No. DA 23-0288

IN THE SUPREME COURT OF THE STATE OF MONTANA

PLANNED PARENTHOOD OF MONTANA, et al.,

Plaintiffs-Appellees,

v.

STATE OF MONTANA, et al.,

Defendants-Appellants.

On Appeal from the Montana First Judicial District Court, Lewis & Clark County, No. ADV-23-231, Honorable Judge Mike Menahan

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, SOCIETY FOR MATERNAL-FETAL MEDICINE, AND SOCIETY OF FAMILY PLANNING IN SUPPORT OF PLAINTIFFS

Appearances:

Rylee Sommers-Flanagan
Dimitrios Tsolakidis
Mikaela Koski
UPPER SEVEN LAW
P.O. Box 31
Helena, MT 59624
(406) 396-3373
rylee@uppersevenlaw.com
dimitrios@uppersevenlaw.com
mikaela@uppersevenlaw.com

Nicole A. Saharsky (*pro hac vice forthcoming)*
MAYER BROWN LLP
1999 K Street NW
Washington, DC 20006
(202) 362-3000
nsaharsky@mayerbrown.com

Counsel for Amici Curiae *American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, and Society of Family Planning*

Austin Knudsen
Michael D. Russell
Thane Johnson
Alwyn Lansing
MONTANA DEPARTMENT OF JUSTICE
P.O. Box 201401
Helena, MT 59620-1401
(406) 444-2026
michael.russell@mt.gov
thane.johnson@mt.gov
alwyn.lansing@mt.gov

Emily Jones
JONES LAW FIRM, PLLC
115 N. Broadway, Suite 410
Billings, MT 59101
(406) 384-7990
emily@joneslawmt.com

Counsel for Defendants-Appellants

Raph Graybill
GRAYBILL LAW FIRM, P.C.
300 4th Street North, PO Box 3586
Great Falls, MT 59403
(406) 452-8566
rgraybill@silverstatelaw.net

Michelle Nicole Diamond*
Alan E. Schoenfeld*
Rishita Apsani
Sean Chang*
WILMER CUTLER PICKERING
HALE AND DORR LLP
7 World Trade Center
250 Greenwich Street
New York, NY 10007
(212) 230-8800
michelle.diamond@wilmerhale.com
alan.schoenfeld@wilmerhale.com
rishita.apsani@wilmerhale.com
sean.chang@wilmerhale.com

Peter Kurtz*
WILMER CUTLER PICKERING
HALE AND DORR LLP
1225 17th St., Suite 2600
Denver, CO 80202
(720) 274-3135
peter.kurtz@wilmerhale.com

Dylan Cowit*
PLANNED PARENTHOOD
FEDERATION OF AMERICA
123 William Street, 9th Floor
New York, NY 10038
(212) 541-7800
dylan.cowit@ppfa.org

Diana O. Salgado*
PLANNED PARENTHOOD
FEDERATION OF AMERICA
1110 Vermont Avenue NW,
Ste. 300
Washington, DC 20005
(202) 973-4862
diana.salgado@ppfa.org

Counsel for Plaintiffs-Appellees
* Admitted *pro hac vice*

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Statutes

Other Authorities

INTERESTS OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit organization of more than 60,000 members, ACOG advocates for equitable, exceptional, and respectful care for all people in need of obstetric and gynecologic care; 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 patients and their families and communities. ACOG's Montana Section has over 130 members 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. Its briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, which recognize ACOG as a leading provider of authoritative scientific data regarding childbirth and abortion.

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 6,500 members 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 medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by many courts.

The Society of Family Planning (SFP) is a leading source for abortion and contraception science. It represents more than 1,800 clinicians and scholars who believe in just and equitable abortion and contraception informed by science. SFP works to build a diverse, equitable, inclusive, and multidisciplinary community of scholars and partners engaged in the science and medicine of abortion and contraception. It seeks to support the production and resourcing of research primed for impact, ensure clinical care is evidence-informed and person-centered through guidance, medical education, and other activities, and develop leaders in abortion and contraception to transform the health care system.

INTRODUCTION

Abortion is an essential component of comprehensive health care, and the overwhelming weight of medical evidence shows that it is safe. Despite this, House Bills 721 and 575 impose significant restrictions on abortion procedures that have no medical justification and that will significantly limit access to abortion should they go into effect.

