CASE NO. SC22-1050

IN THE SUPREME COURT OF FLORIDA

PLANNED PARENTHOOD OF SOUTHWEST AND CENTRAL FLORIDA, *ET AL.*,
Petitioners,

v.

STATE OF FLORIDA, *ET AL.*,
Respondents.

Discretionary Proceeding to Review Decision of the
First District Court of Appeal

Consolidated With Case No. SC2022-1127
Lower Tribunal Nos. 1D22-2034; 2022-CA-912

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

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INTEREST OF AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG"), American Medical Association ("AMA"), and Society for Maternal-Fetal Medicine ("SMFM") submit this amici curiae brief in support of Petitioners.

Amici are major medical organizations representing physicians and other clinicians who serve patients in Florida and nationwide. ACOG is the nation's leading group of physicians providing health care for women. With more than 60,000 members, 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 been cited frequently as a leading provider of authoritative scientific data regarding childbirth and abortion.[1]

AMA is the largest professional association of physicians, residents, and medical students in the United States. AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in all fields of medical specialization and in

[1] *See, e.g.*, *Stenberg* v. *Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue).

every state, including Florida. Courts have cited the AMA's publications and amicus curiae briefs in cases implicating a variety of medical questions.[2]

SMFM is the medical professional society for maternal-fetal medicine subspecialists, obstetricians who have additional training in high-risk pregnancies. Representing over 5,000 members, SMFM supports the clinical practice of maternal-fetal medicine by providing education, promoting research, and engaging in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing a high-risk pregnancy.

[2] *See, e.g.*, *Birchfield* v. *North Dakota*, 579 U.S. 438 (2016) (citing AMA research on blood-alcohol levels that constitute drunk driving); *Graham* v. *Florida*, 560 U.S. 48 (2010) (citing AMA brief as medical authority on juvenile development); *Ferguson* v. *City of Charleston*, 532 U.S. 67 (2001) (citing AMA brief in assessing patient privacy).

INTRODUCTION AND SUMMARY OF ARGUMENT

Reproductive health care is essential. Access to abortion is an important component of reproductive health care. Amici curiae are leading medical societies representing physicians, nurses, and others who serve patients in Florida and nationwide, and whose policies contribute to the education, training, and experience of clinicians in this country. Amici's position is that laws regulating abortion should be evidence-based, supported by a valid medical or scientific justification, and designed to improve—not harm—patients' health.

Florida's attempt to ban nearly all abortions after fifteen weeks of pregnancy[3] is fundamentally at odds with the provision of safe and essential health care, scientific evidence, and medical ethics. Contrary to the assertions made by the Florida legislature and the State below, there is no medical or scientific justification for House Bill 5 (the "fifteen-week ban" or "Ban"). Instead, the Ban threatens the health of pregnant patients by arbitrarily barring their access to a safe and essential component of health care.

The Ban also impermissibly intrudes into the patient-physician relationship by limiting a physician's ability to provide the health care that the patient, in consultation with her physician, decides is best for her health. Moreover, the Ban undermines longstanding principles of medical ethics and places clinicians in the

[3] As dated from the first day of a patient's last menstrual period.

untenable position of choosing between providing care consistent with their best medical judgment, scientific evidence, and the clinicians' ethical obligations *or* risking criminal sanction and losing their medical licenses.

For these reasons and those discussed below, amici urge this Court to reverse the appellate court's decision and reinstate the temporary injunction against the enforcement of the Ban.

ARGUMENT

I. Abortion Is A Safe, Common, And Essential Component Of Health Care

Abortion is a common medical procedure. In 2020, over 930,000 abortions were performed nationwide,[4] including 77,400 in Florida.[5] Approximately one quarter of American women have an abortion before the age of 45.[6]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[7] Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and

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[4] Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States*, *2020*, 54 Persp. on Sexual & Reprod. Health 128, 132 tbl. 2 (2022).

[5] *Id.*

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

[7] *See, e.g.*, National Academies of Sciences, Engineering, Medicine, *The Safety and Quality of Abortion Care in the United States* 10 (2018) ("*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.").

easily treatable.[8] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[9] The risk of death from an abortion is even rarer: nationally, fewer than one in 100,000 patients die from an abortion-related complication.[10] In contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[11] 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.[12]

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

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

[10] *See* Jatlaoui et al., *Abortion Surveillance—United States, 2015*, 67 Morbidity & Mortality Weekly Rep. 1, 45 tbl. 23 (2018) (finding mortality rate from 0.00052 to 0.00078% for approximately five-year periods from 1978 to 2014); Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 Obstetrics & Gynecology 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

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

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

Nor are there significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies have found that patients 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-traumatic stress, or suicidal ideation compared to patients who were forced to carry a pregnancy to term.[13]

Moreover, access to abortion remains vital for pregnant patients' overall health and well-being. One recent study noted that 95% of participants believed an abortion had been the "right decision for them" three years after the procedure.[14] The medical community recognizes abortion as a safe and essential component of health care.[15]

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[13] 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).

