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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 *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 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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INTERESTS OF *AMICI CURIAE*

Amici are leading 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 H.B. 136, H.B. 140, and H.B. 171, which substitute lawmakers' political agenda for the educated and considered decisions that patients make in consultation with their medical professionals.

INTRODUCTION

Abortion care is an essential part of comprehensive health care and is safe. Despite this, H.B. 136, H.B. 140, and H.B. 171 seek to impose

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.

ARGUMENT

I. Abortion Care Is A Safe And Essential Component Of Health Care

The medical community recognizes that abortion care is a safe, common, and essential component of reproductive health care.[1] In 2020, more than 1,500 abortions were performed in Montana.[2]

The overwhelming weight of medical evidence conclusively demonstrates that abortion care is a very safe medical procedure.[3] Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and easily treatable.[4] Major complications from

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[1] *See, e.g.*, Eds. of the New Eng. J. of Med. et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979, 979 (2019) ("Access to legal and safe pregnancy termination . . . is essential to the public health of women everywhere."); Am. Coll. of Obstet. & Gynecol. (ACOG), *Abortion Policy* (May 2022), https://bit.ly/3uWMKUV; Soc'y for Maternal-Fetal Med. (SMFM), *Access to Abortion Care* (July 2024).

[2] Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2020*, 54 Persp. on Sexual & Reprod. Health 128, 133 tbl.2 (2022).

[3] *See, e.g.*, Nat'l Acad. of Scis., Eng'g, Med., *The Safety and Quality of Abortion Care in the United States* 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.").

[4] *See, e.g.*, Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstet. & Gynecol. 175, 181 (2015) (finding 2.1% abortion-related complication rate); Nat'l Acad. of Scis., Eng'g, Med., *supra* note 1, at 55, 60.

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 is so safe that there is a greater risk of complications or mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[7]

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[5] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015). This is also true for medication abortions, which account for about half of abortions nationwide. Elizabeth G. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013); Rachel K. Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Dec. 1, 2022).

[6] Katherine Kortsmit et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Abortion Surveillance—United States, 2019*, 70 Morbidity & Mortality Weekly Rep. No. 9, 29 tbl.15 (Nov. 26, 2021) (finding mortality rate from 0.00041% to 0.00078% for approximately five-year periods from 1978 to 2014); Suzanne Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 Obstet. & Gynecol. 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

[7] Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (2014) (2.1% of abortions result in complications—with 1.88% resulting in minor complications and 0.23% resulting in major complications—compared to 7% of wisdom-tooth extractions, 8-9% of tonsillectomies, and 29% of childbirths); Am. Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011) (33% of colonoscopies result

There are no significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies found that those who obtained wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and that receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to those who were forced to continue a pregnancy.[8] One recent study noted that 95% of participants believed an abortion was the "right decision for them" three years after the procedure.[9]

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in minor complications); Frederick M. Grazer & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000) (mortality rate from liposuction in late 1990s was 20 per 100,000); Kortsmit et al., *supra* note 6, at 29 tbl.15 (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in 2013-2018).

[8] M. Antonia 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).

[9] Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS One 1, 7 (2015).

Notably, continuing with a pregnancy carries a greater risk of death than obtaining a desired abortion. Statistically, the risk of death associated with childbirth is approximately 14 times higher than the risk associated with abortion care.[10] The risk is even higher for Black and Indigenous pregnant people, for whom rates of maternal mortality are three to four times the national average.[11] The United States has the highest maternal mortality rate among developed countries, and this has been exacerbated by the COVID-19 pandemic.[12] Maternal mortality rates may

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[10] ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, 136 Obstet. & Gynecol. e107, e108 (2020); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215, 216 (2012). The risk is even higher for Black and Indigenous pregnant people, for whom rates of maternal mortality are three to four times the national average.

[11] Elizabeth Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 Clinical Obstet. & Gynecol. 387, 387 (2018).

[12] *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, Nat'l Ctr. for Health Stats., *Maternal Mortality Rates in the United States, 2020* at 1 (Feb. 2022) (between 2019 and 2020, maternal mortality in the U.S. rose by 14%).

