IN THE SUPREME COURT OF OHIO	
State ex rel. Preterm-Cleveland, *et al.*, Appellees, vs. David Yost, Attorney General of Ohio, *et al.*, Appellants.	Case No. 2023-0004 On appeal from the Hamilton County Court of Appeals, First Appellate District Court of Appeals Case No. C-220504

BRIEF OF *AMICI CURIAE* THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF APPELLEES

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**pro hac vice pending*

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INTEREST OF *AMICI CURIAE*

Amici curiae are leading medical organizations whose members represent the nation's physicians and healthcare professionals providing obstetric and gynecologic care to millions of Americans, including people in the state of Ohio.[1] *Amici* are the nation's experts on the realities of medical practice, clinical care, and medical ethics as they relate to obstetric and gynecologic care. *Amici*'s policies represent the education, training, and experience of the vast majority of clinicians in this country who provide care to women.

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading association 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'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's briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court and state supreme courts, as a leading provider of authoritative scientific data regarding childbirth and abortion.[2]

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[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.

[2] *See, e.g.*, *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932–936 (2000) (quoting ACOG extensively and referring to ACOG's work as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson v. Minn.*, 497 U.S. 417, 454 n.38 (1990) (quoting ACOG in assessing disputed parental notification requirement); *Simopoulos v. Va.*, 462 U.S. 506, 507 (1983) (citing ACOG in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including

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.[3]

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 who care 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

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abortions); *Planned Parenthood S. Atlantic v. State*, 882 S.E.2d 770, 787–788 (S.C. Jan 5, 2023) (citing ACOG's practice guidance as authority in opinion considering whether an abortion ban violates the state constitution); *Hodes & Nauser, MDs P.A. v. Schmdit*, 440 P.3d 461, 505 (Kan. 2019) (Biles, J., concurring) (citing ACOG's practice guidance as medical authority in opinion that considered whether Kansas recognizes the state constitutional right to abortion); *see also Gonzales v. Carhart*, 550 U.S. 124, 170–171, 175–178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's brief and congressional submissions regarding abortion procedure).

[3] *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 934–936 (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 and quoting 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).

experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy. SMFM's *amicus* briefs also have been cited by courts in cases raising a variety of medical issues.[4]

All *amici* have an interest in jurisprudence being informed by medical science and evidence, the realities of clinical practice, medical ethics, and patient wellbeing. *Amici* also share an interest in preserving the patient-clinician relationship and ensuring that jurisprudence and laws do not undermine this relationship. Finally, *amici* have an interest in promoting and preserving accessible and obtainable health care and opposing actions that obstruct the ability of clinicians to practice in accordance with medical best practices and their best clinical judgment, or criminalize and/or otherwise penalize medical professionals for caring for their patients.

INTRODUCTION AND SUMMARY OF ARGUMENT

Amici urge this Court to affirm the lower courts' decisions on standing and appealability. Doing so is not only good law; it also supports the practice of good medicine.

As a matter of medicine, it is well-documented that the ability of people to seek and receive comprehensive pregnancy and reproductive health care, including pregnancy termination and

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

abortion, is essential to the health of people, families, and communities.[5] Indeed, laws that restrict the ability of people to obtain reproductive health care jeopardize patient health and wellbeing.[6]

Although this Court is not now considering the merits of Appellees' underlying claims regarding the validity of S.B. 23 under Ohio law,[7] the questions before the Court at this juncture—whether Appellees, who are physicians and medical-care facilities,[8] have standing to bring claims vindicating their patients' interests and whether the appeals court was correct in dismissing the Appellants' appeal—implicate issues regarding clinical practice and patient health. *Amici*,

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[5] *See, e.g.*, ACOG, *Statement of Policy on Abortion* (revised May 2022) ("All people should have access to the full spectrum of comprehensive, evidence-based health care. Abortion is an essential component of comprehensive, evidence-based health care."), *available at* https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/abortion-policy (last accessed June 18, 2023); AMA, *Preserving Access to Reproductive Health Services*, D-5.999 (2022) (recognizing "that healthcare, including reproductive health services like contraception and abortion, is a human right"), *available at* https://policysearch.ama-assn.org/policyfinder/detail/5.999?uri=%2FAMADoc%2Fdirectives.xml-D-5.999.xml (last accessed June 20, 2023).

[6] Diane G. Foster, *The Turnaway Study: Ten Years, A Thousand Women, and the Consequences of Having—or Being Denied—An Abortion* (2021).

[7] S.B. 23 is referred to in Appellants' brief as "The Heartbeat Act." *Amici* note that it is clinically inaccurate to use the word "heartbeat" to describe the sound that can be heard on an ultrasound in early pregnancy. In fact, there are no chambers of the heart developed at an early stage in pregnancy that this word is used to describe and so there is no recognizable "heartbeat" from a clinical perspective. What pregnant people may hear is the ultrasound machine translating electronic impulses that signify fetal cardiac activity.

