROJECT RES. BRIEF, KNOWLEDGE, OPINION AND EXPERIENCE RELATED TO ABORTION SELF-INDUCTION IN TEXAS (2015)......................... 17

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Michael Ollove, *A Shortage in the Nation's Maternal Health Care*, Pew: Stateline, Aug. 15, 2016, https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/15/a-shortage-in-the-nations-maternal-health-care 24

NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES (2018)........................... 14, 16, 17

PREGNANCY, https://www.fda.gov/medical-devices/home-use-tests/pregnancy (Apr. 29, 2019) 13

Press Release, Centers for Disease Control and Prevention (CDC), Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths; Black, American Indian/Alaska Native Women Most Affected (Sept. 5, 2019) 18, 19

Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 AM. J. PUB. HEALTH 1904 (2017) 14

RACHEL K. JONES ET AL., GUTTMACHER INST., ABORTION INCIDENCE AND SERVICE AVAILABILITY IN THE UNITED STATES, 2017 (2019) 16

SEAN PRICE, TEXAS MEDICAL ASSOCIATION, WORK TO IMPROVE MATERNAL HEALTH FOR ALL TEXANS, PHYSICIAN TELLS TMA MEMBERS (2021) 18

Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126 OBSTETRICS & GYNECOLOGY 258 (2015) 15

Tara C. Jatlaoui et al., *Abortion Surveillance — United States, 2015*, 67 MORBIDITY & MORTALITY WEEKLY REP. 1 (2018) 14

TEX. DEP'T OF HEALTH & HUMAN SERVICES, 2020 INDUCED TERMINATIONS OF PREGNANCY FOR TEXAS RESIDENTS (2020) 18

TEX. DEP'T OF STATE HEALTH SERVICES, MATERNAL MORTALITY AND MORBIDITY REVIEW COMMITTEE AND DEPARTMENT OF STATE SERVICES JOINT BIENNIAL REPORT 8 (2020) 19

U.S. DEP'T OF HEALTH & HUMAN SERVICES, PROJECTIONS OF SUPPLY AND DEMAND FOR WOMEN'S HEALTH SERVICE PROVIDERS: 2018-2030 (2021) 24

Unintended Pregnancy in the United States, GUTTMACHER INST., https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf (Jan. 2019) 15

Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 181 (2015) 14

WILLIAM F. RAYBURN, ACOG, THE OBSTETRICIAN-GYNECOLOGIST WORKFORCE IN THE UNITED STATES; FACTS, FIGURES, AND IMPLICATIONS (2017) 24

INTEREST OF *AMICI CURIAE*[1]

Amici curiae are leading medical societies representing physicians and other clinicians who serve patients in Texas and nationwide. They include the American Medical Association ("AMA"), the largest professional association of physicians, residents, and medical students in the country, and the American College of Obstetricians and Gynecologists ("ACOG"), the nation's leading organization of physicians who provide health services unique to women. *Amici* are dedicated to quality health care, research, patient well-being, and evidence-based policy. *Amici* believe that all individuals—including women and girls who live in Texas—are entitled to receive prompt, complete, unbiased, quality, and essential medical care. *Amici* submit this brief to highlight for the Court the ways in which S.B. 8 damages the practice of medicine, the health of Texas women and the clinician-patient relationship.

Amici are the following organizations:

The American College of Obstetricians and Gynecologists ("ACOG") is the nation's premier professional membership organization for obstetrician-

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[1] This brief is filed with the written consent of all of the parties. Pursuant to Rule 37.6, counsel for *amici curiae* authored this brief in whole; no party's counsel authored, in whole or in part, this brief; and no person or entity other than *amici* and their counsel contributed monetarily to preparing or submitting this brief.

gynecologists dedicated to the improvement of women's health. Representing more than 90% of board-certified OB/GYNs in the United States, ACOG is dedicated to the advancement of women's health care, including the core value of access for all women to high quality, safe health care. AGOC maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care, for all women. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care. ACOG has previously appeared as amicus curiae in various courts throughout the country. ACOG's briefs and guidelines have been cited by numerous courts as providing authoritative medical data regarding childbirth and abortion;

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Through the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state. The federal courts have cited the AMA's publications and amicus curiae briefs in cases implicating a variety of

medical questions. The AMA appears on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies (the "Litigation Center"). 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;

