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IN THE SUPREME COURT OF IOWA

Supreme Court No. 17-1579

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

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

On appeal from the Iowa District Court for Polk County
Case No. 05771 EQCE081503
The Honorable Jeffrey D. Farrell, presiding

BRIEF OF AMICUS CURIAE OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF PLAINTIFFS-APPELLEES*

*conditionally filed in final form

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IDENTITY AND INTERESTS OF AMICUS CURIAE

Amicus curiae is The American College of Obstetricians and Gynecologists ("The College"), a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of the health care of women; to establish and maintain the highest possible standards for education; to publish evidence-based practice guidelines; to promote high ethical standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists (the "Congress"), is a professional organization dedicated to the advancement of women's health and the professional interests of its members. Sharing more than 58,000 members, including nearly 300 obstetrician-gynecologists in Iowa, the College and the Congress (collectively, "ACOG") are the leading professional associations of physicians who specialize in the health care of women. ACOG recognizes that abortion is an essential health care service and opposes laws regulating medical care that have no basis in scientific evidence and are not necessary to achieve any important public health objective. The College has previously appeared as *amicus curiae* in various courts throughout the country, including the Supreme Court of the United States and

the Supreme Court of Iowa.[1] In addition, the College's work has been cited by numerous courts seeking authoritative medical information regarding women's health, childbirth, and abortion.

INTRODUCTION

Section 1 of Senate File 471, to be codified as Iowa Code § 146A.1 (2017) ("the Act"), imposes medically unnecessary burdens on all women seeking abortions in Iowa, and make such access impossible for some. The Act's mandatory, yet seemingly arbitrary, 72-hour waiting period and two-visit requirements—among the most burdensome abortion regulations in the country—arrogate women's right to make informed choices and impose significant physical, emotional, and financial burdens without medical justification. The Act will obstruct women's ability to access abortion care safely at an early stage of pregnancy, and according to their treating physician's professional judgment. Many women in Iowa are already forced to travel great distances to seek care from the dwindling number of in-state abortion providers. It is prohibitively burdensome to further require women to spend additional time—including time away from work and/or their

[1] *See, e.g., Planned Parenthood of the Heartland, Inc. v. Iowa Bd. Of Medicine*, No. 14-1415 (June 19, 2015).

families—and to shoulder the increased financial burdens, to take a second, medically unnecessary, trip to their providers.

Additionally, the Act constrains the freedom of Iowa physicians to use their medical judgment to develop the best course of treatment for their patients. Medical treatment plans should be free from legislative intrusion where such intrusion is not scientifically grounded, and particularly where it violates medical ethics. Legislative restrictions on abortion undermine the physician-patient relationship and interfere with the informed consent process.

Moreover, the Act undermines a patient's autonomy in deciding whether an abortion is the right decision for her, based on her own particular circumstances. 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 women electing to receive an abortion.

For these and the reasons set forth below, *amicus* urges this Court to grant the stay requested by the Plaintiffs.

ARGUMENT

I. THE ACT DOES NOT SERVE THE HEALTH OF WOMEN IN IOWA.

A. A Second Visit to a Provider Prior to an Abortion is Medically Unnecessary.

ACOG is opposed to measures that interfere with the patient-provider relationship, including physicians' ethical obligations to their patients, absent scientific evidence that such measures medically benefit the patient. State-imposed waiting periods restrict access to abortion; *amicus* will show that the Act imposes substantial emotional, physical, and financial burdens on women seeking abortions in Iowa and significantly interferes with the patient-physician relationship. Most surgical abortions are a one-day, outpatient procedure. Similarly, while FDA restrictions require women to make a single trip to their physicians to obtain the necessary medications for a medication abortion, a woman may safely self-administer the second required medication at home.[2]

The Act does not require any additional counseling or interaction with a medical provider during the 72-hour waiting period, nor are there tests or

[2] ACOG, *Practice Bulletin No. 143, Medical Management of First-Trimester Abortion* (2014, reaffirmed 2016), https://www.acog.org/Resources-And-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Gynecology/Medical-Management-of-First-Trimester-Abortion.

other procedures required before an abortion that would require a 72-hour period to collect and interpret results. There is no medical benefit to the 72-hour waiting period required by the Act, and in fact, as *amicus* will show, there are significant burdens and potential adverse impacts imposed by the waiting period.

