IN THE SUPREME COURT OF OHIO

State ex rel. Preterm-Cleveland, *et al.*, Relators, vs. David Yost, Attorney General of Ohio, *et al.*, Respondents.	**BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF RELATORS** Case No. 2022-0803

Subodh Chandra
Donald P. Screen
THE CHANDRA LAW FIRM LLC
The Chandra Law Building
1265 West 6th St, Suite 400
Cleveland, OH 44113
(216) 578-1700
Subodh.Chandra@ChandraLaw.com
Donald.Screen@ChandraLaw.com

Nicole A. Saharsky*
Carmen N. Longoria-Green
MAYER BROWN LLP
1999 K St. NW
Washington, DC 20006
(202) 263-5282
nsaharsky@mayerbrown.com
clongoriagreen@mayerbrown.com

Megan E. Stride
MAYER BROWN LLP
71 S. Wacker Drive
Chicago, IL 60606
(312) 782-0600
mstride@mayerbrown.com

Attorneys for *Amici Curiae* American College of Obstetricians and Gynecologists, American Medical Association, and Society for Maternal-Fetal Medicine

Molly A. Meegan*
Shiri A. Hickman
Jessica M. Morris
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
409 12th Street, SW
Washington, DC 20024
(202) 863-2585
mmeegan@acog.org

Attorneys for *Amicus Curiae* American College of Obstetricians and Gynecologists

**pro hac vice application forthcoming*

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INTEREST OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, 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's Ohio Section has over 2,400 members living and practicing in the state who, together with their patients, are directly affected by laws restricting access to abortion care and other reproductive health 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 the U.S. Supreme Court, that recognize ACOG as a leading provider of authoritative scientific data regarding childbirth and abortion.[1]

[1] *See, e.g.*, *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2132 (2020); *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932–36 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *see also Gonzales v. Carhart*, 550 U.S. 124, 170–71, 175–78, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's brief and congressional submissions regarding abortion procedure).

The American Medical Association (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 represented in the AMA's policymaking process. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state. The AMA's publications and *amicus* briefs have been cited by many courts, including the U.S. Supreme Court, in cases implicating a wide variety of medical questions.[2]

The Society for Maternal-Fetal Medicine (SMFM) is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 5,500 members, including 213 professionals who live and practice in Ohio, caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all

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[2] *See, e.g.*, *Ferguson v. City of Charleston*, 532 U.S. 67, 78, 81, 84 n.23 (2001) (citing AMA's *amicus* brief and published opinion in case involving arrests of obstetrics patients based on hospital drug testing); *Stenberg*, 530 U.S. at 934–36 (quoting at length an AMA report on abortion procedures); *Vacco v. Quill*, 521 U.S. 793, 800 n.6 (1997) (quoting AMA articles regarding the withdrawal or withholding of life-sustaining treatment and citing AMA *amicus* brief); *Sullivan v. Zebley*, 493 U.S. 521, 534 n.13, 536 n.17, 541 n.22 (1990) (citing AMA *amicus* brief about federal regulation's list of childhood disabilities); *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) (quoting AMA Code of Ethics provision about physician-assisted suicide).

medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by courts in cases raising a variety of medical issues.[3]

INTRODUCTION AND SUMMARY OF ARGUMENT

Abortion is an essential part of comprehensive health care. When abortion is legal, it is safe. *Amici curiae* are leading medical societies representing physicians, nurses, and other clinicians who serve patients in Ohio and nationwide, and whose policies represent the education, training, and experience of the vast majority of clinicians in this country. *Amici* all agree that state laws that criminalize and effectively ban abortion 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 and undermine longstanding principles of medical ethics. As the AMA has recognized, "it is a violation of human rights when government intrudes into medicine and impedes access to safe, evidence-based reproductive health services, including abortion and contraception."[4]

Ohio's Senate Bill 23 (S.B. 23) imposes criminal penalties on individuals who provide abortions after embryonic cardiac activity becomes detectable, which generally

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[3] *See, e.g.*, *Mayor of Baltimore v. Azar*, 973 F.3d 258, 285 & n.19 (4th Cir. 2020) (quoting *amicus* brief by SMFM and others supporting challenge to federal rule prohibiting physicians and other providers in Title X programs from referring patients for abortion, and noting that SMFM is a "reputable and nonpartisan medical organization[]").

