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NORTH DAKOTA SUPREME COURT

IN THE NORTH DAKOTA SUPREME COURT
No. 20240291

ACCESS INDEPENDENT HEALTH SERVICES, INC., d/b/a Red River Women's Clinic; KATHRYN L. EGGLESTON on behalf of herself and her patients; ANA TOBIASZ, on behalf of herself and her patients; ERICA HOFLAND, on behalf of herself and her patients; and COLLETTE LESSARD, on behalf of herself and her patients,

Plaintiffs-Appellees,

vs.

DREW H. WRIGLEY, in his official capacity as Attorney General for the State of North Dakota,

Defendant-Appellant,

and

KIMBERLEE JO HEGVICK, in her official capacity as the State's Attorney for Cass County; JULIE LAWYER, in her official capacity as the State's Attorney for Burleigh County; AMANDA ENGLESTAD, in her official capacity as the State's Attorney for Stark County; and HALEY WAMSTAD, in her official capacity as the State's Attorney for Grand Forks County,

Defendants.

APPEAL FROM JUDGMENT OF THE NORTH DAKOTA DISTRICT COURT FOR THE COUNTY OF BURLEIGH (SOUTH CENTRAL JUDICIAL DISTRICT)

BRIEF OF MEDICAL STUDENTS FOR CHOICE AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES

Joel M. Fremstad (ND Bar ID 05541)
FREMSTAD LAW
3003 32nd Avenue S, Suite 240
P.O. Box 3143
Fargo, ND 58108
Tel: (701) 478-7620
joel@fremstadlaw.com

Jayme Jonat* (NY Bar No. 4883299)
Monica L. Coscia* (NY Bar No. 5842356)
HOLWELL SHUSTER & GOLDBERG LLP
425 Lexington Avenue
New York, New York 10017
Tel: (646) 837-5151
jjonat@hsgllp.com
mcoscia@hsgllp.com
* *pro hac vice* motions pending

Counsel for Amicus Curiae Medical Students for Choice

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I. INTEREST OF *AMICUS CURIAE*

[¶3] North Dakota's draconian legislation limiting access to reproductive care does not only negatively affect the state's patients—it also impacts medical students and the future of potential residency programs in North Dakota for reasons not backed by science. Medical Students for Choice ("MSFC") is a non-profit organization with nearly 300 chapters in over 30 countries, including approximately 185 chapters across the United States. MSFC seeks to ensure that medical students and trainees have access to comprehensive, evidence-based reproductive healthcare education. A group of medical students formed MSFC in 1993 in response to the lack of abortion and family-planning education in their medical training; it has since grown into a global organization with over 10,000 members. MSFC works to bring family planning and abortion education to medical students through medical training, conferences, meetings, and community organizing, and, therefore, has a strong interest in protecting evidence-based medical education and training. MSFC submits this brief to outline the concerns of its members with respect to Senate Bill 2150—which all but outlaws abortions—including its implications on the quality of medical education and residency programs in North Dakota.

II. ARGUMENT

[¶4] Under Senate Bill 2150, "[i]t is a class C felony for a person, other than the pregnant female upon whom the abortion was performed, to perform an abortion," with few limited exceptions, namely:

1. An abortion deemed necessary based on reasonable medical judgment which was intended to prevent the death or a serious health risk to the pregnant female.
2. An abortion to terminate a pregnancy that based on reasonable medical judgment resulted from gross sexual imposition, sexual imposition, sexual abuse of a ward, or incest . . . if the probable gestational age of the unborn

child is six weeks or less.

N.D. Laws 2023, ch. 122 § 1 (the "Ban" or "S.B. 2150"). Because the Ban contains several vague, non-medical phrases that physicians must attempt to interpret before performing any abortion, the law will, in effect, ban most abortions in North Dakota without science-based medical rationale. Michael Standaert, *OB-GYN Fears, Maternity Deserts Impact Health Care in North Dakota,* N.D. News Coop. (Sept. 3, 2024), http://bit.ly/3Ek1D8z. Put differently, the Ban's impact is a paradoxical role reversal—it was drafted by non-physician lawyers but must be interpreted by non-lawyer physicians often acting in emergency situations and with added pressure of criminal penalties if they incorrectly interpret the law.

