FILED
03/28/2022
Bowen Greenwood
CLERK OF THE SUPREME COURT
STATE OF MONTANA
Case Number: DA 21-0521

IN THE SUPREME COURT OF THE STATE OF MONTANA

DA 21-0521

PLANNED PARENTHOOD OF MONTANA, and JOEY BANKS, M.D., on behalf of themselves and their patients,

Plaintiffs and Appellees,

v.

STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General,

Defendant and Appellant.

On Appeal from the Montana Thirteenth Judicial District Court,
Yellowstone County, The Honorable Michael G. Moses, Presiding

---

BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF NURSING, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF MEDICAL GENETICS AND GENOMICS, AMERICAN COLLEGE OF NURSE-MIDWIVES, AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY, AMERICAN MEDICAL ASSOCIATION, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, AMERICAN UROGYNECOLOGIC SOCIETY, COUNCIL OF UNIVERSITY CHAIRS OF OBSTETRICS AND GYNECOLOGY, MONTANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE, NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN WOMEN'S HEALTH, SOCIETY FOR MATERNAL-FETAL MEDICINE, SOCIETY FOR REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY, SOCIETY OF FAMILY PLANNING, AND SOCIETY OF OB/GYN HOSPITALISTS AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

LINDSAY C. BECK
BECK, AMSDEN & STALPES pllc
2000 S. 3rd Ave., Unit A
Bozeman, MT 59715

JANICE MAC AVOY*
JENNIFER L. COLYER*
LEIGH G. ROME*
ALEXIS R. CASAMASSIMA*
DYLAN B. BOLDUC*

MOLLY MEEGAN*
ROBYN LONG*
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Telephone: 406-586-8700
Email:
lbeck@becklawyers.com

Counsel for Amici Curiae *American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American College of Medical Genetics and Genomics, American College of Nurse-Midwives, American College of Osteopathic Obstetricians and Gynecologists, American College of Physicians, American Gynecological and Obstetrical Society, American Medical Association, American Medical Women's Association, American Society for Reproductive Medicine, American Urogynecologic Society, Council of University Chairs of Obstetrics and Gynecology, Montana Chapter of the American Academy of Pediatrics, Society for Adolescent Health and Medicine, National Association of Nurse Practitioners in Women's Health, Society for Maternal-Fetal Medicine, Society for Reproductive Endocrinology and Infertility, Society of Family Planning, and Society of OB/GYN Hospitalists*

FRIED, FRANK, HARRIS, SHRIVER & JACOBSON LLP
One New York Plaza
New York, NY 10004
Telephone: 212-859-8000
Email:
janice.macavoy@friedfrank.com

Counsel for Amici Curiae *American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Nursing, American Academy of Pediatrics, American College of Medical Genetics and Genomics, American College of Nurse-Midwives, American College of Osteopathic Obstetricians and Gynecologists, American College of Physicians, American Gynecological and Obstetrical Society, American Medical Association, American Medical Women's Association, American Society for Reproductive Medicine, American Urogynecologic Society, Council of University Chairs of Obstetrics and Gynecology, Montana Chapter of the American Academy of Pediatrics, Society for Adolescent Health and Medicine, National Association of Nurse Practitioners in Women's Health, Society for Maternal-Fetal Medicine, Society for Reproductive Endocrinology and Infertility, Society of Family Planning, and Society of OB/GYN Hospitalists*

409 12th Street SW,
Washington, DC 200024
Telephone: 800-673-8444
Email: ralong@acog.org

Counsel for Amicus Curiae *American College of Obstetricians and Gynecologists*

*Not Admitted in Montana

TABLE OF CONTENTS

STATEMENT OF INTEREST 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. THE STATE'S ALLEGED INTERESTS ARE UNSUPPORTED BY MEDICAL EVIDENCE 4
   - A. Abortion Is Safe 5
   - B. Patients Face Greater Risk When Forced to Continue a Pregnancy to Term 9
   - C. Abortion Care Generally Offers Patients Psychological Benefits, Not Risks 12

II. The State's Restrictions Will Undermine the Patient-Clinician Relationship 14
   - A. H.B. 171 Distorts the Process of Informed Consent 15
   - B. H.B. 136 Forces Medical Professionals to Put the State's Interest Above Patients' Interests 18
   - C. The State Should Not Mandate Health Care Outcomes 19

III. The Restrictions Hinder Access to Abortion Care and Disproportionately Impact Marginalized Patients 20

CONCLUSION 24

TABLE OF AUTHORITIES

Page(s)

Cases

Armstrong v. State,
296 Mont. 361 (1999) .... *passim*

June Med. Servs. L.L.C. v. Russo,
140 S. Ct. 2103 (2020) 8

Planned Parenthood of Montana v. Montana,
No. DV-21-00999 (Mont. 13th Jud. Dist. Ct.) 21, 23

Planned Parenthood v. Casey,
505 U.S. 833 (1992) 20

Whole Woman's Health v. Hellerstedt,
136 S. Ct. 2292 (2016) 8, 20

Statutes

H.R. 136, 67th Leg. (Mont. 2021) .... *passim*

H.R. 140, 67th Leg. (Mont. 2021) 2

H.R. 171, 67th Leg. (Mont. 2021) .... *passim*

Other Authorities

Academy of Medical Royal Colleges, by National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors* 8 (Dec. 2011), https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf 13

