Nos. 21-2913, 21-2922

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PLANNED PARENTHOOD MINNESOTA, NORTH DAKOTA, SOUTH DAKOTA, *et al.*,
Plaintiffs-Appellees,

v.

KRISTI NOEM, GOVERNOR, *et al.*,
Defendants-Appellants,

ALPHA CENTER, *et al.*,
Intervenors-Appellants.

On Appeal from the United States District Court
for the District of South Dakota, Southern Division, No. 4:11-cv-04071-KES
Before the Honorable Judge Karen E. Schreier

BRIEF FOR AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF MEDICAL GENETICS AND GENOMICS, AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY, AMERICAN MEDICAL ASSOCIATION, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE, AMERICAN UROGYNECOLOGIC SOCIETY, COUNCIL OF UNIVERSITY CHAIRS OF OBSTETRICS AND GYNECOLOGY, NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY, NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN WOMEN'S HEALTH, SOCIETY FOR ACADEMIC SPECIALISTS IN GENERAL OBSTETRICS AND GYNECOLOGY, SOCIETY OF FAMILY PLANNING, SOCIETY OF GYNECOLOGIC ONCOLOGY, SOCIETY FOR MATERNAL-FETAL MEDICINE, SOCIETY OF OB/GYN HOSPITALISTS, AND SOCIETY FOR REPRODUCTIVE ENDOCRINOLOGY AND INFERTILITY AS AMICI CURIAE IN SUPPORT OF APPELLEES AND AFFIRMANCE

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INTEREST OF AMICI CURIAE[1]

Amici are major medical organizations representing physicians and other clinicians who serve patients in South Dakota and nationwide. Their work has been cited frequently by the Supreme Court and other federal courts seeking authoritative medical data and guidance regarding the provision of health care for pregnant people, including childbirth and abortion.[2] A full list of amici is provided in the appendix to this brief.

Amici submit this brief to provide the medical community's perspective on the challenged provisions restricting abortion enacted in 2011 as part of South Dakota House Bill 1217. It is the consensus of amici that the challenged provisions violate key principles of medical ethics and will harm patients.

INTRODUCTION

In medicine, the patient is paramount, and medical ethics requires all clinicians to respect patient autonomy and assist their patients in making informed

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[1] The parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part, and no party or person other than amici, their members, and their counsel contributed money towards its preparation.

[2] *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 932-936 (2000); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990); *Simopoulos v. Virginia*, 462 U.S. 506, 517 (1983); *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386, 387 (8th Cir. 1999); *Little Rock Fam. Plan. Servs., P.A. v. Jegley*, 192 F.3d 794, 795 (8th Cir. 1999).

decisions about their health.[3] All patients, including in the reproductive health care context, should be able to trust and meaningfully engage with their medical team.

The challenged statutory provisions requiring patients to submit involuntarily to a "private interview"[4] at a Pregnancy Help Center ("PHC"), an entity not directly involved in the provision of the patients' health care, before having an abortion are directly contrary to well-established principles of medical ethics. The provisions compel patients to submit to counseling that, by statutory definition, is designed to undermine their decision to seek abortion, in clear violation of the foundational principle of patient autonomy.

The challenged statutory provisions (the "PHC Mandate") also improperly encroach on the patient-physician relationship. A confidential, trusting, and open dialogue between patient and physician is essential to achieving the best health care outcomes. The PHC Mandate's compulsory and hostile counseling requirement undermines the patient-physician relationship by intruding on the privacy of patient-physician encounters, undercutting a physician's medical advice, and suggesting that a physician is otherwise incapable of securing informed

[3] "Clinicians" includes physicians, nurse practitioners, etc.

[4] S.D.C.L. § 34-23A-56(3)(a).

consent.[5] Finally, the PHC Mandate will cause serious physical and psychological harm to patients by delaying access to abortion, often leading to a denial of care.

All patients should feel safe and respected in their physician's care. Principles of medical ethics, coupled with additional safeguards currently imposed by South Dakota law, already ensure no patient will undergo an abortion if there is any question as to whether the decision is voluntary. The PHC Mandate provides no added protection from coercion. Instead, it deters, shames, and punishes patients seeking abortions, in plain contravention of medical ethics principles.