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

The American Academy of Nursing serves the public by advancing health policy through the generation, synthesis, and dissemination of nursing knowledge. Fellows of the American Academy of Nursing are inducted into the organization for their extraordinary contributions to improve health locally and globally. With more than 2,800 Fellows, the American Academy of Nursing represents nursing's

most accomplished leaders in policy, research, administration, practice, and academia;

The National Association of Nurse Practitioners in Women's Health ("NPWH") is a national non-profit educational and professional organization that works to ensure the provision of quality primary and specialty health care to women of all ages by women's health and women's health-focused nurse practitioners. Its mission includes protecting and promoting a woman's right to make her own choices regarding her health within the context of her personal, religious, cultural, and family beliefs. Since its inception in 1980, NPWH has been a trusted source of information on nurse practitioner education, practice, and women's health issues. In keeping with its mission, NPWH is committed to ensuring the availability of the full spectrum of evidence-based reproductive health care for women and opposes unnecessary restrictions on access that serve to delay or prevent care;

Founded in 1947, the American Academy of Family Physicians ("AAFP") is one of the largest national medical organizations, representing 133,500 family physicians and medical students nationwide. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and by supporting its members in providing continuous comprehensive health care to all;

The American College of Nurse-Midwives ("ACNM") is a professional association that repre-

sents certified nurse-midwives and certified midwives in the United States. ACNM sets the standard for excellence in midwifery education and practice in the United States and strengthens the capacity of midwives in developing countries. Its roughly 7,000 members are primary care providers for women throughout their lives, with a special emphasis on pregnancy, childbirth, and gynecologic and reproductive health, and for newborns;

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

The American College of Physicians ("ACP") is a diverse community of internal medicine specialists and subspecialists applying scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. With 161,000 members in countries across the globe, ACP is the largest medical-specialty society in the world. ACP's mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine;

The American Gynecological and Obstetrical Society ("AGOS") advances the health of women by providing dedicated leadership and promoting excellence in research, education, and medical practice. The AGOS is an organization composed of individuals attaining national prominence in scholarship in the discipline of obstetrics, gynecology, and women's health, and is dedicated to the development of academic leaders in obstetrics and gynecology. For over a century it has championed the highest quality of care for women and the science needed to improve women's health;

The American Psychiatric Association ("APA") is a non-profit organization representing over 38,800 physicians who specialize in the practice of psychiatry. APA members engage in research into and education about diagnosis and treatment of mental health and substance use disorders, and are front-line physicians treating patients who experience mental health and/or substance use disorders;

The American Society for Reproductive Medicine ("ASRP") is a multidisciplinary not-for-profit organization dedicated to the advancement of the science and practice of reproductive medicine. Its members include approximately 8,000 professionals. ASRM accomplishes its mission through the pursuit of excellence in education and research and through advocacy on behalf of patients, physicians, and affiliated health care providers;

The Council of University Chairs of Obstetrics and Gynecology ("CUCOG") was established for the charitable and educational purposes of promoting excellence in education in the fields of obstetrics and gynecology. Its members represent the departments of obstetrics and gynecology of schools of medicine across the country. Today, the organization promotes and supports leadership development of current and future chairs, and encourages excellence in medical student, resident, and fellowship training; clinical practice; research and advocacy in women's health;

The North American Society for Pediatrics and Adolescent Gynecology ("NASPAG") is composed of gynecologists, adolescent medicine specialists, pediatric endocrinologists, and other medical specialists dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth. NASPAG conducts and encourages multidisciplinary and interprofessional programs of medical education and research in the field and advocates for the reproductive well-being of children and adolescents and the provision of unrestricted, unbiased, and evidence-based medical practice;

The Society for Academic Specialists in General Obstetrics and Gynecology ("SASGOG") seeks to enhance women's health by supporting academic generalist physicians in education, research, and scholarship. SASGOG provides a national collaborative network to facilitate development of new initiatives in women's health care, sharing of best practice,

promotion of scholarship, and support for leadership within academic departments. SASGOG's mission is comprised of four pillars: (1) excellence in women's health care, (2) career development of academic specialists, (3) mentorship of academic specialists; and (4) education and research in the gynecology and obstetrics specialty;

The Society for Maternal Fetal Medicine ("SMFM"), founded in 1977, is the medical professional society for obstetricians who have additional training in high-risk, complicated pregnancies. SMFM represents more than 5,000 members who care for high-risk pregnant people and provides education, promotes research, and engages in advocacy to reduce disparities and optimize the health of high-risk pregnant people. SMFM and its members are dedicated to optimizing maternal and fetal outcomes and assuring medically appropriate treatment options are available to all patients;