[4] AMA, *Press Release: AMA Bolsters Opposition to Wider Criminalization of Reproductive Health* (June 14, 2022), https://www.ama-assn.org/press-center/press-releases/ama-bolsters-opposition-wider-criminalization-reproductive-health.

occurs around six weeks of pregnancy.[5] S.B. 23 includes two limited exceptions, permitting abortions after six weeks when necessary to prevent (1) the "death of the pregnant woman" or (2) a "serious risk of the substantial and irreversible impairment of a major bodily function."[6] The law does not include exceptions for cases of rape, incest, or major fetal abnormalities.

In 2019, a federal district court enjoined S.B. 23 because it provides an "insurmountable" obstacle for pregnant people seeking to access abortion care.[7] On June 24, 2022, the district court vacated that injunction in light of *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), and allowed S.B. 23 to take effect.[8]

Amici oppose Ohio's six-week abortion ban because it jeopardizes the health and safety of pregnant people in Ohio and places extreme burdens and risks on providers of essential reproductive health care, without any valid medical justification.

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[5] 2019 Am.Sub.S.B. No. 23 (amending R.C. 2317.56, 2919.171, 2919.19, 2919.191, 2919.192, 2919.193, and 4731.22; amending, for the purpose of adopting new section numbers as indicated in parentheses, R.C. 2919.191 (2919.192), 2919.192 (2919.194), and 2919.193 (2919.198); and enacting new sections R.C. 2919.191, 2919.193, 2919.195, 2919.196, 2919.197, 2919.199, 2919.1910, 2919.1912, 2919.1913, and 5103.11).

[6] 2019 Am.Sub.S.B. No. 23, § 1, at 9, enacting R.C. 2919.195(B).

[7] *See Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 801, 804 (S.D. Ohio 2019).

[8] Order, *Preterm-Cleveland v. Yost*, No. 1-19-cv-00360 (S.D. Ohio June 24, 2022), ECF No. 100.

ARGUMENT

I. Abortion Is a Safe, Common, and Essential Component of Health Care

The medical community recognizes that abortion is a safe, common, and essential component of reproductive health care.[9] In 2020, over 930,000 abortions were performed nationwide,[10] and more than 20,000 abortions were performed in Ohio.[11] Approximately one-quarter of American women have an abortion before they reach age 45.[12]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[13] Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and easily

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[9] *See, e.g.*, Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, *et al.*, *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine that "[a]ccess to legal and safe pregnancy termination … is essential to the public health of women everywhere"); ACOG, *Abortion Policy* (revised and approved May 2022); Soc'y for Maternal-Fetal Med., *Access to Pregnancy Termination Services* (2017).

[10] Jones *et al.*, Guttmacher Inst., *Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court is Poised to Overturn* Roe v. Wade (June 15, 2022).

[11] Ohio Dep't of Health, *Induced Abortions in Ohio, 2020,* at 1 (Sept. 2021) (*Induced Abortions in Ohio*), https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/vital-statistics/resources/vs-abortionreport2020.

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

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

treatable.[14] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[15] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[16] By contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[17] In fact, abortion is so safe that there is a

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[14] *See, e.g.*, Upadhyay *et al.*, *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (finding 2.1% abortion-related complication rate) (*Incidence of Emergency Department Visits*); *Safety and Quality of Abortion Care* 55, 60.

[15] 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 more than 40% of all abortions in Ohio and about half of abortions nationwide. Raymond *et al.*, *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013) (addressing rates at which major complication occur for medication abortion); *Induced Abortions in Ohio* 23 (data on Ohio medication abortions, category labeled "Non-surgical"); Jones *et al.*, Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022) (nationwide data).

[16] *See* Kortsmit *et al.*, U.S. Dep't of Health & Human Services, Centers for Disease Control and Prevention, *Abortion Surveillance – United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl. 15 (2021) (Kortsmit) (finding mortality rate from 0.00041% 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).

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

greater risk of complications or mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[18]

Similarly, there are no 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 associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to women who were forced to continue a pregnancy to term.[19] One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[20]

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[18] Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014) (2.1% of abortions result in minor or major 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); American Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011) (33% of colonoscopies result in minor complications); Grazer & 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 29 tbl. 15 (2021) (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in the years 2013–2018).

[19] 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) (Biggs).

[20] Rocca *et al.*, *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLOS ONE 1, 7 (2015).

II. Despite the Safe and Routine Nature of Abortions, Ohio's Six-Week Ban Would Prohibit Nearly All Abortions with No Medical Justification

S.B. 23 criminalizes nearly all abortions. The law jeopardizes the health and safety of pregnant people in Ohio and places extreme burdens and risks upon providers of essential reproductive health care, without any valid medical justification.

