

No. S25A0300

In the Supreme Court of Georgia

STATE OF GEORGIA,
DEFENDANT-APPELLANT,

v.

SISTERSONG WOMEN OF COLOR
REPRODUCTIVE JUSTICE COLLECTIVE, *ET AL.*,
PLAINTIFF-APPELLEES.

*ON APPEAL FROM THE
SUPERIOR COURT OF FULTON COUNTY
SUPERIOR COURT CASE NO. 2022CV367796*

**BRIEF OF AMERICAN ASSOCIATION OF
PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS
AS *AMICUS CURIAE* IN SUPPORT OF
DEFENDANT-APPELLANT**

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**INTEREST OF *AMICUS CURIAE*
& SUMMARY OF ARGUMENT**

The Association is a nonprofit professional medical organization with more than 7,000 members and associates. Since 1973, the Association has worked to ensure that pregnant women receive the highest-quality medical care and are fully informed of the effects of induced abortion, including its potential long-term consequences for women’s health. Recognized for 40 years as the largest “special interest” entity within the American College of Obstetricians and Gynecologists (until the College abolished special-interest groups in 2013), the Association offers healthcare professionals and the public a better understanding of abortion-related health risks. Some of these risks include abortion-related injuries; future premature (or “preterm”) birth; breast cancer; depression, substance abuse, and suicide. The Association educates the public about human development and recent advancements and findings in obstetrics and gynecology—findings that shed light on the need for Georgia’s LIFE Act.

Study after study shows that, as pregnancies progress, induced abortions correlate with *multiple* increased risks to women’s health. The General Assembly thus acted rationally in restricting abortion of a child with a detectable heartbeat, especially as the LIFE Act allows exceptions for medical emergencies and life-limiting fetal abnormalities, as well as in cases of rape and incest.

Indeed, induced abortion has the sole intent of ending the life of our fetal patient. That is why 93% of obstetrician-gynecologists do not perform them. It is also why, for over 2,000 years, the Hippocratic Oath has forbidden abortion. The LIFE Act thus goes far beyond what rationality would require and what is required for excellent healthcare for our patients. It should be upheld.

ARGUMENT

I. **Given its empirical support, the LIFE Act furthers the State’s interest in protecting maternal health.**

A. **Published, peer-reviewed studies show that induced abortions later in pregnancy are significantly tied to abortion-related deaths.**

1. In restricting abortions post-fetal heartbeat, the General Assembly had strong support from a leading study by a maternal-health specialist at the National Institutes of Health. *See* Linda A. Bartlett, et al., *Risk Factors for Legal Induced Abortion Mortality in the United States*, 103(4) *Obstet. & Gyn.* 729 (2004) (Bartlett Study); *see also, e.g.*, Daniel Grossman, et al., *Complications after Second Trimester Surgical and Medical Abortion*, 16 *Reproductive Health Matters* 173 (2008) (Supp. 31) (relying on Bartlett Study). Published by the journal of the American College of Obstetricians and Gynecologists (ACOG), the Bartlett Study was designed to “provide[] information on risk factors for abortion-related deaths among women who had abortions in recent years that will help inform and update policymakers and practitioners about abortion-related maternal mortality.” Bartlett, 103(4) *Obstet. & Gyn.* at 729–

30. To ensure reliability, the Bartlett Study used data from the Centers for Disease Control and Prevention's Pregnancy Mortality Surveillance System, "which attempts to identify all deaths in the United States caused by pregnancy, including those ending in induced abortion." *Id.* at 730.

As the Bartlett Study found, "the strongest risk factor for abortion-related mortality" was "[g]estational age at the time of abortion." Bartlett, 103(4) *Obstet. & Gyn.* at 731, 735. "The lowest rates were among women who had their abortions in the first trimester of pregnancy, particularly within the first 8 weeks of pregnancy. Women whose abortions were performed in the second trimester (at or after 13 weeks of gestation) had abortion-related mortality rates greater than women whose abortions were performed in the first 8 weeks of pregnancy[.]" *Id.* at 731. Indeed, "[i]f women who had abortions after 8 weeks of gestation had obtained abortions during the first 8 weeks of pregnancy, when risk is lowest, 87% of deaths likely could have been prevented." *Id.*; *id.* at 736 (same).