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

[15] *See, e.g.*, Editors of the *New England Journal of Medicine*, the American Board of Obstetrics and Gynecology, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with "several key organizations in obstetrics, gynecology, and maternal-fetal medicine" including the American Board of Obstetrics and Gynecology, that "[a]ccess to legal and safe pregnancy termination … is essential to the public health of women everywhere"); ACOG, *Abortion Policy* (May 2022); Soc'y for Maternal-Fetal Med., *Access to Pregnancy Termination Services* (2017).

II. The Ban Will Harm, Not Improve, Pregnant Patients' Health

The Ban will cause severe and detrimental physical and psychological health consequences for pregnant patients. The State's health justifications for the Ban defy medical consensus.

A. Pregnant Patients May Seek Abortion Care After Fifteen Weeks' Gestation For Myriad Reasons

There are many reasons patients may seek abortion care after fifteen weeks' gestation; the Ban does not mitigate any of them. Some patients do not know they are pregnant for several weeks; some need time to consult with family or health professionals or arrange child care or time off from work; many face barriers to accessing abortion care. Patients who have abortions later in pregnancy have been found to "have had difficulty finding an abortion provider," "live farther from the clinic," "have had difficulty arranging transportation," "be unsure of their last menstrual period," and "experience fewer pregnancy symptoms."[16] One recent study found that patients were delayed in receiving abortion care for a variety of reasons: 36.5% due to travel and procedure costs, 37.8% due to not recognizing the pregnancy, 20.3% due to insurance problems, and 19.9% due to not knowing where

[16] Drey et al., *Risk Factors Associated with Presenting for Abortion in the Second Trimester*, 107 Obstetrics & Gynecology 128, 128 (Jan. 2006).

to find abortion care.[17] Even greater proportions of patients needing second-trimester abortions faced these obstacles.[18]

B. The Ban Will Harm Pregnant Patients' Health

The medical community recommends "increased access to surgical and nonsurgical abortion services" as they "may increase the proportion of abortions performed at lower-risk, early gestational ages."[19] The Ban does the opposite. It dangerously limits the ability of patients at or near fifteen weeks' gestation to obtain the health care they need: some will be forced to travel outside the State to obtain an abortion; others will attempt self-induced abortion; and others still will be forced to carry their pregnancy to term. Each of these outcomes increases the likelihood of negative consequences to a patient's physical and psychological health that could be avoided if care were available.[20]

Though the risk of complications from abortion care overall remains exceedingly low, increasing gestational age—for example, by forcing a patient to travel outside the State to receive abortion care—results in an increased chance of a

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

[18] *Id*.

[19] Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 736 (2004); *see also* ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020).

[20] *See, e.g.*, ACOG, Committee Opinion No. 815, *Increasing Access to Abortion* (Dec. 2020).

major complication.[21] Studies have also found that patients are more likely to self-induce abortions where they face barriers to reproductive services, and some will use dangerous methods of self-induction (rather than medication abortion, which is exceedingly safe) such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or misusing dangerous hormonal pills.[22]

Those patients who do not—or cannot—obtain an abortion due to the Ban will be forced to carry a pregnancy to term—an outcome with significantly greater risk to maternal health and mortality. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[23] and maternal mortality rates have increased at staggering rates since then.[24] In contrast, the mortality rate associated with abortions performed from 1998 to 2005 was 0.6 deaths per 100,000

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[21] Upadhyay et al., 125 Obstetrics & Gynecology at 181.

[22] Grossman et al., Tex. Pol'y Eval. Proj. Res., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015); *see also* Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (2019) (noting a rise in patients who had attempted to self-manage an abortion, with highest proportions in the South and Midwest).

[23] Raymond & Grimes, 119 Obstetrics & Gynecology at 216.

