No. 20-11401-B

In the United States Court of Appeals *for the* Eleventh Circuit

YASHICA ROBINSON, et al.,
Plaintiffs-Appellees,

v.

ATTORNEY GENERAL, STATE OF ALABAMA, et al.,
Defendants-Appellants.

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:19-CV-00365-MHT-JTA, Hon. Myron H. Thompson

BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND OTHER NATIONWIDE ORGANIZATIONS OF MEDICAL PROFESSIONALS AS *AMICI CURIAE* SUPPORTING PLAINTIFFS-APPELLEES ON THE MERITS AND OPPOSING THE STAY MOTION

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9. American Urogynecologic Society: *amicus curiae*

10. Mayer Brown LLP: counsel for *amici curiae*

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13. National Association of Nurse Practitioners in Women's Health: *amicus curiae*

14. North American Society for Pediatric and Adolescent Gynecology: *amicus curiae*

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18. Society for Maternal-Fetal Medicine: *amicus curiae*

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20. Society of Gynecologic Surgeons: *amicus curiae*

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Dated: April 21, 2020 /s/ *Nicole A. Saharsky*

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INTEREST OF *AMICI CURIAE*

Amici are nationwide, non-partisan organizations of leading medical professionals and experts in the United States. They represent the doctors and nurses who are on the front lines caring for patients and fighting the COVID-19 pandemic, at great personal cost. *Amici*'s members are directly affected by the COVID-19 crisis and the attendant shortages of hospital resources and personal protective equipment (PPE). A full list of *amici* is provided in the appendix to this brief.[1]

Amici submit this brief to provide the medical community's perspective on the state orders at issue in this case. Those orders significantly limit access to abortion care in Alabama during the COVID-19 pandemic.

It is the consensus of the nation's medical experts that the COVID-19 pandemic does not justify restricting or prohibiting abortion care. In fact, the restrictions at issue will increase, rather than decrease, use of hospital resources and personal protective equipment (PPE). And they

[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than *amici curiae*, their members, and their counsel, made a monetary contribution to the preparation or submission of this brief. *See* Fed. R. App. P. 29(a)(4)(E). The parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2).

will pose a severe threat to the health and well-being of women in Alabama. In sum, these restrictions on abortion care are contrary to the considered judgment of the medical community.

STATEMENT OF THE ISSUE

Whether the COVID-19 pandemic justifies an indefinite criminal ban on non-emergency abortions in Alabama.

INTRODUCTION AND SUMMARY OF ARGUMENT

Alabama's State Health Officer (SHO) has issued orders that broadly restrict abortion in Alabama during the COVID-19 pandemic. *Amici* are leading societies of medical professionals, whose policies represent the considered judgment of many health care professionals in this country. In *amici*'s judgment, the SHO's orders lack a valid medical justification. If these restrictions are allowed to take effect, they will render abortion largely inaccessible in Alabama and will severely harm women. They also will severely chill doctors, by subjecting them to criminal penalties for providing necessary medical care. And rather than promote public health, the orders will lead to the increased use of hospital resources and PPE and the further spread of COVID-19.

The SHO's orders require postponement "until further notice" of "all dental, medical, or surgical procedures."[2] The orders have two exceptions: procedures "necessary to treat an emergency medical condition" and procedures "necessary to avoid serious harm from an underlying condition or disease, or necessary as part of a patient's ongoing and active treatment."[3] The state has interpreted the orders to "apply to abortions," and, in particular, to ban all abortions except those "required to protect the life and health of the mother."[4]

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[2] Scott Harris, *Order of the State Health Officer Suspending Certain Public Gatherings Due to Risk of Infection by COVID-19* ¶ 14 (Apr. 3, 2020) (*April 3 Order*), https://perma.cc/8FG4-SFS5. The SHO issued an initial order on March 19, 2020, which he amended on March 27, 2020, and again on April 3, 2020. *See* Scott Harris, *Order of the State Health Officer Suspending Certain Public Gatherings Due to Risk of Infection by COVID-19* (Mar. 19, 2020), https://perma.cc/Z7WM-4PTL; Scott Harris, *Order of the State Health Officer Suspending Certain Public Gatherings Due to Risk of Infection by COVID-19* (Mar. 27, 2020), https://perma.cc/KGV2-CJBE.

[3] *April 3 Order* ¶ 14.

