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IN THE SUPREME COURT OF IOWA

Supreme Court No. 21-0856

PLANNED PARENTHOOD OF THE HEARTLAND
and JILL MEADOWS, M.D.,
Appellees,
vs.

KIMBERLY K. REYNOLDS, ex rel. STATE OF IOWA
and IOWA BOARD OF MEDICINE,
Appellants.

On appeal from the Iowa District Court for Johnson County
Mitchell E. Turner, District Judge

BRIEF OF AMICI CURIAE THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN COLLEGE OF PHYSICIANS, THE AMERICAN GYNECOLOGICAL & OBSTETRICAL SOCIETY, THE AMERICAN MEDICAL ASSOCIATION, THE IOWA MEDICAL SOCIETY, THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, THE AMERICAN PSYCHIATRIC ASSOCIATION, THE COUNCIL OF UNIVERSITY CHAIRS OF OBSTETRICS AND GYNECOLOGY, IOWA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS, THE NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY, THE NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN WOMEN'S HEALTH, THE SOCIETY OF FAMILY PLANNING, THE SOCIETY OF GYNECOLOGIC ONCOLOGY, THE SOCIETY FOR MATERNAL-FETAL MEDICINE, AND THE SOCIETY OF OB/GYN HOSPITALISTS IN SUPPORT OF APPELLEES*

*conditionally filed in final form

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IDENTITY AND INTERESTS OF AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG") is the nation's leading group of physicians providing health care for women. With more than 62,000 members, including 370 obstetrician-gynecologists in Iowa, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care.

ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care. ACOG has appeared as amicus curiae in courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including this Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.[1]

ACP is the largest medical specialty organization in the U.S. Its membership includes 161,000 internal medicine physicians, related subspecialists, and medical students.

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[1] *See, e.g.*, *Planned Parenthood of the Heartland v. Reynolds*, 915 N.W.2d 206, 231 (Iowa 2018); *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Medicine*, 865 N.W.2d 252, 254 (Iowa 2015).

AGOS is an organization composed of individuals attaining national prominence in scholarship in the discipline of Obstetrics, Gynecology, and Women's Health. For over a century it has championed the highest quality of care for women and the science needed to improve women's health.

AMA is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all United States physicians, residents and medical students are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in every medical specialty area and in every state, including Iowa.

IMS is the statewide professional association for Iowa physicians, residents and medical students. IMS helps professionals develop their skills and further their careers by providing access to unique and relevant content and exclusive member services. IMS also works to protect the health of Iowans through a variety of projects and activities at the state and national levels. Today, IMS exists to assure the highest quality healthcare in Iowa through its role as physician and patient advocate.

The AMA and IMS 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, plus the District of Columbia, whose purpose is to represent the viewpoint of organized medicine in the courts.

AMWA is the oldest multispecialty organization dedicated to advancing women in medicine, advocating for equity, and ensuring excellence in healthcare.

APA is a non-profit organization representing over 38,800 physicians who specialize in the practice of psychiatry. APA members engage in research into and education about diagnosis and treatment of mental health and substance use disorders, and are front-line physicians treating patients who experience mental health and/or substance use disorders.

CUCOG is an association promoting excellence in medical education in the fields of obstetrics and gynecology. Its members represent the departments of obstetrics and gynecology of schools of medicine across the country.

The IA AAP's mission is to support the optimal health of children by addressing the needs of children, their families, their communities, and their health care providers.

NASPAG is composed of gynecologists, adolescent medicine specialists, pediatric endocrinologists, and other medical specialists dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth.

NPWH is the nonprofit organization that represents Women's Health Nurse Practitioners and other advanced practice registered nurses who provide women's and gender-related healthcare.

SFP is the source for science on abortion and contraception. SFP represents approximately 1000 scholars and academic clinicians united by a shared interest in advancing the science and clinical care of family planning. The pillars of our strategic plan are: 1) building and supporting a multidisciplinary community of scholars and partners who have a shared focused on the science and clinical care of family planning, 2) supporting the production of research primed for impact, 3) advancing the delivery of clinical care based on the best available evidence, and 4) driving the uptake of family planning evidence into policy and practice.

SGO is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers.

