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UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. and PLANNED PARENTHOOD GOLDEN GATE,

Plaintiffs,

v.

JOHN ASHCROFT, Attorney General of the United States, in his official capacity,

Defendant.

Civil Case No.: C 03-04872 (PJH)

BRIEF OF AMICUS CURIAE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS

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I. INTRODUCTION

The California Medical Association ("CMA") – the state's largest medical association with more than 30,000 members – exists to promote the science and art of medicine, the care and well being of patients, the protection of public health, and the betterment of the medical profession. Adherence to these principles compels CMA to file this amicus brief in support of plaintiffs Planned Parenthood Federation of America and Planned Parenthood Golden Gate (collectively "Planned Parenthood") and the City and County of San Francisco ("San Francisco"). CMA opposes the "Partial-Birth Abortion Ban Act of 2003" ("the Act"), legislation that endangers the health of women throughout California, and makes criminals out of highly trained physicians when they perform the safest and most common procedures available for second-trimester abortions. The Act has no foundation in medical science, disrupts the informed consent relationship between physicians and their patients, and violates firmly established constitutional principles. CMA joins the plaintiffs in seeking adjudication by this Court that the Act is unconstitutional.

II. INTEREST OF THE AMICUS

A. The Duties and Responsibilities of Physicians

The practice of medicine is a noble profession. Physicians undergo intensive training to develop specialized knowledge and skills and carry a great responsibility to provide medical care and exercise judgment to the best of their ability. Within the physician-patient relationship, patients may disclose their most intimate and private concerns, surrender a portion of their decision-making autonomy, and even yield control of their bodies during surgery and other medical procedures. *See* Edmund Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. Comtemp. Health L. & Pol'y 47, 54 (1994). Thus, the patient places an enormous amount of trust in the physician to care for his or her physical and psychological health. In return, physicians are ethically bound to assist the patient in choosing among all of the safe medical options and provide the safest care possible consistent with the patient's wishes. *See* American Med. Ass'n, *Principles of Medical Ethics: Preamble* (June 2001) ("[A] physician must recognize responsibility to patients first and foremost . . ."). As the Modern Hippocratic Oath provides, doctors

must "apply, for the benefit of the sick, all measures which are required . . ." *See* Taber's Cyclopedic Medical Dictionary 765 (15th ed. 1985) (Oath of Hippocrates).

Physicians also have a duty to society to respect and follow the law. *See* American Med. Ass'n, *Principles of Medical Ethics: Preamble* (June 2001) ("A physician shall respect the law . . ."). Ordinarily this duty does not conflict with their duty to provide safe and effective medical care to their patients. But where the duties are in conflict, physicians have a responsibility to seek changes in laws that are contrary to the best interest of the patient. *Id.*

B. The Act Prevents Physicians From Simultaneously Conforming their Conduct to the Requirements of Law and Fulfilling their Ethical Duties to their Patients.

In keeping with the duty to oppose laws that are contrary to the best interest of patients, the CMA has consistently opposed the ban on so-called "partial birth abortions," from the time the ban was first introduced in Congress to the present. *See*, *e.g.*, 142 Cong. Rec. S 11337, S11351 (1996); 144 Cong. Rec. S 10551, S10560 (1998); 149 Cong. Rec. H 9135, H9149 (2003). The Act prevents physicians from exercising their best medical judgment to preserve the health and well-being of their patients. In so doing, the Act dangerously intrudes on a physician's ability (and duty) to provide medical care and jeopardizes the health and safety of women. The Act requires doctors to make a Hobson's choice between performing procedures that they may believe to be safest and thus violating the law, and obeying the law and thus jeopardizing their patients' welfare. Moreover, the Act's vague and broad terms have had and will continue to have a chilling effect on those physicians who, when faced with the fear that their conduct could violate the terms of the Act, will simply forgo performing any second trimester abortions. Finally, the Act will hinder medical advancement by preventing doctors from building on clinical experience to develop safer procedures.

For these reasons, the members of the CMA, whatever their beliefs about abortion, share an interest in opposing the Act. The Act interferes with the physician-patient relationship, criminalizes physicians' efforts to protect women's health, hinders advancement of new and improved reproductive health techniques, and will erode the quality of care that CMA's members strive to achieve. Because the law violates the due process clause and fundamental constitutional rights of privacy, the CMA asks, on behalf of its more than 30,000 physician members, that the Court enjoin the Act.

III. ARGUMENT

A. The Act is an Unwarranted and Unprecedented Intrusion into the Doctor-Patient Relationship.

1. The physician-patient relationship is sacrosanct and must be vigorously defended.

An individual's control over his or her own body is the very essence of autonomy and is fundamental to a free society. As John Stuart Mills wrote over a century ago, "[e]ach is the proper guardian of his own health, whether bodily, or mental and spiritual." JOHN STUART MILL, ON LIBERTY 13 (Alburey Castell ed., Crofts Classics 1947) (1859). This autonomy is essential to effective care because, "with respect to his own feelings and circumstances, the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by anyone else." *Id.*

Consistent with these principles, the informed consent doctrine and ethical codes have arisen to ensure that a patient, in consultation with her physician, has the right and ability to shape her own treatment and choose among all of the safe medical options.[1] *See Planned Parenthood v. Casey*, 505 U.S. 833, 849 (1992) ("It is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity.") (citations omitted); *Canterbury v. Spence,* 464 F.2d 772, 780 (D.C. Cir. 1972) (noting that it has become "fundamental in American jurisprudence, that every human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body") (internal citations and quotations marks omitted); *see also* AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS, 2000-2001, E-8.08 ("The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for the patient's care and to make recommendations for management in accordance with good medical practice."); H-140.989 ("Health care professionals should inform patients or their surrogates of . . . alternative treatments."). Through the process of informed consent, the physician and patient discuss the available treatment methods and determine which procedure is most appropriate under each patient's unique physical and emotional circumstances. Broekhuizen Rpt.

[1] The informed consent doctrine recognizes that a patient's "right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS E-8.08.

¶ 10.[2] Sometimes the decision regarding the best course of treatment is clear. More often, however, the decisions are difficult ones that require the physician and patient to consider a complex array of factors and choose among medical options.[3] The intricacy of this decision-making process only increases as medical science improves and new procedures are developed, particularly because of the increasingly profound changes in the lives and health of patients that result from modern medical advances. *See* George Annas, et. al., *The Right of Privacy Protects the Doctor-Patient Relationship*, 263 JAMA 956, 956 (1990) (noting that the "importance of the doctor-patient relationship to individual citizens increases in proportion to advances in medical science.") Against this backdrop, the question of who makes treatment decisions becomes even more important. *Id.* The CMA strongly believes that only the individual patient, in consultation with a physician, can determine which course of action is best given the patient's particular needs.

2. The federal government should not interfere with the physician's ability to help a patient choose among safe and constitutionally protected procedures.

