

In the Supreme Court of Iowa

PLANNED PARENTHOOD OF THE HEARTLAND, INC.;
EMMA GOLDMAN CLINIC; AND SARAH TRAXLER, M.D.,
PETITIONERS-APPELLEES,

v.

KIM REYNOLDS *EX REL.* STATE OF IOWA
AND IOWA BOARD OF MEDICINE,
RESPONDENTS-APPELLANTS.

*APPEAL FROM THE IOWA DISTRICT COURT
FOR POLK COUNTY
JOSEPH SEIDLIN, DISTRICT JUDGE*

**BRIEF OF AMERICAN ASSOCIATION OF
PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS
AS *AMICUS CURIAE* IN SUPPORT OF
RESPONDENTS-APPELLANTS**

PETER M. SAND
Attorney at Law
1441 29th St., #310
West Des Moines, IA 50266
pete.sand6@gmail.com

Counsel for Amicus Curiae

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INTRODUCTION & INTEREST OF *AMICUS CURIAE*¹

The Association is a nonprofit professional medical organization with approximately 7,000 members and associates. Since 1973, the Association has worked to ensure that pregnant women receive the highest-quality medical care and are fully informed of the effects of abortion, including its potential long-term consequences for women’s health. Recognized for 40 years as the largest “special interest” entity within the American College of Obstetricians and Gynecologists (until the College abolished such entities in 2013), the Association offers healthcare professionals and the public a better understanding of abortion-related health risks. Some of these risks include: abortion-related injuries; future premature (or “preterm”) birth; breast cancer; and depression, substance abuse, and suicide. The Association educates the public about human development and findings in obstetrics and gynecology—

¹ All parties have consented in writing to the filing of this brief (see attached addendum). No party’s counsel authored the brief in whole or part, and no person other than the *amicus* and its counsel made any monetary contribution to fund its preparation or submission.

findings that shed light on the need for the law here, the Fetal Heartbeat Statute.

The Statute is supported by strong empirical evidence. Study after study shows that abortions correlate with *multiple* increased risks to women's health. The Legislature thus acted rationally in restricting abortion, especially as the Statute allows exceptions for medical emergencies. Indeed, abortion—intentional feticide—is *never* medically necessary. That is why 93% of obstetrician-gynecologists perform no abortions at all. It is also why, for over 2,000 years, the Hippocratic Oath has expressly forbidden abortion. For all these reasons, the Court should dissolve the injunction blocking enforcement of the Statute.

ARGUMENT

I. The injunction should be dissolved because the Fetal Heartbeat Statute enjoys strong empirical support and furthers the State's interest in protecting maternal health.

A. Published, peer-reviewed studies show that abortion raises the risk of later premature births.

Iowa has a strong interest in restricting abortions because of the association between abortion and future premature, or “preterm,” births.

Preterm birth is associated with “significant maternal and infant health risks” and is considered an “epidemic” in the United States. Linda S. Franck, et al., *Research Priorities of Women at Risk for Preterm Birth: Findings and a Call to Action*, 20(10) BMC Pregnancy and Childbirth 1, 2 (2020). Despite years of effort, “population level reduction in preterm birth rates have not been achieved.” *Id.* In 2021, after a pattern of increases, the preterm birth rate rose once again, to 10.5%. See Centers for Disease Control and Prevention, *Reproductive Health: Maternal and Infant Health, Preterm Birth* (Nov. 1, 2022).

Babies born preterm—that is before 37 weeks’ gestation—have higher rates of death and disability. According to the Centers for Disease Control and Prevention, in 2020 preterm birth and low birthweight (which is linked to preterm birth) accounted for about 16% of infant deaths. Centers for Disease Control and Prevention, *Preterm Birth, supra*. For related reasons, preterm births also impose substantial costs on society. An analysis by the Institute of Medicine estimated the economic costs associated with preterm birth in the United States to be “at least \$26.2 billion in 2005, or \$51,600 per infant born preterm.” Com-

mittee on Understanding Premature Birth and Assuring Healthy Outcomes, Institute of Medicine, *Preterm Birth: Causes, Consequences, and Prevention* (2007). Based on data from 2008 to 2016, a more recent study estimated the average medical costs in the first six months of life at \$76,153 per preterm birth. Andrew L. Beam, et al., *Estimates of Healthcare Spending for Preterm and Low-birthweight Infants in a Commercially Insured Population: 2008–2016*, 40 *J. Perinatology* 1091–1099 (2020).

