No. DA 24-0147

IN THE SUPREME COURT OF THE STATE OF MONTANA

PLANNED PARENTHOOD OF MONTANA and SAMUEL DICKMAN, M.D., on behalf of themselves and their patients,
Plaintiffs-Appellees,
v.
STATE OF MONTANA, by and through AUSTIN KNUDSEN, in his official capacity as Attorney General,
Defendant-Appellant.

On Appeal from the Montana Thirteenth Judicial District, Yellowstone County, Cause No. DV-21-999, Hon. Kurt Krueger

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 PHYSICIANS, AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY, AMERICAN MEDICAL ASSOCIATION, AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, MONTANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, SOCIETY OF FAMILY PLANNING, SOCIETY FOR MATERNAL-FETAL MEDICINE, AND NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN WOMEN S HEALTH IN SUPPORT OF PLAINTIFFS-APPELLEES AND AFFIRMANCE

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significant restrictions on abortion care that have no medical justification and that will significantly limit access to abortion should they go into effect. Together, these laws threaten to eviscerate access to a safe and legal abortion care.

Amici curiae are leading medical societies representing physicians and other clinicians who serve patients in Montana and nationwide. Their policies represent the education, training, and experience of the vast majority of clinicians in this country. *Amici* all agree that laws that restrict abortion care and target patients and their health care providers are not based on any medical or scientific rationale. Those laws also threaten the health of pregnant patients; disproportionately harm patients of color, patients in rural settings, and patients with low incomes; and impermissibly interfere with the patient-physician relationship, undermining longstanding principles of medical ethics.

This Court recognized in *Armstrong v. State*, 1999 MT 261, 296 Mont. 361, 989 P.2d 364, that the Montana Constitution protects the right to abortion care. In light of that right, the district court correctly held that H.B. 136, H.B. 140, and H.B. 171 are void and unenforceable and granted a permanent injunction. *Amici* urge this Court to affirm.

abortion care are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[5] The risk of patient death from abortion care is even rarer: Nationally, fewer than one in 100,000 patients die from an abortion-related complication.[6] Abortion care

There are no significant risks to mental health or psychological well-

well increase as additional restrictions or prohibitions are placed on abortion care.[13]

Continuing with a pregnancy also poses a greater risk to patients' overall physical health than obtaining abortion care. 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.[14] These complications ranged from moderate to potentially life-threatening complications, including anemia, hypertensive disorders, pelvic or perineal trauma, mental health conditions, obstetric infections, postpartum hemorrhage, antepartum hemorrhage, asthma, and excessive vomiting.[15]

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[13] *See* Amanda Jean 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 Demography 2019, 2023-26 (Oct. 2021).

[14] Raymond & Grimes, *supra* note 10, at 216-17 & fig.1.

[15] *Id.*; *see* ACOG, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia*, 135 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 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 fertilieilie

methods, with potentially devastating consequences.[19]

H.B. 136 bans abortion care after 20 weeks "unless it is necessary to prevent a serious health risk to the unborn child's mother."[22] A primary rationale stated for H.B. 136 is to avoid fetal pain.[23] But every major medical organization that has examined the issue has concluded, based on decades of peer-reviewed studies, that fetal pain perception is not anatomically possible before at least 24 weeks of gestational age.[24]

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[22] H.B. 136 § 3.

[23] H.B. 136 (Preamble).

[24] ACOG, *Facts Are Important: Gestational Development and Capacity for Pain*, https://bit.ly/3wqiwu8 (last accessed Aug. 6, 2024); Royal Coll. of Obstet. & Gynecol., *Fetal Awareness: Review of Research and Recommendations for Practice, Summary* viii, 11 (Mar. 2010) (concluding fetal pain is not possible before 24 weeks gestation, based on expert panel review of over 50 papers in medical and scientific literature); *see* Royal Coll. of Obstet. & Gynecol., *RCOG Fetal Awareness Evidence Review* (Dec. 2022); SMFM, Consult Series No. 59, *The Use of Analgesia and Anesthesia for Maternal-Fetal Procedures* B7 (Dec. 2021) (noting that 24 weeks of gestation "is the minimum gestational age in which in utero pain awareness by the fetus is developmentally plausible"); Ivica Kostovic & Natasa Jovanov-Milosevic, *The Development of Cerebral Connections During the First 20-45 Weeks' Gestation*, 11 Seminars in Fetal & Neonatal Medicine 415, 415 (2006); A. Vania Apkarian et al., *Human Brain Mechanisms of Pain Perception and Regulation in Health and Disease*, 9 Eur. J. Pain 463 (2005); Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 J. Am. Med. Ass'n 947 (2005).