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 fertility, and death); Ann Evensen et al., *Postpartum Hemorrhage: Prevention and Treatment*, 95 Am. Fam. Physician 442, 442 (2017) (noting that about 3-5% of obstetric patients will experience postpartum

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.[16] 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.[17] Patients who previously underwent a cesarean delivery, which puts them at a greater risk of developing placenta accreta, may prefer to obtain abortion care.[18]

Restrictions on abortion care also increase the possibility that patients may attempt self-induced abortion through harmful or unsafe

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hemorrhage, a preventable event that is the cause of 12% of maternal deaths in the United States).

[16] ACOG & SMFM, *Obstetric Care Consensus: Placenta Accreta Spectrum,* 132 Obstet. & Gynecol. e259, e259 (2018); ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus,* 131 Obstet. & Gynecol. e49, e49 (2018) (explaining that gestational diabetes mellitus is one of the most common medical complications of pregnancy).

[17] ACOG & SMFM, *supra* note 16, at e259.

[18] *Id.*

methods, with potentially devastating consequences.[19] Studies have found that patients are more likely to self-induce abortions where they face barriers to reproductive healthcare, and methods of self-induction outside safe medication 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.[20] Approximately 25 million patients worldwide obtain unsafe abortions each year, resulting in approximately 44,000 maternal deaths.[21]

The medical evidence is clear and overwhelming: Abortion care is safe, and when it is desired by a 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.

II. There Is No Medical Justification For H.B. 136, H.B. 140, Or H.B. 171

The State has offered various justifications for H.B. 136, H.B. 140, and H.B. 171. None is supported by the medical evidence.

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[19] Upadhyay et al., *supra* note 4, at 181.

[20] D. Grossman et al., Tex. Pol. Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015).

[21] ACOG, *supra* note 10, at e108.

A. H.B. 136's 20-Week Ban Is Not Required To Avoid Fetal Pain

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] Before birth, the fetus is kept in a sleep-like state by environmental factors in the uterus, including certain

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[25] *See* SMFM, *supra* note 24, at B4.

[26] *See, e.g.*, Apkarian et al., *supra* note 24; Irene Tracey & Patrick W. Mantyh, *The Cerebral Signature for Pain Perception and Its Modulation,* 55 Neuron 377 (2007); Brian Key, *Why Fish Do Not Feel Pain,* 3 Animal Sentience 1 (2016).

[27] Kostovic & Jovanov-Milosevic, *supra* note 24, at 415.

[28] SMFM, *supra* note 24, at B3.

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 prohibition on abortion care.

B. H.B. 140's Ultrasound Requirements Serve No Medical Purpose

H.B. 140 requires clinicians to inform patients of the opportunity to view an ultrasound of the fetus or listen to its "heartbeat."[30] Although ultrasounds are a common part of obstetric care, they are not medically necessary in every case. In particular, ultrasounds are usually not required for abortion care in the first trimester of pregnancy, before there is any possibility of fetal viability.

A common method of abortion during the first trimester of pregnancy is medication abortion, which accounts for more than one-half of all abortions in the United States and is increasingly preferred,

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[29] *See* ACOG, *supra* note 24; Henrique Rigatto et al., *Fetal Breathing and Behavior Measured Through a Double-Wall Plexiglass Window in Sheep*, 61 J. Applied Physiol. 160, 160-61 (1986); Stuart W.G. Derbyshire, *Can Fetuses Feel Pain?*, 332 British Med. J. 909, 912 (2006); David J. Mellor et al., *The Importance of 'Awareness' for Understanding Fetal Pain*, 49 Brain Res. Reviews 455, 465 (2005).

[30] H.B. 140 § 2.

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 provide medication abortions through telehealth consultations without needing to see the patients in person or perform an ultrasound.[33]

H.B. 140 will impose unnecessary costs and additional risks from delaying access to abortion care.[34] Although the risk of complications from abortion care overall is exceedingly low—especially compared to the health risks of carrying a pregnancy to term—increasing gestational age increases the chance of a major complication.[35] Abortion care at later

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[31] Jones et al., *supra* note 5; Nathalie Kapp et al., *Efficacy of Medical Abortion Prior to 6 Gestational Weeks: A Systematic Review*, 97 Contraception 90, 90 (2018); Tara C. Jatlaoui et al., CDC, *Abortion Surveillance—United States, 2013*, at 8 (2016).