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

The Society for Reproductive Endocrinology and Infertility ("SREI") is a professional group of Reproductive Endocrinologists within the American Society for Reproductive Medicine. SREI's mission is to serve a leadership role in reproductive endocrinology and infertility by promoting excellence in patient care; fostering the training and career development of students, residents, associates, members, and affiliates; developing new initiatives in basic and clinical research; and supporting ethical practice and advocacy for the subspecialty; and

The Society of Family Planning ("SFP") is the source for science on abortion and contraception. SFP represents approximately 800 scholars and academic clinicians united by a shared interest in advancing the science and clinical care of family planning. The pillars of its strategic plan are (1) building and supporting a multidisciplinary community of scholars and partners who have a shared focus on the science and clinical care of family planning; (2) supporting the production of research primed for impact; (3) advancing the delivery of clinical care based on the best available evidence; and (4) driving the uptake of family planning evidence into policy and practice.

SUMMARY OF THE ARGUMENT

Reproductive health care is essential to women's overall health. Access to abortion is an important component of reproductive health care. Laws affecting access to abortion, like laws regulating all other forms of health care, should be evidence-based, supported by a valid medical or scientific justification, and designed to improve—not harm—health. Moreover, any regulation of the practice of medicine should be consistent with fundamental principles of medical ethics and uphold—not undermine—the patient-clinician relationship.

S.B. 8 violates the core principles governing the practice of medicine and endangers the lives and well-being of women of reproductive age throughout Texas. Accordingly, *amici*—whose policies, ethical codes, education, and guidance represent the considered judgment of the nation's medical community—submit this brief urging the Court to protect the health and well-being of Texans by vacating the stay issued by the United States Court of Appeals for the Fifth Circuit and re-instating the District Court's order enjoining enforcement of S.B. 8.

Texas S.B. 8 (or "the Act") is contrary to patient health, well-settled law, and core principles of medical ethics. The Act threatens the health and well-being of pregnant patients by barring their access to a safe and essential component of reproductive health care. In so doing, it disproportionately harms the most marginalized people in Texas—communities of color, people with low incomes, and those living in rural areas.

S.B. 8 undermines longstanding principles of medical ethics. It forces clinicians into an untenable position of facing potentially unlimited personal and professional liability if they provide care consistent with their best medical judgment, scientific evidence, and moral and ethical duty. And it does so regardless of applicable clinical standards.

S.B. 8 impermissibly intrudes into the patient-clinician relationship by deputizing community members and citizens to file suit and seek a civil reward of "not less than $10,000" based on allegations that a physician or other health care professional facilitated a banned abortion. The Act creates an open-ended class of potential plaintiffs who might file harassing lawsuits, heavily favoring those plaintiffs in court, and extending liability to anyone in a woman's support network who plays a role in facilitating a prohibited abortion.

The Act represents a harmful, unconstitutional, and unethical intrusion into the ability of women in Texas to seek essential medical care. Accordingly, *amici* urge this Court to reinstate the District Court's injunction.

ARGUMENT

A. S.B. 8 Harms Pregnant Patients' Health.

1. S.B. 8 Effectively Bans Abortion Services.

S.B. 8 provides that "a physician may not knowingly perform or induce an abortion . . . if the physician detect[s] a fetal heart-beat." TEX. HEALTH & SAFETY CODE ANN. § 171.204(a). The term "fetal

heart-beat" is misleading and divorced from the latest medical science when used to describe embryonic cardiac activity at early gestation. Detection of embryonic cardiac activity, which is possible at approximately six weeks after a last menstrual period, is the defining moment when the Act prohibits abortions. But that moment does not carry medical significance for determining the fetus's viability or its ability to sustain life after delivery. While embryonic cardiac activity can signal that an early pregnancy may continue to develop (as opposed to end in a spontaneous abortion or miscarriage),[2] embryonic cardiac activity is a scientifically arbitrary point in pregnancy. It does not by itself indicate whether a pregnancy will develop normally or end in a live birth, and it certainly is not a sign of fetal viability.