Two significant 2009 meta-analyses show a statistically significant link between abortion and preterm birth. A meta-analysis of 22 studies that included 268,379 patients found that just one induced abortion raises the risk of preterm birth by 36%, and more than one increases the risk by 93%. See P.S. Shah, et al., *Induced Termination of Pregnancy and Low Birthweight and Preterm Birth: A Systematic Review and Meta-analysis*, 116 *British J. Obstet. & Gyn.* 1425, 1425 (2009). Another meta-analysis of nine studies found that one induced abortion raised preterm birth risks by 25% and *very*-preterm birth by 64%. See Hanes M. Swingle, et al., *Abortion and the Risk of Subsequent Preterm*

Birth: A Systematic Review with Meta-analyses, 54(2) J. Reproductive Med. 95, 95 (2009).

Later meta-analyses agree. A 2015 meta-analysis of 28 studies, which included 913,297 women, found that women who had a previous surgical abortion had a “significantly higher risk” (52%) of preterm birth. See Gabriele Saccone, et al., *Prior Uterine Evacuation of Pregnancy as Independent Risk Factor for Preterm Birth and Metaanalysis*, 214(5) Am. J. Obstet. & Gyn. 572, 572 (2016). A 2016 meta-analysis of 21 studies that reported on 1,853,017 women who underwent a dilation and curettage (a surgical procedure used for abortion or to complete a miscarriage) had a 29% increased risk of preterm birth and a 69% increased risk of very preterm birth. See Marike Lemmers, et al., *Dilation and Curettage Increases the Risk of Subsequent Preterm Birth: A Systemic Review and Meta-analysis*, Human Reproduction 1, 1 (2015).

It is true that a 2018 committee report from the National Academy of Sciences, which reviewed only five studies, concluded that “having an abortion does not increase a woman’s risk of preterm birth.” Nat’l Acad. Sci., Eng’g, and Med., *The Safety and Quality of Abortion Care in*

the United States 1, 153 (2018)(NAS Report). But the report failed to include at least 70 studies that met the committee’s stated criteria. See Am. Ass’n of Pro-life Obstet. & Gyn., *The Association between Surgical Abortion and Pre-term Birth, An Overview* (2021). And the authors had to acknowledge an “increased risk of very preterm birth” associated with two or more abortions. NAS Report at 147.

B. Published, peer-reviewed studies correlate abortion with breast-cancer risks.

1. Since 1957, at least 41 studies have shown a positive, statistically significant association between induced abortion and breast cancer. Breast Cancer Prevention Institute, *Epidemiological Studies: Induced Abortion and Breast Cancer Risk* (Apr. 2020) (listing studies). To take one example, a 2009 study in the *World Journal of Surgical Oncology* states that “age and induced abortion were found to be significantly associated with increased breast cancer risk.” Vahit Ozmen, et al., *Breast Cancer Risk Factors in Turkish Women – a University Hospital Based Nested Case Control Study*, 7(37) *World J. Surgical Oncology* 1, 1 (2009). But this 2009 study was far from alone. The authors also surveyed a host of analogous studies. And “similar to [the 2009 study’s]

findings, the majority of the studies reported that induced abortion was associated with increased breast cancer risk.” *Id.* at 6.

Likewise, a 2009 study coauthored by Dr. Louise Brinton, Chief of the Hormonal and Reproductive Epidemiology Branch at the National Cancer Institute, found risk factors for breast cancer “consistent with the effects observed in previous studies.” Jessica M. Dolle, et al., *Risk Factors for Triple-Negative Breast Cancer in Women Under the Age of 45 Years*, 18(4) *Cancer Epidemiology, Biomarkers and Prevention* 1157, 1162–63 (2009). “Specifically, older age, family history of breast cancer, earlier menarche [i.e., first menstrual period], *induced abortion*, and oral contraceptive use were associated with an increased risk for breast cancer.” *Id.* at 1163. (emphasis added).

Reaching the same conclusion, Chinese scientists recently included abortion as an important indicator of breast cancer risk in a new model for screening women. See Lu Wang, et al., *Risk Prediction for Breast Cancer in Han Chinese Women Based on a Cause-specific Hazard Model*, 19(128) *BMC Cancer* (2019). In fact, the study found that abor-

tion had the *most* impact: one or two abortions increased the risk 151%; three or more increased the risk by 530%. *Id.* at 4.

