Telephone: 406-586-8700
Email:
lbeck@becklawyers.com

Counsel for 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 Osteopathic Obstetricians and Gynecologists, American College of Physicians, American Gynecological and Obstetrical Society, American Medical Association, American

Association, American Society for Reproductive Medicine, American Urogynecologic Society, Council of University Chairs of Obstetrics and Gynecology, Montana Chapter of the American Academy of Pediatrics, Society for Adolescent Health and Medicine, National Association of Nurse

Health, Society for Maternal-Fetal Medicine, Society for Reproductive Endocrinology and Infertility, Society of Family Planning, and Society of OB/GYN Hospitalists

FRIED, FRANK, HARRIS, SHRIVER & JACOBSON LLP
One New York Plaza
New York, NY 10004
Telephone: 212-859-8000
Email:
janice.macavoy@friedfrank.com

Counsel for 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 Osteopathic Obstetricians and Gynecologists, American College of Physicians, American Gynecological and Obstetrical Society, American Medical Association, American Medical

Society for Reproductive Medicine, American Urogynecologic Society, Council of University Chairs of Obstetrics and Gynecology, Montana Chapter of the American Academy of Pediatrics, Society for Adolescent Health and Medicine, National Association of Nurse

Society for Maternal-Fetal Medicine, Society for Reproductive Endocrinology and Infertility, Society of Family Planning, and Society of OB/GYN Hospitalists

409 12th Street SW,
Washington, DC 200024
Telephone: 800-673-8444
Email: ralong@acog.org

Counsel for Amicus Curiae
American College of Obstetricians and Gynecologists

*Not Admitted in Montana

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

SUMMARY OF ARGUMENT

H.B. 136, H.B. 140, and H.B. 171 (collectively, the Restrictions [1] threaten to eviscerate access to a safe, legal, and routine health service: abortion. The State submits the Restrictions largely under the guise of protecting maternal health. However, the State legislature does not have unfettered ability to intrude into the realm of health care. To pass the Restrictions, this

demonstrate a compelling interest in

a particular class of patients or the general public from a medically-acknowledged, *bonafide* *Armstrong v. State*, 296 Mont. 361, 384 (1999) (emphasis in original). Here, the State has failed to meet its burden. The Restrictions unequivocally do not protect maternal health, and will instead harm Montanans seeking reproductive health care.

-acknowledged, *bonafide* health

Id. Overwhelming peer-reviewed, scientific evidence shows that abortion is safe. Indeed, abortion is undoubtedly in the best interest of many patients, for

---

[1] Among other things, H.B.

weeks or more; H.B. 140 requires clinicians to inform patients of the opportunity to view an ultrasound; and H.B. 171 requires a host of pre- and post-abortion procedures, as well as requires medications for medication abortions to be dispensed in person.

medical and/or personal reasons. Restrictions offer no medical benefit to patients, only obstacles that impede or delay patient access to abortion. Therefore, basis for the Restrictions do not qualify as a compelling state interest. The Restrictions represent the type of ideology and the unrelenting pressure from individuals and organizations that this Court cautioned against in *Armstrong*. *Id.*

The Restrictions not only fail to benefit patients; they affirmatively harm patients and professionals who practice medicine in Montana by undermining the patient-clinician relationship that sits at the core of medical practice. The Restrictions would impermissibly intrude into the patient-clinician relationship by requiring clinicians to deliver medically inaccurate information during pre-abortion counseling and by prohibiting clinicians from providing abortions under certain circumstances, regardless of their informed medical opinion on s best interest . The Restrictions force clinicians to disregard core principles of medical ethics or risk breaking the law. This Court should not countenance such treatment of

A. _____

Numerous studies comprehensively demonstrate that abortion is one of the safest health services available; this is regardless of whether the abortion is induced by medication or procedure. Complications from *any* type of abortion are rare. *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States*, at

clinical evidence clearly shows that legal abortions in the United States whether by medication, aspiration, D&E or induction are safe and effective. Serious

Only an average of 2% of patients experience any complication from abortion care and the majority of complications are minor and easily treatable. *See e.g.*, Upadhyay et al., *Incidence of Emergency Department Visits Complications After Abortion*, 125(1) Obstet. & Gynecol. 175, 181 (2015). The risk of major complications is minimal. As an example, major complications in first trimester aspiration procedures only occur in between 0.1% and 0.5% of patients. White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015).