ARGUMENT

I. THE PHC MANDATE VIOLATES PRINCIPLES OF INFORMED CONSENT

Patient autonomy is the "first among equals" of the foundational principles of medical ethics.[6] Informed consent is the mechanism by which patients exercise

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[5] South Dakota requires that a licensed physician perform all abortions. *See* S.D.C.L. §§ 34-23A-3, 34-23A-4, 34-23A-5; *see also* S.D.C.L. § 36-4A-20.1 (prohibiting physician assistants from performing abortions); S.D.C.L. § 36-9A-17.2 (same for nurse practitioners and nurse midwives).

[6] The other pillars are beneficence, nonmaleficence, and justice. ACOG, Comm. on Ethics, *Opinion No. 819*, 137 Obstet. & Gynecol. e34, e35 (2021). The American College of Obstetricians and Gynecologists' ("ACOG") Committee on Ethics "identifies, evaluates, and publishes documents that provide best practice recommendations regarding ethical issues that affect the specialty of obstetrics and gynecology. Recommendations are developed via consensus of expert opinion and are based on the principles outlined in the codes of ethics of ACOG and the American Medical Association." ACOG, Committees: General Principles for ACOG Committees, Committee Descriptions (2022), https://www.acog.org/about/leadership-and-governance/committees.

their autonomy and choose whether to authorize specific medical care.[7] Protecting informed consent, through proper and patient-centered procedures, is at the very heart of medical ethical standards.[8]

Respect for patient autonomy in the informed consent process requires that physicians convey clinical information "tailored to the desires of the individual patient and to the patient's ability to understand this information" so that patients can make intentional and voluntary choices about health care.[9] Physicians must disclose: the patient's diagnosis, treatment alternatives, burdens, risks, and expected benefits of all options, including foregoing treatment.[10] This effective, patient-centered communication allows patients to make informed decisions about their reproductive health.[11] Obtaining informed consent requires physicians to consider and respect a patient's values and priorities, enabling a patient to make intentional and voluntary choices about health care.[12]

The PHC Mandate exposes patients to coercion—the very harm the PHC Mandate purports to combat—by forcing patients to interact with entities that are

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[7] *See* ACOG, *Opinion No. 819*, at e35.

[8] *Id*. at e34.

[9] *Id*.

[10] *Id*.

[11] *Id*.

[12] *See id*.

opposed to their decision. The anti-abortion bias of PHCs is foundational to their purpose.[13] A PHC "has as one of its principal missions to provide education, counseling, and other assistance to help a pregnant mother maintain her relationship with her unborn child and care for her unborn child."[14] PHCs assume that no patient would choose abortion intentionally and voluntarily, necessarily adopting the view that patients are unable to identify the best course of action for their own medical care.[15] PHCs do not respect patient autonomy.[16]

The PHC Mandate requires a patient who has sought abortion care and has already received counseling from their physician to undergo an invasive interview with someone they *know* disagrees with their stated wishes, violating principles of

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[13] *See* S.D.C.L. § 34-23A-53(1); *see also* Uniform South Dakota Registered Pregnancy Help Center, *Policy and Procedure Guidelines for 1217 Client Counseling* at 36-37 (eff. Sept. 1, 2016) ("PHC Policy"). A "necessary prerequisite to perform an effective assessment for coercion or pressure" is accepting that: "most pregnant [people] considering an abortion, would prefer to keep and raise their child"; pregnant [people] have a "strong ambivalence" about having an abortion; many pregnant [people] are subject to pressure by others to have an abortion; and many pregnant [people] are in fact coerced to have an abortion. PHC Policy 36-37. Moreover, no PHCs may have "referred any pregnant [person] for abortions for the three-year period immediately preceding July 1, 2011." § 34-23A-53(1).

[14] S.D.C.L. § 34-23A-53(1).

[15] *See supra* n.13.