[8] Throughout Appellants' brief, there are references to "abortionists," which presumably is meant to refer to Appellees in this case. *Amici* use clinically accurate terminology when discussing medical care, including pregnancy termination and abortion, and encourage those writing about reproductive health to use language that is medically appropriate, clinically accurate, and without bias. Abortion is a term that refers simply to emptying a uterus. The term "abortionist" does not appear in the clinical lexicon. Clinicians who provide abortion care are highly trained medical experts who provide patients with a wide range of medical care, of which abortion is a part. For example, Appellee Dr. Sharon Liner is a board-certified family physician with nearly two decades of clinical experience, on top of undergraduate studies, at least three years of medical school, and at least three years of family-practice residency.

therefore, submit this brief to provide the Court with the perspective and expertise of the medical community on the questions under consideration so that this Court's decisions and jurisprudence can be informed by medical evidence and science.

Amici submit this brief to provide the Court with research and information regarding the closeness and significance of the patient-clinician relationship, and in particular to correct inaccurate statements and assumptions that appear in Appellants' brief on the reality of clinical care, medical ethics, and the patient experience in Ohio. Further, *amici* detail the numerous hindrances patients face in asserting their own rights in the circumstances presented by this case. Should this Court fail to affirm Appellees' standing, it would not only be upending well-settled principles of law, but it would also be enshrining medically inaccurate assertions and presumptions into this state's jurisprudence. Likewise, failing to preserve the *status quo* would, in addition to disregarding legal precedent regarding the appealability of matters with this posture, negatively impact the health and wellbeing of people in Ohio.

Accordingly, *amici*, whose considered judgment represents the leading voices of medical care for women in the nation and in this State, urge this Court to deny the Appellants' requests.

I. Appellants' Assertions That Appellees Lack Standing Are Wrong as a Matter of Law and Fact

Third-party standing has been long recognized in American law and its common-law antecedents.[9] Although Ohio courts are not bound by the federal doctrine of standing that arises out of the federal court system's comparatively more limited authority to decide cases under the U.S. Constitution, "in deciding issues of standing in the courts of Ohio, the Ohio Supreme Court relies on federal court decisions." *Cincinnati City Sch. Dist. v. State Bd. of Ed*., 113 Ohio App. 3d

[9] *See, e.g.,* Bradley S. Clanton, *Standing and the English Prerogative Writs: The Original Understanding*, 63 Brook. L. Rev. 1001, 1009–1020 (1997).

305, 313 (1996); *see also Brinkman v. Miami Univ.*, 2007-Ohio-4372, ¶ 43 ("Such a rule also would run contrary to clear federal precedent, which Ohio courts regularly follow on matters of standing."); Michael E. Solimine, *Recalibrating Justiciability in Ohio Courts*, 51 Clev. St. L. Rev. 531, 536 (2004) ("Many Ohio cases, both in the supreme court and the lower courts, have routinely followed standing doctrines developed in federal courts. Thus, Ohio courts have held that litigants must have 'standing,' described in ways very similar to federal courts jurisprudence.") (footnote omitted).

While a litigant "[o]rdinarily . . . cannot rest his claim to relief on the legal rights or interests of third parties," *U.S. Dep't of Labor v. Triplett*, 494 U.S. 715, 720 (1990), the Supreme Court and lower federal courts have recognized that this is not a constitutional limitation but a prudential one, *Sec'y of State of Md. v. Joseph H. Munson Co.*, 467 U.S. 947, 955–956 (1984). Courts therefore "have not treated this rule as absolute . . . recognizing that there may be circumstances where it is necessary to grant a third party standing to assert the rights of another." *Kowalski v. Tesmer*, 543 U.S. 125, 129–130 (2004). Specifically, the Supreme Court has "recognized the right of litigants to bring actions on behalf of third parties, provided three important criteria are satisfied: The litigant must have suffered an 'injury in fact,' thus giving him or her a 'sufficiently concrete interest' in the outcome of the issue in dispute; the litigant must have a close relation to the third party; and there must exist some hindrance to the third party's ability to protect his or her own interests." *Powers v. Ohio*, 499 U.S. 400, 410–411 (1991) (citations omitted). Ohio courts, including this Court, have adopted the same approach. *See, e.g.*, *E. Liverpool v. Columbiana Cty. Budget Comm.*, 114 Ohio St. 3d 133, 138 (2007).

As a result, courts have recognized third-party standing in a wide range of contexts where parties assert the rights of those they serve, from attorneys asserting the rights of their clients, *see,*

e.g., *Triplett*, 494 U.S. at 720–721; *Caplin & Drysdale, Chartered v. United States*, 491 U.S. 617, 623 n.3 (1989); to private schools asserting the rights of their students and their students' parents, *see Pierce v. Soc'y of the Sisters of the Holy Names of Jesus & Mary*, 268 U.S. 510, 534–536 (1925); to beer vendors or firearms dealers asserting the rights of their customers, *see Craig v. Boren*, 429 U.S. 190, 192–197 (1976); *Md. Shall Issue, Inc. v. Hogan*, 971 F.3d 199, 216 (4th Cir. 2020).

