Appeal No. 12-16670
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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| PAUL A. ISAACSON, M.D.; WILLIAM CLEWELL, M.D; HUGH MILLER, M.D.,<br><br>Plaintiffs-Appellants,<br><br>v.<br><br>TOM HORNE, Attorney General of Arizona, in his official capacity; WILLIAM (BILL) MONTGOMERY, County Attorney for Maricopa County, in his official capacity; BARBARA LAWALL, County Attorney for Pima County, in her official capacity; ARIZONA MEDICAL BOARD; LISA WYNN, Executive Director of the Arizona Medical Board, in her official capacity,<br><br>Defendants-Appellees. | On appeal from the United States District Court for the District of Arizona<br><br>No. 2:12-cv-01501-JAT-PHX |

# BRIEF *AMICI CURIAE* OF ANDREW M . TOBIN, SPEAKER OF THE ARIZONA HOUSE OF REPRESENTATIVES AND STEVE PIERCE, PRESIDENT OF THE ARIZONA SENATE SUPPORTING APPELLEES AND AFFIRMANCE

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October 11, 2012

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## IDENTITY OF *AMICI*[1]

Andrew M. Tobin is the Speaker of the Arizona House of Representatives. Steve Pierce is the President of the Arizona State Senate. Pursuant to the Arizona Constitution, the Speaker and the President are selected by the members of their respective chambers. Ariz. Const. art. IV., pt. 2. § 8; A.R.S. § 41-1102(B). Under the rules of the House and Senate the Speaker and the President direct the full legislative and administrative functions of their respective chambers.

As the Presiding Officers of the Fiftieth Arizona Legislature, the Speaker and President submit this brief to highlight the legislative findings supporting House Bill 2036 ("H.B. 2036" or "the Act"). The brief focuses on the medical evidence considered by the Legislature.

## RULE 29 STATEMENT

No party's counsel authored the brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting the brief. No person contributed money intended to fund preparing or submitting the brief.

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[1] Pursuant to Rule 29(a), Fed. R. App. Pro., Counsel certifies that all parties have consented to the filing of this brief.

## SUMMARY OF THE ARGUMENT

The Arizona Legislature enacted H.B. 2036 out of an overarching concern for the health and safety of women. The Act contains multiple provisions relating to safeguarding women considering abortion. The specific provision challenged in this case limits induced abortions from twenty-weeks gestation to those necessary for a woman's health (hereinafter "Twenty-Week Limitation").

Throughout this litigation, the Appellants/Plaintiffs have argued that the Twenty-Week Limitation is unconstitutional on its face because it applies in some situations before an unborn child is viable. They maintain that both the medical evidence and Arizona's interests are irrelevant and that the District Court should have disregarded the medical evidence examined by the Legislature and produced by the State supporting the Twenty-Week Limitation. That is not the law. The Speaker and the President agree with the District Court that the Twenty-Week Limitation is not unconstitutional *per se*. The focus of this brief is to assist the Court with its analysis under the undue-burden standard by detailing the legislative purposes behind H.B. 2036 and the medical evidence the Legislature considered when it enacted the measure.

There are two essential legislative findings supporting the Twenty-Week Limitation. First, the Legislature found that the health risks of induced abortion after twenty weeks are significant enough to limit such procedures at that point in

gestation to only those necessary for a woman's health. Second, the Legislature found that unborn children can feel pain by twenty-weeks of age.

As a woman's pregnancy progresses, the risks of induced abortion increase. By twenty weeks of gestation, the risks of major complications, including death, reach a significant level. The medical evidence on this point is compelling. Appellants do not dispute that induced abortion entails elevated risks by the twentieth week. Instead they argue that the Act's health exception is too narrow to cover every situation where a woman's health may require an abortion after the twentieth week. Such a narrow reading of the Act's health exception is inconsistent with the findings of the Legislature and the medical evidence in the legislative record. The health exception is tied to the good faith medical judgment of a woman's attending physician. That is sufficient to withstand Appellants/Plaintiffs' pre-enforcement, facial challenge to the Act.

Appellants also miss the mark when they argue that the Twenty-Week Limitation does not leave enough time to detect fetal anomalies. Women facing the difficult diagnosis of a fetal anomaly are one of the focuses of the Act. Other provisions of the Act—not challenged in this litigation—guaranty women facing those painful circumstances objective information about the severity of their child's condition, the prognosis for the future, and available assistance and support. Fetal anomalies can and should be detected in time to inform women of their

options and avoid high-risk, late-term pregnancy termination. Medical evidence considered by the Legislature and adopted by the District Court demonstrates that most fetal anomalies can be diagnosed before twenty weeks.

