IN THE SUPREME COURT

STATE OF ARIZONA

PLANNED PARENTHOOD ARIZONA, INC., SUCCESSOR-IN-INTEREST TO PLANNED PARENTHOOD CENTER OF TUCSON, INC.; LAURA CONOVER, PIMA COUNTY ATTORNEY,

Appellants,

v.

KRISTIN MAYES, ATTORNEY GENERAL OF THE STATE OF ARIZONA,

Appellee,

and

ERIC HAZELRIGG, M.D., AS GUARDIAN AD LITEM OF UNBORN CHILD OF PLAINTIFF JANE ROE AND ALL OTHER UNBORN INFANTS SIMILARLY SITUATED,

Intervenor.

Supreme Court No. CV-23-0005-PR

Court of Appeals No.
2 CA-CV 2022-0116

Pima County Superior Court
Case No. C127867

FILED WITH WRITTEN CONSENT OF ALL PARTIES

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

Christopher D. Thomas (Bar No. 010482)
Karin Scherner Aldama (Bar No. 023816)
Kristine J. Beaudoin (Bar No. 034853)
PERKINS COIE LLP
2901 North Central Avenue, Suite 2000
Phoenix, Arizona 85012-2788
Telephone: +1.602.351.8000
Facsimile: +1.602.648.7000
CThomas@perkinscoie.com
KAldama@perkinscoie.com
KBeaudoin@perkinscoie.com
Docketphx@perkinscoie.com

Nicole A. Saharsky*
MAYER BROWN LLP
1999 K St. NW
Washington, D.C. 20006
Telephone: (202) 263-5282
nsaharsky@mayerbrown.com

**Pro Hac Vice Application Forthcoming*

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

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INTEREST OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit membership organization of more than 60,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all women and 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 Arizona Section has over 1,000 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 American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Further, through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. The AMA's objectives are to promote the art and science of medicine and the betterment of public health. AMA members

practice in all fields of medical specialization and in every state. Its publications and *amicus* briefs have been cited by many courts, including the U.S. Supreme Court, in cases implicating various medical questions.

The Arizona Medical Association (ArMA) is a voluntary membership organization for all Arizona physicians. It represents the interests of nearly 4,000 physicians, physician assistants, resident physicians, and medical students from all specialties and practice settings. ArMA's vision is to make Arizona the best place to practice medicine and receive care. It has become the foremost advocate and resource in the state for economically sustainable medical practices, the freedom to deliver care in the best interests of patients, and health for all Arizonans.[1]

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, including 106 professionals who practice in Arizona, 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

[1] The AMA and ArMA each join this brief on their own behalf and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in courts.

that all medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by multiple courts.

INTRODUCTION AND SUMMARY OF ARGUMENT

Abortion is an essential part of comprehensive health care. When abortion is legal, it is safe. *Amici curiae* are leading medical societies whose policies represent the education, training, and experience of the vast majority of clinicians in this country. *Amici* all agree that laws that criminalize and effectively ban abortion are not based on any medical or scientific rationale. Those laws also threaten the health of pregnant patients; disproportionately harm patients of color, patients in rural settings, and patients with low incomes; impermissibly profoundly interfere with the patient-physician relationship; and undermine longstanding principles of medical ethics. As the AMA has recognized, "healthcare, including reproductive health services, like contraception and abortion, is a human right."[2]

A.R.S. § 13-3603, enacted in 1901, imposes criminal penalties on individuals who provide abortions "unless it is necessary to save" the pregnant patient's life.[3] The law does not include exceptions for threats to the patient's health, rape, incest, or major fetal abnormalities. In 1973, the Court of Appeals enjoined A.R.S. § 13-3603 based on the U.S. Supreme Court's decision in *Roe v. Wade*. *See Nelson v. Planned Parenthood Ctr. of Tucson, Inc.*, 19 Ariz. App. 142, 152 (1973). Since then, the Legislature has enacted many

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[2] AMA, *Preserving Access to Reproductive Health Service* (2022), bit.ly/3JPSd3y.