In the context of reproductive health care, for more than five decades, courts, including the United States Supreme Court, have recognized that physicians have third-party standing to bring cases on behalf of patients seeking care. *See, e.g.*, *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965) (finding third-party standing by a physician to assert his patients' rights to contraception); *Eisenstadt v. Baird*, 405 U.S. 438, 444–446 (1972) (ruling that an "advocate of the rights of persons to obtain contraceptives" had standing to raise claims of people denied access). This specifically includes practitioners whose services for their patients include abortion care. *See, e.g.*, *Singleton v. Wulff*, 428 U.S. 106, 113–114 (1976); *June Med. Servs.*, 140 S. Ct. at 2118 (collecting cases); *Planned Parenthood of Greater Texas v. Abbott*, 748 F.3d 585, 589 (5th Cir. 2014); *Planned Parenthood of Central New Jersey v. Farmer*, 220 F.3d 127, 147 (3rd Cir. 2000). These cases correctly recognize not only the interconnectedness of those who need abortion care and those who provide it, but also the specific barriers that those who seek abortion and reproductive healthcare face in asserting their rights.

Contrary to the attempt by Appellants and certain *amici* to obfuscate the issue, the principles of third-party standing as recognized by the U.S. Supreme Court remain unchanged in the wake of the Court's decision *Dobbs v. Jackson Women's Health*, 142 S. Ct. 2228 (2022). In *Dobbs*, the Court held that the United States Constitution "does not confer a right to abortion." *Id.*

at 2279. While Appellants' brief references a single sentence in the 79-page majority opinion in *Dobbs* that suggests criticism of the Court's interpretation of the long-standing third-party standing doctrine as applied to the provision of abortion, the *Dobbs* Court did not disturb its prior standing determinations that "long permitted abortion providers to invoke the rights of their actual or potential patients in challenges to abortion-related regulations," *June Med. Servs.*, 140 S. Ct. at 2118—much less call into question the longstanding doctrine of which those cases are but one application. On the contrary, *Dobbs* ***itself*** was a case in which a provider brought a claim on behalf of a patient. The U.S. Supreme Court, which "examine[s] standing *sua sponte* where standing has erroneously been assumed," *Adarand Constructors, Inc. v. Mineta*, 534 U.S. 103, 110 (2001), exercised its jurisdiction as to the merits of the provider's asserted claims. Accordingly, this Court should reject Appellants' argument that *Dobbs* counsels against a recognition of standing here. Indeed, in the aftermath of *Dobbs*, even a state supreme court that denied a right to abortion under its state law nevertheless recognized that third-party standing exists for clinicians to bring challenges to abortion restrictions on behalf of their patients. *E.g.*, *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1160 (Idaho 2023) ("The *Dobbs* decision did not, however, abrogate the basic third-party standing principle that '[a]side from the woman herself . . . the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, that decision [to get an abortion].'") (quoting *Singleton*, 428 U.S. at 117)).[10]

Appellants do not dispute that Appellees, who would face criminal penalties for providing abortion care if S.B. 23 is upheld, have demonstrated injury to themselves. Instead, Appellants

[10] Although one non-Ohio trial court has claimed *Dobbs* denies third-party standing to providers challenging abortion restrictions on behalf of their patients, the decision was incorrect, for the reasons discussed by Appellees and above. *See Cameron v. EMW Women's Surgical Ctr., P.S.C.*, 664 S.W.3d 633, 669 (Ky. 2023) (Bisig, J., concurring in part, dissenting in part).

argue that there is not a "sufficiently close relationship," *Cameron*, 664 S.W.3d at 697 (Bisig, J., concurring in part, dissenting in part), between Appellees and those seeking abortion care and that those seeking care are not hindered in asserting their own rights. These assertions are contrary to precedent and do not reflect the reality of medical ethics, clinical practice, and the experience of patients seeking abortion care.

A. Appellants' position that Appellees lack a "close relationship" with patients whose rights they are asserting ignores the significance of the patient-physician relationship, the interrelationship between patients and physician rights, and the realities of clinical practice.

Appellants' arguments against standing are premised on incorrect information and assumptions regarding the relationship between patients and their clinicians in the context of providing abortion care. A close relationship between a claimant and the person whose rights are being asserted has been recognized in a variety of contexts, one of which exists "when enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights." *Warth v. Seldin*, 422 U.S. 490, 510 (1975); *see also Singleton*, 428 U.S. at 114 (recognizing third party standing when "the [third party's] enjoyment of the right is inextricably bound up with the activity the litigant wishes to pursue."

Here, Appellees have close alignment of interests with those seeking abortion in Ohio because S.B. 23 will impact patients' ability to access abortion by imposing criminal penalties on Appellees. Plain and simple, patient access to abortion care depends on their clinicians' ability to provide this care—an ability that is hindered by S.B. 23's criminal prohibitions on clinicians. *See Singleton*, 428 U.S. at 117 (closeness of a relationship between a doctor and a patient is "patent" given that "[a] woman cannot safely secure an abortion without the aid of a physician"). As the lower court found, "because the 'enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights,' clinicians providing abortion are

'the obvious claimant' and 'the least awkward challenger' to S.B. 23." Preliminary Injunction Order, Case No.: A2203203, Court of Common Pleas, Hamilton Cnty., at 27 (Oct. 12, 2022) ("PI Order"), citing *June Med. Servs*. 140 S. Ct. at 2118-2119).