[4] Opinion 7, D. Ct. Dkt. 137 (M.D. Ala. Apr. 12, 2020) (Opinion).

According to the Attorney General, physicians and medical professionals who violate the order may be subject to criminal penalties, including up to a $500 fine per violation.[5] Violators also may lose their professional licenses.[6] Although the order currently lasts only through April 30, 2020,[7] there is no medical or scientific reason to believe that the COVID-19 pandemic will be resolved by then.

In the course of the litigation, attorneys for the state officials have taken varying – and contradictory – positions on whether the ban permits any non-emergency exceptions.[8] For example, at one point, they suggested that a woman could obtain an abortion if she were nearing the 20-week limit under Alabama law.[9] These possible qualifications appear to

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[5] Steve Marshall, *Guidance for Law Enforcement* (updated Mar. 27, 2020) (*Attorney General Guidance*), https://perma.cc/WCH9-F9WZ; *see* Ala. Code §§ 22-2-2(6), 22-2-14.

[6] *See, e.g.*, Ala. Code § 34-24-360.

[7] *April 3 Order* ¶ 16.

[8] Opinion 20 ("Over the course of this litigation, the defendants themselves have put forth several divergent interpretations of the medical restrictions, each with dramatically different implications for the plaintiffs."); *see id.* at 5 (noting state officials' "multiple inconsistent interpretations" of the SHO's orders).

[9] *Id.* at 10-12.

be nothing more than convenient litigating positions that may not bind the Attorney General or local prosecutors (the officials with authority to enforce the orders).[10] Indeed, although the district court's preliminary injunction simply restates and renders enforceable many of the assurances the state officials gave in litigation,[11] the state officials are appealing that ruling – making it clear that the state's view is that it can broadly ban abortion during the COVID-19 pandemic, and that it will do so in the absence of a court order.

The SHO's ban on abortion is contrary to the considered judgment of the country's leading physician organizations, including guidance from the American Medical Association, the American College of Obstetricians

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[10] *See id.* at 20-21 ("The court has no enforceable guarantee that the medical restrictions will *not* be interpreted [to bar non-emergency abortion] by those tasked with their enforcement"); *id.* at 48 (finding "warranted" plaintiffs' "reticence to trust the representations of the defendants, particularly with respect to non-binding interpretations that emerged after multiple days of litigation"); *id.* at 51 (given Alabama's anti-abortion environment, plaintiffs "might reasonably fear that prosecutions under the medical restrictions will proceed despite the defendants' on-the-record interpretations" of the SHO's orders); *see also W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310, 1328 (11th Cir. 2018) ("Mid-litigation assurances are all too easy to make and all too hard to enforce, which probably explains why the Supreme Court has refused to accept them.").

[11] *See, e.g.*, Opinion 52.

and Gynecologists, and the American College of Surgeons.[12] *Amici* understand that the COVID-19 pandemic is a public health crisis that requires the full attention and resources of our health care system. But banning abortion will not help address the pandemic. Most abortions do not require any hospital resources and use only minimal PPE. Banning abortion will actually increase use of those resources and contribute to spread of the virus. At the same time, the order will severely impair essential health care for women, while placing doctors, nurses, and other medical professionals in an untenable position by criminalizing essential medical care.

This Court should affirm the district court's order entering a preliminary injunction and should deny the motion to stay the preliminary injunction.

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[12] ACOG, *Joint Statement on Abortion Access During the COVID-19 Outbreak* (Mar. 18, 2020) (ACOG Joint Statement), https://perma.cc/52S9-LHUA; Am. Coll. of Surgeons, *COVID-19 Guidelines for Triage of Gynecology Patients* (Mar. 24, 2020) (*American College of Surgeons Statement*), https://perma.cc/4KXE-24KY; Am. Med. Ass'n, *AMA Statement on Government Interference in Reproductive Health Care* (Mar. 30, 2020) (*AMA Statement*), https://perma.cc/2YZR-2UXT.

ARGUMENT

I. ABORTION IS ESSENTIAL, TIME-SENSITIVE, AND SAFE HEALTH CARE

Abortion is an essential component of comprehensive health care. Like all medical matters, decisions regarding abortion should be made by patients in consultation with their physicians and health care professionals and without undue interference from outside parties.[13] The medical community recognizes that "[a]ccess to legal and safe pregnancy termination . . . is essential to the public health of women everywhere."[14]

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[13] ACOG, *Statement of Policy, Abortion* (reaffirmed 2017) (*ACOG Abortion Policy*), https://perma.cc/73RA-RMUK.

