IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

SISTERSONG WOMEN OF COLOR REPRODUCTIVE JUSTICE COLLECTIVE, *et al*., Plaintiffs, v. STATE OF GEORGIA, Defendant.	Civil Action File No. 2022CV367796

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, AND SOCIETY FOR MATERNAL-FETAL MEDICINE IN SUPPORT OF PLAINTIFFS' EMERGENCY MOTION FOR INTERLOCUTORY INJUNCTION AND TEMPORARY RESTRAINING ORDER

Amici Curiae American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), and Society for Maternal-Fetal Medicine ("SMFM") respectfully submit the following *amicus* brief in support of the Plaintiffs' Emergency Motion for Interlocutory Injunction and Temporary Restraining Order.[1]

STATEMENT OF INTEREST

ACOG is the nation's leading group of physicians providing health care for women. With more than 62,000 members, ACOG advocates for quality health care for women, maintains

[1] Janice Mac Avoy, Jennifer L. Colyer, Alexis R. Casamassima, and S. Cynthia Luo of Fried, Frank, Harris, Shriver & Jacobson LLP assisted in the preparation of this *amicus* brief.

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's Georgia Section has over 1,600 members living and practicing in the state who, together with their patients, are directly affected by laws restricting access to abortion care and other reproductive health care. ACOG has appeared as *amicus curiae* in state and federal courts throughout the country. ACOG's briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, as a leading provider of authoritative scientific data regarding childbirth and abortion.[2]

The 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 physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The 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 every medical specialty and in every state, including Georgia.

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[2] *See, e.g.*, *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016); *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); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG in assessing disputed parental notification requirement); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); see also *Gonzales v. Carhart*, 550 U.S. 124, 170-171, 175-178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's brief and congressional submissions regarding abortion procedure).

SMFM is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 5,500 members, including 94 professionals who live and practice in Georgia, caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by courts in cases raising a variety of medical issues.[3]

INTRODUCTION & SUMMARY OF ARGUMENT

Georgia House Bill 481 (the "Ban") is a violation of Georgians' fundamental rights to bodily autonomy under the Georgia Constitution. The Ban prevents access to nearly all needed abortion care without any basis in medical science and without regard to the safety and wellbeing of pregnant people.

As leading medical experts, *amici* can state definitively that the Ban does not protect maternal health. Rather, it severely restricts access, especially for vulnerable groups, to a safe and appropriate medical procedure. Continuing a pregnancy to term and giving birth carries a far greater risk to a person's health and life than obtaining an abortion—a routine and essential health care service. This Ban will, without doubt, endanger peoples' welfare and wellbeing without any medical basis.

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[3] *See, e.g.*, *Mayor of Baltimore v. Azar*, 973 F.3d 258, 285 & n.19 (4th Cir. 2020) (quoting *amicus* brief by SMFM and others supporting challenge to federal rule prohibiting physicians and other providers in Title X programs from referring patients for abortion, and noting that SMFM is a "reputable and nonpartisan medical organization[]").

As the AMA has recently recognized, "it is a violation of human rights when government intrudes into medicine and impedes access to safe, evidence-based reproductive health services, including abortion and contraception."[4] *Amici* and approximately 75 other health care organizations agree that "[a]bortion care is safe and essential reproductive health care. Keeping the patient-clinician relationship safe and private is essential not only to quality individualized care but also to the fabric of our communities and the integrity of our health care infrastructure."[5]

Further, the Ban's narrow exception for medical emergencies does not cover many situations where pregnancy endangers a person's health and life. Clinicians regularly confront complex and nuanced medical situations that require the clinician to draw on training and medical judgment. A "medical emergency" by its nature cannot be effectively defined by a third party that is not in the exam room faced with an actual patient. Under the Ban, a person living with health conditions that will complicate a pregnancy or be complicated by a pregnancy will have no choice but to continue the pregnancy to term, jeopardizing the person's health in violation of rights protected by the Georgia Constitution.

Additionally, the Ban creates legal and ethical challenges for clinicians treating patients in Georgia by forcing them to practice under threat of criminal sanction. The Ban places clinicians in an ethically untenable position: having to navigate a conflict between providing necessary, appropriate medical care and complying with the law.

