IN THE SUPREME COURT OF IOWA
No. 22-2036

PLANNED PARENTHOOD OF THE HEARTLAND, INC., EMMA GOLDMAN CLINIC, and JILL MEADOWS, M.D.,
***Appellees*,**
v.

KIM REYNOLDS EX REL. STATE OF IOWA and IOWA BOARD OF MEDICINE,
***Appellants*.**

Appeal from the Iowa District Court for Polk County

Hon. Celene Gogerty, District Judge

BRIEF OF NON-IOWAN ABORTION CARE PROVIDERS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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***Pro hac vice* pending**

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Other Authorities

STATEMENT OF INTEREST AND DISCLOSURE STATEMENT OF AMICI CURIAE[1]

Amici Curiae are physicians who provide abortion care for patients in states close to Iowa. They have treated patients who have travelled out of state for abortion care because of abortion bans in effect across the United States. *Amici* are among the providers who will provide medically necessary abortion care to Iowans if the permanent injunction on Iowa's abortion ban is lifted by this Court and thousands of Iowans are forced to attempt to seek care out of their home state.

Jonah Fleisher, M.D., M.P.H.

Dr. Fleisher is a Complex Family Planning specialist who provides full-spectrum obstetrics and gynecological care and specializes in contraception, abortion, and miscarriage management in Chicago. Dr. Fleisher attended medical school at Northwestern University, completed his residency in obstetrics and gynecology at Thomas Jefferson University Hospital in Philadelphia, and his fellowship in complex family planning at New York University, where he also earned his Master of Public Health. He is a Fellow of the American Congress of Obstetricians and Gynecologists.

Maritza Gonzalez, M.D.

Dr. Gonzalez is a maternal-fetal medicine physician who specializes in high-risk pregnancies in Chicago. She is also an Assistant Professor of Obstetrics and Gynecology and Co-Director of the Diabetes in Pregnancy Program. Dr. Gonzalez attended medical school at the University of Illinois and completed her residency and fellowship in obstetrics and gynecology at the University of Arizona.

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[1] No counsel for a party authored the brief in whole or in part. No party, counsel for a party, or any person other than *amici curiae* and their counsel made a monetary contribution intended to fund the preparation or submission of the brief. In this brief, *Amici Curiae* provide their personal medical opinions and experiences regarding abortion care, and these beliefs do not necessarily represent the beliefs of the institutions for which they work.

Mae-Lan Winchester, M.D.

Dr. Winchester is an OB-GYN specializing in maternal-fetal medicine in Cleveland, Ohio and provides abortion care in Kansas City, Kansas. Dr. Winchester is also an Assistant Professor of Medicine. Dr. Winchester attended Eastern Virginia Medical School where she also completed her residency in obstetrics and gynecology. She completed her fellowship in maternal and fetal medicine at the University of Kansas Medical Center.

Katherine "Katie" McHugh, M.D.

Dr. McHugh is an OB-GYN specializing in chronic pelvic pain and reproductive health, who practices in Indiana, Ohio, and Maryland. She attended the Indiana University School of Medicine where she also completed her residency in obstetrics and gynecology.

Chelsea Thibodeau, D.O.

Dr. Chelsea Thibodeau is a Minnesota-based full-spectrum family medicine doctor. She provides clinical, pre-natal delivery and abortion care. Dr. Thibodeau received her medical degree from Des Moines University College of Osteopathic Medicine and completed her residency in family medicine at the University of Wisconsin, Madison.

Margaret Baum, M.D.

Dr. Margaret E. Baum is an obstetrician-gynecologist based in St. Louis, Missouri and Fairview Heights, Illinois. She is the Medical Director for Planned Parenthood of the St. Louis Region and Southwest Missouri (PPSLR).[2] *Dr. Baum received her medical degree from Johns Hopkins University School of Medicine, completed her internship at the University of Texas Southwestern at Dallas, and her residency in obstetrics and gynecology at Washington University.*

[2] PPSLR and Petitioner-Appellee Planned Parenthood of the Heartland are independent non-profit corporations that do not have in common any employees, executives, or members of the board of directors.

INTRODUCTION AND SUMMARY OF ARGUMENT

Appellants ask this Court to dissolve a permanent injunction that is currently saving women's lives in Iowa and blocking a medically unnecessary and life-threatening six-week abortion ban from taking effect. Their arguments rest on numerous errors, including fundamental misconceptions of established medical practice and science of abortion care and, most tellingly, the ban's impact on the lives of many Iowans, particularly people of color. In this brief, expert practicing physicians present to this Court, in their own words, what actually happens when a politically and non-medically driven abortion ban takes effect. This brief will help the Court understand (1) that a six-week abortion ban is incompatible with sound medical evidence; (2) why abortion is vital and necessary healthcare; (3) the burdens, obstacles and risks that their patients experience from having to travel out of state to receive abortion care; (4) the ethical and moral implications of having non-medical professionals determine health care for patients; and (5) the impact Iowa's abortion ban would have on patients and providers across the United States.