Ignoring these realities of medical care, Congress enacted this ban on so-called "partial birth" abortions and thus inserted itself into one of the most personal decisions a woman can make. *See* Jeffrey Drazen, *Inserting Government between Patient and Physician*, N. ENG. J. MED. 350:2, January 8, 2004, at 178. In so doing, Congress strayed onto unfamiliar ground and attempted to rigidly specify in minute detail what a physician can or cannot do during a procedure. By establishing an inflexible rule, Congress deliberately ignored "the specific circumstances in which the patient and physician find themselves trapped." *Id.* Congress' ill-advised foray into medical decision-making interferes with a physician's ability to make the most appropriate choice of procedure for a patient and to respond to unforeseen events during a procedure. Broekhuizen Rpt. ¶ 10. The result has been to winnow down

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[2] In this brief, CMA will refer to and rely upon the declarations, expert reports, and discovery generated by the parties in this action. CMA will cite to these materials as "___ Dec. ¶__," "___ Rpt. ¶ __," and "___ Tr. at ___," respectively. So, for example, the Expert Report of Fredrik F. Broekhuizen, M.D. will be cited as Broekhuizen Rpt. ¶ ___. Because Maureen Paul has filed more than one declaration in this action, her declaration filed in support of Planned Parenthood's Motion for a Temporary Restraining Order will be cited as Paul TRO Dec. ¶__ .

[3] Some of these factors include the gestational age of the fetus; the size, presentation and orientation of the fetus; the amount of cervical dilation achieved; the length and condition of the cervix; the condition and shape of the uterus; the patient's overall health and medical condition; and the existence of fetal abnormalities. *See* Paul TRO Dec. ¶¶ 13-14, 48.

women's options to fewer and more dangerous procedures and to tie the hands of physicians who seek to provide effective medical care.

The CMA does not dispute that the government has a role in regulating structural aspects of the medical profession, including the licensing of physicians and hospitals, sales of drugs and other aspects of healthcare. The CMA, however, must protest intrusions by the government that jeopardize a patient's ability to chose among safe alternatives and prevent physicians from caring for a patient's health to the best of their ability.[4] As one physician explained, "[l]aws are blunt instruments that are of little value in helping a patient to select carefully the best path to follow in a particular health crisis." *See* Jeffrey Drazen, *Inserting Government between Patient and Physician*, N. ENG. J. MED. 350:2, Jan. 2004, at 178. Simply put, the legislative process is ill-suited to evaluate complex medical procedures, the appropriateness of which may vary with a particular patient's unique circumstances and with the constantly evolving state of scientific knowledge. That discretion has historically remained within the considered medical judgment of highly-trained physicians in careful consultation with patients. And it should now as well.

For these reasons, the medical profession "strongly condemn[s] any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient." *See* AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS, H-5.989. As acknowledged by the Supreme Court, "the abortion decision in all its aspects is inherently, and primarily, a medical decision" and the basic responsibility for ensuring that a sound decision is made "must rest with the physician." *Roe v. Wade*, 410 U.S. 113, 165-166 (1973). Thus, a "woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it" must be protected from unwarranted governmental interference. *Doe v. Bolton*, 410 U.S. 179, 197 (1973).

[4] To be clear, the CMA is not asserting that physicians are entitled to "unfettered discretion" in choosing abortion methods. *See Stenberg v. Carhart,* 530 U.S. 914, 938 (2000). The CMA believes, however, that Congress cannot ban a particular procedure on moral grounds where the procedure is safe and substantial medical authority indicates that the procedure could benefit women's health. *Id.* Political concerns and religious beliefs simply cannot take precedence over the health and safety of patients, nor should they trump the critically important physician-patient relationship.

B. Doctors Are Unable To Conform Their Conduct To The Requirements Of The Partial Birth Abortion Ban Because It Is Unconstitutionally Vague.

1. The Due Process clause prohibits vague laws.

Laws for which persons "of common intelligence must necessarily guess at [their] meaning and differ as to [their] application" violate the Fifth Amendment's Due Process clause. *See Smith v. Goguen*, 415 U.S. 566, 572 n.8 (1974) (citing *Connally v. General Construction Co*., 269 U.S. 385, 391 (1926)). In order to pass constitutional muster, laws must provide the persons whose conduct is affected with "a reasonable opportunity to know what is prohibited" so that they can conform their behavior, as well as sufficient specificity for those who apply the laws to avoid "impermissibly delegate[ing] basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application." *Grayned v. City of Rockford*, 408 U.S. 104, 108-09 (1972). The Act violates these requirements and subjects CMA members to criminal and civil sanctions without clearly specifying prohibited conduct.

2. The Act's vague language potentially proscribes all safe abortion procedures and thus violates Due Process.

The Act is hopelessly vague, making it impossible for physicians to know which procedures fall within the statutory ban. *See* Broekhuizen Rpt. ¶ 20; Sheehan Rpt. ¶ 4; Westhoff Rpt. ¶ 32. While the government appears to argue that the ban only applies to late second trimester intact D&E variants (*see* Nov. 6 Hearing Tr. at 51-52), the language of the Act itself contains no such limitation. Instead, the Act fails to clearly define the scope of the prohibited procedure, leaving doctors to guess at what conduct is prohibited under threat of prosecution, conviction and imprisonment if their guesses turn out to be incorrect.

a) The terms of the Act are unconstitutionally vague and ambiguous.

The term "partial birth abortion" is itself a medical fiction: it is not a term that appears in medical literature to describe any particular procedure. *See* Paul Rpt. ¶ 20; Creinin Rpt. ¶ 12. Nor does the Act itself provide any meaningful guidance to physicians. Instead, the Act relies on a series of ill-defined terms, including "deliberately and intentionally vaginally delivers," "living fetus," "part of the fetal trunk past the navel," "overt act," and then imposes civil and criminal liability depending on the sequence in which those supposedly clear and distinct actions occur. Act § 3(a), 18 U.S.C. § 1531(b)(1).

This requires physicians to engage in a high-stakes guessing game to determine whether their actions might constitute a crime.

The term "delivers" is a medical term of art meaning to remove a fetus, the placenta, or a part of the fetus from the uterus, and therefore applies to virtually all actions relating to abortions. *See* Paul TRO Dec. ¶ 52. It encompasses abortions that commence because of medical intervention as well as those that begin spontaneously (miscarriages) and are completed by physicians. As a result, doctors are unable to determine, for example, if the phrase "deliberately and intentionally vaginally delivers a living fetus" in the Act encompasses a situation in which a physician delivers a portion of the fetus severed from the remainder, as is the case in many D&E procedures. *See id.* ¶¶ 52-55.

The Act's use of the term "living fetus" introduces further confusion. Physicians cannot tell whether a "living fetus" refers only to an intact fetus with a heartbeat or something else, such as a disarticulated fetus with a heartbeat or a fetus having only a pulsing umbilical cord.[5] *See* Paul TRO Dec. ¶ 53; Broekhuizen Dec. ¶ 26; *see also Planned Parenthood v. Miller*, 30 F. Supp. 2d 1157, 1165 (S.D. Iowa 1998) (holding the fact that the moment at which fetal demise occurs is "extremely variable" further compromises a physician's ability to conform his or her conduct to the requirements of the law) (internal citations and quotations omitted).