ACOG, *Abortion Policy* (2020) 21

ACOG, *ACOG Statement on Medication Abortion* (Mar. 2016) 6

ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists* (2018) 18

ACOG, Committee Opinion No. 390, *Ethical Decision Making In Obstetrics and Gynecology* (2016) 18

ACOG, Committee Opinion No. 587, *Effective Patient-Physician Communication* (2016) 16

ACOG, Committee Opinion No. 798, *Implementing Telehealth in Practice*, 135(2) Obstet. & Gynecol. e73 (2020) 22

ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, 136(6) Obstet. & Gynecol. e107 (2020) 9, 12, 23

ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137(2) Obstet. & Gynecol. e34 (2021) 16

ACOG, *Facts are Important: Medication Abortion "Reversal" Is Not Supported by Science* 15, 16

ACOG and Society for Maternal-Fetal Medicine, *Obstetric Care Consensus: Placenta Accreta Spectrum*, 132(6) Obstet. & Gynecol. e259 (2018) 11

ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage*, 130(4) Obstet. & Gynecol. e168 (2017) 10

ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus*, 131(2) Obstet. & Gynecol. e49 (2018) 11

ACOG, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia*, 135 Obstet. & Gynecol. e237 (2020) 10

ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstet. & Gynecol. e31 (2020) 6, 7, 16, 22

ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2021) 19

Advancing New Standards in Reproductive Health and University of California San Francisco, *The Harms of Denying a Woman a Wanted Abortion: Findings from the Turnaway Study* (last visited Feb. 28, 2022), https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf 14

Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6 (2014) 6

Advancing New Standards in Reproductive Health, *U.S. Studies on Medication Abortion Without In-person Clinician Dispensing of Mifepristone* (2021) 8

Amanda Stevenson, *The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant*, 58(6) Demography 2019 (Oct. 2021) 9

American College of Physicians, *Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship* (July 2012) 17

American Medical Association, *Code of Medical Ethics*, Opinion 1.1.1, *Patient-Physician Relationships* 15, 18

American Medical Association, *Code of Medical Ethics*, Opinion 1.1.3, *Patient Rights* 19

American Medical Association, *Code of Medical Ethics*, Opinion 2.1.3, *Withholding Information from Patients* 15

Biggs et al., *Does Abortion Reduce Self-Esteem and Life Satisfaction?*, 23 Quality Life Res. 2505 (2014) 13

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(2) JAMA Psychiatry 169 (2017) 13

Donna Hoyert, *Maternal Mortality Rates in the United States, 2020*, National Center for Health Statistics (Feb. 2022) 9

Evensen et al., *Postpartum Hemorrhage: Prevention and Treatment*, 95(7) Am. Fam. Physician 442 (2017) 10

Grossman et al., Tex. Pol. Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* (2015) 12

Guttmacher Inst., *State Facts about Abortion: Montana* (2022)....................21

Jatlaoui et al., *Abortion Surveillance—United States, 2015*, 67 Morbidity & Mortality Weekly Rep. (2018) 5

Letter from Janet Woodcock, M.D., Acting Commissioner of Food and Drugs, FDA, to Maureen G. Phipps, MD, MPH, FACOG, CEO, ACOG (Apr. 12, 2021) 8

Letter from Patrizia Cavazzoni, M.D., Director, Center for Drug Evaluation and Research, FDA, to Graham Chelius, M.D., The Society of Family Planning (Dec. 16, 2021) 7

Major et al., *Report of the APA Task Force on Mental Health and Abortion* (2008), http://www.apa.org/pi/women/programs/abortion/mental-health.pdf 13

National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* (2018)....................5, 6

National Women's Health Network, *Safe, Online, Delivered: How to Get the Abortion Pill by Mail* (Mar. 8, 2021), https://nwhn.org/safe-online-delivered-how-to-get-the-abortion-pill-by-mail 7

Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstet. & Gynecol. 215 (Feb. 2012) 10

Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, Commonwealth Fund (Nov. 18, 2020)....................9

Society for Maternal-Fetal Medicine, *Access to Abortion Services* (2020)....................20

The Editors, the American Board of Obstetrics and Gynecology et al., *The Dangerous Threat to Roe v. Wade*, 381 New Eng. J. Med. 979 (2019) 21

Upadhyay et al., *Incidence of Emergency Department Visits Complications After Abortion*, 125(1) Obstet. & Gynecol. 175 (2015) 5, 12

White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 442 (2015) 5

Zane et al., *Abortion-Related Mortality in the United States 1998-2010*, 126 Obstet. & Gynecol. 258 (2015) 6

STATEMENT OF INTEREST

Amici are major local and national organizations representing physicians and other medical professionals who serve patients in Montana and beyond. Collectively, these groups include hundreds of thousands of medical professionals. Among other things, *amici* advocate for patients and practitioners, educate the public about reproductive health, and work to advance the ethical practice of medicine.

Amici are dedicated to ensuring access to the full spectrum of safe and appropriate health care, and work to preserve the patient-clinician relationship. Patients, in consultation with their health care professionals, should have the autonomy to determine the appropriate course of medical care, based on the medical evidence and the patient's own individualized needs, medical history and preferences, without undue interference from third parties. *Amici* oppose the Restrictions, as defined below, which substitute lawmakers' political agenda for the educated and considered decisions that patients make in consultation with their medical professionals.