[14] Editors of the *New England Journal of Medicine* et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979, 979 (2019) (stating the view of the editors, along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine, including the American Board of Obstetrics and Gynecology); *see ACOG Joint Statement*; *American College of Surgeons Statement; AMA Statement*.

Abortion also is a common medical procedure. In 2017, medical professionals performed over 860,000 abortions nationwide,[15] including approximately 6,110 in Alabama.[16] Approximately one-quarter of American women will have an abortion before the age of 45.[17]

Abortion is one of the safest medical procedures performed in the United States, and the vast majority (95%) of abortions are performed in clinics or doctors' offices, not in hospitals.[18] Complication rates from abortion are extremely low – even lower than from other common medical

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[15] Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2017*, at 7 (2019) (*Abortion Incidence 2017*).

[16] Guttmacher Inst., *State Facts About Abortion: Alabama* (2020), https://perma.cc/G29P-QBYH.

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

[18] *See, e.g.*, Rachel K. Jones & Kathryn Kooistra, *Abortion Incidence and Access to Services in the United States, 2008*, 43 Perspectives on Sexual & Reprod. Health 41, 42 (2011) (*Abortion Incidence 2008*); Theodore Joyce, *The Supply-Side Economics of Abortion*, 365 New Eng. J. Med. 1466, 1467 (2011) (Joyce); 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*).

procedures.[19] Most complications are relatively minor and can be easily treated at a clinic and/or with antibiotics.[20]

Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50 percent of cases, depending on the method used.[21] The risk of death from abortion is even rarer. Nationally, fewer than one in 100,000 patients die from abortion-related complications.[22] The risk of death associated with childbirth is approximately fourteen times higher than the risk associated with abortion.[23]

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[19] *Safety and Quality of Abortion Care* 10, 36 ("legal abortions in the United States . . . are safe and effective," and "[s]erious complications are rare," affecting fewer than 1% of patients); *see id.* at 51-68.

[20] *See* Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (Upadhyay); *Safety and Quality of Abortion Care* 60, 116; ACOG, *Induced Abortion: What Complications Can Occur with an Abortion?* (2015), https://perma.cc/DFU5-WL5D.

[21] Kari White et al., *Complications from First Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434, 435 tbl. 7 (2015) (White).

[22] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012) (Raymond & Grimes); *see* ACOG, *Guidelines for Women's Health Care: A Resource Manual* 719 (4th ed. 2014).

[23] Raymond & Grimes 216.

The SHO's orders appear to ban both medication abortion and procedural abortion. Medication abortion is a safe and effective option for most women up through the tenth week of pregnancy.[24] For medication abortions, patients typically take the medication to complete the procedure at home.[25] For some women, medication abortion is not medically appropriate because of underlying health conditions or other factors.[26] In Alabama, 32% of abortions are medication abortions.[27]

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[24] *See Safety and Quality of Abortion Care* 10, 51-55.

[25] Tara C. Jatlaoui et al., *Abortion Surveillance – United States 2015*, 67 Morbidity & Mortality Weekly Rep. 1, 33 tbl. 11 (2018) (Jatlaoui); Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 Perspectives on Sexual & Reprod. Health 17, 24 tbl. 5 (2017) (*Abortion Incidence 2014*).

[26] *See* ACOG & Soc'y of Family Planning, *Practice Bulletin No. 143: Medical Management of First-Trimester Abortion* 6 (Mar. 2014), https://perma.cc/5B6K-2HY3.

[27] Jatlaoui 33 tbl. 11; *see Abortion Incidence 2014*, at 24 tbl. 5.

Procedural abortions (the other 68% of abortions in Alabama) commonly are performed in clinics or doctor's offices, as opposed to hospitals.[28] The safety of abortions performed in office settings is equivalent to that of those performed in hospital settings.[29]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is an extremely safe, common medical procedure. The Supreme Court made just that point in *Whole Woman's Health v. Hellerstedt*, when it noted that "[t]he great weight of evidence demonstrates that," before Texas enacted certain regulations, "abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure."[30]

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[28] *Abortion Incidence 2017*.

[29] Sarah C.M. Roberts et al., *Association of Facility Type with Procedural-Related Morbidities and Adverse Events Among Patients Undergoing Induced Abortions*, 319 JAMA 2497, 2505 (2018); White 440; *see Safety and Quality of Abortion Care* 10, 73, 79.