The gestational age of a pregnancy is measured in weeks from the first day of a person's last menstrual period. The average menstrual cycle is four weeks long, which means that at six weeks gestation, the earliest approximate point that detection of embryonic cardiac activity is possible, a woman would be only two weeks after her missed period. Given this very short window after one of the most obvious physical signs of pregnancy (a missed period for women with regular cycles), many women are not aware that they are pregnant at six- or seven-weeks

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[2] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (ACOG), PRACTICE BULLETIN: EARLY PREGNANCY LOSS (November 2018), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2018/11/early-pregnancy-loss.

gestational age. Additionally, until cardiac activity is detectable, most women are unable to see a physician to confirm their pregnancy, let alone make a thoughtful, fully informed decision about whether to continue the pregnancy.[3] All of this assumes a regular 28-day menstrual cycle, which many women do not experience; thus, for many women, knowledge of pregnancy may lag even further.[4]

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[3] Administering a home pregnancy test too early in a patient's menstrual cycle or too close to the time a patient became pregnant may result in a false negative result, because the hormone produced during pregnancy, human chorionic gonadotrophin, may not be at a level sufficient to trigger a positive test result. PREGNANCY, https://www.fda.gov/medical-devices/home-use-tests/pregnancy (Apr. 29, 2019).

[4] ACOG, PRACTICE BULLETIN: DIAGNOSIS OF ABNORMAL UTERINE BLEEDING IN REPRODUCTIVE-AGED WOMEN (July 2012), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2012/07/diagnosis-of-abnormal-uterine-bleeding-in-reproductive-aged-women (defining a normal menstrual cycle length as 21-35 days). *See also* Jinju Bae et al., *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18 BMC WOMEN'S HEALTH 1, 1-2 (2018) (finding many women experience irregular cycles due to stress, obesity, thyroid dysfunction, premature ovarian failure, etc.); ACOG, COMMITTEE OPINION NO. 651, MENSTRUATION IN GIRLS AND ADOLESCENTS: USING THE MENSTRUAL CYCLE AS A VITAL SIGN (2015, reaff'd 2020) (reporting that adolescents may have cycles that are six weeks or longer).

2. Abortion Is Safe and Effective and an Essential Component of Reproductive Care.

Abortion is one of the safest medical procedures available to patients.[5] Complication rates from abortion are extremely low, averaging around 2%,[6] and major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[7] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[8]

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[5] *See, e.g.*, NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE, THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 10 (2018) [hereinafter SAFETY AND QUALITY OF ABORTION CARE] ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E or induction—are safe and effective. Serious complications are rare."). Abortion is also common: approximately one quarter of American women have an abortion before the age of 45. Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 AM. J. PUB. HEALTH 1904, 1908 (2017).

[6] *See, e.g.*, Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 181 (2015) (finding a 2.1% abortion-related complication rate); SAFETY AND QUALITY OF ABORTION CARE, *supra* note 5, at 55, 60.

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

[8] *See* Tara C. Jatlaoui et al., *Abortion Surveillance — United States, 2015*, 67 MORBIDITY & MORTALITY WEEKLY REP. 1, 45 (2018) (finding mortality rate from 0.00052 to 0.00078% for

Nor are there significant risks to patient mental health or psychological well-being resulting from abortion care. Recent long-term studies have found that women who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion[,]" and that receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to continue a pregnancy to term.[9]

3. Banning Abortion Dangerously Prevents Women from Getting the Care They Need and Results in Harmful Impacts.

More than 45% of pregnancies in the United States are unplanned,[10] and because many medical conditions—including irregular periods—may mask

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approximately five-year periods from 1978 to 2014); Suzanne Zane et al., *Abortion-Related Mortality in the United States: 1998-2010*, 126 OBSTETRICS & GYNECOLOGY 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

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

10 *Unintended Pregnancy in the United States*, GUTTMACHER INST., https://www.guttmacher.org/sites/default/files/factsheet/fb-unintended-pregnancy-us.pdf (Jan. 2019); HEATHER D. BOONSTRA ET AL., GUTTMACHER INST., ABORTION IN WOMEN'S LIVES 20 (2006) ("Nearly half of pregnancies are unintended").

a pregnancy, many women do not discover they are pregnant for several weeks. S.B. 8 dangerously limits the ability of women to obtain health care. Some women will be forced to travel outside the State to obtain an abortion; others will attempt self-induced abortion; and others still will be forced to carry their pregnancy to term. Each of these outcomes increases the likelihood of avoidable, negative consequences to patients' physical and psychological health.[11]

First, by forcing women to travel outside the State, S.B. 8 needlessly delays care to later in gestation when the risks to women are greater. Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of major complication—a risk increased further still by continuing a pregnancy to term.[12]

Second, S.B. 8's ban on care after six weeks increases the possibility that women may attempt self-induced abortions through harmful or unsafe methods.[13] Studies have found that women who face barriers to reproductive services are more likely to rely on harmful self-induction tactics such as herbal or

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[11] *See, e.g.*, ACOG, COMMITTEE OPINION NO. 815, INCREASING ACCESS TO ABORTION (2020).