[32] *See* Nat'l Acads. of Sci., Eng'g & Med., *supra* note 3, at 79; R. Morgan Griffin, *Making the Decision on NSAIDs,* WebMD (Oct. 17, 2005).

[33] Nathaniel DeNicola et al., *Telehealth Interventions to Improve Obstetric and Gynecologic Health Outcomes: A Systematic Review*, 135 Obstet. & Gynecol. 371, 371-72 (2020).

[34] *See, e.g.*, Anne B. Wallis et al., *Secular Trends in the Rates of Preeclampsia, Eclampsia, and Gestational Hypertension, United States, 1987-2004*, 21 Am. J. Hypertension 521, 523-24 (2008).

[35] Upadhyay et al., *supra* note 4, at 181.

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).

C. H.B. 171's Restrictions On Medication Abortions Are Not Justified

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, it would arise after the pills were taken, regardless of how the patient obtained abortion care.

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[40] H.B. 171 § 8.

[41] *Id.* § 7.

[42] ACOG, *supra* note 37, at e33.

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]

III. H.B. 136, H.B. 140, And H.B. 171 Would Disproportionately Affect Patients Living In Rural Areas And Those With Fewer Resources

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 at or below 200% of the federal poverty level.[52] H.B. 136, H.B. 140, and H.B. 171 will eviscerate the already extremely limited access to abortion in the state.

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 populations are the very patients who are stymied by the time and expense of traveling across Montana.[53]

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[49] Mont. Dep't of Com., *Montana 2020 Census Newsletter* (Feb. 19, 2020), https://bit.ly/3v0e6K0.

[50] Mont. Hosp. Ass'n, *Access to Care*, https://bit.ly/46pbH8u (accessed Aug. 6, 2023).

[51] U.S. Census Bureau, *QuickFacts—Montana* (2022), https://bit.ly/3MRxMpD.

[52] Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* at 11 (2016).

[53] *See* ACOG, *supra* note 10, at e111-112.

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.

IV. H.B. 136, H.B. 140, And H.B. 171 Will Undermine Physicians' Ability To Perform Their Jobs

H.B. 136, H.B. 140, and H.B. 171 violate long-established and widely accepted principles of medical ethics by substituting legislators' opinions for a physician's individualized, patient-centered counseling and creating a manufactured conflict of interest between patients and medical professionals. H.B. 136, H.B. 140, and H.B. 171 attempt to force medical professionals to violate the age-old principles of beneficence and non-maleficence and require medical professionals to ignore the ethical principle of respect for patient autonomy.

A. Statutes That Restrict Access To Abortion Care Undermine The Patient-Physician Relationship

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 issues and concerns based on patients' best medical interests with the best available scientific evidence.[55] The American College of Obstetricians and Gynecologists 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."[56] The American Medical Association 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."[57] H.B. 136, H.B. 140,

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

[55] Am. Med. Ass'n (AMA), Code of Medical Ethics Opinion 1.1.1, *Patient-Physician Relationships* (Aug. 2022).

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

[57] AMA, *supra* note 55.

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 and in the clinician having the patient's best interest in mind, the foundation of the relationship is unsound.[60] Providing inaccurate information or incomplete information (such as the information set out in the state-mandated counseling materials) not only erodes the trust at the core of the patient-clinician relationship, but also impedes a patient's ability to make informed health care decisions and may be dangerous to patient health.[61]

Laws and regulations should not mandate the content of what clinicians may or may not say to their patients.[62] Through abortion restrictions like H.B. 136, H.B. 140, and H.B. 171, the State inappropriately and unjustifiably inserts itself into the patient-clinician relationship. Such laws undermine the efficacy of the patient-clinician relationship and leave clinicians in untenable positions. Ethically, medical

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[60] AMA, *supra* note 55.

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

[62] Am. Coll. of Physicians, *Statement of Principles on the Role of Governments in Regulating the Patient-Physician Relationship* (July 2012).

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

B. Statutes That Restrict Access To Abortion Care 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, 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."

C. Statutes That Restrict Access To Abortion Care 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.[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).

CONCLUSION

The decision of the district court should be affirmed.

Dated: August 13, 2024

Respectfully submitted,

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Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this amicus curiae brief is printed with a proportionately spaced Century Schoolbook typeface in 14-point font, is double spaced, and the word count calculated by the word processing software is 4,924 words, excluding the cover page, tables, and certificates.

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