B. The Act Imposes Significant Undue Burdens on Women Seeking Abortions in Iowa.

Restrictions on abortion "disrupt the patient-provider relationship, create substantial obstacles to the provision of safe medical care, and disproportionately affect low-income women and those living long distances from abortion providers." Thus, such restrictions should not be imposed where medically unnecessary.[3] The Act serves no purpose other than to increase those restrictions, making it significantly more burdensome for women in Iowa to access safe, legal abortion care.

Iowa already has a limited number of reproductive health facilities that provide abortions and that number is shrinking, due in large part to recent legislative action in the state. As of 2014, "89% of Iowa counties had no clinics that provided abortions, and 42% of Iowa women lived in those

[3] ACOG, *Comm. Op. No. 613: Increasing Access to Abortion* (2014, reaffirmed 2017), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf?dmc=1&ts=20170810T1451325499.

counties."[4] Only 13 abortion-providing facilities existed in Iowa in 2014, nearly a 30 percent decline from 2011.[5] The provider shortage has only worsened since 2014; three of Iowa's abortion-providing facilities were closed in the past few months alone, with a fourth expected by the end of 2017. [6]

This pattern is being repeated throughout the country. The number of facilities providing abortions in the United States decreased 38% from 1982 to 2000.[7] Moreover, since 2011, one out of every 10 such clinics have either ceased providing abortion services, or closed altogether.[8] With already limited access to abortion, the Iowa legislature should not act to further restrict access by imposing additional unnecessary burdens on women seeking abortion care.

Women in Iowa also face significant travel barriers when accessing abortion care. Many women in the state must travel over 100 miles round trip

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[4] Guttmacher Institute, *State Facts About Abortion: Iowa Fact Sheet* (2017), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-iowa (4,380 abortions provided in Iowa in 2014).
[5] *Id.*
[6] *See Planned Parenthood of the Heartland, Inc. v. Reynolds ex rel. State of Iowa*, Eq. Case No. EQCE081503, Ruling on Petitioner's Petition for Declaratory and Injunctive Relief at 5-6, (Sept. 29, 2017).
[7] *Id.*
[8] Esmé E. Deprez, *Abortion Clinics Close at Record Pace After States Tighten Rules*, Bloomberg (Sept. 3, 2013), https://www.bloomberg.com/news/articles/2013-09-03/abortion-clinics-close-at-record-pace-after-states-tighten-rules.

to access their nearest provider. About 162,000 women, nearly 28% of women of reproductive age in Iowa, live in a county at least 50 miles from their nearest in-state abortion provider, while 260,000 women, approximately 44% of women of reproductive age in Iowa, live in a county that is 50 miles or further from the nearest surgical abortion provider in the state.[9] The requirement of an additional, medically unnecessary, visit to an abortion provider thereby threatens nearly half of Iowa's population of reproductive-aged women—costing them not only time, but significant financial losses in the form of travel costs, missed work, and childcare. This burden is likely to prevent women from receiving the abortion care they want and need.

Further, the Act's burdens fall heaviest on low income women, who comprise the majority of women in need of abortion care. Most women seeking an abortion are below the poverty line. In fact, as of 2014, research showed that, on a national basis, 75% of abortion patients were low income, with family incomes of less than 200% of the federal poverty level.[10] According to the lower court's Ruling on Declaratory and Injunctive Relief,

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[9] *Planned Parenthood of the Heartland, Inc. v. Reynolds ex rel. State of Iowa*, Eq. Case No. EQCE081503, Trial Transcript ("Tr.") 1 at 143:2–9 (Grossman).

