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No. DA 23-0272

IN THE SUPREME COURT OF THE STATE OF MONTANA

PLANNED PARENTHOOD OF MONTANA, et al.,

Plaintiffs-Appellees,

v.

STATE OF MONTANA, et al.,

Defendants-Appellants.

On Appeal from the District Court for Lewis & Clark County,
No. DDV-2013-407

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL ASSOCIATION, MONTANA MEDICAL ASSOCIATION, SOCIETY FOR MATERNAL-FETAL MEDICINE, AND SOCIETY OF FAMILY PLANNING IN SUPPORT OF PLAINTIFFS

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INTERESTS OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit membership organization of more than 60,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all women and people in need of obstetric and gynecologic care; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing patients and their families and communities. ACOG's Montana Section has over 900 members who, together with their patients, are directly affected by laws restricting access to abortion care and other reproductive health care.

ACOG has appeared as *amicus curiae* in courts throughout the country. Its briefs and medical practice guidelines have been cited by numerous authorities, including the U.S. Supreme Court, which recognize ACOG as a leading provider of authoritative scientific data regarding childbirth and abortion.

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Further, through state and specialty medical societies and other physician groups seated in the AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policymaking process. The AMA's objectives 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. Its publications and *amicus* briefs have been cited by many courts, including the U.S. Supreme Court, in cases implicating a variety of medical issues.

The Montana Medical Association (MMA) is a voluntary membership organization for all Montana physicians. It represents the interests of approximately 1,400 physicians, physician assistants, resident physicians, and medical students from all specialties and practice settings. MMA's vision is to make Montana the best place to practice medicine and receive care. It has become the foremost advocate and resource in the

state for economically sustainable medical practices, the freedom to deliver care in the best interests of patients, and health for all Montanans.[1]

The Society for Maternal-Fetal Medicine (SMFM) is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 6,500 members caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by many courts.

The Society of Family Planning (SFP) is a leading source for abortion and contraception science. It represents more than 1,800 clinicians

[1] The AMA and MMA each join this brief on their own behalf and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in courts.

and scholars who believe in just and equitable abortion and contraception informed by science. SFP works to build a diverse, equitable, inclusive, and multidisciplinary community of scholars and partners engaged in the science and medicine of abortion and contraception. It seeks to support the production and resourcing of research primed for impact, ensure clinical care is evidence-informed and person-centered through guidance, medical education, and other activities, and develop leaders in abortion and contraception to transform the health care system.

INTRODUCTION

Abortion is an essential part of comprehensive health care. When abortion is legal and accessible, it is safe. Despite this, the Legislature has passed a parental consent law (Mont. Code Ann. §§ 50-20-501 to -511, the Consent Act) that would create barriers to access, serve no medical purpose, and expose Montana minors to increased risk of harm.

Amici curiae are leading medical societies representing physicians, nurses, and other clinicians who serve patients in Montana and nationwide, and whose policies represent the education, training, and experience of the vast majority of clinicians in this country. As the AMA has

explained, "healthcare, including reproductive health services, like contraception and abortion, is a human right."[2]

Amici all agree that laws that restrict abortion and target patients and their health care providers are not based on any medical or scientific rationale. Those laws also threaten the health of pregnant patients; disproportionately harm patients of color, patients in rural settings, and patients with low incomes; and impermissibly interfere with the patient-physician relationship, undermining longstanding principles of medical ethics.

All of these concerns are heightened when a pregnancy involves a minor. Despite declines in recent years, the United States continues to have the highest teen pregnancy rates of all developed nations. Adolescents face increased risks from pregnancy, are more likely to experience miscarriages and suffer pregnancy complications, and typically have lower levels of education and less financial resources than adults. These factors place pregnant Montana minors at increased risk of adverse health outcomes.

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[2] AMA, *Preserving Access to Reproductive Health Services* (2023), https://bit.ly/3JPSd3y.

This Court recognized in *Armstrong v. State*, 1999 MT 261, that the Montana Constitution protects the right to abortion. In light of that right, the district court correctly held that the Consent Act, which would require a parent or guardian to consent before a minor can obtain an abortion, is unconstitutional. *Amici* urge this Court to affirm.