[16] Decl. of Paul Appelbaum ¶ 21 (June 1, 2021) ("[I]t is hard to think of a more blatant violation of the principles of respect for autonomy and self-determination than requiring women who want to have abortions to go, against their will" to an organization "morally and ideologically opposed to abortion.").

informed consent and patient autonomy.[17] The PHC interview is not simply a matter of checking boxes: it is an intimate experience, where patients are forced to sit in a room with a PHC counselor and be asked lengthy, invasive, and personal questions, all with the looming threat of being denied access to their chosen care.[18] Having to enter this hostile environment in order to obtain medical care flouts the principles of medical ethics, which counsel a physician to explain all medically appropriate options for care, and then to prioritize a patient's independent capacity to make an intentional and voluntary choice about their own body.

II. THE PHC MANDATE INTRUDES INTO THE PATIENT-PHYSICIAN RELATIONSHIP WITHOUT PROVIDING ANY ADDITIONAL PROTECTION

A. The PHC Mandate Disrupts The Patient-Physician Relationship

Informed consent is best achieved through shared decision-making, a "patient-centered, individualized approach … that involves discussion of the benefits and risks of available treatment options in the context of a patient's values and priorities."[19] By tailoring information and communication, a physician works with a patient to identify the best course of treatment while respecting patient

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[17] S.D.C.L. § 34-23A-56(3) (physicians must provide the PHC contact information and instruct the patient that they must "obtain[] a consultation" with a PHC before the patient can sign a consent form for an abortion).

[18] *See* PHC Policy at 40 (outlining process by which a PHC may determine that a patient is being coerced and notify their physician).

[19] ACOG, *Opinion No. 819*, at e36.

autonomy.[20] Referrals to other providers are made only when requested by the patient or when they are necessary and promote the patient's best interests.[21]

Laws should not interfere with the ability of physicians and patients to determine appropriate treatment options and communicate in the way that best advances patients' health care.[22] The compulsory, hostile counseling imposed by the PHC Mandate creates the harmful implication that informed consent does not work as intended and that patients are incapable of making decisions in consultation with their doctors regarding their own care.

The PHC Mandate intrudes upon the privacy essential to the patient-physician relationship, which is grounded in confidentiality, trust, and honesty.[23] When trust is established, patients share deeply personal information with their physician, leading to the best, individualized course of treatment. Patients are unlikely to establish a trusting relationship in a statutorily forced interaction, yet they must disclose sensitive information to a PHC from the moment they arrive.[24]

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[20] *Id.* at e34, e36.

[21] *See id.* at e36; *see also* AMA, Code of Medical Ethics: Principles (2016); AMA, Code of Medical Ethics Opinion 1.2.3 (2016).

[22] ACOG, *Opinion No. 819*, at e38.

[23] ACOG, Code of Professional Ethics at 2 (2018); AMA Code of Medical Ethics Opinion 1.1.1 (2016).

[24] PHC staff and unlicensed volunteers ask: "what advice [the patient] was given by [their] boyfriend, parents, friends, siblings" and the patient's reaction; "if

This mandated disclosure subverts principles that patients are "entitled to decide whether and to whom their personal health information is disclosed"[25] and that "[l]aws should not interfere with the ability of physicians to have open, honest, and confidential communications with their patients."[26] Because PHCs are not bound by the same ethical or legal obligations as physicians, patients will be justified in any reluctance in sharing sensitive information.[27] Laws should not force patients to share information with people outside their chosen health care team.

Moreover, the PHC Mandate gives a nonmedical third party unusual and inappropriate control over a patient's health care. Adult patients are presumed to have decision-making capacity and are best situated to make informed decisions

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[the patient] is living at home … how [their] parents reacted"; if the patient's boyfriend is "generally supportive, disinterested, or hostile"; the reaction of the patient's peers; if the patient's initial decision changed, "how [the patient] reached the decision that [they have] now come to"; what other options were presented "by those who know, especially [their] boyfriend and family"; and "if [the patient] was threatened, were the threats direct e.g. refusing to pay for [them] to attend college, threats from [their] boyfriend that he would leave [them] or were the threats more subtle." Alpha Interrog. Resps. at 7-8; Black Hills Interrog. Resps. at 7-8, 14-15.