[24] MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016) (finding a 26.6% increase in maternal mortality rates between 2000 and 2014).

procedures.[25] A woman's risk of death associated with childbirth is approximately 14 times higher than any risk of death from an abortion.[26]

In addition to much greater maternal mortality, continued pregnancy and childbirth also entail other substantial health risks for pregnant patients. Even an uncomplicated pregnancy causes significant stress on the body and involves physiological and anatomical changes. Continuing a pregnancy to term can exacerbate underlying health conditions or cause new conditions.[27] Labor and delivery are likewise not without significant risk, including that of hemorrhage, placenta accreta spectrum, hysterectomy, cervical laceration, and debilitating postpartum pain, among others.[28] Moreover, every complication associated with abortion, including anemia, hypertensive disorders, and pelvic and perineal trauma

[25] Raymond & Grimes, 119 Obstetrics & Gynecology at 216.

[26] *Id*.

[27] *See, e.g.*, ACOG Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018); ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (Dec. 2018).

[28] ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017); ACOG Obstetric Care Consensus, *Placenta Accreta Spectrum* (July 2012, reaff'd 2021); ACOG Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018); ACOG Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* (Sept. 2021).

is "more common among women having live births than among those having abortions."[29]

C. The Narrow Medical Emergency Exception Does Not Adequately Protect Patients' Health

Under the Ban, a physician may perform an abortion after fifteen weeks only in cases (1) when the abortion "is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function" or (2) involving a "fatal fetal abnormality." Fla. Stat. §§ 390.011(6), 390.0111(1)(a)-(c). This forecloses an abortion for patients who might face serious medical complications later in pregnancy that, while posing grave risks to their health, are not urgent or extreme enough in the State's narrow view to fall within the Act's medical emergency exception.

Each pregnancy and pregnant person is different, and there are many serious medical conditions that may not qualify under the Ban's narrow definition but would nevertheless jeopardize a patient's health. These include, but are in no way limited to: Alport syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve that can occur in patients with

[29] Raymond & Grimes, 119 Obstetrics & Gynecology at 216-217; *see also* Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 Obstetrics & Gynecology 1089, 1092 (2008) ("Rates of anemia, hypertensive disorders of pregnancy, pelvic and perineal trauma, excessive vomiting, and postpartum hemorrhage each occurred more frequently in women who had a live birth or stillbirth.").

no history of cardiac symptoms), lupus (a connective tissue disorder that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy), and diabetes (which can worsen to the point of causing blindness as a result of pregnancy).[30] Moreover, the Ban makes no allowances for—and specifically discounts—mental health issues that might put a woman's health and life at risk if the pregnancy is not terminated.[31] All of these conditions, and many more complex and nuanced situations, can progress and become more serious or lead to additional health risks if abortion care is not available.

It is medically inappropriate to force a pregnant patient to wait until her medical condition escalates to the point that "an abortion is necessary to save [her]

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[30] *See* Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 2007); Stout & Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); Cortes-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-647 (2002); Kiely et al., *Pregnancy and Pulmonary Hypertension; A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013); Greene & Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

[31] Fla. Stat. §§ 390.011(6), 390.0111(1)(a)-(c) (allowing abortion if it "is necessary … avert a serious risk of substantial and irreversible *physical* impairment of a major bodily function of the pregnant woman *other than a psychological condition*" (emphasis added)); *see also, e.g.*, Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

life" or her pregnancy creates "serious risk of substantial and irreversible physical impairment of a major bodily function" before being able to seek potentially life-saving care. Fla. Stat. §§ 390.011(6), 390.0111(1)(a)-(c). Nor should physicians be put in the impossible position of either letting a patient deteriorate until one of these conditions is met or face criminal and civil penalties for performing an abortion in contravention of the Ban. In forcing physicians to wait until a patient is close enough to death that they will risk prosecution to save her life by providing needed abortion care, the State indefensibly jeopardizes patients' health.

D. The Ban Will Hurt Rural, Minority, And Poor Patients The Most

The Ban will disproportionality 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.[32] Similarly, traveling out of State for medical care is more difficult, if not impossible, for patients with limited means or living in remote areas.

The inequities continue after an abortion is denied. As explained *supra* pp.8-11, forcing patients to continue pregnancy increases their risk of complications,

[32] Jerman et al., Guttmacher Inst., *Characteristics of U.S. abortion patients in 2014 and changes since 2008* (2016).

and the risk of death associated with childbirth is approximately 14-times higher than that associated with abortion. Nationwide, Black patients' pregnancy-related mortality rate is 3.2 times higher than that of white patients, with significant disparities persisting even in areas with the lowest overall rates and among patients with higher levels of education.[33] Indeed, pregnant Black patients in Florida are nearly three times more likely to die from pregnancy-related causes than white patients, making carrying an unwanted pregnancy to term disproportionately dangerous for them.[34] The Ban thus exacerbates inequities in health and health care, negatively affecting the most vulnerable Floridians.