ARGUMENT

I. Abortion Is a Safe, Common, and Essential Component of Health Care

The medical community recognizes that abortion is a safe, common, and essential component of reproductive health care.[3] In 2020, over 930,000 abortions were performed nationwide, and more than 1,600 abortions were performed in Montana.[4] Up to 8% of those abortions involved

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[3] *See, e.g.*, Eds. of the New Eng. J. of Med. et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979, 979 (2019) ("Access to legal and safe pregnancy termination . . . is essential to the public health of women everywhere."); ACOG, *Abortion Policy* (May 2022), https://bit.ly/3uWMKUV; SMFM, *Access to Abortion Services* (June 2020).

[4] Rachel K. Jones et al., Guttmacher Inst., *Long-Term Decline in US Abortions Reverses, Showing Rising Need for Abortion as Supreme Court is Poised to Overturn* Roe v. Wade (June 15, 2022); Rachel K. Jones et al., *Abortion Incidence and Service Availability in the United States, 2020*, 54 Persp. on Sexual & Reprod. Health 128, 133 tbl.2 (2022).

teenagers.[5] Approximately one-quarter of American women have an abortion before they reach age 45.[6]

The overwhelming weight of medical evidence conclusively demonstrates that abortion is a very safe medical procedure.[7] Complication rates from abortion are extremely low, averaging around 2%, and most complications are minor and easily treatable.[8] Major complications from abortion are exceptionally rare, occurring in just 0.23 to 0.50% of instances across gestational ages and types of abortion methods.[9] The risk

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[5] Isaac Maddow-Zimet & Kathryn Kost, Guttmacher Inst., *Pregnancies, Births and Abortions in the United States, 1973-2017: National and State Trends by Age Appendix Tables* 4 (2021), https://bit.ly/3REuCIm.

[6] Rachel K. Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008-2014*, 107 Am. J. Pub. Health 1904, 1908 (2017).

[7] *See, e.g.*, Nat'l Acad. of Scis., Eng'g, Med., *The Safety and Quality of Abortion Care in the United States* 10 (2018) (*Safety and Quality of Abortion Care*) ("The clinical evidence clearly shows that legal abortions in the United States – whether by medication, aspiration, D&E, or induction – are safe and effective. Serious complications are rare.").

[8] *See, e.g.*, Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 181 (2015) (*Incidence of Visits*) (finding 2.1% abortion-related complication rate); *Safety and Quality of Abortion Care* 55, 60.

[9] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434 (2015). This is also true for medication abortions, which account for about half of abortions nationwide. Elizabeth G. Raymond et al., *First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review*, 87 Contraception 26, 30 (2013); Rachel K. Jones et

of patient death from an abortion is even rarer: Nationally, fewer than one in 100,000 patients die from an abortion-related complication.[10] Abortion is so safe that there is a greater risk of complications or mortality for procedures like wisdom-tooth removal, cancer-screening colonoscopy, and plastic surgery.[11] By contrast, the "risk of death associated

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al., Guttmacher Inst., *Medication Abortion Now Accounts for More than Half of All US Abortions* (Dec. 1, 2022) (Jones).

[10] Katherine Kortsmit et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control and Prevention, *Abortion Surveillance – United States, 2019*, 70 Morbidity & Mortality Weekly Rep. No. 9, 29 tbl.15 (Nov. 26, 2021) (Kortsmit) (finding mortality rate from 0.00041% to 0.00078% for approximately five-year periods from 1978 to 2014); Suzanne Zane et al., *Abortion-Related Mortality in the United States, 1998-2010*, 126 Obstetrics & Gynecology 258, 261 (2015) (noting an approximate 0.0007% mortality rate for abortion).