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[4] AMA, *AMA Bolsters Opposition to Wider Criminalization of Reproductive Health* (June 14, 2022).

[5] ACOG, *More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference* (July 7, 2022), https://www.acog.org/news/news-releases/2022/07/more-than-75-health-care-organizations-release-joint-statement-in-opposition-to-legislative-interference.

Because the Ban prohibits people from making the decision about whether to continue pregnancy, this Court should grant the Plaintiffs' Emergency Motion for Interlocutory Injunction and Temporary Restraining Order.

ARGUMENT

I. ABORTION IS SAFE AND ESSENTIAL MEDICAL CARE

Abortion is widely acknowledged by the medical community as a safe and essential component of reproductive health care.[6] Abortion is also a common medical procedure: in 2020, over 930,000 abortions were performed nationwide,[7] including roughly 31,248 in Georgia.[8] Study after study demonstrates that abortion is very safe, regardless of whether the abortion is induced by medication or procedure.[9] This has been demonstrated time and time again by

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[6] *See, e.g.*, ACOG, *Abortion Policy* (revised and approved May 2022); ACOG, Committee Opinion No. 815, *Increasing Access to Abortion*, 136(6) Obstet. & Gynecol. e107, e108 (Dec. 2020); *June Med. Servs. L.L.C.*, 140 S. Ct. at 2122 (noting that "abortions are so safe," and as a result, providers would be unlikely to admit patients to a hospital); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119(2) Obstet. & Gynecol. 215, 215 (Feb. 2012); David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 140(8) Annals Internal Med. 620, 621, 623 (Apr. 20, 2004); 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 that "[a]ccess to legal and safe pregnancy termination … is essential to the public health of women everywhere"); ACOG, Abortion Policy (revised and approved May 2022); SMFM, Access to Pregnancy Termination Services (2017); ACOG, *More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference*, *supra* note 3.

[7] Jones et al., *Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court is Poised to Overturn* Roe v. Wade, GUTTMACHER INST. (June 15, 2022).

[8] Georgia Online Analytical Statistical Information System, https://oasis.state.ga.us/oasis/webquery/qryITOP.aspx.

[9] *See* Report by Committee on Reproductive Health Services: *The Safety and Quality of Abortion Care in the United States*, 10 (National Academies Press 2018); Raymond & Grimes, 119(2) Obstet. & Gynecol. at 215; Grimes & Creinin, 140(8) Annals Internal Med. at 623.

randomized controlled trials, large retrospective cohort studies, patient and clinician surveys, systematic reviews, and epidemiological studies examining abortion care. Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and easily treatable.[10]

Nor are there significant risks of psychological harm resulting from abortion care. Comprehensive reviews of the scientific evidence by the American Psychological Association ("APA") and the Academy of Royal Medical Colleges in the United Kingdom make clear that there is no causal association between abortion and adverse mental health outcomes.[11] The 2008 APA Task Force Report, in particular, found that "[t]he best scientific evidence published indicates that among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy."[12] And the 2018 Position Statement on Abortion of the APA notes that "available evidence does not support that having an abortion is associated with an increase in depressive, anxiety, or post-traumatic stress symptoms."[13]

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[10] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstet. & Gynecol. 175, 181 (Jan. 2015).

[11] Brenda Major et al., *Report of the APA Task Force on Mental Health and Abortion*, at 4 (2008), http://www.apa.org/pi/women/programs/abortion/mental-health.pdf [hereinafter "APA Task Force Report"]; Academy of Medical Royal Colleges, by National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including Their Prevalence an Associated Factors* 8 (Dec. 2011), https://www.aomrc.org.uk/wp-content/uploads/2016/05/Induced_Abortion_Mental_Health_1211.pdf.

[12] APA Task Force Report, at 4.

[13] APA, *Position Statement on Abortion*, at 1 (July 2018), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Abortion.pdf.