III. The Ban Forces Clinicians To Make An Impossible Choice Between Upholding Their Ethical Obligations And Following The Law

Abortion bans such as the one at issue in this case violate long-established—and widely accepted—principles of medical ethics and intrude upon the foundation of the patient-physician relationship: honest, open communication. Such bans require medical professionals to violate the age-old principles of beneficence, non-

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[33] CDC, *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths* (Sept. 5, 2019).

[34] Hernandez, *Maternal Deaths in Miami Dade are Increasing at a Higher Rate than in the Rest of South Florida (Includes Multimedia Content)*, South Florida Media Network (Dec. 12, 2022) (In 2020, the maternal mortality rate for Black and other non-White races was 51.1 in comparison to White patients with a 14.2 rate); *see also* Fla. Ass'n of Healthy Start Coalitions, *Improving Outcomes for Mothers and Babies: Maternal Mortality in Florida* (Black patients in Florida are 2-3 times more likely to die from pregnancy-related causes than White patients).

maleficence, and respect for patient autonomy in order to avoid negative personal and professional consequences such as having their licenses to practice medicine revoked. Fla. Stat. §§ 390.0111(13), 456.072(2). It is abortion bans—not the ability to perform medically indicated care—that threaten the medical ethics.

A. The Ban Undermines The Patient-Physician Relationship

Legislation that substitutes lawmakers' views for a physician's expert medical judgment impermissibly interferes with the patient-physician relationship and poses grave dangers to patient 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."[35] 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."[36]

A strong patient-physician relationship is critical for the provision of safe and quality medical care.[37] At the core of this relationship is a clinician's ability to counsel frankly and confidentially about important issues and concerns based on

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

[36] AMA, *Code of Medical Ethics Opinion 1.1.1*.

[37] 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*").

patients' best medical interests, and with the best available scientific evidence.[38] 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."[39] Laws should not interfere with the ability of physicians to offer appropriate treatment options to their patients without regard for their own self-interests.

By prohibiting abortions at fifteen weeks' gestation, the Ban interferes with the patient-physician relationship. For example, if a patient's health were compromised, but the fetus was at approximately fifteen weeks' gestation, the Ban would only allow a physician to perform an abortion "to save the pregnant woman's life or prevent a serious risk of substantial or irreversible physical impairment of a major bodily function" or if "the fetus has a fatal fetal abnormality," regardless of the overall medical advisability of the procedure or the desire of the patient. Fla. Stat. § 390.0111(1)(a)-(c). In reality, a physician and patient together may conclude

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[38] AMA, *Patient-Physician Relationships*, *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.").

[39] *ACOG, Legis. Policy Statement, supra* note 37.

that an abortion was in the patient's best medical interests even though the risk posed by continuing the pregnancy did not rise to the level of immediately life-threatening or risking substantial and irreversible physical impairment of a major bodily function. The Ban thus forces physicians to choose between the ethical practice of medicine or obeying the law.[40]

B. The Ban Violates The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the well-being 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 nearly 2500 years ago.[41] Both of these principles arise from the foundation of medical ethics which requires that the welfare of the patient forms the basis of all medical decision-making.[42]

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing

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[40] *Cf. AMA, Patient Rights, Code of Medical Ethics Opinion 1.1.3* ("Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.").

[41] AMA *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* 1, 3 (Dec. 2007, reaff'd 2016).

[42] ACOG, *Code of Professional Ethics* 2 (Dec. 2018); AMA, *Code of Medical Ethics Opinion 1.1.1*.

patients with non-judgmental information about risks, benefits, and pregnancy options, and ultimately empowering patients to make a decision informed by both medical science and their individual lived experiences.[43]

The fifteen-week ban compromises these principles and practices by pitting 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. And 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 the Ban and its extremely narrow exceptions prohibit physicians from providing that treatment after fifteen weeks' gestation and expose physicians to significant penalties if they do so. The Ban therefore places physicians in the ethical dilemma of choosing between providing the best available medical care or protecting themselves personally. This decision, between possible loss of the ability to practice medicine and the practice of scientific, ethical, high-quality health care is one that challenges the very core of the Hippocratic Oath: "Do no harm."

