IN THE SUPREME COURT OF IOWA

No. 23-1145

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

Hon. Joseph Seidlin, District Judge

BRIEF OF NON-IOWAN ABORTION CARE PROVIDERS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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INTEREST OF AMICI CURIAE[1]

Amici Curiae are physicians who provide abortion care for patients in states close to Iowa. They have treated patients who have travelled out of state for abortion care because of abortion bans across the United States. *Amici* are among the providers who may provide necessary abortion care to Iowans if the temporary injunction on Iowa's abortion ban is lifted. The "*amici* providers" are:

Jonah Fleisher, M.D., M.P.H.

Dr. Fleisher is a Complex Family Planning specialist who provides full-spectrum obstetrics and gynecological care in Chicago. Dr. Fleisher attended medical school at Northwestern University, completed his residency in obstetrics and gynecology at Thomas Jefferson University Hospital in Philadelphia and his fellowship in complex family planning at New York University, where he also earned his Master of Public Health. He is a Fellow of the American Congress of Obstetricians and Gynecologists.

Mae-Lan Winchester, M.D.

Dr. Winchester is an obstetrician-gynecologist specializing in maternal-fetal medicine in Cleveland, Ohio and provides abortion care in Kansas City, Kansas. Dr. Winchester is also an Assistant Professor of Medicine. Dr. Winchester attended Eastern Virginia Medical School where she also completed her residency in obstetrics and gynecology. She completed her fellowship in maternal-fetal medicine at the University of Kansas Medical Center.

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[1] No counsel for a party authored the brief in whole or in part. No party, counsel for a party, or any person other than *amici curiae* and their counsel made a monetary contribution intended to fund the preparation or submission of the brief. In this brief, *amici curiae* provide their personal medical opinions and experiences regarding abortion care, and these beliefs do not necessarily represent the beliefs of the institutions for which they work. Some of the amici providers work for PPSLR, PPSA, PPGNWHAIK, and PPIL, which are independent non-profit corporations that do not have in common any employees, executives, or members of their boards of directors with Petitioner-Appellee Planned Parenthood of the Heartland.

Katherine "Katie" McHugh, M.D.

Dr. McHugh is an obstetrician-gynecologist specializing in chronic pelvic pain and reproductive health, who practices in Indiana, Ohio, and Maryland. She attended the Indiana University School of Medicine where she also completed her residency in obstetrics and gynecology.

Margaret Baum, M.D.

Dr. Margaret E. Baum is an obstetrician-gynecologist based in St. Louis, Missouri and Fairview Heights, Illinois. She is the Medical Director for Planned Parenthood of the St. Louis Region and Southwest Missouri (PPSLR). Dr. Baum received her medical degree from Johns Hopkins University School of Medicine, completed her internship at the University of Texas M.D. Anderson Cancer Center and her residency in obstetrics and gynecology at Washington University.

Michael A. Belmonte, M.D.

Dr. Michael A. Belmonte is an obstetrician-gynecologist and complex family planning specialist based in Washington, D.C. He is the Clinical Instructor of Obstetrics & Gynecology at George Washington University School of Medicine & Health Services. Before holding this position, Dr. Belmonte practiced and taught at the University of Colorado in Denver, Colorado. Dr. Belmonte received his medical degree from the University of Illinois, completed his internship and residency at Indiana University, and his fellowship in complex family planning at the University of Colorado.

Gopika Krishna, M.D., FACOG

Dr. Gopika Krishna is an obstetrician-gynecologist and complex family planning specialist based in Chapel Hill, North Carolina. She is an adjunct assistant professor and practices as a contract physician at Planned Parenthood South Atlantic ("PPSA"). Dr. Krishna received her medical degree from Warren Alpert Medical School of Brown University, completed her residency at Emory University School of Medicine, and completed her complex family planning fellowship at Columbia University Medical Center.

Caitlin Bernard, M.D.

Dr. Caitlin Bernard is an obstetrician-gynecologist and complex family planning specialist based in Indianapolis, Indiana. She is an assistant clinical

professor and is a physician at Planned Parenthood of Illinois ("PPIL") and Planned Parenthood Great Northwest, Hawai'i, Alaska, Indiana, Kentucky ("PPGNHAIK"). Dr. Bernard received her medical degree from and completed her residency in obstetrics and gynecology from Upstate Medical University, and completed her fellowship in complex family planning at Washington University in St. Louis. Dr. Bernard also received a masters of science in clinical investigation from Washington University in St. Louis.