[12] SAFETY AND QUALITY OF ABORTION CARE, *supra* note 5, at 10 ("the risk of a serious complication increase with weeks' gestation.").

[13] RACHEL K. JONES ET AL., GUTTMACHER INST., ABORTION INCIDENCE AND SERVICE AVAILABILITY IN THE UNITED STATES, 2017 3, 8 (2019) (noting a rise in patients who had attempted to self-induce an abortion, with highest proportions in the South and Midwest).

homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills.[14] This reality is consistent with a recent study by the National Academies of Medicine, Engineering, and Science concluding that the greatest threats to the safety and quality of abortion in the United States are unnecessary government regulations on abortion.[15]

Third and finally, those who cannot obtain an abortion in an alternative manner and are forced to continue a pregnancy to term will face significantly greater risk to maternal health and mortality due to S.B. 8. The "risk of death associated with childbirth [is] approximately 14 times higher" than that of legal abortion.[16] This is particularly concerning given that the maternal mortality rate in Texas is one of the highest in the United States,[17] and people of color,

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[14] LIZA FUENTES ET AL., TEX. POL'Y EVALUATION PROJECT RES. BRIEF, KNOWLEDGE, OPINION AND EXPERIENCE RELATED TO ABORTION SELF-INDUCTION IN TEXAS 3 (2015).

[15] SAFETY AND QUALITY OF ABORTION CARE, *supra* note 5, at 77 *et seq.* ("the extensive regulatory requirements that state laws impose on the provision of abortion services … reduce the availability of care"). *See also* ACOG, *Increasing Access to Abortion*, *supra* note 11 ("ACOG calls for the cease and repeal of legislation that creates barriers to abortion access and interferes with the patient-clinician relationship and the practice of medicine").

[16] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216 (2012).

[17] Casey Leins, *States with the Highest Maternal Mortality Rates*, US News, June 12, 2019, https://www.usnews.com/news/best-states/articles/2019-06-

those living in rural areas, and those with limited economic resources will be disproportionately affected.[18]

4. S.B. 8 Disproportionately Harms the Health of People and Communities That Are Marginalized.

As a result of myriad factors, including systemic barriers to preventive care and contraception, the majority of patients seeking abortions identify as non-white[19] and 75% of those seeking abortion are living at or below 200% of the federal poverty level.[20]

12/these-states-have-the-highest-maternal-mortality-rates (reporting that the maternal mortality rate in Texas was the fourth highest in the United States).

[18] DONNA HOYERT, NAT'L CTR. HEALTH STAT., Maternal Mortality Rates in the United States, 2019 1 (2021). *See also* SEAN PRICE, TEXAS MEDICAL ASSOCIATION, WORK TO IMPROVE MATERNAL HEALTH FOR ALL TEXANS, PHYSICIAN TELLS TMA MEMBERS (2021); Press Release, Centers for Disease Control and Prevention (CDC), Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths; Black, American Indian/Alaska Native Women Most Affected (Sept. 5, 2019) (reporting that nationwide, Black women's pregnancy-related mortality rate is 3.2 times higher than that of white women).

[19] *See* TEX. DEP'T OF HEALTH & HUMAN SERVICES, 2020 INDUCED TERMINATIONS OF PREGNANCY FOR TEXAS RESIDENTS (2020) (finding 27% of Texas abortion recipients in 2020 to be white, 30% black, 37% Hispanic, and 7% other racial/ethnic group).

[20] JENNA JERMAN ET AL., GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008 6 (2016).