SMFM, founded in 1977, is the medical professional society for obstetricians who have additional training in high-risk, complicated pregnancies. SMFM represents more than 5,000 members who care for high-risk pregnant people and provides education, promotes research, and engages in advocacy to reduce disparities and optimize the health of high-risk pregnant people. SMFM and its members are dedicated to ensuring that medically appropriate treatment options are available for all high-risk people.

SOGH is a rapidly growing group of physicians, midwives, nurses and other individuals in the healthcare field who support the OB/GYN Hospitalist model. SOGH is dedicated to improving outcomes for hospitalist women and supporting those who share this mission. SOGH's vision is to shape the future of OB/GYN by establishing the hospitalist model as the care standard and the Society values excellence, collaboration, leadership, quality and community.

INTRODUCTION

In 2018, this Court recognized the fundamental right of patients in Iowa to seek abortion care without medically unnecessary interference by the State.[2] The Court understood that

> Autonomy and dominion over one's body go to the very heart of what it means to be free. At stake in this case is the right to shape, for oneself, without unwarranted governmental intrusion, one's own identity, destiny, and place in the world. Nothing could be more fundamental to the notion of liberty.[3]

The Court recognized "that implicit in the concept of ordered liberty is the ability to decide whether to continue or terminate a pregnancy."[4] Applying strict scrutiny to protect a fundamental right, the Court found that a 72-hour mandatory waiting period was unconstitutional.

The State now attempts to circumvent this Court's settled jurisprudence. While Amendment H-8314 to House File 594, 88th Gen. Assemb. (Iowa 2020), to be codified at Iowa Code § 146A.1(1) (2020), (the "Amendment") replaces the 72-hour mandatory waiting period with a 24-hour mandatory waiting period, the change does not make a difference: the 24-hour Amendment remains an unwarranted governmental intrusion that lacks sound

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[2] 915 N.W.2d at 246.
[3] *Id.* at 237.
[4] *Id.*

medical or scientific basis. As the State concedes, the Amendment is nothing more than a blatant attempt to re-litigate issues already settled by this Court.

The Amendment imposes medically unnecessary burdens on all people seeking abortions in Iowa and makes access to safe abortion care impossible for some. The Amendment impacts patients' ability to access abortion care safely at early stages of pregnancy. The Amendment will require patients to spend additional time—including time away from work and/or their families—and to shoulder the increased financial burdens, to take a second, medically unnecessary, trip to obtain the care they need.

Additionally, the Amendment intrudes into the patient-physician relationship by limiting physicians' ability to provide the health care that patients, in consultation with their physician, decide is best for their health. Medical treatment plans should be free from government intrusion where such intrusion is not scientifically grounded, particularly where it also violates medical ethics. The Amendment undermines patients' autonomy to determine the best course of treatment for their health, based on the patients' particular circumstances and consultations with their physicians. These types of intrusive measures rely on the outdated notion—disproven by scientific studies—that abortion decision-making is somehow exceptional compared to other healthcare decisions and thus requires additional legislative burdens. In

fact, recent scientific evidence has shown an exceptionally high rate of decisional certainty among people who seek abortion care. There is no legitimate reason for the government to second-guess the manner and means by which patients come to their individual, private pregnancy decisions or the manner and means by which physicians counsel their patients about their care options during pregnancy. Legislative restrictions on abortion, such as the Amendment, undermine the patient-physician relationship and interfere with the informed consent process.

For these and the reasons set forth below, amici urge this Court to affirm the district court's ruling.

ARGUMENT

I. THE AMENDMENT DOES NOT SERVE THE HEALTH OF IOWANS.

The Amendment requires that patients seeking an abortion "first receive an ultrasound and certain state-mandated information, and then wait at least 24 hours before returning to the health center to have an abortion."[5] The Amendment requires that patients seeking abortions—many of whom have limited resources—go to an abortion facility, receive a potentially unindicated invasive test, leave, then return at least 24 hours later. Restrictions on abortion such as the Amendment "disrupt the patient-clinician relationship, create substantial obstacles to the provision of safe medical care, and disproportionately affect those with low incomes and those living long distances from clinicians who provide abortion care."[6] Thus, such restrictions should not be imposed where medically unnecessary.[7]

This two-appointment requirement and 24-hour waiting period is—in fact—medically unnecessary.[8] It provides no medical benefit. There is no