INTRODUCTION AND SUMMARY OF ARGUMENT

Appellants ask this Court to vacate the temporary injunction which is blocking a medically unnecessary and life-threatening six-week abortion ban from taking effect and is thus saving women's lives in Iowa. Their arguments rest on numerous errors, including fundamental misconceptions of established medical practice and science of abortion care and, most tellingly, the ban's impact on the lives of many Iowans, particularly Iowans of color. In this brief, practicing physicians present to this Court, in their own words, what actually happens when an abortion ban takes effect. This brief will help the Court understand (1) that a six-week abortion ban is incompatible with sound medical evidence; (2) why abortion is vital and necessary healthcare; (3) the burdens, obstacles and risks that their patients experience from having to travel out of state to receive abortion care; (4) the ethical and moral implications of non-medical professionals determining healthcare for patients; and (5) the impact Iowa's abortion ban would have on patients and providers across the United States.

ARGUMENT

"Abortion is a common medical procedure and a familiar experience in women's lives. About 18 percent of pregnancies in this country end in abortion, and about one quarter of American women will have an abortion by the age of 45." *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2343–44 (2022) (Breyer, Sotomayor, and Kagan, JJ., dissenting). Physicians who have dedicated their professional lives to providing abortion care know that abortion care is vital and necessary healthcare. "Even an uncomplicated pregnancy imposes significant strain on the body, unavoidably involving significant physiological change and excruciating pain," and that "[f]or some women, pregnancy and childbirth can mean life-altering physical ailments or even death." *Id.* at 2338.

Each patient seeks abortion care for that person's own reasons. Regardless of the patient's reason, *amici* providers agree that, in their professional medical opinions, the decision of whether to obtain abortion care should always be left to the pregnant person. Legislation and judicial intervention stripping patients of this fundamental liberty facilitates bad healthcare and dehumanizes patients. The *amici* providers are experts who know that the choice to have an abortion is amongst the "most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and

autonomy[.]" *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992). Despite significant obstacles aimed at disrupting access to abortion care, it will continue to be necessary healthcare that patients will obtain, and ethical providers will provide.

I. A Ban on Abortion at Six Weeks is Contrary to Medical Evidence and Practice

The currently enjoined Iowa law is based on multiple medically incorrect assumptions about the definition of pregnancy, the risks and complications that can arise during pregnancy, and the timeline of fetal development. Each misconception contributes to Iowa's disingenuous claim that it is not banning almost all abortion care.

The enjoined law bans abortion if a "fetal heartbeat" is detected using an abdominal ultrasound, which usually occurs around the sixth week of pregnancy, measured from the first day of the last normal menstrual period ("LMP"). This occurs so early in a pregnancy that, even under the most ideal circumstances, Dr. Fleisher explains, a ban on abortion at the sixth week of pregnancy will prevent almost everyone in Iowa from accessing abortion care simply because they will not know that they are pregnant during that early, arbitrary timeframe.

As the *amici* providers explain, many pregnant people suffer complications because of their pregnancies. Many conditions cannot be diagnosed by the time the Iowa abortion ban would prevent the patients from obtaining an abortion in-state. Dr. Winchester specializes in maternal-fetal medicine, and most of their patients have health complications, conditions, or significant risks associated with pregnancy. These conditions include, among others, fatal fetal anomalies, uncontrolled high blood pressure, hyperthyroidism, heart disease, diabetes, hypertension, cancer, and blood clots. Drs. Fleisher, Belmonte, and Krishna specialize in complex family planning and also treat patients with complex pregnancy conditions. The *amici* providers agree that most of these conditions cannot be diagnosed by the sixth week of gestation. As Dr. Fleisher states:

Jonah Fleisher, M.D.

> Other complications that can impact pregnancy, or be impacted by pregnancy, are almost never diagnosed by 6 weeks. If the pregnant person is close to 40 weeks pregnant, then the treatment for a patient with these medical problems is delivery. But the most common time that people discover medical conditions that can complicate pregnancy is between 18 and 22 weeks when, as a part of normal prenatal care, they receive testing like an anatomy ultrasound scan. Approximately 3% of all pregnancies are complicated by a fetal anomaly. When anomalies are discovered during this scan, the process to diagnose the cause of the anomaly and the prognosis for the fetus begins, but this takes time. The patient might require other specialized tests to diagnose the anomaly like a fetal echo cardiogram, or an amniocentesis, which can take several weeks to obtain.

Because of the medically incorrect assumptions about pregnancy and pregnancy care underlying the Iowa ban, a patient in a state with such a ban will either face labyrinthine protocols to receive lifesaving abortion care or must quickly be referred out of state. As explained further below by *amici* providers, neither option permits providers in states with abortion bans, who have spent years studying and training to help guide patients through these important medical decisions, the ability to provide medical care in accordance with their training and best medical judgment because abortion bans tie their hands.

