No. 2022-SC-0329-TG

In the

Supreme Court of Kentucky

DANIEL CAMERON,

Appellant,

v.

EMW WOMEN'S SURGICAL CENTER, P.S.C., ET AL.,

Appellees.

On Appeal from Jefferson Circuit Court No. 22-CI-3225

BRIEF FOR *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN COLLEGE OF PHYSICIANS, AND SOCIETY FOR MATERNAL-FETAL MEDICINE

Molly A. Meegan*
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
409 12th Street, SW
Washington, D.C. 20024
(202) 863-2585
mmeegan@acog.org

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

* *admitted pro hac vice*

Michael P. Abate (KBA No. 95259)
KAPLAN JOHNSON ABATE & BIRD LLP
710 West Main Street, 4th Floor
Louisville, KY 40202
(502) 416-1630
mabate@kaplanjohnsonlaw.com

Kimberly Parker*
WILMER CUTLER PICKERING HALE AND DORR LLP
1875 Pennsylvania Avenue NW
Washington, D.C. 20006
(202) 663-6000
kimberly.parker@wilmerhale.com

Counsel for Amici Curiae *the American College of Obstetricians and Gynecologists, American Medical Association, American Academy of Family Physicians, American College of Physicians, and Society for Maternal-Fetal Medicine*

CERTIFICATE OF SERVICE

In accordance with CR 76.12(5), on October 3, 2022, the undersigned sent for filing, via Federal Express, the original and nine (9) true and correct copies of this brief to Kelly Stephens, Clerk of Supreme Court of Kentucky, State Capitol, Room 235, 700 Capital Ave., Frankfort, KY 40601-3415. The undersigned counsel further certifies that he served a true and correct copy of this brief by mailing the same, First-Class U.S. Mail, postage prepaid, to:

Hon. Mitch Perry, Circuit Judge
Jefferson County Judicial Center
700 West Jefferson Street
Louisville, KY 40202

Matt Kuhn
Office of the Attorney General
700 Capital Avenue, Suite 118
Frankfort, KY 40601
Matt.Kuhn@ky.gov

Wesley W. Duke
Office of Legal Services
Cabinet for Health and Family Services
275 East Main Street 5W-A
Frankfort, KY 40621
WesleyW.Duke@ky.gov

Leanne Diakov
Kentucky Board of Medical Licensure
310 Whittington Parkway, Suite 1B
Louisville, KY 40222
Leanne.Diakov@ky.gov

Thomas Wine
Jason Moore
Office of the Commonwealth's Attorney
30th Judicial Circuit
514 West Liberty Street
Louisville, KY 40202
jbmoore@louisvilleprosecutor.com

Michele Henry
Craig Henry PLC
401 West Main Street, Suite 1900
Louisville, KY 40202

Brigitte Amiri
Chelsea Tejada
Faren Tang
ACLU Foundation
125 Broad Street, 18th Floor
New York, NY 10004

Heather L. Gatnarek
ACLU of Kentucky
325 Main Street, Suite 2210
Louisville, KY 40202

Carrie Flaxman
Planned Parenthood Federation of America
1110 Vermont Avenue, NW, Suite 300
Washington, D.C. 20005

Leah Godesky
Kendall Turner
O'Melveny & Myers LLP
1999 Avenue of the Stars
Los Angeles, CA 90067

Clerk, Kentucky Court of Appeals
360 Democrat Drive
Frankfort, KY 40601

Counsel for *Amici Curiae*

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INTEREST OF AMICI CURIAE

Amici Curiae the American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), the American Academy of Family Physicians ("AAFP"), the American College of Physicians ("ACP"), and the Society for Maternal-Fetal Medicine ("SMFM") are leading medical societies representing physicians, nurses, and other clinicians who serve patients in Kentucky and nationwide, and whose policies represent the education, training, and experience of the vast majority of clinicians in this country.

ACOG is the nation's leading group of physicians providing health care for women. With over 60,000 members, ACOG advocates for quality health care for women, and is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.[1]

The AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in 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.

[1] *See, e.g., June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue).