H.B. 721 restricts clinicians from performing dilation and evacuation (D&E) abortions – the safest and most common abortion procedure for pregnancies in the second trimester. The statute bans a clinician from performing a D&E abortion in all but narrowly defined medical emergencies, unless the clinician first induces fetal demise. That restriction is both medically unnecessary and potentially dangerous to pregnant patients' health. H.B. 575 requires that any abortion be preceded by an ultrasound. That requirement also lacks medical justification and will impose significant burdens on patients seeking abortions.

Amici curiae are leading medical societies representing physicians and other clinicians who serve patients in Montana and nationwide. Their policies represent the education, training, and experience of the vast majority of clinicians in this country. *Amici* all agree that H.B. 721

and H.B. 575 are not based on any medical or scientific rationale. If these laws go into effect, they will 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-clinician relationship, undermining longstanding principles of medical ethics. *Amici* accordingly urge this Court to affirm the district court's temporary injunction.

ARGUMENT

I. There Is No Medical Justification For H.B. 721 Or H.B. 575

A. H.B. 721 Serves No Medical Purpose

H.B. 721 bans clinicians from performing D&E abortions in Montana, except in very limited circumstances specified by statute, unless the clinicians first induce fetal demise.[1] A clinician who violates the statute could face felony charges, with a criminal penalty of a fine up to $50,000 or imprisonment between 5 and 10 years, or both.[2] The statute's stated rationales are to "preserve the integrity of the medical profession," "respect . . . prenatal life," protect "maternal health and safety," prevent racial discrimination, "eliminat[e] . . . gruesome or barbaric medical

[1] H.B. 721, §§ 2(1)(a), 2(4)(b), 2(12), 3.
[2] *Id.* § 3(2).

procedures," and avoid fetal pain – all concerns that have no grounding in the extensive scientific research relating to abortion and which instead project value judgments onto patients' private health care decisions.[3] In fact, rather than protecting patients, the law threatens the health of pregnant patients and decreases access to safe abortion care.

There is no medical justification for either the near-total ban on D&E abortions or for requiring fetal demise before performing a D&E abortion. On the contrary, decades of research show D&E abortions to be safe. The medical evidence also shows that inducing fetal demise imposes additional health risks on the patient that are not justified by any countervailing health benefits. And the medical evidence shows that fetuses cannot experience pain during the relevant gestational period.

1. D&E Abortions Are Safe, Common, And An Essential Component Of Health Care

The medical community recognizes that abortion is a safe, common, and essential component of reproductive health care.[4] In 2020, over

---

[3] *Id.* (Preamble).

[4] *See, e.g.*, Eds. of the New Eng. J. of Med. et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979, 979 (2019) ("Access to legal and safe pregnancy termination . . . is essential to the public health of women everywhere."); ACOG, *Abortion Policy* (May 2022), https://bit.ly/

930,000 abortions were performed nationwide, and more than 1,500 abortions were performed in Montana.[5]

Some pregnant patients, in consultation with their clinicians, seek abortion care in the second trimester.[6] In particular, screening and diagnostic testing that lead to the identification of major anatomic or genetic anomalies in the fetus most commonly occurs in the second trimester.[7] Beginning around 15 weeks of gestational age, abortions are typically performed using the standard D&E method.[8] To perform a D&E abortion, a clinician dilates a patient's cervix and evacuates the uterus by

---

3uWMKUV; SMFM, *Access to Abortion Services* (June 2020), https://bit.ly/3SXnmrT.

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

[6] ACOG, Practice Bulletin No. 135, *Second Trimester Abortion*, 121 Obstetrics & Gynecology 1394, 1394 (2013, reaffirmed 2017) (ACOG Bulletin 135) ("Circumstances that can lead to second-trimester abortion include delays in suspecting and testing for pregnancy, delay in obtaining insurance or other funding, and delay in obtaining referral, as well as difficulties in locating and traveling to a provider.").

[7] *Id.*

[8] *Id.*

removing tissue through the cervix and vagina.[9] The procedure typically is completed in less than thirty minutes.[10]

Clinicians have performed D&E abortions for decades, which has given rise to an extensive body of evidence demonstrating that it is the safest method of performing abortions for pregnant persons in the second trimester.[11] Major complications arise in fewer than one percent of D&E procedures.[12] D&E abortions also do not require hospitalization, which allows more clinicians to provide D&E abortions and makes the procedure more affordable for patients.[13]

For these reasons, D&E abortions account for the overwhelming majority of abortions in the United States starting early in the second trimester.[14] By restricting the availability of D&E abortions, H.B. 721

---

[9] *Id.* at 1395.