II. Abortion is Necessary to Protect Maternal Health

All of the *amici* providers agree that pregnancy can be dangerous even for a healthy person. As Dr. Fleisher describes unequivocally, the maternal "mortality rate of childbirth is fourteen times higher than that of an abortion, so no one should be forced to stay pregnant if they do not wish to be."[2] Every pregnancy imposes significant strain, stress, and physiological changes to the body of the pregnant person. The *amici* providers explain that in many cases,

[2] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, OBSTETRICS & GYNECOLOGY 119 (2 Part 1): p. 215–19 (2012), https://pubmed.ncbi.nlm.nih.gov/22270271/.

abortion is medically necessary to protect the lives and well-being of their patients and is quite literally a lifesaving procedure.

As explained by Drs. Fleisher and McHugh:

Jonah Fleisher, M.D.

> As a hospital provider, many of my patients are referred to me because they have health conditions or significant risks associated with their pregnancy. I see many people travelling from outside Illinois with major fetal anomalies, uncontrolled high blood pressure, hyperthyroidism, heart disease, dangerous blood clots (called "deep vein thromboses" ("DVTs")), and other medical problems.

Katie McHugh, M.D.

> I recently treated a patient who had traveled from a state with an abortion ban. She had a history of a condition called pulmonary hypertension which is a type of high pressure in vessels in and around the lungs. This condition is extremely dangerous when the patient is not pregnant, and if the patient is pregnant, there is a very high maternal mortality rate. In many cases, someone who receives this diagnosis is told to never get pregnant, and if they do, they are immediately recommended to have an abortion.
>
> It was plainly bad healthcare for a provider to tell her that she should risk her life for this very slim possibility that she could get far enough into her pregnancy that there might be viability of the fetus, and yet that is what those providers were forced to do because of the legal restrictions in their state around this medical decision.

The narratives of the *amici* providers are but a few examples of the conditions that real live patients experience during pregnancy and that require prompt abortion care. As Dr. Winchester explains, "If you are presented with

these symptoms on your oral boards to become a board-certified OB/GYN, and you provide any answer other than providing abortion care, YOU FAIL." Conditions that warrant abortion care are not limited to gynecological conditions. Abortion bans also implicate and prevent other life-saving medical care that a pregnant patient may need. As Dr. Belmonte describes:

Michael A. Belmonte, M.D.

> Patients with cervical or breast cancer diagnoses are not able to receive life-saving chemotherapy, radiation or other cancer treatments because the state is more concerned with the potential impact on the patient's fetus. Those patients cannot receive treatments until they are no longer pregnant, but they also cannot receive abortion care to then be able to receive life-saving chemotherapy, radiation or other cancer treatments. Many doctors will not even discuss any potential options with pregnant patients who are diagnosed with cancer because of the fear of legal repercussions. Instead, these patients are left to seek all medical care out of state.
>
> One of my patients who had been diagnosed with cervical cancer became pregnant in a state with a six-week abortion ban. By the time she realized she was pregnant, she was past six-weeks gestational age. Her providers refused to discuss any options with her even though she wanted a termination. By the time I was able to see her, and my team spent additional time coordinating the logistics and procedural plan for her abortion to avoid causing unnecessary harm or compromising her chances for curative treatment relating to the cervical cancer, such as cancer cells from spreading, life-threatening bleeding or a hysterectomy, her gestational age had doubled.

The abortion bans also do not account for other life circumstances that threaten the life of the pregnant patient because of the pregnancy, such as mental illness, sex trafficking, and intimate partner violence. Intimate partner

violence is especially high during pregnancy, and pregnant people who experience intimate partner violence during pregnancy are about three times more likely to suffer perinatal death than those who do not experience intimate partner violence.[3] Despite the risk to the patient's life, providers practicing under abortion bans cannot provide the appropriate treatment. Dr. Bernard explains:

Caitlin Bernard, M.D.

> Although some might attempt to justify abortion bans with the exceptions for the life of the mother or lethal fetal anomalies, those exceptions do not function as intended because of the fear of retribution. Nor do the exceptions properly consider every possibility, complication or condition that can arise when a patient is pregnant. For example, mental health conditions such as severe depression or suicidal ideation are not covered by the health/life exceptions to most abortion bans. I have seen several suicide attempts related to unplanned pregnancies. Adolescents who are trafficked and become pregnant cannot receive abortion care under the exceptions. Patients who experience intimate partner violence due to an unplanned pregnancy may not be able to receive abortion care under the exceptions, even when their life is at risk.

