No. 12-16670

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PAUL A. ISAACSON, M.D., et al.,

Plaintiffs-Appellants,

v.

TOM HORNE, Attorney General of Arizona, in his official capacity, et al.,

Defendants-Appellees.

On Appeal from the District of Arizona, No. 12-01501
(Hon. James A. Teilborg)

AMICUS CURIAE BRIEF OF THE
ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS
AND OTHER NATIONAL MEDICAL ORGANIZATIONS
IN SUPPORT OF DEFENDANTS-APPELLEES
AND AFFIRMANCE OF THE DISTRICT OF ARIZONA

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CORPORATE DISCLOSURE STATEMENT

Amici Association of American Physicians & Surgeons, American Association of Pro-Life Obstetricians and Gynecologists, Christian Medical & Dental Associations, Catholic Medical Association, Physicians for Life, and National Association of Prolife Nurses are nongovernmental corporate entities, but they have no parent corporations and no publicly held corporations hold 10 percent or more of their stock.

s/ Denise M. Burke
Counsel for Amici

Dated October 10, 2012

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici curiae are six national organizations whose members include physicians and other healthcare professionals who have a profound interest in protecting the health and welfare of women considering abortion.

Association of American Physicians & Surgeons, Inc. ("AAPS") is a national association of physicians. Founded in 1943, AAPS has been dedicated to the highest ethical standards of the Oath of Hippocrates and to preserving the sanctity of the patient-physician relationship. AAPS has been a litigant in the U.S. Supreme Court and in other appellate courts. *See, e.g.*, *Cheney v. United States Dist. Court*, 542 U.S. 367, 374 (2004) (citing *Association of American Physicians & Surgeons v. Clinton*, 997 F.2d 898 (D.C. Cir. 1993)); *Association of American Physicians & Surgeons v. Mathews*, 423 U.S. 975 (1975). In addition, the U.S. Supreme Court has expressly made use of *amicus* briefs submitted by AAPS in high-profile cases. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 933 (2000); *id.* at 959, 963 (Kennedy, J., dissenting); *District of Columbia v. Heller*, 554 U.S. 570, 704 (2008) (Breyer, J., dissenting). The Third Circuit cited AAPS in the first

[1] In accordance with Fed. R. App. P. 29, the parties have consented to the filing of this *amicus* brief. No party's counsel has authored the brief in whole or in part. No party or party's counsel has contributed money intended to fund preparing or submitting this brief. No person other than *Amici*, their members, or their counsel has contributed money that was intended to fund preparing or submitting the brief.

paragraph of one of its opinions, which ruled in favor of AAPS's position. *See Springer v. Henry*, 435 F.3d 268, 271 (3d Cir. 2006).

American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG") is a non-profit professional medical organization consisting of 2,500 obstetrician-gynecologist members and associates. Significantly, the American College of Obstetricians and Gynecologists (ACOG)—an *amicus* for the plaintiffs-appellants in this case—has recognized AAPLOG as one of its largest special interest groups. AAPLOG is extremely concerned about the potential long-term adverse consequences of abortion on a woman's future health and continues to explore data from around the world regarding abortion-associated complications (such as depression, substance abuse, suicide, other pregnancy-associated mortality, subsequent preterm birth, placenta previa, and breast cancer) in order to provide a realistic appreciation of abortion-related health risks.

Christian Medical & Dental Associations ("CMDA") is a nonprofit national organization of Christian physicians and allied healthcare professionals with over 16,000 members. In addition to its physician members, it also has associate members from a number of allied health professions, including nurses and physician assistants. CMDA provides up-to-date information on the legislative, ethical, and medical aspects of abortion and its impact on maternal health.

Catholic Medical Association ("CMA") is a nonprofit national organization comprised of almost 2,000 members covering over 75 medical specialties. CMA helps to educate the medical profession and society at large about issues in medical ethics, including abortion and maternal health, through its annual conferences and quarterly journal, *The Linacre Quarterly*.

Physicians for Life ("PFL") is a national nonprofit medical organization that exists to draw attention to the issues of abortion, teen pregnancy, and sexually transmitted diseases. PFL encourages physicians to educate their patients not only regarding the innate value of human life at all stages of development, but also on the physical and psychological risks inherent in abortion.

National Association of Prolife Nurses ("NAPN") is a national not-for-profit nurses' organization with members in every state. NAPN unites nurses who seek excellence in nurturing for all, including mothers and the unborn. As a professional organization, NAPN seeks to establish and protect ethical values of the nursing profession.