[25] AMA, Code of Medical Ethics Opinion 3.2.1 (2016).

[26] ACOG, *Opinion No. 819*, at e38.

[27] *See* PHC Policy at 28 ("Whether or not Federal HIPPA [sic] Laws apply to a 1217 client, the spirit and requirements of HIPPA [sic] shall be employed by the pregnancy help center."). While the PHC Mandate "shall be" conducted pursuant to the PHC Policy, S.D.C.L. § 34-23A-59(5), it eliminates any meaningful protection by specifying that failure to follow the PHC Policy "may [not] be construed to impose any liability" on a PHC, S.D.C.L. § 34-23A-59.

regarding their care.[28] The PHC Mandate enables a PHC to supplement a patient's medical record unilaterally with its assessment of whether the patient has been coerced, without the patient's consent or the patient independently seeking out the PHC for a consultation.[29] In the extreme, this statutory power also gives PHCs the ability to prevent a patient from obtaining an abortion.[30] If the PHC concludes that the patient has been coerced, for any reason, the PHC may inform the physician, effectively nullifying the doctor's ability to perform a wanted abortion.[31]

PHCs are under no legal obligation to notify physicians of their assessments regarding coercion.[32] The specter of PHCs' power to declare a "coercive abortion" will have a chilling effect on physicians due to fears of reported coercion, no matter how baseless, emerging after the abortion is completed.[33] Given the limited

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[28] ACOG, *Opinion No. 819*, at e34.

[29] S.D.C.L. § 34-23A-59(4) ("If forwarded to the physician, the written statement or summary of assessment [created by the PHC] shall be maintained as a permanent part of the pregnant mother's medical records.").

[30] S.D.C.L § 34-23A-59(3).

[31] S.D.C.L § 34-23A-59(3)-(4).

[32] *Id.*

[33] If a physician determines a patient has made a voluntary and informed decision and provides an abortion notwithstanding a PHC assessment of coercion, the physician and clinic are exposed to civil and criminal liability. *See* S.D.C.L. §§ 34-23A-60 to -61 (civil action for damages by woman or her survivors); *id.* § 34-23A-51 (facility license suspension or revocation); *id.* § 36-4-29 (physician license suspension or revocation); *id.* § 34-23A-10.2 (criminal penalties).

access to abortion care in South Dakota,[34] physicians' fears of post-procedure reports of coercion may eliminate access to the procedure altogether.[35]

Finally, the PHC Mandate improperly singles out abortion and the relationship between physicians providing abortion care and their patients. South Dakota law does not mandate a third-party inquiry into whether a patient has been coerced for *any* other medical procedure.[36] This mandatory inquisition is a far cry from referrals to counseling, like genetic[37] or substance use[38] counseling, where a patient has actively requested additional treatment or their physician believes a referral to another clinician to be in the patient's best interest. Those sorts of referrals are inextricably part of medical care ethics,[39] and delay or failure to refer

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[34] *See infra* Part III.C.

[35] *See* ACOG, Comm. on Health Care for Underserved Women, *Opinion No. 815*, 136 Obstet. & Gyencol. e107, e111 (2020) ("Laws that unnecessarily curtail scope of practice diminish the number of qualified medical professionals who can provide abortion care.").

[36] *See, e.g.*, S.D.C.L § 27A-8-1 (provider-acquired consent sufficient for voluntary hospitalization of patients with mental illness); *id.* § 27B-8-41 (same for developmentally disabled patients to undergo experimental or hazardous procedures); *id.* § 27B-8-54 (same for developmentally disabled patients to participate in behavior intervention programs).

[37] ACOG, Comm. on Ethics and Comm. on Genetics, *Opinion No. 410*, at 1 (2008; reaffirmed 2020).

[38] ACOG, Comm. on Health Care for Underserved Women, *Opinion No. 473*, at 2 (2011; reaffirmed 2019).