Although the Iowa abortion ban includes a limited exception for abortions later in pregnancy for medical emergencies, fetal abnormalities that are

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[3] *See* Shaina Goodman, *Intimate Partner Violence Endangers Pregnant People and their Infants*, NATIONAL PARTNERSHIP FOR WOMEN & FAMILIES: NATIONAL BIRTH EQUITY COLLABORATIVE, https://nationalpartnership.org/wp-content/uploads/2023/02/intimate-partner-violence-endangers-pregnant-people-and-their-infants.pdf (last visited Dec. 31, 2023).

incompatible with life and , as Dr. Winchester explains, this exception is patently vague and ambiguous, does not cover all circumstances where abortion care would protect the pregnant person's life, and is not clearly interpreted or applied by hospital lawyers, administrators, and medical staff:

> There's just no way anyone could ever imagine all the potential circumstances in which someone may need an abortion. It's an endless list. Legislators pretend they can plan for it with these bans. Each person is so different, each pregnancy is unique. This ban just create harm for patients and physicians.

III. There Are Significant Implications of Travel on Patients Seeking Abortion Care

Abortion bans, like Iowa's currently enjoined six-week ban, force patients (at least those who have the ability and resources) to travel to seek and obtain legal abortion care. As the *amici* providers explain, there are not only medical risks associated with travelling for abortion care, but also monetary, logistical, and familial negative implications that disrupt the patients' lives, livelihood, and health, and pose significant burdens to obtaining basic healthcare.

A. There Are Risks Associated with Travelling for Abortion Care

The *amici* providers have seen and treated patients who have travelled from every state that restricts abortion care. It is not unusual for these patients to be travelling for ten hours or more. For most patients, abortion involves

either taking medications or a short aspiration or dilation and evacuation procedure; forcing patients to travel to a different state makes accessing such care much more onerous than necessary. Several *amici* providers specialize in care for patients with medical complications or conditions that make pregnancy especially dangerous, and these patients would be forced to undergo more complex procedures far from home.

Even for patients who do not have dangerous underlying medical conditions, travelling for abortion care imposes medical risks for the average pregnant person. Dr. Fleisher explains:

> Pregnant people are at a higher risk for deep vein thrombosis, which is a blood clot in the legs that can travel to the lungs and be fatal. The risk of these blood clots forming increases when someone is sedentary for longer periods of time, such as when riding on long car trips or on planes. As a hospital-based abortion provider, I also treat people who are at even higher risk of clots because of a genetic condition that makes them even more prone to develop these blood clots. These patients are at particular risk when traveling for abortion care.

In addition, as many of the *amici* providers explain, patients often drive hours to obtain out-of-state abortion care, facing practical safety risks when doing so, such as severe weather and a variety of travel hazards. These risks can easily be avoided if the patient can receive abortion care in the patient's own local community. However, if the ban at issue is allowed to take effect, these mortality and other risks will be forced upon thousands of patients.

The factor producing the second highest risk associated with having to travel for abortion care is the delay. As the *amici* providers below explain, travel for abortion care is not an immediate action that these patients can take the minute they decide it is the best, healthiest medical option for them. They must figure out where they can go to get an abortion, arrange travel logistics, figure out how to pay for their travel and care, find childcare for their children, secure time off from work, and then travel hundreds or thousands of miles. The influx of patients travelling to states that still permit abortion have also caused significant delays in scheduling appointments. These delays pose additional medical risks to the patients, and often result in longer, more complex procedures than would be unnecessary had the patients not been delayed by obstacles imposed by abortion bans in their home states. Dr. Jonah Fleisher and Dr. Gopika Krishna explain:

Jonah Fleisher, M.D.

> The delay in accessing abortion care that abortion bans create increases the danger and cost of abortion. Although abortion is safe, and always safer than childbirth, each week that passes slightly increases the medical risks of abortion. As a hospital-based provider, many of the patients that I see are seeking abortion care because they have more complex medical complications or conditions that make the pregnancy especially dangerous, such as genetic abnormalities, heart disease, blood clots, high blood pressure, preeclampsia and other high-risk conditions. Some of these patients travel to Illinois only to find that they cannot get abortion care from a freestanding abortion clinic or Planned Parenthood because their medical conditions

require hospital-based care. Then they must start the process over again to make appointments with a hospital-based provider like me. This creates unnecessary delay, stress, cost, and physical risk of harm.

Gopika Krishna, M.D.

With the continued abortion bans, my colleagues in Georgia have now been forced to transfer pregnant patients with pre-term water breaks or cancer diagnoses to nearby states such as North Carolina. The time it takes to transfer these patients and for them to receive the appropriate care in North Carolina put these patients at risk for additional avoidable and severe complications including heavy bleeding and infections.

