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No. 2023AP002362

IN THE SUPREME COURT OF WISCONSIN

JOSH KAUL, WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES, WISCONSIN MEDICAL EXAMINING BOARD, and CLARENCE P. CHOU, M.D.,

Plaintiffs-Respondents,

CHRISTOPHER J. FORD, KRISTIN J. LYERLY, and JENNIFER J. MCINTOSH,

Intervenors-Respondents,

v.

JOEL URMANSKI, as District Attorney for Sheboygan County, WI,

Defendant-Appellant,

JOHN T. CHISHOLM, as District Attorney for Milwaukee County, WI, and ISMAEL R. OZANNE, as District Attorney for Dane County WI,

Defendants-Respondents.

On Appeal from the Circuit Court of Dane County, No. 2022CV001594
Hon. Diane Schlipper

PROPOSED *AMICUS* BRIEF OF THE AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, THE WISCONSIN MEDICAL SOCIETY, AND THE SOCIETY FOR MATERNAL-FETAL MEDICINE

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INTEREST OF *AMICI CURIAE*

Amici are leading organizations representing physicians and other medical professionals who serve patients in Wisconsin and beyond. Collectively, *amici* include hundreds of thousands of medical professionals. Among other things, *amici* advocate for patients and practitioners, educate the public about reproductive health, and work to advance the ethical practice of medicine.

Amici are dedicated to ensuring access to the full spectrum of safe and appropriate health care, and work to preserve the patient-clinician relationship. Patients, in consultation with their health care professionals, should have the autonomy to determine the appropriate course of medical care, based on the medical evidence and the patient's own individualized needs, medical history and preferences, without undue interference from third parties. *Amici* oppose laws that would substitute lawmakers' political agenda for the educated and considered decisions that patients make in consultation with their medical professionals.

INTRODUCTION AND SUMMARY OF ARGUMENT

Abortion care is an essential part of comprehensive health care. When abortion is legal, it is safe. *Amici* are leading medical societies whose policies represent the education, training, and experience of the vast majority of clinicians in this country. *Amici* believe that laws that

criminalize and effectively ban abortion care are not based on any medical or scientific rationale. Those laws also threaten the health of pregnant patients; disproportionately harm patients of color, patients in rural settings, and patients with low incomes; and profoundly interfere with the patient-physician relationship and undermine longstanding principles of medical ethics.

Since 1973, the Wisconsin Legislature has enacted several statutes that regulate abortion as a lawful medical procedure.[1] Wisconsin Statute § 940.15 permits abortion care up to the point of fetal "viability," with exceptions to "preserve the life or health of the woman." Wisconsin Statute § 253.107 prohibits abortion care after 20 weeks except in a "medical emergency." In light of these statutes, the Circuit Court correctly held that Wisconsin Statute § 940.04 (originally enacted in 1849) applies only to feticide and does not ban impose a near-total ban on abortion care. *Amici* oppose any interpretation of Section 940.04 that would ban abortion care, because that interpretation would jeopardize the health and safety of pregnant people in Wisconsin and places extreme burdens and risks on providers of essential reproductive health care, without a valid medical justification. *Amici* urge the Court to affirm.

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[1] *See, e.g.*, Wis. Stat. § 253.095(2).

ARGUMENT

I. Abortion Care Is A Safe, Common, And Essential Component Of Health Care

The medical community recognizes that abortion care is a safe, common, and essential component of reproductive health care.[2] In 2020, over 930,000 abortions were performed nationwide.[3] More than 6,000 abortions were performed in Wisconsin.[4] Approximately one-quarter of American women have an abortion before age 45.[5]

The medical evidence conclusively demonstrates that abortion care is very safe.[6] Complication rates are extremely low, averaging around

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[2] *See, e.g.*, Eds. of the New Eng. J. of Med. et al., ACOG, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019); ACOG, *Abortion Policy* (revised and approved May 2022); SMFM, *Access to Abortion Services* (2020).