[3] A.R.S. § 13-3603 initially was enacted as A.R.S. § 13-211 and renumbered in 1977.

laws that regulate abortion as a lawful medical procedure.[4] In 1984, it enacted A.R.S. § 36-2301.01(A), which allows abortion up to the point of fetal viability with limited exceptions to "preserve the life or health of the woman." In 2022, the Legislature enacted a law prohibiting abortion after 15 weeks "[e]xcept in a medical emergency."[5]

On July 13, 2022, the then-Attorney General asked the Superior Court in Pima County to dissolve the 1973 injunction against enforcement of A.R.S. § 13-3603. He asserted that A.R.S. § 13-3603 prohibits physicians from providing abortion care, despite the later-enacted statutes that authorize physician-provided abortions. The Superior Court dissolved the injunction and declined to address the interaction between A.R.S. § 13-3603 and statutes enacted since the 1973 injunction. *See Planned Parenthood Ctr. of Tucson, Inc. v. Brnovich*, 2022 WL 4487408, at *1 (Ariz. Super. Ct. Sep. 23, 2022). The Court of Appeals reversed in part, holding that the later-enacted statutes authorize physician-provided abortions and that A.R.S. § 13-3603 cannot apply to licensed physicians. *Planned Parenthood Ariz., Inc. v. Brnovich*, 254 Ariz. 401 (Ct. App. 2022).

Amici urge this Court to affirm the Court of Appeals' decision. Applying A.R.S. § 13-3603 to physician-provided abortions will jeopardize the health and safety of pregnant people in Arizona and place extreme burdens and risks on providers of essential reproductive health care, without a valid medical justification.

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[4] *See, e.g.*, A.R.S. § 36-449.01 *et seq.* (1999) (amended 2021); A.R.S. § 36-2153 *et seq.* (2009) (amended 2021); A.R.S. § 36-2161 (2010) (amended 2021).

[5] S.B. 1164, 55th Leg., 2d Reg. Session (Ariz. 2022).

ARGUMENT

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

The medical community recognizes that abortion is a safe, common, and essential component of reproductive health care.[6] In 2020, over 930,000 abortions were performed nationwide, and over 13,000 abortions were performed in Arizona.[7] Approximately one-quarter of American women have an abortion before age 45.[8]

There have been significant advancements in medicine since A.R.S. § 13-3603 was enacted 122 years ago. The overwhelming weight of medical evidence conclusively demonstrates that abortion is very safe.[9] Complication rates are extremely low, averaging around 2%, and most complications are minor and easily treatable.[10] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50%.[11] The

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[6] *See, e.g.*, Eds. of the *New Eng. J. of Med.*, ACOG, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979, 979 (2019); ACOG, *Abortion Policy* (revised and approved May 2022); SMFM, *Access to Abortion Services* (2020).

[7] 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); Ariz. Dep't of Health Servs., *Abortions in Arizona: 2020 Abortion Report* 1 (Sept. 21, 2021), bit.ly/3BYDKAk (*Abortions in Arizona*).

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

[9] *See, e.g.*, Nat'l Acads. of Scis., Eng'g, Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018) (*Safety and Quality of Abortion Care*)

[10] *See, e.g.*, Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (*Incidence of Visits*); *Safety and Quality of Abortion Care* 55, 60.

[11] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015). This is also true for medication abortions, which account for more than 50% of all abortions in Arizona and about half

risk of death is even rarer: Nationally, fewer than one in 100,000 patients die from an abortion-related complication.[12] By contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[13] Abortion is so safe that there is a greater risk of complications or mortality for wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[14] And the rate of abortion-related complications remains low later in pregnancy.[15]

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of abortions nationwide. Elizabeth G. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013); *Abortions in Arizona*, *supra* note 7, at 12; Rachel K. Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Mar. 2, 2022).

[12] *See* Katherine Kortsmit et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Abortion Surveillance – United States, 2019*, 70 Morbidity & Mortality Weekly Rep. No. 9, 29 tbl.15 (Nov. 26, 2021) (Kortsmit); Suzanne Zane et al., *Abortion-Related Mortality in the United States*, *1998-2010*, 126 Obstetrics & Gynecology 258, 261 (2015).

[13] 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) (Raymond & Grimes).

[14] Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (2014) (2.1% of abortions result in complications compared to 7% of wisdom-tooth extractions, 8-9% of tonsillectomies, and 29% of childbirths); Am. Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011) (33% of colonoscopies result in minor complications); Frederick M. Grazer & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000) (mortality rate from liposuction in late 1990s was 20 per 100,000); Kortsmit, *supra* note 12, at 29 tbl.15 (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in the years 2013-2018).

[15] ACOG, Practice Bulletin No. 135, *Second Trimester Abortion*, 121 Obstetrics & Gynecology 1394, 1394 (2013, reaff'd 2021).

