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IN THE SUPREME COURT
STATE OF NORTH DAKOTA

Supreme Court No. 20220260

Drew H. Wrigley, in his official capacity as Attorney General for the State of North Dakota,

Petitioner,

v.

The Honorable Bruce A. Romanick, Judge of District Court, South Central Judicial District; Access Independent Health Services, Inc., d/b/a Red River Women's Clinic, on behalf of itself and its patients, and Kathryn L. Eggleston, M.D., on behalf of herself and her patients; and Birch P. Burdick, in his official capacity as the State Attorney for Cass County,

Respondents.

PETITION FOR SUPERVISORY WRIT FROM THE DISTRICT COURT ORDER DATED AUGUST 25, 2022, BURLEIGH COUNTY, NORTH DAKOTA, SOUTH CENTRAL JUDICIAL DISTRICT, HON. BRUCE ROMANICK

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF PLAINTIFFS-RESPONDENTS, IN OPPOSITION TO PETITION FOR SUPERVISORY WRIT, AND IN OPPOSITION TO REVERSAL OR VACATION OF PRELIMINARY INJUNCTION

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INTEREST OF *AMICI CURIAE*

[¶1] *Amici curiae* are leading medical societies representing physicians, nurses, and other clinicians who serve patients in North Dakota and nationwide, and whose policies represent the education, training, and experience of the vast majority of clinicians in this country.[1] The American College of Obstetricians and Gynecologists ("ACOG") is the nation's leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, 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. The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state. The Society for Maternal-Fetal Medicine ("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, and is dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

[1] No counsel for a party authored this brief in whole or in part, and no party, party's counsel, or other entity or person—other than *amici curiae*, their members, and their counsel—made a monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

[¶2] Abortion is an essential part of comprehensive health care.[2] *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; and (3) impermissibly interfere with the patient-physician relationship, longstanding principles of medical ethics, and patient autonomy.

[¶3] When abortion is legal, it is safe. Despite this fact, *amici* understand that, in the wake of *Dobbs v. Jackson Women's Health Org.*, 597 U.S. ___ (2022), North Dakota seeks to enforce its statute criminalizing abortion: N.D. Cent. Code § 12.1-31-12 (the "Ban"). The Ban criminalizes performing abortions.[3] It contains three extraordinarily limited affirmative defenses that are insufficient to protect the health and safety of North Dakotans.[4] *Amici* oppose the Ban because it jeopardizes—without any valid medical justification—the health and safety of pregnant people in North Dakota, and places health care providers in the untenable position of navigating conflict between medical ethics and North Dakota law.

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[2] AMA, Policy D-5.999, *Preserving Access to Reproductive Health Services* (2022) ("[H]ealthcare, including reproductive health services like contraception and abortion, is a human right.").

[3] N.D. Cent. Code § 12.1-31-12. Individuals convicted of violating the Ban are subject to a penalty of five years of imprisonment and a fine of up to $10,000. *See* N.D. Cent. Code § 12.1-32-01(4) (2019).

[4] N.D. Cent. Code § 12.1-31-12(3) (providing affirmative defenses where the abortion "was necessary in professional judgment and was intended to prevent the death of the pregnant female;" the "pregnancy . . . resulted from gross sexual imposition, sexual imposition, sexual abuse of a ward, or incest;" or for an individual "acting . . . under the direction of or at the direction of a physician").

ARGUMENT

I. The Ban Is Not Justified by Any Medical or Scientific Rationale

[¶4] The medical community overwhelmingly recognizes abortion as an essential component of reproductive health care.[5] Abortions are routine,[6] safe,[7] and for many patients, the best medical choice for their specific health circumstances. Approximately one quarter of American women have an abortion before the age of 45.[8] Major complications are exceptionally rare.[9] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[10] In addition, there are no significant risks to mental health or psychological well-being

[5] *See, e.g.*, Editors of the *New England Journal of Medicine*, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating view of the Editors as well as several key organizations in obstetrics, gynecology, and maternal-fetal medicine); ACOG, *Abortion Policy* (revised and approved May 2022); Soc'y for Maternal-Fetal Med., *Access to Abortion Services* (2020).