ARGUMENT

"Abortion is a common medical procedure and a familiar experience in women's lives. About 18 percent of pregnancies in this country end in abortion, and about one quarter of American women will have an abortion by the age of 45." *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2343–44 (2022) (Breyer, Sotomayor, and Kagan, JJ., dissenting). Physicians who have dedicated their professional lives to providing abortion care know that it is vital and necessary healthcare. These physicians provide abortion care because they know that "[e]ven an uncomplicated pregnancy imposes significant strain on the body, unavoidably involving significant physiological change and excruciating pain," and that "[f]or some women, pregnancy and childbirth can mean life-altering physical ailments or even death." *Id.* at 2338.

Patients seek abortion care for unique reasons. Regardless of the reason, *Amici* providers agree that in their professional medical opinions the decision of whether to obtain abortion care should always be left to the pregnant person. Legislation and judicial intervention stripping patients of this fundamental liberty facilitates bad healthcare and dehumanizes patients. These experts know that the choice to have an abortion is amongst the "most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy[.]" *Planned Parenthood of Se. Pa. v. Casey*,

505 U.S. 833, 851 (1992). Despite significant obstacles aimed at disrupting access to abortion care, it will continue to be necessary healthcare that patients will obtain, and ethical providers will provide.

I. A Ban on Abortion at Six Weeks is Contrary to Medical Evidence and Practice

The Iowa legislation currently enjoined contains multiple medically incorrect assumptions about the definition of pregnancy, the term "fetal heartbeat," the risks and complications that can arise during pregnancy, and the timeline of fetal development. Each misconception contributes to Iowa's disingenuous claim that it is not banning almost all abortion care.

The statute bans abortion if a "fetal heartbeat" is detected using an abdominal ultrasound, which usually occurs around the sixth week of pregnancy. However, as Dr. Fleisher explains this does not mean that the patient has actually been pregnant for six weeks, nor does it mean that the patient even knows they are pregnant. Dr. Fleisher explains that physicians count the weeks of pregnancy starting from the first day of the last normal menstrual period ("LMP"), because it is the most consistent way to measure gestational age. However, in medicine, pregnancy is defined to begin when the fertilized ovum implants, usually in the uterus. Implantation usually does not occur until one or two weeks after fertilization, and thus, a person is typically not actually pregnant until approximately two to three weeks after

the first day of their LMP. Accordingly, when lawmakers and courts speak about the weeks of pregnancy, the description is deceptive and vague because there are at least two weeks built into the definition during which the person is not yet actually pregnant.

Most patients will not discover they are pregnant during the timeframe before the six-week ban is intended to take effect. Dr. Fleisher explains that physicians themselves cannot detect a pregnancy until the fourth week after their LMP, and that is the earliest a blood or urine pregnancy test will show a positive result. But as Dr. Fleisher explains:

> That is assuming that the person has symptoms of pregnancy right away and immediately takes a pregnancy test. Not everyone experiences morning sickness or other symptoms that might suggest to them that they are pregnant, and many people have irregular period cycles. People with irregular periods cannot rely on noticing that their period is a few days late as a symptom of pregnancy indicating that they should take a pregnancy test.

Even those patients who *do* notice their period is a few days late, by the time they can go to the pharmacy to buy a test and take it, they are likely already at five weeks after their LMP, at the earliest. Then, if the patient is in a state with a six-week abortion ban, all within a week, they "have to call a clinic, find an appointment *that week*, find the money, find childcare, and take time off of work to travel to the appointment." Even under ideal circumstances, Dr. Fleisher explains, a ban on abortion at the sixth week of pregnancy will

prevent almost everyone in Iowa from accessing abortion care simply because they will not know that they are pregnant during that arbitrary timeframe.

As the providers explain, many pregnant people suffer complications because of their pregnancies. Many conditions cannot be diagnosed by the time the Iowa abortion ban would prevent the patients from obtaining an abortion in-state. Drs. Gonzalez and Winchester both specialize in maternal-fetal medicine and most of their patients have health complications, conditions, or significant risks associated with pregnancy. These conditions include, among others, fatal fetal anomalies, uncontrolled high blood pressure, hyperthyroidism, heart disease, diabetes, hypertension, cancer, and blood clots. The providers agree that most of these conditions cannot be diagnosed by the sixth week of gestation.