[10] Jenna Jerman, Rachel K. Jones, & Tsuyoshi Onda, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, at 11 (Guttmacher Inst., 2016).

"[Planned Parenthood of the Heartland] data shows that more than half of its patients are at or below 110 percent of the federal poverty guideline."[11] Low income women are also more likely to work jobs with inflexible leave requirements and lack the job security and childcare coverage to be able to miss work or engage in long-distance travel. Requiring a woman to travel over 100 miles round trip—or to otherwise stay within the vicinity of the abortion providing facility for a period of at least four consecutive days—subjects her to medically unnecessary delays in treatment and drastically increased costs. These roadblocks to treatment are likely to prevent some women from accessing abortion care altogether.

C. The Act Deprives Women in Iowa from Access to Medically Sound Procedures Early in a Pregnancy When Abortion is Safest.

Access to the safest abortion techniques is essential to women's reproductive health care. The Act imposes barriers to women's abortion access, and delays in abortion care that may result in women being forced to have abortions later in pregnancy or to unwillingly carry a pregnancy to term.

Abortion is among the safest medical procedures performed in the United States—posing far fewer risks than carrying a pregnancy to term and

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

going through labor and delivery.[12] Nationally, the risk of death resulting from an abortion is exceptionally low—0.6 per 100,000 (or 0.0006 percent).[13] The risk of death increases, however, when abortions are carried out later in pregnancy. According to Centers for Disease Control and Prevention ("CDC") statistics published by the Iowa Department of Public Health, "the risk of death associated with abortion increases with the length of pregnancy."[14] In fact, in the five year period between 2008-2012, CDC statistics showed that the risk of maternal death from abortion approximately doubled for every one- to two-week period in the first trimester: "[o]ne death per one million abortions performed at 8 weeks or less" and "[o]ne death per one 500,000 abortions performed at 9-10 weeks."[15] Most strikingly, the CDC evidence showed that the risk of maternal death from a legal abortion

[12] *See* David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140 Annals Internal Med. 620, 623 (2004).
[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).
[14] Iowa Department of Public Health, *Pregnancy Mortality*, https://www.idph.iowa.gov/Portals/1/userfiles/142/Pregnancy%20Mortality.pdf (last visited Oct. 13, 2017).
[15] Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstet. & Gynecol. 729 (2004).

procedure increased more than eight-fold between the end of the first trimester, weeks 11 and 12, and 16-20 weeks of pregnancy.[16]

The risk of death from continuing a pregnancy through childbirth is approximately 14 times higher than that of abortion.[17] According to statistics from the CDC's Pregnancy Mortality Surveillance System, implemented in 1987, "the number of reported pregnancy-related deaths in the United States steadily increased" between 1987 and 2013 and in fact nearly doubled during that period, from 7.2 deaths per 100,000 live births in 1987 to a high of 17.8 deaths per 100,000 live births in 2009 and 2011.[18] In pregnancies carried to

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[16] *Id.* (One death per 250,000 abortions performed at 11-12 weeks; one death per 29,411 abortions performed at 16-20 weeks). *See also* Daniel Grossman et al., *Complications after Second Trimester Surgical and Medical Abortion*, 16 Reproductive Health Matters 173 (31 Supp.) (2008) ("In the United States … the risk of death has been found to increase significantly with advancing gestation;" citing 1988-1997 mortality data indicating that the mortality ratio for abortions performed at eight weeks or earlier was 0.1 deaths per 100,000, while the mortality ratio for abortions at 16-20 weeks was 3.4 deaths per 100,000).

[17] 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).