ARGUMENT

This Court recently acknowledged that laws regulating abortion traditionally seek to protect the health and welfare of pregnant women. *McCormack v. Hiedeman*, 2012 U.S. App. LEXIS 19051, **12-13 (9th Cir. Sept. 11, 2012). Likewise, at issue before this court is House Bill (HB) 2036, an act which regulates

abortion because the State of Arizona seeks to protect pregnant women from the significant risk of harm to maternal health at and after 20 weeks gestation.

It is universally agreed that risk to maternal health from abortion increases as gestation increases. It is upon that undisputed bedrock that Arizona framed HB 2036. Relying on scientific data from well-respected peer-reviewed journals, the State adopted a number of scientific findings. Each of these findings, explained and supported below, demonstrate the dangers inherent in abortion, especially at or after 20 weeks gestation.

This evidence simply cannot be ignored, and the district court below gave it the proper weight. While the Plaintiffs disagree with the aim of the statute and the State's use of peer-reviewed evidence, the fact remains that the State acted within its wide discretion, seeking to protect the health and welfare of women from the harms inherent in later-term abortions.

In fact, as stated in *Gonzales v. Carhart*, state and federal legislatures are given "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales*, 550 U.S. 124, 163 (2007). In sum, the Plaintiffs have a very high burden. They must demonstrate that there is no medical or scientific uncertainty regarding the increased risk of harm from abortion to maternal health at or after 20 weeks gestation. In other words, they must claim and

prove that there is zero evidence demonstrating increased harm at or after 20 weeks gestation. This they cannot do.

I. THE LEGISLATURE RELIED ON WELL-RESPECTED PEER-REVIEWED STUDIES IN FORMULATING HB 2036.

It is undisputed and universally accepted that risk to maternal health from abortion increases as gestation increases. There is no debate on that fact. And peer-reviewed evidence utilized by the Arizona Legislature demonstrates that abortion imposes significant risks of harm at and after 20 weeks gestation. Under *Gonzales*, it is the State's role to evaluate the medical evidence and determine the best way to protect women in light of that evidence. As demonstrated below, medical evidence demonstrates that abortion poses significant risks by 20 weeks gestation and that childbirth is safer than abortion after this point.

A. Abortion poses significant risk to maternal health by 20 weeks gestation.

Citing a well-respected peer-reviewed journal—one which is also frequently cited by abortion advocates—the Arizona Legislature stated in its findings, "Abortion has a higher medical risk when the procedure is performed later in pregnancy. Compared to abortion at eight weeks of gestation or earlier, the relative risk increases exponentially at higher gestations." HB 2036, Sec. 9(A)(2) (citing L.A. Bartlett et al., *Risk factors for legal induced abortion-related mortality in the United States*, OBSTETRICS & GYNECOLOGY 103(4):729-37 (2004)).

Likewise, the Legislature cited a second source, noting that "The incidence of major complications is highest after twenty weeks of gestation." *Id*. at Sec. 9(A)(3) (citing J. Pregler & A. DeCherney, WOMEN'S HEALTH: PRINCIPLES AND CLINICAL PRACTICE 232 (2002)).

The Legislature went on to cite the following from the Bartlett study:

> The risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks gestation to one per 29,000 abortions at sixteen to twenty weeks and one per 11,000 abortions at twenty-one or more weeks.

HB 2036, Sec. 9(A)(4). As noted in the Bartlett study, gestational age is the strongest risk factor for abortion-related mortality.[2] Compared to abortion at eight weeks gestation, the relative risk of mortality increases exponentially (by 38 percent for each additional week) at higher gestations.[3]

In other words, a woman seeking an abortion in Arizona ***at 20 weeks is 35 times more likely to die from abortion*** than she was in the first trimester. ***At 21 weeks or more, she is 91 times more likely to die*** from abortion than she was in the first trimester.

Moreover, the researchers in the Bartlett study concluded that it may not be possible to reduce the risk of death in later-term abortions because of the

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[2] L.A. Bartlett et al., *supra*, at 731.

[3] *See id.* at 729, 731.

"inherently greater technical complexity of later abortions."[4] This is because later-term abortions require a greater degree of cervical dilation, an increased blood flow in a later-term abortion predisposes the woman to hemorrhage, and the myometrium is relaxed and more subject to perforation.[5]

While Plaintiffs and their *amici* attempt to brush aside the Bartlett study, the same exact study is relied upon by the pro-abortion Guttmacher Institute in its *Facts on Induced Abortion in the United States*.[6] In fact, Guttmacher *emphasizes* the increased risk by setting it apart in the text:

> The risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks to one per 29,000 at 16–20 weeks—and one per 11,000 at 21 or more weeks.[7]

Thus, Plaintiffs and their *amici* seek to ignore a well-established conclusion that is even relied upon by their pro-abortion allies.