SUMMARY OF ARGUMENT

Montana House Bill ("H.B.") 136, H.B. 140, and H.B. 171 (collectively, the "Restrictions")[1] threaten to eviscerate access to a safe, legal, and routine health service: abortion. The State submits the Restrictions largely under the guise of protecting maternal health. However, the State legislature does not have unfettered ability to intrude into the realm of health care. To pass the Restrictions, this Court's precedent requires the State to demonstrate a compelling interest in "narrowly defined instances" such as to "preserve the safety, health and welfare of a particular class of patients or the general public from a medically-acknowledged, *bonafide* health risk." *Armstrong v. State*, 296 Mont. 361, 384 (1999) (emphasis in original). Here, the State has failed to meet its burden. The Restrictions unequivocally do not protect maternal health, and will instead harm Montanans seeking reproductive health care.

Abortion does not present a "medically-acknowledged, *bonafide* health risk." *Id.* Overwhelming peer-reviewed, scientific evidence shows that abortion is safe. Indeed, abortion is undoubtedly in the best interest of many patients, for

---

[1] Among other things, H.B. 136 prohibits an abortion of an "unborn child capable of feeling pain," defined as when the gestational age of the "unborn child" is 20 weeks or more; H.B. 140 requires clinicians to inform patients of the opportunity to view an ultrasound; and H.B. 171 requires a host of pre- and post-abortion procedures, as well as requires medications for medication abortions to be dispensed in person.

medical and/or personal reasons. By contrast, the State's Restrictions offer no medical benefit to patients, only obstacles that impede or delay patient access to abortion. Therefore, the State's proffered basis for the Restrictions do not qualify as a compelling state interest. The Restrictions represent the type of "political ideology and the unrelenting pressure from individuals and organizations promoting their own beliefs and values" that this Court cautioned against in *Armstrong*. *Id.*

The Restrictions not only fail to benefit patients; they affirmatively harm patients and professionals who practice medicine in Montana by undermining the patient-clinician relationship that sits at the core of medical practice. The Restrictions would impermissibly intrude into the patient-clinician relationship by requiring clinicians to deliver medically inaccurate information during pre-abortion counseling and by prohibiting clinicians from providing abortions under certain circumstances, regardless of their informed medical opinion on the patient's best interest and the patient's decision. The Restrictions force clinicians to disregard core principles of medical ethics or risk breaking the law. This Court should not countenance such treatment of Montana patients or medical professionals.

Moreover, if the Court allows the Restrictions to go into effect, they will endanger patient health by increasing barriers to access abortion. The Restrictions impose burdens that may make obtaining abortion care impracticable, or in some

circumstances, impossible—especially for marginalized patients who historically face difficulty in accessing abortion.

For all these reasons, *amici* ask this Court to affirm the Montana Thirteenth Judicial District Court's decision granting a preliminary injunction prohibiting the State from enforcing the Restrictions.

ARGUMENT[2]

I. THE STATE'S ALLEGED INTERESTS ARE UNSUPPORTED BY MEDICAL EVIDENCE

The medical community consistently recognizes abortion as one of the safest health services. This fact is demonstrated time and time again by randomized controlled trials, large retrospective cohort studies, patient and clinician surveys, systematic reviews, and epidemiological studies examining abortion cases. Abortion can also offer physiological and psychological benefits to patients. The State's unscientific and unproven assertions that the Restrictions will benefit patients fly in the face of this concrete medical evidence. All the State is doing is making access to highly safe healthcare impracticable or in some instances, impossible.

---

[2] Failure to object specifically in this brief to any provision within the Restrictions should not be construed as *amici's* endorsement of, or agreement with, that provision.

A. Abortion Is Safe

Numerous studies comprehensively demonstrate that abortion is one of the safest health services available; this is regardless of whether the abortion is induced by medication or procedure. Complications from *any* type of abortion are rare. *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States*, at 10 (2018) ("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."). Only an average of 2% of patients experience any complication from abortion care and the majority of complications are minor and easily treatable. *See e.g.*, Upadhyay et al., *Incidence of Emergency Department Visits Complications After Abortion*, 125(1) Obstet. & Gynecol. 175, 181 (2015). The risk of major complications is minimal. As an example, major complications in first trimester aspiration procedures only occur in between 0.1% and 0.5% of patients. White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015).

Death resulting from abortion is extremely rare, occurring in fewer than one in 100,000 patients. *See* Jatlaoui et al., *Abortion Surveillance—United States, 2015*, 67 Morbidity & Mortality Weekly Rep. 1, 45 & tbl. 23 (2018) (finding mortality rate from 0.00052 to 0.00078% for approximate five-year periods from

1978 to 2014); Zane et al., *Abortion-Related Mortality in the United States 1998-2010*, 126 Obstet. & Gynecol. 258, 261-62 (2015) (noting an approximate 0.0007% mortality rate for abortion). By comparison, other routine medical procedures, such as wisdom-tooth removal, colonoscopy, and adult tonsillectomy carry a greater risk of complication and mortality. National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States*, at 75; Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (2014).