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

[4] Wis. Dep't of Health Servs., *Reported Induced Abortions in Wisconsin, 2020* at 6 tbl.3 (May 2020), https://bit.ly/3kz2bxi (*Abortions in Wisconsin*).

[5] 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).

[6] *See, e.g.*, Nat'l Acads. of Scis., Eng'g, Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018) (*Safety and Quality of Abortion Care*).

2%, and most complications are minor and easily treatable.[7] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances.[8] The risk of death is even rarer. Nationally, fewer than one in 100,000 patients die from an abortion-related complication.[9] By contrast, the "risk of death associated with childbirth [is] approximately 14 times higher."[10] Abortion care is so safe that there is a greater risk of complications or mortality for wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[11] And the rate of abortion-

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[7] *See, e.g.*, Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (*Incidence of Visits)*; *Safety and Quality of Abortion Care* 55, 60.

[8] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015). This is also true for medication abortions, which account for nearly 40% of all abortions in Wisconsin obtained by Wisconsin residents and about half of abortions nationwide. Elizabeth G. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013); *Abortions in Wisconsin* 11 tbl.11; Rachel K. Jones et al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Dec. 1, 2022).

[9] *See* Katherine Kortsmit et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Abortion Surveillance – United States, 2019*, 70 Morbidity & Mortality Weekly Rep. 1, 29 tbl.15 (2021) (Kortsmit); Suzanne Zane et al., *Abortion-Related Mortality in the United States*, *1998-2010*, 126 Obstetrics & Gynecology 258, 261 (2015).

[10] 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).

[11] Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (Dec. 2014); Am. Soc'y for

related complications remains low later in pregnancy. For example, starting at 14 weeks gestational age, the predominant method of abortion is dilation and evacuation, which is a safe and routine procedure.[12]

Abortion care poses no significant risks to mental health or psychological well-being. People who obtain wanted abortion care had "similar or better mental health outcomes than those who were denied a wanted abortion," and receiving abortion care does not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to those who were forced to continue a pregnancy.[13] One recent study noted that 95% of participants believed an abortion was the "right decision for them" three years after the procedure.[14]

Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011); Frederick M. Grazer & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000); Kortsmit 29 tbl.15.

[12] ACOG, Practice Bulletin No. 135, *Second Trimester Abortion*, 121 Obstetrics & Gynecology 1394, 1394 (2013, reaff'd 2021).

[13] 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, 177 (2017) (Biggs).

[14] Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, 10 PLOS ONE 1, 7 (2015).

II. Statutes That Ban Abortion Care Harm Pregnant Patients' Health

Statutes that ban or restrict access to abortion care cause severe physical and psychological health consequences for pregnant patients that seek that care. Limited exceptions, such as those that would allow abortion care only when necessary to save the patient's life, are insufficient to protect the health of pregnant patients.

A. Statutes That Ban Abortion Care Endanger The Physical And Psychological Health Of Pregnant Patients

Criminalizing safe abortion care will result in delays in obtaining abortion care, increased use of unsafe self-managed abortion methods, and an increased likelihood that patients will be forced to continue pregnancies to term. All of these consequences entail significant health risks.

Many delays in seeking abortion care are caused by a lack of information about where to find that care.[15] The need to travel out of state and consider various states' criminal and civil penalties further increases confusion about where to access needed health care. In addition, almost one-third of delays are caused by travel and procedure costs.[16]

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[15] Ushma D. Upadhyay et al., *Denial of Abortion Because of Provider Gestational Age Limits in the United States*, 104 Am. J. Pub. Health 1687, 1689 (Sept. 2014).

[16] *Id.*

Interpreting Section 940.04 to eliminate licensed abortion clinics and impose a near-total ban on abortion care will increase these costs. A 2021 analysis found that closing Wisconsin's abortion clinics would result in a 171% increase in the average required travel distance for Wisconsinites seeking abortion care.[17] Longer travel distances mean higher travel costs, which can cause a patient to delay needed abortion care until later in a pregnancy. Although the risk of complications from abortion care overall remains exceedingly low – especially compared to the health risks of carrying a pregnancy to term – increasing gestational age increases the chance of a major complication.[18] Abortion care at later gestational ages also is typically more expensive.[19]

Interpreting Section 940.04 as removing access to safe, legal abortion care would also increase the possibility that a pregnant patient will attempt a self-managed abortion through a harmful or unsafe method.[20] Studies have found that people are more likely to self-manage abortions when they face barriers to reproductive services, and methods of self-

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[17] Guttmacher Inst., *If* Roe v. Wade *Falls: Travel Distance for People Seeking Abortion* (June 23, 2022), https://bit.ly/3DUckfY.