S.B. 8 therefore results in an inequitable and unjust threat to the physical and psychological health of under-resourced populations. Forcing women to continue pregnancy increases the risk of complications and death overall, but the risks are particularly acute for Black women, who in Texas account for 11% of live births but 31% of the maternal deaths, making carrying an unwanted pregnancy to term disproportionately dangerous for them.[21] Black women's pregnancy-related mortality rate nationally is 3.2 times higher than that of white women, a disparity that persists across socioeconomic and education levels.[22] Access to care is not equitable, and its inequities are exacerbated by S.B. 8's ban on one safe and essential form of care at such an early stage in pregnancy: among other things, traveling out of State for abortion care may be nearly impossible for patients with low incomes or those who live in rural areas. By drastically restricting in-state care for pregnant patients, S.B. 8 meaningfully exacerbates already deep inequities in women's health and health care, negatively affecting the most vulnerable Texans

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[21] TEX. DEP'T OF STATE HEALTH SERVICES, MATERNAL MORTALITY AND MORBIDITY REVIEW COMMITTEE AND DEPARTMENT OF STATE SERVICES JOINT BIENNIAL REPORT 8 (2020).

[22] CDC, *Racial and Ethnic Disparities*, *supra* note 18.

B. S.B. 8 Is Contrary to Bedrock Principles of Medical Ethics.

By isolating and banning pre-viability abortion, S.B. 8 violates long-established and widely accepted principles of medical ethics (beneficence, non-maleficence, justice, and autonomy) and intrudes upon the foundation of the patient-physician relationship: honest, open communication. S.B. 8 forces medical professionals to choose between long-established scientific, ethical, and clinical standards of care and their personal and professional risk of being bankrupted by civil lawsuits.

1. S.B. 8 Violates the Principles of Beneficence and Non-Maleficence, and Respect for Patient Autonomy.

Medical ethics codes unequivocally place the patient first.[23] Beneficence, the obligation to promote the well-being of others, and non-maleficence, the

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[23] American Medical Association, Code of Medical Ethics, Principles of Medical Ethics VIII (2001) [hereinafter AMA Code] (describing a physician's "responsibility to the patient as paramount."); *id.* § 1.1.1 (enshrining the "physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."); ACOG Code of Professional Ethics, Ethical Foundations (2018) ("welfare of the patient (beneficence) is central to all considerations in the patient–physician relationship."). Other medical professionals represented by *Amici* make similar pledges to patient well-being.

obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2,500 years ago.[24] Obstetricians, gynecologists, and other clinicians must respect these ethical duties by engaging in patient-centered counseling; providing patients with information about pregnancy risks, benefits, and options; and ultimately empowering patients to make decisions.

Clinicians must not only care for patients, but also "coordinat[e] medically indicated care with other health care professionals" and "not discontinue treat[ment] when further treatment is medically indicated without . . . sufficient notice and reasonable assistance[.]"[25] Patient autonomy holds that patients should be free to both act without constraints[26] and provide informed consent.[27] Physicians cannot withhold relevant care based on personal legal liabil-

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[24] ACOG, COMMITTEE OPINION NO. 390, ETHICAL DECISION MAKING IN OBSTETRICS AND GYNECOLOGY 1, 3 (2007, reaff'd 2016).

[25] AMA Code, *supra* note 23, § 1.1.3. *See also id.* § 1.2.3 ("Physicians' fiduciary obligation … can include . . . referring patients to other professionals to provide care.").

[26] *See* ACOG, COMMITTEE OPINION NO. 385, THE LIMITS OF CONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE 3 (2007, reaff'd 2016) 1–3; American College of Emergency Physicians, Code of Ethics for Emergency Physicians, § II.B.3 ("physicians must inform the patient with decision-making capacity about the nature of his or her medical condition, treatment alternatives, and their expected consequences").

[27] ACOG, COMMITTEE OPINION NO. 819, INFORMED CONSENT 2 (2021).

ity concerns without violating this fundamental duty.[28]

S.B. 8 places clinicians in an impossible position: they cannot provide the best available medical care consistent with the foregoing ethical principles without risking substantial legal and personal penalties. Indeed, by creating liability for *any person*—including, but not limited to, a clinician—who "induces," "aids or abets," or "intends" to induce or aid or abet a woman obtaining an abortion after any cardiac activity has been detected, S.B. 8 not only prevents abortions but it prevents clinicians from practicing medicine. § 171.208(a)(1)-(3).