[5] Ruling on Mot. for Summ. J. at 1.
[6] ACOG, *Comm. Op. No. 815: Increasing Access to Abortion*, 136 Obstet. Gynecol. e107 (2020), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/12/increasing-access-to-abortion.pdf.
[7] *Id.*
[8] Guttmacher Inst., *Waiting Periods for Abortion* (2020) https://www.guttmacher.org/evidence-you-can-use/waiting-periods-abortion.

need for a patient to wait 24 hours to provide informed consent for an abortion; the patient can provide that consent on the same day as the medical appointment that includes pregnancy option counseling, informed consent, and abortion, as patients do for other medical procedures. There is no purpose to this requirement, other than to make abortions less accessible.[9]

A. The Amendment Imposes Significant Undue Burdens on People Seeking Abortions in Iowa.

The Amendment imposes barriers to patients' abortion access and creates delays in abortion care through its two-visit requirement. Returning to the clinic for a second visit as the Amendment requires may be impracticable and even impossible for some patients. Iowa already has a limited number of reproductive health facilities that provide abortions, and that number is shrinking, due in large part to recent restrictive legislative action in the State. As of 2017, "93% of Iowa counties had no clinics that provided abortions, and 58% of Iowa women lived in those counties."[10] Only

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[9] *Id.*

[10] Guttmacher Inst., *State Facts About Abortion: Iowa Fact Sheet* (2021), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-iowa (3,760 abortions provided in Iowa in 2017).

nine abortion-providing facilities existed in Iowa in 2017, nearly a 33% decline from 2014.[11]

Patients in Iowa also face significant travel barriers when accessing abortion care. As of 2017, about 162,000 women, nearly 28% of women of reproductive age in Iowa, lived in a county at least 50 miles from their nearest in-state clinician who provides abortion, while 260,000 women, approximately 44% of women of reproductive age in Iowa, lived in a county that was 50 miles or further from the nearest clinician who provides procedural abortions in the State.[12] The majority of patients seeking abortions already have children[13] and the additional difficulty and expense of arranging a second round of childcare to return to the facility can be prohibitive.[14] The requirement of an additional, medically unnecessary, visit to a clinician unduly burdens individuals seeking abortion care in Iowa, many of whom

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[11] *Id.*; *see also Planned Parenthood of the Heartland, Inc. v. Reynolds ex rel. State of Iowa*, Eq. Case No. EQCE081503, Ruling on Pet'r's Pet. for Declaratory and Injunctive Relief (Sept. 29, 2017) at 5-6.

[12] *Planned Parenthood of the Heartland, Inc. v. Reynolds ex rel. State of Iowa*, Eq. Case No. EQCE081503, Expert Rep. of Daniel Grossman, M.D., for Pet'rs (May 30, 2017) at 7.

[13] *See* Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, at 11 (2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014 ("*Characteristics of U.S. abortion patients*").

[14] Caitlin Myers, *Cooling off or Burdened? The Effects of Mandatory Waiting Periods on Abortions and Births*, Inst. of Labor Economics Discussion Paper Series No. 14434, at 19 (2021), https://ftp.iza.org/dp14434.pdf.

have to travel more than 50 miles to access care, not only taking unnecessary time, but imposing significant financial costs to cover additional travel, missed work, and childcare.

The Amendment will disproportionally impact people of color, those living in rural areas, and those with limited economic resources. This is because, as a general matter, 75% of those seeking abortion are living at or below 200% of the federal poverty level, and the majority of patients seeking abortions identify as Black, Hispanic, Asian, or Pacific Islander.[15] Those with limited economic resources are also more likely to work in hourly jobs with inflexible leave requirements and lack the job security and childcare coverage to be able to miss shifts or engage in long-distance travel. Accordingly, the Amendment will have the effect of deterring access to abortion care and causing unnecessary harm.

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[15] *Characteristics of U.S. abortion patients* at 5, 7.

B. The Amendment Deprives Patients in Iowa from Access to Medically Sound Procedures Early in a Pregnancy When Abortion is Safest.

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[16] Complication rates are extremely low, averaging around 2%, and most complications are minor and easily treatable.[17] Major complications from abortion are exceptionally rare, occurring in just 0.1 to 0.5% of instances across gestational ages and types of abortion methods.[18] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[19] In contrast, the "risk of death associated with

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[16] *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (2018), http://nap.edu/24950 ("*Safety and Quality of Abortion Care*") ("The clinical evidence clearly shows that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective. Serious complications are rare.").