[11] Advancing New Standards in Reproductive Health, *Safety of Abortion in the United States*, Issue Brief No. 6, at 2 (2014) (2.1% of abortions result in complications – with 1.88% resulting in minor complications and 0.23% resulting in major complications – compared to 7% of wisdom-tooth extractions, 8-9% of tonsillectomies, and 29% of childbirths); Am. Soc'y for Gastrointestinal Endoscopy, *Complications of Colonoscopy*, 74 Gastrointestinal Endoscopy 745, 747 (2011) (33% of colonoscopies result in minor complications); Frederick M. Grazer & Rudolph H. de Jong, *Fatal Outcomes from Liposuction: Census Survey of Cosmetic Surgeons*, 105 Plastic & Reconstructive Surgery 436, 441 (2000) (mortality rate from liposuction in late 1990s was 20 per 100,000); Kortsmit, *supra* note 10, at 29 tbl.15 (mortality rate from legal induced abortion was between 0.52 and 0.63 per 100,000 in late 1990s, dropping to 0.41 in 2013-2018).

with childbirth [is] approximately 14 times higher,"[12] with pregnant adolescents facing even higher risks.[13]

There are no significant risks to mental health or psychological well-being resulting from abortion care. Recent long-term studies found that those who obtained wanted abortions had "similar or better mental health outcomes than those who were denied a wanted abortion," and that receiving an abortion did not increase the likelihood of developing symptoms associated with depression, anxiety, post-traumatic stress, or suicidal ideation compared to those who were forced to continue a pregnancy.[14] One recent study noted that 95% of participants believed an

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[12] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012) (Raymond & Grimes). The risk is even higher for Black and Indigenous pregnant people, for whom rates of maternal mortality are three to four times the national average. Elizabeth Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 Clinical Obstetrics & Gynecology 387, 387 (2018) (Howell).

[13] Maria de la Calle et al., *Younger Age in Adolescent Pregnancies Is Associated with Higher Risk of Adverse Outcomes*, 18 Int'l J. Env't Rsch. & Pub. Health 8514 (2021) (Calle) (noting that adolescent pregnancies have a higher risk of complications than adult pregnancies and that maternal mortality in the 13-19 age group is two times that of the 20-34 age group).

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

abortion was the “right decision for them” three years after the procedure.[15]

II. Mandatory Parent or Guardian Consent Serves No Medical Purpose and Endangers Minors

The Consent Act is not rooted in any sound medical rationale. In fact, by requiring mandatory parental or guardian consent, the Consent Act increases the risk of harm to minors seeking an abortion.

A. Mandatory Consent Serves No Medical Purpose

The underlying presumption of the Consent Act is that minors are not capable of determining whether to end pregnancies. That presumption is unsupported by medical evidence. Minors can provide their medical history to physicians to receive the appropriate care[16] and can understand and choose among their treatment options.[17] No evidence supports the notion that an individual first becomes a competent decision-maker

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

[16] Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents’ Psychological and Legal Competence to Consent to Abortion*, 16 Law. Hum. Behav. 129 (1992).

[17] Nancy E. Adler et al., *Abortion Among Adolescents*, 58 Am. Psychol. 211, 213 (Mar. 2003) (Adler).

at 18 years old.[18] Indeed, Montana law presumes that pregnant minors are capable of making *all other decisions related to a pregnancy* without parental consent.[19] Under Montana law, pregnant minors are able, without parental consent, to make an informed decision to undergo amniocentesis testing, pre-natal surgeries, or Cesarean section deliveries; to be administered epidurals; or to have labor induced[20] – decisions that may pose greater health risks than abortion but are equally as critical to their health care.[21] It is wholly illogical to presume that minors are not competent to determine whether to terminate their pregnancies, but are

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[18] Am. Acad. of Pediatrics Comm. on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 139 Pediatrics 1, 3 (2017) (Comm. on Adolescence) (finding that teenagers who obtained an abortion were no more likely to have psychological problems than those who carried to term).

[19] Mont. Code Ann. § 41-1-402.