And as noted by the State, at least two studies have now concluded that second-trimester abortions (13-24 weeks) and third-trimester abortions (25-26

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[4] *Id*. at 735.

[5] *Id*.

[6] Guttmacher Institute, *Facts on Induced Abortion in the United States* (Aug. 2011), available at http://www.guttmacher.org/pubs/fb_induced_abortion.html/#14a (last visited Sept. 19, 2012).

[7] *Id*.

weeks) pose more serious risks to women's physical health than first-trimester abortions.[8] Other researchers confirm a substantially increased risk of death from abortions performed later in gestation, equaling or surpassing the risk of death from live birth.[9] Researchers have also found that women who undergo abortions at 13 weeks or beyond report "more disturbing dreams, more frequent reliving of the abortion, and more trouble falling asleep."[10]

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[8] P.K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, J. PREGNANCY 2010:1, 7 (2010) (citing S.V. Gaufberg & P.L Dyne, ABORTION COMPLICATIONS (2012), available at http://emedicine.medscape.com/article/795001-overview (last visited Aug. 31, 2012); L.A. Bartlett et al., *supra*).

[9] For example, one study found that the mortality ratio at 21 weeks is 8.9 deaths per 100,000 abortions. D. Grossman et al., *Complications after second trimester surgical and medical abortion*, REPROD. HEALTH MATTERS 16:173-82 (May 2008). Another study found that the mortality ratio at the same gestation is 10.4 deaths per 100,000 abortions. M. Paul et al., A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTION Chap. 15 (1999). *See also* H.W. Lawson et al., *Abortion mortality, United States, 1972 through 1987*, AM. J. OBSTET. GYNECOL. 171(5):1365 (1994) (demonstrating through Table 15-1 that the combined mortality for abortions at or after 21 weeks was 10.4 per 100,000 procedures). On the other hand, the mortality ratio for women who give birth is just 8.8 per 100,000 live births—clearly demonstrating that the risk of death from abortion is at least equal to, if not greater than, the risk of death from live birth. Again, such medical data places the determination of how to best protect maternal health into the hands of the Arizona legislature.

[10] P.K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, *supra*, at 7.

Further, even Planned Parenthood, the largest abortion provider in the United States, agrees that abortion becomes riskier later in pregnancy. Planned Parenthood states on its national website, "The risks [of surgical abortion] increase the longer you are pregnant. They also increase if you have sedation or general anesthesia [which would be necessary at or after 20 weeks gestation]."[11]

In sum, it is undisputed that the later in pregnancy an abortion occurs, the riskier it is and the greater the chance for significant complications.

B. Childbirth is safer than abortion.

When the Supreme Court decided *Roe v. Wade* in 1973, there was no evidence on the record related to medical data. The "abortion is safer than childbirth" mantra of 1973 has been undermined by the plethora of peer-reviewed studies published in the last 40 years.[12] Specifically, recent studies demonstrate that childbirth is safer than abortion.

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[11] Planned Parenthood Federation of America, *In-Clinic Abortion Procedures* (2012), available at http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp (last visited Sept. 19, 2012).

[12] The Plaintiffs cannot show that abortion is safer than childbirth after 16 weeks gestation. This was a pivotal assumption in *Roe v. Wade*, 410 U.S. 113 (1973), and in *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983). Specifically, the Court concluded that abortion might be as safe as childbirth *up to 16 weeks* and noted that "[t]he comparison between abortion and childbirth mortality rates may be relevant only where the State employs a health rationale as a justification for a complete *prohibition* on abortions in certain circumstances." *Akron*, 462 U.S. at 429

In August 2012, a study out of Denmark reviewed medical records for almost a half million women who had their first pregnancies between 1980 and 2004, and compared these records with the death register and the abortion register. The results were significant: "Compared to women who delivered, women who had an early or late abortion had significantly higher mortality rates within 1 through 10 years."[13] This study is particularly striking in the range studied—even up to 10 years after birth or abortion, more women die after abortion than after childbirth.

A May 2012 study out of Chile is particularly significant because it examined trends in maternal death both when abortion was legal in Chile and after abortion was prohibited. The study found that death rates did not increase after abortion was made illegal. In fact, the maternal mortality ratio decreased from 41.3 deaths per 100,000 live births when abortion was legal, to just 12.7 maternal deaths per 100,000 live births after abortion was made illegal.[14] Today, Chile has a

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n.11 (emphasis added). As demonstrated herein, studies about maternal mortality and long-term health risks of abortion effectively rebut any claim that abortion is safer than childbirth.

[13] D.C. Reardon & P.K. Coleman, *Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004*, MED. SCI. MONIT. 18(9):71-76 (Aug. 2012).