The phrase "part of the fetal trunk past the navel" adds an imprecise physical measurement issue whose occurrence in time is also determinative. Whether a portion of the fetus is removed "past the navel" is a subjective determination that will depend on individual observation, and it should be readily appreciated that reasonable minds might differ on whether and, more importantly, when this has occurred. The use of this term will therefore result in physicians being second-guessed later as to whether the part of the fetal trunk that was removed outside the woman's body crossed this imprecise threshold at the wrong time. Worse, it will pit medical personnel in the operating room against each other, each testifying as to their own subjective observations from differing angles and

[5] This vague term is similar to the term "living unborn child" used in the Nebraska statute struck down in *Stenberg*. *See Stenberg*, 530 U.S. at 942.

distances as to whether the fetus was removed "past the navel" or not, the former triggering criminal liability while the latter does not.

Physicians are also unclear as to how the terms "deliberately and intentionally" are to apply. *See also* Broekhuizen Rpt. ¶ 20; Sheehan Rpt. ¶ 4; Westhoff Rpt. ¶ 34(d). Does this term apply only to what a physician intends before going in to the operating room, or to each decision made during the course of the procedure? As phrased, it is unclear whether a physician who begins an induction abortion but who in responding to rapidly changing conditions (e.g., hemorrhage) is forced to remove the fetus using instruments in such a way as to trigger the Act has "deliberately and intentionally" performed the delivery and overt act to kill the fetus. It is also unclear whether this state of mind requirement applies only to the term "delivery" or whether it applies to the requirement that the physician "deliver" enough of the fetus to trigger liability under the Act. In other words, has a physician who intends to remove a portion of the fetus but does not intend to remove "part of the fetal trunk past the navel" violated the terms of the Act? Under these circumstances, physicians are left to guess as to whether the steps taken to protect women's health will result in criminal liability.[6]

Similarly, the Act is unclear on what "overt act" must take place for liability to attach. *See also* Creinin Rpt. ¶ 8; Westhoff Rpt. ¶¶ 34 (c), 35. Virtually any physician conduct could potentially be understood as an "overt act." For example, during the course of a D&E procedure in which a physician expects that the fetus will die as a result of the stress of delivery or from prematurity, a physician may use forceps to remove the fetus head-first. If the fetus dies after its entire head has been removed as a result of applying continued pressure to remove the rest of its body, has the physician performed an "overt act" that he or she knows will result in fetal demise? In other words, is the application of pressure using the forceps which kills the fetus an "overt act other than the completion of delivery" that triggers liability, even if the physician did not intend to cause fetal demise through applying pressure with the forceps?

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[6] Indeed, even the government concedes that it will be very difficult to determine, from an evidentiary point of view, whether a physician intended to perform a proscribed procedure. *See* November 6, Hearing Tr. at 46-47: "…I think the evidentiary complications of that [proving what a physician intended when an abortion was initiated] are certainly going to be out there…."

Each of these terms taken alone is vague and ambiguous. When strung together, the effect is greatly compounded, making it impossible for physicians to determine when and how the line between appropriate medical care and criminal conduct is crossed. This approach is inexplicable, or at least inexcusable, as Congress could easily have devised more precise and narrow language during the eight years it considered this bill.

b) The Act reaches many D&E abortion procedures.

Because the Act uses multiple terms that are subject to reasonable differences in interpretation, its potential scope encompasses most second trimester abortion procedures. Physicians may perform each step in the Act's definition, provided above, in many D&E procedures. *See* Sheehan Rpt. ¶ 3; Creinin Rpt. ¶ 8. Because D&E procedures make up 95% of all second-trimester abortions, the Act creates a risk of criminal liability during virtually all abortions performed after the first trimester. *See* Paul TRO Dec. ¶ 34 (citing *CDC Abortion Surveillance*, at 28). The breadth of the Act, therefore, interferes with the physicians ability to exercise their medical judgment and provide safe abortions for their patients.

In D&E procedures, a physician will "deliberately and intentionally" extract the fetus from the uterus through the woman's vagina. *See* Paul TRO Dec. ¶ 52; Broekhuizen Dec. ¶ 26. As shown above, a "living fetus" may encompass both an intact fetus with a heartbeat as well as a disarticulated fetus showing other signs of life. Thus, deliberate and intentional delivery of a "living fetus" will nearly always occur in D&E and other abortions, including induction abortions.

In the course of a D&E procedure, a physician may remove the fetus intact or relatively intact so that the entire head or the fetal trunk past the navel is outside the woman's body before fetal demise. *See* Paul TRO Dec. ¶¶ 54-56; Broekhuizen Dec. ¶¶ 27-30. Even in cases of disarticulation, the fetus may not be disarticulated until enough of the fetus is outside the woman's body to result in violation of the Act. After the fetus has emerged to the point specified in the Act – whether by way of a D&E procedure or an induction – the doctor may perform an overt act that the fetus cannot survive. *See* Paul TRO Dec. ¶¶ 52-57; Broekhuizen Dec. ¶¶ 26-32.

Accordingly, a physician may purposefully perform actions that satisfy the Act's requirements in any D&E procedure. *See* Paul TRO Dec. ¶ 61; Broekhuizen Dec. ¶ 34. Requiring

physicians to consider the potential criminal and civil liability stemming from D&E procedures will distract physicians from providing the best care possible to their patients. Furthermore, it will interfere with the primary goal of any abortion procedure – to complete the extraction of the fetus as quickly and safely as possible. *See* Paul TRO Dec. ¶ 61.

c) The Act reaches other non-D&E abortion procedures.

The broad reach of the Act could extend to other non-D&E procedures, including inductions. For example, sometimes in the course of an induction, the fetus is not fully expelled within a reasonable time, or the woman develops health complications (e.g., hemorrhage, sepsis, or pre-eclampsia) before the procedure can be completed. In these situations, the physician is forced to complete the fetal evacuation using instruments. *See* Broekhuizen Dec. ¶¶ 14-15. In other instances, certain fetal anomalies render the fetal calvarium too large to pass through the woman's cervix (e.g., hydrocephalus), thus requiring the physicians to reduce its size in order to extract the fetus. *See* Paul TRO Dec. ¶ 49. In these cases, in order to protect the health of their patents, physicians may have to alter the steps of the procedure in such fashion as to invoke the Act. Indeed, each step defined in the Act can occur during any induction in which the fetus has not died before enough of it is outside the body to trigger the Act, and the doctor performs an overt act that causes fetal demise. *See* Paul TRO Dec. ¶¶ 52, 56-58; Broekhuizen Dec. ¶¶ 26-27, 30-32. Thus, because the Act extends to induction abortions, even physicians who determine that the induction procedure is in the their patient's best interest cannot provide this procedure without risking criminal liability.