1. Both courts and canons of medical ethics recognize a special and close relationship between physicians and their patients, including in the context of the clinical provision of abortion care.

"The doctor-patient relationship . . . is one of special consequence." *Caplin & Drysdale*, 491 U.S. at 623 n.3 (1989). Courts have long recognized in this and other medical contexts that such a relationship is sufficient to demonstrate standing. *See June Med. Servs.*, 140 S. Ct. at 2118 (collecting cases in the context of abortion); *see also Griswold*, 381 U.S. at 485 (contraception); *Washington*, 521 U.S. at 707–708 (recognizing the right of physicians to raise claims on behalf of their patients after their patients had died and upholding state bans on assisted suicide); *Vacco*, 521 U.S. at 797–798 (similar).

Moreover, as a matter of medical ethics, the patient-clinician relationship is special and fundamental. Clinicians are obligated not only to put their responsibility to their patients as paramount but also "to serve as the patient's advocate and to exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[11] If a clinician and patient together conclude that an abortion is in the patient's best medical interests but S.B. 23 prohibits abortion care in the patient's particular circumstances, the law profoundly intrudes upon the patient-clinician relationship and compels action by Appellees in this case. Indeed, denying the ability of

[11] ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists* 2 (Dec. 2018) ("ACOG *Code of Professional Ethics*"), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf.

clinicians to assert claims vindicating their patients' rights obstructs the ability of clinicians to fulfill their ethical obligations.

To distract from the clear interrelationship of interests between Appellees and their patients, Appellants claim that "a woman who obtains an abortion typically does not develop a close relationship to the doctor who performs the procedure." Appellants' Br. at 30 (quoting *June Med. Servs.*, 140 S. Ct. at 2168 (Alito, J., dissenting)). It is not clear how Appellants are defining "close relationship," but it cannot be squared with caselaw. Appellants cite no legal authority, for example, where the test for third-party standing has depended on whether the claimant has a particular form of a *personal* relationship with the party's whose right it is asserting. Nor could they. The touchpoint for assessing the closeness of the relationship is whether enforcement "of the challenged restriction . . . would result indirectly in the violation of third parties' rights." *E.g.*, *Craig*, 429 U.S. at 195 (quoting *Warth*, 422 U.S. at 510); *id.* ("[V]endors and those in like positions have been uniformly permitted to resist efforts at restricting their operations by acting as advocates of the rights of third parties who seek access to their market or function."); *accord, e.g.*, *Md. Shall Issue*, 971 F.3d at 216 (collecting federal court of appeals cases). If a beer vendor or firearms dealer has a sufficiently close relationship with their customers for standing purposes, *see id.*, it is unimaginable that a clinician providing medical care to a patient that the challenged law would criminalize would lack such a relationship with her patients. Where, as here, clinicians and patients' rights are bound up together such that the clinician's subjection to criminal sanctions threatens the asserted rights of her patients, a sufficiently close relationship exists under the standing inquiry.

Even if Appellants' argument had some conceivable basis in the law, it would be wrong on the facts. Appellants incorrectly assert that Appellees have provided "no evidence" demonstrating

that a patient and their clinician who performs an abortion procedure develop a close relationship. Though the alignment of interests between the clinicians and their patients creates a sufficiently close relationship for third-party standing, Appellees have also specifically demonstrated the close relationships they have fostered with their patients. Indeed, in lower-court proceedings, Appellees entered into the record affidavits that provide significant details supporting the closeness of the clinician-patient relationship. Dr. David Burkons, for example, referenced numerous relationships that he and his clinic staff have with patients, recounting details about his patients and their conditions ("she was so ill that she could not sit in a classroom without throwing up"), as well as the range of emotions expressed by patients in his clinic ("[m]any patients became extremely angry," and "other patients express feeling extremely rushed").[12] Similarly, Dr. Adarsh Krishen demonstrated clearly knowing intimate details about his patients' lives, such as their childcare situations, their struggling with intimate partner violence, and experiencing homelessness.[13]

Of course, as a matter of clinical practice, there are some elements of the patient-clinician relationship that may vary between and among patients and their clinicians. In some cases, patients who seek abortion have ongoing relationships with their clinicians—indeed, Dr. Krishen's affidavit, for example, discusses patients who he and his clinic staff treated over the course of multiple visits[14]—and in other cases the relationship may be shorter and more focused in nature.[15] In all cases, however, the intimate, special, and close nature of the patient-clinician relationship

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[12] Affidavit of Dr. Burkons, ¶¶ 9, 10, 14.

[13] Affidavit of Dr. Krishen, ¶¶ 11, 13.

[14] *Id.* ¶¶ 9, 20.

[15] Appellants, when asserting that future patients of physicians are "unknowable," seemingly overlook the fact that state law *requires* at least two in-person visits to a clinician, at least 24 hours apart, to obtain an abortion. Ohio Rev. Code Ann. § 2317.56 (West).

grounded in medical ethics and professional responsibility does not vary. *Caplin & Drysdale*, 491 U.S. at 623 n.3.