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Maritza Gonzalez, M.D.

> Many of the complications I help manage, such as complex heart disease, that impact or can be exacerbated by a pregnancy are not often diagnosed until after the patient discovers that they are pregnant. On the other hand, pregnancy itself can mask the symptoms of some of these medical conditions, making diagnoses more likely later in gestation. Thus, by the time an Iowan could realize that they are pregnant, get diagnosed with a complication or condition that is incompatible with carrying the pregnancy to term, and is able to schedule a doctor's appointment, and then get to the doctor, the six-week ban would prevent them from getting life-saving care in Iowa. In terms of fatal fetal abnormalities, doctors can *only*

> do an anatomy ultrasound to look for these abnormalities approximately halfway through the pregnancy, between 18 and 20 weeks gestation. If a patient is in a state where abortion is restricted before 20 weeks, that patient would have to continue the pregnancy or travel to another state for an abortion - even when it is plainly and medically inevitable that the fetus will not survive.
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The Iowa legislators who drafted the abortion ban bill, claim that the abortion ban furthers the state's interest in protecting unborn life when the embryo has a "heartbeat." This language is deceptive and medically incorrect. As Drs. Fleisher and Baum explain, this is an arbitrary determination with no foundation in medical science. At six weeks following a patient's LMP, "the fetus has no heart," and therefore, "there is no heartbeat." "The phenomenon that doctors can detect on an ultrasound early in pregnancy is actually a tube of primitive muscle cells that twitch because of electrical activity." *Dr. Fleisher*. **It is not a heartbeat**. A so-called "fetal heartbeat" ban on abortion is simply "an arbitrary way to effectively ban almost all abortions, based on no medical evidence, without admitting that the intent is to ban all abortions." *Dr. Fleisher*.

Because of these medically incorrect assertions about pregnancy and pregnancy care, if the patient is in a state with an abortion ban like Iowa, they will either be subject to labyrinthine protocols to receive lifesaving abortion care, or they must quickly be referred out of state. Neither option permits

providers, who have spent years studying and training to make these important medical decisions, the ability to provide medical care in accordance with their training and best medical judgment.

II. Abortion is Necessary to Protect Maternal Health

All providers agree that pregnancy can be dangerous even for a healthy person. As Dr. Fleisher describes unequivocally, the maternal "mortality rate of childbirth is fourteen times higher than that of an abortion, so no one should be forced to stay pregnant if they do not wish to be."[3] Every pregnancy imposes significant strain, stress, and physiological changes to the body of the pregnant person. The providers explain that in many cases, abortion is medically necessary to protect the lives and well-being of their patients and is quite literally a lifesaving procedure.

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Jonah Fleisher, M.D.

> As a hospital provider, many of my patients are referred to me because they have health conditions or significant risks associated with their pregnancy. I see many people travelling from outside Illinois with major fetal anomalies, uncontrolled high blood pressure, hyperthyroidism, heart disease, dangerous blood clots (called "deep vein thromboses" ("DVTs")), and other

[3] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, OBSTETRICS & GYNECOLOGY 119 (2 Part 1): p. 215–19 (2012), https://pubmed.ncbi.nlm.nih.gov/22270271/.

> medical problems. Most every patient I see needs and deserves timely abortion care.
>
> **Katie McHugh, M.D.**
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> I recently treated a patient who had traveled from a state with an abortion ban, and had a history of a condition called pulmonary hypertension which is a type of high pressure in vessels in and around the lungs. This condition is extremely dangerous when the patient is not pregnant, and if the patient is pregnant, there is a very high maternal mortality rate. In many cases, someone who receives this diagnosis is told to never get pregnant, and if they do, they are immediately recommended to have an abortion.
>
> It was plainly bad healthcare for a provider to tell her that she should risk her life for this very slim possibility that she could get far enough into her pregnancy that there might be viability of the fetus, and yet that is what those providers were forced to do because of the legal restrictions in their state around this medical decision. My patient had to endure months of physiological changes that put her life at high risk, just to get to Indiana so she could choose to live.
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The narratives of these providers are limited examples of the conditions that real live patients experience during pregnancy and that require prompt abortion care. As Dr. Winchester explains, "If you are presented with these symptoms on your oral boards to become a board-certified OB/GYN, and you provide any answer other than providing abortion care, YOU FAIL." While the Iowa abortion ban includes a limited exception for abortions later in pregnancy to save the pregnant person's life, as Dr. Winchester explains, this

exception is patently ambiguous and not clearly interpreted or applied by hospital lawyers, administrators, and medical staff:

> There's just no way anyone could ever imagine all the potential circumstances in which someone may need an abortion. It's an endless list. Legislators pretend they can plan for it with these bans. Each person is so different, each pregnancy is unique. These bans just create harm for patients and physicians.