Death resulting from abortion is extremely rare, occurring in fewer than one in 100,000 patients. *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 approximate five-year periods from

1978 to 2014); Zane et al., *Abortion-Related Mortality in the United States 1998-2010*, 126 Obstet. & Gynecol. 258, 261-62 (2015) (noting an approximate 0.0007% mortality rate for abortion). By comparison, other routine medical procedures, such as wisdom-tooth removal, colonoscopy, and adult tonsillectomy carry a greater risk of complication and mortality. National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States*, at 75; Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (2014).

It is particularly crucial here to address the safety of medication abortion, given that the State disingenuously claims that H.B. 171 which in part prohibits a clinician from providing medication abortion pills via courier, delivery, or mail service is necessary to protect patient health. Like procedural abortion, medication abortion is safe. ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstet. & Gynecol. e31, e32 (2020). Mifepristone and misoprostol are the typical pharmaceuticals used for medication abortion in the U.S. and supported by major medical organizations nationally and internationally; the U.S.

ACOG Statement on Medication Abortion

Network, *Safe, Online, Delivered: How to Get the Abortion Pill by Mail* (Mar. 8, 2021), https://nwhn.org/safe-online-delivered-how-to-get

medicine in person. Letter from Janet Woodcock, M.D., Acting Commissioner of Food and Drugs, FDA, to Maureen G. Phipps, MD, MPH, FACOG, CEO, ACOG (Apr. 12, 2021). Similarly, in October 2021, Advancing New Standards in

University of California San F

U.S. studies on medication abortion provided without in person clinician dispensing of mifepristone. It concluded that serious adverse events occurred in less than 1% of the cases, and no patients died. ANSIRH, *U.S. Studies on Medication Abortion Without In-person Clinician Dispensing of Mifepristone*, at 1 (2021).

All told, both medication and procedural abortion are extremely safe. Not only is the safety of abortion widely recognized by the medical community, the U.S. Supreme Court, among other courts, also recognize the safety of abortions. *See e.g.*, *June Med. Servs. L.L.C. v. Russo*, 140 S. Ct. 2103, 2122 (2020) (noting

B. _____

Continuing with a pregnancy carries a greater risk of death and health complications than obtaining a desired abortion. Statistically, the risk of death associated with childbirth in the U.S. is approximately 14 times higher than the risk

Increased Deaths Due to Remaining Pregnant, 58(6) Demography 2019, 2023-26 (Oct. 2021).

Moreover, continuing with a pregnancy poses a greater risk to overall physical health when compared to the risk of obtaining an abortion. 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. Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstet. & Gynecol. 215, 216 17 & Fig. 1 (Feb. 2012).

; *see also* ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstet. & Gynecol. at experimental; there is no FDA- of medication abortion. *See* ACOG, *Not Supported by Science*. The State provides no medical or scientific justification for Sections 7 and 8 of H.B. 171 and there is none and thus fails to meet its burden established in *Armstrong*.

Requiring clinicians to deliver medically and scientifically inaccurate information to patients fundamentally destabilizes the patient-clinician relationship. The patient-centered informed consent process for abortion care includes the clinician counseling their patient through open and frank conversation on the risks and benefits of abortion, based on current scientific evidence and medical knowledge. *See* ACOG, Committee Opinion No. 587, *Effective Patient-Physician Communication*, at 1-3 (2016). The State should not insert itself into these sensitive personal conversations by requiring medically inaccurate information. Providing inaccurate information not only erodes the trust at the core of the patient-clinician relationship, but such a mandate based on unproven, speculati care decisions and may be dangerous to patient health. *See* ACOG, Committee Opinion

No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137(2) Obstet. & Gynecol. e34, e34 (2021). One possible result of H.B. 171 is that patients may decide to have an abortion under the mistaken belief that they can later change their minds, which could clearly have harmful consequences for patient health.

As another example, Section 7 of H.B. 171 requires that prior to obtaining a medication abortion

.B. 171 § 7(5)(k). That information includes a state-created consent form t

Principles on the Role of Governments in Regulating the Patient-Physician Relationship (July 2012). Such laws undermine the efficacy of the patient-clinician relationship and leave clinicians in untenable positions; ethically, medical professionals

obligations to repeat State-mandated doctrine. *See* AMA, *Code of Medical Ethics*, Opinion 1.1.1, *Patient-Physician Relationships*.