An examination of basic principles of medical ethics—which Appellants also fail to consider—further illustrates why the patient-clinician relationship is one that is sufficiently close for the standing inquiry.

For centuries, the patient-clinician relationship has been the foundation of medical practice. This relationship, as embodied in the clinical encounter, has an ethical foundation and is built on confidentiality, trust, and honesty.[16] In the relationship, the welfare of the patient must form the basis of all medical judgments. The relationship is so foundational that principles of medical ethics suggest that clinicians should advocate for the rights of their patients outside the examination room, as Appellees are doing here.[17] Indeed, the patient-clinician relationship rises to the level of a "moral activity" given the clinician's ethical duty, enshrined in medical practice for centuries, to prioritize the interests of the patient at all times in providing care.[18] The patient-clinician relationship is based on trust and intimacy; clinicians are obligated at all times to treat the interests of the patient as paramount in ways that are not typical of other types of relationships.[19]

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16 AMA, Code of Medical Ethics, *Opinion 1.1.1: Patient Physician Relationships*, *available at* https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/1.1.1.pdf.

17 ACOG *Code of Professional Ethics* 2 (clinicians are obligated to "serve as the patient's advocate and exercise all reasonable means to ensure that the most appropriate care is provided to the patient").

18 AMA, *Patient-Physician Relationships*, *supra* n.16.

19 *Id*. ("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."); *see also* ACOG *Code of Professional Ethics* 2.

Appellants' and certain amici's suggestion that the particular length of the clinical encounter between a patient and clinician undermines the essential nature of the relationship—or prevents it from being close for the purposes of the standing inquiry—belies the realities of clinical practice and the foundations of medical practice and ethical principles. Not to mention the law.[20]

2. Appellants' assertions regarding potential conflicts of interest between Appellees and their patients are factually inaccurate and legally misguided.

Appellants argue that clinicians face "a conflict of interest" in asserting the rights of their patients because "patients can sue [clinicians] for abortions performed in violation of the Act." Appellants' Br. at 4. This argument is logically inconsistent and legally unsupported. Appellants are not entitled to avoid review on standing grounds based on a manufactured conflict created by the law itself.

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[20] Appellants' reliance on *Utility Service Partners, Inc. v. Public Utilities Commission* and *North Canton v. Canton*, Appellant s' Br. 27–29, only serves to emphasize Appellants' mischaracterization of the patient-physician relationship. In those cases, the lack of "interdependen[ce]" in the relationships, which consisted of no more than contractual agreements tangentially affected by the challenged action, meant that there was insufficient relation for third-party standing. *See Util. Serv. Partners, Inc. v. Pub. Util. Comm.*, 2009-Ohio-6764, ¶ 51; *N. Canton v. Canton*, 2007-Ohio-4005, ¶ 16. Indeed, in one case, the litigant's interest was *opposed* to the third party's interest. *Utility Serv. Partners*, 2009-Ohio-6764, ¶ 51. These cases did not involve relationships that are defined by moral and ethical codes obligating one party to the other. They do not involve relationships like those here, where the rights of the parties are bound together so that the physician is "uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, that [abortion] decision." *Singleton*, 428 U.S. at 117. Nor are the unique circumstances of *Kowalski*, 543 U.S. at 127, 130–131, where the Supreme Court denied standing to "invoke the rights of hypothetical" clients, present here; Appellees have already identified known circumstances where particular patients would be denied rights under S.B. 23. *See, e.g.*, Affidavit of Dr. Krishen ¶ 7; Affidavit of Dr. Burkons ¶¶ 7, 8, 10, 12, 15, 17. Further, in the years since *Kowalski*, and even as recently as in *Dobbs*, the Court has continued to exercise jurisdiction where physicians who provide abortion may bring claims on behalf of their patients in circumstances like the one presented here, *see supra* Section I, and in *Kowalski* itself the Court noted that it had "allowed standing to litigate the rights of third parties when enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights." *Kowalski*, 543 U.S. at 130–131 (emphasis omitted).

Appellants' position is logically inconsistent because it assumes that Appellees will lose on the merits of their asserted claims, which this Court is not considering at this juncture. Merits determinations are inappropriate to consider as part of jurisdictional standing inquiry. *See Steel Co. v. Citizens for Better Env't*, 523 U.S. 83, 89 (1998); *Bell v. Hood*, 327 U.S. 678, 682 (1946) ("Jurisdiction … is not defeated … by the possibility that the averments might fail to state a cause of action on which petitioners could actually recover."). Moreover, courts have recognized standing in cases where claimants had certain interests that could, in some hypothetical situations, be in tension with the persons whose rights the claimants were asserting. *See, e.g.*, *Triplett*, 494 U.S. at 720–721 (finding third-party standing for an attorney to invoke clients' rights in challenging a statute that, if upheld, would prevent clients from paying fees to the attorney). Appellants' position would upend third-party standing in several cases even outside the abortion context.