It is particularly crucial here to address the safety of medication abortion, given that the State disingenuously claims that H.B. 171—which in part prohibits a clinician from providing medication abortion pills via courier, delivery, or mail service—is necessary to protect patient health. Like procedural abortion, medication abortion is safe. ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstet. & Gynecol. e31, e32 (2020). Mifepristone and misoprostol are the typical pharmaceuticals used for medication abortion in the U.S. and supported by major medical organizations nationally and internationally; the U.S. Food and Drug Administration ("FDA") approved them more than two decades ago. *Id.* at e31. These medications are just as safe as commonly prescribed and over-the-counter medications such as antibiotics and nonsteroidal anti-inflammatory drugs like Advil or Tylenol. *See, e.g.*, ACOG,

ACOG Statement on Medication Abortion (Mar. 2016); National Women's Health Network, *Safe, Online, Delivered: How to Get the Abortion Pill by Mail* (Mar. 8, 2021), https://nwhn.org/safe-online-delivered-how-to-get-the-abortion-pill-by-mail. Requiring patients to obtain these medications in person burdens patients and provides no medical benefit.

The State claims that the possibility of life-threatening risks is a rationale for H.B. 171, but the possibility of complications occurring is so low that it does not support this type of state restriction. Less than 1% of patients will obtain an emergency intervention for excessive bleeding after a medication abortion. ACOG, Practice Bulletin No. 225, 136(4) Obstet. & Gynecol. at e33. However, since the Restrictions are not grounded in medical evidence, they would not mitigate the risks even for the less than 1% of patients who experience complications—if a complication arose, it would arise after the pills were taken, regardless of where the patient obtained them.

Recognizing the safety of medication abortion, last year the FDA eliminated a rule that required mifepristone to be dispensed in person. Letter from Patrizia Cavazzoni, M.D., Director, Center for Drug Evaluation and Research, FDA, to Graham Chelius, M.D., The Society of Family Planning (Dec. 16, 2021). The FDA eliminated it after reviewing medical studies and finding that there was no material increase in serious safety risk that would be garnered by dispensing the

medicine in person. Letter from Janet Woodcock, M.D., Acting Commissioner of Food and Drugs, FDA, to Maureen G. Phipps, MD, MPH, FACOG, CEO, ACOG (Apr. 12, 2021). Similarly, in October 2021, Advancing New Standards in Reproductive Health ("ANSIRH"), a leading research program based at the University of California San Francisco ("UCSF"), published an overview of four U.S. studies on medication abortion provided without in person clinician dispensing of mifepristone. It concluded that serious adverse events occurred in less than 1% of the cases, and no patients died. ANSIRH, *U.S. Studies on Medication Abortion Without In-person Clinician Dispensing of Mifepristone*, at 1 (2021).

All told, both medication and procedural abortion are extremely safe. Not only is the safety of abortion widely recognized by the medical community, the U.S. Supreme Court, among other courts, also recognize the safety of abortions. *See e.g.*, *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2122 (2020) (noting that "abortions are so safe" and as a result, physicians would be unlikely to admit patients to a hospital)); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016) (same). *Amici* oppose medically unnecessary restrictions and prohibitions on safe (and necessary) health care.

B. Patients Face Greater Risk When Forced to Continue a Pregnancy to Term

Continuing with a pregnancy carries a greater risk of death and health complications than obtaining a desired abortion. Statistically, the risk of death associated with childbirth in the U.S. is approximately 14 times higher than the risk associated with getting an abortion. ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, 136(6) Obstet. & Gynecol. e107, e108 (2020). The U.S. has the highest maternal mortality rate among developed countries, and this has been exacerbated by the COVID-19 pandemic. *See, e.g.*, Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, Commonwealth Fund (Nov. 18, 2020) (noting that, in 2018, the rate of maternal deaths in the U.S. was more than double that of most other high-income countries); Donna Hoyert, *Maternal Mortality Rates in the United States, 2020*, National Center for Health Statistics, at 1 (Feb. 2022) (between 2019 and 2020, maternal mortality in the U.S. rose by 14%). Maternal mortality rates may well increase as additional restrictions or prohibitions are placed on abortion care. *See* Amanda Stevenson, *The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on*

Increased Deaths Due to Remaining Pregnant, 58(6) Demography 2019, 2023-26 (Oct. 2021).

Moreover, continuing with a pregnancy poses a greater risk to patients' overall physical health when compared to the risk of obtaining an abortion. A 1998 to 2001 study of maternal complications found them more common in patients who gave birth as compared to patients who obtained abortion care. Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstet. & Gynecol. 215, 216–17 & Fig. 1 (Feb. 2012). These complications ranged from moderate to potentially life-threatening, including anemia, hypertensive disorders, pelvic or perineal trauma, mental health conditions, obstetric infections, postpartum hemorrhage, antepartum hemorrhage, asthma, and excessive vomiting. *Id. See also* ACOG, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia*, 135(6) Obstet. & Gynecol. e237, e237 (2020) (noting that hypertensive disorders of pregnancy is a leading cause of maternal and perinatal mortality worldwide); ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage,* 130(4) Obstet. & Gynecol. e168, e168 (2017) (noting that postpartum hemorrhage may lead to adult respiratory distress syndrome, shock, abnormal blood clotting, acute renal failure, loss of fertility, and death); Evensen et al., *Postpartum Hemorrhage: Prevention and Treatment*, 95(7) Am. Fam. Physician 442, 442 (2017) (noting that about 3-5% of obstetric patients

will experience postpartum hemorrhage, a preventable event that is the cause of 12% of maternal deaths in the U.S.).