[30] 136 S. Ct. 2292, 2302 (2016) (quoting district court's order); *see June Medical Services LLC v. Kliebert*, 250 F. Supp. 3d 27, 61 (M.D. La. 2017) ("Abortion is one of the safest medical procedures in the United States."), *rev'd*, 905 F.3d 787 (5th Cir. 2018), *cert. granted*, 140 S. Ct. 35 (2019) (No. 18-1323) (argued Mar. 4, 2020).

While abortion is a safe and common medical procedure, it is also a time-sensitive one for which a delay may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person's life, health, and well-being.

II. THE SHO'S ORDERS WILL MAKE SAFE, LEGAL ABORTION INACCESSIBLE IN ALABAMA

The SHO's orders appear to require Alabama's abortion facilities to indefinitely suspend all non-emergency abortion services. This will lead to abortion care being delayed or denied.

The state characterizes the SHO's orders as merely delaying abortion care because the ban will be lifted once the COVID-19 pandemic has subsided.[31] But in the meantime, many women will pass the 20-week mark at which Alabama prohibits most abortions.[32] For those women, care delayed would mean care denied.

While some women may be able to seek care once the executive orders expire, at that time existing facilities may not have enough capacity

[31] Appellants' Opening Br. 37-38.

[32] *See* Ala. Code § 26-23B-5.

to immediately provide abortion care to patients seeking that care, which will delay the service even further.[33] There are only three operating abortion clinics in the entire state of Alabama,[34] serving some 953,000 women of reproductive age.[35]

Delay would mean that many patients seeking abortion care in early pregnancy would not be able to obtain care until the second trimester. Those women would no longer be eligible for medication abortion, which is safe and effective only in the first trimester.[36]

Further, delays in receiving care can compromise patients' health. Abortion should be performed as early as possible because, although abortion procedures are among the safest medical procedures, the rate of complications increases as the pregnancy progresses.[37] The chance of a

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[33] Kari White et al., *The Potential Impacts of Texas' Executive Order on Patients' Access to Abortion Care* 2, Tex. Policy Evaluation Project, Research Brief (2020) (*Potential Impacts*), https://perma.cc/5V3F-25UK.

[34] *See* Hearing Tr. 78:4-9, D. Ct. Dkt. 133 (Apr. 6, 2020).

[35] Jonathan Bearak et al., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care*, Guttmacher Inst. (updated Apr. 8, 2020) (Bearak), https://perma.cc/E398-SVJ8.

[36] *Safety and Quality of Abortion Care* 10, 51-55.

[37] *Safety and Quality of Abortion Care* 75; *see ACOG Abortion Policy*.

major complication is higher in the second trimester than in the first trimester.[38] The fact that it is relatively safer for a woman to obtain abortion care earlier in pregnancy than later is one of the reasons that the nation's leading medical experts oppose laws that delay abortion care during the COVID-19 pandemic.[39] Also, second-trimester abortions "are more expensive [than first-trimester abortions], and fewer facilities offer the service."[40]

Many women face resource constraints, work schedules, and family demands that make it difficult or impossible to plan to seek abortion care during a narrow window of time. For women who face barriers to access due to lack of resources, requiring that an abortion procedure be delayed indefinitely could mean, as a practical matter, that the woman will not be able to obtain abortion care.

As a result of the SHO's orders, some women will travel out of state to obtain abortion care. One recent study concluded that if Alabama were to shut down legal abortion care, the need to travel out of state would

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[38] Upadhyay 181.

[39] *See ACOG Joint Statement*; *American College of Surgeons Statement*; *AMA Statement*.

[40] *See Potential Impacts* 2.

mean that "[t]he average (median) one-way driving distance to an abortion clinic for a woman of reproductive age (15-44) in Alabama would increase from 26 miles to 108 miles (or 315% longer)."[41] While the out-of-state travel itself poses an undue burden on women seeking abortion care, three of Alabama's four neighboring states also impose a waiting period of 24 hours or more.[42] Two of those states (Mississippi and Tennessee) also require a mandatory in-person consultation visit, necessitating two separate visits to the same facility.[43]

Many women will not have the means to travel out of state, particularly as COVID-19 has created "economic uncertainty from lost wages and need to care for children who are at home."[44] Especially for low-income women, "[i]t is often difficult . . . to make the necessary arrangements to travel to a clinic, especially one that is far away. Finding child

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[41] Bearak.

