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SOCIETY OF GENERAL INTERNAL MEDICINE,
SOCIETY OF GYNECOLOGIC ONCOLOGY, AND
SOCIETY OF OB/GYN HOSPITALISTS

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INTEREST OF AMICI CURIAE ¹

The American College of Obstetricians and Gynecologists (•ACOGŽ), American Medical Association (•AMAŽ), American Academy of Family Physicians (•AAFPŽ), American Academy of Nursing (•AANŽ), American Academy of Pediatrics (•AAPŽ), American Association of Public Health Physicians (•AAPHPŽ), American College of Medical Genetics and Genomics (•ACMGŽ), American College of Nurse-Midwives (•ACNMŽ), American College of Osteopathic Obstetricians and Gynecologists (•ACOOGŽ), American College of Physicians (•ACPŽ), American Gynecological and Obstetrical Society (•AGOSŽ), American Medical Women's Association (•AMWAŽ), American Psychiatric Association (•APAŽ), American Society for Reproductive Medicine (•ASRMŽ), Association of Women's Health, Obstetric and Neonatal Nurses (•AWHONNŽ), Council of University Chairs of Obstetrics and Gynecology (•CUCOGŽ), GLMA: Health Professionals Advancing LGBTQ Equality (•GLMAŽ), North American Society for Pediatric and Adolescent Gynecology (•NASPAGŽ), National Medical Association (•NMAŽ), National Association of Nurse Practitioners in Women's Health (•NPWHŽ), Society for Academic Specialists in General Obstetrics and Gynecology (•SAS-GOGŽ), Society of Family Planning (•SFPŽ), Society of General Internal Medicine (•SGIMŽ), Society of Gynecologic Oncology (•SGOŽ), and Society of OB/GYN Hospitalists (•SOGHŽ) submit this amici curiae brief in support of Respondents.

¹ No counsel for a party authored this brief in whole or in part, and no 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. Letters from the parties consenting to the filing of this brief are on file with the Clerk.

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, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG has appeared as amicus curiae in courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including this Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.²

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 represent-

ed in the AMA's policymaking process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every State. This Court and the federal courts of appeals have cited the AMA's publications and amicus curiae briefs in cases implicating a variety of medical questions.³

AAFP, founded in 1947, is one of the largest national medical organizations, representing 133,500 members nationwide who provide continuous comprehensive health care to the public.

AAN represents more than 2,800 of nursing's most accomplished leaders and serves the public by advancing health policy through the generation, synthesis, and dissemination of nursing knowledge.

AAP is a professional medical organization dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Founded in 1930, its membership is comprised of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists.

AAPHP represents public health physicians in promoting public health and preventive services.

ACMG is the only nationally recognized medical professional organization solely dedicated to improving

³ See, e.g., *Birchfield v. North Dakota*, 136 S. Ct. 2160 (2016) (citing AMA research on blood-alcohol levels that constitute drunk driving); *Graham v. Florida*, 560 U.S. 48 (2010) (citing AMA brief as medical authority on juvenile development); *Ferguson v. City of Charleston*, 532 U.S. 67 (2001) (citing AMA brief in assessing patient privacy).

health through the practice of medical genetics and genomics.

ACNM works to advance the practice of midwifery to achieve optimal health for women. Its members include approximately 7,000 certified nurse midwives and certified midwives who provide primary and maternity care services to help women and their newborns.

ACOGG is a nonprofit organization committed to excellence in women's health representing over 2,500 osteopathic providers.

ACP is the largest medical specialty organization in the U.S. Its membership includes 161,000 internal medicine physicians, related subspecialists, and medical students.

AGOS is an organization composed of individuals attaining national prominence in scholarship in the discipline of Obstetrics, Gynecology, and Women's Health. For over a century it has championed the highest quality of care for women and the science needed to improve women's health.

AMWA is the oldest (founded in 1888) national organization

to empower and support nurses caring for women, newborns, and their families.

CUCOG is an association promoting excellence in medical education in the fields of obstetrics and gynecology. Its members represent the departments of obstetrics and gynecology of schools of medicine across the country.