Just as strikingly, "the risk of death increased exponentially with increasing gestational age. According to this model, there is a 38% increase in risk of death for each additional week of gestation." Bartlett, 103(4) *Obstet. & Gyn.* at 731. "Thus, the estimated increase in the risk of death due to delaying the procedure by 1 week at 17 weeks of gestation is 18 times greater than the

estimated increase in the risk of death by delaying the procedure by 1 week at 8 weeks of gestation.” *Id.* at 732.

This increase in risk, the Bartlett Study found, calls for earlier abortions. “Because access to abortions even 1 week earlier reduces the risk of death disproportionately as gestational age increases, addressing this risk factor by further reducing the gestational age at which women have abortions may help to further reduce the risk of death.” Bartlett, 103(4) *Obstet. & Gyn.* at 735.

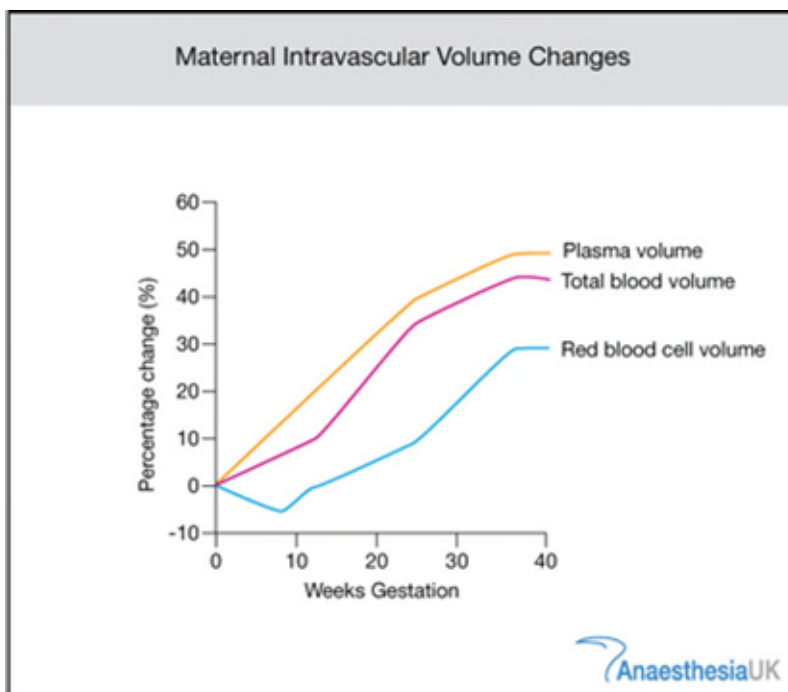
The Bartlett Study is not alone. Seven years later, researchers found an “increased risk of complications” associated with abortion with “increasing gestational age.” Maarit, J. Mentula, et al., *Immediate Adverse Events after Second Trimester Medical Termination of Pregnancy: Results of a Nationwide Registry Study*, 26(4) *Human Reproduction* 927, 927 (2011). “The purpose of the ... study was to assess the rate of adverse events and complications following the second trimester medical [abortion] and to compare it with those following the first trimester medical [abortion]. [The authors] focused ... on [hemorrhage], infection and surgical evacuation in cases of incomplete abortion.” *Id.* at 928. The result? “[S]econd trimester medical [abortion] was associated with an increased risk of surgical evacuation and infection.” *Id.* at 930.

Even early abortions—and pregnancy losses generally—are tied to higher mortality rates. According to a recent meta-analysis, “11 studies from three countries reported mortality rates associated with termination of

pregnancy, miscarriage or failed pregnancy. Within a year of their pregnancy outcomes, women experiencing a pregnancy loss are over *twice as likely* to die compared to women giving birth.” David C. Reardon & John M. Thorp, *Pregnancy Associated Death in Record Linkage Studies Relative to Delivery, Termination of Pregnancy, and Natural Losses: A Systematic Review with a Narrative Synthesis and Meta-analysis*, 5 SAGE Open Med. 1, 1 (2017) (emphasis added). “[T]his elevated mortality risk persists over many years, is multiplied by repeat exposure to pregnancy loss, and may be reduced by successful deliveries. The quality of these eleven studies is very high, with all but the one earliest attempt scoring 8 or above on the [National Committee for Quality Assurance Standards] (with a range 0-9).” *Id.* at 9.