III. There Are Significant Implications of Travel on Patients Seeking Abortion Care

Abortion bans, like Iowa's six-week enjoined ban, force patients, who have the ability and resources, to travel to seek and obtain legal abortion care. As the providers explain, there are not only medical risks associated with travelling for abortion care, but also monetary, logistical and familial negative implications that disrupt the patients' lives, livelihood, and health, and pose significant burdens to obtaining basic healthcare.

A. There Are Risks Associated with Travelling for Abortion Care

The providers have seen and treated patients who have travelled from every state that restricts abortion and it is not unusual for these patients to be travelling for hours in the double digits. For most patients, abortion involves either taking medications or a short aspiration or dilation and evacuation procedure; forcing patients to travel to a different state makes accessing such care much more onerous than necessary. Several *amici* providers specialize

in care for patients with medical complications or conditions that make pregnancy especially dangerous, and these patients would be forced to undergo more complex procedures far from home.

Even for patients who do not have dangerous underlying medical conditions, travelling for abortion care imposes medical risks for the average pregnant person. Dr. Fleisher explains:

> Pregnant people are at a higher risk for deep vein thrombosis, which is a blood clot in the legs that can travel to the lungs and be fatal.[4] The risk of these blood clots forming increases when someone is sedentary for longer periods of time, such as when riding on long car trips or on planes.[5] As a hospital-based abortion provider, I also treat people who are at even higher risk of clots because of a genetic condition that makes them even more prone to develop these blood clots. These patients are at particular risk when traveling for abortion care.

In addition, Dr. Thibodeau explains, patients travelling out-of-state for abortion care, particularly in the Midwest, face practical safety risks when

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[4] *See also Venous Thromboembolism (Blood Clots)*, CENTERS FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/ncbddd/dvt/pregnancy.html (last visited Mar. 13, 2023) ("While everyone is at risk for developing a blood clot . . . pregnancy **increases that risk fivefold**.") (emphasis added).

[5] *See Know the Warning Signs: Blood Clots Are a Silent Threat*, UNIV. OF PITTSBURGH MED. CTR., https://bit.ly/3T9oO92 (last visited Mar. 13, 2023) ("When you sit for a long period of time, the blood flow to your legs slows down, and when your legs are still and hanging down, blood tends to pool in the muscular beds of the calf. These factors can make it easier for a clot to form and increase your risk for DVT.").

doing so, such as severe weather and a variety of travel hazards that "can turn a four-hour drive from South Dakota to Minneapolis, for example, into a ten-hour drive." These risks can easily be avoided by being able to receive abortion care in the patient's own local communities, but for thousands of patients, this mortality risk has been forced upon them by state governments that choose to ignore real life implications of its legislative actions. Iowa should not sanction irresponsibly putting its citizens' lives at risk.

The second highest risk associated with having to travel for abortion care is the delay. As the providers below explain, travel for abortion care is not an immediate action that these patients can take the minute they decide it is the best, healthiest medical option for them. They must arrange travel logistics, figure out how to pay for their travel and care, find childcare for their children,[6] secure time off from work, and then travel hundreds or thousands of miles. The influx of patients travelling to states that still permit abortion have also caused significant delays in scheduling appointments. These delays pose additional medical risks to the patients, and often result in longer, more complex procedures than would be unnecessary had the patients not been delayed by obstacles imposed by abortion bans in their home states.

[6] *See* Katherine Kortsmit et al., *Abortion Surveillance – United States*, 2020, CENTERS FOR DISEASE CONTROL AND PREVENTION (Nov. 25, 2022), http://dx.doi.org/10.15585/mmwr.ss7110a1.

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Jonah Fleisher, M.D.

The delay in accessing abortion care that abortion bans create increases the danger and cost of abortion. Although abortion is safe, and always safer than childbirth, each week that passes slightly increases the medical risks of abortion. As a hospital-based provider, many of the patients that I see are seeking abortion care because they have more complex medical complications or conditions that make the pregnancy especially dangerous, such as genetic abnormalities, heart disease, blood clots, high blood pressure, preeclampsia and other high-risk conditions. Some of these patients travel to Illinois only to find that they cannot get abortion care from a freestanding abortion clinic or Planned Parenthood because their medical conditions require hospital-based care. Then they must start the process over again to make appointments with a hospital-based provider like me. This delay creates unnecessary delay, stress, cost, and physical risk of harm.

Maritza Gonzalez, M.D.