The state legislature has asserted that the law promotes the state's "valid interest in protecting the health of the woman."[21] But the law does not further that stated interest, nor is it medically justified. To the contrary, Ohio's six-week ban harms the health of pregnant people in Ohio and creates arbitrary, unnecessary, and conflicting responsibilities for clinicians.

A. The Six-Week Ban Criminalizes Providing Abortion Care Where There Is Detectable Cardiac Activity, Which Has the Effect of Prohibiting the Majority of Abortions

S.B. 23 radically restricts access to abortion care. The law requires providers to determine whether a "fetal heartbeat" is present, and if there is such a "detectable heartbeat," the law makes it a felony to "perform or induce an abortion."[22] The law defines "fetal heartbeat" to include "cardiac activity . . . of the fetal heart,"[23] which is typically detectable at approximately six weeks' gestation. S.B. 23 reflects a misunderstanding by the legislature of key medical issues and terminology. *Amici* understand that Ohio believes its definition of "fetal heartbeat" includes the embryonic cardiac activity that occurs as a

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21 2019 Am.Sub.S.B. No. 23, § 3(G), at 24.

22 2019 Am.Sub.S.B. No. 23, § 1, at 8, enacting R.C. 2919.195(A).

23 2019 Am.Sub.S.B. No. 23, § 1, at 5, amending R.C. 2919.19.

result of electrical flickering of a portion of the embryonic tissue, which typically is detectable at approximately six weeks' gestation. As a matter of medical science, however, a true fetal heartbeat exists only after the chambers of the heart have been developed and can be detected via ultrasound, which typically occurs around 17–20 weeks' gestation.[24]

A person who is convicted of "performing or inducing" an abortion after detecting embryonic cardiac activity, or without determining whether there is embryonic cardiac activity, is subject to imprisonment of six to twelve months and a fine of $2,500.[25] In addition to criminal penalties, the state medical board may limit, revoke, or suspend a physician's medical license and may assess a forfeiture of up to $20,000 for each violation.[26] The state also may impose civil penalties and revoke a clinic's ambulatory surgical facility license.[27] And a patient may bring a civil action against a provider who violates the law and recover damages of $10,000 or more.[28]

S.B. 23 will prevent many pregnant patients who want abortions from obtaining them. First, many people do not know they are pregnant by six weeks' gestational age, or only learn they are pregnant shortly before that window closes. The gestational age of a pregnancy is measured in weeks from the first day of a person's last menstrual period. The

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24 *See ACOG Guide to Language and Abortion* 1 (Mar. 2022).

25 S.B. 23, § 1, at 8–9, enacting R.C. 2919.193(A), 2919.195(A) (providing that a violation constitutes a "felony of the fifth degree"); R.C. 2929.14(A)(5) (providing that the prison term for a fifth-degree felony shall be between six and twelve months); R.C. 2929.18(A)(3)(e) (providing for a fine of up to $2,500 for a fifth-degree felony).

26 *See* S.B. 23, § 1, at 12, enacting R.C. 2919.1912(A); R.C. 4371.22(B)(10).

27 R.C. 3702.32.

28 S.B. 23, § 1, at 10–11, enacting R.C. 2919.199(B)(1).

average menstrual cycle is four weeks long, which means that at six weeks' gestation, a person would be only two weeks from a missed period. And for a variety of reasons—including stress, obesity, thyroid dysfunction, and premature ovarian failure—many people experience irregular menstrual cycles.[29] Also, adolescents may have cycles that are six weeks or longer in early menstrual life.[30] As a result of these variations in cycle length, a person might not even notice a missed period before six weeks have passed. Further, nearly half of the pregnancies in the United States are unplanned,[31] and many pregnant patients may not realize they are pregnant based on other symptoms (either because they do not associate symptoms such as nausea or vomiting with pregnancy, or because they do not experience these symptoms before six weeks).[32]

Even if people suspect they may be pregnant before six weeks pass, many people are unable to see physicians to confirm their pregnancies, let alone make thoughtful, informed decisions about whether to continue their pregnancies before six weeks' gestation.[33] It often takes time before patients who have decided they need to end their

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29 *See* Bae *et al.*, *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18 BMC Women's Health 1, 2 (2018).

30 ACOG, Committee Opinion No. 651, *Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign* 2 (Nov. 2006).

31 Guttmacher Inst., Fact Sheet, *Unintended Pregnancy in the United States* (Jan. 2019); Boonstra *et al.*, Guttmacher Inst., *Abortion in Women's Lives* 29 (May 2006).