[39] ACOG, *Opinion No. 819*, at e38; AMA, Code of Medical Ethics: Principles (2016); AMA, Code of Medical Ethics Opinion 1.2.3 (2016).

is often grounds for medical malpractice claims.[40] The PHC Mandate forces a patient to meet with a PHC despite the fact that the patient has determined with their physician they want an abortion and has not asked for an outside opinion, and the physician does not believe that PHC counseling would be in the patient's best interest.[41] For no other medical procedure does South Dakota presume that a physician is incapable of properly seeking, receiving, and documenting informed consent and outsource the role of coercion arbiter to an unrelated third party.[42]

B. The PHC Mandate Adds No Protection From Coercion

Adherence to well-accepted principles of medical ethics, coupled with South Dakota's already-stringent informed consent regime, provides ample protection against coercion. The PHC Mandate provides no added safeguards. Instead, by flouting the doctrine of informed consent, it subjects patients to coercive practices.

Physicians whom patients have sought out for care are bound by a code of medical ethics and are best positioned to make the individualized determination as to whether a patient is making an informed, autonomous decision. Through open, honest, and confidential communications with their patient, a physician can

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[40] Xu et al., *The Effect of Medical Malpractice Liability on Rate of Referrals Received by Specialist Physicians*, 8 Health Econ. Pol'y Law 453, 454 (2013).

[41] *See supra* text accompanying n.28.

[42] Similarly, for no other procedure does South Dakota presume that a patient is incapable of determining whether they want to speak with and get the advice of an outside entity that is not their chosen clinician.

determine if consent is a voluntary choice. Indeed, existing South Dakota law recognizes the physician's competence in securing informed consent given that no abortion may be performed until a physician obtains a "voluntary and informed written consent" form from the patient.[43]

III. THE PHC MANDATE WILL CAUSE SERIOUS HARMS TO PATIENTS

A. The PHC Mandate Will Cause Delays In Care

The PHC Mandate creates an incentive for PHCs—organizations which are by definition opposed to abortion—to delay. South Dakota already requires a 72-hour delay between a patient's consultation with a physician and an abortion, not including weekends and holidays.[44] But 72 hours is the least a patient is currently required to wait. The PHC Mandate does not include a timeframe by which a PHC must schedule the counseling appointment. This ambiguity invites delay.

Patients may also delay seeking care, either to put off the oppositional and invasive interview with a stranger or out of fears about privacy. Patients may reasonably believe their privacy is at risk because PHCs are not subject to federal or state privacy laws, like the Health Insurance Portability and Accountability Act. In other words, patients' personal health information is not protected by PHCs in

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[43] S.D.C.L § 34-23A-10.1; *see also* ACOG, *Opinion No. 819*, at e36 (Informed consent requires accurate and comprehensive assessment and documentation of a patient's consent.).

[44] S.D.C.L. § 34-23A-56.

the same way it is protected by their physicians when they seek actual medical care. This fear will be especially great for victims of intimate partner violence, because abusive partners often force their partners to continue a pregnancy to term to prevent them from leaving.[45] The PHC Mandate creates no guarantee of privacy for patients who must conceal their abortion from abusive partners.

B. Delay In Obtaining An Abortion Poses Health Risks

Many pregnant patients are at high risk for health complications caused by underlying or developing conditions, like high blood pressure, diabetes, and heart disease. In addition, new and dangerous conditions like preeclampsia can develop during pregnancy.[46] Delaying an abortion increases the risk that one of these conditions will develop or worsen.[47] Delay also increases the likelihood that a patient will attempt a self-managed abortion using harmful, unsafe methods.[48]

Delay may also eliminate patients' treatment options. Medication abortion is available until 77 days after the first day of the patient's last menstrual period

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[45] Decl. of Lisa Goodman ¶¶ 14-16 (June 1, 2021).

[46] ACOG, *Practice Bulletin No. 222: Gestational Hypertension and Preeclampsia*, 135 Obstet. & Gynecol. e237 (June 2020).