S.B. 8—an unconstitutional pre-viability ban on abortion—also dangerously limits a clinician's ability to act in accordance with common medical standards. There are countless examples of how this manifests. As merely one example, a patient may seek care while having what is medically known as an "inevitable abortion," during which a woman's cervix has dilated, but the embryo or fetus has not been expelled.[29] In such cases, a woman may be hemorrhaging blood and, at the same time, the embryo or fetus may still produce cardiac activity. A miscarriage is nevertheless imminent and cannot be prevented. Clinical guidelines suggest a clinician should immediately evacuate her uterus.[30] S.B. 8, however, pre-

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[28] *Id.* at 3.

[29] Craig P. Griebel et al., *Management of Spontaneous Abortion*, 72 AM. FAM. PHYSICIAN 1243, 1243 (2005).

[30] ACOG, PRACTICE BULLETIN: EARLY PREGNANCY LOSS, *supra* note 2 ("Women who present with hemorrhage, hemodynamic

vents physicians from effectuating urgent, medically appropriate care. Instead, the Act commands them to wait until (if ever) the situation becomes a life-threatening "medical emergency,"[31] or face significant civil liability for performing, inducing, or "aiding or abetting" an abortion in contravention of the Act.[32] As a result, patients endure needless pain and suffering, increased medical bills, prolonged hospital stays with time away from family, and child care struggles.

2. S.B. 8 Fundamentally Undermines the Patient-Clinician Relationship.

The patient-physician relationship is critical for the provision of safe and quality medical care.[33] It is also a bedrock principle of medical ethics. At the core of this relationship is the ability to counsel patients, honestly, without judgment, and confidential-

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instability, or signs of infection should be treated urgently with surgical uterine evacuation.").

31 *See* TEX. HEALTH & SAFETY CODE ANN. § 171.002(3) (defining "Medical emergency" as "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that … places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed").

32 *Id.* § 171.205(a).

33 *See* ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship*, Statement of Policy (2013, reaff'd & amended 2021) (calling laws which "require physicians to give, or withhold, specific information when counseling patients, or that mandate" which procedures physicians can perform "ill-advised.").

ly, based on patients' best interests and the best available scientific evidence.[34] *Amici* oppose laws that threaten this relationship.[35] S.B. 8 restricts the free flow of accurate and scientific information and counseling about abortion. The Act delegitimizes medical care by trying to force clinicians to withhold medically-indicated information for fear of professional and personal civil liability. It intrudes directly into the patient-clinician relationship and undermines the trust that is essential to safe, evidenced-based, ethical care.

S.B. 8 will also exacerbate the already perilous shortage of women's health care providers,[36] as clini-

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[34] *See* AMA Code, *supra* note 23, § 2.1.1 ("Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care."); *id.* § 1.1.3 (enshrining patients' right "[t]o receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives").

[35] *Id.*

[36] *See* WILLIAM F. RAYBURN, ACOG, THE OBSTETRICIAN-GYNECOLOGIST WORKFORCE IN THE UNITED STATES; FACTS, FIGURES, AND IMPLICATIONS 4, 121 (2017) (finding that approximately half of the counties in the United States already do not have any OB-GYNs). Leading groups predict that by 2030 there will be a significant nationwide shortage of OB-GYNs. *See, e.g.*, Bhagwan Satiani et al., *A Critical Deficit of OBGYN Surgeons in the U.S. by 2030*, 2 SCI. RES. 95 (2011); U.S. DEP'T OF HEALTH & HUMAN SERVICES, PROJECTIONS OF SUPPLY AND DEMAND FOR WOMEN'S HEALTH SERVICE PROVIDERS: 2018-2030 (2021); Michael Ollove, *A Shortage in the Nation's Maternal Health Care*, PEW: STATELINE, Aug. 15, 2016, https://www.pewtrusts.org/en/research-and-

cians will be harassed with suits. While S.B. 8 may be intended to deter clinicians from providing abortion care with the threat of endless liability, given that many physicians who provide abortion care also provide other types of reproductive health care, S.B. 8 is likely to impact access to all types of women's health care, not just abortion.

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analysis/blogs/stateline/2016/08/15/a-shortage-in-the-nations-maternal-health-care.

CONCLUSION

Amici respectfully urge the Court to grant Petitioners' requested relief. For the reasons explained above and outlined more fully in the Petitioners' submissions, S.B. 8 will continue to cause grave harm to patients and public health, is contrary to principles of medical ethics, and sanctions the unconstitutional ban of pre-viability abortions.

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