GLMA is the largest and oldest association of lesbian, gay, bisexual, transgender and queer (LGBTQ) health professionals and their allies whose mission is to ensure health equity for LGBTQ and all sexual and gender minority (SGM) individuals, and equality for LGBTQ/SGM health professionals.

NASPAG is composed of gynecologists, adolescent medicine specialists, pediatric endocrinologists, and other medical specialists dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth.

NMA, established in 1895, is the nation's oldest and largest professional and scientific organization representing more than 50,000 African American physicians and their patients, and advocating for parity and justice in medicine, the elimination of disparities in health and promotion of health equity.

NPWH is the nonprofit organization that represents Women's Health Nurse Practitioners and other advanced practice registered nurses who provide women's and gender-related healthcare.

SASGOG seeks to enhance women's health by supporting academic generalist physicians in all phases of their careers.

point in pregnancy at which fetal life can be medically sustained outside the pregnant person's body. Indeed, the Ban reflects a fundamental misunderstanding and misrepresentation of the science of fetal development. The science conclusively establishes that a fetus at fifteen weeks gestational age is incapable of experiencing pain. The science also makes clear that, at fifteen weeks, a fetus is nowhere near viability because it is months away from when it could survive delivery, even with the latest advances in technology and medical care.

The Ban also impermissibly intrudes into the patient-physician relationship by limiting a physician's ability to provide the health care that the patient, in consultation with her physician, decides is best for her health. Moreover, the Ban undermines longstanding principles of medical ethics and places clinicians in the untenable position of choosing between providing care consistent with their best medical judgment, scientific evidence, and the clinicians' ethical obligations or risk losing their medical licenses. The provision of safe abortion services after careful consultation with a patient does not demean the practice of medicine. But infringement on a clinician's ability to honor patient autonomy, by allowing patients to make their own health care decisions, certainly does.

ARGUMENT

I. A

tional ages and types of abortion methods.¹⁰ The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.¹¹ In contrast, the risk of death associated with childbirth [is] approximately 14 times higher.¹² In fact, abortion 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.¹³

Nor are there significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies have found that women who obtain 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 associat-

¹⁰ White et al., Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature, 92 *Contraception* 422, 434 (2015).

¹¹ See Jatlaoui et al., Abortion Surveillance, United States, 2015 67 *Morbidity & Mortality Weekly Rep.* 1, 45 tbl. 23 (2018) (finding mortality rate from 0.00052 to 0.00078% for approximately five-year periods from 1978 to 2014); Zane et al., Abortion-Related Mortality in the United States, 1998-2010, 126 *Obstetrics & Gynecology* 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

¹² Raymond & Grimes, The Comparative Safety of Legal Induced Abortion and Childbirth in the United States, 119 *Obstetrics & Gynecology* 215, 216 (2012).

¹³ ANSIRH, Safety of Abortion in the United States, Issue Brief No. 6, at 2 (Dec. 2014); American Society for Gastrointestinal Endoscopy, Complications of Colonoscopy, 74 *Gastrointestinal Endoscopy* 745, 747 (2011); Grazer & de Jong, Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons, 105 *Plastic & Reconstructive Surgery* 436, 441 (2000).

ed with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to carry a pregnancy to term.^{1□}

Moreover, access to abortion remains vital for pregnant patients' overall health and well-being. One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.^{1□} The medical community recognizes abortion as a safe and essential component of women's health care.^{1□}

II. SCIENTIFIC EVIDENCE CONCLUSIVELY DEMONSTRATES THAT A FETUS IS NOT VIABLE AT FIFTEEN WEEKS

This Court has long recognized viability as the critical point of fetal development after which the State's asserted interest in protecting potential fetal life may outweigh a woman's privacy and autonomy interests in terminating her pregnancy. In *Planned Parenthood of*

^{1□}Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*

Southeastern Pennsylvania v. Casey, the Court reaffirmed *Roe*'s holding that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure." 505 U.S. 833, 846 (1992). But it explained that, in weighing a woman's privacy and autonomy interests in obtaining an abortion against the State's asserted interest in protecting potential fetal life, viability is where "the line should be drawn" and "the point at which the balance of interests tips." *Id.* at 860-861, 870.