In addition to developing pregnancy-related conditions such as gestational diabetes mellitus or placenta accreta, pregnancy can also exacerbate or complicate pre-existing medical conditions that frequently (and sometimes severely) worsen with pregnancy such as congenital heart disease, postpartum cardiomyopathy, and pulmonary hypertension. ACOG and Society for Maternal-Fetal Medicine ("SMFM"), *Obstetric Care Consensus: Placenta Accreta Spectrum,* 132(6) Obstet. & Gynecol. e259, e259 (2018); ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus,* 131(2) Obstet. & Gynecol. e49, e49 (2018) (explaining that gestational diabetes mellitus is one of the most common medical complications of pregnancy). Pregnant patients who develop placenta accreta, where the placenta grows too deeply into the uterine wall, are more likely to require hysterectomy and experience greater rates of maternal morbidity and mortality. *See* ACOG and SMFM, *Obstetric Care Consensus: Placenta Accreta Spectrum,* 132(6) Obstet. & Gynecol. at e259. Patients who previously underwent a cesarean delivery, which puts them at a greater risk of developing placenta accreta, may have a strong preference to obtain an abortion. *Id.* When abortion—a safe health service—is desired by the patient and is medically appropriate, the patient should not be forced

to continue a pregnancy to term and be subjected to serious health risks, and possibly death.

The Restrictions will also increase the possibility that Montanans may attempt self-induced abortions through harmful or unsafe methods, and some of those unsafe abortions will be fatal. Upadhyay et al., 125 Obstetrics & Gynecology at 181. Studies have found that women are more likely to self-induce abortions where they face barriers to reproductive healthcare, and methods of self-induction outside safe medical abortion (i.e., abortion by pill) may rely on harmful methods such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills. Grossman et al., Tex. Pol. Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015). Approximately 25 million patients worldwide obtain unsafe abortions each year, resulting in approximately 44,000 maternal deaths. ACOG, *Increasing Access to Abortion*, 136(6) Obstet. & Gynecol. at e108. Montana patients should have access to safe abortions and not to be forced to risk their lives to terminate a pregnancy.

C. Abortion Care Generally Offers Patients Psychological Benefits, Not Risks

The scientific evidence reviewed by the American Psychological Association ("APA") and the Academy of Royal Medical Colleges in the United Kingdom establishes that there is no causal association between abortion and

adverse mental health outcomes. Major et al., *Report of the APA Task Force on Mental Health and Abortion*, at 4 (2008), http://www.apa.org/pi/women/programs/abortion/mental-health.pdf; Academy of Medical Royal Colleges, by National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence and Associated Factors* 8 (Dec. 2011), https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf; *see also* 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(2) JAMA Psychiatry 169, 177 (2017); Biggs et al., *Does Abortion Reduce Self-Esteem and Life Satisfaction?*, 23 Quality Life Res. 2505, 2509-12 (2014). The 2008 APA Task Force Report found that "[t]he best scientific evidence published indicates that among adult [patients] who have an *unplanned pregnancy* the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy." Major et al., *Report of the APA Task Force on Mental Health and Abortion*, at 4.

In fact, evidence shows that there are mental health benefits associated with patients who want an abortion and are able to obtain it. For example, according to a five-year, longitudinal cohort study of more than 900 patients conducted at

UCSF, patients who obtained a wanted abortion are more financially stable, set more ambitious goals, raise children under more stable conditions, and are more likely to have a wanted child later in life. ANSIRH and UCSF, *The Harms of Denying a Woman a Wanted Abortion: Findings from the Turnaway Study*, at 2 (last visited Feb. 28, 2022), https://www.ansirh.org/sites/default/files/publications/files/the_harms_of_denying_a_woman_a_wanted_abortion_4-16-2020.pdf. The totality of this evidence suggests that the State would be endangering the physical and psychological well-being of Montana patients if the Restrictions effectively forced patients to continue unwanted pregnancies to term by the Restrictions.

II. The State's Restrictions Will Undermine the Patient-Clinician Relationship

In many instances, the Restrictions will seriously undermine the mutually respectful alliance that is the patient-clinician relationship. The patient-clinician relationship is the central focus of ethical considerations in the health care setting. Trust between clinicians and patients is critical for the provision of safe, high quality medical care. Yet, the Restrictions disrupt and intrude into the patient-clinician relationship by, among other things, requiring clinicians to (i) deliver medically inaccurate and/or unnecessary information to patients; and (ii) abstain from providing appropriate health care to patients with a pregnancy of certain gestational ages.