Further filling in the picture, another study “found an increased [breast-cancer] risk associated with an increasing number of induced abortions. However, this risk appeared to be restricted to pregnancies with induced interruptions before the first [full-term pregnancy].” Julie Lecarpentier, et al., *Variation in Breast Cancer Risk Associated with Factors Related to Pregnancies According to Truncating Mutation Location, in the French National BRCA1/2 Carrier Cohort*, 14(R99) Breast Cancer Research 1, 16 (2012). In other words, women faced a higher risk of cancer after having an abortion *if* the abortion occurred before the woman had her first child.

2. Breast cancer is linked to abortion because of how breasts grow during pregnancy. Immature, newly formed breast tissue is susceptible to cancer. Mature breast tissue, which can produce milk, resists cancer. Abortion arrests breast tissue in an immature state, before it can produce milk, leaving it vulnerable to cancer.

For this reason, “[e]arly full-term pregnancy is one of the most effective natural protections against breast cancer.” Sibgat Choudhury, et al., *Molecular Profiling of Human Mammary Gland Links Breast Cancer Risk to a p27+ Cell Population with Progenitor Characteristics*, 13(1) Cell Stem Cell 117, 2 (2013). The connection between childlessness and breast cancer has been known since at least 1842, when a higher incidence of breast cancer was observed among nuns than in other women. See Christopher I. Li, ed., *Breast Cancer Epidemiology* 120 (2010) (collecting 18th, 19th, and early 20th-century studies). Planned Parenthood agrees. “It is known that having a full-term pregnancy early in a woman’s childbearing years is protective against breast cancer[.]” Planned Parenthood, *Myths About Abortion and Breast Cancer* (2013).

The reason a full-term pregnancy makes breast cancer less likely is that pregnancy changes the physiology of the breast. Early in pregnancy, estrogen stimulates the growth of immature stem-cell breast tissue—growth that increases in the second trimester. At 20 weeks’ gestation, the body produces a hormonal signal that causes the immature

stem-cell breast tissue to begin to develop the capacity to make milk. By 32 weeks' gestation, roughly half of the breast tissue can make milk; and that tissue is much less susceptible to cancerous changes. By full term, over 90% of the breast tissue is fully genetically mature and can make milk, and thus is no longer susceptible to cancerous changes. See Jose Russo, et al., *Full-term Pregnancy Induces a Specific Genomic Signature in the Human Breast*, 17(1) *Cancer Epidemiology, Biomarkers and Prevention* 51 (Jan. 2008); I. Verlinden, et al., *Parity-Induced Changes in Global Gene Expression in the Human Mammary Gland*, 14(2) *European J. Cancer Prevention* 129 (2005).

As a result, a woman's risk of breast cancer rises if she has never brought a pregnancy to term and then loses the pregnancy before 32 weeks—whether the cause is a preterm birth, a second-trimester miscarriage, or an induced abortion. See L.J. Vatten, et al., *Pregnancy Related Protection Against Breast Cancer Depends on Length of Gestation*, 87 *British J. Cancer* 289 (2002); M. Melbye, et al., *Preterm Delivery and Risk of Breast Cancer*, 80 *British J. Cancer* 609 (1999).

In short, inducing abortion deprives a woman of the risk-reducing effects of a full-term pregnancy. She will either: (a) remain childless, thus losing the dramatic risk-reduction of a full-term pregnancy; or (b) have one fewer full-term pregnancy than she otherwise would, losing another 10% risk reduction. No matter what, inducing abortion will postpone a full-term pregnancy, thus raising her risk by 5% per year until she carries a pregnancy to term. Meanwhile, the abortion also will increase her risk for a preterm birth, which will double her breast-cancer risk. See C.C. Hsieh, et al., *Delivery of Premature Newborns and Maternal Breast Cancer Risk*, 353 *The Lancet* 1239 (1999).

C. Published, peer-reviewed studies increasingly show that abortion raises the risk of depression, drug abuse, and suicide.

Increasingly, research published in leading journals also shows that abortion is tied to an increased risk of psychological harm, including anxiety, depression, substance abuse, thoughts of suicide, and suicide.