AAFP, headquartered in Leawood, Kansas, is the national medical specialty society representing family physicians. Founded in 1947 as a not-for-profit corporation, its 136,700 members are physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and serving the needs of its members with professionalism and creativity.

ACP is the largest medical specialty organization and the second-largest physician membership society in the United States. ACP members include 160,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness.

SMFM, founded in 1977, is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM represents more than 5,500 members who care for high-risk pregnant people. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

INTRODUCTION AND PURPOSE OF AMICI'S BRIEF

Abortion is an essential part of comprehensive health care. When abortion is legal, it is safe. *Amici*'s position is that state laws that criminalize and effectively ban abortion: (1) are not based on any medical or scientific rationale; (2) threaten the health of pregnant patients; (3) disproportionately harm patients of color, patients in rural settings, and patients with low income; and (4) impermissibly interfere with the patient-physician relationship and undermine

longstanding principles of medical ethics.[2]

In the wake of *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), two statutory abortion restrictions went into effect in Kentucky: KRS 311.772, which imposes criminal penalties on individuals who provide abortions (the "Trigger Ban")[3] and KRS 311.7701 to -11, which imposes criminal penalties on individuals who provide abortions after embryonic cardiac activity is detectable, typically around the sixth week of pregnancy (the "Six-Week Ban").[4] Collectively and individually, the Bans are—without any valid medical justification—jeopardizing the health and safety of pregnant Kentuckians and placing extreme burdens and risks upon providers of essential reproductive health care. *Amici* oppose these laws.

ARGUMENT

I. Despite the Safe and Routine Nature of Abortions, Kentucky's Bans Effectively Prohibit All Abortions with No Medical Justification

As discussed in the *amicus* brief filed in the Circuit Court, the medical community

[2] *See* AMA, *Press Release: AMA bolsters opposition to wider criminalization of reproductive health* (June 14, 2022) ("[I]t is a violation of human rights when government intrudes into medicine and impedes the access to safe, evidence-based reproductive health services, including abortion and contraception."); ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference* (July 7, 2022).

[3] Ky. Rev. Stat. Ann. ("KRS") § 311.772 (West).

[4] KRS § 311.7701-11.

recognizes abortion is a safe,[5] routine,[6] and essential[7] component of reproductive health care. *See* Br. *Amici Curiae* Supp. Pls.' Mot. Restraining Order & Temp. Inj. ("ACOG Br.") at 4-6. Despite these facts, the Trigger Ban and the Six-Week Ban individually and collectively effect a near-total prohibition against any and all abortion care. Each Ban has narrow exceptions, essentially permitting abortion only where it is intended to prevent the death or permanent impairment of a major bodily function of the pregnant person.[8] ACOG Br. at 7-13, 17-20.

Neither the Bans nor their extraordinarily limited exceptions are grounded in medical science and best practices. For example, the Six-Week Ban reflects the legislature's misunderstanding of key medical issues and terminology. *Amici* understand that Kentucky

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[5] *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (2018) ("*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."); Kortsmit et al., U.S. Dep't of Health & Human Services, Centers for Disease Control and Prevention, *Abortion Surveillance—United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl. 15 (2021); Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012); 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).

[6] In 2020, over 930,000 abortions were performed nationwide. Jones et al., Guttmacher Inst., *Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court is Poised to Overturn* Roe v. Wade (June 15, 2022). More than 4,000 abortions were performed in Kentucky in 2020. KY Dept. for Pub. Health, *Kentucky Annual Abortion Report for 2020*, at 2. Approximately one quarter of American women have an abortion before the age of 45. Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).

[7] *See, e.g.*, Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine that "[a]ccess to legal and safe pregnancy termination … is essential to the public health of women everywhere"); ACOG, *Abortion Policy* (revised and approved May 2022); Soc'y for Maternal-Fetal Med., *Access to Abortion Services* (2020); ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference*, *supra* note 2.