A. <u>H.B. 171 Distorts the Process of Informed Consent</u>

H.B. 171 allows the State to intrude into the patient-clinician relationship by usurping clinicians' professional judgment and mandating a variety of pre-abortion processes that are medically inaccurate and/or medically unnecessary. The patient-clinician relationship is built upon trust and open, forthright communication. Clinicians are ethically obligated to provide truthful, comprehensive, relevant and evidence-based information, not scientifically inaccurate, politically-motivated information. *See* American Medical Association ("AMA"), *Code of Medical Ethics*, Opinion 2.1.3, *Withholding Information from Patients* ("Truthful and open communication between physician and patient is essential for trust in the relationship and for respect for autonomy."). Unless a patient has a high level of confidence in the clinician's professional skill and in the clinician having the patient's best interest in mind, the foundation of the relationship is unsound. AMA, *Code of Medical Ethics*, Opinion 1.1.1, *Patient-Physician Relationships*.

Sections 7 and 8 of H.B. 171 undermine these core values by requiring medical professionals to misinform their patients. For example, clinicians must provide "state-prepared materials," about "reversing" the effects of a medication abortion. H.B. 171 §§ 7, 8. Yet claims regarding abortion "reversal" are not based on science and do not meet clinical standards. ACOG, *Facts are Important:*

Medication Abortion "Reversal" Is Not Supported by Science; *see also* ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstet. & Gynecol. at e33. Any such "reversal" treatments are purely experimental; there is no FDA-approved protocol for a "reversal" of medication abortion. *See* ACOG, *Facts are Important: Medication Abortion "Reversal" Is Not Supported by Science*. The State provides no medical or scientific justification for Sections 7 and 8 of H.B. 171—and there is none—and thus fails to meet its burden established in *Armstrong*.

Requiring clinicians to deliver medically and scientifically inaccurate information to patients fundamentally destabilizes the patient-clinician relationship. The patient-centered informed consent process for abortion care includes the clinician counseling their patient through open and frank conversation on the risks and benefits of abortion, based on current scientific evidence and medical knowledge. *See* ACOG, Committee Opinion No. 587, *Effective Patient-Physician Communication*, at 1-3 (2016). The State should not insert itself into these sensitive personal conversations by requiring medically inaccurate information. Providing inaccurate information not only erodes the trust at the core of the patient-clinician relationship, but such a mandate based on unproven, speculative research impedes a patient's ability to make informed health care decisions and may be dangerous to patient health. *See* ACOG, Committee Opinion

No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137(2) Obstet. & Gynecol. e34, e34 (2021). One possible result of H.B. 171 is that patients may decide to have an abortion under the mistaken belief that they can later change their minds, which could clearly have harmful consequences for patient health.

As another example, Section 7 of H.B. 171 requires that prior to obtaining a medication abortion a clinician "provide" a patient with "all of the information required in this subsection (5)." H.B. 171 § 7(5)(k). That information includes a state-created consent form that the patient must sign and initial, and that "must include" the statement that the medication abortion "will result in the death of the unborn child." *Id.* at § 7(5)(j). This is not medical information and would require a clinician to "provide" information that refers to a fetus as an "unborn child" for political and not scientific reasons. This statement is wholly irrelevant to providing abortion care and enlists medical professionals as state agents. It compels clinicians to convey a political point of view that is not grounded in science or accepted by the medical community. The State would like to coerce clinicians into providing misinformation, which obviously would undermine informed consent.

Laws and regulations should not mandate the content of what clinicians may or may not say to their patients. American College of Physicians, *Statement of*

Principles on the Role of Governments in Regulating the Patient-Physician Relationship (July 2012). Such laws undermine the efficacy of the patient-clinician relationship and leave clinicians in untenable positions; ethically, medical professionals must place their patients' welfare above other obligations, such as obligations to repeat State-mandated doctrine. *See* AMA, *Code of Medical Ethics*, Opinion 1.1.1, *Patient-Physician Relationships*.

B. H.B. 136 Forces Medical Professionals to Put the State's Interest Above Patients' Interests

H.B. 136 also comes between patients and medical professionals by effectively forcing clinicians to choose between providing medically appropriate care and complying with state law. The patient-clinician relationship is grounded in an understanding that clinicians will adhere to certain medical ethics. Of utmost importance, clinicians must act in a way that is likely to benefit their patients and clinicians must refrain from acting in ways that might harm their patients, unless the harm is justified by concomitant benefits. ACOG, Committee Opinion No. 390, *Ethical Decision Making In Obstetrics and Gynecology*, at 3-4 (2016). Similarly, medical professionals should take all reasonable steps to ensure that they provide the most appropriate care to the patient. ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, at 2 (2018). Patients rightfully expect that their clinician will provide guidance about what they consider the optimal course of action for the patient based on the clinician's

objective professional judgment. AMA, *Code of Medical Ethics*, Opinion 1.1.3, *Patient Rights*.

In direct contravention of these principles, H.B. 136 replaces medical judgment by prohibiting safe and medically appropriate abortions. A patient who has decided to obtain an abortion after 20 weeks is unable to access such care from a trained, qualified clinician "unless it is necessary to prevent a serious health risk to the unborn child's mother." H.B. 136 § 3. Patients rely on their clinician's medical judgment, based on the trust established in the patient-clinician relationship. H.B. 136 undermines this relationship by commandeering the clinician's ability to provide a highly safe health service to patients with a pregnancy of certain gestational ages. In essence, H.B. 136 substitutes the judgment of legislators for patients' personal health care decisions and clinicians' professional judgments.