For these reasons, the vagueness and overbreadth of the Act leave physicians to wonder whether they can perform *any* second trimester abortions without facing criminal liability. Accordingly, the Act violates the due process clause, which guarantees individuals the right to fair notice of whether their conduct is prohibited by law. *See Colautti v. Franklin*, 439 U.S. 379, 390-91 (1979); *see also Winters v. New York*, 333 U.S. 507, 515 (1948) (holding that where a statute imposes criminal penalties, the standard of certainty involved in vagueness review is higher).

C. The Act's Civil and Criminal Penalties Will Chill Doctors From Providing Safe Second Trimester Abortions.

The Act encompasses a broad set of abortion procedures and its vague language, coupled with the lack of an adequate health or life exception, makes it impossible for physicians to take steps necessary to protect women's health and simultaneously comply with the law. As a result, physicians will choose not to provide procedures they believe to be the safest and most appropriate for their patients, despite years of professional training that would lead them to do so.[7] Moreover, physicians in the midst of performing legally permissible abortions procedures will not be able to respond adequately to changing conditions, and instead will be forced to choose to protect a patient's health by committing a felony, or choosing to perform an alternate procedure that endangers her health. This dilemma exists as a direct result of the Act's arbitrary and blurred line which, if crossed, constitutes criminal conduct.

Physicians will worry that others present in the operating room might later be called upon to testify against them if a procedure, perhaps unintentionally, comes close to crossing that line. Such an environment dangerously undermines the ability of healthcare professionals to work together to provide the best and safest care possible. Moreover, physicians who perform D&Es or inductions may have their medical judgment second-guessed later on by a "medical expert" appointed by criminal prosecutors on such subjective inquiries as whether the fetus passed outside the woman "past the navel" or not, or whether the fetus was a "living fetus" at the time of the physician's "overt act." Under this threat of liability, many physicians will refuse to perform these procedures – even though they may be the safest procedures available to perform abortions after the first trimester. *See* Jeffrey Drazen, *Inserting Government Between Patient and Physician*, N. ENG. J. MED. 350:2, Jan. 2004, at 178 (noting that "few physicians want to risk a prison term over the details of what is or is not permitted.")

When faced with the prospect of criminal sanction, the only logical choice is for doctors to stop performing the procedure. As Judge Kozinski recently explained, doctors who are threatened in this manner are "peculiarly vulnerable to intimidation; with little to gain and much to lose, only the most foolish or committed of doctors will defy the federal government's policy and continue to [provide the

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[7] AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS, E-10.015 (stating that "a physician is ethically required to use sound medical judgment, holding the best interest of the patient as paramount.")

proscribed services.]" *Conant v. Walters*, 309 F.3d 629, 639-40 (9th Cir. 2002) (Kozinski, J., concurring) (enjoining federal government from threatening licenses to prescribe controlled substances of doctors who recommend medical marijuana). As a devastating consequence, individual physician judgment will be squelched and women will be deprived of the safest second-trimester abortion procedures available today. *See* Paul TRO Dec. ¶¶ 34, 62-67.

These concerns over the vagueness and chilling effect of the Act are not hypothetical. As explained by Drs. Michael Greene and Jeffrey Ecker soon after the passage of the Act, "[a]n immediate concern for everyone who performs the standard dilation and evacuation procedure, however, is the possibility that the wording of the current bill is sufficiently imprecise that the procedures they are now doing could be construed to meet the criteria of the banned procedure." Michael Greene and Jeffrey Ecker, *Abortion, Health and the Law*, N. ENG. J. MED. 350:2, Jan. 2004, at 185; *see also* Paul Blumenthal, *The Federal Ban on So-Called "Partial-Birth Abortion" is a Dangerous Intrusion into Medical Practice*, Medscape General Medicine 5(2) at http://www.medscape.com/viewarticle/457581 (June 25, 2003) ("None of my colleagues know or could state whether the abortion procedures they now perform are covered under this law. Indeed, as I read the definition of the banned procedures, any of the safest, most common abortion methods used throughout the second trimester of pregnancy could proceed in such a manner as to be outlawed"); *see also* Lockwood Dep. Tr. 68:5-68:16 (affirming that he "find[s] distressing [ ] the Act's imposition of criminal penalties on a physician who performs a 'partial birth abortion,' further unraveling physician's social contract with patients.")

Because of these fears, the number of physicians, hospitals and clinics willing to perform abortions has declined and will continue to decline if the Act is not permanently enjoined. *See, e.g.,* Paul Rpt. ¶ 20 ("Many physicians to whom I have spoken would choose to stop doing second-trimester abortion procedures rather than risk facing liability or imprisonment for violating the Act."); Grunebaum Rpt. ¶ 27 ("At the present time I feel that I cannot safely perform second trimester abortions because of the vagueness of the ban and because I am unclear which procedures I can and cannot perform."); *see also* Sheehan Rpt. ¶ 13. Fear of liability caused at least one academic medical center-teaching hospital to stop performing all second-trimester abortion procedures before the Act was temporarily enjoined. *See* Greene and Ecker, *Abortion, Health and the Law*, N. ENG. J. MED. 350:2, Jan. 2004, at 185.

Similarly, after Wisconsin passed a ban on "partial birth abortions," medical clinics in Wisconsin stopped performing *all* abortions for fear of being prosecuted under the new law. Only after receiving assurance from prosecutors that they would not be prosecuted for performing *first-trimester* abortions did the clinics in Wisconsin resume providing any abortions at all. *See* Jon Jeter, *Reassured by Prosecutors on New Law, Wisconsin Clinics Resume Abortions*, THE WASHINGTON POST, May 21, 1998, at A08. Wisconsin women seeking second trimester abortions remained without treatment options unless they were able to travel to either Illinois or Minnesota. *Id.*

The Act's imposition of civil penalties will have a similar effect. Because the Act exposes physicians who perform abortions to substantial financial liability, 18 U.S.C. § 1531(c)(2), insurance carriers may effectively prevent physicians from performing abortions by refusing to provide affordable coverage for the added risk. *See* Monique A. Anawis, *Symposium: Medical Malpractice: Innovative Practice Applications*, 6 DePaul J. Health Care L. 309, 313 (2003) (noting that a substantial number of physicians have "planned to or considered discontinuing high-risk surgical procedures in order to lower their liability insurance rates.") Further, hospitals already running on small profit margins may not allow physicians to perform these procedures in their hospitals for fear of such civil suits.

This chilling effect intolerably burdens women's constitutionally-protected right to abortions. As the Supreme Court has explained, governmental regulations of abortions are unconstitutional where the regulation "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877. The Act's effect of narrowing the number of facilities and physicians willing to perform the procedure will necessarily place a "substantial obstacle in the path" of women seeking abortions. This is particularly true with respect to poor, rural, or other under-served communities in which women who currently have few abortion options soon may have none. *See* Jon Jeter, *Reassured by Prosecutors on New Law, Wisconsin Clinics Resume Abortions*, THE WASHINGTON POST, May 21, 1998, at A08.