Abortion poses no significant risks to mental health or psychological well-being. People who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to those who were forced to continue a pregnancy.[16] One study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[17]

II. Statutes That Ban Abortion Harm Pregnant Patients' Health

Statutes that effectively ban abortion cause severe physical and psychological health consequences for pregnant patients who want to obtain an abortion. The limited exception in A.R.S. § 13-3603 – allowing an abortion solely when "necessary to save" the patient's life – is insufficient to protect the health of pregnant patients.

A. Statutes That Ban Abortion Endanger the Physical and Psychological Health of Pregnant Patients

Criminalizing safe abortions provided by licensed clinicians will result in delays in obtaining abortions, increased use of unsafe self-managed abortion methods, and an increased likelihood that patients will be forced to continue pregnancies to term. All of these consequences entail significant health risks.

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[16] M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169, 177 (2017) (Biggs).

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

Typically, many delays in seeking an abortion are caused by the patient's lack of information about where to find abortion care.[18] The need to travel out of state and consider various other states' criminal and civil penalties likely will further increase confusion about where to find needed health care. In addition, almost one-third of delays are caused by travel and procedure costs.[19]

With A.R.S. § 13-3603 in effect, the travel and procedure costs for Arizonans seeking abortions will increase significantly. A 2021 analysis found that closing Arizona's abortion clinics would result in a 2,175% increase in the average required travel distance for Arizonans seeking abortions.[20] A.R.S. § 13-3603 does not mandate closure of abortion clinics on its face, but the near-total abortion ban will render Arizona abortion clinics unavailable to almost all individuals seeking abortions. Although the risk of complications from abortions overall remains exceedingly low – especially when compared with the health risks of carrying a pregnancy to term – increasing gestational age increases the chance of a major complication.[21] Abortions at later gestational ages also are typically more expensive, further increasing the barriers to obtaining care.[22]

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

[19] *Id.*

[20] Guttmacher Inst., *If* Roe v. Wade *Falls: Travel Distance for People Seeking Abortion* (June 23, 2022), bit.ly/3bQHqJO.

[21] *Incidence of Visits*, *supra* note 10, at 181.

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

By removing access to safe, legal abortion, A.R.S. § 13-3603 also will increase the possibility that a pregnant patient will attempt a self-managed abortion through a harmful or unsafe method.[23] Studies have found that people are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-management may rely on harmful tactics such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or dangerously misusing hormonal pills, rather than use of clinician-prescribed abortion medication, which is a safe way to self-manage abortion.[24]

Patients who do not, or cannot, obtain an abortion because of A.R.S. § 13-3603 will be forced to continue a pregnancy to term – an outcome with significant risk to the health of the pregnant individual. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[25] and rates have sharply increased since then.[26] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures, meaning that a pregnant

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[23] *See, e.g.*, Rachel K. Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, 3, 8 (2019).

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

[25] Raymond & Grimes, *supra* note 13, at 216.

[26] Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016).

patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[27]

Continued pregnancy and childbirth also entail other substantial health risks. Even an uncomplicated pregnancy causes significant stress on the body. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or lead to new health issues. Sickle cell disease can worsen during pregnancy, leading to severe anemia and vaso-occlusive crisis, which results in significant pain.[28] Pregnant patients with inherited thrombophilia, which can be undetected until a triggering event such as pregnancy, have a high risk of developing life threatening blood-clots.[29] Pregnancy can exacerbate asthma, making it life-threatening.[30] Approximately 6-7% of pregnancies are complicated by gestational diabetes mellitus, which frequently leads to maternal and fetal complications, including developing diabetes later in life.[31] And preeclampsia, a relatively common complication, occurs most often after 20 weeks of gestation and can result in fluctuating blood pressure, heart disease, liver issues, and seizures.[32]

Labor and delivery likewise carry significant risks. Those risks include hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs

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[27] Raymond & Grimes, *supra* note 13, at 216.

[28] ACOG, Prac. Bull. 78, *Hemoglobinopathies in Pregnancy* (2007, reaff'd 2021).

[29] ACOG, Prac. Bull. 97, *Inherited Thrombophilias in Pregnancy* (2018, reaff'd 2022) (*Inherited Thrombophilias*).

[30] ACOG, Prac. Bull. 90, *Asthma in Pregnancy* (2008, reaff'd 2020).

[31] ACOG, Prac. Bull. 190, *Gestational Diabetes Mellitus* (2018, reaff'd 2019).