[8] KRS § 311.772; KRS § 311.7701-11.

believes its definition of "fetal heartbeat" includes the embryonic cardiac activity that occurs as a result of electrical flickering of a portion of the embryonic tissue, which typically is detectable at approximately six weeks' gestation. However, as a matter of medical science, a true fetal heartbeat exists only after the chambers of the heart have been developed and can be detected via ultrasound, which typically occurs around 17-20 weeks' gestation.[9]

In addition, as discussed in the *amicus* brief filed in the Circuit Court, although the Six-Week Ban purports to allow individuals to seek an abortion before approximately six weeks' gestation, in practice, due to the ways in which pregnancy symptoms are observed and challenges in seeking care, the Six-Week Ban will prevent many pregnant patients who seek abortion care from obtaining that care. *See* ACOG Br. 9-10.

Moreover, the Bans do not permit patients to consult with their clinicians about the risks of continuing a pregnancy that may not be viable or that involves genetic, chromosomal, or other issues that may affect the likelihood of survival of a fetus or child after birth.[10] Most major fetal anomalies are not detected until after at least 11 weeks of gestation,[11] weeks after even the Six-Week Ban prohibits abortion care. The Bans will therefore force pregnant patients who cannot obtain abortion care to carry to term fetuses with little or no life

[9] *See* ACOG, *Guide to Language and Abortion* 1 (Mar. 2022).

[10] Soc'y for Maternal-Fetal Med., *Access to Abortion Services*, *supra* note 7, at 1.

[11] Fong et al., *Detection of Fetal Structural Abnormalities with US During Early Pregnancy*, 24 RadioGraphics 157, 172-173 (Jan.-Feb. 2004); Kashyap et al., *Early Detection of Fetal Malformation, a Long Distance Yet to Cover! Present Status and Potential of First Trimester Ultrasonography in Detection of Fetal Congenital Malformation in a Developing Country: Experience at a Tertiary Care Centre in India*, 2015 Journal of Pregnancy 1, 6 (2015) (finding that, out of the total number of women with diagnosed fetal malformation, 65% presented before 20 weeks of gestation and of that, only 1.6% were diagnosed prior to 12 weeks of gestation); Rydberg & Tunon, *Detection of Fetal Abnormalities by Second-Trimester Ultrasound Screening in a Non-Selected Population*, 96 Acta Obstetricia Gynecologica Scandinavica 176, 176 (Nov. 22, 2016) (finding that half of the major structural malformations in otherwise normal fetuses were detected by routine ultrasound examination in the second trimester).

expectancy, which may also present life-threatening or life-altering risks to the pregnant patient.

II. By Prohibiting Abortions, the Bans Will Harm Pregnant Patients' Health

Either of Kentucky's bans will cause severe and detrimental physical and psychological health consequences for pregnant patients. The Bans will cause (i) delays in abortion care, (ii) a likely increase in the number of self-managed abortions using harmful or unsafe methods—that is, self-managed methods other than procuring appropriate medications through licensed providers,[12] and (iii) the forced continuation of pregnancies to term despite the informed judgment of the patient and clinician that termination is appropriate in a given case. Each of these scenarios can increase the risk of harm to pregnant patients.

Both the Trigger Ban and Six-Week Ban have limited medical-necessity exceptions, but they do not mitigate the risks posed to pregnant patients. The narrow exceptions are vague and create risks that clinicians' judgment and expertise will be questioned or displaced by elected officials with no medical training and who are not present in the exam room with the patient. Moreover, they are inadequate to protect the health of pregnant patients because they do not permit patients to obtain an abortion in a wide range of circumstances that could risk substantial harm to patients and yet do not fall within the narrow exceptions, as is described *infra* Part **Error! Reference source not found.**.

A. The Bans Will Endanger the Physical and Psychological Health of Pregnant Patients

Criminalizing safe abortions provided by a licensed clinician in the State of Kentucky

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[12] The safety of medication abortion is well established. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013) (regarding major complication rates for medication abortion); Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

will likely result in delays in obtaining abortions and/or an increased number of self-managed abortions through harmful or unsafe methods. *See* ACOG Br. at 13-14. Though the risk of complications from an abortion overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication.[13] In addition, studies have found that women are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-management outside safe medication abortion (i.e., abortion by pill) may rely on harmful tactics such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or dangerously misusing hormonal pills.[14]

Those patients who do not, or cannot, obtain an abortion due to the Bans will be forced to continue a pregnancy to term—an outcome with significantly greater health and mortality risks. A pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[15] Evidence also suggests that pregnant people denied abortions because of gestational age limits are more likely to experience negative psychological health outcomes—such as anxiety, lower self-esteem, and lower life satisfaction—than those who obtained an abortion.[16]

B. The Narrow Exceptions Do Not Adequately Protect Patients' Health

The narrow maternal health-related exceptions of the Trigger Ban and Six-Week Ban are insufficient to protect the health of the pregnant patient. Pregnancy can exacerbate existing

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[13] *See* Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015).

