NO. 18-837

In the

Supreme Court of the United States

STEVEN T. MARSHALL, IN HIS OFFICIAL CAPACITY AS ALABAMA ATTORNEY GENERAL, et al.,
Petitioners,

v.

WEST ALABAMA WOMEN'S CENTER, et al.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF AMICUS CURIAE CHRISTIAN MEDICAL & DENTAL ASSOCIATIONS IN SUPPORT OF PETITIONERS

KRISTEN K. WAGGONER
JOHN BURSCH
KEVIN H. THERIOT
Counsel of Record
DENISE BURKE
Alliance Defending Freedom
15100 N. 90th Street
Scottsdale, AZ 85260
(480) 444-0020
ktheriot@ADFlegal.org

DAVID A. CORTMAN
DENISE M. HARLE
Alliance Defending Freedom
1000 Hurricane Shoals Rd. N.E.,
Ste. D-1100
Lawrenceville, GA 30043
(770) 339-0774

Counsel for Amicus Curiae

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Other Authorities

INTEREST OF AMICUS CURIAE[1]

Christian Medical & Dental Associations ("CMDA") is a nonprofit national organization of Christian physicians and allied healthcare professionals with over 19,000 members. In addition to its physician members, it has associate members from a number of allied health professions, including nurses and physician assistants. CMDA provides up-to-date information on the legislative, ethical, and medical aspects of abortion and its impact on maternal health.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

The State of Alabama has "legitimate interests from the outset of pregnancy in protecting the health of women," *Planned Parenthood v. Casey*, 505 U.S. 833, 846 (1992) (plurality opinion). That is because the "medical, emotional, and psychological consequences of an abortion are serious and can be lasting." *H.L. v. Matheson*, 450 U.S. 398, 411 (1981). The State's interest in safeguarding maternal health is particularly compelling when abortions are contemplated or performed later in pregnancy. That

[1] Pursuant to this Court's Rule 37.2, all parties received timely notice of Amicus Curiae's intent to file this brief. All parties have consented to the filing of this brief. Pursuant to this Court's Rule 37.6, Amicus states that no counsel for any party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of the brief.

interest is implicated in so-called "dismemberment" abortions, a procedure that can take place only after the first trimester, when the unborn child has limbs and organs to dismember.

It is undisputed that abortion has higher medical risks when the procedure is performed later in pregnancy. Medical studies have repeatedly concluded that later-term abortions pose more serious risks to women's physical and mental health than first-trimester abortions. *E.g.*, L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, OBSTET. & GYN. 103(4), 729 (2004); P.K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, 2010 J. PREGNANCY 1, 7 (2010). Dismemberment abortions and other abortion procedures performed after the first trimester account for "a disproportionate amount of abortion-related morbidity and mortality." E.M. Johnson, *The Reality of Late-Term Abortion Procedures*, Charlotte Lozier Institute, Jan. 20, 2015, at 6.

The medical evidence documenting the increased risks associated with later-term abortions is sufficient to support a comprehensive state ban on abortions in the second trimester. And it is more than sufficient to sustain a lesser abortion limitation, such as the Alabama law at issue here.

The Alabama Unborn Child Protection from Dismemberment Abortion Act, Ala. Code § 26-23G-3(a), prohibits "a method of abortion that is clinically referred to as Dilation and Evacuation (D & E). Or

dismemberment abortion, as the State less clinically calls it. That name is more accurate because the method involves tearing apart and extracting piece-by-piece from the uterus what was until then a living unborn child. This is usually done during the 15 to 18 week stage of development, at which time the unborn child's heart is already beating." *West Alabama Women's Ctr. v. Williamson*, 900 F.3d 1310, 1314 (11th Cir. 2018).