[20] *See id.*

[21] Zarko Alfirevic, Kate Navaratnam & Faris Mujezinovic, *Amniocentesis and Chorionic Villus Sampling for Prenatal Diagnosis*, 9 Cochrane Database Syst. Revs. CD3252, at 22-29 (2017); Aditi Jindal et al., *Amniocentesis*, StatPearls (Aug. 2023), https://bit.ly/3tl8big; Lucy Halliday, Scott Nelson & Rachel Kearns, *Epidural Analgesia in Labor: A Narrative Review*, 159 Int. J. Gynecology & Obstetrics 356, 358 tbl.1 (2022); Alyaa Al-Refai, Greg Ryan & Tim Van Mieghem, *Maternal Risks of Fetal Therapy*, 29 Current Op. Obstetrics & Gynecology 80, 80 (2017); Jane Sandall et al., *Short-term and Long-term Effects of Caesarean Section on the Health of Women and Children*, 392 Lancet 1349, 1350-52 (2018); ACOG, Practice Bulletin No. 107, *Induction of Labor* (Aug. 2009), https://bit.ly/3TnwKWg.

competent to make all other decisions related to pregnancy, carry pregnancies to term, give birth, and make decisions regarding parenting.

The low risk of abortion also means that it is safe for minors to decide whether to terminate pregnancies. As explained, abortion is one of the safest medical procedures in the United States. Abortion patients "may return to their normal daily activities when they feel ready," which generally occurs "within hours or 1-2 days following a first trimester abortion."[22] And adolescents are able to follow the simple aftercare instructions given to patients and to recognize their symptoms in the rare cases of complications.[23]

B. Mandatory Consent Puts Minors at Risk of Immediate Danger and Adverse Health Effects

Obtaining parental or guardian consent necessarily involves notifying a parent or guardian of a pregnancy, which can risk severe parental reaction, such as anger and rejection.[24] A third of minors who do not inform parents of an abortion decision have experienced family violence

[22] Kathleen M. McIntosh, RN, et al., *Routine Aftercare and Contraception*, *in A Clinician's Guide to Medical and Surgical Abortion* 188 (Maureen Paul ed., 1999).
[23] *Id.*
[24] Comm. on Adolescence, *supra* note 18, at 4-5.

in the past and fear more violence if they share their decisions.[25] The potential for violence, abuse, coercion, conflict, and rejection is particularly significant in non-supportive or dysfunctional families.[26]

Even for minors who are not at direct risk of violence, a lack of confidentiality is dangerous. Confidentiality is a paramount concern for many adolescents and young adults seeking sensitive health care services.[27] When confidentiality is assured, adolescents and young adults are more willing to seek and obtain care, disclose sensitive information, and seek health care in the future.[28]

In contrast, mandatory consent and notification can be a critical barrier to adolescents receiving appropriate health care.[29] Indeed,

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[25] *Id.*; *see* J. Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents*, 18 Berkeley Women's Law J., 61, 166 (2003).

[26] Comm. on Adolescence, *supra* note 18, at 4.

[27] Soc'y Adolescent Health & Med. et al., *Confidentiality Protections for Adolescents and Young Adults in the Healthcare Billing and Insurance Claims Process*, 58 J. Adolescent Health 374, 375 (2016).

[28] Carol A. Ford et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care: A Randomized Controlled Trial*, 278 J. Am. Med. Ass'n 1029, 1029 (1997).

[29] *See* ACOG Committee Opinion No. 803, *Confidentiality in Adolescent Healthcare,* 135 Obstetrics & Gynecology e172 (April 2020) (*Confidentiality*).

confidentiality concerns are the leading reason adolescents forgo necessary medical care of all kinds,[30] and they are an especially strong barrier when it comes to reproductive health care services.[31] Forgoing care due to confidentiality concerns also has broader consequences: adolescents who are deterred by a lack of confidentiality not only forgo care, but face a substantially higher prevalence of risk factors related to sexual and reproductive health, substance use, and mental health, such as depressive symptoms, suicidal ideation, and suicide attempts.[32]

While *amici* support efforts to encourage minors to involve their parents in their decisions to seek reproductive health care,[33] the mandatory consent required by the Consent Act is dangerous for minors, both in the short and long term. It does not promote family communication or

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[30] Jocelyn A. Lehrer et al., *Forgone Health Care Among U.S. Adolescents: Associations between Risk Characteristics and Confidentiality Concern*, 40 J. Adolescent Health 218, 218-19 (2007) (Lehrer).