2. There are good reasons that abortions later in pregnancy are particularly associated with complications and risks. “The increased amount of fetal and placental tissue requires a greater degree of cervical dilation, the increased blood flow predisposes to hemorrhage, and the relaxed myometrium [i.e., the wall of the uterus] is more subject to mechanical perforation. The technical challenges of the procedure during the second trimester are different from those present in the first trimester, and the inherently greater risk of complications may be less amenable to prevention.” Bartlett, 103(4) *Obstet. & Gyn.* at 735. We address these risks in turn.

“[T]he increased blood flow predisposes to hemorrhage.” As the pregnancy progresses, blood flow rises some 50%, as do plasma volumes:



AnaesthesiaUK, *Physiological Changes of Pregnancy* (2006).

The increased blood flow is also due, in part, to dramatic changes pregnancy triggers in the uterus, which grows and increases in vascularity. “The greater size of the uterus as a result of pregnancy is due to a marked increase in the number of muscle fibres, blood vessels, nerves, and lymphatic vessels in the uterine wall. There is also a five- to tenfold increase in the size of the individual muscle fibre and marked enlargement in the diameters of the blood and lymph vessels.” John W. Huffman, *Pregnancy*, Encyclopedia Britannica (Feb. 7, 2020). In this blood-vessel-rich environment, hemorrhaging is an ever-present danger. World Health Org., *Safe Abortion: Technical & Policy*

Guidance for Health Systems 54 (2d ed. 2012). Unsurprisingly, given the changes in the uterus, “[t]he risk of ... hemorrhage increases with advancing gestational age[.]” Cassing Hammond, *Second-Trimester Pregnancy Termination: Dilation and Evacuation*, UpToDate (2020).

“[T]he relaxed myometrium is more subject to mechanical perforation.” The risk of hemorrhaging rises because the thinned wall (or myometrium) of the uterus is more vulnerable to “mechanical perforation”—that is, puncturing. Bartlett, 103(4) *Obstet. & Gyn.* at 735. Indeed, “[u]terine perforation is one of the more common complications” even in dilation-and-curettage abortions; and the risk rises with “gestational age.” Eugene C. Toy, *Perforation with Uterine Sound and Suction Cannula During a D&C*, SASGOG (2014).

Punctures in the uterus can also be caused by pieces of the fetus itself. To avoid this danger, abortion providers “must be very careful to avoid pushing fetal parts with the forceps since this may push them deeper into the [cavity of the uterus] and even through the uterine wall.” Hammond, *supra*. Instead, “fetal parts should be brought down to the lower uterine segment for disarticulation. Caution should be employed since bony spicules [i.e., spikes] exposed during fetal disarticulation can perforate the uterine walls and abrade the cervix.” *Id.*

Given these risks of hemorrhage and punctures, the Bartlett Study spoke rightly, if delicately, of the “technical challenges” of second-trimester abortions. The U.S. Supreme Court described the procedure more bluntly:

The surgical procedure referred to as “dilation and evacuation” or “D&E” is the usual abortion method in this trimester. Although individual techniques for performing D&E differ, the general steps are the same.

A doctor must first dilate the cervix at least to the extent needed to insert surgical instruments into the uterus and to maneuver them to evacuate the fetus. The steps taken to cause dilation differ by physician and gestational age of the fetus. A doctor often begins the dilation process by inserting osmotic dilators, such as laminaria (sticks of seaweed), into the cervix. The dilators can be used in combination with drugs, such as misoprostol, that increase dilation. ... In general the longer dilators remain in the cervix, the more it will dilate. Yet the length of time doctors employ osmotic dilators varies. Some may keep dilators in the cervix for two days, while others use dilators for a day or less.