[42] *See* Guttmacher Inst., *Counseling and Waiting Periods for Abortion* (2020), https://perma.cc/TW5C-ZNBJ. A federal court has enjoined enforcement of the waiting period enacted in the fourth state (Florida). *See id.*

[43] *See id.*

[44] *See Potential Impacts* 3.

care, taking time off work and covering the cost of gas increase patients' out-of-pocket expenses and are logistically challenging to arrange."[45]

The SHO's orders will likely cause some women to resort to unsafe methods of care. Studies have found that women are more likely to self-induce abortions when they face barriers to reproductive services.[46] For example, from 2011 to 2013, Texas severely curtailed the ability to obtain abortion care, leading to sharp declines in abortions performed in that state.[47] A study that surveyed Texas women seeking abortions in 2013 concluded that "self-managed abortion may become more common if clinic-based abortion care becomes more difficult to access," especially "among poor women – who make up more than half of all abortion patients."[48] Women who lack resources to travel out of state are more likely to attempt to self-induce abortion or seek an illegal abortion.[49] Methods

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[45] *See id.*

[46] *See, e.g.*, Lisa H. Harris & Daniel Grossman, *Complications of Unsafe and Self-Managed Abortion*, 382 New Eng. J. Med. 1029, 1029 (2020).

[47] Liza Fuentes et al., *Texas Women's Decisions and Experiences Regarding Self-Managed Abortion*, BMC Women's Health 2 (2020) (Fuentes).

[48] *Id.* at 11.

[49] *See* ACOG, Comm. on Health Care for Underserved Women, *Opinion Number 613: Increasing Access to Abortion*, 124 Obstetrics & Gynecology 1060, 1061-62 (2014) (*ACOG Opinion 613*); Elizabeth G. Raymond et al.,

of self-induction may rely on harmful tactics such as herbal or homeopathic remedies, getting punched in the abdomen, using alcohol or illicit drugs, or taking hormonal pills.[50]

Finally, evidence suggests that women are more likely to experience short-term psychological issues when denied an abortion. For example, women denied abortions because of gestational age bans are more likely to report short-term symptoms of anxiety than those women who received an abortion.[51] Accordingly, restrictions on abortion, such as those at issue, are detrimental to women's physical and psychological health and well-being.

Mortality of Induced Abortion, Other Outpatient Surgical Procedures and Common Activities in the United States, 90 Contraception 476, 478 (2014); Fuentes 2, 11.

[50] Daniel Grossman et al., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas*, Tex. Policy Evaluation Project, Research Brief 3 (2015).

[51] M. Antonia Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169, 172 (2017).

III. THERE IS NO MEDICAL JUSTIFICATION FOR THE SHO'S ORDERS, AND THEY WILL SEVERELY HARM WOMEN AND MEDICAL PROFESSIONALS

A. The COVID-19 Pandemic Does Not Justify Restricting Or Prohibiting Abortion Care In Alabama

It is the consensus of the nation's medical experts that the COVID-19 pandemic does not justify restricting abortion care.[52] The Attorney General has sought to justify the SHO's orders by pointing to goals of preventing "crowded waiting rooms" and preserving hospital resources and PPE.[53] But restrictions on abortion would not serve those goals.

Physicians and other clinicians who provide abortion can mitigate concerns about crowded waiting rooms by rescheduling appointments or transferring services such as contraceptive counseling to telemedicine, so

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[52] *ACOG Joint Statement* (ACOG and several other medical organizations "do not support COVID-19 responses that cancel or delay abortion procedures."); *American College of Surgeons Statement* (listing "[p]regnancy termination (for medical indication or patient request)" as a "[s]urger[y] that if significantly delayed could cause significant harm"); *AMA Statement* (In response to states issuing orders "ban[ning] or dramatically limit[ing] women's reproductive health care," the AMA's view is that "physicians – not politicians – should be the ones deciding which procedures are urgent-emergent and need to be performed, and which ones can wait, in partnership with our patients.").

[53] Steve Marshall, Press Release, *Attorney General Steve Marshall Responds to ACLU Effort to Keep Alabama Abortion Clinics Open* (Mar. 30, 2020), https://perma.cc/9988-NP8F.

that only patients who require in-person care are seen in person.[54] And crowded conditions may be further avoided by other means, such as limiting the number of appointments per day.