[31] ACOG Committee Opinion No. 811, *The Initial Reproductive Health Visit*, 136 Obstetrics & Gynecology e70 (Oct. 2020); M. Diane McKee et al., *Predictors of Timely Initiation of Gynecologic Care among Urban Adolescent Girls*, 39 J. Adolescent Health 183, 184 (2006); Liza Fuentes et al., *Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. Adolescent Health 36, 43 (2018).

[32] Lehrer, *supra* note 30, at 218-19.

[33] *S*ee *Confidentiality*, *supra* note 29, at e173.

the physical or emotional health of young people.[34] Parental involvement should be voluntary, not mandatory, and should not be an obstacle to a minor's ability to seek timely reproductive health care or to confidentially consult with a medical provider.

C. Mandatory Consent Delays or Prevents Minors' Access to Abortion, Which Causes Harm

Delaying access to abortion creates barriers to obtaining safe care that are particularly acute for adolescents. Proper medical care allows qualified health professionals to assess and mitigate risks associated with the state of pregnancy. The additional time that abortion is delayed is therefore time during which a pregnant person may suffer significant health problems that could have been avoided had the person had access to timely abortion care.[35]

Delay may also altogether foreclose the option of obtaining abortion care. Medication abortion, which accounts for more than half of all abortions in the United States, is a common method of abortion during the

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[34] Comm. On Adolescence, *supra* note 18, at 3; Adler, *supra* note 17, at 214.

[35] *See, e.g.*, Anne B. Wallis et al., *Secular Trends in the Rates of Preeclampsia, Eclampsia, and Gestational Hypertension, United States, 1987-2004*, 21 Am. J. Hypertension 521, 523-24 (2008).

first trimester of pregnancy and is increasingly preferred, especially among survivors of rape.[36] Medication abortion generally is not performed in the United States after ten weeks of gestation and, as a result, those who are delayed in obtaining an abortion may be deprived of this option,[37] including those for whom it may have been the more medically appropriate procedure.[38] Further, more than 50% of Montana counties are defined as maternity care deserts, meaning that they lack access to birthing facilities or maternity care providers.[39] In those counties, removing access to medication abortion may mean residents have no access to abortion care at all.

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[36] Jones, *supra* note 9, at 2; Nathalie Kapp et al., *Efficacy of Medical Abortion Prior to 6 Gestational Weeks: A Systematic Review*, 97 Contraception 90, 90 (2018); Tara C. Jatlouti et al., CDC, *Abortion Surveillance – United States, 2013*, at 8 (2016).

[37] *See* ACOG, Practice Bulletin No. 143, *Medical Management of First-Trimester Abortion* 6 (Mar. 2014); Jillian T. Henderson et al., *Safety of Mifepristone Abortions in Clinical Use*, 72 Contraception 175, 178 (2005) ("[M]ortality risk increase[es] by 38% per additional week of gestation.").

[38] For example, medical abortion is frequently the most appropriate method for pregnant people who have uterine fibroids. *See* Mitchell D. Creinin, *Medically Induced Abortion in a Woman with a Large Myomatous Uterus*, 175 Am. J. Obstetrics & Gynecology 1379, 1379 (1996).

[39] March of Dimes, *Where You Live Matters: Maternity Care in Montana* 1, http://bit.ly/3Rl8LVe (accessed Dec. 14, 2023).

As a result, those who are denied an abortion and who remain pregnant, whether to term or simply longer than necessary, are exposed to avoidable pregnancy-related health risks.[40] These risks are appreciably higher in adolescents than in adults.[41] Denial of abortion also may have negative effects on the emotional health of the pregnant person.[42]

III. Requiring Parental or Guardian Consent for Minors' Abortions Would Disproportionately Affect Minors Living in Rural Areas and With Less Resources

The Consent Act would disproportionately affect minors living in rural areas and those with limited economic resources. *Amici* are opposed to abortion policies that increase the inequities that already plague the health care system in this country.