After sufficient dilation the surgical operation can commence. The woman is placed under general anesthesia or conscious sedation. The doctor, often guided by ultrasound, inserts grasping forceps through the woman’s cervix and into the uterus to grab the fetus. The doctor grips a fetal part with the forceps and pulls it back through the cervix and vagina, continuing to pull even after meeting resistance from the cervix. The friction causes the fetus to tear apart. For example, a leg might be ripped off the fetus as it is pulled through the cervix and out of the woman. The process of evacuating the fetus piece by piece continues until it has been completely removed. A doctor may make 10 to 15 passes with the forceps to evacuate the fetus in its entirety, though sometimes removal is completed with fewer passes. Once the fetus has been evacuated, the placenta and any remaining fetal material are suctioned or scraped out of the uterus.

Gonzales v. Carhart, 550 U.S. 124, 135–35 (2007) (citations omitted).

To sum up, a second-trimester induced abortion requires: extensive dilation; grasping forceps; force powerful enough to dismember the fetus; and

suctioning and scraping. And it does so when there is 50% greater blood flow, a profusion of blood vessels, a softened uterus, and sharp fetal bone fragments. Given all this, abortions later in pregnancy unsurprisingly pose an “inherently greater risk of complications” than earlier abortions. Bartlett, 103(4) *Obstet. & Gyn.* at 735. What is more, these abortions risk leaving behind “retained products of conception”—that is, parts of the fetus or placenta, which can cause bleeding and other complications such as infection if not removed. Hammond, *supra*. So, “[a]t the end of the procedure, the surgeon should inventory evacuated contents and account for the major fetal parts (calvaria [i.e., skull cap], thorax, pelvis, four extremities [i.e., limbs]).” *Id.*

Given all these complications, the General Assembly was on solid ground in protecting women by requiring that abortions take place early in pregnancy.

B. Published, peer-reviewed studies show that abortions later in pregnancy raise the risk of premature births in future pregnancies.

Georgia also has a substantial interest in requiring early abortions because of the tie between surgical induced abortions (which, as noted, are necessary later in the pregnancy) and later premature, or “preterm,” births.

Preterm birth is associated with “significant maternal and infant health risks” and is considered an “epidemic” in the United States. Linda S. Franck, et al., *Research Priorities of Women at Risk for Preterm Birth: Findings and a Call to Action*, 20(10) *BMC Pregnancy and Childbirth* 1, 2 (2020). Despite

years of effort and widespread interventions, “population level reduction in preterm birth rates have not been achieved.” *Id.* In 2022, after a pattern of increases, the preterm birth rate in the United States fell slightly to 10.4% but remained significantly higher than in 2020 and still remains the highest among developed countries. See Centers for Disease Control and Prevention, *Reproductive Health: Maternal and Infant Health, Preterm Birth* (Nov. 8, 2024); Ohuma, Eric O., et al., *National, Regional, and Global Estimates of Preterm Birth in 2020, with Trends from 2010: A Systematic Analysis*, 402 *The Lancet* 10409 (2023).

Babies born preterm—that is before 37 weeks’ gestation—have higher rates of death and disability. According to the Centers for Disease Control and Prevention, in 2022 preterm birth and low birthweight (which is linked to preterm birth) accounted for about 14% of infant deaths. Centers for Disease Control and Prevention, *Preterm Birth, supra*. For related reasons, preterm births also impose substantial costs on society. An analysis by the Institute of Medicine estimated the economic costs associated with preterm birth in the United States to be “at least \$26.2 billion in 2005, or \$51,600 per infant born preterm.” Committee on Understanding Premature Birth and Assuring Healthy Outcomes, Institute of Medicine, *Preterm Birth: Causes, Consequences, and Prevention* (2007). Based on data spanning 2008 to 2016, a more recent study estimated the average medical costs in the first six months of life at \$76,153

per preterm birth. Andrew L. Beam, et al., *Estimates of Healthcare Spending for Preterm and Low-birthweight Infants in a Commercially Insured Population: 2008–2016*, 40 J. Perinatology 1091 1, 1 (2020).