[18] *Incidence of Visits* 181.

[19] Bonnie Scott Jones & Tracy A. Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences,* 99 Am. J. Pub. Health 623, 624 (2009).

[20] *See, e.g.*, Rachel K. Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017* at 3, 8 (2019).

management may rely on harmful tactics such as herbal or homeopathic remedies, intentional trauma to the abdomen, abusing alcohol or illicit drugs, or dangerously misusing hormonal pills, rather than using FDA-approved abortion medication, which is a safe way to self-manage abortion.[21]

Patients who do not, or cannot, obtain abortion care will be forced to continue a pregnancy to term – an outcome with significant health risks. The U.S. mortality rate associated with live births from 1998 to 2005 was 8.8 deaths per 100,000 live births,[22] and rates have sharply increased since then.[23] In contrast, the mortality rate associated with abortion care performed from 1998 to 2005 was 0.6 deaths per 100,000 procedures, meaning that a pregnant patient's risk of death associated with childbirth is approximately 14 times higher than any risk of death from abortion care.[24]

Continued pregnancy and childbirth also entail other substantial health risks. Even an uncomplicated pregnancy causes significant stress

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[21] David Grossman et al., Tex. Pol'y Eval. Proj. Res. Br., *Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas* 3 (2015).

[22] Raymond & Grimes 216.

[23] Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 447 (2016).

[24] Raymond & Grimes 216.

on the body. Moreover, continuing a pregnancy to term can exacerbate underlying health conditions or lead to newly arising health issues. Sickle-cell disease can worsen during pregnancy, leading to severe anemia and vaso-occlusive crisis, a condition resulting in significant pain.[25] Pregnant patients with inherited thrombophilia, which can be undetected until a triggering event such as pregnancy, have a high risk of developing life-threatening blood clots.[26] Pregnancy can exacerbate asthma, making it a life-threatening condition.[27] Approximately 6-7% of pregnancies are complicated by gestational diabetes mellitus, which frequently leads to maternal and fetal complications, including developing diabetes later in life.[28] And preeclampsia, a relatively common complication, is a disorder associated with new-onset hypertension that occurs most often after 20 weeks of gestation and can result in fluctuating blood pressure, heart disease, liver issues, seizures, and death.[29]

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[25] ACOG, Practice Bulletin No. 78, *Hemoglobinopathies in Pregnancy* (Jan. 2007, reaff'd 2021).
[26] ACOG, Practice Bulletin No. 197, *Inherited Thrombophilias in Pregnancy* (July 2018, reaff'd 2022) (*Inherited Thrombophilias in Pregnancy*).
[27] ACOG, Practice Bulletin No. 90, *Asthma in Pregnancy* (Feb. 2008, reaff'd 2020).
[28] ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus* (Feb. 2018, reaff'd 2019).
[29] ACOG, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (June 2020) (*Gestational Hypertension*).

Labor and delivery likewise carry significant risks. These include hemorrhage, placenta accreta spectrum (a potentially life-threatening complication that occurs when the placenta is unable to detach at child-birth), hysterectomy, cervical laceration, and debilitating postpartum pain.[30] Approximately one in three people who give birth in the United States do so by cesarean delivery, a major surgical procedure that carries increased risk of complications.[31]

Evidence also suggests that pregnant people denied abortion care are more likely to experience negative psychological health outcomes – like anxiety, lower self-esteem, and lower life satisfaction – than those who obtained needed abortion care.[32]

B. The Statute's Limited Exception Will Not Adequately Protect Patients' Health

If Section 940.04 were interpreted to ban abortion care, its sole exception would be insufficient to protect the health of pregnant patients.