[32] ACOG, Prac. Bull. 222, *Gestational Hypertension and Preeclampsia* (2020) (*Preeclampsia).*

when the placenta is unable to detach at childbirth), hysterectomy, cervical laceration, and debilitating postpartum pain.[33] Approximately one in three people who give birth in the United States do so by cesarean delivery, a major surgical procedure that carries increased risk of complications.[34]

Evidence also suggests that pregnant people denied abortions are more likely to experience negative psychological health outcomes – such as anxiety, lower self-esteem, and lower life satisfaction – than those who obtained a needed abortion.[35]

In contrast to the established and known harms that will happen to pregnant patients who are denied abortions, there is a medical consensus that fetal pain perception is not possible before at least 24 weeks' gestation.[36] Pain perception requires an intact neural pathway from the periphery of the body (the skin), through the spinal cord, into the thalamus (the part of the brain that relays sensory signals), and on to the

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[33] ACOG, Prac. Bull. 183, *Postpartum Hemorrhage* (2017, reaff'd 2019); ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum* 1-2 (2012, reaff'd 2021) (*Placenta Accreta Spectrum*); ACOG, Prac. Bull. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (2018, reaff'd 2022); ACOG, Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* 507 (2021).

[34] Ctrs. for Disease Control & Prevention, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* (2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* 1-3 (2014, reaff'd 2019).

[35] Biggs, *supra* note 16, at 172.

[36] *See* SMFM, *Consult Series #59: The Use of Analgesia and Anesthesia for Maternal-Fetal Procedures* B7 (Dec. 2021); Royal Coll. of Obstetricians & Gynecologists, *Fetal Awareness: Review of Research and Recommendations for Practice* 23 (Mar. 2010); A. Vania Apkarian et al., *Human Brain Mechanisms of Pain Perception and Regulation in Health and Disease*, 9 Eur. J. Pain 463, 463-84 (2005) (Apkarian); Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947, 952 (2005).

cerebral cortex.[37] Those neural connections do not develop until after at least 24 weeks' gestation, and the cerebral cortex does not fully mature until after birth.[38] Additionally, the literature shows that a fetus likely cannot experience pain at any gestational age, because it is kept in a sleep-like state by environmental factors in the uterus, including certain hormones and low oxygen levels.[39]

B. The Ban's Limited Exception Will Not Adequately Protect Patients' Health

The exception in A.R.S. § 13-3603 is insufficient to protect the health of the pregnant patient. The exception allows for abortion if "necessary to save [the patient's] life," but does not define "necessary." The law does not include exceptions for threats to the patient's health, or for rape, incest, or major fetal abnormalities.

Medical advancements since the enactment of A.R.S. § 13-3603 show that pregnancy can exacerbate existing health issues that do not necessarily or immediately lead to death, but nevertheless pose serious health risks. Examples include Alport Syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve), lupus (a connective tissue disease that may suddenly worsen

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[37] *See, e.g.*, Apkarian, *supra* note 36, at 463-84; Irene Tracey & Patrick W. Mantyh, *The Cerebral Signature for Pain Perception and Its Modulation*, 55 Neuron 377, 378-80 (2007).

[38] Ivica Kostović & Jovanov Milošević, *The Development of Cerebral Connections During The First 20-45 Weeks' Gestation*, 11 Seminars in Fetal & Neonatal Med. 415, 416-21 (2006).

[39] *See* H. Rigatto et al., *Fetal Breathing and Behavior Measured Through a Double-Wall Plexiglass Window in Sheep*, 61 J. Applied Physiol. 160 (1986); Stuart W.G. Derbyshire, *Can Fetuses Feel Pain?*, 332 Brit. Med. J. 909 (2006); David J. Mellor et al., *The Importance of 'Awareness' for Understanding Fetal Pain*, 49 Brain Rsch. Revs. 455 (2005).

during pregnancy and lead to blood clots and other serious complications), and pulmonary hypertension (increased pressure within the lung's circulation system).[40] Maternal mental health issues also can put a pregnant patient's health and life at risk.[41] Additionally, sometimes patients seek abortion care because of significant medical issues that the patients experienced during prior pregnancies. If abortion care is unavailable, those prior conditions could progress or reoccur, endangering the health of the pregnant patient and directly affecting fetal development and survival. Examples include preeclampsia, placental abruption (separation of the placenta from the uterine wall), placenta accreta, peripartum cardiomyopathy (enlargement of the heart in or after pregnancy), and thrombophilia.[42]

The narrow exception in A.R.S. § 13-3603 allows abortion care solely when "necessary" to protect the patient's health. Coupled as it is with the threat of criminal sanctions, A.R.S. § 13-3603 will necessarily chill the provision of critical medical care

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[40] *See* Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (2007); Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (2007); J. Cortés-Hernández et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-47 (2002); David G. Kiely et al., *Pregnancy and Pulmonary Hypertension: A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013).