Post *Dobbs*, I see many more patients from out of state. The wait time to schedule a procedure is now approximately two weeks. Because patients are now being forced to travel across state lines, not only are they having to get care from someone they do not know, but the delay associated with that travel means that these patients are later in gestation and must have more complicated and risky multi-day procedures.

These multi-day procedures are still safe, and in many cases lifesaving, but they come with risks that could have easily been avoided had my patients had access to the care they needed in their own states. Many of my patients travelling from out of state come to my hospital the first day for measurements and tests. They come in a second day to start the procedure. Many patients must begin their travel home immediately after or within a small window after receiving abortion care—which is not recommended or as safe—because they need to return to their

families, kids, and jobs. Regardless of circumstance, multi-day travel out of state for abortion care is burdensome.

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B. The Costs and Burdens of Travel for Abortion Care

As the providers explain, aside from the medical risks of having to travel to receive abortion care, there are also unexpected costs and burdens associated with travelling across state lines for abortion care.

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Jonah Fleisher, M.D.

Even with the assistance of family, friends, neighbors, and philanthropic abortion funds that help arrange travel and pay for medical care, people sometimes have to choose between paying for their abortion or their rent that month. Some cannot arrange childcare. I have seen people lose their jobs because of all the workdays they have missed when travelling for abortion care.

Margaret Baum, M.D.

As a result of *Dobbs*, our wait times increased from three days to 3 weeks—and that is with expanding hours and days of operations. When patients come to me later in their pregnancies, the procedure is longer and takes 2-3 days, is more expensive, and has more risks than if the patient had had access to a provider earlier or in their home state.

I had one 14-year-old patient who travelled from the South with her mother for an abortion. They did not realize how far along her pregnancy was before her exam and were not prepared to stay for a multi-day procedure. The patient's mother had a court date the next day and other young children back at home. These logistical complications of having to travel a far distance for routine abortion care caused the patient to have to leave that

day without getting the abortion because the patient's mother could not stay multiple days for the abortion procedure.

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Approximately 60 percent of patients seeking abortion care already have children,[7] and they must coordinate, and be able to afford, childcare as well as food and lodging to travel for abortions.

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Margaret Baum, M.D.

There is no easy way to get to Illinois on public transportation, and many patients, especially patients with low incomes, do not have access to a vehicle to make the drive. Patients who can drive, sometimes long distances to receive care in Illinois, often do so by themselves and may have to stay for multi-day procedures. The travel requires money for gas, food, lodging, as well as the procedures, and arranging childcare and time off work—all of which can take significant time. For example, a patient told me that she had spent all her money on travel to access abortion care and did not have money left for food. I have had patients show up for their abortion procedures with their children because they were unable to secure childcare. One patient came alone with her three-year-old. These are costs, burdens and risks that are avoidable.

Mae-Lan Winchester, M.D.

One patient I talked to described driving to Washington, D.C., with her partner. Because of her unique situation, she required a three-day procedure. So, it was five days, all-in, driving one day each way and the three-day procedure. She didn't feel like she could breathe the entire time. It was like a five-day panic attack. And it cost her $11,000.

[7] See *id*.

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Many patients also experience unforeseen issues related to their travel, which cause outrageous situations and compound the stress they are under.

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Mae-Lan Winchester, M.D.

I had one patient recently who came to Kansas from Texas, but it ended up she wasn't pregnant. She drove ten hours for me to tell her that she wasn't pregnant. But she didn't want to go to a doctor in Texas and then there would be a record that she was pregnant. She didn't know who she could trust.

Chelsea Thibodeau, D.O.

I had a patient recently who flew to Minneapolis from a state that had banned abortion. She left three children at home to come to Minneapolis for her procedure, flew in the night before, and was scheduled to come in the next morning. For whatever reason, her ride did not pick her up from her hotel. So, this woman began walking down the interstate in December. A Minnesota State Trooper picked her up and dropped her off at the clinic. Patients will find a way to access the care they need, even as it puts them at great personal risk.

Margaret Baum, M.D.

I saw one patient who was under the age of 21, who was travelling with their partner to Illinois for a multi-day abortion procedure. When they arrived in Illinois, they were unable to get a hotel room because they were not 21. Another patient took a multi-hour bus ride to see me for abortion care in Illinois. We had helped arrange a hotel for her to stay in, but when she arrived, she was unable to check in because she had no form of ID.

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Patients who can navigate the logistics, costs and personal burden to access abortion care are the lucky ones, as these burdens are prohibitive for many others who are now forced to continue their pregnancies to term or self-manage their abortions.