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[40] Even if a patient eventually obtains an abortion, delays expose the patient to preventable health risks. Pregnancy-related risks include hypertension disorders which affect approximately 5-10% of pregnant people and account for "approximately a quarter of maternal deaths and near misses." World Health Org., *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience* 40 (2016); ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus*, 131 Obstetrics & Gynecology e49, e49 (2018).

[41] Ivo Brosens et al., *Adolescent Preeclampsia: Pathological Drivers and Clinical Prevention*, 26 Reproductive Sci. 159, 159 (2019) (Brosens) (finding that pregnant adolescents face a significantly higher risk of experiencing preeclampsia and eclampsia than pregnant adults).

[42] Comm. on Adolescence, *supra* note 18, at 5.

Nearly half of all Montanans live in rural areas,[43] with limited access to clinics and hospitals.[44] 12.1% of Montanans live below the federal poverty line.[45] In addition, 75% of abortion patients nationwide are living at or below 200% of the federal poverty level.[46]

The Consent Act would impose additional barriers to accessing abortion by requiring minors to obtain notarized statements from their parents or guardians or to initiate court proceedings to obtain exemptions in order to seek an abortion, both costly and resource-consuming processes. Patients with limited means and patients living in geographically remote areas would be disproportionately affected by these restrictions, which require additional travel and costs.

Further, because notifying a parent of a desire to obtain an abortion can result in harsh repercussions for the minor,[47] a minor with limited financial or other resources who fears losing family support may forgo

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[43] Mont. Dep't of Com., *Montana 2020 Census Newsletter* (2020), https://bit.ly/3v0e6K0 (accessed Dec. 13, 2023).

[44] Mont. Hosp. Ass'n, *Access to Care*, https://bit.ly/46pbH8u (accessed Dec. 13, 2023).

[45] U.S. Census Bureau, *QuickFacts – Montana* (2022), https://bit.ly/3MRxMpD.

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

[47] Comm. on Adolescence, *supra* note 18, at 4.

seeking an abortion altogether. Forcing patients to continue pregnancies increases their risk of complications and death. For adults, the risk of death associated with childbirth is about 14 times higher than that associated with abortion,[48] with Black and Indigenous pregnant people facing higher risks.[49] The risk is even higher for adolescents,[50] particularly because they are more likely to be unmarried, have lower educational attainment, and live in rural or resource-challenged areas – each of which is associated with a 50 to 120% higher risk of maternal mortality.[51] The Consent Act thus would exacerbate inequities in health care and disproportionately harm the very Montana minors it purports to protect.

IV. Requiring Parental or Guardian Consent for Minors' Abortions Would Undermine Physicians' Ability to Perform Their Jobs

Abortion restrictions like those imposed by the Consent Act violate long-established and widely accepted principles of medical ethics by substituting legislators' opinions for a physician's individualized patient-

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[48] Raymond & Grimes, *supra* note 12, at 216.

[49] Howell, *supra* note 12, at 387.

[50] Calle, *supra* note 13; Brosens, *supra* note 41.

[51] Gopal K. Singh, *Trends and Social Inequalities in Maternal Mortality in the United States, 1969-2018*, 10 Int'l J. of Maternal & Child Health & Aids I 29, 29-42 (2021).

centered counseling and creating an inherent conflict of interest between patients and medical professionals; asking medical professionals to violate the age-old principles of beneficence and non-maleficence; and requiring medical professionals to ignore the ethical principle of respect for patient autonomy.

A. Statutes that Restrict Access to Abortion Undermine the Patient-Physician Relationship

The patient-physician relationship is critical for the provision of safe and quality medical care.[52] At the core of this relationship is the ability to counsel frankly and confidentially about important issues and concerns based on patients' best medical interests with the best available scientific evidence.[53] ACOG's Code of Professional Ethics states that "the welfare of the patient must form the basis of all medical judgments," and that obstetrician-gynecologists should "exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[54] The AMA Code of Medical Ethics places on physicians the "ethical

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[52] ACOG, Statement of Policy, *Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaff'd and amended Aug. 2021) (Legis. Policy Statement).

[53] AMA, Code of Medical Ethics Opinion 1.1.1, *Patient-Physician Relationships* (Aug. 2022) (AMA Opinion 1.1.1).