This Court explained that the balance shifts because viability "is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman" and accordingly "there is no line other than viability which is more workable." *Casey*, 505 U.S. at 870. As Justice Blackmun explained in his concurrence in *Webster v. Reproductive Health Services*, "[t]he viability line reflects the biological facts and truths of fetal development; it marks the threshold moment prior to which a fetus cannot survive separate from the woman and cannot reasonably and objectively be regarded as a subject of rights or interests distinct from, or paramount to, those of the pregnant woman." 492 U.S. 490, 553 (1989); see also *Roe v. Wade*

support alone could sustain it, and its continued existence is no longer entirely dependent on the pregnant

attempts to manufacture a concern that medical consensus rejects as scientifically unfounded. There is no credible scientific evidence of fetal pain perception pre-viability, and certainly none at fifteen weeks LMP, approximately two months before a fetus approaches viability. Every major medical organization that has examined the issue of fetal pain and peer-reviewed studies on the matter have consistently reached the conclusion that pre-viability abortion does not result in fetal pain perception.^{1□}

The medical consensus is that fetal pain perception is not possible before at least twenty-four weeks gestation because the neural circuitry required to sense, perceive, or experience pain is not developed in earlier gestations. 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 the region of the cerebral cortex.²⁰ These neural connections do not develop until after at least twenty-

^{1□} See ACOG, Facts Are Important, Fetal Pain (July 2013); Royal College of Obstetricians and Gynaecologists, Fetal Awareness: Review of Research and Recommendations for Practice (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); SMFM et al., SMFM Consult Series #59: The use of analgesia and anesthesia for maternal-fetal procedures, *Am. J. Obstetrics & Gynecology* 4-5 (2021); Apkarian et al., Human Brain Mechanisms of Pain Perception and Regulation in Health and Disease, 9 *Eur. J. Pain* 463 (2005); Lee et al., Fetal Pain: A Systematic Multidisciplinary Review of the Evidence, 294 *J. Am. Med. Ass'n* 947 (2005).

²⁰ See, e.g. Apkarian et al., 9 *Eur. J. Pain* at 463-484; Tracey & Mantyh, The Cerebral Signature for Pain Perception and Its Modulation, 55 *Neuron* 377 (2007); Key, Why Fish Do Not Feel Pain, 3 *Animal Sentience* 1 (2016).

four weeks gestation.²¹ The scientific evidence therefore demonstrates that an asserted concern about fetal pain² should have no place in determining the constitutionality of the Ban or the understanding of viability.

III. THE BAN WILL HARM, NOT IMPROVE, PREGNANT PATIENTS' HEALTH

The State's health justifications for the Ban equally defy medical consensus. The Ban bars the provision of abortions after fifteen weeks of pregnancy with only narrowly defined exceptions for medical emergencies and severe fetal abnormalities. Miss. Code § 41-41-191(3)(h) & (j); (4)(a) (2018). Physicians and other clinicians could have their professional licenses suspended or revoked for providing an abortion in contravention of the Ban. Id. § 41-41-191(6). This Ban, an unconstitutional pre-viability ban on abortion, would cause severe and detrimental physical and psychological health consequences for pregnant patients.

A. The Ban Will Endanger The Physical And Psychological Health Of Pregnant Patients

While individuals who need an abortion want to obtain one as early as they can, there are a variety of reasons some patients may require a pre-viability abortion after the first trimester. Tens of thousands of abortions nationwide are performed at or after 14 weeks of gestation.²² Because more than 45% of pregnancies in

²¹ Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice*, vii, 8-9 (Mar. 2010); SMFM et al., *SMFM Consult Series #59: The use of analgesia and anesthesia for maternal-fetal procedures*, *Am. J. Obstetrics & Gynecology* 4-5 (2021).