In addition to the logistical travel barriers, patients travelling from out of state to North Carolina have to navigate a new health care system, cannot see providers that they know, and are isolated from their support network. Because of the medically unnecessary mandatory 72-hour waiting period, and the mandatory in-person follow-up appointment, many patients have to either stay for over 4 days or travel multiple times to receive abortion care.

B. The Costs and Burdens of Travel for Abortion Care

As the *amici* providers explain, aside from the medical risks of having to travel to receive abortion care, there are also unexpected costs and burdens associated with travelling across state lines for abortion care. As Dr. Jonah Fleisher and Dr. Margaret Baum attest:

Jonah Fleisher, M.D.

Even with the assistance of family, friends, neighbors, and philanthropic abortion funds that help arrange travel and pay for medical care, people sometimes have to choose between paying

> for their abortion or their rent that month. Some cannot arrange childcare. I have seen people lose their jobs because of all the workdays they have missed when travelling for abortion care.
>
> **Margaret Baum, M.D.**
>
> As a result of *Dobbs*, our wait times increased from three days to 3 weeks—and that is with expanding hours and days of operations. When patients come to me later in their pregnancies, the procedure is longer and takes 2-3 days, is more expensive, and has more risks than if the patient had had access to a provider earlier or in their home state.
>
> I had one minor patient who travelled from out of state her mother for an abortion. They did not realize how far along her pregnancy was before her exam and were not prepared to stay for a multi-day procedure. The patient's mother had to be back home the next day. These logistical complications of having to travel a far distance for routine abortion care caused the patient to have to leave that day without getting the abortion because the patient's mother could not stay multiple days for the abortion procedure.

Approximately 60 percent of patients seeking abortion care already have children, and they must coordinate, and be able to afford, childcare as well as food and lodging to travel for abortions. Drs. Baum and Winchester describe:

> **Margaret Baum, M.D.**
>
> There is no easy way to get to Illinois on public transportation, and many patients, especially patients with low incomes, do not have access to a vehicle to make the drive. Patients who can drive, sometimes long distances to receive care in Illinois, often do so by themselves and may have to stay for multi-day procedures. The travel requires money for gas, food, lodging, as well as the procedures, and arranging childcare and time off work

> – all of which can take significant time. For example, a patient told me that she had spent all her money on travel to access abortion care and did not have money left for food. I have had patients show up for their abortion procedures with their children because they were unable to secure childcare.
>
> **Mae-Lan Winchester, M.D.**
>
> One patient I talked to described driving out-of-state for her abortion. Because of her unique situation, she required a three-day procedure. So, it was five days, all-in, driving one day each way and the three-day procedure. She didn't feel like she could breathe the entire time. It was like a five-day panic attack. And it cost her $11,000.

Many patients also experience unforeseen issues related to their travel which make the logistics extraordinarily and unnecessarily difficult, burdensome, risky and stressful. Such examples that Drs. Baum, Winchester, and Belmonte have witnessed include:

> **Margaret Baum, M.D.**
>
> I saw one patient, who was travelling with their partner to Illinois for a multi-day abortion procedure. When they arrived in Illinois, they were unable to get a hotel room because they were not 21. Another patient took a multi-hour bus ride to see me for abortion care in Illinois. We had helped arrange a hotel for her to stay in, but when she arrived, she was unable to check in because she had no form of ID.
>
> **Mae-Lan Winchester, M.D.**
>
> I had one patient recently who came to Kansas from out-of-state, and drove ten hours for me to tell her that she wasn't pregnant. But she didn't want to go to a doctor at home because she didn't know who she could trust.

Michael A. Belmonte, M.D.

> Some patients that I have seen in Colorado that travelled from out of state were so concerned about any records or documentation of their pregnancy existing in their home state that once they suspected they were pregnant, or took an at home pregnancy test, they would immediately seek out-of-state care. Several of these patients were so scared of potential legal repercussions that they travelled hundreds of miles to see me only to be told they were not in fact pregnant and have to turn around to go home. The legal landscape in many states with abortion bans is so uncertain that patients spend valuable time and money, and tremendous anxiety to see a doctor out of state even to just confirm a suspected pregnancy.

Patients who can navigate the logistics, costs and personal burden to access abortion care are the lucky ones, as the burdens are prohibitive for many others who are now forced to continue their pregnancies to term or self-manage their abortions.

C. Differential Impact on Minority and Low-Income Patients

If allowed to take effect, Iowa's six-week abortion ban will disproportionately and more severely impact minority and low-income patients.[4] As Dr. Baum explains, "for patients with low incomes or BIPOC [Black, Indigenous, and people of color] patients, there are already significant barriers and lack of access to get basic health care." Barriers to medical care

[4] *See* Katherine Kortsmit et al., *Abortion Surveillance – United States*, 2020, Centers for Disease Control and Prevention, Table 6 (Nov. 25, 2022), http://dx.doi.org/10.15585/mmwr.ss7110a1.

are compounded for low-income and minority patients who seek abortion care, and in many cases become prohibitive. For example, as mentioned above, patients travelling for abortion access need identification for flights and hotels. Although some may take for granted having a form of identification, millions of Americans do not have government-issued identification, which is common amongst low-income and minority populations with unstable housing.