32 Gadsby *et al.*, *A Prospective Study of Nausea and Vomiting During Pregnancy*, 43 Brit. J. of Gen. Prac. 245, 246 (June 1993).

33 In addition, administering a home-pregnancy test too early in a patient's menstrual cycle or too close to the time a patient became pregnant may result in a false negative result. FDA.gov, *Pregnancy*, https://www.fda.gov/medical-devices/home-use-tests/pregnancy (Apr. 29, 2019).

pregnancies can access abortion care, given the logistical and financial barriers many face, which include a state-mandated waiting period, health-center wait times, and the need to organize funds, transportation, accommodation, childcare, and time off from work.[34] Moreover, before six weeks' gestation, physicians cannot always confirm an intrauterine pregnancy via ultrasound and therefore in some cases may not be able to offer an abortion.[35]

For all of these reasons, the majority of abortions provided nationwide are performed after six weeks' gestational age. Because of its criminal penalties and limited exceptions, combined with the fact that many individuals do not know they are pregnant and cannot access reproductive health care before six weeks' gestation, S.B. 23 functions as a near-absolute ban on abortion care.

B. The Six-Week Ban Does Not Allow Sufficient Time for Patients and Clinicians to Consult Regarding Potential Risks Involving the Fetus

The Ohio General Assembly asserts that embryonic cardiac activity is a "key medical predictor that an unborn human individual will reach live birth."[36] That assertion is inconsistent with scientific understanding and medical practice. While embryonic cardiac activity can signal that an early pregnancy may continue to develop (as opposed to ending in a spontaneous abortion or miscarriage),[37] embryonic cardiac activity is a scientifically arbitrary point in pregnancy. It does not by itself indicate whether a

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34 *Cf.* Drey *et al.*, *Risk Factors Associated With Presenting for Abortion in the Second Trimester*, 107 Obstet. & Gynecol. 128, 130 (Jan. 2006).

35 Heller & Cameron, *Termination of Pregnancy at Very Early Gestation Without Visible Yolk Sac on Ultrasound*, 41 J. Fam. Plan. Reprod. Health Care 90, 90–91 (2015).

36 2019 Am.Sub.S.B. No. 23, § 3(E), at 24.

37 ACOG, Practice Bulletin No. 200, *Early Pregnancy Loss* (Nov. 2018).

pregnancy will develop normally or end in a live birth, and it certainly is not a sign of fetal viability.

Further, embryonic cardiac activity occurs too early in a pregnancy for patients to have undergone screening for genetic, chromosomal, or other issues that could detect potentially life-threatening fetal anomalies. Pregnant patients typically undergo ultrasound scans late in the first trimester (the time from the pregnant person's first missed period through 12 weeks of pregnancy) and again in the second trimester (the time from 12 through 24 weeks of pregnancy) to detect potential abnormalities.[38] One study concluded that 23% of major fetal anomalies were detected between 11 to 14 weeks of gestation and that 33.7% were detected in the second trimester.[39] Two additional studies found that in over one-half of the pregnancies studied, fetal malformations were not detected until the second trimester.[40]

Major fetal anomalies are often incompatible with survival; a pregnant patient who cannot obtain abortion care under these circumstances can be forced to carry to term a fetus

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38 ACOG, Practice Bulletin No. 175, *Ultrasound in Pregnancy* (Dec. 2016).

39 Fong *et al.*, *Detection of Fetal Structural Abnormalities with US During Early Pregnancy*, 24(1) RadioGraphics 157, 172–73 (Jan.–Feb. 2004).

40 Kashyap *et al.*, *Early Detection of Fetal Malformation, a Long Distance Yet to Cover! Present Status and Potential of First Trimester Ultrasonography in Detection of Fetal Congenital Malformation in a Developing Country: Experience at a Tertiary Care Centre in India*, 2015 Journal of Pregnancy 1, 6 (2015) (finding that, out of the total number of women with diagnosed fetal malformation, 65% presented before 20 weeks of gestation and of that, only 1.6% were diagnosed prior to 12 weeks of gestation); Rydberg & Tunon, *Detection of Fetal Abnormalities by Second-Trimester Ultrasound Screening in a Non-Selected Population*, 96(2) Acta. Obstet. Gynecol. Scand. 176, 176 (Nov. 22, 2016) (finding that half of the major structural malformations in otherwise normal fetuses were detected by routine ultrasound examination in the second trimester).

that has little or no life expectancy. Carrying such a pregnancy to term may present life-threatening or life-altering risks to the pregnant patient. Forcing abortions to occur before this screening occurs or not at all deprives patients of the opportunity to discuss these personal, complex, medical considerations with their clinicians and families and to make informed decisions about their health and the health of their families.