Two significant 2009 meta-analyses show a statistically significant link between induced abortion, especially surgical abortion, and preterm birth. A meta-analysis of 22 studies that included 268,379 patients found that just one induced abortion raises the risk of preterm birth by 36%, and more than one increases the risk by 93%. See P.S. Shah, et al., *Induced Termination of Pregnancy and Low Birthweight and Preterm Birth: A Systematic Review and Meta-analysis*, 116 British J. Obstet. & Gyn. 1425, 1425 (2009). Another meta-analysis of nine studies found that a single induced abortion raised the risk of preterm birth by 25% and *very*-preterm birth by 64%. See Hanes M. Swingle, et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses*, 54(2) J. Reproductive Med. 95, 95 (2009).

Later meta-analyses agree. A 2015 meta-analysis of 28 studies, which included 913,297 women, found that women who had a previous surgical abortion had a “significantly higher risk” (52%) of preterm birth. See Gabriele Saccone, et al., *Prior Uterine Evacuation of Pregnancy as Independent Risk Factor for Preterm Birth and Metaanalysis*, 214(5) Am. J. Obstet. & Gyn. 572, 572 (2016). A 2016 meta-analysis of 21 studies that reported on 1,853,017 women who underwent a dilation and curettage (a surgical procedure used for abortion

or to complete a miscarriage) had a 29% increased risk of preterm birth and a 69% increased risk of very preterm birth. See Marike Lemmers, et al., *Dilation and Curettage Increases the Risk of Subsequent Preterm Birth: A Systemic Review and Meta-analysis*, *Human Reproduction* 1, 1 (2015).

It is true that a 2018 committee report from the National Academy of Sciences, which reviewed only five studies, concluded that “having an abortion does not increase a woman’s risk of ... preterm birth.” Nat’l Acad. Sci., Eng’g, and Med., *The Safety and Quality of Abortion Care in the United States* 1, 153 (2018) (NAS Report). But the report failed to include at least 70 studies that met the committee’s stated criteria. See Am. Ass’n of Pro-life Obstet. & Gyn., 11 Practice Guideline, *A Detailed Examination of the Data on Surgical Abortion and Preterm Birth* 1, 2 (2021). And the authors had to acknowledge an “increased risk of very preterm birth” associated with two or more abortions. NAS Report at 147.

C. Published, peer-reviewed studies correlate induced abortions with breast-cancer risks, which rise with gestational age.

1. Since 1957, at least 41 studies have shown a positive, statistically significant association between induced abortion and breast cancer. Breast Cancer Prevention Institute, *Epidemiological Studies: Induced Abortion and Breast Cancer Risk* (Apr. 2020) (listing studies). To take one example, a 2009 study in the *World Journal of Surgical Oncology* states that “age and induced

abortion were found to be significantly associated with increased breast cancer risk.” Vahit Ozmen, et al., *Breast Cancer Risk Factors in Turkish Women – a University Hospital Based Nested Case Control Study*, 7(37) *World J. Surgical Oncology* 1, 1 (2009). But this 2009 study was far from alone. The authors also surveyed a host of analogous studies. And “similar to [the 2009 study’s] findings, the majority of the studies reported that induced abortion was associated with increased breast cancer risk.” *Id.* at 6.

Likewise, a 2009 study coauthored by Dr. Louise Brinton, Chief of the Hormonal and Reproductive Epidemiology Branch at the National Cancer Institute, found risk factors for breast cancer “consistent with the effects observed in previous studies.” Jessica M. Dolle, et al., *Risk Factors for Triple-Negative Breast Cancer in Women Under the Age of 45 Years*, 18(4) *Cancer Epidemiology, Biomarkers and Prevention* 1157, 1162–63 (2009). “Specifically, older age, family history of breast cancer, earlier menarche [i.e., first menstrual period], *induced abortion*, and oral contraceptive use were associated with an increased risk for breast cancer.” *Id.* at 1163. (emphasis added).