Even if a low-income or minority patient can be seen by a community provider in Iowa and somehow put the resources together to travel for abortion care, the patients in many instances will not get that care out-of-state because they will not know where to go. Many minority patients reside in healthcare deserts and their providers do not have a broad network of healthcare providers out-of-state to whom they can refer patients. As Dr. Winchester explains, accessing abortion care becomes "a 'who you know' thing to access medical care." Thus, Iowa's abortion ban, if allowed to go into effect, will disproportionately harm the most vulnerable members of its population. Drs. Bernard, McHugh and Winchester explain:

Caitlin Bernard, M.D.

> The restrictions on abortion care do not just impact the ability for physicians to provide abortions, but rather all obstetrics and gynecological care. Three labor and delivery centers closed in Indiana this year. Hospitals cannot train and recruit OBGYNs in

order to keep the centers open. The result is maternity care deserts throughout the state. Without the availability of any practicing OBGYNs in significant portions of the state – what are pregnant patients supposed to do for any prenatal care, aside from abortion care? Serious conditions are left untreated, or undiagnosed. Patients suffer unnecessary complications and their health is significantly impacted, including death from treatable conditions like ectopic pregnancy, which requires expert OBGYN care. The lack of availability of OBGYN care is also an issue for women who are at term and in labor, but do not live near a hospital. Or if they do make it to a hospital, it may not have an OBGYN on staff, and therefore no one to perform a Cesarean section if complications occur with the patient's labor.

Katie McHugh, M.D.

Low-income and minority patients have difficulty traveling to even the in-state clinics let alone out-of-state because of the lack of public transportation and lack of access to their own private transportation. This means that the financial barriers to accessing abortion care are huge, and disproportionately impact low-income and minority patients.

Even if these patients were to recognize the symptoms of pregnancy before six weeks, many patients live in huge healthcare deserts[5] without access to ultrasound equipment that would be required to diagnose and date a pregnancy that early into gestation. Thus, a six-week ban would effectively ban abortion for these patients.

Mae-Lan Winchester, M.D.

The medical system has historically been biased against persons of color and in no area is that truer than abortion care.

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[5] *See, e.g.*, Eli Saslow, *'Out Here, It's Just Me': In The Medical Desert of Rural America, One Doctor for 11,000 Square Miles*, THE WASHINGTON POST, Sept. 28, 2019, https://www.washingtonpost.com/national/out-here-its-just-me/2019/09/28/fa1df9b6-deef-11e9-be96-6adb81821e90_story.html.

IV. Iowa's Abortion Ban Would Create Substantial Ethical and Moral Implications for Healthcare Providers

Practically, abortion ban laws do not and cannot account for every possible complication, condition, or situation that pregnant patients and their providers may face. Iowa's abortion ban may result in medically and ethically compromised medical care for any person who can become pregnant. This ban would substitute the opinions and decisions of hospital lawyers, administrators, politicians, legislators, and judges for the medical opinions and decisions of physicians who have spent years training and treating patients and who are considering the best medical interests of a particular patient. These situations are no longer theoretical exercises for the Court to understand. Abortion bans are causing medically compromised care all over the country, and the reality is horrific.

A. The Conflict Between Legal Concerns and Proper Patient Care

Dr. Winchester, who specializes in maternal-fetal medicine in Ohio, provided abortion care during the 66 days when the Ohio "heartbeat abortion ban" was in effect in 2022. Under the ban, if she could receive approval from hospital lawyers, Dr. Winchester was permitted to provide care in the interest of maternal life. As she explains, the process of having to (1) get the attention of hospital lawyers, (2) explain to non-medical professionals the medical

reasons why abortion was necessary to protect the life of the patient, and (3) argue with lawyers over whether the patient's condition was "bad enough" to warrant approval, was excruciating. Exceptions to abortion bans to save maternal life are not clearly defined. The process delayed necessary care for each of her patients and compromised her ability to provide the best medical care in the best interest of her patient. Dr. Winchester recounts:

Mae-Lan Winchester, M.D.