[10] Cassing Hammond, *Recent Advances in Second-Trimester Abortion: An Evidence-Based Review*, 200 Am. J. Obstetrics & Gynecology 347, 348 (2009).

[11] ACOG Bulletin 135, *supra* note 6, at 1395.

[12] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (Upadhyay).

[13] ACOG Bulletin 135, *supra* note 6, at 1395-98.

[14] *Id.* at 1394.

will require clinicians to perform other types of abortions that may be harder to access and costlier for patients, with no medical justification.[15]

2. There Is No Medical Justification For Requiring Fetal Demise

H.B. 721 allows clinicians to perform D&E abortions if they first induce fetal demise. But that legislatively imposed procedure is not recognized as a medically necessary part of performing a D&E abortion.[16] In particular, there is no evidence showing that inducing fetal demise makes D&E abortions safer.[17] The decision whether to induce fetal demise before performing a D&E abortion should be made by the clinician

---

[15] For example, although medical induction generally is safe, it involves risks and potential side effects that D&E does not, such as a risk of uterine rupture, a rare but potentially life-threatening condition, and a retained placenta, a condition which can cause hemorrhaging and requires a surgical intervention. *See* ACOG Bulletin 135, *supra* note 6, at 1397-98.

[16] ACOG Bulletin 135, *supra* note 6, at 1396.

[17] Society of Family Planning, *Induction of Fetal Demise Before Abortion*, 81 Contraception 462, 463 (2010) (SFP, *Induction*) ("Although numerous methods have been used over the years to achieve fetal demise, data remain scarce documenting the effect of these techniques upon the safety of the abortion itself."); David A. Grimes et al., *Feticidal Digoxin Injection Before Dilation and Evacuation Abortion Evidence and Ethics*, 85 Contraception 140, 140 (2012) (Grimes) (noting there is no evidence showing that fetal demise makes D&E easier); Danielle Roncari et al., *Inflammation or Injection at the Time of Second Trimester Induced Abortio*n, 87 Contraception 67, 67 (2013) (Roncari) (noting that the usefulness of induced fetal demise remains unknown).

and patient, based on the individual needs of that patient – not mandated for all patients by legislators.

A blanket requirement is particularly inappropriate because the procedures required to induce fetal demise can be associated with increased costs and risks to the patient, are contraindicated for certain patient groups, and provide no medical benefit.[18] For example, one of the most common methods of inducing fetal demise in the United States is by injecting digoxin.[19] To do so, a clinician inserts a long hypodermic needle to administer the drug transabdominally (through the abdomen into the uterus) or transvaginally (through the vaginal wall or cervix) approximately 24 hours before the D&E procedure.[20]

Beyond being invasive, painful, and requiring an additional visit to a clinician, a digoxin injection can increase the risk of harm to the patient's health. Although digoxin injections are very safe overall, digoxin injections can increase the risk of infection and extramural delivery (*i.e.*,

---

[18] Roncari, *supra* note 17; *see* Gillian Dean et al., *Safety of Digoxin for Fetal Demise Before Second-Trimester Abortion by Dilation and Evacuation,* 85 Contraception 144, 148 (2012) (finding that digoxin before D&E is associated with increased rates of spontaneous abortion and recommending that digoxin injections not be administered prior to D&E).

[19] ACOG Bulletin 135, *supra* note 6, at 1396.

[20] *See* Grimes, *supra* note 17, at 140.

delivery outside of a medical facility), which is associated with a greater likelihood of the patient hemorrhaging and experiencing heightened emotional distress.[21] Digoxin injections also fail to cause demise in up to approximately 20% of cases.[22] Following a failed digoxin attempt, the patient's cervix remains dilated, and delaying the D&E procedure to re-attempt fetal demise thus exposes the patient to further risks of infection and extramural delivery.[23] In light of these potential risks, it should be up to individual patients, in consultation with their clinicians, to decide for themselves whether to undergo digoxin injections before D&E abortions. By requiring fetal demise in every case, H.B. 721 runs directly contrary to the evidence-based, patient-centered practice of medicine.