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[30] ACOG, Practice Bulletin No. 183, *Postpartum Hemorrhage* (Oct. 2017, reaff'd 2019); ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum* 1-2 (July 2012, reaff'd 2021) (*Placenta Accreta Spectrum*); ACOG, Practice Bulletin No. 198, *Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018, reaff'd 2022); ACOG, Clinical Consensus No. 1, *Pharmacologic Stepwise Multimodal Approach for Postpartum Pain Management* 507 (Sept. 2021).

[31] CDC, *National Vital Statistics Reports Vol. 70, No. 2, Births: Final Data for 2019* (2021); ACOG, Obstetric Care Consensus No. 1, *Safe Prevention of the Primary Cesarean Delivery* 1-3 (Mar. 2014, reaff'd 2019).

[32] Biggs 172.

The exception would allow for abortion care if it "is necessary . . . to save the life of" the patient. The law does not define "necessary." The law does not include any exceptions for cases of threats to the patient's health, or for rape, incest, or fetal abnormalities.

Pregnancy can exacerbate existing health issues that do not necessarily or immediately lead to death, but nevertheless pose serious health risks. Examples include Alport Syndrome (a form of kidney inflammation), valvular heart disease (abnormal leakage or partial closure of a heart valve), lupus (a connective tissue disease that may suddenly worsen during pregnancy and lead to blood clots and other serious complications), and pulmonary hypertension (increased pressure within the lung's circulation system that can escalate during pregnancy).[33] Maternal mental health issues also can put a pregnant patient's health and

[33] *See* Koji Matsuo et al., *Alport Syndrome and Pregnancy*, 109 Obstetrics & Gynecology 531, 531 (Feb. 2007); Karen K. Stout & Catherine M. Otto, *Pregnancy in Women with Valvular Heart Disease*, 93 Heart Rev. 552, 552 (May 2007); J. Cortés-Hernández et al., *Clinical Predictors of Fetal and Maternal Outcome in Systemic Lupus Erythematosus: A Prospective Study of 103 Pregnancies*, 41 Rheumatology 643, 646-647 (2002); David G. Kiely et al., *Pregnancy and Pulmonary Hypertension: A Practical Approach to Management*, 6 Obstetric Med. 144, 153 (2013); Michael F. Greene & Jeffrey L. Ecker, *Abortion, Health and the Law*, 350 New Eng. J. Med. 184, 184 (2004).

life at risk.[34] Additionally, sometimes patients seek abortion care because of significant medical issues that they experienced during prior pregnancies. If abortion care is unavailable, those prior conditions could progress or reoccur, endangering the health of the pregnant patient and directly affecting fetal development and survival. Examples include preeclampsia,[35] placental abruption (separation of the placenta from the uterine wall),[36] placenta accreta,[37] peripartum cardiomyopathy (enlargement of the heart in or after pregnancy),[38] and thrombophilia.[39]

The narrow exception in Section 940.04 applies only when "necessary" to save the patient's life. Coupled with the threat of criminal sanctions, interpreting this statute to cover abortion care necessarily will chill the provision of critical medical care in the examples just described because doctors will be unsure when they will be able to provide needed abortion care for their patients. It is untenable to force pregnant pa-

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[34] *See, e.g.*, Kimberly Mangla et al., *Maternal Self-Harm Deaths: An Unrecognized and Preventable Outcome*, 221 Am. J. Obstetrics & Gynecology 295 (2019).

[35] *Gestational Hypertension*.

[36] ACOG, Obstetric Care Consensus No. 10, *Management of Stillbirth* 7, 11 (March 2009, reaff'd 2021).

[37] *Placenta Accreta Spectrum* 2.

[38] ACOG, Practice Bulletin No. 212, *Pregnancy and Heart Disease* (May 2019, reaff'd 2021).