II. THE BAN PROHIBITS NEARLY ALL ABORTIONS IN GEORGIA WITHOUT MEDICAL JUSTIFICATION

Despite abortion being a safe form of medical care, the Ban effectively prohibits nearly all abortions in Georgia by outlawing abortion once a "human heartbeat" is detected, which the State inaccurately sets at approximately six weeks of gestation. At this point in pregnancy, many people are unaware that they are pregnant, but even people who know they are pregnant are frequently stymied from accessing abortion care before six weeks. The ban operates in addition to the obstacles that Georgia already has in place, including restrictions that make it more difficult for people to pay for abortion care, government-mandated counseling, and a waiting period. The Ban deliberately relies on erroneous, non-scientific information which, in practice, will prevent all or almost all abortions in Georgia, which will create a public health crisis and negatively impact the lives of thousands of Georgians.

A. The Ban Lacks Medical Justification

The Ban is not grounded in science and lacks any medical justification for severely restricting abortion care. Specifically, the Ban prohibits abortions when an "unborn child has been determined…to have a detectable human heartbeat…." The Ban defines "detectable human heartbeat" to mean "embryonic or fetal cardiac activity or the steady and repetitive rhythmic contraction of the heart within the gestational sac."[14] From these statements, ACOG understands that the State believes its definition of "detectable human heartbeat" includes the embryonic cardiac activity that occurs as a result of electrical flickering of a portion of the embryonic tissue, which typically is detectable at approximately six weeks of gestation. However, this is inconsistent with the scientific understanding of when during gestation a "heartbeat" becomes

[14] Ga. Code Ann. § 16-12-141(a)(2)

detectable. As a matter of medical science, a true fetal heartbeat exists only after the chambers of the heart have developed and can be detected via ultrasound, which typically occurs around 17-20 weeks of gestation.[15] Given that many people will not know they are pregnant at six weeks of gestation, as discussed *infra* Section II.B, and even if they are aware of the pregnancy, many will be unable able to navigate the existing restrictions in that short amount of time, the Ban is functionally a total ban on abortion care in Georgia.

B. People May Not Know They Are Pregnant at Six Weeks of Gestation

The majority of abortions in Georgia take place after six weeks of gestation for practical, biological reasons.[16] The most common sign of a potential pregnancy is a missed period; until then, most people (particularly those who are not planning a pregnancy) will have no reason to suspect they are pregnant.[17]

A person's menstrual cycle is typically about four weeks long, although many people have longer or irregular cycles. Even a person with highly regular cycles would be four weeks pregnant, as measured from the last menstrual period, when they first have reason to suspect they

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[15] *See ACOG Guide to Language and Abortion* 1 (Mar. 2022). Moreover, while embryonic cardiac activity can signal that an early pregnancy may continue to develop, embryonic cardiac activity is a scientifically arbitrary point in pregnancy. It does not by itself indicate whether a pregnancy will develop normally or end in a live birth, and it certainly is not a sign of fetal viability.

[16] In 2019, only a minority of abortions occurred at or before 6 weeks of pregnancy. Kortsmit et al. Abortion Surveillance — United States, 2019.
Center for Disease Control and Prevention MMWR Surveill Summ 2021;70(No. SS-9): Table 10, https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm#T10_down.

[17] Administering a home pregnancy test too early in a person's menstrual cycle or too close to the time a person became pregnant may result in a false negative result, because the hormone a person's body produces when they become pregnant, human chorionic gonadotrophin, may not yet be at a detectable level to trigger a positive test result. *Pregnancy*, U.S. Food & Drug Administration (Apr. 29, 2019), https://www.fda.gov/medical-devices/home-use-tests/pregnancy.

may be pregnant. The Ban prohibits abortion just two weeks later. Before six weeks of gestation, physicians cannot always confirm an intrauterine pregnancy via ultrasound and therefore in some cases, may not be able to offer an abortion.[18] Even if a person has a positive pregnancy test and is able to obtain an appointment for an abortion and complete the mandatory waiting period within six weeks of gestation, abortion care may not be available to them.