[14] E. Koch et al., *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, PLoS ONE 7(5):e36613 (May 4, 2012), available at

lower maternal mortality ratio than the United States and it has the lowest maternal mortality ratio in all of Latin America.[15] This data convincingly demonstrates that the 1989 law prohibiting abortion has not put women's lives at risk, effectively refuting the claims that abortion advocates routinely employ against most abortion restrictions.

Another recent publication compared maternal mortality rates in Ireland (where abortion is illegal) to England and Scotland (where abortion is legal). Researchers found that maternal mortality rates were much lower in Ireland than in England or Scotland. Specifically, in Ireland, there are 1-2 maternal deaths per 100,000 live births, whereas in England/Wales there are 10 deaths per 100,000 live births, and in Scotland there are 10-12 deaths per 100,000 live births.[16] If abortion is safer than childbirth, as Plaintiffs and their *amici* claim, then the data should

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http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3344918/ (last visited Oct. 6, 2012). Moreover, the leading cause of death for a pregnant woman between 1957 and 1989 (the time in which abortion was legal) was abortion. *Id*.

[15] *Id*. Factors that helped influence the decline were education, delivery by skilled birth attendants, and the implementation of a prenatal primary care program—factors that are, arguably, already present in the United States and should be contributing to a lower maternal mortality rate here, but not when abortion is legal up to birth. *Id*.

[16] P. Carroll, *Ireland's Gain: The Demographic Impact and Consequences for the Health of Women of the Abortion Laws in Ireland and Northern Ireland since 1968,* at Figure 8 (Dec. 2011), available at http://papriresearch.org/ESW/Files/Irelands_Gain.pdf (last visited Sept. 26, 2012).

confirm that assumption in countries where abortion is illegal. But studies prove exactly the opposite: where abortion is restricted, maternal mortality rates decrease.

Moreover, studies reveal that abortion carries serious long-term risks other than the risk of death. These studies, relied upon by the State and discussed in Part II *infra*, reveal significant long-term physical and psychological risks inherent in abortion—risks that, as agreed by both pro-life and pro-abortion advocates, increase with advancing gestational age.

In passing HB 2036, the Legislature was recognizing that the women at risk for harm or even death from later-term abortions are more than data points or potential case studies. They are real women. In 2010 alone, 106 women in Arizona had abortions at 20 weeks and after.[17] In HB 2036, Arizona is seeking to protect women who, like the 106 women in 2010, could die or otherwise be harmed from abortions at 20 weeks gestation.

Simply put, Plaintiffs and their *amici*, such as ACOG,[18] do not maintain a monopoly on medical information.[19] Instead, the Supreme Court has given state

[17] Bureau of Public Health Statistics, Arizona Dep't of Health Services, Arizona ABORTION REPORT (2010), at Table 1D-3 (showing 29 abortions at 20 weeks and 77 abortions at 21 or more weeks).

[18] In every major abortion-related case before the U.S. Supreme Court since 2000—and in many cases before 2000—ACOG has supported extreme pro-abortion positions and has filed *amicus* briefs against commonsense abortion

and federal legislatures wide discretion to regulate abortion where there may be "medical uncertainty." *See Gonzales*, 550 U.S. at 163. As discussed in Part III *infra*, the State of Arizona was free to examine the peer-reviewed studies and make a determination that it could best protect the women of Arizona from the harms inherent in later-term abortion by restricting it at and after 20 weeks gestation. Critically, the Legislature used *peer-reviewed* studies in *well-respected journals*, studies that stringently document and support their conclusions that risks increase with increasing gestational age and that abortion is more harmful than childbirth. The Legislature acted well within the discretion afforded it under *Gonzales*.

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regulation. *See*, *e.g.*, *Gonzales*, 550 U.S. 124 (ACOG filed a brief supporting the partial-birth abortion procedure); *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006) (ACOG filed a brief lobbying against parental involvement legislation); *Stenberg*, 530 U.S. 914 (ACOG filed a brief supporting the partial-birth abortion procedure cited by Justice Kennedy in his dissent as being considered "ethically wrong" by the American Medical Association). As such, ACOG has a clear pro-abortion bias.

[19] ACOG has never polled its membership regarding their opinions about abortion, and not all of its members agree with its stated belief that abortion is safe. For example, *Amicus* AAPLOG has been recognized by ACOG as one of ACOG's largest special interest groups. Based on the evidence available in the peer-reviewed medical literature, AAPLOG disagrees with ACOG's pro-abortion activism and ACOG's false claims that abortion is safer than childbirth.