Even more fundamentally, Appellants' assertion regarding the purported "conflict of interest" is based on inaccurate information about the nature of the patient-clinician relationship and misapprehends foundational principles of medical ethics. Settled principles of medical ethics dictate that even if a conflict of interest were to arise between a clinician and their patient, medical professionals who provide abortions, like all medical professionals, must "regard responsibility to the patient as paramount."[21] This includes "plac[ing] patients' welfare above the physician's own self-interest or obligations to others."[22] These mandatory ethical requirements are foundational to

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[21] AMA, *Principles of Medical Ethics* (rev. June 2001), https://code-medical-ethics.ama-assn.org/principles; *see also* ACOG *Code of Professional Ethics*.

[22] AMA, Code of Medical Ethics, *Opinion 1.1.1: Patient Physician Relationships*; ACOG *Code of Professional Ethics* 1-2 (including as an "ethical foundation" that the "welfare of the patient ... is central to all considerations in the patient-physician relationship" and that an "obstetrician-gynecologist should serve as the patient's advocate").

medical practice, and S.B. 23 denies the realities of medical practice and the foundational principles of medical ethics. Allowing S.B. 23 to create an alleged conflict of interest, and then use that manufactured conflict to abrogate long-standing principles of third-party standing, would be unprecedented and should not be allowed here.

B. Patients Seeking Abortion Face Hindrances to Asserting Their Own Rights.

"It generally is appropriate to allow a physician to assert the rights of women patients as against governmental interference with the abortion decision," given the "obstacles" a pregnant patient faces in asserting her own rights. *Singleton*, 428 U.S. at 117–118. These hindrances, long recognized by courts across the country, are prevalent in Ohio and support standing here.

In its order granting a temporary restraining order against enforcement of S.B. 23, the lower court cites to "[d]ecades of precedent" finding that "[t]hird party standing is available in circumstances like these." Decision and Entry, Case No.: A2203203, Court of Common Pleas, Hamilton Cnty., at 10 (Oct. 12, 2022) ("TRO Decision") (citation omitted). In particular, the lower court rejected the Appellants' assertion that "the absence of claims by patients somehow validates the statute." Instead, the court found that this absence "demonstrates the proprietary of third party standing." *Id*. at 8.

The lower court detailed the numerous "patients who have experienced enormous distress" because of S.B. 23 and found that "[i]t is not surprising that individuals dealing with such situations do not hire lawyers and file lawsuits, but rather focus their energies on their health, keeping their jobs, caring for their families or keeping up with their educational studies." *Id.* at 9–10; *see also* PI Order at 26–27 ("Plaintiffs' affidavits and testimony recount numerous obstacles that hinder patients from advancing the claims brought by Plaintiffs."). The conclusions of the lower court reflect the realities of patient experience and clinical practice. It is difficult for pregnant people to

personally challenge abortion restrictions during the time-limited duration of their pregnancy, while often facing numerous obstacles including financial limitations and concerns for privacy and personal safety. Laws that ban abortions impact low-income patients disproportionately, thus falling most heavily on patients without the resources to challenge them.[23] And patients denied abortions are at increased risk for mental health problems, facing "higher stress and anxiety, lower self-esteem, and lower life satisfaction,"[24] which can impede the ability to bring suit.

More broadly, many patients consider reproductive healthcare to be intensely private and, although abortion care is essential reproductive healthcare, social stigma remains. This stigma dissuades patients from speaking openly even to friends and family,[25] so the publicity involved in consulting an attorney and filing a lawsuit is especially daunting. The lower court found the same, writing that "the circumstances that lead women to seek an abortion can be intensely private. It is understandable that many women would be reluctant to place the deeply personal details of their experiences in the public record, even under a pseudonym, in such a highly charged and divisive

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[23] ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, American College of Obstetricians and Gynecologists, Obstet. & Gynecol. 2020; 136:6, e107-15 (Dec. 2020), *available at* https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf; *see also* Diane G. Foster, *New abortion bans will increase existing health and economic disparities*, 112(9) Am. J. Pub. Health 1276 (2022).

[24] Zara Abrams, *Abortion bans cause outsized harm for people of color*, Monitor on Psychology, Vol. 54, No. 4 (2023), https://www.apa.org/monitor/2023/06/abortion-bans-harm-people-of-color (last accessed June 19, 2023) (citing M. Antonia Biggs, et al., *Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion, A Prospective, Longitudinal Cohort Study*, 74(2) JAMA Psychiatry 169 (2017), http://unmfamilyplanning.pbworks.com/w/file/fetch/119310024/ Biggs%20et%20al-Womens%20Mental%20Health%20and%20Well%20Being.pdf (last viewed June 19, 2023)).

[25] Franz Hanschmidt et al., *Abortion Stigma: A Systematic Review*, 48 Perspectives on Sexual & Reprod. Health 169, 171–173 (Dec. 2016); ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*.

matter." TRO Decision at 10. Since the Court's decision in *Dobbs*, reports have suggested that abortion stigma and shame have resulted from people being forced to travel to obtain care.[26] Because privacy, stigma, and cost concerns hinder patients' ability to enforce their own constitutional rights to abortion care, these rights will not be vindicated unless clinicians have standing to do so on their patients' behalf.