C. Differential Impact on Minority and Low-Income Patients

If allowed to take effect, Iowa's abortion ban will disproportionately and more severely impact minority and low-income patients. As Dr. Baum explains, "for patients with low incomes or BIPOC [Black, Indigenous, and People of Color] patients, there are already significant barriers and lack of access to get basic health care." Barriers to medical care are compounded for low-income and minority patients who seek abortion care, and in many cases become prohibitive. For example, as mentioned above, patients travelling for abortion access require identification for flights and hotels. While having forms of identification may be taken for granted, millions of Americans do not have government issued identification,[8] which is common amongst low-income and minority populations with unstable housing.

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[8] *See Citizens Without Proof: A Survey of Americans' Possession of Documentary Proof of Citizenship and Photo Identification*, BRENNAN CENTER FOR JUSTICE AT NYU SCHOOL OF LAW, (2006), https://www.brennancenter.org/sites/default/files/legacy/d/download_file_39242.pdf

Even if a low-income or minority patient can be seen by a community provider and somehow put the resources together to travel for abortion care, many doctors do not know competent abortion providers out of state, making accessing abortion care practically impossible. In other words, many minority patients reside in healthcare deserts and their providers do not have a broad network of healthcare providers out-of-state to whom they can refer patients. As Dr. Winchester explains, accessing abortion care becomes "a 'who you know' thing to access medical care." Thus, Iowa's abortion ban, if allowed to go into effect, will disproportionately harm the most vulnerable members of its population.

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Maritza Gonzalez, M.D.

> Most of my patients for whom staying pregnant is not medically recommended either because of pregnancy complications or underlying medical conditions are from low-income and minority backgrounds. If they are able to gather enough resources to travel out of state, while they were waiting to get an appointment, schedule travel, take time off from work, childcare and logistics, they crossed a time threshold where they now need a multi-day procedure instead of a one-day procedure, which increases their costs to a prohibitive level.

Katie McHugh, M.D.

> Low-income and minority patients have difficulty traveling to even the in-state clinics let alone out-of-state because of the lack of public transportation and lack of access to their own private transportation. This means that the financial barriers to accessing abortion care are huge, and disproportionately impact low-income and minority patients.[9]
>
> Even if these patients were to recognize the symptoms of pregnancy before six weeks, many patients live in huge healthcare deserts[10] without access to ultrasound equipment that would be required to diagnose and date a pregnancy that early into gestation. Thus, a six-week ban would effectively ban abortion for these patients.

Mae-Lan Winchester, M.D.

> The medical system has historically been biased against persons of color and in no area is that truer than abortion care.

IV. Iowa's Abortion Ban Would Create Substantial Ethical and Moral Implications for Healthcare Providers

Practically, abortion ban laws do not, and cannot account for every possible complication, condition, or situation that pregnant patients and their

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[9] "In 2021 the maternal mortality rate for non-Hispanic Black women was 69.9 deaths per 100,000 live births, 2.6 times the rate for non-Hispanic White women." *Maternal Mortality Rates in the United States, 2021*, NATIONAL CENTER FOR HEALTH STATISTICS, (Mar. 16, 2023), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

[10] *See, e.g.*, Eli Saslow, *'Out Here, It's Just Me': In The Medical Desert of Rural America, One Doctor for 11,000 Square Miles*, THE WASHINGTON POST, Sept. 28, 2019, https://www.washingtonpost.com/national/out-here-its-just-me/2019/09/28/fa1df9b6-deef-11e9-be96-6adb81821e90_story.html (describing healthcare deserts in rural America).

providers may face. Dr. Gonzalez explains, "abortion bans are not about protecting the life of the fetus, because every single case is so much more delicate and nuanced that cannot be anticipated by an abortion ban law." Iowa's abortion ban will result in medically and ethically compromised medical care for any person who can become pregnant. This ban would supersede the medical opinions and decisions of physicians who have spent years training and treating patients, in exchange for the opinions and decisions of hospital lawyers, administrators, politicians, legislators, and judges who do not put the best interests of the patient first. These situations are no longer theoretical exercises for the Court to understand. It has happened and is happening to providers and patients all over the country, and the reality is horrific.

A. The Conflict Between Legal Concerns and Proper Patient Care

Dr. Winchester, who specializes in maternal-fetal medicine in Ohio, provided abortion care during the sixty-six days that the Ohio "heartbeat abortion ban" was in effect last year. Under the ban, if she could receive adequate approval from hospital lawyers, Dr. Winchester was permitted to provide care in the interest of maternal life. As she explains, the process of having to (1) get ahold of hospital lawyers, (2) explain to non-medical professionals the medical reasons why abortion was necessary to protect the life of the patient,

and (3) argue with lawyers over whether the patient's condition was "bad enough" to warrant approval, was excruciating. Exceptions to abortion bans to save maternal life are not clearly defined, and lawyers and doctors alike are faced with confusion regarding potential legal exposure when presented with patients who need lifesaving abortion procedures. The process delayed necessary care for each of her patients and compromised her ability to provide the best medical care in the best interest of her patient.