[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 1,150 abortions were performed in North Dakota in 2021. North Dakota Dep't of Health and Human Services, *ND Induced Termination of Pregnancy Data: 2021*, at 4 (2022).

[7] *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (Nat'l Academies Press 2018).

[8] Jones & Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).

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

[10] 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).

resulting from abortion care.[11] Accordingly, there is no medical or safety-driven rationale for banning abortion.

[¶5] Laws that have the effect of prohibiting abortion in nearly all circumstances are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine. For example, while the Ban purports to exclude procedures related to spontaneous miscarriage or other trauma,[12] the limited language of this exclusion does not protect patients and physicians in all non-viable pregnancy situations. For example, studies show that bleeding in early pregnancy coupled with slower than average embryonic cardiac activity accurately predicts early pregnancy loss.[13] In such cases, if intervention to terminate the pregnancy is the medically indicated treatment, it does not appear to be covered by the Ban's exclusion. Nor does the Ban contain an exception for an ectopic pregnancy (when a fertilized egg implants and grows in a location that cannot support the pregnancy), which are life-threatening and must be treated urgently through medication or surgery.[14] Nor does the Ban provide any exception for termination of a pregnancy that

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[11] 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).

[12] N.D. Cent. Code § 12.1-31-12(1)(a) (defining abortion to exclude acts to "remove a dead, unborn child who died as a result of a spontaneous miscarriage, an accidental trauma, or a criminal assault").

[13] 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).

[14] ACOG, *Facts Are Important: Understanding Ectopic Pregnancy* (last visited Nov. 17, 2022).

involves genetic, chromosomal, or other issues that may affect the likelihood of survival of a fetus after birth.[15]

[¶6] The Ban's uncertainty around these types of common pregnancy-related scenarios threatens health care well beyond patients seeking abortions. For example, it jeopardizes the care provided to pregnant patients who are experiencing medical emergencies, as well as the emergency medicine, hospitalist, and other health care providers who serve them. Pregnant patients visit emergency rooms for a number of reasons, such as premature rupture of membranes and infection, preeclampsia, and placental abruption,[16] all of which may put a patient at risk of extensive blood loss, stroke, and/or septic shock (and all of which would negatively affect the fetus). Pregnant patients are also affected by any number of non-pregnancy-related emergency conditions, such as car accidents or falls. When these situations present, clinicians and patients together need to make decisions about how to manage risks to the health and survival of the pregnant individual and whether continuing a pregnancy contributes to that risk, without any constraints or ambiguity created by legislators acting without reference to specific facts and medical evidence.

II. By Prohibiting Abortions, the Ban Will Harm Pregnant Patients' Health, and the Ban's "Affirmative Defenses" Do Not Make It Less Harmful

A. The Ban Will Cause Substantial Harm to Pregnant Patients Who Would Seek Safe Abortion Care

[¶7] The Ban 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

[15] Soc'y for Maternal-Fetal Med., *Access to Abortion Services*, *supra* note 5, at 1.
[16] ACOG, Committee Opinion No. 667, *Hospital-Based Triage of Obstetric Patients* (Jul. 2016, reaff'd 2020).

methods other than procuring appropriate medications through licensed providers, 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 outcomes increases the likelihood of negative consequences to the patient's physical and psychological health that could be avoided if abortion were available.[17]

[¶8] First, criminalizing safe abortions provided by a licensed clinician in the State of North Dakota causes delays in and increases the costs of abortions. In the wake of *Dobbs*, North Dakota's only dedicated abortion clinic moved to an adjacent state. With no dedicated in-state abortion providers, the travel and procedure costs for North Dakotans seeking abortion likely have already increased, which delays access to abortion.[18] While abortion is overall a safe medical procedure, the risk of complications is lower the earlier the abortion is performed,[19] so these delays will harm patients.

[¶9] Second, by removing access to safe, legal abortion, the Ban will also increase the possibility that pregnant patients will attempt self-managed abortions through harmful or unsafe methods.[20] Studies have found that women are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-

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[17] *See, e.g.*, ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020).

[18] More than a third of delays are caused by travel and procedure costs. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014); *see also* Bearak et. al., Guttmacher Inst., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care* (updated Apr. 23, 2020).