[54] ACOG, *Code of Professional Ethics* 2 (Dec. 2018) (ACOG Code).

responsibility to place patients' welfare above the physician's own self-interest or obligations to others."[55]

The Consent Act would undermine the patient-physician relationship by preventing physicians from respecting an adolescent patient's interest in confidentiality. The act also would force physicians to supplant their own medical judgments – and their patients' judgments – regarding what is in the patients' best interests with legislators' non-expert determination regarding whether and when parents must be notified or physicians may provide abortions.

Abortions are safe, routine, and, for many patients, the best medical choice available for their specific health circumstances. There is no rational or legitimate basis for interfering with a physician's ability to provide an abortion when the physician and patient conclude that it is the medically appropriate course, especially given Montana's statutory recognition of an adolescent's ability to make all other decisions related to a pregnancy. Laws that would restrict abortion – such as the Consent Act – are out of touch with the reality of contemporary medical practice and have no grounding in science or medicine.

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[55] AMA Opinion 1.1.1, *supra* note 53.

Such laws also would create inherent conflicts of interest. Physicians need to be able to offer appropriate treatment options based on patients' individualized interests without regard for the physicians' own self-interest.[56] The Consent Act would profoundly intrude upon the patient-physician relationship by subjecting clinicians to criminal fines and imprisonment and civil actions for violation of a professional obligation if they fail to obtain parental consent or provide care to a minor that has not gone through the judicial process to obtain a waiver of the consent requirement, even if that is not in the best interests of the patient. The Consent Act thus would force physicians to choose between the ethical practice of medicine and obeying the law.

B. Statutes that Restrict Access to Abortion Violate the Principles of Beneficence and Non-Maleficence

Beneficence, the obligation to promote the wellbeing of others, and non-maleficence, the obligation to do no harm, have been the cornerstones of the medical profession since the Hippocratic traditions.[57] Both

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[56] *See* Legis. Policy Statement, *supra* note 52, at 2-3.
[57] AMA, *Principles of Medical Ethics* (rev. June 2001); ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481-82 (Dec. 2007, reaff'd 2019).

principles arise from the foundation of medical ethics that requires the welfare of the patient to form the basis of medical decision-making.

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling, providing patients with information about risks, benefits, and pregnancy options, and ultimately empowering patients to make decisions informed by both medical science and their individual lived experiences.[58]

But the Consent Act would prohibit physicians from providing that treatment unless the patients' parents or guardians have given signed, notarized consent. The act also would expose physicians to civil and criminal penalties if they provide abortions without the required parental consent, even if providing that treatment is in the patients' best interests. It therefore places physicians at the ethical impasse of choosing between providing the best available medical care and risking substantial penalties or protecting themselves personally. This dilemma challenges the very core of the Hippocratic Oath: "Do no harm."

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[58] ACOG Code, *supra* note 54, at 1-2.

C. Statutes that Restrict Access to Abortion Violate the Ethical Principle of Respect for Patient Autonomy

Finally, a core principle of medical practice is patient autonomy – the respect for patients' ultimate control over their bodies and right to a meaningful choice when making medical decisions.[59] Patient autonomy revolves around self-determination, which, in turn, is safeguarded by the ethical concept of informed consent and its rigorous application to a patient's medical decisions.[60] The Consent Act would deny patients the right to fully make their own choices about health care if they decide they need to seek an abortion.

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[59] *Id.* at 1 ("[R]espect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental.").

[60] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstetrics & Gynecology e35 (Feb. 2021); AMA, Code of Medical Ethics Opinion 2.1.1, *Informed Consent* (2017).

CONCLUSION

For the foregoing reasons, the decision of the district court should be affirmed.

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Respectfully submitted,

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Pursuant to Rule 11 of the Montana Rules of Appellate Procedure, I certify that this *amicus curiae* brief is printed with a proportionately spaced Century Schoolbook typeface in 14-point font, is double spaced, and the word count calculated by the word processing software is 4,994 words, excluding the cover page, tables, and certificates.

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