[¶5] As the experiences of patients and medical providers in other states demonstrate, restrictive abortion laws lead to a lack of medical education and training on reproductive healthcare, the inability of residency programs for obstetricians and gynecologists ("OB/GYN") to provide in-state abortion training to fulfill accreditation requirements, and ultimately, physician attrition. Moreover, the Ban prevents medical students in North Dakota from learning about and receiving training on life-saving maternal health procedures beyond abortion. Thus, if the Ban goes back into effect, North Dakotans will suffer from lower-quality maternal healthcare, including for services unrelated to abortion.

A. The Ban Will Exacerbate Care Deserts In North Dakota

[¶6] The United States is facing a healthcare access crisis. The availability of skilled medical service providers in certain states has resulted in "care deserts," i.e., broad swathes of states that lack critical medical services, especially maternal healthcare. In fact, "[t]he United States currently experiences a shortfall of thousands of obstetricians, licensed midwives, family physicians, and other women's health providers—a gap that is expected

to grow in the coming decades." White House, *White House Blueprint for Addressing the Maternal Health Crisis* 6 (2022), https://bit.ly/4aEkrLW.

[¶7] Nationally, over 400 maternity wards closed between 2006 and 2020, and more than 55% of rural counties lack hospital-based obstetric services. *Id.* at 16; *Care Deserts Grow Across the US as Obstetric Units Shut Down*, PBS News (Sept. 4, 2022), https://bit.ly/40wBESE. The United States' maternal mortality rate is "the highest of any developed nation in the world and more than double the rate of peer countries, and most pregnancy-related deaths are considered preventable." White House, *supra* ¶ 6, at 3. In North Dakota, the maternal mortality rate is 20.1 per 100,000 births. Standaert, *supra* ¶ 4.

[¶8] Restrictive abortion laws such as North Dakota's S.B. 2150 exacerbate maternal care deserts. States with abortion bans are experiencing a "medical brain drain," in which many future physicians are choosing to study, and then practice, out-of-state. This means that, physician losses "will be concentrated in states that ban or severely restrict abortion." Sarah McNeilly & Vivian Kim, *A Call to Standardize Abortion Education Across U.S. Medical Schools*, Albert Einstein Coll. of Med. (Jul. 7, 2022), https://bit.ly/4gnCuY7. Further, data shows that "[a]bortion providers, OB-GYNs, [and] nurse practitioners are being pushed out of certain parts of the country that . . . have . . . restrictive abortion laws," which has detrimental effects for maternal healthcare, including for women who want to continue their pregnancies. Alice M. Ollstein & Megan Messerly, *"It's a Crisis": Maternal Health Care Disappears for Millions*, Politico (Aug. 1, 2023), https://bit.ly/3PWFzTU.

[¶9] Indeed, according to a survey of more than 2,000 current and future physicians, 82.3% of respondents reported that they preferred to apply to work or train in states with abortion access, and 76.4% of respondents reported that they would not apply to work or train in

states where there are legal consequences for providing abortion care. Simone A. Bernstein, et al., *Practice Location Preferences in Response to State Abortion Restrictions*, 38 J. Gen. Internal Med. 2419, 2149 (Feb. 23, 2023), http://bit.ly/40SiKHs.

[¶10] North Dakota already suffers from the pervasiveness of maternity care deserts. As of 2023, 71.7% of counties in North Dakota were considered maternity care deserts. In rural areas, 71.3% of women live over thirty minutes (and often two hours or more) from a birthing hospital. March of Dimes, *Where You Live Matters: Maternity Care in North Dakota* at 1–2 (2023), https://bit.ly/4jEfVB6. 43.8% of North Dakotan women cannot access a birthing hospital within thirty minutes of drive time (compared to a 9.7% nationally), and there are currently only eleven hospitals in the entire state where mothers can give birth. *Id.*

[¶11] Only one such hospital is on a Native American reservation, despite there being five federally recognized Native American reservations in North Dakota, and Native Americans comprise 4.9% of the state's population. *Tribal Nations*, North Dakota Indian Affairs, https://bit.ly/42vPtUe (last visited Feb. 5, 2025). North Dakota's maternal care problem affects Native American women more severely—they are 1.4 times more likely to receive inadequate prenatal care compared to those in areas of "low environmental vulnerability." *Maternity Care in North Dakota*, *supra* ¶ 10.