[18] Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, https://www.cdc.gov/reproductivehealth/maternal infanthealth /pmss.html (last updated June 29, 2017).

term, as many as 10% of women are hospitalized for complications associated with pregnancy, not including hospitalization and delivery.[19]

Medically unnecessary delays in access to abortion can also prevent women from obtaining medication abortion, an option only available in the first 10 weeks of gestation and which some women may prefer to more invasive surgical abortion procedures. Moreover, preliminary research in the United States shows that, as restrictions on abortion increase, women begin researching self-abortion. A 2016 study of three nonprofit clinics in Iowa found that 30% of women surveyed following their abortion investigated options for clandestine home use of misoprostol, and 8.6% of women who investigated online medical abortion reported prior attempts to end the pregnancy at home.[20] More broadly, where there are significant barriers to safe, legal abortion, women may attempt to self-induce abortion outside of a clinic.[21]

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[19] Anne Elixhauser & Lauren M. Wier, Agency for Healthcare Research & Quality, *Complicating Conditions of Pregnancy and Childbirth, 2008, HCUP Statistical Brief No. 113*, at 2 (2011), http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf.

[20] C. Kerestes et al., *Prevalence, attitudes and knowledge of misoprostol for self-induction of abortion in women presenting for abortion at reproductive health clinics*, 95 Contraception 515 (2017).

[21] Daniel Grossman et al., *Self-induction of abortion among women in the United States*, 18 Reproductive Health Matters, 136, 140 (2010).

Studies in other countries have found a clear correlation between additional legal restrictions on abortion access and a rise in self-induced abortion, thereafter leading to higher rates of mortality and patient complications including infections and loss of fertility. For example, a study of abortion mortality rates in Romania found that, "where abortion was available upon request until 1966, the abortion mortality ratio was 20 per 100,000 live births in 1960. New legal restrictions were imposed in 1966, and by 1989 the ratio reached 148 deaths per 100,000 live births. The restrictions were reversed in 1989, and within a year the ratio dropped to 68 of 100,000 live births; by 2002 it was as low as 9 deaths per 100,000 births."[22]

"Similarly, in South Africa, after abortion became legal and available on request in 1997, abortion-related infection decreased by 52%, and the abortion mortality ratio from 1998 to 2001 dropped by 91% from its 1994 level."[23] The World Health Organization "estimates that about 20–30% of unsafe abortions result in reproductive tract infections and that about 20–40% of these result in upper-genital-tract infection and infertility. An estimated 2%

[22] Lisa B. Haddad & Nawal M. Nour, *Unsafe Abortion: Unnecessary Maternal Mortality*, 2 Revs. Obstet. Gynecol. 122, 124 (2009).
[23] *Id.*

of women of reproductive age are infertile as a result of unsafe abortion, and 5% have chronic infections."[24]

Indeed, medically unnecessary delays may prevent a woman from obtaining a medically indicated abortion entirely. The Act imposes a 20-week ban on abortion. If a woman discovers a fetal anomaly near 20 weeks into her pregnancy, for example, the mandated 72-hour waiting period and the two-visit requirement may prevent her from obtaining an abortion if the waiting period takes her past the 20th week of her pregnancy. Moreover, many lethal or serious fetal conditions are structural (not chromosomal) and are not susceptible to testing by amniocentesis, and thus can only be diagnosed by detailed ultrasound examination. In non-obese patients, this cannot happen until 18 weeks of pregnancy at the earliest, and in practice such tests typically take place between 18 and 20 weeks. Perhaps most importantly, however, given that 59% of Iowa women are obese,[25] there are many patients for whom a detailed ultrasound examination will not reveal structural anomalies in the

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[24] David A. Grimes et al., *Unsafe abortion: the preventable pandemic*, 368 The Lancet 1908 (2006).

[25] *See* The Henry J. Kaiser Family Foundation, *Iowa: Overweight and Obesity Rates for Adults by Gender, 2015*, https://www.kff.org/other/state-indicator/adult-overweightobesity-rate-by-gender/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22iowa%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

fetus until those anomalies become more pronounced, and thus visible, later in the pregnancy.

Finally, returning to the clinic may be impracticable and even impossible for some patients. The majority of women seeking abortions are already mothers and the additional difficulty and expense of arranging a second round of childcare to return to the facility can be prohibitive. A patient may also be deterred or prevented from returning to the facility for a timely second visit by the burden of additional fuel costs, difficulty of gaining access to a car, and/or wage loss from additional time off work. The Act requires a physician to send away a woman who needs abortion care, knowing that the patient may never be able to return for that care. It may, therefore be dangerous to patients to have medically unnecessary, state-mandated interference of this nature dictate the decision-making and treatment planning process between physician and patient.