Many people experience irregular menstrual cycles due to factors including stress, obesity, smoking, endocrine conditions, such as polycystic ovary syndrome, thyroid dysfunction, premature ovarian failure, exercise-induced amenorrhea, eating disorders, and ovarian and adrenal tumors.[19] Moreover, young adolescents, within the first few years of menstrual life, may have irregular menstrual cycles or longer menstrual cycles that may be six weeks or more. Other people experience metrorrhagia, or bleeding during their menstrual cycle, which can be mistaken for a period and may lead a person to believe they did not miss a period when they are actually pregnant. Because a missed period tends to be the most definitive signal of potential pregnancy before testing, people who experience irregular menstrual cycles and bleeding would have no reason to suspect pregnancy before six weeks.[20] Under the Ban, many people who experience irregular menstrual cycle activity would be foreclosed from accessing abortion care.

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[18] Heller & Cameron, Termination of Pregnancy at Very Early Gestation Without Visible Yolk Sac on Ultrasound, 41 J. Fam. Plann. Reprod. Health Care 90, 90-91 (2015).

[19] Jinju Bae et al., *Factors Associated with Menstrual Cycle Irregularity and Menopause*, 18:36 BMC Women's Health 1, 1 (2018); ACOG, Committee Opinion No. 651, *Menstruation in Girls and Adolescents: Using the Menstrual Cycle as a Vital Sign*, at 3 (2006, re-aff'd 2020).

[20] Indeed, other than a missed period, pregnancy symptoms differ and are not always predictable. Amy E. Sayle et al., *A Prospective Study of the Onset of Symptoms of Pregnancy*, 55 J. of Clinical Epidemiology 676, 676 (2002).

Moreover, about one in two pregnancies in America are unplanned.[21] Given this fact, almost half of pregnant people may not immediately consider other potential symptoms of early pregnancy, such as nausea or vomiting, to be indicative of pregnancy.[22] Some people also may never experience nausea or vomiting before six weeks of gestation (or at all); one study showed that the average number of days from the last menstrual period to the onset of nausea and vomiting was 39 days, roughly 5.5 weeks.[23] Therefore, people who mistake pregnancy symptoms as something else or do not experience these ancillary symptoms until after six weeks of gestation will be unable to obtain wanted and necessary abortions in Georgia under the Ban.

C. Other Georgia Laws that Hinder Access to Abortion Care Make it Practically Impossible to Obtain Abortion Care Before Six Weeks of Gestation

Georgians currently have extremely limited access to abortion care given that, as of 2017, 95% of Georgia counties have no abortion provider.[24] More than half of all Georgians live in one of those counties and would need to travel beyond their county borders to obtain abortion care.[25]

Georgia law also creates financial barriers to abortion care. For example, Georgia forbids the use of state funding for abortion care, with only narrow exceptions where the person's life is

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21 Office on Women's Health, U.S. Department of Health and Human Services, *Unplanned Pregnancy* (last updated Feb. 22, 2021), https://www.womenshealth.gov/pregnancy/you-get-pregnant/unplanned-pregnancy.

22 Lawrence B. Finer and Mia R. Zolna, *Declines in Unintended Pregnancy in the United States, 2008 - 2011*, 374 N. Eng. J. Med. 843, 843 (Mar. 3, 2016).

23 Roger Gadsby et al., *A prospective study of nausea and vomiting during pregnancy*, 43(371) Brit. J. of Gen. Prac. 245, 245 (June 1993).

24 Guttmacher Institute, *State Facts About Abortion: Georgia* (2021), https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-georgia#.

25 *Id*.

at risk, or if the pregnancy results from rape or incest.[26] Similarly, Georgia law forbids private health insurance plans offered through the state exchange under the Patient Protection and Affordable Care Act from covering abortion care in any way.[27] Patients needing abortion care are disproportionately low-income and will therefore require time to raise, if they even can, the hundreds of dollars needed to pay for abortion care themselves.[28]

In addition to the limited access to service providers and financial barriers imposed by the State, Georgia law restricts access for patients needing abortion care in a number of other ways. For example, Georgia law requires that people undergo government-scripted counseling and then wait 24 hours before obtaining abortion care.[29] Georgia minors are subjected to parental notification requirements unless they obtain a judicial bypass before they can obtain abortion care, with only a narrow exception in a case of "medical emergency." [30] Several studies highlight the correlation between such requirements and an increase in abortion care later than six weeks[31] because obtaining a judicial bypass can delay access to abortion care for up to four

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[26] Georgia implements these restrictions through Georgia Community Health Department manuals. *See, e.g.*, *Feminist Women's Health Ctr. v. Burgess*, 651 S.E.2d 36, 37 (Ga. 2007) (citing several Georgia Department of Health *Policies and Procedures* manuals noting that the State will reimburse abortion care received by eligible persons only "if the life of the [person] would be endangered if the fetus were carried to term or if the [person] was a victim of rape or incest").