[¶12] The Ban will exacerbate North Dakota's abysmal maternity care desert problem. As MSFC member and University of North Dakota School of Medicine ("UNDSM") medical

student, Emma Weisner, described:[1]

> North Dakota is home to only one medical school, which produces a significant percentage of the state's doctors and residents who provide care to the people of North Dakota. Limiting the ability of UNDSM to educate its students about a foundational area of healthcare creates a fundamental disadvantage to the school and the state in recruiting and maintaining the medical talent that the people of the state of North Dakota deserve.

See University of North Dakota, Sch. of Med. & Health Scis., https://bit.ly/3WOqlEp. The experiences of other states with abortion bans are instructive.

[¶13] Alabama's abortion ban, which provides exceptions only to save the life of the mother or prevent a serious health risk, has resulted in closures of obstetric care centers and an exodus of maternal health care providers. Bracey Harris, *Driving 100 Miles In Labor; Giving Birth in the ER: Fears Rise As 3 Maternity Units Prepare to Close in Alabama*, NBC News (Oct. 15, 2023), https://bit.ly/3Q0sitI. These closures have ramifications on the quality of medical education and the quality of care provided to patients. Applicants for OB-GYN residency programs in Alabama dropped 21.2% in the first full cycle after Alabama's abortion ban went into effect. Alander Rocha, *Alabama OB-GYN Residencies Dropped over 20% After Dobbs, State Abortion Ban, Says Analysis*, Ala. Reflector (May 21, 2024), https://bit.ly/40U5dz2.

[¶14] Texas, which has a near-total ban in place, has also seen attrition of OB/GYN physicians. Elizabeth Tobin-Tyler et al., *A Year After Dobbs: Diminishing Access to*

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[1] The statements provided herein express the views of each speaker as a member of MSFC and should not be attributed to any other institutions with which such speakers may be affiliated. Some names have been anonymized for privacy. All statements have been provided to MSFC by verified MSFC members.

Obstetric-Gynecologic and Maternal-Fetal Care, Health Affs. (Aug. 3, 2023), https://bit.ly/4hexKVZ. Today, nearly 60% of Texas counties do not have a maternal care-designated hospital and approximately half of all counties in Texas are considered maternity care deserts. *See* Texas Dep't of State Health Servs., *Strategic Review of Maternal Level Care Designations* 13 (2022), https://bit.ly/4hhHY7U; March of Dimes, *Where You Live Matters: Maternity Care in Texas* (2023), https://bit.ly/4hNjpQe.

[¶15] The Texas Supreme Court's recent decision to prevent a pregnant woman whose fetus was diagnosed with a fatal condition from having a safe and timely abortion underscores the fears of current and future physicians deciding whether to practice in states with restrictive abortion laws. *State v. Zurawski*, 690 S.W.3d 644, 671 (Tex. 2024); J. David Goodman, *Texas Supreme Court Rules Against Woman Who Sought Court-Approved Abortion*, New York Times (Dec. 11, 2023), https://bit.ly/4jByki1.

[¶16] Refocusing on North Dakota, one MSFC member and UNDSM student, John Doe, explained:

> If the abortion ban goes into effect, North Dakota will struggle to attract individuals who want to practice OB/GYN in the state because of the immense legal liability they could face if they performed an abortion. No physician wants to risk going to jail or spending her life savings in legal fees trying to defend themselves for something that is considered the standard of care by every professional organization that governs the conduct of the OB/GYN specialty.

[¶17] North Dakota's care deserts will worsen if medical students and residents fear facing legal restrictions and even potential prosecution for providing evidence-based treatment, and often life-saving treatment, to their patients. Janet Shamlian, *OB-GYN Shortage Expected to Get Worse as Medical Students Fear Prosecution in States with Abortion Restrictions*, CBS News (Jun. 19, 2023), https://bit.ly/3vy7V07. As Ms. Weisner said of

her own experience:

> The possibility of an abortion ban directly impacts my own decision about whether to practice medicine in the state of North Dakota. There is a lack of residency programs for OB/GYN in North Dakota to begin with, and if the abortion ban goes into effect, my day-to-day work will become immeasurably more difficult from a logistical and a mental health standpoint. If that happens, I will see no choice but to leave North Dakota and practice elsewhere. The possibility of being on the receiving end of a summons for simply doing one's job would amplify the already-stressful world of medicine more than I can put into words.