²² CDC, *Abortion Surveillance...United States* (Nov. 27, 2020).

the United States are unplanned, and because many medical conditions, including irregular periods, may mask a pregnancy, many women do not discover they are pregnant for several weeks.²³ In fact, one study found that approximately half of those who obtain abortions in their second trimester do so because delays in suspecting and testing for pregnancy caused them to miss the opportunity for an earlier abortion.²⁴

After patients become aware of their pregnancies, they may need time to consult with family or health professionals. It often takes time before patients who have decided they need to end their pregnancy can access abortion care given the host of logistical and financial barriers many face, including paying for the procedure, and organizing transportation, accommodation, childcare, and time off from work. Women who have abortions later in pregnancy have been found to •have had difficulty finding an abortion provider,Ž •live farther from the clinic,Ž •be less educated,Ž •have had difficulty arranging transportation,Ž •be unsure of their last menstrual period,Ž and •experience fewer pregnancy symptoms.Ž²⁵ One recent study found that women receiving first-trimester abortions were delayed in doing so for a variety of reasons: 36.5% due to travel and procedure costs, 37.8% due to not recognizing the pregnancy, 20.3% due to insurance problems, and 19.9% due

²³ 06)at4 6Je /TT0 1 Tf 0.0038 Tc 0 Tw 7.98 0 0 7.98 237.42 234.181465.22

to not knowing where to find abortion care.^{2□} Even greater proportions of women needing second-trimester abortions faced these obstacles.^{2□} These hurdles are accentuated by the fact that in several states,, including Mississippi,,there is presently only one clinic providing abortions.

The Ban dangerously limits the ability of women at or near fifteen weeks• gestation to obtain the health care they need: some will be forced to travel outside the State to obtain an abortion; others will attempt self-induced abortion; and others still will be forced to carry their pregnancy to term. Each of these outcomes increases the likelihood of negative consequences to a woman's physical and psychological health that could be avoided if care were available.^{2□}

For instance, being forced to travel outside the State needlessly delays the abortion to later in pregnancy. Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication,,a risk increased further still by continuing a pregnancy to term.^{2□} The Ban will also increase the possibility that women may attempt self-induced abortions through harmful or unsafe methods.³⁰ Stud-

^{2□}Udaphyay et al., Denial of Abortion Because of Provider Gestational Age Limits in the United States , 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014).

^{2□}Id.

^{2□}See, e.g., ACOG, Committee Opinion No. 815, Increasing Access to Abortion (Dec. 2020).

^{2□}Upadhyay et al., 125 Obstetrics & Gynecology at 181.

³⁰See, e.g., Jones et al., Abortion Incidence and Service Availability in the United States, 2017 , at 3, 8 (2019) (noting a rise

ies have found that women are more likely to self-induce abortions where they face barriers to reproductive services, and methods of self-induction outside safe medical 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.³¹

Those patients who do not, or cannot, obtain an abortion due to the Ban will be forced to carry a pregnancy to term, an outcome with significantly greater risk to maternal health and mortality. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births³² and maternal mortality rates have increased staggeringly since then.³³ In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.³⁴ A woman's risk of death associated with childbirth is accordingly approximately 14 times higher than any risk of death from an abortion.³⁴

in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

³¹ Grossman et al., *Tex. Policy Eval. Proj. Res., Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas 3* (2015).

³² Raymond & Grimes, 119 *Obstetrics & Gynecology* at 216.

³³ MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 *Obstetrics & Gynecology* 447 (2016) (finding a 26.6% increase in maternal mortality rates between 2000 and 2014).

³⁴ Raymond & Grimes, 119 *Obstetrics & Gynecology* at 216.

³⁴ *Id.*

In addition to much greater maternal mortality, continued pregnancy and childbirth also entail other substantial health risks for women. Even an uncomplicated pregnancy causes significant stress on the body and involves physiological and anatomical changes. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or cause new conditions. For example, approximately 6 to 7% of pregnancies are complicated by gestational diabetes mellitus, a condition in which carbohydrate intolerance develops during pregnancy and which frequently leads to maternal and fetal complications, including developing diabetes later in life.^{3□} Another complication is preeclampsia, a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in blood pressure swings, liver issues, and seizures, among other conditions.^{3□} Labor and delivery are likewise not without significant risk, including that of hemorrhage, placenta accreta spectrum, hysterectomy, cervical laceration, and debilitating postpartum pain, among others.^{3□} Approximately one in three women who give birth in the United States do so by cesarean delivery, a major procedure that carries in-

^{3□} ACOG Practice Bulletin No. 190, Gestational Diabetes Mellitus (Feb. 2018).