[27] Ga. Code Ann. § 33-24-59.17 (2020).

[28] 75% of abortion patients nationwide have household incomes below 200% of the federal poverty level. Jerman et al., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008*, GUTTMACHER INST. (2016).

[29] Ga. Code Ann. § 31-9A-3.

[30] Ga. Code Ann. §§ 15-11-682, 15-11-684, 15-11-686.

[31] AAP Committee on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 139(2) PEDIATRICS 1, 5 (Feb. 2017) (noting that in one study, second-trimester abortion rates among 17-year old adolescents increased by 21% following the enactment of a parental involvement law).

weeks.[32] These restrictions already foreclose abortion care for untold numbers of Georgians, and the Ban will only further limit the practical ability of people to access abortion care.

When coupled with the restrictions Georgians already face, the Ban effectively prevents access to abortion care. Even for people who can confirm pregnancy before six weeks of gestation, it is often difficult or impossible to access care in Georgia within the six-week window. During this short time, a person must (1) make a decision about whether to continue the pregnancy; (2) notify parents or obtain a judicial bypass if the person is a minor; (3) schedule an appointment with one of the few clinicians who provide abortion care in the state; and (4) navigate the restrictions Georgia laws erect, including the 24-hour waiting period. Many people will need to gather resources to pay for the abortion and its related costs, arrange transportation to the facility, and take time off from work and obtain childcare. Less time means that more people will fail in their endeavors to comply with the law while still obtaining care.

Traveling out of state is not likewise a viable option for many people. For the overwhelming majority of people seeking abortion, the logistical and financial burden of traveling out of state for care is far greater than if the person could obtain an abortion in Georgia. Travelling longer distances equates to increased financial burdens, absences from work, and difficulties in finding and paying for childcare. This is likely to result in substantial delay, which may further increase costs and may subject the person to a more involved procedure that could have otherwise been avoided. Moreover, the need to travel out of state and consider various states' individual criminal and/or civil penalties related to abortion is likely to cause

[32] *Id*. at 6–7 (noting delays ranging from 4 days to several weeks); Lauren J. Ralph et al., *Reasons for and Logistical Burdens of Judicial Bypass for Abortion in Illinois*, 68 Journal of Adolescent Health 71, 75 (2021) (finding an average delay of 6.4 days).

increased delay and confusion. This is especially true in light of the current uncertainty of abortion care access in several states across the country, including those that border Georgia.

Research shows that, where abortion access is limited, increased numbers of people may resort to unsafe means to end unwanted pregnancies, including self-inflicted abdominal and bodily trauma or ingesting dangerous chemicals.[33] The Ban deprives Georgians of their fundamental rights under the Georgia Constitution to bodily autonomy free of unwarranted State interference, places Georgians in the unfortunate position of having to choose between following the law and obtaining safe care, and acts as a near-absolute ban to abortion care in Georgia, particularly for people with low income.

III. BY PROHIBITING ABORTION, THE BAN WILL HARM PREGNANT PEOPLES' HEALTH

A. People Face Greater Risk When Forced to Continue a Pregnancy to Term

Continuing with a pregnancy carries a greater risk of death and health complications than obtaining a desired abortion. Statistically, the risk of death associated with childbirth in the U.S. is approximately 14 times higher than the risk associated with getting an abortion.[34] The U.S. has the highest mortality rate associated with childbirth among developed countries, and this has been exacerbated by the COVID-19 pandemic.[35] It is expected that maternal mortality rates will

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[33] ACOG, Committee Opinion No. 815, at e108; SMFM, *Access to Abortion Services*, at 1 (Dec. 2017, re-aff'd June 2020), https://s3.amazonaws.com/cdn.smfm.org/media/2418/Access_to_Abortion_Services_(2020).pdf.