[47] *Id.*; ACOG, *Practice Bulletin No. 212: Pregnancy and Heart Disease*, 133 Obstet. & Gynecol. e320 (May 2019); ACOG, *Practice Bulletin No. 201: Pregestational Diabetes Mellitus*, 132 Obstet. & Gynecol. e228 (Dec. 2018).

[48] *See* Jones et al., Guttmacher Inst., *Abortion Incidence and Service Availability in the United States, 2017*, at 3, 8 (Sept. 2019) (noting a rise in patients who had attempted to perform a self-managed abortion).

("LMP"), after which a patient's only option is a procedural abortion.[49] The denial of choice of procedure undermines patient autonomy. Delay can increase health risks. While abortion-related complications are exceptionally rare, delay can result in an increased chance of a major complication.[50]

C. Delay Means That Some Patients Will Be Denied An Abortion

The PHC Mandate adds an extra trip to an already-onerous two-trip procedure, a particular burden for those living in poverty in rural South Dakota.[51] This patients must already navigate the mandatory 72-hour delay between initial counseling—with physicians who travel from out of state—and an abortion.[52] Young, poor, and less-educated patients are most likely to be denied care because they tend to confirm their pregnancies later.[53] Each added trip exacerbates difficulties in finding childcare and money for travel, taking time off work, or justifying absence to an abusive partner opposed to the patient's choice.[54] The

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[49] Decl. of Sarah Traxler ¶ 5 (June 1, 2021) ("Traxler Decl.").

[50] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet. & Gynecol. 215, 217 (Feb. 2012).

[51] ACOG *Opinion No. 815*, at e108 (75% of women seeking abortions live below 200% of the federal poverty line).

[52] S.D.C.L. § 34-23A-56; Decl. of Misty Parrow ¶¶ 11-12 (June 1, 2021).

[53] Rosen, *The Public Health Risks of Crisis Pregnancy Centers*, 44 Perspectives on Sexual & Reproductive Health 201, 202 (2012).

[54] 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); Goodman Decl. ¶¶ 16, 26.

more obstacles, the less likely a patient can manage three trips before 13.6 weeks LMP, the last day abortions are available in South Dakota. [55]

D. The PHC Mandate Will Cause Psychological Harm To Patients

The PHC Mandate forces patients into an environment organized around the principle not only that the decision the patients want is wrong, but also that the patients are wrong in wanting it.[56] It is degrading to force a patient to share intimate details with someone looking to support their own preconceived ideas.

Denial of a wanted abortion can have negative effects on mental health, such as an increased likelihood of anxiety, low self-esteem, and lower life satisfaction.[57] Long term, patients denied an abortion are more likely to remain with abusive partners and in poverty, resulting in collateral mental health burdens.[58]

CONCLUSION

For the reasons set forth above, amici respectfully ask this court to uphold the district court's denial of the Motion to Dissolve the Preliminary Injunction.

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[55] Traxler Decl. ¶ 5.

[56] *See* Decl. of Jennifer Barber ¶ 10 (June 1, 2021).

[57] Biggs et al., *Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA Psychiatry 169, 172, 177 (2017).

[58] *See generally* Foster, *The Turnaway Study* (2020) (a longitudinal study examining the effects of unwanted pregnancy on women's lives).

Respectfully submitted,

/s/ Kimberly A. Parker

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CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g)(1), the undersigned hereby certifies that this brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and Fed. R. App. P. 32(a)(7)(B)(i).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(f), the brief contains 3,664 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word for Microsoft 365 MSO in 14-point Times New Roman font. As permitted by Fed. R. App. P. 32(g)(1), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

/s/ Kimberly A. Parker
KIMBERLY A. PARKER

March 23, 2022

CIRCUIT RULE 28A(h) CERTIFICATION

I hereby certify that I have filed electronically, pursuant to Circuit Rule 28A(h), a version of the brief in non-scanned PDF format. I hereby certify that the file has been scanned for viruses and that it is virus-free.