---

[21] Grimes, *supra* note 17, at 141 tbl.1 (summarizing evidence regarding harms of feticidal digoxin injection before D&E abortions, including "[s]ignificantly more complications (spontaneous abortion and infection) with digoxin").

[22] *See, e.g.,* SFP, *Induction*, *supra* note 17, at 467 (retrospective cohort study finding 8% failure rate for intra-amniotic digoxin and 4% failure rate among women for intrafetal digoxin); Grimes, *supra* note 17, at 140 (finding up to 70% failure rate for digoxin injections depending on dose and administration); Aileen M. Gariepy et al., *Transvaginal Administration of Intraamniotic Digoxin Prior to Dilation and Evacuation,* 87 Contraception 76 (2013) (Gariepy) (finding digoxin administration unsuccessful in 8% of prospective study participants).

[23] Roncari, *supra* note 17, at 67-68.

Further, digoxin injections and other common methods of inducing fetal demise may not be feasible for many patients. These include when the pregnant person has uterine fibroids, is obese, or has scarring from a previous cesarean section.[24] So for those patients, H.B. 721 effectively will function as a near-total ban on D&E abortions.

3. Fetal Pain Is Not Possible Before The Third Trimester

A primary rationale stated for H.B. 721 and its restrictions on D&E abortions is to avoid fetal pain.[25] But every major medical organization that has examined the issue has concluded, based on decades of peer-reviewed studies, that fetal pain perception is not anatomically possible before at least 24 weeks of gestational age.[26] Indeed, the medical

---

[24] Gariepy, *supra* note 22, at 76 (finding that it can be difficult for physicians to administer digoxin transabdominally on obese patients).

[25] H.B. 721 (Preamble).

[26] ACOG, *Facts Are Important: Gestational Development and Capacity for Pain*, https://bit.ly/3wqiwu8 (last accessed Feb. 12, 2024) (ACOG, *Facts*); Royal Coll. of Obstetricians & Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice,* Summary viii, 11 (Mar. 2010) (concluding fetal pain is not possible before 24 weeks gestation, based on expert panel review of over 50 papers in medical and scientific literature); *see also* Royal Coll. of Obstetricians & Gynaecologists, *RCOG Fetal Awareness Evidence Review* (Dec. 2022); SMFM, Consult Series No. 59, *The Use of Analgesia and Anesthesia for Maternal-Fetal Procedures* B7 (Dec. 2021) (SMFM, *Use of Analgesia*) (noting that 24 weeks

literature indicates that a fetus likely cannot experience pain at *any* gestational age.[27] D&E abortions typically are performed before 24 weeks of gestational age.[28]

Fetal development occurs on a continuum, and the neurological circuitry required to experience pain is not developed in a fetus before 24 weeks of gestational age. Pain perception requires an intact neural pathway from the periphery of the body (the skin), through the spinal cord, into the thalamus (the gray matter in the brain that relays sensory signals), and on to regions of the cerebral cortex.[29] These neural connections

---

of gestation "is the minimum gestational age in which in utero pain awareness by the fetus is developmentally plausible"); Ivica Kostovic & Natasa Jovanov-Milosevic, *The Development of Cerebral Connections During the First 20-45 Weeks' Gestation*, 11 Seminars in Fetal & Neonatal Medicine 415, 415 (2006) (Kostovic & Jovanov-Milosevic); A. Vania Apkarian et al., *Human Brain Mechanisms of Pain Perception and Regulation in Health and Disease*, 9 Eur. J. Pain 463 (2005) (Apkarian); Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 J. Am. Med. Ass'n 947 (2005).

[27] *See* SMFM, *Use of Analgesia*, *supra* note 26, at B4.

[28] ACOG Bulletin 135, *supra* note 6, at 1394-95.

[29] *See, e.g.,* Apkarian, *supra* note 26, at 463-84; Irene Tracey & Patrick W. Mantyh, *The Cerebral Signature for Pain Perception and Its Modulation,* 55 Neuron 377 (2007); Brian Key, *Why Fish Do Not Feel Pain,* 3 Animal Sentience 1 (2016).

do not develop until after at least 24 weeks of gestational age, and the cerebral cortex does not fully mature until after birth.[30]

Further, even if a fetus has developed the necessary neurological connections, the medical literature suggests that the fetus still does not perceive pain until after birth.[31] Before birth, the fetus is kept in a sleep-like state by environmental factors in the uterus, including certain hormones and low oxygen levels, which likely prevents the fetus from perceiving pain at all.[32]

Simply put, there is no evidence to support H.B. 721's restrictions on D&E abortions, which introduce additional risk to and burdens on patients seeking safe and essential reproductive health care.