As noted, the Act implicates an abortion procedure performed exclusively after the first trimester. And the Act advances the State of Alabama's interest in protecting maternal health and is supported by compelling and substantial medical evidence. Moreover, given the growing medical evidence of abortion's harm to women, the constitutional validity of the Alabama Unborn Child Protection from Dismemberment Abortion Act is an important question of federal law that should be decided by this Court. For these reasons, Amicus urges this Court to grant certiorari and reverse the court of appeals.

ARGUMENT

I. Abortion's medical risks—including the risk of death—increase exponentially later in pregnancy.

Abortion carries substantial maternal health risks. These short-term and long-term risks include numerous physical and psychological complications. The risk for these complications increases significantly as pregnancy progresses. Of particular

note, the risk of death from abortion increases exponentially after 8 weeks of pregnancy.

A. Abortion carries the risk of significant physical and psychological harm.

Abortion can cause serious short-term and long-term physical and psychological complications for women, including but not limited to uterine perforation, uterine scarring, cervical perforation or other cervical injury, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, organ damage, adverse reactions to anesthesia and other drugs, psychological or emotional complications such as depression, anxiety or sleeping disorders, and death. *E.g.,* P.K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199, BRIT. J. OF PSYCHIATRY 180-86 (2011); P. Shah et al., *Induced termination of pregnancy and low birth weight and preterm birth: a systematic review and meta-analysis*, 116(11), BRIT. J. OF PSYCHIATRY 1425 (2009); H.M. Swingle et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review and Meta-Analysis*, 54, J. REPROD. MED. 95 (2009); R.H. van Oppenraaij et al., *Predicting adverse obstetric outcome after early pregnancy events and complications: a review*, 15(4), HUMAN REPROD.

UPDATE ADVANCE ACCESS, 409 (2009); J.M. Thorp et al., *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58, OBSTET. & GYN. SURVEY, 67, 75 (2003); J.M. Barrett, *Induced Abortion: A Risk Factor for Placenta Previa*, AM. J. OBSTET. & GYN. 141:7 (1981).

It is also undisputed that abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to an abortion at 8 weeks gestation or earlier, the relative risk increases exponentially at higher gestations. L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, OBSTETRICS & GYNECOLOGY 103(4), 729 (2004). Abortion procedures, including dismemberment, performed after the first trimester account for "a disproportionate amount of abortion-related morbidity and mortality." E.M. Johnson, *The Reality of Late-Term Abortion Procedures*, Charlotte Lozier Institute, Jan. 20, 2015, at 6.

B. The risk of death from abortion increases exponentially after 8 weeks gestation.

Compared to abortion at eight weeks gestation, the relative risk of mortality increases by 38% for each additional week at higher gestations. L. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, OBSTETRICS & GYNECOLOGY 103(4), 729 (2004). For example, the risk of death at 8 weeks gestation is one death per one million abortions; at 16 to 20 weeks, that risk rises to one death per 29,000 abortions; and at 21 weeks

gestation or later, the risk of death is one per every 11,000 abortions. *Id.* In other words, a woman seeking an abortion at 20 weeks is 35 times more likely to die from the abortion than she was in the first trimester. At 21 weeks or more, she is 91 times more likely to die from the abortion than she was in the first trimester.

Researchers in the Bartlett study concluded that it may not be possible to reduce the risk of death in later-term abortions because of the "inherently greater technical complexity of later abortions." *Id.* at 735. This is because later-term abortions require a greater degree of cervical dilation, an increased blood flow later in pregnancy predisposes the woman to hemorrhage, and the myometrium is relaxed and more subject to perforation. *Id.*

Other researchers confirm the substantially increased risk of death from abortions performed later in gestation. For example, a 2008 study by pro-choice researcher, Dr. Daniel Grossman, found that the mortality ratio at 21 weeks is 8.9 deaths per 100,000 abortions. D. Grossman et al., *Complications after second trimester surgical and medical abortion*, 16(31), REPROD. HEALTH MATTERS, 173 (2008). An earlier study found that the mortality ratio at the same gestation is 10.4 deaths per 100,000 abortions. Maureen Paul et al., A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION Chap. 15 (Churchill Livingstone 1999).