[17] *See, e.g.*, Ushma Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstet. Gynecol. 175, 181 (2015) (finding 2.1% abortion-related complication rate); *Safety and Quality of Abortion Care* at 55, 60.

[18] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015).

[19] *See* Tara Jatlaoui et al., *Abortion Surveillance — United States, 2015*, 67 Morbidity & Mortality Wkly. Rep. 1, 45 tbl. 23 (2018), https://www.cdc.gov/mmwr/volumes/67/ss/pdfs/ss6713a1-H.pdf (finding mortality rate from 0.00052 to 0.00078% for approximately five-year periods from 1978 to 2014); Suzanne Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 Obstet. Gynecol. 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

childbirth [is] approximately 14 times higher."[20] In fact, abortion is so safe that there is a greater risk of complications or mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[21]

Given the financial and social barriers to abortion access the Amendment introduces, the Amendment will also increase the possibility that women may attempt self-managed abortions through harmful or unsafe methods.[22] Studies have found that women are more likely to unsafely self-manage abortions where they face barriers to reproductive services, and methods of self-management outside safe medical abortion (i.e., abortion by pill) may rely on harmful tactics such as herbal or homeopathic remedies,

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[20] Elizabeth Raymond & David Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. Gynecol. 215, 216 (2012).

[21] ANSIRH, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014); Am. Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011); Frederick Grazer & Rudolph de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000).

[22] *See, e.g.*, Rachel Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States*, 2017, 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills.[23]

The Amendment's medically unnecessary, state-mandated waiting period, which effectively requires two visits to a clinic, is dangerous and serves no legitimate medical purpose.

C. The 2018 Decision Did Not Cause Rising Abortion Rates.

Amici 60 Members of the Iowa Legislature speculate, without evidence, that the Court's 2018 decision in *Planned Parenthood of the Heartland, Inc. v. Reynolds* contributed to Iowa's rising abortion rates.[24] In fact, amici concede that "societal factors are mostly to blame for those increases,"[25] but nonetheless attempt to argue that the increase is an "undesirable result" of the Court's decision.[26] Amici ignore that individuals seek abortion as a result of a complex interplay of socioeconomic factors and that rates of abortions reflect a collection of private decisions made based on

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[23] Daniel Grossman et al., Tex. Pol'y Eval. Proj., *Res. Br.: Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015), https://www.ibisreproductivehealth.org/sites/default/files/files/publications/TxPEP_KnowledgeOpinionExperience%20with%20self%20induction_Research%20Brief_17Nov2015.pdf.
[24] Br. of Amicus Curiae 60 Members of the Iowa Legislature in Support of Appellants at 40.
[25] *Id.*
[26] *Id.* at 38, 41.

individual life and pregnancy circumstances.[27] Amici also ignore other, much more likely, factors that may contribute to the rising abortion rate. Following the legislature's 2017 decision to remove Planned Parenthood from a family planning funding program, rates of sexually transmitted infections[28] and abortions increased.[29] Amici are wrong to draw unsupported conclusions from a Court decision that did not change the status quo.

II. THE AMENDMENT DOES NOT HAVE AN EXCEPTION FOR MEDICAL EMERGENCIES, NOR DOES IT PROTECT PATIENTS AT RISK OF SERIOUS HARM.

The Amendment does not provide an exception for patients who may be at risk of serious harm, such as those experiencing domestic violence or mental health crises. Survivors of intimate partner violence ("IPV") are "likely to have a particularly high risk of experiencing an unintended

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[27] Antonia Biggs et al., *Understanding why women seek abortions in the US*, 13 BMC Women's Health (2013) https://bmcwomenshealth.biomedcentral.com/articles/10.1186/1472-6874-13-29.

[28] Michaela Ramm, *Iowa's family planning service use plummets 85 percent after switch to new program*, THE GAZETTE (Dec. 10, 2019), https://www.thegazette.com/health-care-medicine/iowas-family-planning-service-use-plummets-85-percent-after-switch-to-new-program/.