C. The State Should Not Mandate Health Care Outcomes

Through the Restrictions, the State inserts itself into the patient-clinician relationship without demonstrating what this Court requires: a "medically-acknowledged *bonafide* health risk." *Armstrong,* 296 Mont. at 384 (emphasis in original). *Amici*, along with many other medical organizations, oppose legislation that interferes with the patient-clinician relationship. *See, e.g.*, ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the*

Patient-Physician Relationship (2021); SMFM, *Access to Abortion Services*, at 1 (2020). The U.S. Supreme Court has consistently held that laws regulating abortion care that unduly interfere with medical professionals' ability to act in the best interest of their patients, and interfere with a patient's right to access abortion, should be struck down. *See, e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 877-79 (1992); *June Med. Servs. L.L.C.*, 140 S. Ct. at 2132-33; *Whole Woman's Health*, 136 S. Ct. at 2312-13. Moreover, in *Armstrong*, this Court held that, subject to *narrow* qualification, the legislature has neither "a legitimate presence nor voice in the patient/health care provider relationship superior to the patient's right of personal autonomy which protects the relationship from infringement by the state." *Armstrong*, 296 Mont. at 384. The State has demonstrated no "bonafide" health risk to justify the significant intrusions into the patient-clinician relationship represented by the Restrictions, and they should continue to be enjoined. Any other result may have profoundly harmful consequences to the integrity of the medical profession and the patient-clinician relationship, as well as the safety and well-being of patients.

III. The Restrictions Hinder Access to Abortion Care and Disproportionately Impact Marginalized Patients

The Restrictions threaten to destabilize reproductive health care in Montana, which is an essential component of health care. As *amici* recognize, "[a]ccess to legal and safe pregnancy termination . . . is essential to the public health of women

everywhere." The Editors, the American Board of Obstetrics and Gynecology et al., *The Dangerous Threat to Roe v. Wade*, 381 New Eng. J. Med. 979, 979 (2019); *see also* ACOG, *Abortion Policy* (2020). At present, notwithstanding the Restrictions, Montana patients already have extremely limited access to abortion care. There are only seven generally available abortion clinics in the State, meaning that patients already have to travel long distances. An astounding 93% of Montana counties, where over half of Montana women live, have no clinic providing abortion. Guttmacher Inst., *State Facts about Abortion: Montana* (2022). The Restrictions will eviscerate that already limited access, with the most dire consequences falling on the most vulnerable Montanans.

The impact of the Restrictions will be immediate and tangible. For example, the prohibition on dispensing medications for medication abortions by courier, delivery, or mail service will force Montanans living in remote areas to travel vast distances across the state to obtain medication they can now access by delivery. *See* Rebuttal Affidavit of Colleen McNicholas at ¶ 30, *Planned Parenthood of Montana v. Montana*, No. DV-21-00999 (Mont. 13th Jud. Dist. Ct. Sept. 17, 2021). Because medication abortion is only available in Montana up to 77 days of gestation, requiring in person visits for medication abortions is an obvious attempt to interfere with Montanans seeking medication abortion regardless of whether their clinician believes it is the best medical course of action. ACOG, Practice

Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstet. & Gynecol. at e32. By limiting care in this way, the State ignores evidence showing that telehealth provides comparable health outcomes when compared to other methods of health care delivery without compromising the patient-clinician relationship. Telehealth also enhances patient satisfaction and improves patient engagement. ACOG, Committee Opinion No. 798*, Implementing Telehealth in Practice*, 135(2) Obstet. & Gynecol. e73, e74 (2020). The State attempts to ban a form of medical counseling that is increasingly used in "nearly *every* aspect of obstetrics and gynecology," when there is no basis to suggest that requiring in person visits offers patients any health benefit. *See id.* (emphasis added).

As a second example, Section 7 of H.B. 171 requires a patient seeking a medication abortion to provide informed consent at least 24 hours before the medication is provided to the patient. Under Section 4 of H.B. 171, the patient must then pick up the medication in person. Section 5 of H.B. 171 requires clinicians to "schedule a follow-up visit for the [patient] at approximately 7 to 14 days" after the medication abortion. H.B. 171 §5(3). The clinician must "make all reasonable efforts to ensure that the patient returns for the scheduled appointment." *Id.* Thus, under this proposed statutory scheme, the patient must make *at least* two trips to a clinic to obtain an abortion, and for clinicians to be in compliance, the

patient must make a *third* trip. This requirement obstructs patients trying to access safe, basic health care, and provides absolutely no medical benefit.

As a third example, the Restrictions may deter clinicians from providing abortion care at all due to the strict penalties, including criminal, civil, and/or professional sanctions, for violating the Restrictions. This situation may only further exacerbate the shortage of health care professionals providing abortion in Montana and would mean patients may need to travel even further to access such care, or forego it entirely.