II. Abortion poses significant long-term risks to maternal health.

Among the best-documented long-term risks of abortion are the risk of preterm birth in subsequent pregnancies and the risk of psychological harm, including anxiety, depression, and suicidal ideation. As noted above, the risks associated with these long-term complications increase as pregnancy progresses. Current medical evidence also dispels the myths that abortion is safe and "safer than childbirth," providing compelling support for the Alabama Unborn Child Protection from Dismemberment Abortion Act.

A. Abortion increases the risk of preterm birth in subsequent pregnancies.

Preterm birth occurs prior to the 37th week of pregnancy and is very dangerous to both child and mother. According to the U.S. Centers for Disease Control, premature birth is the leading cause of infant mortality in the United States. J.M. Thorp et al., *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58, OBSTET. & GYN. SURVEY, 67, 75 (2003). It is also a risk factor for later disabilities for the child, such as cerebral palsy and behavioral problems. W.M. Callaghan et al., *The Contribution of Preterm Birth to Infant Mortality Rates in the U.S.*, 118(4), PEDIATRICS, 1566 (2006); B. Rooney & B.C. Calhoun, *Induced Abortion and Risk of Later Premature Births*, 8(2), J. AM. PHYSICIANS & SURGEONS, 46-47 (2003).

Induced abortions, including later-term abortions, increase the risk in subsequent pregnancies of preterm birth and very low birth weight. Induced abortion has also been associated with an increased risk of the premature rupture of membranes, hemorrhage, and cervical and uterine abnormalities, which are in turn responsible for an increased risk of preterm birth. C. Moreau et al., *Previous Induced Abortions and the Risk of Very Preterm Delivery: Results of the EPIPAGE Study*, 112(4) BRIT. J. OBSTET. & GYN., 430 (2005).

There are more than 130 published studies showing a statistically significant association between induced abortion and subsequent preterm birth or low birth weight. For example, a 2009 study reported that induced abortion increases the risk of preterm birth in a subsequent pregnancy by 37%, with two or more abortions increasing the risk by 93%. P. Shah et al., *Induced termination of pregnancy and low birth weight and preterm birth: a systematic review and meta-analysis*, 116(11), BRIT. J. OBSTET. & GYN., 1425 (2009); *see also*, R.H. van Oppenraaij et al., *Predicting adverse obstetric outcome after early pregnancy events and complications: a review*, 15(4), HUMAN REPROD. UPDATE ADVANCE ACCESS, 409 (2009) (a single induced abortion raises the risk of subsequent preterm birth by 20%, with two or more abortions increasing the risk by 90%).

B. Multiple studies document abortion's mental health risks.

Numerous peer-reviewed studies have examined the mental health implications of abortion, finding that abortion poses increased risk of depression, anxiety, and even suicide. Notably, in a 2011 landmark study published in the British Journal of Psychiatry (a publication of the Royal College of Psychiatrists), researchers disclosed that women face an 81% increased risk of mental health problems following abortion. P.K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199, BRIT. J. OF PSYCHIATRY, 180 (2011).

Specifically, women with a history of abortion had a 34% increased risk of anxiety, a 37% increased risk of depression, a 110% increased risk of alcohol use, and a 155% increased risk of suicide following abortion. *Id*. Significantly, the study examined the results of 22 studies published between 1995 and 2009 and included 877,181 women (163,831 who had aborted) from six countries.