D. The Act Unconstitutionally Prevents Physicians From Satisfying Their Duty To Protect The Health And Lives Of Their Patients.

1. Physicians need the constitutionally required health exception to fulfill their ethical duty to patients.

The Act's lack of a health exception greatly concerns the CMA. In order to provide optimal medical care to patients, physicians must be able to utilize the procedures that they believe to be in their patients' best interest. But under the Act, even if a woman's health would be acutely negatively affected,[8] her physician cannot perform "a partial birth abortion" without threat of prosecution. Instead, the woman may be forced to undergo a far less safe procedure, such as a hysterotomy or hysterectomy, or continue her pregnancy and suffer the health consequences.[9] *See* Broekhuizen Dec. ¶¶ 37, 41. This is an unacceptable alternative to physicians whose ethical duties require them to provide the safest care possible. *See* American Med. Ass'n, Code of Medical Ethics, E-10.015.

To provide the safest care, a physician must exercise his or her best medical judgment in light of the woman's physical condition, her psychological needs and the risk of health complications from the procedure. In doing so, many physicians have determined that under certain circumstances the intact D&E variant may be in the best interest of individual patients because of the safety advantages offered by the procedure. For instance, physicians have discovered that removing the fetus intact minimizes the number of times that forceps or other instruments must be inserted into the uterus. Because surgical instruments can puncture or tear the uterus when inserted, many physicians believe that inserting these instruments fewer times lowers the risk of uterine injury. *See Id.*; Paul TRO Dec. ¶ 44, Broekhuizen Dec. ¶¶ 10, 18, 20; Sheehan Rpt. ¶ 5.

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[8] For instance, a diabetic woman with active proliferation retinopathy may risk blindness if a pregnancy is carried to term. *See* Greene and Ecker, *Abortion, Health and the Law*, N. ENG. J. MED. 350:2, Jan. 2004, at 184. As another example, a woman who learns late in the second trimester that she is carrying a fetus with trisomy 13 would be at a significantly higher risk for complications or even maternal death if she carried the fetus to term, even though the fetal abnormalities prevent any hope that the child could survive for any significant period of time outside of the womb. *Id.* at 185.

[9] In fact, even where continuing the pregnancy would risk her ability to bear children in the future, a woman would have no other option under the Act except possibly the riskier hysterotomy or hysterectomy, which themselves threaten the ability to have children in the future. Broekhuizen Dec. ¶¶ 37, 41.

Physicians also have discovered that removing the fetus intact or as intact as possible may reduce the chance that sharp fetal bone fragments will cause cervical laceration as the fragments pass through the cervical canal. If fewer fragments are created, there are fewer chances for one to create a tear or puncture. *See* Paul TRO Dec. ¶ 44 , Broekhuizen Dec. ¶ 20. Intact removal also reduces the chance that any disarticulated fetal tissue will remain in the uterus following the procedure. If fewer fragments are created, there are fewer chances for any tissue to be missed and left behind to cause a life threatening infection. Paul TRO Dec. ¶ 44. Each of these three potential safety advantages have been recognized by the Supreme Court and numerous other courts who have examined this issue. *See, e.g.*, *Stenberg*, 530 U.S. at 936 (quoting Br. of Amicus Curiae Am. Coll. of Obstetricians and Gynecologists et. al.); *Women's Med. Prof'l Corp. v. Taft*, 162 F. Supp. 2d 929, 942 (S.D. Ohio 2001), *rev'd on other grounds*; *R. I. Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 314 (D. R.I. 1999), *aff'd* 239 F.3d 104 (1st Cir. 2001); *Hope Clinic v. Ryan*, 995 F. Supp. 847, 852 (N.D. Ill. 1998), *aff'd, Hope Clinic v. Ryan*, 249 F. 3d 603 (7th Cir. 2001) (per curium).

These considerations cause some experienced doctors to prefer that the fetus be evacuated as far as possible whenever performing a second trimester abortion procedure.[10] *See* Broekhuizen Dec. ¶ 10; Paul Rpt. ¶ 13. In addition, there are circumstances under which an experienced doctor may conclude that it would be safest not merely to allow the fetus to emerge intact if the procedure happens to progress in this way, but to take steps to achieve greater dilation in order to ensure that it can emerge intact up to the calvarium. *See* Paul Rpt. ¶ 13; Broekhuizen Dec. ¶ 17. For instance, physicians may determine that this is the safest course of action when the woman has serious medical problems that limit the amount of stress she can safely endure. The intact D&E variant can minimize stress on the patient by allowing for less analgesia and anesthesia to be used, involving less blood loss, and minimizing the chances of complications which the woman cannot overcome as readily as a healthy patient. *See* Broekhuizen Dec. ¶¶ 18-20. Physicians may also believe that the intact D&E variant is the

[10] Because a tenaculum is used to pull the cervix as close as possible to the vaginal introitus, this also means that the doctor prefers that fetus emerge intact from the woman's body as far as possible. *See* Paul TRO Dec. ¶ 41; Broekhuizen Dec. ¶ 9.

safest procedure to use where a fetal anomaly results in a particularly enlarged head or neck.[11] *See* Paul TRO Dec. ¶ 45; Broekhuizen Dec. ¶¶ 14, 22-23. Furthermore, an intact procedure may be more conducive to a woman's psychological health based on informed consent.[12] *See* Broekhuizen Dec. ¶ 21; *see also* American Med. Ass'n, Code of Medical Ethics, H-140.989 ("Informed Consent and Decision-Making in Health Care") and E-8.08 ("Informed Consent"). Finally, the intact D&E variant facilitates post-operative analysis of the causes of fetal anomalies, thereby leading to better treatment and more informed counseling should the woman wish to attempt another pregnancy. *See* Broekhuizen Dec. ¶ 21.

The CMA recognizes that not all doctors may share these views. But the CMA also submits that a substantial portion of the medical community both within California and elsewhere believe that the intact D&E variant may be the safest or best procedure for some patients given the particular circumstances of their pregnancy, and share the more general view that it is best to allow the fetus to emerge intact as far as possible in any D&E or induction procedure. Because these positions are, at a minimum, rational from a medical perspective and because no controlled medical studies indicate that the intact D&E variant is unsafe, CMA believes that it is absolutely critical for doctors to continue to be able to choose this safe and effective means of treatment when it appears to be in their patients' best interests. More fundamentally, CMA believes that the physician with years of extensive

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[11] The Congressional record contains testimony from many women who required the intact D&E abortions to preserve their health where fetal anomalies prevented natural childbirth. *See* 141 Cong. Rec. S17881 at S17888 (1995) (hereinafter "SJC 11/17/95") at 158-160 (statements of Coreen Costello) (stating that due to fetal abnormalities, "[n]atural birth or induced labor were not possible" and "[t]he doctors all agreed that our only option was the intact D&E procedure."); SJC 11/17/95 at 160-163 (statement of Vicki Wilson) (describing intact D&E as her "salvation.;" explaining that neither induced labor nor caesarean delivery were safe options); *see also Partial Birth Abortion: Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 71-74 (June 15, 1995) (statement of Tammy Watts); *Partial Birth Abortion: The Truth*, *Hearing on S.6 and H.R. 929 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary and the Senate Comm. on the Judiciary*, 105th Cong. 124-26 (Mar. 11, 1997) (testimony of Eileen Sullivan); *id.* at 126-129 (testimony of Maureen Britell).