B. _____

H.B. 136 also comes between patients and medical professionals by effectively forcing clinicians to choose between providing medically appropriate care and complying with state law. The patient-clinician relationship is grounded in an understanding that clinicians will adhere to certain medical ethics. Of utmost importance, clinicians must act in a way that is likely to benefit their patients and clinicians must refrain from acting in ways that might harm their patients, unless the harm is justified by concomitant benefits. ACOG, Committee Opinion No. 390, *Ethical Decision Making In Obstetrics and Gynecology*, at 3-4 (2016). Similarly, medical professionals should take all reasonable steps to ensure that they provide the most appropriate care to the patient. ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, at 2 (2018). Patients rightfully expect that their clinician will provide guidance about what they ct they

objective professional judgment. AMA, *Code of Medical Ethics*, Opinion 1.1.3, *Patient Rights*.

In direct contravention of these principles, H.B. 136 replaces medical judgment by prohibiting safe and medically appropriate abortions. A patient who has decided to obtain an abortion after 20 weeks is unable to access such care from a trained, qualified clinician

to s mother. H.B. 136 § 3. Patients rely on their clinician medical judgment, based on the trust established in the patient-clinician relationship. H.B. 136 undermines this relationship by commandeering the

provide a highly safe health service to patients with a pregnancy of certain gestational ages. In essence, H.B. 136 substitutes the judgment of legislators for personal health care decisions and clinicians professional judgments.

C. _____

Through the Restrictions, the State inserts itself into the patient-clinician relationship without demonstrating what this Court requires: a - acknowledged *bonafide* health risk. *Armstrong*, 296 Mont. at 384 (emphasis in original). *Amici*, along with many other medical organizations, oppose legislation that interferes with the patient-clinician relationship. *See, e.g.*, ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the*

Patient-Physician Relationship (2021); SMFM, *Access to Abortion Services*, at 1 (2020). The U.S. Supreme Court has consistently held that laws regulating abortion care that unduly interfere with medical professional ability to act in the best interest of their patients, and should be struck down. *See, e.g.*, *Planned Parenthood v. Casey*, 505 U.S. 833, 877-79 (1992); *June Med. Servs. L.L.C.*, 140 S. Ct. at 2132-33; *Health*, 136 S. Ct. at 2312-13. Moreover, in *Armstrong*, this Court held that, subject to *narrow* qualification, the

right of personal autonomy which protects the relationship from infringement by

Armstrong, 296 Mont. at 384. The State has demonstrated no

t intrusions into the patient-clinician relationship represented by the Restrictions, and they should continue to be enjoined. Any other result may have profoundly harmful consequences to the integrity of the medical profession and the patient-clinician relationship, as well as the safety and well-being of patients.

The Restrictions Hinder Access to Abortion Care and Disproportionately Impact Marginalized Patients

The Restrictions threaten to destabilize reproductive health care in Montana, which is an essential component of health care. As *amici*

legal and safe pregnancy termination . . . is essential to the public health of women

The Editors, the American Board of Obstetrics and Gynecology et al.,

Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation*, 136(4) Obstet. & Gynecol. at e32. By limiting care in this way, the State ignores evidence showing that telehealth provides comparable health outcomes when compared to other methods of health care delivery without compromising the patient-clinician relationship. Telehealth also enhances patient satisfaction and improves patient engagement. ACOG, Committee Opinion No. 798, *Implementing Telehealth in Practice*, 135(2) Obstet. & Gynecol. e73, e74 (2020). The State attempts to ban a

every aspect of

person visits offers patients any health benefit. *See id.* (emphasis added).

As a second example, Section 7 of H.B. 171 requires a patient seeking a medication abortion to provide informed consent at least 24 hours before the medication is provided to the patient. Under Section 4 of H.B. 171, the patient must then pick up the medication in person. Section 5 of H.B. 171 requires clinicians -up visit for the [patient] at approximately 7 to 14

H.B. 171 §5(3). The clinician reasonable efforts to ensure that the patient returns for the scheduled app *Id.* Thus, under this proposed statutory scheme, the patient must make *at least* two trips to a clinic to obtain an abortion, and for clinicians to be in compliance, the

patient must make a *third* trip. This requirement obstructs patients trying to access safe, basic health care, and provides absolutely no medical benefit.