The Legislature reviewed substantial medical evidence—which was unchallenged in the District Court—that by twenty weeks an unborn baby is fully able to feel pain. Not only is the ability to sense pain present, but some medical evidence suggests that an unborn baby's experience of pain may be more acute than that of a newborn. During fetal surgeries both mothers and their unborn babies are treated as patients, each with independent pain-control needs. Arizona's clear interests in both the life of an unborn infant and preserving the integrity of the medical profession are clearly implicated once fetal development progresses to the point where unborn babies can feel pain.

## ARGUMENT

### I. The First Legislative Finding: After twenty weeks the health risks of induced abortion are so significant that the procedure should only take place if it is necessary for a woman's health.

The first reason for the Twenty-Week Limitation is that late-term abortions pose significantly higher health risks for pregnant women.[2] All induced abortion procedures are not the same. Some carry more risk than others. The medical

[2] When it passed H.B. 2036, the Legislature noted that under Supreme-Court precedent it has "legitimate interests from the outset of pregnancy in protecting the health of women." H.B. 2036, § 9(A)(6), (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847 (1992).)

evidence demonstrates that the timing of an abortion is a significant risk factor. The Legislature looked at this evidence and determined that late-term abortions carry more risk than abortions induced earlier in pregnancy. As the Supreme Court has recognized in the *Gonzales* decision,

> Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends. When standard medical options are available, mere convenience does not suffice to displace them; and if some procedures have different risks than others, it does not follow that the State is altogether barred from imposing reasonable regulations.

*Gonzales v. Carhart*, 550 U.S. 124, 166-167 (2007). In enacting the Twenty-Week Limitation the Arizona Legislature weighed the risks associated with late-term induced abortion and concluded that regulation was necessary to limit the procedure from occurring when the risks are highest, beginning at twenty weeks gestation. In some cases, the restriction will result in abortion procedures taking place earlier in pregnancy. This is a safer alternative than induced abortion at or beyond twenty weeks. In other cases, the limitation might result in encouraging a mother to carry her child to term. Both results advance Arizona's interests in protecting maternal health. Both results are permissible under the Supreme Court's guidance.

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### A. The parties agree that the relative risks of abortion increase as a woman's pregnancy progresses.

The relative risk of late-term abortion was not disputed below. Citing peer reviewed literature, the Legislature found that as a woman's pregnancy progresses induced abortion becomes more dangerous. H.B. 2036, § 9(A)(2). Indeed, "the relative risk increases exponentially at higher gestations." *Id*. Twenty weeks is a significant milestone in maternal health. At that point "the incidence of major complications is highest." *Id*. at §9(A)(3). By twenty one weeks the risk of death associated with abortion increases significantly. *Id*. at §9(A)(4).

The Appellants/Plaintiffs do not challenge these facts. Indeed, their own expert agrees that abortion is inherently more risky after 21 weeks.

> As pregnancy progresses, the risks of induced pregnancy termination increase, so that starting at 21 weeks LMP, legal induced termination and carrying to term entail comparable risks of death for the woman.

Declaration of William H. Clewell ("Clewell Decl") (Dkt. 2, p. 20 at ¶ 11.) This observation is strikingly similar to one made by one of Appellees/Defendants' experts, Dr. Allan Sawyer, who stated that "the risk of maternal morbidity and mortality with termination of pregnancy after twenty weeks is still significant and arguably no safer than carrying the pregnancy to term." Declaration of Allan T. Sawyer ("Sawyer Decl.") (SER 0033, ¶15.) Thus, all the parties below agreed with the Legislature's finding that "[a]bortion has a higher medical risk when the procedure is performed later in pregnancy." H.B. 2036, §9(A)(2).

Appellants/Plaintiffs do not challenge the fact that abortion after twenty weeks is more risky for women. Instead they focus on two specific medical scenarios: (1) women facing serious health challenges; and (2) women facing a diagnosis of fetal anomaly. The District Court was correct to concluded that neither category of health risk requires the law to be enjoined on its face.

**B. The health exception fully safeguards women's health.**

When it passed H.B. 2036, the Legislature made it clear that the safety of women was its primary concern. The entire Act consists of eight sections of substantive law. These provisions make numerous changes related to the safety of women, including enhanced safety protocols for abortion clinics, providing additional information for women considering abortion so they can make an informed decision, and specific requirements for the safe administration of medication abortion. H.B. 2036, §§ 1-8. Additionally, the Legislature determined that induced abortion after twenty weeks presents an elevated risk and should only be resorted to if that risk is superseded by a medical emergency. H.B. 2036, §§9(A)(2-4); 9(B)(1). Representative Kimberly Yee, the legislative sponsor of H.B. 2036, summarized the policy behind the Twenty-Week Limitation on the floor of the House during the bill's final passage:

> It is imperative that we protect maternal health and safety which is why there <u>are</u> exemptions in the legislation if there is <u>ever</u> a medical emergency that places the mother's life or health at risk.