[39] *See Inherited Thrombophilias in Pregnancy*.

tients to wait to obtain abortion care until their medical condition escalates to the point that abortion care is necessary to prevent death. Further confusion will arise when doctors manage early pregnancy loss. For example, incomplete miscarriages are commonly treated via uterine aspiration, which is an abortion. But Section 940.04 does not clearly state that miscarriage management is permissible.

Physicians should not be put in the impossible position of either letting a patient deteriorate until death is possible or facing potential criminal punishment for providing needed care consistent with their medical judgment but still potentially in contravention of Section 940.04. The many examples just provided of the potential health problems faced by pregnant patients demonstrate why decisions about whether to continue a pregnancy are properly left to clinicians and patients, rather than legislators. Legislators are not and should not be in the exam room, and do not have the training or experience to exercise medical judgment to evaluate complex or developing situations and recommend a course of treatment. Interpreting Section 940.04 to cover abortion care would indefensibly jeopardize patients' health.

III. Laws That Ban Abortion Care Hurt Rural, Minority, And Poor Patients The Most

Abortion care bans disproportionately affect people of color, those living in rural areas, and those with limited economic resources. *Amici* are opposed to policies that increase the inequities that already plague the nation's health care system.

In Wisconsin, 34% of the Wisconsinites who obtained abortions in 2020 were Black and 12% were Hispanic.[40] According to 2021 data, 27.8% of Black Wisconsinites live in poverty, as do 18.6% of Hispanic Wisconsinites, while the poverty rate in Wisconsin is 10.9% overall.[41] In addition, 75% of abortion care patients nationwide are living at or below 200% of the federal poverty level.[42] Patients with limited means and patients living in geographically remote areas will be disproportionately affected by Section 940.04, which will require them to travel longer distances (and pay higher associated costs) to obtain safe, legal abortion care. These travel and procedure costs will be compounded by the fact that other Wisconsin laws create substantial financial barriers to abortion care, such as lack of coverage under insurance policies for public

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[40] *See Abortions in Wisconsin* 9 tbl.7.

[41] Kaiser Family Foundation, *Poverty Rate by Race/Ethnicity* (2021), https://bit.ly/3QbzDoA.

[42] Jenna Jerman et al., Guttmacher Inst., *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* at 11 (2016).

employees and health plans offered in the state's health exchange, except in cases of life endangerment, severely compromised health, or rape or incest.[43]

The inequities continue after abortion care is denied. Forcing patients to continue pregnancies increases their risk of complications.[44] Nationwide, Black patients' pregnancy-related mortality rate is at least 3.2 times higher than that of white patients, with significant disparities persisting even in areas with low overall mortality rates and among patients with higher levels of education.[45] Section 940.04 thus exacerbates health care inequities, disproportionately harming the most vulnerable Wisconsinites.

IV. Statutes That Ban Abortion Care Force Clinicians To Make An Impossible Choice Between Upholding Their Ethical Obligations And Following The Law

Abortion care bans violate long-established and widely accepted principles of medical ethics by (1) substituting legislators' opinions for a

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[43] Guttmacher Inst., *State Facts About Abortion: Wisconsin* (June 2022), https://bit.ly/3fkcOS1.

[44] Raymond & Grimes 216.

[45] Emily E. Petersen et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016*, 68 Morbidity & Mortality Weekly Report 762, 763 (Sept. 6, 2019); *see* Marian F. MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 Am. J. Pub. Health 1673, 1676-77 (Sept. 2021).

physician's individualized patient-centered counseling and manufacturing a conflict of interest between patients and medical professionals; (2) asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and (3) requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. Statutes That Ban Abortion Care Undermine The Patient-Physician Relationship

The patient-physician relationship is critical for the provision of safe, quality medical care.[46] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests with the best available scientific evidence.[47] ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments," and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[48] The

[46] ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended Aug. 2021) (*Legis. Policy Statement*).
[47] AMA, *Patient-Physician Relationships, Code of Medical Ethics Opinion 1.1.1* (Opinion 1.1.1).
[48] ACOG, *Code of Professional Ethics* 2 (Dec. 2018) (ACOG, *Code*).