Reaching the same conclusion, Chinese scientists treat abortion as a key indicator of breast-cancer risk in a new model for screening women. See Lu Wang, et al., *Risk Prediction for Breast Cancer in Han Chinese Women Based on a Cause-specific Hazard Model*, 19(128) *BMC Cancer* (2019). In fact, the

study found that induced abortion had the *most* impact: one or two abortions increased the risk 151%; three or more increased the risk by 530%. *Id.* at 4.

Further filling in the picture, another study “found an increased [breast-cancer] risk associated with an increasing number of induced abortions. However, this risk appeared to be restricted to pregnancies with induced interruptions before the first [full-term pregnancy].” Julie Lecarpentier, et al., *Variation in Breast Cancer Risk Associated with Factors Related to Pregnancies According to Truncating Mutation Location, in the French National BRCA1/2 Carrier Cohort*, 14(R99) Breast Cancer Research 1, 16 (2012). In other words, women faced a higher risk of cancer after having an induced abortion *if* the abortion occurred before the woman had her first child.

2. Breast cancer is linked to abortion because of how breasts grow during pregnancy. Immature, newly formed breast tissue is susceptible to cancer. Mature breast tissue, which can produce milk, resists cancer. Abortion arrests breast tissue in an immature state, before it can produce milk, leaving it vulnerable to cancer.

For this reason, “[e]arly full-term pregnancy is one of the most effective natural protections against breast cancer.” Sibgat Choudhury, et al., *Molecular Profiling of Human Mammary Gland Links Breast Cancer Risk to a p27+ Cell Population with Progenitor Characteristics*, 13(1) Cell Stem Cell 117, 2 (2013). The connection between childlessness and breast cancer has been

known since at least 1842, when a higher incidence of breast cancer was observed among nuns than in other women. Christopher I. Li, ed., *Breast Cancer Epidemiology* 120 (2010) (collecting 18th, 19th, and early 20th-century studies). Planned Parenthood agrees. “It is known that having a full-term pregnancy early in a woman’s childbearing years is protective against breast cancer[.]” Planned Parenthood, *Myths About Abortion and Breast Cancer* (2013).

The reason a full-term pregnancy makes breast cancer less likely is that pregnancy changes the physiology of the breast. Early in pregnancy, estrogen stimulates the growth of immature stem-cell breast tissue—growth that increases in the second trimester. At 20 weeks’ gestation, the body produces a hormonal signal that causes the immature stem-cell breast tissue to begin to develop the capacity to make milk. By 32 weeks’ gestation, roughly half of the breast tissue can make milk; and that tissue is much less susceptible to cancerous changes. By full term, over 90% of the breast tissue is fully genetically mature and can make milk and thus is no longer susceptible to cancerous changes. See Jose Russo, et al., *Full-term Pregnancy Induces a Specific Genomic Signature in the Human Breast*, 17(1) *Cancer Epidemiology, Biomarkers and Prevention* 51 (Jan. 2008); I. Verlinden, et al., *Parity-Induced Changes in Global Gene Expression in the Human Mammary Gland*, 14(2) *European J. Cancer Prevention* 129 (2005).

As a result, a woman's risk of breast cancer rises if she has never brought a pregnancy to term and then loses the pregnancy before 32 weeks—whether the cause is a preterm birth, a second-trimester miscarriage, or an induced abortion. See L.J. Vatten, et al., *Pregnancy Related Protection Against Breast Cancer Depends on Length of Gestation*, 87 *British J. Cancer* 289 (2002); M. Melbye, et al., *Preterm Delivery and Risk of Breast Cancer*, 80 *British J. Cancer* 609 (1999).

Additionally, inducing abortion deprives a woman of the risk-reducing effects of a full-term pregnancy. She will either: (a) remain childless, thus losing the dramatic risk-reduction of a full-term pregnancy; or (b) have one fewer full-term pregnancy than she otherwise would, losing another 10% risk reduction. No matter what, inducing abortion will postpone a full-term pregnancy, thus raising her risk by 5% per year until she carries a pregnancy to term. Meanwhile, the abortion also will increase her risk for a preterm birth, which will also increase her breast-cancer risk. See C.C. Hsieh, et al., *Delivery of Premature Newborns and Maternal Breast Cancer Risk*, 353 *The Lancet* 1239 (1999).