---

[30] Kostovic & Jovanov-Milosevic, *supra* note 26, at 415.

[31] SMFM, *Use of Analgesia*, *supra* note 26, at B3.

[32] *See* ACOG, *Facts*, *supra* note 26; Henrique Rigatto et al., *Fetal Breathing and Behavior Measured Through a Double-Wall Plexiglass Window in Sheep*, 61 J. Applied Physiol. 160-61 (1986); Stuart W.G. Derbyshire, *Can Fetuses Feel Pain?*, 332 British Med. J. 909, 912 (2006); David J. Mellor et al., *The Importance of 'Awareness' for Understanding Fetal Pain*, 49 Brain Res. Reviews 455 (2005).

B. H.B. 575's Ultrasound Requirement Has No Medical Justification And Will Limit Access To Abortion

H.B. 575 requires a clinician to perform an ultrasound to determine viability before any abortion.[33] There is no medical justification for that requirement, and it will delay and limit patients' access to medication abortion by mandating a procedure that can only be performed in person.

Although ultrasounds are a common part of obstetric care, they are not medically necessary in every case. In particular, ultrasounds are usually not required for abortions in the first trimester of pregnancy, before there is any possibility of fetal viability. A common method of abortion during the first trimester of pregnancy is medication abortion, which accounts for more than one-half of all abortions in the United States and is increasingly preferred, especially among patients that live in maternity care deserts.[34] For many patients, clinicians can safely provide

---

[33] H.B. 575, §§ 1(6)(b)(i), 2(1)(b)(ii).

[34] Rachel K. Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Dec. 1, 2022); Nathalie Kapp et al., *Efficacy of Medical Abortion Prior to 6 Gestational Weeks: A Systematic Review*, 97 Contraception 90, 90 (2018); Tara C. Jatlouti et al., CDC, *Abortion Surveillance – United States, 2013*, at 8 (2016).

medication abortions through telehealth consultations without needing to see the patients in person or perform an ultrasound.[35]

H.B. 575's ultrasound requirement will foreclose the possibility of receiving abortion services through telehealth consultations and will delay many patients in obtaining abortions. That delay will expose patients to unnecessary costs and potential risks.[36] Although the risk of complications from abortions overall is exceedingly low – especially compared to the health risks of carrying a pregnancy to term – increasing gestational age increases the chance of a major complication.[37] Abortions at later gestational ages also typically are more expensive and more difficult to access.[38]

For some patients, delay may altogether foreclose the option of obtaining abortion care. Medication abortion often is not offered in the

---

[35] Nathaniel DeNicola et al., *Telehealth Interventions to Improve Obstetric and Gynecologic Health Outcomes*, 135 Obstetrics & Gynecology 371, 371-72 (2020).

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

[37] Upadhyay, *supra* note 12, at 181.

[38] Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences,* 99 Am. J. Pub. Health 623, 624 (2009).

United States after 10 weeks of gestation. Delay caused by the need to obtain an ultrasound could deprive the patient of a medication abortion option altogether,[39] including those for whom it may have been the more medically appropriate procedure.[40] Further, more than 90% of Montana counties do not have a single abortion provider.[41] In those counties, adding additional barriers to obtaining medication abortion may mean residents have no access to abortion care at all.

II. H.B. 721 And H.B. 575 Will Disproportionately Affect Patients Living In Rural Areas And Those With Fewer Resources

H.B. 721 and H.B. 575 will disproportionately affect patients 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. Nearly half of all Montanans live

---

[39] *See* ACOG, Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation* (Oct. 2020).

[40] For example, medical abortion is frequently the most appropriate method for pregnant people who have uterine fibroids. *See* Mitchell D. Creinin, *Medically Induced Abortion in a Woman with a Large Myomatous Uterus*, 175 Am. J. Obstetrics & Gynecology 1379, 1379 (1996).