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

[20] *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).

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 misusing dangerous hormonal pills.[21]

[¶10] Third, those patients who cannot obtain an abortion due to the Ban will be forced to continue a pregnancy, which presents significantly greater risk to the health and life of the pregnant patient than obtaining a safe, legal abortion. The "risk of death associated with childbirth [is] approximately 14 times higher" than the risk of death from receiving an abortion.[22] This is a particular concern in North Dakota, where the maternal mortality rate is already higher than the national average.[23] Short of death, even an uncomplicated pregnancy causes significant stress on the body and involves physiological and anatomical changes, and continuing a pregnancy to term can exacerbate underlying health conditions or cause new conditions.[24]

[¶11] Finally, the Ban will disproportionately impact people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to abortion policies that increase the inequities that already plague the health care system in this country. Nationwide, 75% of abortion patients are living at or below 200% of the federal poverty level.[25] In North Dakota, approximately 17.3% of patients who obtained abortions

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[21] Grossman et al., Tex. Pol'y Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015).
[22] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).
[23] House Committee on Ways & Means, *North Dakota Health Equity Facts.*
[24] *See, e.g.*, ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018); ACOG, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (Dec. 2018).
[25] Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* (2016).

in 2021 were Black and approximately 12.8% were Native American.[26] Black patients' pregnancy-related mortality rate is 3.2 to 3.5 times higher than that of white patients, with significant disparities persisting even in areas with the lowest overall mortality rates and among patients with higher levels of education.[27] The Ban thus exacerbates inequities in maternal health and reproductive health care, disproportionately harming the most vulnerable North Dakotans.

B. The Ban's Affirmative Defense Related to Maternal Health Is Insufficient to Protect Patient Health

[¶12] The Ban's affirmative defense related to maternal health, which applies where an abortion "was necessary in professional judgment and was intended to prevent the death of the pregnant female,"[28] is insufficient to protect the health of the pregnant patient.

[¶13] First, the nature of an affirmative defense—which places the legal burden of proof on the physician and provides no protection whatsoever against *prosecution*—may deter physicians from providing care they otherwise would have. Legally and practically, an affirmative defense is distinct from an exception. An affirmative defense can only be raised *after* a physician has been arrested, charged with a crime, (possibly) detained prior to trial, and subjected to the ordeal of a criminal trial. For that reason, among others, *all* of the Ban's affirmative defenses are extremely concerning to *amici*.

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[26] *See* North Dakota Dep't of Health and Human Services, *ND Induced Termination of Pregnancy Data: 2021*, supra note 6, at 7 (2022).
[27] CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019) (3.2 times); MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 Am. J. Pub. Health 1673, 1676-77 (Sept. 22, 2021) (3.55 times).
[28] N.D. Cent. Code § 12.1-31-12(3)(a).

[¶14] Second, the affirmative defense related to maternal health does not permit abortion care in a wide range of circumstances that fall short of death but nonetheless place the patient's health in serious jeopardy, such as pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy) and diabetes (which can worsen to the point of causing blindness as a result of pregnancy).[29] Additionally, it is not always possible for a physician to know whether treatment for any particular condition, at any particular moment in time, is "necessary…to prevent the death" of the pregnant patient.[30] Some complications—such as preeclampsia, rupture of membranes, and placental abruption—can present emergent situations[31] where death is a possibility but is not certain. Even if a patient survives such a complication, they may suffer lifelong disabilities and chronic medical conditions as a result of being denied abortion care.

[¶15] Further, making prevention of death the only permissible health-related ground for an abortion puts physicians in the impossible position of either letting a patient deteriorate until their life is threatened, or facing potential criminal prosecution for providing medical care in contravention of the Ban. In addition to worsening outcomes, patients will be forced to endure both physical and psychological pain while watching their health decline. *Amici* are concerned by reports of patients who have been denied or

[29] *See* 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).
[30] N.D. Cent. Code § 12.1-31-12(3)(a).
[31] *See* ACOG, *Hospital-Based Triage of Obstetric Patients, supra* note 16.

received delayed medically indicated care due to laws similar to the Trigger Ban.[32] It is untenable to force a patient (and their doctor) to wait until their condition escalates to the point that an abortion is necessary to prevent death before being able to obtain potentially life-saving medical care.