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Mae-Lan Winchester, M.D.

> The first Monday after *Dobbs* came down, I had a 21-year-old patient come in at 19 weeks gestation. Her symptoms are all very diagnostic for an in-utero infection, which will kill the patient unless you perform an abortion. There's no question that an abortion was the right medical decision for this patient. But I had to call the hospital lawyers to make sure that they were okay with what I was doing, and make sure that the hospital was covered. The whole process was extremely disruptive to providing the care my patient needed.
>
> I had another case where the patient had twins at 21 weeks gestation. The first twin was abnormally small. Because the first baby was so small, it was going to die no matter what, so my focus, and the focus of my patient, had shifted to doing everything possible to provide care for the surviving baby.
>
> This was an emergency situation over the weekend, and I was trying to call our lawyers for clearance to provide the care my patient needed. I handed my cell phone to a medical student on rotation with me, told them to call the lawyer's number over and over and over until they reached someone. It is difficult for a layperson to understand the intricacies of the medicine and my

> patient's situation. It's an emergency, we need to decide right now what course of care to provide.
>
> My patient was lying in the operating room, alone, without me there, because I was out in the hall on the phone with the lawyers. I didn't want to have this conversation on the phone in front of the patient. So, I have no idea what's going on with the patient in the OR while I'm pleading with the lawyers on the phone in this emergency. Although the lawyers eventually approved the medically necessary care for my patient, her care was delayed, and she was placed at added risk because of the delay.

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As Dr. Winchester explains lawyers and administrators, not only lack medical training, but owe their duty of loyalty to the hospital or institution itself, and thus their job is to make decisions based on the best interest of their client, and not the patient.

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Mae-Lan Winchester, M.D.

> If I tell a lawyer that in my best medical opinion the mother's pregnancy is very, very risky and I believe an abortion is the proper medical care, and the lawyers tell me "well, it's not risky enough," it's insulting. It is *very* clear that they're not my lawyer, they're not my patient's lawyer, they're the hospital's lawyer. They're there to protect the institution, not the patient.
>
> I had one patient where I thought my hospital would understand and let me proceed, but refused and so my patient had to travel to Michigan. When we did the 20-week anatomy scan, there was no fluid around the baby and some blockage in the baby's bladder to where it couldn't pee; it also had a major heart

> condition. For me, this is a lethal fetal anomaly in a patient who has *significant* risk because of the pregnancy.
>
> I wrote to the hospital's lawyers, explained all the major risks to the mother, and wrote specifically that "in my best medical opinion, her condition presents a significantly increased risk to maternal life." The lawyers disagreed, concerned about the complexity that lethal fetal anomalies threw into the equation because abortion for fetal anomalies was not allowed under Ohio's ban. So I had to call my patient back. I had to tell her that I couldn't provide her care. She was shocked, angry, and more scared than ever.

***

Abortion bans put providers in ethically compromising situations where they are legally unable to provide the best proper medical care to their patients without the risk of legal liability, creating chaos and uncertainty for providers and patients alike. If this Court dissolves the permanent injunction of Iowa's abortion ban, it will be imposing the moral beliefs of a minority of the population on innocent patients and providers who do not share those beliefs, in direct contradiction of proper medical care and the Iowa Constitution.

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Jonah Fleisher, M.D.

> The chilling effect from abortion bans, including especially six-week bans, causes harm to many pregnant people with complicated pregnancies. Even when there are exceptions to the abortion ban for the life of the pregnant person – doctors do not know what that means or how close the patient has to be to death before the doctors can intervene. Because doctors do not know at what point the exceptions would apply, they do not or cannot treat patients as quickly or according to the standard of

care. ObGyn's often do not know how sick someone has to get before we are allowed to intervene, and, if the fetus has a so-called "heartbeat" detectable on an ultrasound, doctors are often unsure if treating the patient could mean losing their license, or even imprisonment.

V. Abortion Bans Impact Patients and Providers in Surrounding States

An abortion ban will not stop pregnant Iowans from seeking or obtaining abortion care—most are persistent, and many will travel to clinics and hospitals out of state. As the providers explain, they have experienced a significant increase in patient volume due to abortion bans that are in effect in multiple states across the U.S.

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Jonah Fleisher, M.D.