III. By Prohibiting Most Abortions, The Six-Week Ban Will Harm Pregnant Patients' Health

Ohio's six-week ban will cause severe and detrimental physical and psychological health consequences for pregnant patients who want to obtain an abortion. While abortion is overall a safe medical procedure, S.B. 23 will force clinicians to delay providing needed medical care until a patient is in a critical situation, and/or cause patients to travel outside of the state to obtain needed medical care. These delays will result in an increased risk of the complications and costs associated with delayed abortion care. Further, in light of S.B. 23, pregnant individuals may be more likely to attempt self-managed abortions using harmful or unsafe methods—specifically, self-managed methods other than procuring appropriate medications through licensed providers. Each of these outcomes increases the likelihood of negative consequences for the patient's physical and psychological health that could be avoided if abortion were available.

S.B. 23's limited exceptions are insufficient to protect the health of pregnant patients. They do not permit abortion care in circumstances that present a risk of substantial harm to patients, including circumstances related to a pregnant patient's mental health. They also contain elements that are too vague to provide workable guidance for clinicians

to use in structuring their practices to comply with the law, and they compromise clinicians' ability to rely on their sound medical judgment to determine the best treatment plan and provide care. The legislature's attempt to identify a list of serious risks is necessarily incomplete, ill-advised, and medically unsound.

A. The Six-Week Ban Will Endanger the Physical and Psychological Health of Pregnant Patients

Criminalizing safe abortions provided by licensed clinicians in the state of Ohio will result in delays in obtaining abortions. Typically, many delays in seeking an abortion are caused by the patient's lack of information about where to find abortion care.[41] The need to travel out of state and consider various states' individual criminal and civil penalties related to abortion likely will further increase confusion for patients about where they can find needed health care. In addition, almost one-third of delays are caused by travel and procedure costs.[42]

With S.B. 23 in effect, the travel and procedure costs for Ohioans seeking abortion will increase. For example, a 2020 analysis found that the closure of Ohio's abortion clinics would result in a 700% increase in the average required travel distance for Ohioans seeking an abortion.[43] While S.B. 23 does not mandate closure of abortion clinics on its

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41 Upadhyay *et al.*, *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014).

42 *Id.*

43 Bearak *et al.*, Guttmacher Inst., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care* (updated Apr. 23, 2020) (finding that, on average, Ohio abortion clinic closures would increase abortion-seeking Ohioans' driving distance from 15 miles to 120 miles).

face, its restriction on abortions performed after approximately six weeks of gestation effectively renders all Ohio abortion clinics unavailable to women who seek abortion care after that point in time. Although the risk of complications from abortion care overall remains exceedingly low, increasing gestational age results in an increased chance of a major complication.[44] Moreover, abortions at later gestational ages are typically more expensive, further increasing the barriers to obtaining care.[45]

By removing access to safe, legal abortion, S.B. 23 will also increase the possibility that a pregnant patient will attempt a self-managed abortion through a harmful or unsafe method.[46] Studies have found that women are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-management may rely on harmful tactics such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing hormonal pills, rather than use of FDA-approved abortion medication, which is a safe way to self-manage abortion.[47]

Those patients who do not, or cannot, obtain an abortion due to S.B. 23 will be forced to continue a pregnancy to term—an outcome with significantly greater risk to the health of the pregnant individual. The U.S. mortality rate associated with live births from

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44 *Incidence of Emergency Department Visits* 181.

45 Jones *et al.*, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009).

46 *See, e.g.*, Jones *et al.*, Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion).

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

1998 to 2005 was 8.8 deaths per 100,000 live births,[48] and rates have sharply increased since then.[49] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[50] A pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[51]

Continued pregnancy and childbirth also entail other substantial health risks for the pregnant person. 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 lead to newly arising health issues. For example, sickle-cell disease can worsen during pregnancy, leading to severe anemia and vaso-occlusive crisis, a condition that results in significant pain.[52] Pregnant patients with inherited thrombophilia, which can be undetected until a triggering event such as pregnancy, have a high risk of developing blood clots in their lungs that can become life threatening.[53] And pregnancy can exacerbate asthma, making it a severe and life-

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48 Raymond & Grimes 216.

49 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).