These are merely three examples of the multiple negative impacts the Restrictions would have on patients. The State well knows that many patients seeking abortion cannot manage multiple clinic visits and long-distance travel while caring for children and keeping their jobs. *Amici* work to combat the disparities in health outcomes and access to reproductive health care for members of racial and ethnic minority groups, socioeconomically disadvantaged populations, and underserved rural populations. These people are the very patients who are stymied by the time and expense of traveling across a large state like Montana. *See generally* ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, at e111-112; *see also* Affidavit of Colleen McNicholas at ¶ 12, *Planned Parenthood of Montana v. Montana*, No. DV-21-00999) (Mont. 13th Jud. Dist. Ct. Aug. 13, 2021) (noting that approximately 75% of abortion patients

nationwide are poor or low income). Marginalized patients are more likely to work hourly jobs with inflexible time off and limited ability to miss shifts. For the many patients seeking abortion who already have children, finding appropriate child care for clinic visits, especially multiple trips, is challenging and often infeasible. The Restrictions will especially burden these marginalized patients who have faced systemic barriers to abortion access, exacerbating the very disparities in reproductive health and health care that *amici* work to combat.

CONCLUSION

For all the reasons stated above, the Court should affirm the Montana Thirteenth Judicial District Court's decision granting a preliminary injunction prohibiting the State from enforcing the Restrictions.

DATED this 28 day of March, 2022.

Respectfully submitted,

/s/ Lindsay Beck
LINDSAY BECK, ESQ.
Counsel for Amici

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this brief is printed with a proportionately-spaced, 14-point Times New Roman typeface, is double spaced (excluding footnotes, quoted, and indented material), has margins of 1-inch, and has a word count of 4,999 words, excluding the exempted cover page, tables, certificates, and signature.

DATED this 28 day of March, 2022.

/s/ Lindsay Beck
LINDSAY BECK, ESQ.

CERTIFICATE OF SERVICE

I, Lindsay Beck, hereby certify that I have served true and accurate copies of the foregoing Brief - Amicus to the following on 03-28-2022:

Austin Miles Knudsen (Govt Attorney)
215 N. Sanders
Helena MT 59620
Representing: State of Montana
Service Method: eService

Kristin N. Hansen (Govt Attorney)
215 N. Sanders
Helena MT 59601
Representing: State of Montana
Service Method: eService

David M.S. Dewhirst (Govt Attorney)
215 N Sanders
Helena MT 59601
Representing: State of Montana
Service Method: eService

Kathleen Lynn Smithgall (Govt Attorney)
215 N. Sanders St.
Helena MT 59601
Representing: State of Montana
Service Method: eService

Brent A. Mead (Govt Attorney)
215 North Sanders
Helena MT 59601
Representing: State of Montana
Service Method: eService

Patrick Mark Risken (Govt Attorney)
215 N. Sanders
Helena MT 59620-1401
Representing: State of Montana
Service Method: eService

Raphael Jeffrey Carlisle Graybill (Attorney)
300 4th Street North
PO Box 3586
Great Falls MT 59403
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: eService

Gene R. Jarussi (Attorney)
Bishop, Heenan & Davies
1631 Zimmerman Tr, No. 1
Billings MT 59102
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: eService

Emily Jayne Cross (Attorney)
401 North 31st Street
Suite 1500
P.O. Box 639
Billings MT 59103-0639
Representing: Montana Constitutional Convention Delegates
Service Method: eService

Akilah Maya Lane (Attorney)
2248 Deerfield Ln
Apt B
Helena MT 59601
Representing: ACLU of Montana Foundation, Inc., National Women's Law Center, Center for Reproductive Rights
Service Method: eService

Kyle Anne Gray (Attorney)
P.O. Box 639
Billings MT 59103
Representing: Montana Constitutional Convention Delegates
Service Method: eService

Brianne McClafferty (Attorney)
401 North 31st Street, Suite 1500
P. O. Box 639
Billings MT 59103-0639
Representing: Montana Constitutional Convention Delegates
Service Method: eService

Alexander H. Rate (Attorney)
713 Loch Leven Drive
Livingston MT 59047
Representing: ACLU of Montana Foundation, Inc., National Women's Law Center, Center for Reproductive Rights
Service Method: eService

Matthew Prairie Gordon (Attorney)
1201 Third Ave
Seattle WA 98101
Representing: Asian Institute on Gender-Based Violence, Aspen, Caminar Latino, Custer Network Against Domestic Abuse, Inc., District 4 Human Resources Development Council, Domestic and Sexual Violence Services, Idaho Coalition Against Sexual & Domestic Violence, Latinos United for Peace and Equity, Legal Voice, Montana Coalition Against Domestic and Sexual Violence, National Coalition Against Domestic Violence, National Network to End Domestic Violence, Richland County Coalition Against Domestic Violence, Safe in the Bitterroot, Safe Space, Sanders County Coalition for Families, Sexual Assault Counseling Center, UJIMA, Inc., Victim-Witness Assistance Services, YWCA Great Falls, YWCA Missoula
Service Method: eService

Kimberly Parker (Attorney)
1875 Pennsylvania Avenue NW
Washington DC 20006
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Hana Bajramovic (Attorney)
123 William St., Floor 9
New York NY 10038
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Alice Clapman (Attorney)
1110 Vermont Ave, NW Ste 300
Washington DC 20005
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Nicole Rabner (Attorney)
1875 Pennsylvania Avenue NW
Washington DC 20006
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Alan Schoenfeld (Attorney)
7 World Trade Center, 250 Greenwich Street
New York NY 10007
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Michelle Diamond (Attorney)
7 World Trade Center, 250 Greenwich Street
New York NY 10007
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Electronically Signed By: Lindsay Beck
Dated: 03-28-2022