II. THE ACT INTERFERES WITH THE PATIENT-PHYSICIAN RELATIONSHIP.

A. The Patient-Physician Relationship is Paramount to the Delivery of Safe and Quality Medical Care and Should be Protected from Legislative Intrusion.

The Act requires all women in Iowa seeking an abortion to endure a mandatory waiting period and an additional visit to a provider, both of which are medically unnecessary and interfere with the physician's duty to do what

is best for the patient. 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."[26] The Act requires physicians to substitute a legislative requirement for their own professional judgment as to when, and under what circumstances, a patient can choose to have an abortion. As with other medical decisions, physicians, in collaboration with their patients and respectful of their patients' individual health needs, are best-suited to determine appropriate abortion treatment options.

While partnerships between state governments and physicians can be crucial in protecting the health and safety of the public, abortion restrictions that are not based on scientific evidence, and include no provisions to protect the safety of a woman accomplish no end other than to "drive a wedge between a patient and her healthcare provider."[27] Patient trust is a crucial element to the patient-physician relationship; when a patient can no longer

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[26] ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists* 2, https://www.acog.org/About_ACOG/~/media/Departments/National%20Officer%20Nominations%20Process/ACOGcode.pdf.

[27] ACOG, *Statement of Policy: Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (2013), https://www.acog.org/~/media/Statements%20of%20Policy/Public/2013LegislativeInterference.pdf.

rely on her physician's honest and unbiased medical opinion, that relationship is compromised.[28] Abortion care, in particular, should be administered by physicians without undue interference by outside parties. Women make reproductive health decisions with a complicated "history of relationships, personal and social, familial and institutional" in mind.[29] Open and honest communication between a woman and her treating physician is essential for the parties to work together to determine all available treatment options and reach a health care decision that best meets the patient's particular needs.

Under the constraints of the Act, the legislature interrupts that open conversation and dictates that both physician and patient agree to a treatment plan riddled with mandatory, but medically unnecessary, burdens to healthcare. The Act forces a physician to prescribe a treatment plan that at best, may not be in her patient's best interest and at worst, could completely prevent the patient from accessing medically indicated treatment.

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[28] *Id*.

[29] ACOG, *Comm. Op. No. 439: Informed Consent* (2009), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20170810T2105342813.

B. The Act's Requirement of a 72-Hour Waiting Period for all Patients Is Contrary to Medical Ethics Because It Undermines Patient Autonomy.

A mandatory waiting period for abortion is unnecessary where the informed consent process underlying all medical care is designed to support well-informed patient decision-making. Physicians are ethically required to have open and honest relationships and conversations with their patients about their health, their care, and the physician's medical recommendations, all within a culture of mutual respect.[30] The informed consent process in obstetrics and gynecology focuses on open communication between the physician, who offers his or her professional opinion, and the patient, who is encouraged to actively participate by sharing what is most important to her personal decision-making process.[31] Physicians must obtain informed consent from their patients immediately prior to performing any medical procedure, including abortion. The Act forces a woman to undergo an arbitrary waiting period between appointments presumably to create the impression that she should reconsider the decision to undergo the procedure. This requirement completely ignores the informed consent process that will take place during the appointment in which the abortion procedure will be performed. At this

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[30] ACOG, *Comm. Op. No. 439 Informed Consent*, at 1.
[31] *Id.* at 2.

appointment, a woman's treating physician must share with her the risks and benefits of the procedure so that her consent can be informed. "Consenting freely is incompatible with being coerced or unwillingly pressured by forces beyond oneself," and the imposition of a waiting period and multiple appointments interferes with the sound informed consent process already in place.[32]

Further, the Act abrogates or supplants a woman's autonomy to make an informed and timely decision regarding whether abortion is the right decision in her particular circumstances. 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 notions that abortion causes women long term emotional or psychological harm, or that a significant portion of women later regret abortions they decided to have. A 2015 study of over 700 abortion patients that followed women for three years after their abortion found that more than 99% consistently reported at various intervals in that three-year period that "abortion was the right decision for them."[33]

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[32] *Id.* at 3.
[33] 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).