/s/ Kimberly A. Parker
KIMBERLY A. PARKER

March 23, 2022

CERTIFICATE OF SERVICE

I hereby certify that on this 23rd day of March 2022, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Eighth Circuit using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

/s/ Kimberly A. Parker
KIMBERLY A. PARKER

APPENDIX

LIST OF AMICI CURIAE

1. The **American College of Obstetricians and Gynecologists** ("ACOG") is the nation's leading group of physicians providing reproductive health care. With more than 60,000 members—representing more than 90% of all board-certified obstetricians-gynecologists in the United States including in the State of South Dakota—ACOG advocates for quality health care, maintains the highest standards of clinical practice and continuing education for its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing reproductive health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care, for all patients. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care.

2. Founded in 1947, the **American Academy of Family Physicians** ("AAFP") is one of the largest national medical organizations, representing 133,500 family physicians and medical students nationwide. AAFP seeks to improve the health of patients, families, and communities by advocating for the health of the public and by supporting its members in providing continuous comprehensive health care to all.

3. The **American Academy of Pediatrics** ("AAP") is a non-profit professional organization founded in 1930 dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. Its membership is comprised of 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. AAP has become a powerful voice for child and adolescent health through education, research, advocacy, and the provision of expert advice. AAP has worked with the federal and state governments, health care providers, and parents on behalf of America's families to ensure the availability of safe and effective reproductive health services.

4. The **American College of Medical Genetics and Genomics** ("ACMG") is the only nationally recognized medical professional organization solely dedicated to improving health through the practice of medical genetics and genomics, and the only medical specialty society in the U.S. that represents the full spectrum of medical genetics disciplines in a single organization. The ACMG is dedicated to improving health through the clinical and laboratory practice of medical genetics and to guiding the safe and effective integration of genetics and genomics into all of medicine and health care, resulting in improved personal and public health.

5. The **American College of Osteopathic Obstetricians and Gynecologists** ("ACOOG") is a non-profit, non-partisan organization committed to excellence in women's health representing over 2,500 providers. ACOOG educates and

supports osteopathic physicians to improve the quality of life for women by promoting programs that are innovative, visionary, inclusive, and socially relevant. ACOOG is likewise committed to the physical, emotional, and spiritual health of women.

6. The **American College of Physicians** ("ACP") is a diverse community of internal medicine specialists and subspecialists applying scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. With 161,000 members in countries across the globe, ACP is the largest medical-specialty society in the world. ACP's mission is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in the practice of medicine.

7. The **American Gynecological and Obstetrical Society** ("AGOS") advances the health of women by providing dedicated leadership and promoting excellence in research, education, and medical practice. The AGOS is an organization composed of individuals attaining national prominence in scholarship in the discipline of obstetrics, gynecology, and women's health, and is dedicated to the development of academic leaders in obstetrics and gynecology. For over a century it has championed the highest quality of care for women and the science needed to improve women's health.

8. The **American Medical Association** ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Through the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. The objectives of the AMA are to promote the art and science of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state. The federal courts have cited the AMA's publications and amicus curiae briefs in cases implicating a variety of medical questions.

9. The **American Medical Women's Association** ("AMWA") is the oldest multispecialty organization dedicated to advancing women in medicine and improving women's health. With a mission to advance women in medicine, advocate for equity, and ensure excellence in health care, AMWA envisions a healthier world where women physicians achieve equity in the medical profession and realize their full potential and where patients receive unbiased care.

10. The **American Psychiatric Association** ("APA") is a non-profit organization representing over 37,000 physicians who specialize in the practice of psychiatry. APA members engage in research into and education about diagnosis and treatment of mental health and substance use disorders, and are front-line

physicians treating patients who experience mental health and/or substance use disorders.

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

12. The **American Urogynecologic Society** ("AUGS") is the leader in urogynecology and drives excellence in comprehensive care for women with pelvic floor disorders. Founded in 1979, AUGS represents more than 2,000 members, including practicing physicians, nurse practitioners, physical therapists, nurses and health care professionals, and researchers from many disciplines.