^{3□} ACOG Practice Bulletin No. 222, Gestational Hypertension and Preeclampsia (Dec. 2018).

^{3□} ACOG Practice Bulletin No. 183, Postpartum Hemorrhage (Oct. 2017); ACOG Obstetric Care Consensus, Placenta Accreta Spectrum (July 2012, reaffirmed 2021); ACOG Practice Bulletin No. 198, Prevention and Management of Obstetric Lacerations at Vaginal Delivery (Sept. 2018); ACOG Clinical Consensus No. 1, Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management (Sept. 2021).

creased risk of complications.³ Finally, evidence suggests that women 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 women who obtained a needed abortion.⁰ Accordingly, as a medical and scientific matter, the fifteen-week ban is detrimental to women's physical and psychological health and well-being.¹

B. There Is No Health Or Safety Justification For The Fifteen-Week Ban

Similar to its disregard of the greater risks of forcing patients to continue a pregnancy, the State's affirmative attempt to justify the Ban as a means of protecting the health of women is scientifically baseless. Pet. Br. 7-8; Miss. Code § 41-41-191. In enacting the Ban, the Legislature relied on a single study to conclude that abortion carries significant physical and psychological risks to the maternal patient.² Pet. Br. 8.; Miss. Code §41-41-191. But the State ignores the rest of that study's findings, which show that, although the risks of abortion marginally increase as

continued pregnancy and childbirth¹², as well as the conclusions of the broader scientific and medical community, and decades of clinical experience.

Contrary to the State's assertion, the overwhelming weight of medical consensus finds induced abortion is one of the least risky procedures in modern medicine and is several times safer than the only alternative, carrying a pregnancy to term and giving birth.¹³ Moreover, every complication associated with abortion, including anemia, hypertensive disorders, and pelvic and perineal trauma is more common among women having live births than among those having abortions.¹⁴

As discussed above (see supra pp.17), although the risk of complications does increase somewhat as pregnancy progresses, the absolute risk of complications associated with an abortion remains exceedingly low across all gestational ages and methods.¹⁵ There are a variety of reasons why abortion carries a comparatively greater risk of complications as pregnancy progresses, including that abortions in the second trimester typical-

¹² Bartlett et al., Risk Factors for Legal Induced Abortion-Related Mortality in the United States, 103 *Obstetrics & Gynecology* 729 (2004).

¹³ *Id.* at 729; see also supranotes 8-14 and accompanying text.

¹⁴ Raymond & Grimes, 119 *Obstetrics & Gynecology* at 216-217; see also Bruce et al., Maternal Morbidity Rates in a Managed Care Population, 111 *Obstetrics & Gynecology* 1089, 1092 (2008) (Rates of anemia, hypertensive disorders of pregnancy, pelvic and perineal trauma, excessive vomiting, and postpartum hemorrhage each occurred more frequently in women who had a live birth or stillbirth.).

¹⁵ See supranotes 8-14 and accompanying text.

ly require more involved procedures and more sedation than procedures in the first trimester. ¹¹

The medical community has not, however, recommended any pre-viability limits, rather, it has recommended, as the study the State relies on explains, "increased access to surgical and nonsurgical abortion services" as they "may increase the proportion of abortions performed at lower-risk, early gestational ages."¹² This conclusion is consistent with a recent study published by the National Academies of Medicine, Engineering, and Science showing that the greatest threats to the safety and quality of abortion in the United States are unnecessary government regulations that restrict access to abortion.¹³

experiencing symptoms of posttraumatic stress, depression, or anxiety, or of experiencing lower self-esteem or life satisfaction

tion. Id. This accordingly forecloses an abortion for women who might face serious medical complications that, while posing grave risks to their health, are not urgent or extreme enough in the State's narrow view to fall within the Act's medical emergency exception.