Further, the vast majority of abortions are performed in non-hospital settings,[55] and do not use hospital resources or hospital PPE. Medication abortions in particular require no PPE other than perhaps a pair of gloves.[56] Procedural abortions typically require only minimal PPE (gloves, a surgical mask, and reusable eyewear).[57] Absent unusual circumstances (such as a patient suspected of having contracted COVID-19), neither form of abortion requires use of the PPE most needed to fight

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[54] *See* ACOG, *COVID-19 FAQs for Obstetrician-Gynecologists, Telehealth* (last visited Apr. 21, 2020) (reporting that in a recent survey, "[t]elehealth interventions were effective for continuation of oral and injectable contraception"), https://perma.cc/8L9V-JBWG.

[55] Jatlaoui 33 tbl. 11; Joyce 1467; *see Abortion Incidence 2014*, at 24 tbl. 5; *Abortion Incidence 2008*, at 42.

[56] Opinion 39 & n.15.

[57] *See* Daniel Grossman, *Abortions Don't Drain Hospital Resources*, Boston Review (Apr. 17, 2020), https://perma.cc/822S-RXDW; *see also* Corrected Robinson Decl. ¶ 30, D. Ct. Dkt. 99-1 (Apr. 2, 2020) (procedural abortion requires only "gloves, . . . a gown, a surgical mask and reusable eyewear"); Opinion 38 ("[M]ost abortions and related appointments require a limited amount of personal protective equipment (PPE).").

the COVID-19 pandemic, such as N95 face masks.[58] And very few abortions result in complications requiring hospitalization.[59]

Restricting abortion will make hospital and PPE shortages worse. Pregnant women remain in the health care system. They often visit hospitals (including emergency rooms) for evaluation, using bed space and resources. Most women give birth in hospitals, and some births require surgery. As one district court recently explained, "[p]regnant women prevented from accessing abortion will still require medical care," and "delaying access to abortion will not conserve PPE" or "hospital resources."[60] Further, women who attempt unsafe, unmanaged abortions may require

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[58] *See, e.g.*, Corrected Robinson Decl. ¶ 31, D. Ct. Dkt. 99-1 (Apr. 2, 2020) ("We do not use N-95 masks to perform abortions"); *Planned Parenthood Center for Choice v. Abbott*, No. A-20-CV-323-LY, 2020 WL 1815587, at *4 (W.D. Tex. Apr. 9, 2020) ("Abortion providers generally do not use N95 masks"), *vacated by In re Abbott*, No. 20-50296 (5th Cir. Apr. 20, 2020).

[59] Ushma D. Upadhyay et al., *Incidence of Post-Abortion Complications and Emergency Department Visits Among Nearly 55,000 Abortions Covered by the California Medi-Cal Program* slide 28 (Jan. 28, 2014), https://perma.cc/Y4NJ-WM7Q.

[60] *Planned Parenthood*, 2020 WL 1815587, at *4; *see* Michelle J. Bayefsky et al., *Abortion During the Covid-19 Pandemic – Ensuring Access to an Essential Health Service*, New Eng. J. Med. (Apr. 9, 2020) (pregnancy "could lead to much more contact with clinicians and greater need for PPE, thereby increasing risks to both patients and staff").

emergency hospitalization. And women who travel to other states to obtain abortions may contribute to the spread of COVID-19.[61]

Amici are on the front lines of the COVID-19 pandemic. Their members are caring for patients every day in trying circumstances and in cases where they have not been provided adequate PPE or testing. *Amici* recognize the importance of conserving scarce resources during this critical time. But banning abortion will not increase the hospital resources and PPE needed to care for people affected by the pandemic.

B. The Order Will Harm Women And Pose A Serious Threat To Medical Professionals In Alabama

Banning non-emergency abortion increases the likelihood that women will delay abortion care or will not be able to obtain it at all. Women may travel outside the state to obtain abortions, attempt to self-induce abortions, or be unable to obtain abortions at all, forcing them to

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[61] Centers for Disease Control & Prevention, *Coronavirus Disease 2019 (COVID-19) – Travel in the US* (last visited Apr. 9, 2020), https://perma.cc/2QA7-TL9M; *see Planned Parenthood*, 2020 WL 1815587, at *5 ("long-distance travel" to obtain abortion "increases an individual's risk of contracting COVID-19").

carry unwanted pregnancies to term.[62] Each outcome increases the likelihood of negative consequences to a woman's physical and psychological health that could be avoided if abortion services were available.[63]

Banning abortion also seriously threatens physicians and medical professionals. In addition to fighting the COVID-19 pandemic, doctors and medical professionals must try to figure out how they can continue providing care without violating the orders. Under the orders, doctors, nurses, and other medical professionals who perform abortion care that is constitutionally protected and medically necessary could lose their licenses and even be subject to criminal penalties. Those are draconian sanctions to place on individuals who are only attempting to offer the best possible care to their patients.