[¶18] The risk of physician liability for an abortion performed contrary to the Ban—even when done in a good faith attempt to comply—will further lead medical students and residents to choose to study and practice elsewhere. Erika Edwards, *Abortion Bans Could Drive Away Young Doctors, New Survey Finds*, NBC News (May 18, 2023), bit.ly/3RW6KPw. Under the Ban, there are enumerated exceptions to the prohibition on abortions in the case of "prevent[ing] the death or serious health risk" of the mother (the "health of the mother exception") or "gross sexual imposition, sexual imposition, sexual abuse of a ward, or incest" at six weeks or less of pregnancy (the "rape or incest exception"). S.B. 2150, § 1 (2024). Doctors face legal consequences, however, if they perform abortions in circumstances later deemed not to be a medical emergency or rape. *See id.* ("It is a class C felony for a person, other than the pregnant female upon whom the abortion was performed, to perform an abortion."). Mr. Doe articulated the difficulty that physicians forced to interpret the exceptions will face:

> The "health of the mother" exception is alarmingly vague and leaves too much room for interpretation. For instance, how severe must a condition be before intervention is legally justified? Conditions like severe preeclampsia or a ruptured ectopic pregnancy are life-threatening, yet delays caused by uncertainty could lead to catastrophic outcomes. Additionally, the lack of clarity in the rape/incest exception forces non-lawyer physicians into the role of lawyers and judges, which undermines patient care. Determining whether a pregnancy resulted from a sex offense often involves invasive

> questioning, delays in care, and a breakdown of trust between the patient and provider. This uncertainty discourages physicians from practicing here and creates additional stress for students and residents.

[¶19] The Ban creates a sense of uncertainty and anxiety for North Dakota medical students who intend to practice OB/GYN—they are forced to choose between pursuing the specialty of their choice and staying in the state where they trained. Ms. Doe is one of those students:

> I plan to pursue OB/GYN as a specialty and would like to practice medicine without fearing that I will lose the medical license that I have worked so hard to obtain. Therefore, North Dakota's abortion ban is absolutely a barrier to my coming back to the state to practice medicine. I love the people I have met here, and I would love to provide the best possible care for North Dakota's patients and my future patients in general. But unfortunately, I just don't see how I could do that in a state where I will be forced to worry if my medical decision-making will lead to the loss of my license. I cannot practice in a state that forces me to think about my own well-being and protections for myself over my patients' well-being.

In light of these enormous difficulties, it is no surprise that medical students would choose to leave North Dakota than be forced to interpret vague laws not backed by science in the midst of already high-pressure, time-sensitive maternal care situations.

B. The Ban Will Negatively Impact Medical Education

[¶20] If the Ban remains in place, medical education in North Dakota will suffer greatly in a myriad of ways, ranging from defying Hippocratic principles medical students learn in school and pledge to uphold upon graduation, disadvantaging medical students' exam performance, and chilling important dialogue about abortion on campus.

[¶21] *First*, medical school curricula in the U.S. are founded on evidence-based medicine, which teaches students to use the scientific method combined with clinical experience to arrive at the best medical decisions. Steven Tenny & Matthew A. Varacallo, *Evidence-Based Medicine* 1, (2022), https://bit.ly/3O1RYpo ("Evidence-based medicine . . . uses

the scientific method to organize and apply current data to improve healthcare decisions."). Neither of S.B. 2150's exceptions is rooted in science.

[¶22] The rape/incest exception only applies during the first six weeks of a pregnancy. Thus, within *only six* weeks of pregnancy, the following must happen: a victim of rape or incest discovers she is pregnant, she seeks an abortion, she explains to her doctor she was a victim, and the doctor—a nonlawyer—makes the "medical judgment" that the legal elements of rape were met. There is no evidence-based medical standard for determining whether someone was raped, let alone an explanation for prohibiting abortions after six weeks of pregnancy—a pregnancy is no different at six weeks resulting from rape or incest from one resulting from consensual sex. *See* R.603:21:Order on Defs.' Mot. S.J. Equally important, many women do not know they are pregnant within the first six weeks of pregnancy. Jessica Ravitz, *Reasons a Woman May Not Know She's Pregnant at Six Weeks*, CNN (May 9, 2019), https://bit.ly/40T30nE.