[14] *See, e.g.*, Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest); Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, 92 Contraception 360 (2015).

[15] *Id.*

[16] 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, 172 (2017).

health issues that do not always lead to death or permanent impairment of a life-sustaining organ, but nevertheless pose serious health risks for patients during pregnancy.[17] The Kentucky Bans and their exceptions do not and cannot give clinicians workable guidance about when procedures are permitted or prohibited in what are often complex and nuanced situations that call for medical judgment and expertise, rather than legislatively-imagined but medically non-existent bright lines.

The risks of such uncertainty are especially evident with respect to managing early pregnancy loss. For example, incomplete miscarriages are commonly treated via uterine aspiration, which is the same procedure used for the majority of abortions (other than medication abortions).[18] Neither of the Kentucky Bans clearly state that miscarriage management is permissible or protect clinicians that must use their medical judgment to determine the best treatment plan and provide care in the moment. And the State's bare assertion that the Bans' *mens rea* requirements exempt miscarriage care offers little certainty to clinicians. The State asserts that neither Ban "applies when a pregnant mother suffers a miscarriage" because each requires the "knowing[]" or "intent[ional]" "termination of the life of an unborn human being." Opening Br. Atty. Gen. 26-27. But intervention to terminate a non-viable pregnancy can be medically indicated for patients showing signs of early pregnancy

[17] *See, e.g.*, Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (2007); Stout & Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-647 (2002); Kiely et al., *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013); Greene & Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

[18] Allen et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625, 632 (2013) (uterine aspiration is used for induced abortion and treatment of miscarriages); Dennis et al., *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141, 141, 143 (2015) (technical aspects of miscarriage management and induced abortion are the same).

loss even where embryonic cardiac activity is detected. For example, studies show that bleeding in early pregnancy coupled with slower than average embryonic cardiac activity accurately predicts early pregnancy loss.[19] Medical intervention to terminate a non-viable pregnancy may be the medically indicated treatment to prevent excessive blood loss even where some cardiac activity remains.

Indeed, *amici* are aware of many recent examples in the news of patients being denied medically indicated care for miscarriages as a result of bans similar to those in Kentucky. In Texas, for example, a patient experiencing a miscarriage was turned away from the hospital and told to return "only if she was bleeding so excessively that her blood filled a diaper more than once per hour."[20] Another Texas patient whose water broke at 18 weeks' gestation was forced to wait until she had a severe infection before receiving treatment.[21] And in Wisconsin, a patient bled for ten days before she was treated for an incomplete miscarriage, putting her at risk of severe blood loss and infection.[22]

Similarly, the Trigger Ban does not contain an explicit exception for an ectopic pregnancy (which occurs when a fertilized egg implants and grows in a location that cannot

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[19] Bromley et al., *An Imaging Approach to Early Pregnancy Failure*, 65 Contemporary OB/GYN 37, 39-40 (2020) (100% chance of loss if cardiac activity is slower than 100 beats per minute at 7 weeks of gestation); *accord* ACOG, Practice Bulletin No. 200: *Early Pregnancy Loss* (Nov. 2018, reaff'd 2021) (slow fetal heart rate and subchorionic hemorrhage suggestive of early pregnancy loss); Doubilet et al., *Long-term Prognosis of Pregnancies Complicated by Slow Embryonic Heart Rates in the Early First Trimester*, 18 J. of Ultrasound in Med. 537 (1999) (slow embryonic heart rate at 7 weeks' gestation associated with high risk of first trimester death). And even in cases of normal cardiac activity, a small gestational sac in relation to embryonic or fetal size leads to early pregnancy loss in 94% of cases. Bromley et al., *supra* at 40.