[29] Associated Press, *Iowa abortion numbers climb after plummeting for decades*, THE GAZETTE (Jul. 13, 2020), https://www.thegazette.com/health-care-medicine/iowa-abortion-numbers-climb-after-plummeting-for-decades/.

pregnancy."[30] In 2007, patients seeking an abortion were nearly four times as likely to be IPV survivors when compared with patients who intended to continue their pregnancies.[31] Several smaller-scale studies suggest much higher prevalence of IPV during pregnancy. A study of over 1,000 prenatal patients at public clinics in the U.S. revealed 15% were abused during pregnancy, as did a study of nearly 1,000 patients seeking care in U.S. family practice clinics.[32] Another study that relied on a more detailed and behaviorally-specific tool found that 81% of prenatal patients at a family practice clinic reported some type of IPV during pregnancy, including both physical abuse and sexual violence.[33]

Studies further show that pregnant and postpartum women aged 10–29 years are at twice the risk of homicide compared with their nonpregnant or

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[30] Kinsey Hasstedt & Andrea Rowan, Guttmacher Inst., *Guttmacher Pol'y Rev. Vol. 19: Understanding Intimate Partner Violence as a Sexual and Reproductive Health and Rights Issue in the United States* 38 (2016), https://www.guttmacher.org/gpr/2016/07/understanding-intimate-partner-violence-sexual-and-reproductive-health-and-rights-issue.

[31] Dominique Bourassa & Jocelyn Bérubé, *The prevalence of intimate partner violence among women and teenagers seeking abortion compared with those continuing pregnancy*, 29 J. Obstet. Gynaecol. Can. 415, 416 (2007).

[32] Beth A. Bailey, *Partner violence during pregnancy: prevalence, effects, screening, and management*, 2 Int'l J. of Women's Health 183, 185 (2010).

[33] *Id.*

nonpostpartum peers.[34] For the period between 2005 and 2010, the pregnancy-associated homicide rate was 2.2 to 6.2 per 100,000 live births, as compared to the 2.5 to 2.6 per 100,000 for nonpregnancy and nonpostpartum individuals.[35] Among 16 states reporting to the National Violent Death Reporting System from 2003 to 2007, the pregnancy-associated homicide rate was 2.9 per 100,000 live births, with 45.3% of those homicides associated with intimate partner violence, a higher mortality rate than for specific direct obstetric causes (hemorrhage, hypertensive disorders, or amniotic fluid embolism).[36]

Domestic violence survivors face compounded hurdles to abortion access. They may need to conceal their clinic visits from a violent partner and may be unable to safely return for a second visit. As written, the Amendment does not enable a physician to take a patient's known risk of physical harm

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[34] Abigail R. Koch et al., *Higher Risk of Homicide Among Pregnant and Postpartum Females Aged 10–29 Years in Illinois, 2002–2011*, 128 Obstet. Gynecol. 440, 440-41 (2016).
[35] Maeve Wallace et al., *Pregnancy-associated homicide and suicide in 37 US states with enhanced pregnancy surveillance*, 215 Am. J. Obstet. Gynecol. 364, 364 (2016).
[36] Jacquelyn Campbell et al., *Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence*, 30 J. Women's Health 236, 237 (2021); Christie Lancaster et al., *Homicide and Suicide During the Perinatal Period: Findings From the National Violent Death Reporting System*, 118 Obstet. Gynecol. 1056, 1059-60 (2011).

into account when designing a patient's treatment plan, preventing the physician from performing an abortion at the time that may be safest for the patient.

Similarly, the Amendment does not provide an exception to allow physicians to immediately treat patients with mental health risks that might put a woman's health and life at risk if she is forced to remain pregnant. Scientific research has shown that pregnancy alone may put patients with a history of mental health issues at greater risk for depression, both during pregnancy and post-partum.[37] At least one study in Colorado found that in the past 10 years, "self-harm" has been the leading cause of pregnancy-related deaths, accounting for 30% of maternal deaths between 2004 and 2012.[38] In fact, recent long-term studies have found that women who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and that receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-

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[37] Office on Women's Health, U.S. Dep't of Health and Human Servs., *Depression during and after pregnancy*, https://www.womenshealth.gov/a-z-topics/depression-during-and-after-pregnancy (last updated June 12, 2017).