[¶23] The "health of the mother" exception is, as explained by Ms. Weisner, similarly divorced from evidence-based medicine:

> The human body has no regard for laws that are in place. If a woman goes into sepsis and physicians have their hands tied while the care team tries to decide whether the "health of the mother" is at risk, that woman will experience preventable bodily harm that will worsen as the complicated decision is made. In other words, physicians will be forced to play a guessing game because of the vaguely worded abortion ban put into place by legislators with no medical experience. But physicians are not lawyers. We are not trained to think like lawyers, research like lawyers, or to interpret the law. In situations where minutes matter to protect the patient or patients, there simply is no time for a physician to have to deal with the issue of "does this pass the threshold to be considered a risk to the life of the mother?"

[¶24] Another principle medical students learn and pledge to follow—the Hippocratic oath—is also placed at risk in light of the Ban. Complying with the Ban and refusing to

perform abortions could result in violations of the oath medical students take. Ms. Weisner elaborated:

> The abortion ban fundamentally conflicts with the principles of the Hippocratic oath, which we take upon entry to medical school. The oath pledges that "I will strive to alleviate suffering." It is impossible to do so when we must stand by and watch suffering happen because the law has tied our hands until some nebulous threshold has been crossed. As future physicians, we are taught to prioritize patient safety, yet the abortion ban will prevent us from providing evidence-based, and often life-saving care. This conflict erodes trust in the healthcare system and creates ethical dilemmas that are deeply demoralizing for medical students and residents.

Ms. Bakkum commented further:

> My responsibility is to the pregnant woman. Refusing care to her, in my opinion, violates several parts of the Hippocratic Oath. When applying the "health of the mother" exception, where do we draw the line? What if two doctors have conflicting opinions on how imminent or severe the threat to the mother's life is? The only way to know definitively whether a mother's life is imminently at risk is to do nothing and see if she dies. That is not quality healthcare.

[¶25] *Second*, if the Ban goes back into effect, the quality of medical education—specifically, medical students' knowledge of general maternal healthcare—will almost certainly decline. Medical students across the country have expressed a strong desire for abortion-care education in medical schools. One study found 96% of medical students indicated abortion education was appropriate in the preclinical and clinical curricula, and 84% found it to be "valuable." Eve Espey et al., *Abortion Education in The Medical Curriculum: A Survey of Student Attitudes*, 77(3) J. Contraception 205, 206–07 (2008), https://bit.ly/40Tctv0. It makes sense, then, that many medical students in North Dakota fear the Ban means their school will continue to fail to provide essential abortion care training. As explained by Ms. Doe:

> At UNDSM, there is already limited access to family planning education and NO access to abortion training. This is because the school is funded by

> the state, which implemented the abortion ban. Maternal healthcare education is not only important for abortion training, but a D&C procedure can also be lifesaving in the instance of intrauterine fetal demise. The lack of education and training does nothing but further stigmatize the topic of abortion and prevent us from learning about other maternal healthcare procedures—both elective and medically necessary.

[¶26] Not only will the Ban hinder education regarding abortion itself, but it will also continue to harm medical students' opportunities to learn about other maternal healthcare procedures. Abortion education is a vital part of maternal healthcare training. Whitney S. Rice et al., *"Post-Roe" Abortion Policy Context Heightens the Imperative for Multilevel, Comprehensive, Integrated Health Education*, 49(6) Health Educ. Behav. 913, 914–15 (2022), https://bit.ly/3CELTMT. Abortion education teaches students "highly transferable skills such as medical and surgical uterine evacuation techniques relevant for miscarriage management, emergency uterine evacuation, ectopic pregnancy screening, ultrasound, contraception provision, and empathetic counselling." Jayne Kavanaugh & Patricia A. Lohr, *Educating the Next Generation of Abortion Providers*, U.K., Royal Coll. of Obstetricians & Gynecologists (May 17, 2022), https://bit.ly/3NX94nZ.