Indeed, the medical literature indicates that a fetus likely cannot experience pain at *any* gestational age.[25]

Fetal development occurs on a continuum, and the neurological circuitry required to experience pain is not developed in a fetus before at least 24 weeks of gestational age. Pain perception requires an intact neural pathway from the periphery of the body (the skin), through the spinal cord, into the thalamus (the gray matter in the brain that relays sensory signals), and on to regions of the cerebral cortex.[26] These neural connections do not develop until after at least 24 weeks of gestational age, and the cerebral cortex does not fully mature until after birth.[27]

Further, even if a fetus has developed the necessary neurological connections, the medical literature suggests that the fetus still does not perceive pain until after birth.[28]

hormones and low oxygen levels, which likely prevents the fetus from perceiving pain at all.[29] Simply put, there is no evidence to support H.B. 136's 20-week

especially among patients that live in maternity care deserts.[31] Medication abortion is safe: The medications used are just as safe as commonly used medications such as antibiotics and nonsteroidal anti-inflammatory drugs like Advil or Tylenol.[32] For many patients, clinicians can safely

gestational ages also typically are more expensive and more difficult to access.[36]

For some patients, delay may altogether foreclose the option of obtaining abortion care. Under the FDA's regulations, medication abortion is approved in the United States up to 10 weeks of gestation. Delay thus could deprive the patient of a medication abortion option altogether,[37] including those for whom it may have been the more medically appropriate option.[38] Further, 93% of Montana counties do not have a single abortion provider.[39] In those counties, adding additional barriers to obtaining medication abortion may mean residents have no access to abortion care at all.

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[36] Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

[37] *See* ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136 Obstet. & Gynecol. e31, e33 (2020).

[38] For example, medication abortion is frequently the most appropriate method for pregnant people who have uterine fibroids. *See* Mitchell D. Creinin, *Medically Induced Abortion in a Woman with a Large Myomatous Uterus*, 175 Am. J. Obstet. & Gynecol. 1379, 1379 (1996).

[39] Guttmacher Inst., *Data Center*, https://bit.ly/3OEhIrU (last accessed Aug. 6, 2024).

H.B. 171 would impose a panoply of unnecessary restrictions on medication abortion. It would require physicians to misinform their patients with medically inaccurate counseling.[40] It also would ban telehealth services, require in-person dispensing of the medication, and require a mandatory 24-hour waiting period between informed consent and treatment.[41]

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 the statute. Fewer than 1% of patients will obtain an emergency intervention for excessive bleeding after a medication abortion.[42] And H.B. 171 would not mitigate the risks of harm even for the exceptionally rare patients who experience complications: If a complication arose, 2( )1(io)-1ac] TJETQ0.24 0 0 0.24 0 601.92 cmBT58 0 0 58 695.5

In fact, H.B. 171 would increase the risk of harm for patients, by requiring clinicians to provide medically inaccurate counseling to their patients regarding medication abortion. For example, clinicians must provide "state-prepared materials," about "reversing" the effects of a medication abortion.[43] Claims regarding abortion "reversal" are not based on science and do not meet clinical standards.[44] Any such "reversal" treatments are purely experimental; there is no FDA-approved protocol for a "reversal" of medication abortion.[45] The state-mandated materials do not meet medical or ethical standards required for informed consent because they do not provide information either about the lack of reliable clinical evidence showing that "reversal" treatment is safe or the existence of actual clinical evidence showing that "reversal" treatment is ineffective and potentially dangerous. Patients may decide to have an abortion under the mistaken belief that they can later change their minds, with harmful consequences for their health.