There are a significant number of serious medical conditions that may not qualify as a "medical emergency" under the Ban's narrow definition but would nevertheless jeopardize a patient's health. These include, but are not limited to: Alport syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve that can occur in patients with no history of cardiac symptoms), lupus (a connective tissue disorder that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), 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).¹² The Ban also makes no exception for women who may have experienced conditions constituting a "medical emergency" in previous pregnancies and now seek to terminate a subsequent pregnancy to avoid future life-threatening complications. Moreover, the Ban makes no allowances for mental health issues that might put a woman's health and life

¹² See Matsuo et al., Alport Syndrome and Pregnancy , 109

at risk if the pregnancy is not terminated. ¹³ Any of these conditions can progress and become more serious or lead to additional health risks if abortion care is not available.

It is untenable to force a pregnant patient to wait until her medical condition escalates to the point that •an abortion is necessary to preserve [her] lifeŽ or her pregnancy creates •serious risk of substantial and irreversible impairment of a major bodily functionŽ before being able to seek potentially life-saving care. Miss. Code § 41-41-191. Nor should physicians be put in the impossible position of either letting a patient deteriorate until one of these conditions is met or face possible loss of their medical licenses for performing an abortion in contravention of the Ban. In forcing physicians to wait until a patient is close enough to death that they will risk their license to practice medicine to save her life by providing needed abortion care, the State indefensibly jeopardizes patients• health.

D. The Ban Will Hurt Rural, Minority, And Poor Patients The Most

The Ban will disproportionality impact people of color, those living in rural areas, and those with limited economic resources. This is because, as a general matter, 75% of those seeking abortion are living at or below 200% of the federal poverty level, and the majority of patients seeking abortions identify as Black, Hispanic,

¹³ Miss. Code § 41-41-191 (2018) (•medical emergencyŽ defined as when •life is endangered by a physical disorder, physical illness, or physical

Asian, or Pacific Islander.

the foundation of the patient-physician relationship: honest, open communication. Such bans require medical professionals to violate the age-old principles of beneficence, non-maleficence, and respect for patient autonomy in order to avoid negative personal and professional consequences such as having their licenses to practice medicine revoked. Miss. Code § 41-41-191(6). It is pre-viability abortion bans, not the ability to perform safe abortions before a fetus could ever survive outside the womb, that threaten the medical profession's integrity. See Pet. Br. 5 (framing the Ban as furthering Mississippi's interest in protecting the medical profession's integrity).

A. The Ban Undermines The Patient-Physician Relationship

Patient safety is of paramount importance to amici. While some regulation of medical practice is necessary to protect patient safety, legislation that substitutes lay lawmakers' views for a physician's expert medical judgment impermissibly interferes with the patient-physician relationship and poses grave dangers to patient well-being. 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."¹ 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.²

¹ ACOG, Code of Professional Ethics 2 (Dec. 2018).

² AMA, Code of Medical Ethics Opinion 1.1.1.

The patient-physician relationship is critical for the

overall medical advisability of the procedure or the desire of the patient. Miss. Code § 41-41-191(3). The Ban defines a qualifying “medical emergency” to mean that the pregnant patient’s life must be “endangered by a physical disorder, physical illness, or physical injury” or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function.” *Id.* (3)(j). A physician and patient together may conclude that an abortion was in the patient’s best medical interests even though the risk posed by continuing the pregnancy does not rise to the level of immediately life threatening or risking substantial and irreversible physical impairment of a major bodily function. The Ban thus forces physicians to choose between the ethical practice of medicine or obeying the law.¹²

B. The Ban Violates The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the well-being 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 2500 years ago.¹³ Both of these principles arise from the foundation of medical ethics which

¹² 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.”).

¹³ 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).

informed decision is in her own best interest. Instead, the medical profession's integrity is safeguarded when physicians are permitted to exercise their duty to counsel and care for patients based on objective professional judgment and ultimately respect patients' autonomy to make decisions about their own bodies and health. □

CONCLUSION

For the foregoing reasons, amici urge this Court to affirm the Fifth Circuit's decision.