[¶27] The same clinical skills used in abortion procedures are also used to save lives in the event of a miscarriage, pregnancy causing hemorrhaging, and other complications, and physicians lacking abortion education "are often less skilled at performing these lifesaving procedures." Sarah Varney, *Fewer Medical Students Trained for Abortion Procedures*, NBC News (Mar. 22, 2022), https://bit.ly/49ba5RV. Competitive OB/GYN residency programs look for and often require training in abortion care—training that will not be sufficiently available in North Dakota in light of the Ban. As Mr. Doe described:

> The abortion ban impacts several maternal care procedures in addition to abortion. There are a number of congenital conditions that can arise during pregnancy and eliminate any chance of fetal life. The procedures to ensure

> the mother's safety are routine and the potential for them to be criminalized sends a clear signal to the medical community that these things are not to be done and discussed. As a result, North Dakotans receive lower-quality healthcare, which is a direct function of medical students' and residents' inability to learn about the latest OB/GYN techniques and technologies.

[¶28] *Third*, the Ban will continue to hinder open discussion regarding abortion on the UNDSM's campus. In the wake of *Dobbs* and the Ban, medical students and professors have faced uncertainty and anxiety regarding whether they can discuss abortion on campus. As Mr. Doe expressed:

> The *Dobbs* decision and its aftermath have had a chilling effect on medical school campuses. Discussions about reproductive healthcare are often tense, and many students feel uncertain about their future careers in a state with restrictive laws. The ND decision to block the ban temporarily provided some hope, but the ongoing litigation keeps students in limbo. It is difficult to focus on training when the legal landscape is so unstable and when fundamental rights are at stake.

Medical schools in states with abortion bans now need to "consider a variety of legal questions: Can the topic of abortion be discussed in the classroom? Is the instructor at risk if they discuss [] abortion?" Marilyn Cooper, *Dobbs v. Medical Education*, Am. Assoc. Colls. & Univs. (2023), https://bit.ly/42AXUNW. Ms. Weisner shared the following:

> As a medical student we have had very little discussion regarding *Dobbs*. We are future physicians and a lack of discussion on this prevents us from being educated on an issue directly affecting our patients' health. We have not discussed how the ban may impact our ability to provide care, and we also do not have the tools to advocate for our patients at a higher level.

Institutions of higher education such as medical schools should be vibrant public forums where students are encouraged to discuss salient current effects that affect them and their futures. It is frankly paradoxical that the Ban will cause the opposite effect.

C. The Ban Will Negatively Impact Students' Residency Opportunities

[¶29] There is currently no OB/GYN residency program in North Dakota, and the Ban

makes it all but impossible that one could be established. In order for an OB/GYN residency program to receive accreditation, it must provide in-state abortion training (or, if abortion is illegal in that state, provide access to such training in a state where it is lawful) pursuant to the Accreditation Council for Graduate Medical Education's ("ACGME") rules. ACGME, *ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology* IV.C.7.a(4) (2022), http://bit.ly/4gp3gPN. North Dakota's abortion ban necessarily bans abortion training as well. *See* Jenna Nobles, et al., *Abortion Restrictions Threaten Miscarriage Management in the United States*, 43 Health Affs. J. 1219 (2024), bit.ly/3C8Se2Z. Without this training, a potential North Dakota OB/GYN residency program could not meet accreditation requirements, which would almost certainly discourage institutions in the state from creating such a program. *See* Am. Coll. of Obstetricians and Gynecologists, *Committee Opinion 612: Abortion Training and Education* 2–3 (2014), https://bit.ly/40EnAH5.

[¶30] The logical outcome of this deficiency is it is unlikely (if not impossible) an OB/GYN residency program in North Dakota could get accreditation. Ms. Weisner states:

> North Dakota's abortion ban significantly limits access to continuing education in reproductive healthcare. Students and residents must seek OB/GYN training out-of-state, which is not only costly, but also disrupts continuity in education. These barriers disproportionately affect those from low-income or rural backgrounds, worsening existing inequities. Over time, this will likely lead to a medical workforce that is less prepared to handle complex reproductive health cases.