1. At least 53 published studies show abortion associated with elevated mental-health risk. For instance, an analysis of data for a nationally representative cohort of 8,005 women found abortion consist-

ently tied to a 45% increased risk of mental-health disorder. See Donald Paul Sullins, *Abortion, Substance Abuse and Mental Health in Early Adulthood: Thirteen-year Longitudinal Evidence from the United States*, 4 Sage Open Med. 1, 1 (2016). A Finnish study of suicide after induced abortion found that, despite changes in medical care to address the issue, women who had an abortion remained at a twofold risk of suicide. See Mika Gissler, et al., *Decreased Suicide Rate after Induced Abortion, after the Current Care Guidelines in Finland 1987–2012*, 43 Scandinavian J. Pub. Health 99 (2015).

A 2011 meta-analysis of 22 published studies, which together included 877,181 participants, found that, compared to women who carried a pregnancy to term, women who had an abortion had an 81% increased risk of mental-health problems. See Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995–2009*, 199 British J. Psychiatry 180, 180 (2011). The analysis showed a 34% increased risk for anxiety disorders, 37% increased risk for major depression, 110% increased risk for alcohol abuse, 220% increased risk for marijuana abuse, and a 155% increased

risk of suicide attempts. *Id.* at 182. When compared to women who carried an *unwanted* pregnancy to term, women who underwent an abortion still experienced a 55% increased risk of mental-health problems. *Id.*

Similarly, a 2013 review of 30 studies examining abortion and mental-health issues, such as depression, anxiety disorders, and substance-abuse disorders, concluded that “abortion is a risk factor for subsequent mental illness when compared with childbirth.” Carlo Valerio Bellieni, et al., *Abortion and Subsequent Mental Health: Review of the Literature*, 67 *Psychiatry and Clinical Neurosciences* 301, 307 (2013). When abortion was “compared with the other two possible outcomes (miscarriage or the birth of an unplanned baby),” the risk of mental-health issues was greater or similar. *Id.* In other words, abortion was no remedy for mental-health issues; if anything, abortion made matters worse.

2. It is true that a 2008 report from the American Psychiatric Association concluded that “the relative risk of mental health problems among adult women who have an unplanned pregnancy is no greater if

they have an elective first-trimester abortion than if they deliver that pregnancy.” Am. Psychiatric Ass’n, *Mental Health and Abortion* 1, 90 (2008). But to draw this conclusion, the authors had to exclude:

- the 48%–52% of women who already had a history of one or more abortions;
- the 18% of patients who were minors;
- the 7% of women aborting for therapeutic reasons regarding their own health or concerns about the health of the fetus; and
- the 11%–64% of women whose pregnancies were wanted or planned, or for which the women had developed an attachment.

David C. Reardon, *The Abortion and Mental Health Controversy: A Comprehensive Literature Review of Common Ground Agreements, Disagreements, Actionable Recommendations, and Research Opportunities*, 6 SAGE Open Med. 1, 8–9 (2018). In short, the authors chose women *least* likely to suffer from mental-health issues, skewing the results in their report. It thus sheds no light on this case.

Moreover, over a decade’s-worth of studies since the 2008 report has led to “the consensus of expert opinion” that: (a) “a history of abortion is consistently associated with elevated rates of mental illness”; and (b) “the abortion experience can directly contribute to mental

health problems in some women.” Reardon, 6 SAGE Open Med. at 8. Thus, it is no answer to say that some studies have failed to link abortion and mental-health issues. A 2018 literature review found the “association between abortion and higher rates of anxiety, depression, substance use, traumatic symptoms, sleep disorders, and other negative outcomes is statistically significant in most analyses.” *Id.* at 6. And “the minority of analyses that do not show statistically significant higher rates of negative outcomes do not contradict those that do.” *Id.*

* * *

In sum, a rich literature shows that abortion threatens maternal health. The Fetal Heartbeat Statute thus rests on a solid rational basis.

II. The injunction should also be dissolved because the Fetal Heartbeat Statute exceeds the demands of medicine and medical ethics.

Nor is it an answer to say that restricting induced abortions endangers women’s lives. The Fetal Heartbeat Statute allows abortion after a fetal heartbeat is detected to save the mother’s life, or if the mother was a victim of rape or incest. That said, induced abortion is *never* medically necessary. Indeed, 93% of obstetrician-gynecologists *never*

perform elective abortions. See Sheila Desai, et al., *Estimating Abortion Provision and Abortion Referrals Among United States Obstetrician-Gynecologists in Private Practice*, 97 *Contraception* 297, 299 (2017).