[34] ACOG, Committee Opinion No. 815, at e108.

[35] *See, e.g.*, Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, Commonwealth Fund (Nov. 18, 2020) (noting that, in 2018, the rate of maternal deaths in the U.S. was more than double that of most other high-income countries); Donna Hoyert, *Maternal Mortality Rates in the United States, 2020*, National Center for Health Statistics, at 1 (Feb. 2022) (between 2019 and 2020, maternal mortality in the U.S. rose by 14%).

increase as additional restrictions or prohibitions are placed on abortion care.[36] This is particularly concerning given the mortality rate associated with childbirth in Georgia. The State has been consistently ranked as having one of the highest maternal mortality rates in the country[37] and the mortality rate is far worse for Black people in Georgia.[38]

While the risk related to abortion may become greater as pregnancy advances, serious risk from abortion at all gestational ages is extremely rare and does not approach the threshold of risk associated with carrying a pregnancy to term.[39] In a 1998 to 2001 study, all complications studied were found to be more common in people who gave birth as compared to people who received abortion care.[40] These complications ranged from moderate to potentially life-threatening, including anemia, hypertensive disorders, pelvic or perineal trauma, mental health conditions, obstetric infections, postpartum hemorrhage, antepartum hemorrhage, asthma, and excessive vomiting.[41]

In addition, pregnancy can also exacerbate or complicate pre-existing medical conditions that frequently (and sometimes severely) worsen with pregnancy. For example, approximately 6-7% of pregnancies are complicated by gestational diabetes mellitus, a condition which

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36 *See* Amanda Stevenson, *The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant*, 58(6) Demography 2019, 2023-26 (Oct. 2021).

37 Elizabeth Armstrong-Mensah et. al., *Geographic, Health Care Access, Racial Discrimination, and Socioeconomic Determinants of Maternal Mortality in Georgia, United States*, Int J MCH AIDS 10(2) 278, 278 (2021).

38 Georgia Maternal Mortality Review Committee, Maternal Mortality Factsheet 2015-2017 Data, Ga. Dep't of Pub. Health, https://dph.georgia.gov/maternal-mortality.

39 ACOG, Committee Opinion No. 815, at e108; Raymond & Grimes, 119(2) Obstet. & Gynecol. at 217.

40 Raymond & Grimes, 119(2) Obstet. & Gynecol. at 216–17 & Fig. 1.

41 *Id.*

frequently leads to maternal and fetal complications, including developing diabetes later in life.[42] Preeclampsia, another relatively common complication, is a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in blood pressure swings, heart disease, liver issues, and seizures, among other conditions.[43] In addition, some pregnant people may develop placenta accreta, where the placenta grows too deeply into the uterine wall, which makes them more likely to require hysterectomy and experience greater rates of maternal morbidity and mortality.[44] Even if a pregnant person develops none of these conditions, pregnancy alone causes significant stress on the body and involves physiological and anatomical changes. Labor and delivery likewise carry significant risks, including hemorrhage, hysterectomy, cervical laceration, and debilitating postpartum pain.[45] When abortion is medically appropriate and desired by a person, they should not be required to continue a pregnancy to term, which may subject them to serious or potentially fatal health risks.

B. The "Medical Emergency" Exception to the Ban Does Not Adequately Protect a Person's Health

Georgians who require an abortion, particularly those experiencing high-risk pregnancies, will face significant challenges under the Ban that harm their health and wellbeing. The Ban limits a "medical emergency" to a situation where "an abortion is necessary in order to prevent

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42 ACOG Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018).

43 ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (June 2020).

44 *See* ACOG and SMFM, *Obstetric Care Consensus: Placenta Accreta Spectrum,* 132(6) Obstet. & Gynecol. e259, e259 (Dec. 2018).