Another leading study examined a sample group of over 500 women from birth to the age of 25 and found that 27% of women who aborted reported experiencing suicidal ideation, with as many as 50% of minors who had aborted experiencing suicide or suicidal ideation. D.M. Fergusson et al., *Abortion in young women and subsequent mental health*, 47, J. CHILD PSYCHOLOGY & PSYCHIATRY, 16, 19 (2006). The risk of suicide was three times greater for women who

aborted than for women who delivered. Likewise, the researchers found that 42% of women who aborted reported major depression by age 25, and 39% of post-abortive women suffered from anxiety disorders by age 25. *Id.* Importantly, the study was controlled for prior histories of depression, anxiety, and suicide ideation. *Id.*

The Fergusson study was not the first (or the last) to demonstrate a connection between abortion and suicide. A team led by Finnish researcher Mika Gissler twice found that the suicide rate was nearly six times greater among women who aborted compared to women who gave birth. M. Gissler et al., *Injury deaths, suicides and homicides associated with pregnancy*, Finland 1987-2000, 15, EUROPEAN J. PUB. HEALTH, 459 (2005); M. Gissler et al., *Suicides after pregnancy in Finland, 1987-94: Register linkage study*, 313, BRIT. MED. J., 1431 (1996). Further, Gilchrist et al. reported that, among women with no history of psychiatric illness, the rate of deliberate self-harm was 70% higher after abortion than childbirth. A.C. Gilchrist et al., *Termination of pregnancy and psychiatric morbidity*, 167, BRIT. J. PSYCHIATRY, 243 (1995).

The statistics related to depression and anxiety are equally staggering. A study performed by J.R. Cougle et al. found that women whose first pregnancies ended in abortion were 65% more likely to score in the "high risk" range for clinical depression than women whose first pregnancies resulted in a birth—even after controlling for age, race, marital status, divorce history, education, income, and pre-

pregnancy psychological state. J.R. Cougle et al., *Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort*, 9(4), MED. SCI. MONITOR, CR157 (2003).

Additional studies have found that up to 30% of women experience extremely high levels of anxiety and stress one month after abortion. P.K. Coleman, *Induced Abortion and Increased Risk of Substance Abuse: A Review of the Evidence*, 1, CURRENT WOMEN'S HEALTH ISSUES, 21, 23 (2005); Z. Bradshaw & P. Slade, *The Effects of Induced Abortion on Emotional Experiences and Relationships: A Critical Review of the Literature*, 23, CLINICAL PSYCH. REV., 929-58 (2003).

Researchers have also found that women who undergo abortions at 13 weeks or beyond report "more disturbing dreams, more frequent reliving of the abortion, and more trouble falling asleep." P.K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, 2010 J. PREGNANCY, 1, 7 (2010).

These studies represent just a sampling of medical research demonstrating an increased risk of mental health problems following abortion.

C. Childbirth is safer than abortion.

Medical evidence clearly establishes that the later in pregnancy an abortion occurs, the riskier it is and the greater the chance for significant

complications. Notably, recent international studies demonstrate that childbirth is safer than abortion.

In August 2012, a Danish study reviewed medical records for almost a half million women who had their first pregnancies between 1980 and 2004, and compared these records with the death register and the abortion register. The results were significant: "Compared to women who delivered, women who had an early or late abortion had significantly higher mortality rates within 1 through 10 years." D.C. Reardon & P.K. Coleman, *Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004*, 18(9), MED. SCI. MONIT., 71-76 (2012).

A May 2012 study out of Chile is particularly significant because it examined trends in maternal death both when abortion was legal in Chile and after abortion was prohibited in 1989. The study found that death rates did not increase after abortion was made illegal. In fact, the maternal mortality ratio decreased from 41.3 deaths per 100,000 live births when abortion was legal, to just 12.7 maternal deaths per 100,000 live births after abortion was made illegal. E. Koch et al., *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, 7(5), PLOS ONE, e36613 (May 4, 2012).