In declining to perform abortions, doctors are keeping with the longstanding tradition of their profession. For thousands of years, the Hippocratic Oath, which codifies “the ethics of the medical profession,” has forbidden physicians from performing abortions. *Roe v. Wade*, 410 U.S. 113, 131 (1973) (“I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy.”) (quoting the Oath).

Instead, in the rare circumstance in which a mother’s life is endangered by a complication before the fetus is viable, a premature separation may be required—for example, by inducing labor or performing a cesarean section. Am. Ass’n. of Pro-Life Obstet. & Gyn., 10 *Practice Guideline, Concluding Pregnancy Ethically* 1, 11 (2022). Those steps are allowed under the Fetal Heartbeat Statute. And they can be taken in a way that respects both the life of the mother and the dignity of the

fetus, whose life may be lost only incidentally and not as an essential goal.

But again, in medical emergencies, the Statute allows premature separation *and* abortion. It should be allowed to take effect.

CONCLUSION

For all these reasons, the Court should dissolve the injunction.

Respectfully submitted,

/s/ Peter M. Sand
PETER M. SAND AT0006939
Attorney at Law
1441 29th St., #310
West Des Moines, IA 50266
[*pete.sand6@gmail.com*](mailto:pete.sand6@gmail.com)
Counsel for Amicus Curiae

Dated: Nov. 15, 2023

CERTIFICATE OF COST

No costs were incurred to print or duplicate paper copies of this brief because the brief is being filed only electronically.

CERTIFICATE OF COMPLIANCE

This brief complies with the typeface requirements of Iowa Rules of Appellate Procedure 6.903(a)(d) and 6.903(1)(g)(1) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Century Schoolbook, 14-point font and contains 2,933 words, excluding the parts exempted by Rule 6.903(1)(g)(1).

/s/ Peter M. Sand
Peter M. Sand

CERTIFICATE OF FILING AND SERVICE

I certify that on November 15, 2023, this brief was electronically filed with the Clerk of Court and served on all counsel of record to this appeal using EDMS.

/s/ Peter M. Sand
Peter M. Sand



ADDENDUM

WRITTEN CONSENT OF THE PARTIES

[PPH v. Reynolds] Consent for Amicus Briefs

3 messages

Im, Peter <peter.im@ppfa.org>

Tue, Oct 17, 2023 at 11:04 AM

To: "Wessan, Eric" <eric.wessan@ag.iowa.gov>, daniel.johnston@ag.iowa.gov, Rita Bettis Austen <rita.bettis@aclu-ia.org>, Sharon Wegner <sharon.wegner@aclu-ia.org>, Anjali Salvador <anjali.salvador@ppfa.org>, Dylan Cowit <dylan.cowit@ppfa.org>, Caitlin Slessor <CLS@shuttleworthlaw.com>, Sam Jones <SEJ@shuttleworthlaw.com>

Good morning counsel,

We have received a request for consent to file an amicus brief in support of the appellants in Planned Parenthood of the Heartland v. Reynolds. As we've done in previous cases, would you consent to a blanket agreement to consent to all amicus briefs filed for either side?

Thanks,
Peter

--

Peter Im (he/him)

Staff Attorney
Public Policy Litigation & Law
Planned Parenthood Federation of America
peter.im@ppfa.org
(646) 398-1453

Wessan, Eric <Eric.Wessan@ag.iowa.gov>

Tue, Oct 17, 2023 at 11:08 AM

To: "Im, Peter" <peter.im@ppfa.org>, "Johnston, Daniel" <Daniel.Johnston@ag.iowa.gov>, Rita Bettis <rita.bettis@aclu-ia.org>, Sharon Wegner <sharon.wegner@aclu-ia.org>, Anjali Salvador <anjali.salvador@ppfa.org>, Dylan Cowit <dylan.cowit@ppfa.org>, Caitlin Slessor <CLS@shuttleworthlaw.com>, "sej@shuttleworthlaw.com" <sej@shuttleworthlaw.com>

Dear Peter,

Yes, that makes sense to me. The State agrees to blanket consent. Thank you for affirmatively reaching out.

Best,
EHW

Eric Wessan

Solicitor General



Office of the Attorney General of Iowa

1305 E. Walnut St.

Des Moines, Iowa 50319

Phone: (515) 823-9117