II. ABORTION POSES SIGNIFICANT LONG-TERM RISKS.

The Arizona Legislature was aware of the significant long-term risks inherent in abortion. Citing peer-reviewed studies, the Legislature listed numerous serious abortion complications—the risk of which undisputedly increases with increasing gestational age.[20] Among these well-documented risks are the risk of pre-term birth in subsequent pregnancies, and the risk of psychological harm.

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[20] Specifically, the Legislature found:

> Abortion can cause serious both short-term and long-term physical and psychological complications for women, including but not limited to uterine perforation, uterine scarring, cervical perforation or other injury, infection, bleeding, hemorrhage, blood clots, failure to actually terminate the pregnancy, incomplete abortion (retained tissue), pelvic inflammatory disease, endometritis, missed ectopic pregnancy, cardiac arrest, respiratory arrest, renal failure, metabolic disorder, shock, embolism, coma, placenta previa in subsequent pregnancies, preterm delivery in subsequent pregnancies, free fluid in the abdomen, organ damage, adverse reactions to anesthesia and other drugs, psychological or emotional complications such as depression, anxiety or sleeping disorders and death. *See* HB 2036, Sec. 9(A)(1) (citing P.K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, BRIT. J. OF PSYCHIATRY 199:180-86 (2011); P. Shah et al., *Induced termination of pregnancy and low birth weight and preterm birth: a systematic review and meta-analysis*, B.J.O.G. 116(11):1425 (2009); H.M. Swingle et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review and Meta-Analysis*, J. REPROD. MED. 54:95 (2009); R.H. van Oppenraaij et al., *Predicting adverse obstetric outcome after early pregnancy events and complications: a review*, HUMAN REPROD. UPDATE ADVANCE ACCESS 1:1 (Mar. 7, 2009); R.E. Behrman, PRETERM BIRTH: CAUSES, CONSEQUENCES, AND PREVENTION 519 (2006); J.M. Thorp et al., *Long-Term Physical and Psychological*

A. Studies indicate that abortion increases risk of subsequent pre-term birth

Pre-term birth occurs prior to the 37th week of pregnancy and is very dangerous to the child. According to the U.S. Centers for Disease Control, premature birth is the leading cause of infant mortality in the United States.[21] It is also a risk factor for later disabilities for the child, such as cerebral palsy and behavioral problems.[22]

Most women who abort do so early in their reproductive lives while desiring to have children at a later time.[23] And as Plaintiffs and their *amici* acknowledge, a woman who aborts at or after 20 weeks likely "wanted" the child, making it all the more likely that the woman will desire pregnancy again.

Health Consequences of Induced Abortion: Review of the Evidence, OBSTET. & GYNECOL. SURVEY 58(1):67, 75 (2003); J.M. Barrett, *Induced Abortion: A Risk Factor for Placenta Previa*, AM. J. OBSTET. & GYNECOL. 141:7 (1981).

[21] *See* J.M. Thorp et al., *supra*.

[22] W.M. Callaghan et al., *The Contribution of Preterm Birth to Infant Mortality Rates in the U.S.*, PEDIATRICS 118(4):1566 (Oct. 2006); B. Rooney & B.C. Calhoun, *Induced Abortion and Risk of Later Premature Births*, J. AM. PHYSICIANS & SURGEONS 8(2):46, 46-47 (2003).

[23] C. Moreau et al., *Previous Induced Abortions and the Risk of Very Preterm Delivery: Results of the EPIPAGE Study*, BRIT. J. OBSTET. & GYN. 112:430, 431 (2005).

However, induced abortion increases the risk of pre-term birth (premature birth) and very low birth weight in subsequent pregnancies. Induced abortion has been associated with an increased risk of the premature rupture of membranes, hemorrhage, and cervical and uterine abnormalities, which are in turn responsible for an increased risk of pre-term birth.[24]

There are currently over 130 published studies showing a statistically significant association between induced abortion and subsequent pre-term birth or low birth weight—which in and of itself makes suspect ACOG's claim that "recent evidence" shows no significant risk of preterm birth. *See* Brief for Amici Curiae ACOG, at 16. ACOG highlights one study (and inappropriately so, as discussed below) and ignores 130 others.[25]

In 2009 alone, three different systematic studies demonstrated the risk of pre-term birth following abortion, each of which was cited by the Legislature in

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[24] *Id*.

[25] Generalized statements that "older" studies "merely" show an association and not causation are beside the point. The State need not demonstrate that abortion *causes* pre-term birth in order to fall squarely within the *Gonzales* "wide discretion" standard. Further, as demonstrated in the text above, the *association* between abortion and pre-term birth is undeniably significant. As recently stated by the Eighth Circuit, "[t]here is no basis in … *Casey* for imposing a new, stricter definition of medical risk—a standard that requires certainty of causation—simply because the medical procedure at issue is abortion." *Planned Parenthood Minnesota, North Dakota, South Dakota v. Rounds*, 686 F.3d 889, 900 (8th Cir. 2012).