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

[42] *Preeclampsia*, *supra* note 32; ACOG, Obstetric Care Consensus No. 10, *Management of Stillbirth* 7, 11 (2009, reaff'd 2021); *Placenta Accreta Spectrum*, *supra* note 33, at 2; ACOG, Prac. Bull. 212, *Pregnancy and Heart Disease* (2019, reaff'd 2021); *Inherited Thrombophilias*, *supra* note 29.

because doctors will be unsure when they will be able to provide needed abortions for their patients. It is untenable to force pregnant patients to wait until their medical condition escalates to the point that an abortion is necessary to prevent death. Further confusion will arise when doctors are managing early pregnancy loss. For example, incomplete miscarriages are commonly treated via uterine aspiration, which is the same procedure as that used for most procedural abortions.[43] But A.R.S. § 13-3603 does not clearly state that miscarriage management is permissible.

Physicians should not be put in the impossible position of either letting a patient deteriorate until death is possible or facing potential criminal punishment for providing needed care consistent with their medical judgment but still potentially in contravention of A.R.S. § 13-3603. Indeed, that impossible choice could cause some physicians to second guess the necessity of critical abortion care until it is too late to save the pregnant patient's life. The many examples just provided of the potential health problems faced by pregnant patients demonstrate why decisions about whether to continue a pregnancy are properly left to the clinicians and patients involved, rather than entrusted to legislators. Legislators are not and should not be in the exam room and do not have the training or experience to exercise medical judgment to evaluate complex or developing

[43] Rebecca H. Allen et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625, 632 (2013); Amanda Dennis et al., *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141, 141, 143 (2015).

situations and recommend a course of treatment. The limited exception in A.R.S. § 13-3603 therefore indefensibly jeopardizes patients' health.

III. Statutes That Ban Abortion Hurt Rural, Minority, and Poor Patients the Most

A.R.S. § 13-3603 will disproportionately impact people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to policies that increase the inequities that already plague the health care system in this country.

In Arizona, 41% of the patients who obtained abortions in 2020 were Hispanic; 12% were Black; and 3% were American Indian or Alaska Native.[44] According to 2019 data, 18% of Hispanic Arizonans live in poverty; 18% of Black Arizonans live in poverty; and 29% of American Indian or Alaska Native Arizonans live in poverty.[45] In addition, 75% of abortion patients nationwide live at or below 200% of the federal poverty level.[46] Patients with limited means or living in geographically remote areas will be disproportionately affected by the lack of clinics, as they must travel longer distances (and pay higher associated costs) to obtain safe legal abortions, including out of state.[47] These costs will be compounded by other Arizona laws that create substantial financial barriers to abortion care, such as lack of coverage under insurance policies for public

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[44] *See Abortions in Arizona*, *supra* note 7, at 8.

[45] Kaiser Fam. Found., *Poverty Rate by Race/Ethnicity (2019)*, bit.ly/3QbzDoA.

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

[47] Amelia Thomson-DeVeauz, *The Dobbs Divide*, FiveThirtyEight (Jun. 15, 2023), bit.ly/3rGyHl4.

employees and health plans offered in the state's health exchange, except when the patient's life is endangered or health is severely compromised.[48]

The inequities continue after an abortion is denied. Forcing patients to continue pregnancies increases their risk of complications, and the risk of death associated with childbirth is about 14 times higher than that associated with abortion.[49] Nationwide, Black patients' pregnancy-related mortality rate is at least 3.2 times higher than that of white patients, while American Indian/Alaska Native patients' pregnancy-related mortality rate is 2.3 times higher than that of white patients, with significant disparities persisting even in areas with low overall mortality rates and among patients with higher levels of education.[50] A.R.S. § 13-3603 thus exacerbates health care inequities disproportionately harming the most vulnerable Arizonans.

IV. Statutes That Ban Abortion Force Clinicians to Make an Impossible Choice Between Upholding Their Ethical Obligations and Following the Law

Statutes that ban abortions violate long-established and widely accepted principles of medical ethics by (1) substituting legislators' opinions for a physician's individualized patient-centered counseling and creating an inherent conflict of interest between

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[48] Guttmacher Inst., *State Facts About Abortion: Arizona* (2022), bit.ly/3deLsfj.