III. The Ban Impermissibly Interferes with the Patient-Physician Relationship, Key Principles of Medical Ethics, and Patient Autonomy

[¶16] The patient-physician relationship is critical for the provision of safe and quality medical care.[33] 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 with the best available scientific evidence.[34] At times, a physician and patient together may conclude that an abortion is in the patient's best medical interests. The Ban intrudes upon the patient-physician relationship by displacing the physician's and the patient's judgment in favor of the judgment of elected officials (with no medical training and who are unfamiliar with the specific circumstances of the case).

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[32] *See, e.g.*, Belluck, *They Had Miscarriages, and New Abortion Laws Obstructed Treatment*, The N.Y. Times (July 17, 2022); Feibel, *Because of Texas Abortion Law, Her Wanted Pregnancy Became a Medical Nightmare*, NPR (July 26, 2022); Sellers & Nirappil, *Confusion Post-Roe Spurs Delays, Denials For Some Lifesaving Pregnancy Care*, The Wash. Post (July 16, 2022); 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).

[33] ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended Aug. 2021) ("*Legis. Policy Statement*"); ACOG, *Press Release: More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference* (July 7, 2022).

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

[¶17] Additionally, a key principle of medical ethics is that patient welfare is paramount and must take precedence over a physician's own self-interest.[35] But the Trigger Ban creates an inherent conflict of interest: physicians must choose between the patient's welfare and the ethical practice of medicine,[36] on the one hand, and their own self-interest in avoiding criminal prosecution, on the other.

[¶18] The Ban also asks medical professionals to violate the cornerstone ethical principles of beneficence (the obligation to promote the wellbeing of others), and non-maleficence (the obligation to do no harm and cause no injury), which have been the cornerstones of the medical profession for nearly 2,500 years.[37] If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician 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 Ban prohibits physicians from providing that treatment in all but extremely limited cases. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

[¶19] 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

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[35] ACOG, *Code of Professional Ethics* 2 (Dec. 2018); AMA, *Code of Medical Ethics Opinion 1.1.1*, *supra* note 34; *see also* ACOG, *Legis. Policy Statement*, *supra* note 33.

[36] *Cf.* AMA, *Code of Medical Ethics Opinion 1.1.3*, *Patient Rights* ("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.").

[37] 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).

making medical decisions.[38] 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.[39] The Ban would deny patients the right to make their own choices about health care if they decide they need to seek an abortion.

CONCLUSION

[¶20] For the foregoing reasons, the undersigned respectfully request that this Court decline to issue a supervisory writ, decline to reverse or vacate the preliminary injunction, or, in the alternative, affirm the issuance of the preliminary injunction.

[38] ACOG, *Code of Professional Ethics*, *supra* note 35, at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

[39] 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, Informed Consent*.

Respectfully submitted, this 21st day of November 2022.

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CERTIFICATE OF COMPLIANCE

The undersigned, as attorneys for the *amici curiae* in the above matter, and as the authors of the above brief, hereby certify, in compliance with Rule 32(d) of the North Dakota Rules of Appellate Procedure, that the above brief was prepared with a plain, roman type style in a size 12-point font and that the brief totals 19 pages.

Dated this 21st day of November 2022.

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Supreme Court No. 20220260

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Petitioner,

v.

The Honorable Bruce A. Romanick, Judge of District Court, South Central Judicial District; Access Independent Health Services, Inc., d/b/a Red River Women's Clinic, on behalf of itself and its patients, and Kathryn L. Eggleston, M.D., on behalf of herself and her patients; and Birch P. Burdick, in his official capacity as the State Attorney for Cass County,

Respondents.

I hereby certify that a true and correct copy of the following document:

> **Brief of *Amici Curiae* American College of Obstetricians and Gynecologists, American Medical Association, and Society for Maternal-Fetal Medicine in Support of Plaintiffs-Respondents, in Opposition to Petition for Supervisory Writ, and in Opposition to Reversal or Vacation of Preliminary Injunction**

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