Finally, the SHO's orders further burden women and medical professionals for an additional reason: They are far too vague and uncertain. The orders on their face prohibit "all dental, medical, or surgical procedures," with exceptions only for procedures "necessary to treat an emergency medical condition" and those "necessary to avoid serious harm from

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[62] *See, e.g.*, *Abortion Incidence 2017*, at 3, 8.

[63] *See, e.g.*, *ACOG Opinion 613*.

an underlying condition or disease, or necessary as part of a patient's ongoing and active treatment."[64] Both before and during this litigation, the state officials have offered a range of confusing and conflicting interpretations of the orders' language, ranging from an initial assurance that the initial March 19 order would not apply to abortion clinics, to an assurance that women may obtain abortions if they are approaching 20 weeks, to an assertion that only abortions necessary to preserve the patient's life or health may go forward.[65] None of the state officials' assurances appear to be binding in the absence of an injunction. Indeed, the SHO has disclaimed any knowledge about how the Attorney General would enforce the orders in practice.[66] Doctors and their patients should not be forced to make judgment calls about what the SHO's orders allow, under threat of criminal punishment if they guess wrong about how the orders will be enforced.

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[64] *April 3 Order* ¶ 14.

[65] *See* Opinion 5-16 (recounting at length defendants' shifting interpretations of the SHO's orders).

[66] *See id.* at 20-21 (citing Hearing Tr. 44:15-25, D. Ct. Dkt. 133 (April 6, 2020)).

Abortion is essential health care for women, protected by the Constitution. No valid medical justification supports the SHO's restrictions on abortion. *Amici* urge this Court to affirm the order granting the preliminary injunction and deny the motion to stay that order.

CONCLUSION

The Court should affirm the order granting the preliminary injunction and should deny the motion to stay that order.

Respectfully submitted,

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Dated: April 21, 2020

CERTIFICATE OF SERVICE

I hereby certify that on April 21, 2020, I electronically filed the foregoing brief with the Clerk of the Court using the appellate CM/ECF system. I further certify that all participants in this case are registered CM/ECF users and that service will be accomplished via CM/ECF.

Dated: April 21, 2020 /s/ *Nicole A. Saharsky*

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), the undersigned counsel for *Amici Curiae* certifies that this brief:

(i) complies with the type-volume limitation of Rule 29(a)(5) because it contains 4,568 words, including footnotes and excluding the parts of the brief exempted by Rule 32(f); and

(ii) complies with the typeface and type style requirements of Rule 32(a) because it has been prepared using Microsoft Office Word 2016 and is set in Century Schoolbook font in a size equivalent to 14 points or larger.

Dated: April 21, 2020 /s/ *Nicole A. Saharsky*

APPENDIX

LIST OF *AMICI CURIAE*

1. The **American College of Obstetricians and Gynecologists** (ACOG) is the nation's leading group of physicians providing health care for women. With more than 60,000 members – representing more than 90 percent of all obstetricians-gynecologists in the United States – 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, for all women. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care. ACOG has previously appeared as *amicus curiae* in various courts throughout the country. ACOG's briefs and guidelines have been cited by numerous courts as providing authoritative medical data regarding childbirth and abortion.

2. The **American Academy of Family Physicians** (AAFP) is the national medical specialty society representing family physicians.

Founded in 1947 as a not-for-profit corporation, its 134,600 members are physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and serving the needs of its members with professionalism and creativity.

3. The **American Academy of Nursing** (Academy) serves the public by advancing health policy through the generation, synthesis, and dissemination of nursing knowledge. Academy Fellows are inducted into the organization for their extraordinary contributions to improve health locally and globally. With more than 2,800 Fellows, the Academy represents nursing's most accomplished leaders in policy, research, administration, practice, and academia.