Sec. 9(A)(1). P. Shah et al. reported that induced abortion increases the risk of pre-term birth in a subsequent pregnancy by 37 percent, with two or more abortions increasing the risk by 93 percent.[26] Similarly, R.H. van Oppenraaij et al. found that a single induced abortion raises the risk of subsequent pre-term birth by 20 percent, with two or more abortions increasing the risk by 90 percent.[27] Those researchers also found that a woman who has two or more abortions doubles her risk of subsequently having a "very" premature baby (before 34 weeks gestation).[28] Likewise, Swingle et al. reported an odds ratio of a statistically significant 64 percent higher risk of "very pre-term birth" (before 32 weeks gestation) for women with one prior induced abortion.[29]

Then in 2012, a study found that two or more abortions increases the risk for very pre-term delivery (less than 28 weeks). In fact, the researchers demonstrated that two or more abortions increases the risk of delivering before 28 weeks by 69 percent, and with three or more abortions the risk for delivering before 28 weeks rises by a staggering 178 percent. Further, they found that after more than three abortions the risk for preterm delivery before 37 weeks increases by 35 percent.

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[26] P. Shah et al., *supra*.

[27] R.H. van Oppenraaij et al., *supra*.

[28] *Id*.

[29] H.M. Swingle et al., *supra*.

The risk for low birth weight of less than 2,500 grams (5.5 pounds) increased by 43 percent, while the risk for low birth weight of less than 1,500 grams (3.3 pounds) increased by over 125 percent.[30]

These recent studies simply confirmed what was already in the medical literature. For example, a 2005 study demonstrated that a woman who has an abortion is 50 percent more likely to deliver before 33 weeks, and 70 percent more likely to deliver before 28 weeks in subsequent pregnancies.[31] A 2003 study demonstrated that a woman who has two abortions doubles her future risk of pre-term birth, and a woman who has four or more abortions increases the risk of pre-term birth by 800 percent.[32] Thus, not only does an abortion increase the risk of pre-term birth, but each additional abortion increases that risk.

The Institute of Medicine, which is part of the National Academy of Science, lists abortion (even in the first trimester) as a risk factor associated with subsequent pre-term birth.[33] Likewise, a renowned pregnancy resource book

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[30] R. Klemetti et al., *Birth outcomes after induced abortion: A nationwide register-based study of first births in Finland*, HUMAN REPROD. (Aug. 29, 2012). This is the only study cited by Plaintiffs' *amici* ACOG, and yet it clearly shows an association between abortion and pre-term birth.

[31] J.M. Thorp et al., *supra*, at 75.

[32] B. Rooney & B.C. Calhoun, *supra*, at 46-47.

[33] R.E. Behrman, *supra*, at 519.

states, "if you have had one or more induced abortions, your risk of prematurity with this pregnancy increases by about 30 percent."[34] The resource also states that birth before 32 weeks is ten times more likely when a woman has an incompetent cervix, which is a common risk following abortion.[35]

The scientific data is clear: numerous studies have found that women who have abortions are at greater risk for pre-term birth in subsequent pregnancies. In passing HB 2036, the Legislature was acting to protect women from this documented risk.

B. Studies indicate that abortion increases risk of psychological harm.

Numerous peer-reviewed studies have examined the effect abortion has on the mental state of women and have found that abortion poses increased risk of depression, anxiety, and even suicide. Then in 2011, a landmark study published in the British Journal of Psychiatry (a publication of the Royal College of Psychiatrists) found that women face an 81 percent increased risk of mental health problems following abortion.[36] Specifically, women with a history of abortion had

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[34] B. Luke, EVERY PREGNANT WOMAN'S GUIDE TO PREVENTING PREMATURE BIRTH 32 (1995).

[35] *Id*. Planned Parenthood cites "injury to the cervix" as a potential risk of surgical abortion which increases with increasing gestational age. Planned Parenthood Federation of America, *In-Clinic Abortion Procedures*, *supra*.

[36] P.K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, *supra*.

a 34 percent increased risk of anxiety, a 37 percent increased risk of depression, a 110 percent increased risk of alcohol use, and a 155 percent increased risk of suicide following abortion.[37]

Significantly, the study examined the results of 22 studies published between 1995 and 2009, included 877,181 women (163,831 who had aborted) from six countries, and utilized very stringent criteria. Plaintiffs and their *amici* attempt to rebut the findings, but this peer-reviewed study simply confirmed what was already in the medical literature.