[20] Belluck, *They Had Miscarriages, and New Abortion Laws Obstructed Treatment*, THE N.Y. TIMES (July 17, 2022).

[21] Feibel, *Because of Texas Abortion Law, Her Wanted Pregnancy Became a Medical Nightmare*, NPR (July 26, 2022).

[22] Sellers & Nirappil, *Confusion Post-Roe Spurs Delays, Denials For Some Lifesaving Pregnancy Care*, THE WASH. POST (July 16, 2022).

support the pregnancy). Ectopic pregnancies in any location are life threatening and must be treated urgently through medication or surgery.[23] As with miscarriage management, *amici* are concerned by news stories of patients who have been denied or received delayed care in the event of ectopic pregnancies due to abortion bans similar to those now in place in Kentucky.[24] For example, in Texas, the Texas Medical Association reportedly told state authorities that a doctor was "allegedly instructed to not treat an ectopic pregnancy until a rupture occurred, which puts patient health at serious risk."[25] Other news reports reflect instances of doctors needing to take time to consult with lawyers and/or colleagues before treating ectopic pregnancies—not because such consults were medically indicated, but to protect against criminal liability—which "turned [] attention away from the bedside of the critical-care patient toward documentation."[26]

Other elements of the Kentucky Bans' exceptions are equally problematic. For example, the Trigger Ban states that if the death or permanent impairment exception is applied, the physician must still "make reasonable medical efforts under the circumstances to preserve both the life of the mother and the life of the unborn human being in a manner consistent with reasonable medical practice."[27] Every clinical interaction with a patient is unique and requires the exercise of medical judgment based on individualized care, analysis, and decision making. This Trigger Ban exception leaves clinicians in the impossible position of providing care that will be second-guessed and disputed for ideological, not medical,

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[23] ACOG, *Facts Are Important: Understanding Ectopic Pregnancy.*

[24] Oxer & Méndez, *Texas Hospitals are Putting Pregnant Patients at Risk by Denying Care Out of Fear of Abortion Laws, Medical Group Says*, THE TEXAS TRIBUNE (July 15, 2022).

[25] *Id.*

[26] Sellers & Nirappil, *supra* note 22.

[27] KRS § 311.772

purposes. In addition, by limiting its exception to only potentially fatal "physical condition[s]" and "permanent impairment of a life-sustaining organ," neither the Trigger Ban nor the Six-Week Ban take into account mental health issues that can put a pregnant patient's health and life at risk.[28]

The lack of clarity with respect to the Kentucky Bans is creating unacceptable barriers to care and unacceptable risks for physicians seeking to provide necessary, routine care in real time under changing circumstances. It is untenable to force pregnant patients to wait until their medical condition escalates to the point that an abortion is necessary to prevent death or permanent injury to a major bodily function before being able to seek potentially life-saving medical care. Nor should physicians be put in the impossible position of either letting a patient deteriorate until one of these narrow exceptions is met or facing potential criminal punishment for providing medical care in contravention of the Bans.

III. The Bans Will Hurt Rural, Minority, and Poor Patients the Most

The Bans will disproportionately affect people of color, those living in rural areas, and those with limited economic resources. In Kentucky, 34.5% of patients who obtained abortions in 2020 were Black and 7.5% were Hispanic.[29]

Seventy-five percent of abortion patients nationwide have household incomes below 200% of the federal poverty level.[30] Patients with limited means and patients living in geographically remote areas will be disproportionately affected by the closure of clinics, which

[28] *See, e.g.*, Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

[29] KY Dept. for Pub Health, Office of Vital Statistics, *Kentucky Annual Abortion Report for 2020*, at 5-6.

[30] Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (2016).

requires them to travel longer distances (and pay higher associated costs) to obtain safe, legal abortions. These travel and procedure costs are compounded by the fact that other Kentucky laws create substantial financial barriers to abortion care (e.g., lack of coverage under insurance policies).[31] This impact of the Bans on low-income people will likely be particularly acute in Kentucky, which had the fourth highest poverty rate in the United States as of 2019.[32]

The inequities continue after an abortion is denied. Forcing patients to continue pregnancy increases their risk of complications, and the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion. Black patients in Kentucky are nearly two-and-a-half times more likely to die from pregnancy-related causes than white patients,[33] making continuing an unwanted pregnancy to term disproportionately dangerous. The Bans thus exacerbate inequities in maternal health and reproductive health care.