As a third example, the Restrictions may deter clinicians from providing abortion care at all due to the strict penalties, including criminal, civil, and/or professional sanctions, for violating the Restrictions. This situation may only further exacerbate the shortage of health care professionals providing abortion in Montana and would mean patients may need to travel even further to access such care, or forego it entirely.

These are merely three examples of the multiple negative impacts the Restrictions would have on patients. The State well knows that 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 people are the very patients who are stymied by the time and expense of traveling across a large state like Montana. *See generally* ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, at e111-112; *see also* Affidavit of Colleen McNicholas at ¶ 12, *Planned Parenthood of Montana v. Montana*, No. DV-21-00999) (Mont. 13th Jud. Dist. Ct. Aug. 13, 2021) (noting that approximately 75% of abortion patients

nationwide are poor or low income). 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 who already have children, finding appropriate child care for clinic visits, especially multiple trips, is challenging and often infeasible. The Restrictions will especially burden these marginalized patients who have faced systemic barriers to abortion access, exacerbating the very disparities in reproductive health and health care that *amici* work to combat.

CONCLUSION

For all the reasons stated above, the Court should affirm the Montana preliminary injunction prohibiting the State from enforcing the Restrictions.

DATED this 28 day of March, 2022.

Respectfully submitted,

/s/ Lindsay Beck
LINDSAY BECK, ESQ.
Counsel for Amici

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this brief is printed with a proportionately-spaced, 14-point Times New Roman typeface, is double spaced (excluding footnotes, quoted, and indented material), has margins of 1-inch, and has a word count of 4,999 words, excluding the exempted cover page, tables, certificates, and signature.

DATED this 28 day of March, 2022.

/s/ Lindsay Beck
LINDSAY BECK, ESQ.

Raphael Jeffrey Carlisle Graybill (Attorney)
300 4th Street North
PO Box 3586
Great Falls MT 59403
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: eService

Gene R. Jarussi (Attorney)
Bishop, Heenan & Davies
1631 Zimmerman Tr, No. 1
Billings MT 59102
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: eService

Emily Jayne Cross (Attorney)
401 North 31st Street
Suite 1500
P.O. Box 639
Billings MT 59103-0639
Representing: Montana Constitutional Convention Delegates
Service Method: eService

Akilah Maya Lane (Attorney)
2248 Deerfield Ln
Apt B
Helena MT 59601
Representing: ACLU of Montana Foundation, Inc., National Women's Law Center, Center for Reproductive Rights
Service Method: eService

Kyle Anne Gray (Attorney)
P.O. Box 639
Billings MT 59103
Representing: Montana Constitutional Convention Delegates
Service Method: eService

Brianne McClafferty (Attorney)
401 North 31st Street, Suite 1500
P. O. Box 639
Billings MT 59103-0639
Representing: Montana Constitutional Convention Delegates

Matthew Prairie Gordon (Attorney)
1201 Third Ave
Seattle WA 98101
Representing: Asian Institute on Gender-Based Violence, Aspen, Caminar Latino, Custer Network Against Domestic Abuse, Inc., District 4 Human Resources Development Council, Domestic and Sexual Violence Services, Idaho Coalition Against Sexual & Domestic Violence, Latinos United for Peace and Equity, Legal Voice, Montana Coalition Against Domestic and Sexual Violence, National Coalition Against Domestic Violence, National Network to End Domestic Violence, Richland County Coalition Against Domestic Violence, the erroot, , ition for
Families, Sexual Assault Counseling Center, UJIMA, Inc., Victim-Witness Assistance Services, YWCA Great Falls, YWCA Missoula
Service Method: eService

Kimberly Parker (Attorney)
1875 Pennsylvania Avenue NW
Washington DC 20006
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Hana Bajramovic (Attorney)
123 William St., Floor 9
New York NY 10038
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Alice Clapman (Attorney)
1110 Vermont Ave, NW Ste 300
Washington DC 20005
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Nicole Rabner (Attorney)
1875 Pennsylvania Avenue NW
Washington DC 20006
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Alan Schoenfeld (Attorney)
7 World Trade Center, 250 Greenwich Street
New York NY 10007
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Michelle Diamond (Attorney)
7 World Trade Center, 250 Greenwich Street
New York NY 10007
Representing: Planned Parenthood of Montana, Joey Banks
Service Method: E-mail Delivery

Electronically Signed By: Lindsay Beck
Dated: 03-28-2022