[41] Guttmacher Inst., *Data Center*, https://bit.ly/3OEhIrU (last accessed Feb. 8, 2024).

in rural areas,[42] with limited access to clinics and hospitals.[43] 12.1% of Montanans live below the federal poverty line.[44] In addition, 75% of abortion patients nationwide live at or below 200% of the federal poverty level.[45]

Collectively, H.B. 721 and H.B. 575 will impose additional barriers to accessing abortion by restricting the availability of D&E abortions, the most common method of abortion for pregnancies in the second trimester, and by impairing patients' ability to obtain medication abortions, the most common method of abortion for pregnancies in the first trimester. Effectively forcing patients to continue pregnancies increases their risk of complications and death. For adults, the risk of death associated with childbirth is about 14 times higher than that associated with abortion,[46]

---

[42] Mont. Dep't of Commerce, *Montana 2020 Census Newsletter* (2020), https://bit.ly/3v0e6K0.

[43] Mont. Hosp. Ass'n, *Access to Care*, https://bit.ly/46pbH8u (accessed Dec. 13, 2023).

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

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

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

with Black and Indigenous pregnant people facing higher risks.[47] H.B. 721 and H.B. 525 will thus exacerbate inequities in health care and disproportionately harm the most vulnerable Montanans.

III. H.B. 721 And H.B. 575 Will Undermine Clinicians' Ability To Perform Their Jobs

Abortion restrictions like those imposed by H.B. 721 and H.B. 575 violate long-established and widely accepted principles of medical ethics by substituting legislators' opinions for a clinician's individualized, patient-centered counseling and undermining the patient-clinician relationship; asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

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

The patient-physician relationship is critical for the provision of safe and quality medical care.[48] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and

---

[47] Elizabeth Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 Clinical Obstetrics & Gynecology 387, 387 (2018) (Howell).

[48] 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).

concerns based on patients' best medical interests with the best available scientific evidence.[49] 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."[50] The American Medical Association (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."[51]

Abortions are safe, routine, and, for many patients, the best medical choice available for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician's ability to provide an abortion when the physician and patient conclude that it is the medically appropriate course. Laws that restrict abortion or place unnecessary conditions on obtaining an abortion – such as H.B. 721 and H.B. 575 – are inconsistent with the reality of contemporary medical practice and have no grounding in science or medicine.

---

[49] Am. Med. Ass'n, Code of Medical Ethics Opinion 1.1.1, *Patient-Physician Relationships* (Aug. 2022) (AMA Opinion 1.1.1).
[50] ACOG, *Code of Professional Ethics* at 2 (Dec. 2018) (ACOG Code).
[51] AMA Opinion 1.1.1, *supra* note 49.

Such laws also create legislatively manufactured conflicts of interest. Physicians need to be able to offer appropriate treatment options based on patients' individualized interests without fear of disciplinary action or criminal sanction.[52] H.B. 721 and H.B. 575 will profoundly intrude upon the patient-physician relationship by subjecting clinicians to potential criminal, financial, and professional penalties. For example, while D&E abortions in the second trimester are overwhelmingly the most appropriate medical treatment for patients, if H.B. 721 were to go into effect, physicians will not be able to abide by their ethical duty to "place [the] patient['s] welfare above the physician's own self-interest" without subjecting themselves to liability or performing medically unnecessary procedures.[53] H.B. 721 thus forces physicians to choose between the ethical practice of medicine and obeying the law.

B. Statutes That Restrict Access To Abortion Violate The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm, have been the

---

[52] *See* Legis. Policy Statement, *supra* note 48, at 2-3.
[53] AMA Opinion 1.1.1, *supra* note 49.

cornerstones of the medical profession since the Hippocratic traditions.[54] Both principles arise from the foundation of medical ethics that requires the welfare of the patient to form the basis of medical decision-making.

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make decisions informed by both medical science and their individual lived experiences.[55]

But H.B. 721 and H.B. 575 prohibit clinicians from providing appropriate treatment, even if providing that treatment is in the patients' best interests. The laws therefore place clinicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or violating the law. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

---

[54] Am. Med. Ass'n, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481-82 (Dec. 2007, reaff'd 2019).

[55] ACOG Code, *supra* note 50, at 1-2.

C. Statutes That Restrict Access To Abortion Violate The Ethical Principle Of Respect For Patient Autonomy

Finally, a core principle of medical practice is patient autonomy – the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[56] 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.[57] H.B. 721 and H.B. 575 will deny patients the right to fully make their own choices about health care if they decide they need to seek an abortion.