[43] ACOG, Practice Bulletin No. 162: *Prenatal Diagnostic Testing for Genetic Disorders*, 127 Obstetrics & Gynecology e108 (May 2016).

C. The Ban Violates The Ethical Principle Of Respect For Patient Autonomy

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.[44] 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.[45] The Ban denies patients the right to make their own choices about health care if they decide they need to seek an abortion at, for example, sixteen weeks' gestation.

By undermining the patient-physician relationship, violating the principles of beneficence and non-maleficence, and threatening clinicians' ability to respect patient autonomy, the Ban harms both the ethical practice of medicine and patient health and safety. Therefore, contrary to the State's assertion that "doctors are not irreparably harmed simply because they cannot perform a procedure prohibited by state law," the Ban will undermine the practice of medicine.[46] The medical profession is *not* protected by preventing physicians from utilizing their extensive

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[44] ACOG, *Code of Professional Ethics* 1 (Dec. 2018) ("respect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental").

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

[46] ROA 1878.

training and practicing evidence-based medicine to safely perform a routine procedure that a patient has made an informed decision about in her own best interest. Instead, the medical profession is safeguarded when physicians are permitted to exercise their duty to counsel and care for patients based on "objective professional judgment" and ultimately respect patients' autonomy to make decisions about their own bodies and health.[47]

IV. Medical Consensus Establishes That Abortion Before Twenty-Four Weeks Does Not Cause Fetal Pain

In asserting an interest in preventing "fetal pain," Florida attempts to manufacture a concern that medical consensus rejects as scientifically unfounded. Every major medical organization that has examined the issue of fetal pain and peer-reviewed studies on the matter have consistently reached the conclusion that fetal pain perception is not possible before *at least* twenty-four weeks gestation.[48]

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[47] AMA, *Patient Rights, Code of Medical Ethics Opinion 1.1.3*.

[48] *See* ACOG, *Facts Are Important: Gestational Development and Capacity for Pain*; Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice* (Mar. 2010) (concluding fetal pain is not possible before 24 weeks gestation, based on expert panel review of over 50 papers in medical and scientific literature); SMFM et al., *SMFM Consult Series #59: The use of analgesia and anesthesia for maternal-fetal procedures*, Am. J. Obstetrics & Gynecology 4-5 (2021); Apkarian et al., *Human Brain Mechanisms of Pain Perception and Regulation in Health and Disease*, 9 Eur. J. Pain 463 (2005); Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947 (2005).

This is because the neural circuitry required to sense, perceive, or experience pain is not developed in earlier gestations. Pain perception requires an intact neural pathway from the periphery of the body (the skin), through the spinal cord, into the thalamus (the gray matter in the brain that relays sensory signals) and on to the region of the cerebral cortex.[49] These neural connections do not develop until after at least twenty-four weeks' gestation.[50] The scientific evidence therefore demonstrates that an asserted concern about "fetal pain" should have no place in assessing the legality of the Ban.

CONCLUSION

For the foregoing reasons, amici urge this Court to reverse the appellate court's decision and reinstate the temporary injunction against the enforcement of the Ban.

Respectfully submitted this 9th day of March, 2023.

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[49] *See, e.g.*, Apkarian et al., 9 Eur. J. Pain at 463-484; Tracey & Mantyh, *The Cerebral Signature for Pain Perception and Its Modulation*, 55 Neuron 377 (2007); Key, *Why Fish Do Not Feel Pain*, 3 Animal Sentience 1 (2016).

[50] Royal College of Obstetricians and Gynaecologists, *Fetal Awareness: Review of Research and Recommendations for Practice*, vii, 8-9 (Mar. 2010); SMFM et al., *SMFM Consult Series #59: The use of analgesia and anesthesia for maternal-fetal procedures*, Am. J. Obstetrics & Gynecology 4-5 (2021).

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CERTIFICATE OF SERVICE

I certify that a true and correct copy of Amici Curiae's Brief has been furnished by electronic mail to all counsel of record by filing this document with service through the e-Service system, Fla. R. Jud. Admin. 2.516(b)(1), this 9th day of March, 2023.

/s/ Sean Shaw

CERTIFICATE OF COMPLIANCE FOR COMPUTER-GENERATED BRIEFS

I certify that this brief complies with the applicable form and font requirements under Florida Rule of Appellate Procedure 9.045. I further certify that this brief complies with the word limit for computer-generated amicus briefs stated in Florida Rule of Appellate Procedure 9.370(b).

/s/ Sean Shaw