[49] Raymond & Grimes, *supra* note 13, at 216.

[50] Emily E. Petersen et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016*, 68 Morbidity & Mortality Weekly Report 762, 763 (Sept. 6, 2019); *see* Marian F. MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 Am. J. Pub. Health 1673, 1676-77 (2021).

patients and medical professionals; (2) asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. Statutes That Ban Abortion Undermine the Patient-Physician Relationship

The patient-physician relationship is critical for the provision of safe and quality medical care.[51] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests with the best available scientific evidence. ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments," and that physicians should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[52] The AMA Code of Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[53]

A.R.S. § 13-3603 forces physicians to supplant their own medical judgments – and their patients' judgments – regarding what is in the patients' best interests with the Legislature's non-expert determination regarding whether and when physicians may provide abortions. Abortions are safe, routine, and, for many patients, the best medical

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[51] ACOG, Statement of Pol'y, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013, reaff'd and am. 2021) (Legis. Pol'y Statement).

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

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

choice available. There is thus 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 ban abortion in a wide variety of circumstances – such as A.R.S. § 13-3603 – are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

Those laws also create inherent conflicts of interest. Physicians must be able to offer appropriate treatment options without regard for their own self-interest.[54] A.R.S. § 13-3603 profoundly intrudes upon the patient-physician relationship by prohibiting physicians from performing abortions in many circumstances. Even if a patient's health were compromised, the law would allow an abortion only in life-threatening circumstances, regardless of the overall medical advisability of the procedure or the patient's desires. A physician and patient together may conclude that an abortion is in the patient's best medical interests even though the risk posed by continuing the pregnancy does not yet rise to the standard in the law's exception. Arizona's ban forces physicians to choose between the ethical practice of medicine and obeying the law.

The risks posed by A.R.S. § 13-3603 and similar laws are causing recent medical-school graduates to avoid the specialties most likely to be affected and causing existing specialists to leave. Since 2022, the number of residency applicants for internal medicine, emergency medicine, family medicine, and obstetrics and gynecology have

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[54] *See* Legis. Pol'y Statement, *supra* note 51.

dropped, with the highest decreases in states with complete abortion bans.[55] And many obstetricians and gynecologists practicing in states with new restrictive abortion policies are leaving those states entirely.[56] A.R.S. § 13-3603 thus threatens Arizonans' access to vital medical care unrelated to abortions.

B. Statutes That Ban 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 and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions.[57] Both principles arise from the foundation of medical ethics that requires the welfare of the patient to form the basis of medical decision-making. Physicians 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 lived experiences.[58]

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[55] Kendal Orgera, Hasan Mahmood & Atul Grover, *Training Location Preferences of U.S. Medical School Graduates Post* Dobbs v. Jackson, Women's Health (Apr. 13, 2023), bit.ly/48w7ZMP; Erika Edwards, *Abortion Bans Could Drive Away Young Doctors, New Survey Finds*, NBC News (May 18, 2023), bit.ly/469tSA0.

[56] Nadine El-Bawab, *Doctors Face Tough Decision to Leave States with Abortion Bans*, ABC News (June 23, 2023), bit.ly/3LGXSuB.

[57] AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Comm. Op. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481-82 (2007, reaff'd 2016).

[58] ACOG, *Ethics Code*, *supra* note 52, at 1-2.

A.R.S. § 13-3603 pits physicians' interests against those of their patients. If a clinician concludes that an abortion is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. If a patient decides that an abortion is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But A.R.S. § 13-3603 prohibits physicians from providing that treatment and exposes them to criminal penalties if they do. It places them at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

C. Statutes That Ban 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.[59] Patient autonomy revolves around self-determination, which is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[60] A.R.S. § 13-3603 denies patients the right to make their own choices about health care if they decide to seek an abortion.

CONCLUSION

The Court should affirm the Court of Appeals' decision.

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[59] *Id.* at 1.

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

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PERKINS COIE LLP

By: *s/ Kristine J. Beaudoin*

Christopher D. Thomas
Karin Scherner Aldama
Kristine J. Beaudoin
Austin C. Yost
2901 North Central Avenue, Suite 2000
Phoenix, Arizona 85012-2788

Nicole A. Saharsky*
Mayer Brown LLP
1999 K St. NW
Washington, D.C. 20006

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

** Pro Hac Vice Application Forthcoming*