---

[56] *Id.* at 1 ("[R]espect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental.").

[57] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstetrics & Gynecology e35 (Feb. 2021); Am. Med. Ass'n, Code of Medical Ethics Opinion 2.1.1, *Informed Consent* (2017).

CONCLUSION

This Court should affirm the district court's temporary injunction.

Dated: February 14, 2024

Respectfully submitted,

/s/ *Mikaela J. Koski*
Mikaela Koski
Dimitrios Tsolakidis
Rylee Sommers-Flanagan
UPPER SEVEN LAW

Nicole A. Saharsky (*pro hac vice forthcoming)*
MAYER BROWN LLP

Counsel for Amicus Curiae

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this *amicus curiae* brief is printed with a proportionately spaced Century Schoolbook typeface in 14-point font, is double-spaced, and the word count calculated by the word processing software is 4,440 words, excluding the cover page, tables, and certificates.

/s/ *Mikaela J. Koski*

CERTIFICATE OF SERVICE

I, Mikaela Joan Koski, hereby certify that I have served true and accurate copies of the foregoing Brief - Amicus to the following on 02-14-2024:

Alwyn T. Lansing (Govt Attorney)
215 N. Sanders St.
Helena MT 59620
Representing: Charles Brereton, Montana Department of Public Health and Human Services, State of Montana
Service Method: eService

Michael D. Russell (Govt Attorney)
215 N Sanders
Helena MT 59620
Representing: Charles Brereton, Montana Department of Public Health and Human Services, State of Montana
Service Method: eService

Thane P. Johnson (Govt Attorney)
215 N SANDERS ST
P.O. Box 201401
HELENA MT 59620-1401
Representing: Charles Brereton, Montana Department of Public Health and Human Services, State of Montana
Service Method: eService

Emily Jones (Attorney)
115 North Broadway
Suite 410
Billings MT 59101
Representing: Charles Brereton, Montana Department of Public Health and Human Services, State of Montana
Service Method: eService

Dylan Cowit (Attorney)
123 William St.
9th Floor
New York NY 10038
Representing: Samuel Dickman, M.D., Planned Parenthood of Montana
Service Method: eService

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

Michael Noonan (Govt Attorney)
215 N SANDERS ST
HELENA MT 59601-4522
Representing: Charles Brereton, Montana Department of Public Health and Human Services, State of Montana
Service Method: eService

Rylee Sommers-Flanagan (Attorney)
P.O. Box 31
Helena MT 59624
Representing: American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, Society of Family Planning
Service Method: eService

Dimitrios Tsolakidis (Attorney)
PO box 31
Helena MT 59601
Representing: American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, Society of Family Planning
Service Method: eService

Alan Schoenfeld (Attorney)
7 World Trade Center, 250 Greenwich Street
New York NY 10007
Representing: Samuel Dickman, M.D., Planned Parenthood of Montana
Service Method: Conventional

Michelle Nicole Diamond (Attorney)
7 World Trade Center, 250 Greenwich Street
New York NY 10007
Representing: Samuel Dickman, M.D., Planned Parenthood of Montana
Service Method: Conventional

Rishita Apsani (Attorney)
7 World Trade Center, 250 Greenwich Street
New York NY 10007
Representing: Samuel Dickman, M.D., Planned Parenthood of Montana
Service Method: Conventional

Sean C. Chang (Attorney)
7 World Trade Center 250 Greenwich Street

New York NY 10007
Representing: Samuel Dickman, M.D., Planned Parenthood of Montana
Service Method: Conventional

Peter Kurtz (Attorney)
1225 Seventeenth Street, Suite 2600
Denver CO 80202
Representing: Samuel Dickman, M.D., Planned Parenthood of Montana
Service Method: Conventional

Diana Olga Salgado (Attorney)
1110 Vermont Ave, NW, Ste 300
Washington DC 20005
Representing: Samuel Dickman, M.D., Planned Parenthood of Montana
Service Method: Conventional

Nicole A Saharsky (Attorney)
1999 K Street NW
Washington DC 20006
Representing: American College of Obstetricians and Gynecologists, Society for Maternal-Fetal Medicine, Society of Family Planning
Service Method: Conventional

Electronically Signed By: Mikaela Joan Koski
Dated: 02-14-2024