[38] Amy Norton, *Self-Harm a Cause of Death During Pregnancy and for New Moms*, HealthDay News (Nov. 8, 2016), https://consumer.healthday.com/pregnancy-information-29/pregnancy-news-543/self-harm-a-cause-of-death-during-pregnancy-and-for-new-moms-716668.html.

traumatic stress, or suicidal ideation compared to women who were forced to carry a pregnancy to term.[39] Forcing a patient to continue an unwanted pregnancy to term may compound these risks.[40] Evidence indicates that being denied a wanted abortion can have a *detrimental* impact on women's mental health.[41] Yet, the Amendment does not provide an exception for patients who will face significant risk as a result of their mental health and psychological well-being if they are forced to remain pregnant against their wishes.

III. THE AMENDMENT UNJUSTIFIABLY INTERFERES WITH THE PATIENT-PHYSICIAN RELATIONSHIP.

Amici are opposed to measures that interfere with the patient-physician relationship, including physicians' ethical obligations to their patients, absent scientific evidence that such measures medically benefit the patient. Iowa's government-imposed waiting period restricts access to abortion and imposes substantial emotional, physical, and financial burdens on patients. As

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[39] 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).

[40] *Id.* at 169.

[41] *Id*. at 172 (finding that a week after seeking an abortion, women denied abortion because of gestational age limits are significantly more likely to report symptoms of anxiety than women who receive an abortion); *id*. (finding that depression and anxiety in women who had abortions declined following the abortion, but that those symptoms remained in women who were denied abortions and subsequently gave birth).

explained below, it also significantly—and unjustifiably—interferes with the patient-physician relationship.

The patient-physician relationship is the central focus of all ethical considerations in the healthcare setting and "the welfare of the patient must form the basis of all medical judgments."[42] The Amendment requires patients and physicians to substitute a legislative requirement for their own personal and professional judgments as to when, and under what circumstances, a patient may seek abortion care. The Amendment also colors the manner and means in which physicians counsel their patients about their options during pregnancy and impermissibly substitutes the state's judgment in place of the physician's clinical judgment. As with other medical decisions, patients, in collaboration with their physicians and support system, are best-suited to decide whether to continue a pregnancy. Physicians, as with other medical decisions, do not need the input of the state in regards to appropriate abortion care options and how best to counsel their patients about those options.

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

A. The Amendment Intrudes on the Patient-Physician Relationship, Which is Paramount to the Delivery of Safe and Quality Medical Care.

Patient autonomy, dignity, and safety is of paramount importance to amici. While some regulation of medical practice is necessary to protect patient safety, legislation that substitutes lay lawmakers' views for a physician's expert medical judgment impermissibly interferes with the patient-physician relationship and poses grave dangers to patient autonomy, dignity, and well-being. ACOG's *Code of Professional Ethics* states that "the welfare of the patient must form the basis of all medical judgments" and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[43] Likewise, 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."[44]

[43] *Id.* at 2.

[44] AMA, Code of Medical Ethics Opinion 1.1.1, https://www.ama-assn.org/delivering-care/ethics/patient-physician-relationships.

The patient-physician relationship is critical for the provision of safe and high-quality medical care.[45] 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, and with the best available scientific evidence.[46] Amici oppose laws that threaten the patient-physician relationship absent a justifiable health reason. "Laws . . . that require physicians to give, or withhold, specific information when counseling patients, or that mandate which tests, procedures, treatment alternatives or medicines physicians can perform, prescribe, or administer are ill-advised."[47] Laws should not interfere with the ability of physicians to offer appropriate treatment options to their patients without regard for their own self-interests.

Under the constraints of the Amendment, both physician and patient have no choice but to agree to the state's treatment plan and timeline, a blatant

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[45] ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended August 2021) ("ACOG Legis. Policy Statement"), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2019/legislative-interference-with-patient-care-medical-decisions-and-the-patient-physician-relationship.

[46] AMA, Code of Medical Ethics Opinion 1.1.1 ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.").

[47] ACOG Legis. Policy Statement.

interference with the patient-physician relationship. As a consequence, clinicians are forced to depart from their best medical judgment and, in many cases, prevent the patient from accessing medically indicated care.

B. The Amendment's Requirement of a 24-Hour Waiting Period for All Patients Is Contrary to Medical Ethics Because It Undermines Patient Autonomy to Provide Informed Consent.