In fact, a 2016 study measuring the decisional certainty of women 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."[34] 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[.]"[35] Requiring a mandatory waiting period for all women serves only to undermine patient autonomy and force physicians to question, or appear to question, their patients' well-informed decisions.

Physicians are focused on providing patient-centered and individualized care to their patients. Informed consent is, by and large, a woman's ability to make a reasoned, educated decision about her own health. The Act requires every Iowa physician, following an initial patient screening visit, to then instruct their patient to take a completely arbitrary amount of additional time to reconsider her decision. This creates the harmful implication that the physician is not satisfied with the patient's choice, that

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[34] Lauren J. Ralph et al., *Measuring decisional certainty among women seeking abortion*, 95 Contraception 269 (2017).
[35] *Id.*

somehow a patient will wholly reconsider her decision within a span of three days, and/or that the patient's fully-informed decision was deficient as a matter of course. The Act 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 choice. In that circumstance, a patient should be free to undergo the abortion procedure in a timely manner and free of unnecessary, often devastating, costs.

C. The Act's Medical Emergency Exemption is Unclear and Could Interfere with the Physician's Sound Medical Judgment.

The medical emergency exemption in the Act is vague, overly narrow, and interferes with the sound medical judgment of Iowa physicians. The Act only exempts a patient from the waiting period in case of a physical condition that either poses an immediate threat to the patient's life or "will create a serious risk of substantial and irreversible impairment of a major bodily function."[36] First, the language of the Act is unsuitably vague, providing no guidance as to how to assess a patient's level of risk, or ultimately determine what constitutes a "serious" risk. Further, the Act focuses solely on the patient's current physical condition, providing no exception for women who may risk future harm by continuing their pregnancy, such as, for example,

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[36] 2017 S.F. 471, § 146B.1(6).

victims of domestic violence or women who face significant mental health issues. The Act's lack of clarity puts physicians in the impossible and dangerous position of making ethically ambiguous decisions to comply with its terms, putting patients at risk of both physical and mental harm.

The Act's exemption language is also vague because it does not define, nor offer any further guidance, as to what might constitute "substantial" impairment, or might be considered a "major bodily function." Physicians forced to make their own determinations regarding the meaning and extent of these terms, may face liability down the road should their judgment be challenged by, for example, lawyers, hospital administrators, or a licensing board. The Act forces physicians to weigh their own risk of liability or negative repercussions against their patients' healthcare needs, regardless of whether it is their professional judgement that an immediate abortion is medical necessary.

The Act neither recognizes nor provides an exception for women who may be in danger of other types of serious harm, such as domestic violence or serious mental health issues. It has been documented that victims of intimate partner violence ("IPV") "are also likely to have a particularly high risk of

experiencing an unintended pregnancy."[37] In 2007, women seeking an abortion were nearly four times as likely to be victims of IPV when compared with women who intended to continue their pregnancies.[38] 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 women seeking care in U.S. family practice clinics.[39] 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.[40]

Studies have further shown that pregnant and postpartum females aged 10–29 years were at twice the risk of homicide compared with their