50 Raymond & Grimes 216.

51 *Id.*

52 ACOG, Practice Bulletin No. 78, *Hemoglobinopathies in Pregnancy* (Jan. 2007, reaff'd 2018).

53 ACOG, Practice Bulletin No. 197, *Inherited Thrombophilias in Pregnancy* (July 2018).

threatening condition.[54] Labor and delivery likewise carry significant risks. Those risks include hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs when the placenta is unable to detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum pain.[55] Approximately one in three people who give birth in the United States do so by cesarean delivery, a major surgical procedure that carries increased risk of complications.[56]

Evidence also suggests that pregnant people 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 who obtained a needed abortion.[57]

B. The Limited Exceptions to the Six-Week Ban Do Not Adequately Protect Patients' Health

Ohio's two limited exceptions are insufficient to protect the health of the pregnant patient. Those exceptions allow for an abortion after the detection of embryonic cardiac activity if the abortion is necessary to prevent (1) the "death of the pregnant woman" or (2)

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54 ACOG, Practice Bulletin No. 90, *Asthma in Pregnancy* (Feb. 2008, reaff'd 2016).

55 ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017); ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum*, 1–2 (July 2012, reaff'd 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*, 507 (Sept. 2021).

56 CDC, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* (2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery*, 1–3 (Mar. 2014, reaff'd 2016).

57 Biggs 172.

a "serious risk of the substantial and irreversible impairment of a major bodily function."[58] "Serious risk of the substantial and irreversible impairment of a major bodily function" is defined to include preeclampsia, inevitable abortion, and premature rupture of the membranes, but expressly excludes any "condition related to the woman's mental health."[59] The law does not include any exceptions for cases of rape, incest, or major fetal abnormalities.

Pregnancy can exacerbate existing health issues that do not necessarily or immediately lead to death or permanent impairment of a "major bodily function," but nevertheless pose serious health risks for patients during pregnancy. Examples (in addition to those listed above) include Alport Syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve), lupus (a connective tissue disease that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), and pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy).[60]

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58 2019 Am.Sub.S.B. No. 23, § 1, at 9, enacting R.C. 2919.195(B).

59 *Id.*

60 *See* Matsuo *et al.*, *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 2007); Stout & Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); Cortes-Hernandez *et al.*, *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646–647 (2002); Kiely *et al.*, *Pregnancy and Pulmonary Hypertension: A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013); Greene & Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

Further, Ohio's six-week ban does not account for significant medical issues patients experienced during prior pregnancies. If patients do not learn that they are pregnant until after six weeks of gestation, and abortion care is unavailable, those prior conditions could go on to progress or reoccur. Those complications can endanger the health of the pregnant patient and directly affect fetal development and survival. Examples of these conditions include placental abruption (separation of the placenta from the uterine wall),[61] placenta accreta (when the placenta is unable to detach at childbirth),[62] peripartum cardiomyopathy (enlargement of the heart in or after pregnancy),[63] and thrombophilia (blood clotting).[64] These examples demonstrate why decisions about whether to continue a pregnancy are properly left to the clinicians and patients involved, rather than entrusted to legislators without reference to facts and medical evidence. Indeed, it is both inadvisable and impossible for a legislative body to identify a comprehensive list of medical emergencies or conditions that pose significant health risks in pregnancy. Legislators are not in the exam room and have neither the training nor experience to exercise medical judgment to evaluate complex or developing situations and recommend a course of treatment.

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61 ACOG, Obstetric Care Consensus No. 10, *Management of Stillbirth*, 7, 11 (March 2009, reaff'd 2021).

62 ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum*, 2 (July 2012, reaff'd 2021).

63 ACOG, Practice Bulletin No. 212, *Pregnancy and Heart Disease* (May 2019).

64 ACOG, Practice Bulletin No. 197, *Inherited Thrombophilias in Pregnancy* (July 2018).

Other elements of the exceptions also are problematic. For example, by limiting the exceptions to death and "substantial and irreversible impairment of a major bodily function," the latter of which expressly excludes "condition[s] related to the woman's mental health,"[65] the law fails to consider maternal mental-health issues that can put a pregnant patient's health and life at risk.[66] In addition, the law requires that physicians who perform abortions under one of the law's exceptions document their rationale and retain those records for at least seven years.[67] That requirement suggests that the state is willing to second-guess medical judgments in a way that exposes physicians to substantial risk and may interfere with the exercise of that medical judgment.

Further, the Ohio law is too vague to give clinicians workable guidance about which procedures are permitted and which are prohibited, especially with respect to managing early pregnancy loss. For example, incomplete miscarriages are commonly treated via uterine aspiration, which is the same procedure as that used for the majority of abortions (other than medication abortions).[68] Ohio's six-week ban does not clearly state that miscarriage management is permissible, nor does it protect clinicians who must use their

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65 *See* 2019 Am.Sub.S.B. No. 23, § 1, at 6; R.C. 2919.16(K).