III. The dismemberment abortion procedure specifically poses significant risks to maternal health.

Dismemberment abortions carry inherent risks of infection, bleeding, damage to other genitourinary and gastrointestinal organs, incomplete emptying of the uterus, cervical laceration, and uterine perforation. L. Bartlett et. al., *Risk factors for legal induced abortion-related mortality in the United States*, 103(4), OBSTET. GYN., 729 (2004); C. Hammond, *Recent advances in second trimester abortion: an evidence-based* review, AM. J. OBSTET. GYN. 2009;200(4):347-356; J. Diedrich et al., *Complications of Surgical Abortion*, CLIN. OBSTET. GYN. 2009;52(2):205-212. During the second trimester, the uterus thins and softens significantly and there is an increased risk of perforating or puncturing the uterine wall with instruments when attempting to tear the baby's limbs apart or crush his or her skull. Testimony of Anthony Levatino, M.D., Before the Subcomm. on the Constitution and Civil Justice, U.S. House of Representatives (May 23, 2013).

In preparation for the dismemberment abortion procedure, an osmotic dilator along with one or two gauze sponges are inserted into a woman's vagina. Depending on gestational age, several dilators — as many as 10 or 20 laminaria — may need to be inserted at once. Maureen Paul et al., MANAGEMENT OF UNINTENDED AND ABNORMAL PREGNANCY, COMPREHENSIVE ABORTION CARE 162 (Lynn Borgatta et al., eds 2009). Abortion providers

should warn women "that the gauze sponge(s), as well as some of the dilators, might dislodge" and ask "patients to track the number of devices expelled or to bring them to the facility . . . to account for all devices." *Id.* Every type of dilator used in a dismemberment abortion "can migrate into the uterine cavity resulting in ongoing pain, bleeding, or infection." *Id.* at 163.

Inserting these devices as required before a dismemberment abortion also increases the risk that a woman "will experience spontaneous rupture of membranes during or after osmotic dilator insertion," which can lead to infection and fever. *Id.* Insertion can also "traumatiz[e] the cervix" or "creat[e] a false channel"—that is, it can form a hole or fracture in a woman's vaginal or cervical tissue where there should not be one. *Id.*

Between five and 20% of women will suffer vasovagal symptoms — fainting, nausea, blurred vision, lightheadedness, cold sweats, weak pulse, a drop in blood pressure, low heart rate, and more — because of the pre-dismemberment abortion dilation procedures. *Id.* at 164. Leaving the dilators in for multiple days also poses the risk that the woman (and the baby) will contract a serious infection. *Id.* at 163, 165. Laminaria, the most commonly used dilators, are natural products derived from seaweed and algae, and, therefore, can harbor genital pathogens — even after sterilization. *Id.* at 164. Finally, some women suffer anaphylaxis in response to luminaria insertion. *Id.* at 165. Anaphylaxis is "a severe, potentially life-threatening allergic reaction" characterized by

vomiting, dizziness, hives, hypotension, airway constriction, and a weak and rapid pulse. *See* Mayo Clinic, *Anaphylaxis*, https://mayocl.in/2GYVjoL (2019).

***

Medical evidence shows conclusively that (1) there are significant physical and mental-health risks to the mother following an abortion, especially when compared to going through childbirth, (2) those risks materially increase as the pregnancy progresses, and (3) there are additional risks associated with the dismemberment abortion procedure in particular. Given these risks, Alabama has a substantial interest in regulating the practice of abortion in the State.

Alabama's interest in protecting women's health is strong enough that it would warrant limiting late-term abortions entirely. At a minimum, Alabama's interest is more than sufficient to sustain a lesser abortion limitation, such as the Alabama law at issue here.

CONCLUSION

The Court should grant certiorari and reverse the court of appeals.

Respectfully submitted,

KRISTEN K. WAGGONER
JOHN BURSCH
KEVIN H. THERIOT
Counsel of Record
DENISE BURKE
Alliance Defending Freedom
15100 N. 90th Street
Scottsdale, AZ 85260
(480) 444-0020
ktheriot@ADFlegal.org

DAVID A. CORTMAN
DENISE M. HARLE
Alliance Defending Freedom
1000 Hurricane Shoals Rd.
N.E., Ste. D-1100
Lawrenceville, GA 30043
(770) 339-0774

FEBRUARY 4, 2019