> Immediately after *Dobbs* came down, I had a patient come in late in her second trimester. Her symptoms are all very diagnostic for an in-utero infection, which will kill the patient unless you perform an abortion. There's no question that an abortion was the right medical decision for this patient. But I had to call the hospital lawyers to make sure that they were okay with what I was doing, and make sure that the hospital was covered. The whole process was extremely disruptive to providing the care my patient needed.
>
> I had another case where the patient had twins in her second trimester. The first twin was abnormally small. Because the first baby was so small, it was going to die no matter what, so my focus, and the focus of my patient, had shifted to doing everything possible to provide care for the surviving baby.
>
> This was an emergency situation over the weekend, and I was trying to call our lawyers for clearance to provide the care my patient needed. I handed my cell phone to a medical student on rotation with me, told them to call the lawyer's number over and over and over until they reached someone. It is difficult for a layperson to understand the intricacies of the medicine and my patient's situation. It's an emergency, we need to decide right now what course of care to provide.

> My patient was lying in the operating room, alone, without me there, because I was out in the hall on the phone with the lawyers. I didn't want to have this conversation on the phone in front of the patient. So, I have no idea what's going on with the patient in the OR while I'm pleading with the lawyers on the phone in this emergency situation. Although the lawyers eventually approved the medically necessary care for my patient, her care was delayed, which placed her at added risk.

As Dr. Winchester explains, lawyers and administrators not only lack medical training, but owe their duty of loyalty to the hospital or institution itself, and thus their job is to make decisions based on the best interest of their client, and not the patient:

Mae-Lan Winchester, M.D.

> If I tell a lawyer that in my best medical opinion the mother's pregnancy is very, very risky and I believe an abortion is the proper medical care, and the lawyers tell me "well, it's not risky enough," it's insulting. It is *very* clear that they're not my lawyer, they're not my patient's lawyer, they're the hospital's lawyer. They're there to protect the institution, not the patient.
>
> I had one patient where I thought my hospital would understand and let me proceed, but refused and so my patient had to travel out-of-state. When we did the 20-week anatomy scan, there were several anomalies, which in my best clinical judgments were lethal fetal anomalies in a patient who had *significant* risk because of the pregnancy.
>
> I wrote to the hospital's lawyers, explained all the major risks to the mother, and wrote specifically that "in my best medical opinion, her condition presents a significantly increased risk to maternal life." The lawyers disagreed, concerned about the complexity that lethal fetal anomalies threw into the equation because abortion for fetal anomalies was not allowed under Ohio's ban. So I had to call my patient back. I had to tell her

> that I couldn't provide her care. She was shocked, angry, and more scared than ever.

Abortion bans put providers in ethically compromising situations where they are legally unable to provide the best medical care to their patients without the risk of legal liability, creating chaos and uncertainty for providers and patients alike. Lawyers and doctors alike are confused and worried regarding potential legal exposure when presented with patients who need lifesaving abortion procedures. If this Court dissolves the temporary injunction barring Iowa's abortion ban from taking effect, it will be imposing the beliefs of a minority of the population on innocent patients and providers, in direct contradiction of the medical standard of care and the Iowa Constitution. The chilling effect of such legislation compromises patient care, as Drs. Fleisher and Bernard explain:

Jonah Fleisher, M.D.

> The chilling effect from abortion bans, including especially six-week bans, causes harm to many pregnant people with complicated pregnancies. Even when there are exceptions to the abortion ban for the life of the pregnant person – doctors do not know what that means or how close the patient has to be to death before the doctors can intervene. Because doctors do not know at what point the exceptions would apply, they do not or cannot treat patients as quickly or according to the standard of care. OBGYNs often do not know how sick someone has to get before we are allowed to intervene, and, if the fetus has a so-called "heartbeat" detectable on an ultrasound, doctors are often unsure if treating the patient could mean losing their license, or even imprisonment.

Caitlin Bernard, M.D.

> Doctors are refusing to provide appropriate treatment to their patients for fear of legal retribution due to abortion bans and restrictions. We have seen patients with incomplete abortions, which should be treated as a miscarriage, arrive at an ER with significant bleeding who were previously sent home. Ectopic pregnancies are not treated for fear of being considered a prohibited abortion. Doctors would rather send patients to other hospitals or out of state and let someone else bear the risk of providing proper treatment due to the arbitrary and unclear legal limits on abortion care.
>
> One patient of mine was diagnosed with a condition that is uniformly lethal to the fetus, but not always within 3 months of birth, which is the legal definition for an exception in Indiana. Due to the arbitrary and unreasonable law, we could not provide her with abortion care, forcing her to continue the pregnancy knowing the baby would die within a year of birth.

V. Abortion Bans Impact Patients and Providers in Surrounding States

An abortion ban will not stop pregnant Iowans from seeking or obtaining abortion care. Most are persistent, and many will travel to clinics and hospitals out of state. As the *amici* providers explain, they have experienced a significant increase in patient volume due to abortion bans that are in effect in other states:

Jonah Fleisher, M.D.