D. Published, peer-reviewed studies increasingly show that abortions later in pregnancy raise the risk of depression, drug abuse, and suicide.

Increasingly, research published in leading journals shows that abortion is tied to an increased risk of psychological harm, including anxiety, depression, substance abuse, thoughts of suicide, and suicide.

1. At least 53 published studies show abortion associated with elevated mental-health risk. For instance, an analysis of data for a nationally representative cohort of 8,005 women found abortion consistently tied to a 45% increased risk of mental-health disorder. *See* Donald Paul Sullins, *Abortion, Substance Abuse and Mental Health in Early Adulthood: Thirteen-year Longitudinal Evidence from the United States*, 4 Sage Open Med. 1, 1 (2016). A Finnish study of suicide after induced abortion found that, despite changes in medical care to address the issue, women who had an abortion remained at a twofold risk of suicide. *See* Mika Gissler, et al., *Decreased Suicide Rate after Induced Abortion, after the Current Care Guidelines in Finland 1987–2012*, 43 Scandinavian J. Pub. Health 99 (2015).

A 2011 meta-analysis of 22 published studies, which together included 877,181 participants, found that, compared to women who carried a pregnancy to term, women who had an abortion had an 81% increased risk of mental-health problems. *See* Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995–2009*, 199

British J. Psychiatry 180, 180 (2011). The analysis showed a 34% increased risk for anxiety disorders, 37% increased risk for major depression, 110% increased risk for alcohol abuse, 220% increased risk for marijuana abuse, and a 155% increased risk of suicide attempts. *Id.* at 182. When compared to women who carried an *unwanted* pregnancy to term, women who underwent an abortion still experienced a 55% increased risk of mental-health problems. *Id.*

Similarly, a 2013 review of 30 studies examining abortion and mental-health issues, such as depression, anxiety disorders, and substance-abuse disorders, concluded that “abortion is a risk factor for subsequent mental illness when compared with childbirth.” Carlo Valerio Bellieni, et al., *Abortion and Subsequent Mental Health: Review of the Literature*, 67 *Psychiatry and Clinical Neurosciences* 301, 307 (2013). When abortion was “compared with the other two possible outcomes (miscarriage or the birth of an unplanned baby),” the risk of mental-health issues was greater or similar. *Id.* In other words, induced abortion was no remedy for mental-health issues; if anything, it made matters worse.

2. It is true that a 2008 report from the American Psychiatric Association concluded that “the relative risk of mental health problems among adult women who have an unplanned pregnancy is no greater if they have an elective first-trimester abortion than if they deliver that pregnancy.” Am.

Psychiatric Ass'n, *Mental Health and Abortion* 1, 90 (2008). But to draw this conclusion, the authors had to exclude:

- the 48%–52% of women who already had a history of one or more abortions;
- the 18% of patients who were minors;
- the 7% of women aborting for therapeutic reasons regarding their own health or concerns about the health of the fetus; and
- the 11%–64% of women whose pregnancies were wanted or planned, or for which the women had developed an attachment.

David C. Reardon, *The Abortion and Mental Health Controversy: A Comprehensive Literature Review of Common Ground Agreements, Disagreements, Actionable Recommendations, and Research Opportunities*, 6 SAGE Open Med. 1, 8–9 (2018). In short, the authors only included women *least* likely to suffer from mental-health issues, thus skewing the results of their report. It thus sheds no light on this case.