[12] For instance, many women who receive this procedure do so after learning that the fetus has severe abnormalities that are inconsistent with life. In dealing with the loss of a wanted pregnancy to which the woman was deeply committed, many women and their families value the opportunity to hold the fetus and mourn its death. Because removing the fetus intact permits the family to do so, the procedure may assist these families in reaching closure on a tragic situation. *See, e.g.*, SJC 11/17/95 at 158-160 (statements of Coreen Costello); SJC 11/17/95 at 160-163 (statement of Vicki Wilson). In addition, the intact D&E variant permits the performance of a careful autopsy, a procedure that could provide much-needed answers for families who wish to have children and need to know if the same fetal abnormalities would likely occur in future pregnancies. *Id.*

training and direct knowledge of the individual patient is in a far better position than Congress to decide upon the safest course of treatment.

2. The only exception contained within the Act is inadequate to protect women's lives.

The only instance in which the Act allows physicians to perform the banned sequence of events is when it is "necessary to save the life of a mother." This lone exception fails to adequately protect women's lives or satisfy the Constitutional standards set forth in *Stenberg*.

First, this exception will rarely, if ever, apply because it would be extremely unusual for the banned procedure to be absolutely "necessary" to save a woman's life. This is because the Act, while it bans safe methods of second-trimester abortions, leaves available hysterotomy and hysterectomy. Thus, even where a woman's life is in danger, the fact that her life might be saved by one of these far more onerous procedures renders the use of the banned procedure illegal, although her health will be at greater risk and her ability to bear children in the future may be compromised. *See* Paul TRO Dec. ¶ 27; Broekhuizen Dec. at ¶¶ 38, 41. In recognition of the detrimental effects of an hysterectomy, California law requires a physician performing the procedure to inform the patient of "alternative efficacious methods of treatment which may be medically viable" before performing it. Cal. Health & Safety Code § 1691. Failure to do so "constitutes unprofessional conduct." *Id*. Thus, in a situation in which a woman's life and safety are in jeopardy, a doctor is obligated to inform the patient of the intact D&E variant, even though the Act prevents the doctor from providing this safe alternative.

The Act's exception for procedures "necessary to save the life of a mother" is inadequate for another important reason as well. Under Supreme Court precedent, a law regulating abortion must include an exception when a procedure "is necessary, *in appropriate medical judgment*, for the preservation of the life or health of the mother." *Casey*, 505 U.S. at 879 (quoting *Roe v. Wade*, 410 U.S. 113, 164-65 (1973)); *Stenberg*, 530 U.S. at 930. The Act's exception, however, removes the ability of physicians to exercise medical judgment in determining whether a banned procedure is, in fact, necessary to preserve a woman's life. Thus, a physician, when presented with a patient for whom he or she believes a banned procedure is necessary to save the patient's life, will be faced with the knowledge that if he or she proceeds with the procedure, the physician risks prosecution and conviction under the

Act because, in someone else's after-the-fact judgment, the procedure was not "necessary." *See* Paul TRO Dec. ¶ 28; Broekhuizen Dec. ¶ 39.

In order to properly treat patients, physicians must be able to take appropriate actions at the moment a patient's life is in danger without fear of later prosecution. Physicians hold a tremendous power over the health, safety and lives of their patients. This awesome responsibility "demands that the physician be free to use [her training] according to her best judgment." Edmund Pellegrino, *Patient and Physician Autonomy*, 10 J. Comtemp. Health L. & Pol'y at 52. As explained by one physician:

> If the physician is to fulfill the moral requirement to make her knowledge available to those who need it, she must be allowed sufficient discretionary latitude to apply that knowledge as rationally, efficiently and safely as possible. This is essential if physicians are to fulfill their part of the covenant with society and with individual patients.

Id. at 53. In short, allowing physicians to use their best medical judgment in treating their patients is essential to saving patients' lives and providing effective health care.

Physicians have for years relied on Supreme Court precedent that allows them, in consultation with their patients, to exercise appropriate medical judgment in determining whether a particular procedure is the best and most medically sound for a particular patient. Given that women's health and lives are at stake, the CMA strongly believes that physicians must continue to do so without having their hands tied by medically unsound laws.

3. Congressional findings are political, not medical, and should not mandate a different result.

In *Stenberg*, the Supreme Court determined, based on an extensive evidentiary record containing the opinions of medical professionals on both sides of the abortion debate, that "a statute that altogether forbids D&X creates a significant health risk" and that "the statute consequently must contain a health exception." *Stenberg*, 503 U.S. at 938 (citations omitted). In reaching this conclusion, the court recognized the difference of opinion in the medical community regarding the efficacy of the proscribed procedure. The court held, however, that "*Casey's* words 'appropriate medical judgment' must embody the judicial need to tolerate responsible differences of medical opinion – differences of a sort that the American Medical Association and the American College of Obstetricians and Gynecologists' statements together indicate are present here." *Id.* at 937. As the *Stenberg* Court recognized, the

division of medical opinion "means a significant likelihood that those who believe that D&X is a safer abortion method in certain circumstances may turn out to be right." *Id.* In light of this uncertainty, the *Stenberg* Court held that the constitution requires a health exception to avoid the risk of "tragic health consequences" for women. *Id.*

Ignoring this clear guidance from the Supreme Court, Congress banned the same procedures described in *Stenberg* without including a health exception. To justify its stated belief that no health exception was necessary, Congress held two hearings after *Stenberg* was decided.[13] The first, before the House Sub-Committee on the Constitution, lasted less than two hours, during which time two physicians testified against the procedure and none were invited to give the opposing viewpoint. *Partial Birth Abortion Ban Act of 2002: Hearing on H.R. 4965 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 107th Cong. 6-27 (2002). The second hearing, again before the House Subcommittee on the Constitution, lasted one and a half hours and again contained only medical testimony opposing the intact D&E variant. *Partial Birth Abortion Ban Act of 2003: Hearing on H.R. 760 Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 108th Cong. 6-18 (2003). Congress did not hear testimony during these hearings from any of the substantial number of well-respected organizations supporting the use of the intact D&E variant to protect women's health, including the American College of Obstetrics and Gynecology, the American Medical Women's Association, the American Nurses Association, the California Medical Association, Planned Parenthood Federation of America, or the University of California at San Francisco Center for Reproductive Health,

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[13] We focus here on the Congressional hearings held after *Stenberg* as it is clear that the Supreme Court was aware of and considered the record from the pre-*Stenberg* hearings. *See* Br. of Amici Curiae U.S. Rep. Charles T. Canady and Other Members of Cong. in Support of Pet'rs, 2000 WL 228464 (2000), *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830) (reporting on the Congressional hearings and findings); s*ee also Stenberg*, 530 U.S. at 959-60 (Kennedy, J., dissenting); *id* at 995 (Thomas, J., dissenting). We note, however, that the prior hearings contained similar imbalances to those described here. *See, e.g., Partial-Birth Abortion: Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. (June 15, 1995) (hereinafter "HJC 6/15/95") (including testimony from three medical health professionals against the procedure, one in support); HJC/SJC 3/11/97 (including only medical testimony from a physician opposed to the procedure).