45 ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017); 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*, 507 (Sept. 2021).

the death of the pregnant woman or the substantial and irreversible physical impairment of a major bodily function of the . . . woman."[46]

The State's narrow definition of a "medical emergency" is an unworkable framework, inconsistent with standards of care, that fails to account for the many nuanced situations faced by physicians in diagnosing and administering care. For example, the State's definition fails to consider that people may experience medical conditions that may not manifest or require treatment until well after six weeks of gestation and at that time, may not rise to a "medical emergency." Such medical conditions that may arise after six weeks of gestation and have a significant impact on a person's health, but may not always rise to a "medical emergency" include: Alport syndrome (a form of kidney inflammation);[47] valvular heart disease (abnormal leakage or partial closure of a heart valve that can occur in people with no history of cardiac symptoms);[48] lupus (an autoimmune disorder that may suddenly worsen during pregnancy and lead to fatal blood clots and other serious complications);[49] and pulmonary hypertension (increased pressure within the lung's circulation system that can escalate in severity).[50]

Equally concerning, the "medical emergency" definition is too vague to give clinicians workable guidance about whether procedures are permitted or prohibited, especially with respect

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46 Ga. Code Ann. § 16-12-141(a)(3).

47 *See* Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109(2) Obstet. & Gynecol. 531, 531 (Feb. 2007).

48 *See* Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93(5) Heart 552, 552 (May 2007).

49 *See* J. Cortés-Hernandez et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41(6) Rheumatology 643, 646–47 (2002).

50 *See* David G. Kiely et al., *Pregnancy and pulmonary hypertension: a practical approach to management*, 6(4) Obstet. Med. 144, 144, 153 (2013).

to managing pregnancy loss.[51] For example, inevitable miscarriages (where embryonic or fetal cardiac activity is detectible) are commonly treated via uterine aspiration, which is the same procedure as that used for the majority of abortions (other than medication abortions).[52] The Ban does not state that miscarriage management is permissible or protect clinicians who must use their medical judgment to determine the best treatment plan and provide care in the moment.[53] For instance, miscarriages can occur in much-wanted pregnancies, long after six weeks have elapsed, and require critical and often immediate intervention, but under circumstances under which medical professionals fear may not constitute a "medical emergency," causing them to delay (or even entirely withhold) essential care and put pregnant people at risk.

The State's "medical emergency" definition also fails to take into account complications that present danger to maternal health that can affect fetal development and survival. For example, if a person experiences premature rupture of membranes and infection, preeclampsia, placental abruption, and/or placenta accrete, that person may be at risk of extensive blood loss, stroke, and/or septic shock, and it may be impossible for the fetus to survive.

Finally, the State's "medical emergency" definition ignores that a person may develop medical conditions unrelated to pregnancy after six weeks of gestation that may cause the person to seek an abortion. For example, people who learn after six weeks of gestation that they have

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[51] Other health-related exceptions present vagueness concerns, jeopardize a pregnant person's health, and/or require disclosure of confidential medical information.

[52] Allen et al., *Pain Relief for Obstetric and Gynecologic Ambulatory Procedures*, 40 Obstetrics & Gynecology Clinics N. Am. 625, 632 (2013) (uterine aspiration is used for induced abortion and treatment of miscarriages); Dennis et al., *Barriers to and Facilitators of Moving Miscarriage Management Out of the Operating Room*, 47 Persp. on Sexual & Reprod. Health 141, 141, 143 (2015) (technical aspects of miscarriage management and induced abortion are the same).

[53] Other elements of the Ban's exceptions are equally problematic. For example, "psychological or emotional conditions" are explicitly carved out of the definition of "medical emergency."

cancer requiring radiation or chemotherapy may seek an abortion to avoid having the fetus die in utero during treatment. But the Ban would prevent them from doing so. These situations are exemplary of the nuanced situations physicians face when administrating care and illustrate why a "medical emergency" cannot be effectively or accurately defined in legislation.