AMA Code of Medical Ethics places on physicians the "ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[49]

If interpreted to cover abortion care, Section 940.04 would force physicians to supplant their medical judgments regarding what is in patients' best interests with the Legislature's non-expert determination. Abortion care is safe, routine, and, for many patients, the best medical choice available for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician's ability to provide abortion care where both the physician and patient conclude that it is the medically appropriate course. Laws that ban abortion care are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

Those laws also manufacture conflicts of interest between patients and clinicians. The medical decisions that a clinician must make during pregnancy often are nuanced and not black-or-white, because each patient is unique and requires treatment based on the patient's specific medical considerations, which may change over time.[50] Clinicians need

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[49] Opinion 1.1.1.

[50] ACOG, *Understanding and Navigating Medical Emergency Exceptions in Abortion Bans and Restrictions* (Aug. 15, 2022), https://bit.ly/3XLVaKK.

to be able to rely upon their expertise to determine the proper treatment for each situation and the level of care necessary for each patient,[51] and patients should be able to access that treatment.

Physicians need to be able to offer appropriate treatment options without the threat of being second-guessed for ideological reasons, criminal sanctions, or loss of their livelihood.[52] Interpreting Section 940.04 to ban abortion care would profoundly intrude upon the patient-physician relationship by preventing physicians from performing abortions in many circumstances. Even if a patient's health were compromised, the statute would allow abortion care only in life-threatening circumstances, regardless of the overall medical advisability of the procedure or the patient's desires. A physician and patient together may conclude that abortion care is in the patient's best medical interests even though the risk posed by continuing the pregnancy does not yet rise to the standard in the law's exception. Wisconsin's ban thus forces physicians to choose between the ethical practice of medicine – counseling and acting in their patients' best interest – and obeying the law.[53]

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[51] ACOG, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (Aug. 2021), https://bit.ly/3B7mIBL.

[52] *See Legis. Policy Statement.*

[53] *Cf.* AMA, *Patient Rights, Code of Medical Ethics Opinion 1.1.3.*

B. Statutes That Ban Abortion Care Violate The Principles Of Beneficence And Non-Maleficence

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm and cause no injury, have been the cornerstones of the medical profession since the Hippocratic traditions.[54] Both principles arise from the foundation of medical ethics that requires patient welfare to form the basis of medical decision-making.

Physicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make decisions informed by both medical science and their lived experiences.[55]

If interpreted to cover abortion care, Section 940.04 would inappropriately place physicians' interests against those of their patients. If a physician concludes that abortion care is medically advisable, the principles of beneficence and non-maleficence require the physician to recommend that course of treatment. And if a patient decides that abortion

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[54] AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481-82 (Dec. 2007, reaff'd 2016).

[55] ACOG, *Code* 1-2.

care is the best course of action, those principles require the physician to provide, or refer the patient for, that care. But the statute, with its limited exception, would prohibit physicians from providing that treatment and exposes physicians to criminal penalties if they do. It therefore would place physicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

C. Statutes That Ban Abortion Care Violate The Ethical Principle Of Respect For Patient Autonomy

Finally, a core principle of medical practice is patient autonomy – respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[56] Patient autonomy revolves around self-determination, which is safeguarded by the ethical concept of informed consent and its rigorous application to patients' medical decisions.[57] If interpreted to cover abortion care, Section 940.04 would deny patients the right to make their own choices about health care if they decide they need to seek abortion care.

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[56] *Id.* at 1.

[57] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021); AMA, *Code of Medical Ethics Opinion 2.1.1.*

CONCLUSION

This Court should affirm the decision of the Circuit Court.

Dated: September 18, 2024

Electronically Signed by Breanne L. Snapp

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CERTFICATE OF COMPLIANCE

I hereby certify that this proposed brief conforms to the rules contained in Wisconsin Statute Sections 809.19(8)(b), (bm), and (c), for a proposed non-party brief, as well as this Court's order dated July 2, 2024, limiting the length of a proposed non-party brief to 4,400 words. The length of this brief is 4,268 words.

Electronically Signed by Breanne L. Snapp
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