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[37] Kinsey Hasstedt & Andrea Rowan, *Guttmacher Policy Review Volume 19: Understanding Intimate Partner Violence as a Sexual and Reproductive Health and Rights Issue in the United States* (Guttmacher Inst., 2016), https://www.guttmacher.org/gpr/2016/07/understanding-intimate-partner-violence-sexual-and-reproductive-health-and-rights-issue.
[38] Dominique Bourassa & Jocelyn Berube, *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).
[39] Beth A. Bailey, *Partner violence during pregnancy: prevalence, effects, screening, and management*, 2 Int. J. of Women's Health 183, 185 (2010).
[40] *Id.*

nonpregnant or postpartum counterparts.[41] For the period between 1991 and 1999, the Centers for Disease Control and Prevention reported an overall pregnancy-associated homicide rate of 1.7 per 100,000 live births; 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, a higher rate than for specific direct obstetric causes (hemorrhage, hypertensive disorders, or amniotic fluid embolism)."[42]

Victims of domestic violence face compounded hurdles to abortion access, including the potential need to conceal their clinic visits from a violent partner and may be unable to safely return for a second visit. As written, the Act does not enable a physician to take a victim's known risk of physical harm into account when designing a patient's treatment plan, preventing the physician from performing an abortion at the time safest for the patient.

Similarly, the Act does not provide an exception to allow physicians to immediately treat women with diagnosed or perceived mental health risks. Scientific research has shown that pregnancy alone may put women with a history mental health issues at greater risk for depression, both during

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[41] Abigail R. Koch, *Higher Risk of Homicide Among Pregnant and Postpartum Females Aged 10–29 Years in Illinois, 2002–2011*, 128 Obstet. Gynecol. 440, 440-41 (2016).
[42] *Id*.

pregnancy and post-partum.[43] 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.[44] It reasonably follows that forcing a woman to carry an unwanted pregnancy to term may compound these risks. Yet, the Act does not provide an exception for women that physicians identify as particularly vulnerable if they are forced to remain pregnant against their wishes.

Due to its vagueness, the Act forces physicians to choose between what they believe in their professional judgment to be in their patients' best interests and the physician's self-interest in avoiding legal and professional liability.[45] By creating this conflict, the Act places physicians in an ethically unconscionable situation and undermines patients' access to sound medical advice. The 72-hour waiting period and two-visit requirement under the Act

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[43] Office on Women's Health, U.S. Department of Health and Human Services, *Depression during and after pregnancy*, https://www.womenshealth.gov/a-z-topics/depression-during-and-after-pregnancy (last updated June 12, 2017).

[44] Amy Norton, *Self-Harm a Cause of Death During Pregnancy and for New Moms*, HealthDay Reporter (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.

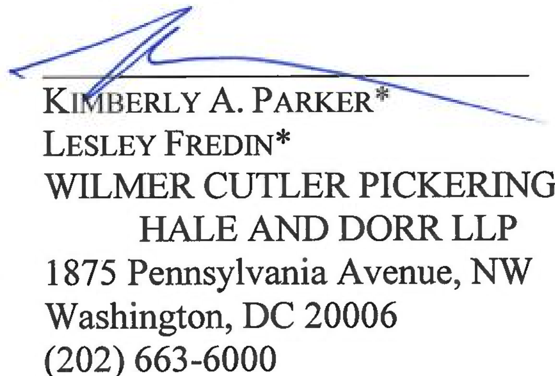
[45] ACOG, *Comm. Op. No. 390: Ethical Decision Making in Obstetrics and Gynecology* (2007), https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Ethical-Decision-Making-in-Obstetrics-and-Gynecology.

may, in fact, increase certain risks of harm to patients, including continued physical and emotional domestic violence, and both imminent and long-term mental health consequences. The potential for harm—both to patients and to the patient-physician relationship—is well documented and based on the best and most recent medical evidence available to the College and should, respectfully, be weighed against any perceived benefit afforded under the Act.

III. CONCLUSION.

For the reasons stated above, *amicus* urges this Court to grant the stay requested by the Plaintiffs.

Respectfully submitted,



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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 5,913 words, excluding the parts of the brief exempted by Iowa R. App. P. 6903(1)(g)(1).

Sincerely,

/s/ Paige Fiedler

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<u>**PROOF OF SERVICE AND CERTIFICATE OF FILING**</u>

I hereby certify that on October 13, 2017, 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,

<u>*/s/ Paige Fiedler*</u>

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