In Illinois, we have faced a tremendous influx of patients who are in dire need of abortion care because of bans in surrounding states. When the *Dobbs* decision issued, the volume of patients seeking abortion care in Illinois—and the complexity of their cases—increased dramatically, with some private clinics experiencing double the volume overnight. In my practice, the proportion of patients that I see travelling from out of state has dramatically increased, as have the complexity of cases.

Katie McHugh, M.D.

The minute that the *Dobbs* decision went into effect, our phones began ringing non-stop. Patients who were sitting in the waiting rooms of clinics in states with trigger bans, such as Kentucky, Tennessee, and Louisiana were calling our clinic to schedule appointments for abortion care. Overnight, our scheduled caseload went from 20 patients per day, two days per week to 50 patients per day five days per week. It felt like a

wake—and we were all working through the death of something incredibly important.

A. Abortion Bans Drain Resources and Availability of Appointments

The influx of patients travelling because of abortion bans puts significant strain on the clinics and institutions that provide abortion care in surrounding states. This includes hospital and out-patient centers that provide medical procedures other than abortions. As Dr. Fleisher explains, providing abortion care and coordinating the logistics required for patients travelling from out of state is a resource intensive process, and "it really 'takes a village' to provide excellent abortion care."

Many of the institutions and clinics in states surrounding those with abortion bans are operating with the same resources and staffing as they were pre-*Dobbs*. As a result, they are not able to provide the same timely care to their patients post-*Dobbs*. These are the down-stream consequences of abortion bans for the entire healthcare system that Iowa is not anticipating or accommodating in its efforts to ban abortion.

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Katie McHugh, M.D.

The demand for abortion care is still physically difficult to accommodate. We are treating the influx of patients and handling the extra paperwork with the same staffing and financial resources that we had pre-*Dobbs*. I have three to five minutes to spend with each patient. If there are any issues, or I

am held up with the patient for any reason, there are thirty-five other patients whose care is delayed. Consequently, I have time only to perform the clinical procedure without providing the same level of emotional support I would prefer.

Maritza Gonzalez, M.D.

Here in Illinois, because of the influx of patients travelling from out of states, the medical, financial, and personnel resources are depleting rapidly. As a result, there is less access to healthcare available to local patients - including those who require non-abortion procedures. Where I work, most abortion procedures are scheduled for the outpatient center, where many other non-abortion procedures also take place. Because these resources are shared, we are unable to immediately accommodate patients travelling from out of state because we cannot monopolize the operating rooms or procedure rooms, resources, and personnel from other non-pregnant patients. This causes the extended wait time to schedule and receive care for all patients.

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VI. Legislation Cannot Change the Medical Reality of Abortion

In the almost nine months since *Dobbs*, real people have faced significant consequences, burdens, and medical risks to exercise what should still be their own autonomous choice over their own bodies and lives. The full spectrum of ramifications of abortion ban legislation has yet to be realized. But unanimously, the *amici* agree that, in their professional medical experience, abortion is both figuratively and literally lifesaving, and the earlier in pregnancy that abortion is banned, the more harm it will cause people who can get pregnant. This Court should avoid imposing ill-conceived

and ill-informed restrictions on abortion, and let the individual pregnant person consult with their doctor and decide for themselves how to handle a pregnancy. As Dr. Thibodeau states:

> "There will never not be a need for abortion care. People can have planned, desired pregnancies and will need abortion care. There is not a world that exists where we will not need to provide safe abortion care to people who can become pregnant.[11] And that care is not relegated to a certain gestational age. There is nothing that any political or judicial decision can do to change that medical truth."

CONCLUSION

The six-week abortion ban before this Court creates a real and undue burden on people in Iowa. The Court should affirm the district court's decision not to disturb the permanent injunction and prevent Iowa's abortion ban from taking effect.

[11] The providers also explain that abortion bans compromise the quality of medical training for new generations of doctors and OB-GYNs, and the care they will be able to provide their communities, because they are not getting the necessary abortion training, counselling experience or necessary technical expertise that they *will need* to properly treat pregnant patients.

Dated: March 20, 2023

Respectfully Submitted,

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***Pro hac vice* pending**

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COST CERTIFICATE

Amici Curiae certify that they expended no funds for the printing of their response brief in this Court.

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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the typeface requirements and type-volume limitations of Iowa Rules of Appellate Procedure 6.903(1)(e), 6.903(1)(g)(1) or (2), and 6.096(4) because it has been prepared in a proportionally spaced typeface using Times New Roman in 14-point font and contains 6,991 words, excluding those portions of the brief exempted by Iowa Rule of Appellate Procedure 6.903(1)(g)(1).

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CERTIFICATE OF FILING AND SERVICE

I certify that on March 20, 2023, this brief was electronically filed with the Clerk of Court and served on all counsel of record to this appeal using EDMS.

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