Research and Policy.[14] *Id.* at 35; *see also* 149 Cong. Rec. H 9135, H9149 (2003) (listing medical organizations opposed to the Act).

Based on this limited and one-sided testimony and in a clear attempt to sidestep the Supreme Court's *Sternberg* decision, Congress asserted in its "Findings" that a health exception is not necessary because the proscribed procedure "is never necessary to preserve the health of a woman." Act § 2(5). The government now appears to assert that this Court must defer to Congress's dubious "Findings" and is precluded from reviewing the facts to determine whether a health exception is constitutionally required under *Stenberg*. This is incorrect. As Justice Thomas has explained:

> We know of no support … for the proposition that if the constitutionality of a statute depends in part on the existence of certain facts, a court may not review a legislature's judgment that the facts exist. If a legislature could make a statute constitutional simply by "finding" that black is white or freedom [is] slavery, judicial review would be an elaborate farce. At least since *Marbury v. Madison*, 1 Cranch 137 (1803), that has not been the law.

Lamprecht v. FCC, 958 F.2d 382, 392 n.2 (D.C. Cir. 1992). This is especially true where, as here, Congress attempts to nullify a decision of the Supreme Court. *See Dickerson v. United State*s, 530 U.S. 428, 437 (2000) (invalidating Congress' attempt to overturn *Miranda*); *City of Boerne v. Flores*, 521 U.S. 507, 519-24 (1997) (holding unconstitutional Congress' attempt to in effect overturn a previous decision of the Supreme Court through the Religious Freedom Restoration Act).

A health exception is required under *Stenberg* regardless of Congress' "Findings" because there remains a responsible difference of opinion in the medical community regarding whether the proscribed procedure is necessary for women's health. *See Stenberg*, 503 U.S. at 937. Although Congress has chosen to favor one side of the medical debate, it has not ended that debate. To the contrary, it cannot reasonably be disputed that the disagreement noted in *Stenberg* continues to this day. *See National Abortion Federation et. al. v. Ashcroft*, 287 F. Supp. 2d 525 (S.D.N.Y. 2003) (holding that

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[14] While the government proclaims the hearings to be "extensive," CMA notes that a number of Congressmen from both sides of the aisle felt otherwise. *See* SJC 11/17/95 at 17 (statement by Arlen Spector (R-PA)) (noting that oral testimony did not include "key people who could shed light on this subject"); *Effects of Anesthesia During a Partial-Birth Abortion: Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 20 (March 21, 1996) (statement by Barney Frank, (D-MA)) (noting that the Partial Birth Abortion bill had "been very inadequately debated."); *id*. at 22, 295 (statements of Patricia Schroeder (D-CO)) (describing hearing as a "witch trial" and stating that the hearings "look[ ] like a political 30-second ad generator machine.")

plaintiffs showed likelihood of success on merits based, in part, on government's admission that "there remains a disagreement in the medical community as to whether the abortion procedures covered by the [Partial Birth Abortion Ban of 2003] are ever necessary to protect a woman's health.") Thus, given that "substantial medical authority" continues to support "the proposition that banning a particular abortion procedure could endanger women's health," Supreme Court authority "requires the statute to include a health exception when the procedure is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Stenberg*, 530 U.S. at 938.

4. Physicians cannot avoid liability under the Act by using chemical injections prior to beginning the procedure.

Digoxin or other chemical injections are sometimes used by physicians in an attempt to cause fetal demise prior to performing an abortion. *See* Sheehan Rpt. ¶ 7. Because the Act's prohibitions are not implicated where the fetus dies before the abortion procedure begins, the government has asserted that doctors can avoid liability under the Act by using these injections.[15] Thus, the government appears to assert, the Act's prohibitions should not concern the Court or the medical community. The Government is wrong on both counts. In caring for women's health, physicians must be afforded the discretion to determine when a procedure is or is not in their patient's best interest. Therefore, just as physicians protest governmental intrusions that forbid them from using medically safe procedures, physicians also protest any interference that compels them to take steps during a procedure that are not medically indicated and that are contrary to physicians' best medical judgment.

First, it should be noted that even physicians who use digoxin or other chemical injections must still fear prosecution under the Act. Although the sole purpose of using a chemical injection is to cause fetal demise, the medication is not fool-proof. Sheehan Rpt. ¶ 8. To the contrary, a number of fetuses show signs of life even after the injection, leaving the physician who performs the proscribed procedure as vulnerable to prosecution under the Act as they would have been without use of the injection. *Id*.

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[15] The government's argument that physicians can avoid liability under the Act by inducing fetal demise before beginning the abortion seriously undermines Congress' assertion that the Act is necessary to protect maternal health. If the banned procedure harms women, it will do so regardless of whether fetal demise occurs before or during the procedure.

More fundamentally, the CMA strongly opposes the notion that doctors should be forced to inject chemical agents into a woman's body for reasons that have nothing to do with medicine or the individual patient's health. Chemical injections do not necessarily make abortion procedures easier for physicians to perform or safer for the patient. *See* Creinin Rpt. ¶ 18; *see also* Nancy K. Rhoden, *Trimesters and Technology: Revamping Roe v. Wade*, 95 Yale L.J. 639, 666 (1986) (noting that digoxin injections are "unrelated to the woman's health and [are] solely designed to ensure fetal death in utero.") Forcing physicians to inject foreign substances into a women's body for legal rather than medical reasons is unconscionable to physicians who have pledged "to place the patient's welfare above their own self-interest" and to not perform unnecessary medical procedures. *See* AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS, E-2.19 ("Physicians should not provide … services that they know are unnecessary.") This is particularly true where, as here, the procedure, at a minimum, adds "another layer of complexity, discomfort, and anxiety for the patient to an already distressing procedure." Greene and Ecker, *Abortion, Health and the Law*, N. ENG. J. MED. 350:2, Jan. 2004, at 185; *see also* Broekhuizen Rpt. ¶ 22 (noting that some patients do not want their physicians to take extra steps to cause fetal demise prior to beginning uterine evacuation); Creinin Rpt. ¶ 10 ("Forcing physicians to alter their surgical technique and medical practice for non-medical reasons threatens their patient's health.")