4. The **American Academy of Pediatrics** (AAP) is a non-profit professional organization founded in 1930 dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Its membership is comprised of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. AAP has

become a powerful voice for child and adolescent health through education, research, advocacy, and the provision of expert advice. AAP has worked with the federal and state governments, health care providers, and parents on behalf of America's families to ensure the availability of safe and effective reproductive health services.

5. The **American College of Osteopathic Obstetricians and Gynecologists** (ACOOG) is a non-profit, non-partisan organization committed to excellence in women's health representing over 2,500 providers. ACOOG educates and supports osteopathic physicians to improve the quality of life for women by promoting programs that are innovative, visionary, inclusive, and socially relevant. ACOOG is likewise committed to the physical, emotional, and spiritual health of women.

6. The **American College of Physicians** (ACP) is the largest medical specialty organization in the U.S. and has members in more than 145 countries worldwide. ACP membership includes 159,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

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

8. The **American Society of Reproductive Medicine** (ASRM) is a multidisciplinary not-for-profit organization dedicated to the advancement of the science and practice of reproductive medicine. Its members include approximately 8,000 professionals. ASRM accomplishes its mission through the pursuit of excellence in education and research and through advocacy on behalf of patients, physicians, and affiliated health care providers.

9. The **American Urogynecologic Society** (AUGS) is the premier non-profit organization representing professionals dedicated to treating female pelvic floor disorders. Founded in 1979, AUGS represents more than 1,900 members, including practicing physicians, nurse practitioners, physical therapists, nurses and health care professionals, and researchers from many disciplines.

10. The **National Association of Nurse Practitioners in Women's Health** (NPWH) is a national non-profit educational and professional organization that works to ensure the provision of quality primary and specialty health care to women of all ages by women's health and women's health-focused nurse practitioners. Its mission includes protecting and promoting a woman's right to make her own choices regarding her health within the context of her personal, religious, cultural, and family beliefs. Since its inception in 1980, NPWH has been a trusted source of information on nurse practitioner education, practice, and women's health issues. In keeping with its mission, NPWH is committed to ensuring the availability of the full spectrum of evidence-based reproductive health care for women and opposes unnecessary restrictions on access that serve to delay or prevent care.

11. The **North American Society for Pediatric and Adolescent Gynecology** (NASPAG) is dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth. NASPAG conducts and encourages multidisciplinary and inter-professional programs of medical education and

research in the field and advocates for the reproductive well-being of children and adolescents and the provision of unrestricted, unbiased, and evidence-based medical practice.

12. The **Society for Adolescent Health and Medicine** (SAHM), founded in 1968, is a non-profit multidisciplinary professional society committed to the promotion of health, well-being, and equity for all adolescents and young adults by supporting adolescent health and medicine professionals through the advancement of clinical practice, care delivery, research, advocacy, and professional development. It strives to empower its 1,200 members who are professionals and trainees in medicine, nursing, research, psychology, public health, social work, nutrition, education, and law from a variety of settings. Through education, research, clinical services and advocacy activities, SAHM enhances public and professional awareness of adolescent health issues among families, educators, policy makers, youth-serving organizations, students in the field as well as other health professionals around the world. SAHM continues to advocate on behalf of all adolescents and young adults on both federal and state government levels for the availability of safe and effective reproductive health services.

13. The **Society of Family Planning** (SFP) is the source for science on abortion and contraception. SFP represents approximately 800 scholars and academic clinicians united by a shared interest in advancing the science and clinical care of family planning. The pillars of its strategic plan are (1) building and supporting a multidisciplinary community of scholars and partners who have a shared focused on the science and clinical care of family planning; (2) supporting the production of research primed for impact; (3) advancing the delivery of clinical care based on the best available evidence; and (4) driving the uptake of family planning evidence into policy and practice.

14. The **Society for Maternal-Fetal Medicine** (SMFM), founded in 1977, is the medical professional society for obstetricians who have additional training in the area of high-risk, complicated pregnancies. Representing over 4,000 members, SMFM supports the clinical practice of maternal-fetal medicine by providing education, promoting research, and engaging in advocacy to reduce disparities and optimize the health of high-risk pregnant women and their babies. SMFM and its members are dedicated to ensuring that medically appropriate treatment options are available for high-risk women.

15. The mission of the **Society of Gynecologic Surgeons** is to promote excellence in gynecologic surgery through acquisition of knowledge and improvement of skills, advancement of basic and clinical research, and professional and public education.

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