13. The **Council of University Chairs of Obstetrics and Gynecology** ("CUCOG") was established for the charitable and educational purposes of promoting excellence in education in the fields of obstetrics and gynecology. Its members represent the departments of obstetrics and gynecology of schools of medicine across the country. Today, the organization promotes and supports leadership development of current and future chairs, and encourages excellence in

medical student, resident, and fellowship training; clinical practice; research and advocacy in women's health.

14. The **North American Society for Pediatrics and Adolescent Gynecology** ("NASPAG") is composed of gynecologists, adolescent medicine specialists, pediatric endocrinologists, and other medical specialists dedicated to providing multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth. NASPAG conducts and encourages multidisciplinary and inter-professional programs of medical education and research in the field and advocates for the reproductive well-being of children and adolescents and the provision of unrestricted, unbiased, and evidence-based medical practice.

15. The **National Association of Nurse Practitioners in Women's Health** ("NPWH") is a national non-profit educational and professional organization for Women's Health Nurse Practitioners ("WHNPs") and other advanced practice registered nurses who provide women's and gender-related health care. NPWH sets a standard of excellence by translating and promoting the latest research and evidence-based clinical guidance, providing high quality continuing education, and advocating for patients, providers, and the WHNP profession. NPWH's mission includes protecting and promoting a woman's right to make her own choices regarding her health and well-being within the context of her lived experience and

her personal, religious, cultural, and family beliefs. Since its inception in 1980, NPWH has been a trusted source of information on nurse practitioner education, practice, and women's health issues. In keeping with its mission, NPWH is committed to ensuring the availability of the full spectrum of evidence-based reproductive health care for women and opposes unnecessary restrictions on access that serve to delay or prevent care.

16. The **Society for Academic Specialists in General Obstetrics and Gynecology** ("SASGOG") seeks to enhance women's health by supporting academic generalist physicians in education, research, and scholarship. SASGOG provides a national collaborative network to facilitate development of new initiatives in women's health care, sharing of best practice, promotion of scholarship, and support for leadership within academic departments. SASGOG's mission is comprised of four pillars: (1) excellence in women's health care, (2) career development of academic specialists, (3) mentorship of academic specialists; and (4) education and research in the gynecology and obstetrics specialty.

17. The **Society of Family Planning** ("SFP") is the source for science on abortion and contraception. The Society represents approximately 1200 scholars and academic clinicians united by a shared interest in advancing the science and clinical care of family planning. The pillars of its strategic plan are (1) building

and supporting a multidisciplinary community of scholars and partners who have a shared focus on the science and clinical care of family planning; (2) supporting the production of research primed for impact; (3) advancing the delivery of clinical care based on the best available evidence; and (4) driving the uptake of family planning evidence into policy and practice.

18. The **Society of Gynecologic Oncology** ("SGO") is the premier medical specialty society for health care professionals trained in the comprehensive management of gynecologic cancers. With 2,500 members representing the entire gynecologic oncology team in the United States and abroad, the SGO contributes to the advancement of women's cancer care by encouraging research, providing education, raising standards of practice, advocating for patients and members, and collaborating with other domestic and international organizations. In that mission, the SGO strives to ensure access to women's health care as part of an overall prevention strategy for gynecologic cancer.

19. The **Society for Maternal-Fetal Medicine** ("SMFM"), founded in 1977, is the medical professional society for obstetricians who have additional training in high-risk, complicated pregnancies. SMFM represents more than 5,000 members who care for high-risk pregnant people and provides education, promotes research, and engages in advocacy to reduce disparities and optimize the health of high-risk pregnant people and their families. SMFM and its members are dedicated to

optimizing maternal and fetal outcomes and assuring medically appropriate treatment options are available to all patients.

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

21. The **Society for Reproductive Endocrinology and Infertility** ("SREI") is a professional group of Reproductive Endocrinologists within the American Society for Reproductive Medicine. SREI's mission is to serve a leadership role in reproductive endocrinology and infertility by promoting excellence in patient care; fostering the training and career development of students, residents, associates, members, and affiliates; developing new initiatives in basic and clinical research; and supporting ethical practice and advocacy for the subspecialty.