Physicians and other clinicians providing abortion care are also better positioned than pregnant patients to assert abortion rights because of the unique nature of pregnancy-related claims. The window of time during which a patient can obtain an abortion is narrow and the risks increase as time passes. Therefore, litigating a claim at the same time the patient is working to overcome any number of other obstacles, including waiting periods, financial constraints, traveling long distances while pregnant, obtaining time off work, childcare responsibilities, and maintaining her own safety and privacy, presents an overwhelming challenge for most abortion patients. Physicians and other clinicians do not face the same obstacles. Further, even patients overcame these obstacles and obtained emergency court-ordered relief during the short window, they would no longer have a need (and may also lack the resources) to continue to litigate the case, potentially for years, through its resolution. Physicians and other clinicians, by contrast, are themselves harmed by laws like S.B. 23 on an ongoing basis, and see patients harmed by such laws every day, and thus have compelling incentives to continue to litigate the claim.

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As noted, the patient-clinician relationship is a unique and special relationship based on trust, honesty, and confidentiality. Physicians and other clinicians are required not only to put

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[26] Katrina Kimport & Maryani Palupy Rasidjan, *Exploring the emotional costs of abortion travel in the United States due to legal restriction*, Contraception, Vol. 120 (Apr. 2023), *available at* https://www.sciencedirect.com/science/article/pii/S0010782423000094.

the wellbeing of their patients first but are also obligated to advocate on behalf of their patients access to care. Upending decades of precedent recognizing a physician's ability to assert claims on behalf of patients who require abortion care would obstruct the ability of clinicians to fully execute their ethical responsibility to seek change when they believe the requirements of a law or policy are contrary to the best interests of patients.[27]

II. Disrupting the Status Quo Would Be Detrimental to the Health and Wellbeing of People in Ohio

Appellees outline in their brief the legal reasons that this Court should affirm the Intermediate Court's decision not to disturb the PI (and thus preserve the almost five-decade status quo). *Amici* write here to highlight for the Court the harms that failing to preserve the status quo while this matter is pending will cause to the health and well-being of people in Ohio.

Failure to preserve the status quo of legal access to abortion in Ohio will cause severe and detrimental physical and psychological health consequences for pregnant patients who seek abortion care. While abortion is incredibly safe,[28] S.B. 23 will force clinicians to deny the care or to delay providing needed medical treatment until a patient is in a critical situation. It will also

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27 ACOG *Code of Professional Ethics* at 3.

28 *See, e.g.*, Nat'l Acads. of Sci., Eng'g, & Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018), *available at* https://nap.nationalacademies.org/catalog/24950/the-safety-and-quality-of-abortion-care-in-the-united-states ("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.") (last visited June 20, 2023); Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstet. Gynecol. 175, 181 (2015), *available at* https://journals.lww.com/greenjournal/fulltext/2015/01000/incidence_of_emergency_department_visits_and.29.aspx (last visited June 20, 2023); Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015), *available at* https://www.contraceptionjournal.org/article/S0010-7824(15)00505-3/fulltext (last visited June 20, 2023); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. Gynecol. 215, 216 (Feb. 2012).

force patients to travel outside of the state to obtain needed medical care. These denials and delays will result in an increased risk of complications and costs associated with delayed abortion care. Further, given S.B. 23, pregnant individuals may be more likely to attempt self-managed abortions using harmful or unsafe methods. Each of these outcomes increases the likelihood of negative consequences to the patient's physical and psychological health that could be avoided if abortion care were available.[29]

Criminalizing safe abortions provided by licensed clinicians in the state of Ohio will result in delays—or denials—of care that patients need. For example, with S.B. 23 in effect, the travel and procedure costs for Ohioans seeking abortion will increase. 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.[30] While S.B. 23 does not mandate closure of abortion clinics on its face, its restriction on abortions performed after approximately six weeks of gestation effectively renders Ohio abortion clinics unavailable to women who seek abortion care after that

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[29] Nor are S.B. 23's limited exceptions sufficient to protect the health of pregnant patients. They do not permit abortion care in circumstances that could risk 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 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.

[30] Jonathan Bearak et. al., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care*, Guttmacher Inst., https://www.guttmacher.org/article/2020/04/covid-19-abortion-bans-would-greatly-increase-driving-distances-those-seeking-care (updated Apr. 23, 2020) (finding that, on average, Ohio abortion clinic closures would increase an abortion-seeking Ohioans' driving distance from 15 miles to 120 miles); *see also* Payal Chakraborty et al, *How Ohio's Proposed Abortion Bans Would Impact Travel Distance to Access Abortion Care*, Perspectives on Sexual and Reproductive Health (June 2022), https://onlinelibrary.wiley.com/doi/epdf/10.1363/psrh.12191.

point in time. Although the risk of complications from abortion care overall remains exceedingly low, delaying abortion care until a more advanced gestational age results in an increased chance of a major complication.[31] Moreover, abortions at later gestational ages are typically more expensive, further increasing the barriers to obtaining care.[32]

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.[33] Studies have found that patients are more likely to self-manage abortions when they face barriers to reproductive services; methods of self-management may involve harmful methods such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills, rather than use of FDA-approved abortion medication, which is an exceedingly safe and effective way to self-manage abortion.[34]

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

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[31] Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*.