For example, one leading study examined a sample group of over 500 women from birth to the age of 25.[38] The study, led by a pro-choice researcher, D. Fergusson, was controlled for all relevant factors, including prior history of depression and anxiety and prior history of suicide ideation.[39]

Significantly, the Fergusson study found that 27 percent of women who aborted reported experiencing suicidal ideation, with as many as 50 percent of minors experiencing suicide or suicidal ideation.[40] The risk of suicide was three

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[37] *Id*.

[38] D.M. Fergusson et al., *Abortion in young women and subsequent mental health*, J. CHILD PSYCHOLOGY & PSYCHIATRY 47:16 (2006).

[39] *Id*.

[40] *Id*. at 19, Table 1.

times greater for women who aborted than for women who delivered. Likewise, the researchers found that 42 percent of women who aborted reported major depression by age 25, and 39 percent of post-abortive women suffered from anxiety disorders by age 25.[41]

The Fergusson study was not the first (nor the last) to demonstrate a connection between abortion and suicide. A team led by M. Gissler twice found that the suicide rate was nearly 6 times greater among women who aborted compared to women who gave birth.[42] Gilchrist et al. reported that, among women with no history of psychiatric illness, the rate of deliberate self-harm was 70 percent higher after abortion than childbirth.[43] In a comparison study of American women and Russian women, V.M. Rue et al. reported that 36.4 percent of the American women and 2.8 percent of the Russian women reported suicide

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[41] *See generally id*.

[42] M. Gissler et al., *Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000*, EUROPEAN J. PUBLIC HEALTH 15:459 (2005); M. Gissler et al., *Suicides after pregnancy in Finland, 1987-94: Register linkage study*, BRIT. MED. J. 313:1431 (1996).

[43] A.C. Gilchrist et al., *Termination of pregnancy and psychiatric morbidity*, BRIT. J. PSYCHIATRY 167:243 (1995).

ideation.[44] And in a study reported by D.C. Reardon et al. and controlled for prior mental illness, the suicide mortality rate was 3.1 times higher among women who aborted compared to those who delivered.[45]

The Reardon study, as well as others, also noted that the increase in suicide rates among aborting women is not related to previous suicidal behavior but is most likely related to adverse reactions to the abortion procedure.[46]

The statistics related to depression and anxiety are equally staggering. For example, a study performed by J.R. Cougle et al. found that women whose first pregnancies ended in abortion were 65 percent more likely to score in the "high risk" range for clinical depression than women whose first pregnancies resulted in a birth—even after controlling for age, race, marital status, divorce history, education, income, and pre-pregnancy psychological state.[47] The study noted that most previous studies employed only short-term follow-up interviews at a small

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[44] V.M. Rue et al., *Induced abortion and traumatic stress: A preliminary comparison of American and Russian women*, MED. SCI. MONITOR 10:SR5 (2004).

[45] D.C. Reardon et al., *Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study*, S. MED. J. 95:834 (2002).

[46] *See*, *e.g.*, *id*. at 838.

[47] J.R. Cougle et al., *Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort*, MED. SCI. MONITOR 9(4):CR157 (2003).

number of abortion clinics. Thus, data on post-abortion reactions was collected within hours or weeks of the event. J.R. Cougle et al., however, examined the long-term psychological effects of abortion on women, looking at depression scores an average of eight years after the women's first pregnancy events.

Yet another study stated that "anxiety and depression have long been associated with induced abortion," and that anxiety is the most common adverse mental effect of abortion.[48] Up to 30 percent of women experience extremely high levels of anxiety and stress one month after abortion.[49]

These studies represent just a sampling of research demonstrating an increased risk of mental health problems following abortion.

Two further factors bear consideration here. First is that the women experiencing the greatest psychological harm are the least likely to report their psychological distress. Women who conceal their abortions from others are more likely to suppress thoughts of the abortion, experience more intrusive abortion-related thoughts, and feel greater psychological distress.[50] In other words, women

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[48] V.M. Rue et al., *supra,* at SR6.

[49] P.K. Coleman, *Induced Abortion and Increased Risk of Substance Abuse: A Review of the Evidence*, CURRENT WOMEN'S HEALTH ISSUES 1:21, 23 (2005); Z. Bradshaw & P. Slade, *The Effects of Induced Abortion on Emotional Experiences and Relationships: A Critical Review of the Literature*, CLINICAL PSYCHOL. REV. 23:929-58 (2003).

[50] J.R. Cougle et al., *supra,* at CR158 (2003).

who admit having abortions may be the ones less likely to experience psychological distress than those who conceal their abortions—meaning that the studies listed here likely reflect an even smaller number of women who admit negative mental health effects than actually experience them.