Moreover, studies *since* the 2008 report have led to “the consensus of expert opinion” that: (a) “a history of abortion is consistently associated with elevated rates of mental illness compared to women without a history of abortion”; and (b) “the abortion experience can directly contribute to mental health problems in some women.” Reardon, 6 SAGE Open Med. at 8. A 2018 literature review found the “association between abortion and higher rates of anxiety, depression, substance use, traumatic symptoms, sleep disorders, and other

negative outcomes is statistically significant in most analyses.” *Id.* at 6. And “the minority of analyses that do not show statistically significant higher rates of negative outcomes do not contradict those that do.” *Id.*

3. Mental-health issues are especially common after abortions later in pregnancy. A 12-month post-abortion study of 854 women in Sweden found that 37.5% of women who underwent second-trimester abortions suffered extreme post-abortion emotional problems. *See* Hanna Söderberg, et al., *Emotional Distress Following Induced Abortion. A Study of its Incidence and Determinants Among Abortees in Malmö, Sweden*, 79 *European J. Obstet. and Gyn. and Reproductive Biology* 173 (1998). Likewise, a 2018 study found that women who underwent an abortion later in pregnancy were more likely to suffer from psychological distress than women undergoing earlier procedures. *See* Sameera Kotta, et al., *A Cross-sectional Study of the Psychosocial Problems Following Abortion*, 60 *Indian J. Psychiatry* 217 (2018).

Similarly, a comparative analysis of women who had a first-trimester abortion with those who had a second- or third-trimester abortion found that 52% of the early abortion group and 67% of the late-term abortion group met the criteria for post-traumatic stress disorder. *See* Priscilla K. Coleman, et al., *Late-term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, 2010 *J. Pregnancy* (2010). Later abortions were linked to persistent, recurrent, and distressing memories, as well as hyper-reactivity to traumatic

stimuli. *Id.* Second-trimester abortion was also associated with a greater likelihood of disturbing dreams, emotional numbness, and trouble falling or staying asleep. *Id.*

In sum, a rich literature shows that abortions later in pregnancy threaten maternal health. The General Assembly thus acted rationally in restricting abortion post-fetal heartbeat. Nor is it relevant that later abortions may be convenient. “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*, 550 U.S. at 166.

II. The LIFE Act’s rationality is confirmed by its exceptions, which exceed the demands of medicine and traditional medical ethics.

It is also no answer to say that induced abortions later in pregnancy are needed to save the life of the mother. The LIFE Act allows abortions in cases of, among other things, medical emergencies and life-limiting fetal abnormalities. O.C.G.A. § 16-12-141(b)(1), (3). These exceptions underscore the rationality of the LIFE Act.

To be sure, the exceptions were unnecessary because elective induced abortion, which has as its sole intent the death of the embryo or fetus, at any stage, is *not* medically necessary. Indeed, 93% of obstetrician-gynecologists never perform elective induced abortions—at any stage of pregnancy. *See*

Sheila Desai et al., *Estimating Abortion Provision and Abortion Referrals Among United States Obstetrician-Gynecologists in Private Practice*, 97 *Contraception* 297, 299 (2017).

In declining to perform induced abortions, doctors are keeping with the longstanding tradition of their profession. For thousands of years, the Hippocratic Oath, which codifies “the ethics of the medical profession,” has expressly forbade physicians from performing abortions. *Roe v. Wade*, 410 U.S. 113, 131 (1973) (“I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. *Similarly, I will not give to a woman an abortive remedy.*”) (quoting the Oath) (emphasis added).

Instead, in the rare circumstance in which a mother’s life is endangered by a complication before the fetus is viable, a premature maternal-fetal separation may be required, but this is not the same as an induced abortion that intends the death of the fetus. Am. Ass’n. of Pro-Life Obstet. & Gyn., 10 *Practice Guideline, Concluding Pregnancy Ethically* 1, 11 (2022). Those steps are allowed under the LIFE Act, which, in emergencies and other rare cases, also allows an abortion. But as *Gonzales* shows in graphic detail, an essential goal of abortion is to produce a dead fetus. 550 U.S. at 135–36. By contrast, the premature maternal-fetal separation can be done in a way that respects both the life of the mother and the dignity of the fetus, whose life may be lost only incidentally and not as an essential goal.

But again, in medical emergencies, the LIFE Act allows premature separation and abortion. It should be upheld.

CONCLUSION

For all these reasons, the Court should uphold the LIFE Act.

Respectfully submitted,

This submission does not exceed the word-count limit of Rule 20.

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