Another 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.[48] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[49] The Amendment undermines this informed consent process and patient autonomy. The Amendment forces all patients to undergo an arbitrary waiting period between appointments, without regard to the patient's wishes, which provides no medical benefit and presumably exists to create the impression that the patient should reconsider the decision to

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[48] ACOG Code of Professional Ethics at 1 ("respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental").

[49] ACOG, *Comm. Op. No. 819: Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstet. Gynecol. e34 (2021), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.pdf; AMA, Code of Medical Ethics Opinion 2.1.1, https://www.ama-assn.org/delivering-care/ethics/informed-consent.

undergo the procedure. It ignores the ethical requirement that informed consent should be "a patient-centered, individualized approach."[50] A patient-centered, individualized approach would be to follow best practices, guidelines, and all available evidence and provide care at the time at which the patient and physician deem safe and appropriate.

Further, the Amendment abrogates a patient's autonomy to make an informed and timely determination regarding whether abortion is the appropriate decision for the patient's health and well-being. Recent scientific evidence refutes many of the arguments previously relied upon to support mandatory waiting periods and other restrictions on the timing of abortions, including the myths that abortion causes long-term emotional or psychological harm and that a significant portion of patients later regret their decisions about having an abortion. Recent long-term studies have found that women who obtain wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and that obtaining an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared

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[50] ACOG, *Comm. Op. No. 819* at 1.

to women who were forced to continue a pregnancy to term.[51] One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[52]

In fact, a 2016 study measuring the decisional certainty of patients who received abortions found that "the level of uncertainty in abortion decision making is comparable to or lower than other health decisions," including, for example, "levels observed in studies of men and women making decisions about reconstructive knee surgery,"[53] a procedure that carries far more risk than an abortion.[54] The study concluded that "[t]he high levels of decisional certainty found in this study challenge the narrative that abortion decision making is exceptional compared to other healthcare decisions and requires additional protection such as laws mandating waiting periods[.]"[55] Requiring a mandatory waiting period for all patients serves only to undermine patient

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[51] 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).
[52] Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLoS ONE 1, 2 (2015), https://doi.org/10.1371/journal.pone.0128832.
[53] Lauren J. Ralph et al., *Measuring decisional certainty among women seeking abortion*, 95 Contraception 269, 269, 276 (2017).
[54] Mathew J. Salzer et al., *Complications after arthroscopic knee surgery*, 42 Am. J. Sports Med. (2014) https://pubmed.ncbi.nlm.nih.gov/24284049/.
[55] Ralph et al. at 269.

autonomy and forces physicians to question, or appear to question, their patients' well-informed decisions.

Physicians are duty bound to provide patient-centered and individualized care to their patients. Informed consent, a process already embedded in abortion care, allows patients to make reasoned, educated decisions about their own health. The Amendment requires every Iowa physician providing abortion care, following an initial patient screening visit, to then instruct the patient to take a completely arbitrary amount of additional time to reconsider the decision. This creates the harmful implication that the physician is not satisfied with the patient's choice, that somehow a patient will wholly reconsider her decision within a span of 24 hours, and/or that the patient's fully informed decision was deficient as a matter of course. If 72 hours is constitutionally impermissible, there is no logical reason why 24 hours should be any different. The Amendment fails to consider—and forces the treating physician not to consider—those circumstances where the informed consent process works as intended and a patient is confident in her decision. In that circumstance, a patient should be free to access and obtain the abortion procedure in a timely manner and free of unnecessary, often devastating, barriers.

IV. CONCLUSION.

For the reasons stated above, amici urge this Court to affirm the judgment of the district court.

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CERTIFICATE OF COMPLIANCE

This brief complies with the typeface requirements of Iowa Rs. App. P. 6.903(1)(d) and 6.903(1)(g)(1) or (2) because this brief has been prepared in a proportionally spaced typeface using Times New Roman, 14 point type and contains 6,533 words, excluding the parts of the brief exempted by Iowa R. App. P. 6.903(1)(g)(1).

Sincerely,

/s/ Paige Fiedler

Paige Fiedler

PROOF OF SERVICE AND CERTIFICATE OF FILING

I hereby certify that on November 1, 2021, I electronically filed the foregoing with the Clerk of the Supreme Court of Iowa using the Iowa Electronic Document Management System, which will send notification to the parties of record.

Sincerely,

/s/ Paige Fiedler

Paige Fiedler