IV. The Bans Force Clinicians To Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law

The Bans violate long-established and widely accepted principles of medical ethics by: (1) substituting legislators' opinions for a physician's individualized patient-centered counseling and creating an inherent conflict of interest between patients and medical professionals; (2) asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

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[31] Guttmacher Inst., *State Facts About Abortion: Kentucky* (June 2022).

[32] United States Census Bureau, *2019 Poverty Rate in the United States* (Sept. 17, 2020).

[33] KY Dept. for Pub. Health, *Annual Report 2021, Public Health Maternal Mortality Review, A Report of Data from Years 2013-2019*, at 5 (Nov. 2020), https://chfs.ky.gov/agencies/dph/dmch/Documents/MMRAnnualReport.pdf.

A. The Bans Undermine the Patient-Physician Relationship by Substituting Flawed Legislative Judgment for a Physician's Individualized Patient-Centered Counseling and by Creating Conflicts of Interest Between Physicians and their Patients

The patient-physician relationship is critical for the provision of safe and quality medical care.[34] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests, and with the best available scientific evidence.[35] ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments" and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[36] Likewise, the AMA Code of Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[37] The Bans, however, force physicians to supplant their own medical judgments—and their patients' judgments—regarding what is in the patients' best interests with the legislature's non-expert decision regarding whether and when physicians may provide abortions.

As described above, abortions are safe, routine, and for many patients the best medical choice available for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician's ability to provide an abortion where both the physician and

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[34] ACOG, *Statement of Policy: Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended Aug. 2021) ("ACOG, *Legis. Policy Statement*").

[35] AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1* ("The relationship between a patient and a physician is based on trust, which gives rise to 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.").

[36] ACOG, *Code of Professional Ethics* 2 (Dec. 2018).

[37] AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion* 1.1.1.

patient conclude that is the medically appropriate course. Laws that have the effect of banning abortion are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

The Bans also create inherent conflicts of interest. Physicians must be able to offer appropriate treatment options based on patients' individualized interests without regard for the physicians' self-interests.[38] Here, however, by prohibiting abortion care, the Kentucky Bans profoundly intrude upon the patient-physician relationship. For example, a physician and patient together may conclude that an abortion is in the patient's best medical interests even though the Bans prohibit abortion under the patient's particular circumstances. The Bans thus force physicians to choose between the ethical practice of medicine—counseling and acting in their patients' best interest—and obeying the law.[39]

B. The Bans Violate the Principles of Beneficence and Non-Maleficence

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the 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.[40] Both of these principles arise from the foundation of medical ethics which requires that the welfare of the patient forms the basis of all medical decision-making.[41]

Obstetricians, gynecologists, family physicians, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients

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[38] *See* ACOG, *Legis. Policy Statement*, *supra* note 34.

[39] *Cf.* AMA, *Patient Rights, Code of Medical Ethics Opinion 1.1.3* ("Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.").

[40] AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaff'd 2016).

[41] *See supra* notes 34-3737 and accompanying text.

with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make a decision informed by both medical science and their individual lived experiences.[42] If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require them to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But the Bans prohibit physicians from providing that treatment in nearly all cases and expose physicians to significant penalties if they do so. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

C. The Bans Violate the Ethical Principle of Respect for Patient Autonomy

Finally, a core principle of medical practice is patient autonomy—the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[43] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[44] The Kentucky Bans would deny patients the right to make their own choices about health care if they decide they need to seek an abortion.

CONCLUSION

For the foregoing reasons, the Court should affirm the Circuit Court's temporary injunction and vacate the Court of Appeals' stay of that relief.

Respectfully Submitted,

Michael P. Abate

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[42] ACOG, Practice Bulletin No. 162: *Prenatal Diagnostic Testing for Genetic Disorders*, 127 Obstetrics & Gynecology e108 (May 2016).

[43] ACOG, *Code of Professional Ethics*, *supra* note 36, at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

[44] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021); AMA, *Code of Medical Ethics Opinion 2.1.1*.