IV. THE BAN FORCES CLINICIANS TO CHOOSE BETWEEN UPHOLDING THEIR OBLIGATIONS AND FOLLOWING THE LAW

Amici, along with many other medical organizations, oppose legislation that interferes with the patient-clinician relationship and is not based on science.[54] The patient-clinician relationship is the keystone of delivering appropriate medical care, and legislative interference with no scientific basis, like the Ban, should not restrict clinicians' ability to exercise sound medical judgment and provide patients with a full range of safe and quality care.[55]

The Ban undermines clinicians' ability to act in the best interests of their patients and in furtherance of a patient's desire to receive a specific course of medically appropriate care. If a patient's health is compromised but the fetus has a detectable cardiac rhythm,[56] unless another exception applies, a physician may only perform an abortion in a "medical emergency," regardless of the medical judgment of the clinician faced with an actual patient in an evolving and complex situation and regardless of the patient's choice. In these circumstances, clinicians are put in a position of having to choose between following the law and acting in accordance

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54 *See, e.g.*, ACOG, *More Than 75 Health Care Organizations Release Joint Statement in Opposition to Legislative Interference*; SMFM, *Access to Abortion Services*, at 1; ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, amended and re-aff'd July 2019).

55 SMFM, *Access to Abortion Services*, at 1–2.

56 As discussed above, while embryonic cardiac activity is detectable around six weeks, it is not considered a human "heartbeat" by the medical community, and the unscientific usage of the word "heartbeat" by the legislature acts as a proxy for banning all abortions after six weeks of gestation.

with medical ethics that prioritize patient wellbeing, as well as a patient's desire to receive certain care. This is an untenable choice.

The Ban frustrates clinicians' abilities to ensure that their patients receive the most appropriate and effective care and impedes adherence to the profession's ethical principles of beneficence, non-maleficence, and patient autonomy.[57] Beneficence requires clinicians to act in a way that is likely to benefit patients.[58] Non-maleficence directs clinicians to refrain from acting in ways that might harm patients unless the harm is justified by concomitant benefits.[59] Yet under the Ban, a physician who believes abortion care is appropriate for a patient facing a medical condition after approximately six weeks of gestation is unable to provide medically necessary care until the patient's health deteriorates to the point of a "medical emergency" (or another exception applies). The physician is then required to report to the State the basis of their determination that a "medical emergency" existed.[60] This suggests that the State is willing to second-guess medical judgments. Knowing they will likely face intense scrutiny in the future and potential criminal consequences, clinicians may well be deterred from providing abortion care in situations where they are unsure whether a "medical emergency" occurred in the opinion of the State.

Similarly, principles of patient autonomy recognize that patients have ultimate control over their bodies and a right to a meaningful choice when making medical decisions.[61]

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57 ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, at 3–5 (Dec. 2007, re-aff'd 2016); *see also* AMA, *Principles of Medical Ethics, Chapter 1: Opinions on Patient-Physician Relationships*, § 1.1.3(b) (2016).

58 ACOG, Committee Opinion No. 390, at 3–4.

59 *Id.*

60 Ga. Code Ann. § 31-8B-3(a).

61 ACOG, Committee Opinion No. 390, at 3.

Physicians are ethically obligated to honor and respect patient decisions about the course of their care through patient-centered counseling, providing patients with 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.[62] The Ban removes these meaningful choices from patients and their physicians and replaces them with a blanket legislative prohibition.

A physician's ability to practice medicine in accordance with bedrock principles of medical ethics is complicated by the looming threat of potential criminal penalties applicable under the Ban. A physician found guilty of violating the Ban faces up to ten years in prison.[63] The Ban's criminal sanctions effectively require physicians not to provide care, even if doing so is consistent with sound medical judgment and their patients' wishes.

CONCLUSION

For all the reasons stated above, the Court should grant the Plaintiffs' Emergency Motion for Interlocutory Injunction and Temporary Restraining Order.

Dated: August 8, 2022

Respectfully submitted,

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62 SMFM, *Access to Abortion Services*, at 2 ("[P]hysicians have a professional responsibility to respect each individual's autonomy in decisions regarding pregnancy and to provide nonjudgmental care.").

63 Ga. Code Ann. § 16-12-140(b).

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CERTIFICATE OF SERVICE

I hereby certify that I have this day caused a true and correct copy of the foregoing document to be served upon all counsel of record by this Court's Odyssey E-fileGA System, as well as sending a copy of the same via e-mail, to the following counsel of record:

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