(Floor Speech, Rep. Yee, SER 0252 (emphasis in original).) As this statement makes clear, the Twenty-Week Limitation and its health exception are closely connected. They share the same purpose: safeguarding women's health. The Twenty-Week Limitation reflects the Legislature's judgment that at a specific point in a normal pregnancy the risks of induced abortion are too great for the procedure to remain an option. The health exception reflects the Legislature's judgment that for some high-risk pregnancies—that have not already terminated in abortion—the risks of having a late-term abortion are outweighed by the risks of carrying to term.

The Appellants/Plaintiffs think that the Legislature got the risk balance wrong. They argue that the health exception is not broad enough because it does not apply in some situations where an abortion after twenty weeks really is the safest option. (Opn. Br. at 10.) The scope of the health exception was a clear focus of the legislative deliberations over H.B. 2036. The Legislature decided to use a standard already applicable in other abortion-related contexts.

> 'Medical emergency' means a condition that, <u>on the basis of the physician's good faith clinical judgment</u>, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

H.B. 2036, § 3 (emphasis added). As the District Court noted, this language is not new to the law. (Order, D. Ct. Dkt. no. 50 at 7—noting that the definition of

"medical emergency" in H.B. 2036 is "identical" to the definition of the same term upheld in the *Casey* decision.) Nevertheless, in his affidavit supporting Appellants/Plaintiffs, Dr. Cewell claims that the definition imposes "awful perversions" on "women and their doctors" and would force him to "wait and let my patient deteriorate until an 'immediate' termination—or a termination without delay—was necessary." (Cewell Dec. at ¶ 22.) This view overlooks the fact that the definition is calibrated to a physician's "good faith clinical judgment" and not to an inflexible standard. A.R.S. § 36-2151(6). Moreover, the legislative record for H.B. 2036 contains a very different perspective from Dr. Sawyer: "the definition of 'medical emergency' affords me as a physician considerable latitude in determining whether my patient's life or health may be endangered without an abortion." (Sawyer Letter, SER 0253.)

Faced with these conflicting medical views, the question must be asked does the Arizona Legislature have the authority to choose between them? The answer is yes. "[S]tate and federal legislatures [have] wide discretion to pass legislation in areas where there is medical and scientific uncertainty." *Gonzales*, 550 U.S. 124, 163 (2007). This is equally true in the abortion context. *Id*. at 164.

**C. Fetal anomalies are detectable by twenty weeks.**

House Bill 2036 clearly anticipates that fetal anomalies are detectable by 20 weeks. Along with the Twenty-Week Limitation, Section 7 of H.B. 2036 adds new

informed consent rights and protections for women facing a diagnosis of fetal abnormality. Women facing diagnosis of a lethal fetal condition must be informed about the availability of perinatal hospice programs. A.R.S. § 36-2158(A)(1)(a-c). Women facing a diagnosis of a nonlethal fetal condition must be provided "up-to-date, evidence based information concerning the range of outcomes for individuals living with the diagnosed condition, including physical, developmental, educational and psychosocial outcomes." *Id*. at (A)(2)(a). These disclosures must take place at least twenty-four hours before an induced abortion and be communicated in person by the "physician who is to perform the abortion." *Id*. at (A)(1); (A)(2). The Appellants/Plaintiffs have not challenged these provisions, most of which went into effect on August 2.[3] These new informed-consent requirements apply unless there is a medical emergency, which uses the same definition Appellants/Plaintiffs challenge in the context of the Twenty-Week Limitation. *Id*. at (A).

Because this information must be provided to women facing a diagnosis of fetal anomaly at least twenty-four hours before an induced abortion, it is clear that the Legislature viewed fetal anomalies as detectable in time to provide an

[3] A State-sponsored website with information for mothers facing a diagnosis of fetal anomaly will be available by November 2. A.R.S. § 36-2158(B) (stating that the Department of Health Services shall establish the informational website within ninety days after the effective date the law.); *see generally* Arizona Department of Health Services: Bureau of Women's Children's Health, *Informed Consent* (2012) http://www.azdhs.gov/phs/owch/informed-consent/index.htm.

informed-consent process for women. The Legislature's final position on this question is evident not only from the enacted law itself, but in the statements of H.B. 2036's sponsor. Addressing when fetal anomalies are detectable, Representative Yee stated "[t]he fact is, unfortunate diagnoses of abnormalities for preborn babies are determined well before five months of pregnancy and well before the gestational period set forth in this bill." (Floor Statement, Rep. Yee, SER 0251.) Representative Yee went on to quote from a letter from Dr. Sawyer which was made part of the legislative record:

> '[T]he diagnosis of fetal anomalies should occur prior to 20 weeks gestation. It is truly rare to find an abortion-mined patient whose baby is diagnosed with a fetal anomaly that loses the opportunity to abort because she is past 20 weeks gestation.'