[32] Bonnie Scott Jones and Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 624 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661467/pdf/623.pdf (last visited June 20, 2023).

[33] *See, e.g.*, Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, Guttmacher Inst., at 3, 8 (2019), https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017 (last visited June 18, 2023) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

[34] D. Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Tex. Pol'y Eval. Proj., 3 (2015), *available at* https://www.researchgate.net/publication/283180282_Knowledge_opinion_and_experience_related_to_abortion_self-induction_in_Texas (last visited June 19, 2023).

pregnant individual. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[35] and rates have sharply increased since then.[36] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures.[37] A pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[38]

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.[39] Pregnant patients with inherited thrombophilia, which can be undetected until a trigger event such as pregnancy, have a high risk of developing blood clots in their lungs that can become life threatening.[40] And pregnancy can exacerbate asthma,

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35 Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 28, at 216.

36 Marian F. 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), *available at* https://pubmed.ncbi.nlm.nih.gov/27500333/.

37 Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 28, at 216.

38 *Id.*

39 ACOG, Practice Bulletin No. 90, *Asthma in Pregnancy* (Feb. 2008).

40 ACOG, Practice Bulletin No. 78, *Hemoglobinopathies in Pregnancy* (Jan. 2007).

making it a severe and life-threatening condition.[41] 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.[42] 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.[43]

Failing to preserve the status quo while the courts consider the merits of this matter will also disproportionately impact people of color, those living in rural areas, and those with limited economic resources. In Ohio, approximately 49% of patients who obtained abortions in 2020 were Black and approximately 5% were Hispanic.[44] In addition, 75% of abortion patients

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41 ACOG, Practice Bulletin No. 138, *Inherited Thrombophilias in Pregnancy* (Sept. 2013).

42 ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/obstetric-care-consensus/articles/2018/12/placenta-accreta-spectrum.pdf (last accessed June 19, 2023); ACOG, Obstetric Care Consensus, *Placenta Accreta Spectrum* (July 2012, reaff'd 2021), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2018/12/placenta-accreta-spectrum (last accessed June 19, 2023); 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), https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2021/09/pharmacologic-stepwise-multimodal-approach-for-postpartum-pain-management (last accessed June 19, 2023).

43 CDC, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* at 2 (Mar. 23, 2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* (Mar. 2014, reaff'd 2023), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery (last accessed June 19, 2023).

44 *See* Ohio Dep't of Health, *Induced Abortions in Ohio, 2021*, at iii, 2, *available at* https://odh.ohio.gov/wps/wcm/connect/gov/22f585e9-1090-473e-8fde-a0f8af08a224/Induced+Abortions+in+Ohio+2021.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-22f585e9-1090-473e-8fde-a0f8af08a224-oefXxn- (last accessed June 19, 2023).

nationwide "hav[e] family incomes of less than 200% of the federal poverty level."[45] 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.[46]

These increased risks of complications and death that result from forcing patients to continue pregnancy will fall unequally on Ohio's citizens.[47] Nationwide, Black patients' pregnancy-related mortality rate is 3.2 to 3.5 times higher than that of white patients, with significant inequities persisting even in areas with the lowest overall mortality rates and among patients with higher levels of education.[48] Black patients in Ohio are 2.5 times as likely to die

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[45] Jenna Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, Guttmacher Inst. (2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014 (last accessed June 18, 2023).

[46] Guttmacher Inst., *State Facts About Abortion: Ohio* (June 2022), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-ohio (last accessed June 18, 2023).

[47] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, *supra* note 28, at 216.

[48] CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019) (3.2 times), https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html (last accessed June 18, 2023); Marian F. 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, 1676–1677 (Sept. 22, 2021) (3.55 times), https://ajph.aphapublications.org/doi/10.2105/AJPH.2021.306375 (last accessed June 19, 2023).

from a pregnancy-related death—defined as death for which the cause was "related to or aggravated by the pregnancy or its management"—as white patients, making continuing an unwanted pregnancy to term disproportionately dangerous for them.[49]

In short, failing to preserve the status quo while the merits of Appellees' claims are considered would exacerbate inequities in maternal health and reproductive health care, disproportionately harming Ohioans who already face systemic and structural barriers to accessing quality, evidence-based care.

CONCLUSION

For the reasons outlined above and in Appellees' submission, the Court should dismiss the Appellants' appeal, affirming that Appellees have standing to challenge S.B. 23 and that the preliminary injunction is not appealable because it preserves the status quo.

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[49] Ohio Dep't of Health, *A Report on Pregnancy-Associated Deaths in Ohio 2008-2016*, at 5, 18 (2019), https://odh.ohio.gov/know-our-programs/pregnancy-associated-mortality-review/reports/pregnancy-Associated-Deaths-Ohio-2008-2016+website+version.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-f5f620c6-d444-4873-bbc8-bbc76bba1a71-nvUTYCq (last accessed June 18, 2023).

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on the 20th day of June, 2023, I electronically filed the foregoing document and my co-counsel served via e-mail on the following counsel of record for the parties:

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Dated: June 20, 2023	s/ *Subodh Chandra* Subodh Chandra Counsel for Amici Curiae