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[43] H.B. 171 §§ 7, 8.

[44] ACOG, *Facts are Important: Medication Abortion "Reversal" Is Not Supported by Science*, https://bit.ly/3SAauay (accessed Aug. 6, 2024).

[45] *See id.*

H.B. 171's ban on telehealth services also would increase the risk of harm for patients. Telehealth is a form of medical counseling that is increasingly used in "nearly every aspect of obstetrics and gynecology," and there is no basis to suggest that requiring in-person visits offers patients any health benefit.[46] Further, as noted, 93% of Montana counties have no clinic providing abortion care.[47] So banning telehealth services will delay access to abortion care for many Montanans—during which a pregnant person may suffer significant health problems that could have been avoided had the person had access to timely abortion care.[48]

H.B. 136, H.B. 140, and H.B. 171 would disproportionately affect patients living in rural areas and those with fewer resources. *Amici* are opposed to policies that increase the inequities that already plague the health care system in this country.

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[46] ACOG, Committee Opinion No. 798, *Implementing Telehealth in Practice* (2020).

[47] Guttmacher Inst., *State Facts about Abortion: Montana* (2022).

[48] *See, e.g.*, Wallis et al., *supra* note 34, at 523-24.

Nearly half of all Montanans live in rural areas,[49] with limited access to clinics and hospitals.[50] 12.1% of Montanans live below the federal poverty line.[51] In addition, 75% of abortion patients nationwide are living

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 care who already have children, finding appropriate child care for clinic visits, especially multiple trips, is challenging and often infeasible.

H.B. 136, H.B. 140, and H.B. 171 would disproportionately harm the most vulnerable Montanans and exacerbate inequities in health care that *amici* work to combat.

H.B. 136, H.B. 140, and H.B. 171 violate long-established and widely accepted principles of

The patient-physician relationship is critical for the provision of safe and quality medical care.[54] At the core of this relationship is the ability to counsel accurately, frankly, and confidentially about important

and H.B. 171 would force physicians to choose between the ethical practice of medicine and obeying the law.

In particular, H.B. 171 would require a clinician "provide" a patient with certain mandated information, including a state-created consent form that the patient must sign and that "must include" the statement that the medication abortion "will result in the death of the unborn child."[58] 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 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.[59] Unless a

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[58] H.B. 171 § 7.

[59] *See* AMA, Code of Medical Ethics Opinion 2.1.3, *Withholding Information from Patients* (2022) ("Truthful and open communication between physician and patient is essential for trust in the relationship and for respect for autonomy.").

patient has a high level of confidence in the clinician's professional skill

professionals must place their patients' welfare above other obligations, such as obligations to repeat State-mandated doctrine.[63]

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm, have been the cornerstones of the medical profession since the Hippocratic traditions.[64] Both principles arise from the foundation of medical ethics that requires the welfare of the patient to form the basis of medical decision-making.

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make decisions informed by both medical science and their individual lived experiences.[65]

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[63] *See* AMA, *supra* note 55.

[64] AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstet. & Gynecol. 1479, 1481-82 (Dec. 2007, reaff'd 2019).

[65] ACOG, *supra* note 56, at 1-2.

H.B. 136, H.B. 140, and H.B. 171 would inhibit or prohibit clinicians from providing appropriate treatment, even if providing that treatment is in the patient's best interests. The laws therefore place clinicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or violating the law. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

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.[66] 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.[67] H.B. 136, H.B. 140, and H.B. 171 will deny patients the right to fully make their own choices about health care if they decide they need to seek an abortion.

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[66] *Id*. at 1 ("[R]espect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental.").

[67] ACOG, *supra* note 61; AMA, Code of Medical Ethics Opinion 2.1.1, *Informed Consent* (2017).

The decision of the district court should be affirmed.

Dated: August 13, 2024

Respectfully submitted,

/s/ Mikaela J. Koski

CERTIFICATE OF SERVICE

I, Mikaela Joan Koski, hereby certify that I have served true and accurate copies of the foregoing Brief - Amicus to the following on 08-13-2024:

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