*Id*. Given the Legislature's clear position on the ability of physicians to diagnose fetal anomalies, the District Court was correct to find that "it would be extremely rare to find a condition that could be diagnosed after 20 weeks that could not have been diagnosed earlier." (Order, D. Ct. Dkt. no. 50, at 11.) At most, Appellants/Plaintiffs suggest medical uncertainty. The law cannot be enjoined on this record. The Supreme Court has made it clear that state legislatures are the appropriate place to weigh and determine between conflicting medical evidence. *Gonzales*, 550 U.S. at 163; *Planned Parenthood Minnesota v. Rounds*, 686 F.3d 889, 905-06 (8th Cir. 2012).

## II. The Second Legislative Finding: By twenty weeks unborn children feel pain.

The second reason for the Twenty-Week Limitation is the fact that unborn children experience pain. The Legislature specifically found that "[t]here is substantial and well-documented medical evidence that an unborn child by at least twenty weeks of gestation has the capacity to feel pain during an abortion." H.B. 2036, § 9(A)(7) (citations omitted). It went on to state its purpose to "prohibit abortions at or after twenty weeks of gestation, except in cases of medical emergency, based on . . . the strong medical evidence that unborn children feel pain during an abortion at that gestational age." *Id*. at § 9(B)(1).

At trial the Legislature's findings were additionally supported by the declarations of Dr. Paul H. Liu (SER 0001-0011) and Dr. Jean A. Wright (D. Ct. Dkt. no. 25-1, p. 16-20). Dr. Wright summarized her testimony by stating "it is reasonable to conclude based on the studies discussed herein and others that the perception of pain begins at some point before twenty weeks gestation." (*Id*. at 20.) The Appellants/Plaintiffs did not introduce any evidence addressing the Legislature's findings with regard to fetal pain. They did, however, question "how this interest could be weightier than the State's interest in potential life, which is not sufficient to support a ban on previability abortion." (Defs. MPI Memo, D. Ct. Dkt. no. 3 at 9, n. 6.)

The Legislature's interest in limiting the instances when unborn children feel pain is supported by state interests that have been repeatedly recognized by the Supreme Court. First, the State has an interest in protecting "the life of the fetus that may become a child." *Gonzales*, 550 U.S. at 145. This interest is closely tied to the State's "legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn." *Id*. at 158. The Arizona Legislature reasonably concluded that late-term abortion raises unique ethical concerns because the unborn child is able to feel pain. The unchallenged record in this case demonstrates that unborn children are even more sensitive to pain than newborns (Wright Decl., D. Ct. Dkt. no. 25-1, 19 at ¶ 24). Moreover, during fetal surgery it is necessary to provide anesthesia to both the mother and the unborn child. (Liu Decl., SER 0002 at 5.) Given these medical facts, it is wholly appropriate for the Legislature to respect and protect unborn human life by limiting induced abortion to gestational development before the unborn baby has developed the ability to feel pain.

As a final matter, the amicus brief submitted by the American College of Obstetricians and Gynecologists ("ACOG") in no way supports reversal of the District Court's findings as to fetal pain. As the District Court noted, the Appellants/Plaintiffs failed to introduce medical evidence to rebut the findings of the Legislature and the State's expert testimony. The ACOG brief seeks to supply

the Appellants/Defendants' evidentiary deficit by citing studies that are outside of both the Legislative and evidentiary record. In the context of this pre-enforcement, facial challenge to a legislative enactment—it would be improper for this material to be used to reverse the decision of the District Court, or to further delay the law from going into effect.

## CONCLUSION

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

Respectfully submitted this 11th day of October, 2012.

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## CERTIFICATE OF COMPLIANCE

I, Peter A. Gentala, certify the following:

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and 29(d) because this brief contains 2,847 words, based on the word count of the word-processing system used to prepare the brief, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. The 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 2003 in 14 point Times New Roman Font.

**DATED** on October 11, 2012.

s/ Peter A. Gentala
Peter A. Gentala
*Attorney for Amici Curiae*
*Speaker Tobin and President Pierce*

## CERTIFICATE OF SERVICE

I, Peter A. Gentala, 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 11, 2012. Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

I further certify that one of the participants in this case is not a registered CM/ECF user. I have mailed the foregoing document by First-Class Mail, postage prepaid, or have dispatched it to a third party commercial carrier for delivery within 3 calendar days to the following non-CM/ECF participant:

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