66 *See, e.g.*, Mangla *et al.*, *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

67 *See* 2019 Am.Sub.S.B. No. 23, § 1, at 10, enacting R.C. 2919.195(B).

68 Allen *et al.*, *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625, 632 (2013) (uterine aspiration is used for induced abortion and treatment of miscarriages); Dennis *et al.*, *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141, 141, 143 (2015) (technical aspects of miscarriage management and induced abortion are the same).

medical judgment to determine the best treatment plan and provide care in the moment. This aspect of the law creates unacceptable risks for physicians seeking to provide necessary, routine care, as well as for the patients requiring that care.

It is untenable to force pregnant patients to wait until their medical condition escalates to the point that an abortion is necessary to prevent death or permanent injury to a major bodily function before being able to seek abortion care. Physicians should not be put in the impossible position of either letting a patient deteriorate until one of these limited exceptions is met or facing potential criminal punishment for providing needed care consistent with their medical judgment but still potentially in contravention of the Ohio law. Indeed, that impossible choice could cause some physicians to second guess the necessity of critical abortion care until the pregnant patient has a serious medical complication or until it is too late to save the pregnant patient's life. The limited exceptions to the six-week ban therefore indefensibly jeopardize patients' health.

IV. The Six-Week Ban Will Hurt Rural, Minority, and Poor Patients the Most

S.B. 23 will disproportionately impact people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to abortion policies that increase the inequities that already plague the health-care system in this country.

In Ohio, approximately 43.2% of patients who obtained abortions in 2020 were Black and approximately 4.6% were Hispanic.[69] In addition, 75% of abortion patients

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[69] *See Induced Abortions in Ohio* 9.

nationwide are living at or below 200% of the federal poverty level.[70] Patients with limited means and patients living in geographically remote areas will be disproportionately affected by the lack of clinics with authorization to provide abortion care after six weeks of gestation, which will require them to travel longer distances (and pay higher associated costs) to obtain safe, legal abortions. These travel and procedure costs will be compounded by the fact that other Ohio laws create substantial financial barriers to abortion care, such as lack of coverage under insurance policies for public employees and health plans offered in the state's health exchange.[71]

The inequities continue after an abortion is denied. Forcing patients to continue pregnancies increases their risk of complications, and the risk of death associated with childbirth is approximately 14 times higher than that associated with abortion.[72] Nationwide, Black patients' pregnancy-related mortality rate is 3.2 to 3.5 times higher than that of white patients, with significant disparities persisting even in areas with the lowest overall mortality rates and among patients with higher levels of education.[73] Black patients in Ohio are 2.5 times as likely to die from a pregnancy-related death—defined as death for which the cause was "related to or aggravated by the pregnancy or its management"—as

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

71 Guttmacher Inst., *State Facts About Abortion: Ohio* (June 2022).

72 Raymond & Grimes 216.

73 CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019) (3.2 times); MacDorman *et al.*, *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 Am. J. Pub. Health 1673, 1676–77 (Sept. 2021) (3.55 times).

white patients, making continuing an unwanted pregnancy to term disproportionately dangerous for them.[74]

Ohio's six-week ban thus exacerbates inequities in maternal health and reproductive health care, disproportionately harming the most vulnerable Ohioans.

V. The Six-Week Ban Forces Clinicians to Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law

Abortion bans such as the one at issue in this case violate long-established and widely accepted principles of medical ethics by (1) substituting legislators' opinions for a physician's individualized patient-centered counseling and creating an inherent conflict of interest between patients and medical professionals; (2) asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. The Six-Week Ban Undermines the Patient-Physician Relationship by Substituting a Flawed Legislative Judgment for a Physician's Individualized Patient-Centered Counseling and by Creating Conflicts of Interest Between Physicians and Their Patients

The patient-physician relationship is critical for the provision of safe and quality medical care.[75] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests

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[74] Ohio Dep't of Health, *A Report on Pregnancy-Associated Deaths in Ohio 2008-2016*, 5, 18 (2019), https://odh.ohio.gov/know-our-programs/pregnancy-associated-mortality-review/Reports/Pregnancy-Associated-Deaths-Ohio-2008-2016.