[¶31] Further, the Ban decreases the likelihood medical students generally—let alone those who are pursuing careers in OB/GYN—will want to complete any residency program in North Dakota. Ms. Doe highlighted the impact the Ban will likely have:

> North Dakota currently does not have a residency program, which can make attracting new OB/GYNs difficult to begin with, especially if these

> providers do not have ties to North Dakota. This is because most physicians practice in the state where they trained (especially their state of residency training). The abortion ban will likely impact the state's ability to recruit future OB/GYNs and attract North Dakotan-trained OB/GYN providers back to the state, especially when these providers could practice much more freely in nearby states like Minnesota.

Indeed, 61% of surveyed medical students would not apply to a residency or job in a state where there was a complete ban on abortion. *Practice Location Preferences*, *supra* ¶ 9. Accordingly, like other states' abortion bans, North Dakota's ban is likely to contribute to the overflooding of programs in pro-choice states with out-of-state residents fleeing states with abortion bans. Nick Anderson, *A Race to Teach Abortion Procedures, Before the Bans Begin*, Wash. Post (June 20, 2022), https://bit.ly/3EuLQUn.

[¶32] Finally, the Ban disadvantages North Dakota medical students who intend to apply for OB/GYN residency programs in other states. Abortion care training in medical schools and clinical programs is important in ensuring that medical students in North Dakota qualify for OB/GYN residency placements. Hillary J. Gyuras et al., *The Double-Edged Sword of Abortion Regulations*, 28(1) Med. Educ. Online at 3–5 (2023), https://bit.ly/48Ruv1V. For future OB/GYNs studying in North Dakota, training in a state with restrictive abortion laws means their lack of abortion training may make them less competitive candidates for residency placements. *ACGME Program Requirement s*at IV.C.7.a(4), *supra* ¶ 29. As Mr. Doe explained, this disadvantages North Dakota's future OB/GYNs:

> The ban has created a pervasive sense of stress and uncertainty among medical students, especially those considering OB/GYN or family medicine. Many of us feel conflicted about staying in North Dakota, knowing that our ability to provide comprehensive care is limited here. This reality makes it harder for the state to recruit and retain future physicians, exacerbating the already pervasive healthcare shortages in rural areas.

[¶33] Further, the ACGME requires OB/GYN residents to educate patients on procedural and medication abortion methods, manage abortion complications, and obtain clinical experience in spontaneous abortion, pregnancy loss, and uterine evacuation. *Id*. at IV.C.7–8. Mr. Doe described the reality of this gap in training:

> The abortion ban severely restricts opportunities for medical students to learn essential reproductive healthcare skills. Procedures like dilation and curettage, which are crucial for managing miscarriages, are often learned in the context of abortion care. Without access to training in these procedures, medical students graduate with gaps in their knowledge, potentially affecting patient safety and care quality. For those interested in OB/GYN, the lack of comprehensive training creates a barrier to entering competitive residency programs or providing the full spectrum of care to future patients.

If the Ban goes back into effect, medical students, residents, and prospective OB/GYNs are likely to study out-of-state and less likely to return. The result would be a reduced quality of medical education and medical training in maternal healthcare and a reduced quality of medical services for women and expectant mothers.

III. STATEMENT OF AUTHORSHIP

[¶34] No counsel for a party authored this brief in whole or in part. No person or entity, other than the *amicus curiae* and its counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

IV. CONCLUSION

[¶35] For the foregoing reasons, this Court should affirm the decision below.

Respectfully submitted,

/s/_*Joel M. Fremstad*
Joel M. Fremstad (ND #05541)
Fremstad Law Firm
P.O. Box 3143
Fargo, ND 58108
joel@fremstadlaw.com
Counsel for *Amicus Curiae*
Medical Students for Choice

CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(d) of the North Dakota Rules of Appellate Procedure, the undersigned certifies that the foregoing *Amicus Curiae* Brief in Support of Plaintiff-Appellee's Appeal of the District Court's Judgment was prepared in a proportionally spaced, 12-point type, is 19 pages in length (excluding this certificate of compliance), and complies with the page limitation applicable to *amicus curiae* briefs under Rule 29(d) and Rule 32(a)(8)(A).

Respectfully submitted,

/s/ *Joel M. Fremstad*
Joel M. Fremstad (ND #05541)
Fremstad Law Firm
P.O. Box 3143
Fargo, ND 58108
joel@fremstadlaw.com
Counsel for *Amicus Curiae*
Medical Students for Choice