For these reasons, the government's assertion that physicians must use chemicals like digoxin where they would not otherwise do so and against their own medical judgment is perhaps an even more alarming intrusion into the doctor-patient relationship than the Act itself. The CMA strongly opposes any suggestion that drugs or chemicals should be inserted into a woman's body for non-medical reasons and rejects any attempt by the government to usurp the role of doctors in deciding what is best for patients by compelling physicians to do so.

E. The Act's Civil Liability Provisions Will Force Doctors To Either Violate Their Patients' Confidentiality Or Risk Civil Damages.

Physicians are ethically required to preserve the confidentiality of their patients' revelations and medical information. *See* AMERICAN MED. ASS'N, CODE OF MEDICAL ETHICS, H-315.983 ("Patient Privacy and Confidentiality"). This sacrosanct duty is so fundamental to the physician patient relationship that it is enshrined in the Hippocratic Oath itself: "Whatever, in connection with my

professional practice, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge as reckoning that all such should be kept secret." *See* Taber's Cyclopedic Medical Dictionary 765 (15th ed. 1985) (Oath of Hippocrates). Confidentiality is of particular importance where the patient seeks an abortion, one of the most sensitive and private medical decisions a woman can make.

Despite the importance of patient privacy, the Act exposes physicians to civil liability unless the physician obtains the consent of the patient's husband or parents (if the patient is under 18 years of age) before performing a procedure that might fall under the Act. 18 U.S.C. § 1531(c). Thus, the only way for a physician to ensure that he or she will not be forced to pay actual and statutory damages is to disclose the patient's personal decision to have an abortion to her husband (or, in some cases, to her parents) for approval. *See* Broekhuizen Rpt. ¶ 21; Sheehan Rpt. ¶ 12. This obligation places physicians in the impossible situation of either violating their duty of confidentiality to their patients, or exposing themselves to civil damages that could threaten their financial stability. No physician should be forced to make this choice.[16]

F. The Act Will Hinder Medical Advancements In Reproductive Health.

The Act endangers the health of women by restricting physicians' ability to develop new and safer abortion procedures and techniques. Bans on individual surgical methods prevent doctors from building on present knowledge and developing potentially safer variants of the procedure through clinical experience. As a complete ban on certain abortion procedures with only meaningless exceptions, the Act threatens women's health by failing to leave any room for scientific advancement or medical evolution. *See* Westhoff Rpt. ¶ 44; Frederiksen Rpt. at 5-6.

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[16] Although the full consequences of this disclosure are beyond the scope of this brief, it must be noted that there are compelling reasons why some women would seek an abortion without discussing this decision with their husbands or parents. As described in *Planned Parenthood v. Casey*, many women are subject to domestic violence and fear reprisal if they inform their husbands that they are pregnant or are seeking an abortion. 505 U.S. at 892-93. Under these conditions, it can hardly be doubted that requiring physicians to receive a husband's consent to avoid civil liability would likely "prevent a significant number of women from obtaining an abortion." *Id.* at 893. The Supreme Court has also ruled that parental consent laws are unconstitutional without a judicial bypass, recognizing that some parents will act abusively when confronted with news of a daughter's pregnancy. *See Hodgson v. Minnesota*, 497 U.S. 417, 450-51 (1990).

Most common abortion methods used today were developed through physicians exploring variations of known abortion techniques in pursuit of safer and more efficient procedures. *See id*. For instance, vacuum aspiration methods of abortion were developed as alternatives to the dilatation and curettage (D&C) method, which was slower, less thorough and had a higher complication rate. *See* Pak Chung Ho, *Termination of Pregnancy between 9 and 14 Weeks* in MODERN METHODS OF INDUCING ABORTION, 54, 56-57 (David T. Baird et al., eds.,1995). Although vacuum aspiration techniques had been known in medical literature for over a hundred years, it was not until after 1973, when abortion became legal nationwide, that physicians were free to explore and perfect vacuum aspiration techniques. *See* A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION, 5-6, 107-08 (Maureen Paul, et. al. eds. 1999). Due to their efforts, vacuum aspiration has replaced D&C as the most common and safest method of first-trimester abortions. *See id.*

Similarly, D&E procedures were initially developed by physicians who sought an abortion procedure that could be reliably performed during the period between 12-16 weeks gestational age and that could be performed in a safer manner than the induction method. *See* EUGENE GLICK, SURGICAL ABORTION 46-48 (1998). Since its inception in the 1970s, D&Es have become the most common and safest post-first trimester abortion procedures. Most of the credit for the rapid improvement in D&E techniques belongs to physicians who, over the years, have experimented with slightly varying techniques in performing the procedure and have shared their discoveries with their colleagues. *Id.* Each of these advancements and evolutions in medical practice have made abortions safer for women. *See* Westhoff Rpt. ¶ 44.

The intact D&E variant evolved from the traditional D&E procedure after some physicians discovered health benefits from minimizing disarticulation. *See* CLINICIAN'S GUIDE, at 136; Westhoff Rpt. ¶ 44; Frederiksen Rpt. at 5-6. As described above, the intact D&E variant may offer numerous safety advantages over other second-trimester abortion methods. As great as these benefits may be, the potential for the procedure to lead to even better choices for physicians and their patients is far greater. If physicians are permitted to perform and improve the variant through clinical experience, it may lead to remarkable progress in the safety of abortion procedures and the advancement of medical knowledge. *See* Doe Rpt. ¶ 8; Westhoff Rpt. ¶ 44; Frederiksen Rpt. at 5-6. If this Act stands, however,

it will stifle clinical progress and ensure that this potential is never realized, causing immeasurable loss to women and their families. *Id*.

IV. CONCLUSION

The CMA strongly opposes this Act because it denies a pregnant woman and her physician the ability to make medically appropriate decisions about the course of her medical care. The Act thus intrudes into the sacrosanct physician-patient relationship by preventing physicians from providing the best available medical care to their patients. This interference, coupled with the Act's vague terms and failure to include an adequate health exception, chills physicians from providing any abortion services that could potentially fit within the Act's broad definition. Physicians should not have their ability to provide constitutionally-protected services stifled in this manner and women should not have to bear the resulting detriment to their health.

On behalf of its physician members, the CMA files this brief in hopes that the Court will recognize the paramount importance of allowing physicians to exercise their best medical judgment, honed over years of training and experience, to determine the safest course of treatment for their patients. The highly individual determination of which procedure is best for a patient must be left to the patient in consultation with her physician. Limiting the ability of physicians to provide a safe and perhaps even the safest abortion procedure imposes a horrendous burden on women and families who are already facing one of the most difficult decisions they will ever have to make. Their physical and emotional anguish should not be compounded by a misguided law that is devoid of scientific justification, and that strikes at the very core of the physician-patient relationship that is the hallmark of modern medical care.

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