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

with the best available scientific evidence.[76] 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."[77] 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."[78]

Ohio's six-week ban forces physicians to supplant their own medical judgments—and their patients' judgments—regarding what is in the patients' best interests with the legislature's non-expert determination regarding whether and when physicians may provide abortions. As described above, abortions are safe, routine, and, for many patients, the best medical choice available for their specific health circumstances. Accordingly, there is no rational or legitimate basis for interfering with a physician's ability to provide an abortion where both the physician and patient conclude that it is the medically appropriate course. Laws that ban abortion in a wide variety of circumstances—such as the law here, which bans abortion before many patients know they are pregnant and without exceptions for circumstances such as mental health of the pregnant patient, rape and incest,

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[76] AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1* ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.").

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

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

or major fetal abnormalities—are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

Ohio's law also creates inherent conflicts of interest. Physicians need to be able to offer appropriate treatment options based on patients' individualized interests without regard for the physicians' own self-interest.[79] Here, the Ohio law profoundly intrudes upon the patient-physician relationship by prohibiting physicians from performing abortions in many circumstances. For example, even if a patient's health were compromised, the law would allow an abortion after detection of embryonic cardiac activity only in the face of death or substantial and irreversible impairment of a major bodily function, regardless of the overall medical advisability of the procedure or the desire of the patient. A physician and patient together may conclude that an abortion is in the patient's best medical interests even though the risk posed by continuing the pregnancy does not yet rise to the standard set forth in the law's exceptions. Ohio's six-week ban thus forces physicians to choose between the ethical practice of medicine—counseling and acting in their patients' best interest—and obeying the law.[80]

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79 *See Legis. Policy Statement*.

80 *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.").

B. The Six-Week Ban Violates 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 and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions nearly 2,500 years ago.[81] Both of these principles arise from the foundation of medical ethics that requires that the welfare of the patient forms the basis of all medical decision-making.[82]

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.[83]

Ohio's six-week ban pits physicians' interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. And if a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But the Ohio law, with its limited medical exceptions, prohibits physicians from providing that treatment and exposes

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81 AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1479, 1481–82 (Dec. 2007, reaff'd 2016).

82 *See supra* notes 75–78 and accompanying text.

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

physicians to significant penalties if they do so. It therefore places physicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."[84]

C. The Six-Week Ban Violates 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.[85] 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.[86] Ohio's six-week ban would deny patients the right to make their own choices about health care if they decide they need to seek an abortion.

CONCLUSION

For the foregoing reasons, this Court should issue a writ of mandamus directing Respondents not to enforce S.B. 23.

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[84] The Chair of the Ohio section of ACOG spoke to this dilemma and other hardships the six-week ban imposes on the physician-patient relationship in a recently published essay. *See* Hackney, *I'm a High-Risk Obstetrician, and I'm Terrified for My Patients*, The New York Times (July 5, 2022), https://www.nytimes.com/2022/07/05/opinion/ob-gyn-roe-v-wade-pregnancy.html.

[85] ACOG, *Code of Professional Ethics* 1 (Dec. 2018) ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

[86] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021); AMA, *Code of Medical Ethics Opinion 2.1.1*.

RESPECTFULLY SUBMITTED this 25th day of July 2022,

s/ *Subodh Chandra*

Subodh Chandra
Donald P. Screen
The Chandra Law Firm LLC
The Chandra Law Building
1265 West 6th St, Suite 400
Cleveland, OH 44113
(216) 578-1700
Subodh.Chandra@ChandraLaw.com
Donald.Screen@ChandraLaw.com

Nicole A. Saharsky
Carmen N. Longoria-Green
MAYER BROWN LLP
1999 K St. NW
Washington, D.C. 20006
(202) 263-5282
nsaharsky@mayerbrown.com
clongoriagreen@mayerbrown.com

Megan E. Stride
MAYER BROWN LLP
71 S. Wacker Drive
Chicago, IL 60606
(312) 782-0600
mstride@mayerbrown.com

Attorneys for *Amici Curiae* American College of Obstetricians and Gynecologists, American Medical Association, and Society for Maternal-Fetal Medicine

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
Molly A. Meegan
Shiri A. Hickman
Jessica M. Morris
409 12th Street, SW
Washington, DC 20024
(202) 863-2585
mmeegan@acog.org

Attorneys only for *Amicus Curiae* American College of Obstetricians and Gynecologists

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 25th day of July 2022, I electronically filed the foregoing **BRIEF OF AMICI CURIAE IN SUPPORT OF RELATORS' VERIFIED COMPLAINT FOR WRIT OF MANDAMUS**, which served all counsel of record.

s/ *Subodh Chandra*