> In Illinois, we have faced a tremendous influx of patients who are in dire need of abortion care because of bans in surrounding states. When the *Dobbs* decision came into effect, the volume of patients seeking abortion care in Illinois – and the complexity of

> their cases – increased dramatically, with some private clinics experiencing double the volume overnight. In my practice, the proportion of patients that I see travelling from out of state has dramatically increased, as have the complexity of cases.
>
> **Katie McHugh, M.D.**
>
> The minute that the *Dobbs* decision went into effect, our phones began ringing non-stop. Patients who were sitting in the waiting rooms of clinics in states with trigger bans, such as Kentucky, Tennessee, and Louisiana were calling our clinic to schedule appointments for abortion care. Overnight, our scheduled caseload went from 20 patients per day, two days per week to 50 patients per day five days per week. It felt like a wake – and we were all working through the death of something incredibly important.

A. Abortion Bans Drain Resources and Availability of Appointments

The influx of patients travelling because of abortion bans puts significant strain on the clinics and institutions that provide abortion care in surrounding states. This includes hospital and outpatient centers that provide medical procedures other than abortions. As Dr. Fleisher explains, providing abortion care and coordinating the logistics required for patients travelling from out of state is a resource intensive process, and "it really 'takes a village' to provide excellent abortion care."

Many of the institutions and clinics in states surrounding those with abortion bans are operating with the same resources and staffing as they were pre-*Dobbs*. As a result, they are not able to provide the same timely care to

their patients post-*Dobbs*. These are the down-stream consequences of abortion bans for the entire healthcare system that Iowa is not anticipating or accommodating in its efforts to ban abortion. Drs. McHugh and Belmonte explain:

Katie McHugh, M.D.

> The demand for abortion care is still physically difficult to accommodate. We are treating the influx of patients and handling the extra paperwork with the same staffing and financial resources that we had pre-*Dobbs*. If there are any issues, or I am held up with the patient for any reason, there are thirty-five other patients whose care is delayed. Consequently, I have time only to perform the clinical procedure without providing the same level of emotional support I would prefer.

Michael A. Belmonte, M.D.

> Almost immediately after the *Dobbs* decision was published, my practice in Colorado experienced a significant increase in patients travelling from out of state for abortion care. I began seeing approximately 40 patients per month for abortion care, a 100% increase from the pre-*Dobbs* numbers. Because of the significant increase in the volume of patients, the wait time to get an appointment increased from one week to approximately six weeks.
>
> The huge influx of patients seeking out-of-state abortion care caused a scheduling nightmare at my clinic. The phones were ringing off the hook and it was a struggle to get the schedules set. We had to increase the number of providers in order to accommodate the increased patient flow, and occasionally opened the clinic for double clinic hours with simultaneous telehealth appointments. We also had to perform more abortions at the hospital for patients with more complex pregnancy complications and later gestational ages.

CONCLUSION

Since *Dobbs*, real people have faced significant consequences, burdens, and medical risks to exercise what should still be their own autonomous choice over their own bodies and lives. Unanimously, the *amici* agree that, in their professional medical experience, abortion is both figuratively and literally lifesaving, and the earlier in pregnancy that abortion is banned, the more harm it will cause people who can get pregnant. This Court should avoid imposing ill-conceived and ill-informed restrictions on abortion, and let the individual pregnant person consult with their doctor and decide for themselves how to handle a pregnancy. As Dr. Krishna states, "The care that patients are able to receive in states like New York should not be a privilege. Laws should not determine what options or the quality of medical care we are able to provide our patients – rather the best medical evidence should."

The six-week abortion ban before this Court creates a real and undue burden on people in Iowa. The Court should affirm the district court's decision granting the temporary injunction and prevent Iowa's abortion ban from taking effect.

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Respectfully Submitted,

/s/ *Katelynn T. McCollough*

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COST CERTIFICATE

Amici Curiae certify that they expended no funds for the printing of their response brief in this Court.

*/s/Katelynn T. McCollough*__
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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with the typeface requirements and type-volume limitations of Iowa Rules of Appellate Procedure 6.903(1)(e), 6.903(1)(g)(1) or (2), and 6.096(4) because it has been prepared in a proportionally spaced typeface using Times New Roman in 14-point font and contains 6,984 words, excluding those portions of the brief exempted by Iowa Rule of Appellate Procedure 6.903(1)(g)(1).

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CERTIFICATE OF FILING AND SERVICE

I certify that on January 16, 2024, this brief was electronically filed with the Clerk of Court and served on all counsel of record to this appeal using EDMS.

*/s/Katelynn T. McCollough*__
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