Second, the Fergusson Study—again, conducted by an unbiased, pro-choice researcher—directly attacked the data used by the American Psychological Association (APA) in its faulty 2008 report claiming that abortion does not harm women, pointing out that the APA's finding was based on a relatively small number of studies which had one or more of the following limitations: a) absence of comprehensive assessment of mental disorders; b) lack of comparison groups; and c) limited statistical controls.[51] The Fergusson Study noted that the APA's statement ignored the findings of a number of studies claiming to show that abortion has negative mental health effects.[52]

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[51] D.M. Fergusson et al., *supra*, at 23.

[52] *Id*.

III. PLAINTIFFS CANNOT MEET THE SUPREME-COURT IMPOSED BURDEN OF PROVING THAT NO MEDICAL EVIDENCE EXISTS THAT SUPPORTS HB 2036.

In *Gonzales v. Carhart*, the U.S. Supreme Court explicitly held that state and federal legislatures are given "wide discretion to pass legislation in areas where there is medical and scientific uncertainty." 550 U.S. 124, 163 (2007).[53]

The context in which the Court enunciated this standard is significant here. The Court was considering the constitutionality of a *pre-viability* prohibition. *See Gonzales*, 550 U.S. at 147, 156 (noting that the partial-birth abortion ban applies both pre-viability and post-viability). The plaintiffs in *Gonzales* posited that the partial-birth abortion ban created certain health risks to women, which in turn created an undue burden—but the Court unequivocally rejected this claim.

Noting that there were documented medical disagreements over whether the partial-birth abortion ban would impose significant health risks to women, the Court stated that the question became whether the ban could stand when such medical uncertainty persists. *Id*. at 162-63. Citing numerous cases, the Court held that state legislatures are given wide discretion in areas where there is medical and scientific uncertainty. *Id*. at 163 (citing *Kansas v. Hendricks*, 521 U.S. 346, 360 n.

[53] Most recently, this standard was followed by the Eighth Circuit Court of Appeals, upholding *en banc* South Dakota's informed consent law requiring that women be informed of the risk of suicide and suicide ideation following abortion. *Rounds*, 686 F.3d at 900.

3 (1997); *Jones v. United States*, 463 U.S. 354, 364-65 n. 13, 370 (1983); *Marshall v. United States*, 414 U.S. 417, 427 (1974) ("When Congress undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad"); *Lambert v. Yellowley*, 272 U.S. 581, 597 (1926); *Collins v. Texas*, 223 U.S. 288, 297-98 (1912); *Jacobson v. Massachusetts*, 197 U.S. 11, 30-31 (1905)).

Then the Court concluded that the "law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community." *Gonzales*, 550 U.S. at 163. The Court stated it yet another way when it said "[m]edical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts." *Id*. at 164. In *Gonzales*, the medical uncertainty over whether the ban's prohibition created a significant health risk provided sufficient basis to conclude that the ban did not impose an undue burden. *Id*. These statements by the Court indicate that the wide discretion given to legislatures is not just limited to regulations.

Moreover, the Court has repeatedly affirmed the states' interest in protecting women from the harms of abortion. In *Planned Parenthood v. Casey*, the Court began by reaffirming an "essential holding" in *Roe v. Wade* that "the State has legitimate interests from the outset of the pregnancy in protecting the health of the

woman…." *Casey*, 505 U.S. 833, 846 (1992); *see also Gonzales*, 550 U.S. at 145 (quoting this central holding of *Roe* and *Casey*). The Court then repeated this premise, stating that "*Roe v. Wade* was express in its recognition of the State's 'important and legitimate interests in preserving and protecting the health of the pregnant woman….'" *Casey*, 505 U.S. at 875-76.

Taken together, U.S. Supreme Court precedent demonstrates that the Plaintiffs have a very high burden to meet. Because states are given wide discretion to legislate in areas where there is medical and scientific uncertainty, in order to sustain its "undue burden" claim Plaintiffs must demonstrate that the State has no medical evidence that abortion after 20 weeks poses serious risks to maternal health. However, the undisputed medical data demonstrating that abortion at and after 20 weeks can be significantly harmful to women effectively strips Plaintiffs of its ability to meet this high standard.

The State relied on medical evidence documented in respected peer-reviewed studies; thus, it was within the State's wide discretion to use that evidence to enact HB 2036.

CONCLUSION

For the reasons set forth above, the decision of the District of Arizona should be affirmed.

Respectfully Submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that:

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B)because it brief contains **6,250** words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

Further, this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2007, Times New Roman font, size 14.

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Dated October 10, 2012

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system on October 10, 2012.

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