No. 13-402

In The Supreme Court of the United States

TOM HORNE, Attorney General of Arizona;
WILLIAM GERARD MONTGOMERY,
County Attorney for Maricopa County,

Petitioners,

v.

PAUL A. ISAACSON, M.D.;
WILLIAM CLEWELL, M.D.;
HUGH MILLER, M.D., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

AMICUS CURIAE BRIEF OF HEARTBEAT INTERNATIONAL, INC., CARE NET, NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, ELISABETH SLOTKIN, MICHELLE GERACI, AND CHRISTINE BRIDGES IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

In *Gonzales v. Carhart*, this Court upheld a prohibition on partial-birth abortion that operated throughout pregnancy, pre- and post-viability, in deference to Congress' legislative findings that the prohibition protected against fetal pain and upheld the integrity of the medical profession by drawing a bright line between abortion and infanticide. Relying on similar advances in medical knowledge, Arizona made legislative findings that documented evidence of fetal pain and dramatically increased maternal health risks warranted limitations on abortion after twenty weeks gestational age (a few weeks short of viability based on currently available medicine) except when necessary to avoid death or serious health risk to the mother. Finding that neither "the factual record" nor the "district court's factual findings" were of any "pertinence to [their] decision," the Ninth Circuit held that "under controlling Supreme Court precedent," Arizona's statute was "*per se* unconstitutional" because it applied to pre-viability abortions. *Isaacson v. Horne*, 716 F.3d 1213, 1217 (9th Cir. 2013). Three questions are presented in Arizona's Petition for a Writ of Certiorari. Brief for Petitioner at i-ii, *Horne et al. v. Isaacson et al.*, No. 13-402 (Sept. 27, 2013).

1. Did the Ninth Circuit correctly hold that the "viability" line from *Roe v. Wade* and *Planned Parenthood v. Casey* remains the only critical factor in determining constitutionality, to the exclusion of other significant governmental interests, or is Arizona's

QUESTIONS PRESENTED – Continued

post-twenty-week limitation facially valid because it does not pose a substantial obstacle to a safe abortion?

2. Did the Ninth Circuit err in declining to recognize that the State's interests in preventing documented fetal pain, protecting against a significantly increased health risk to the mother, and upholding the integrity of the medical profession are sufficient to support limitations on abortion after twenty weeks gestational age when terminating the pregnancy is not necessary to avert death or serious health risk to the mother?

3. If the Ninth Circuit correctly held that its decision is compelled by this Court's precedent in *Roe v. Wade* and its progeny, should those precedents be revisited in light of the recent, compelling evidence of fetal pain and significantly increased health risk to the mother for abortions performed after twenty weeks gestational age?

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae **Heartbeat International, Inc.**, **Care Net**, and **National Institute of Family and Life Advocates** (NIFLA) are 501(c)(3) not-for-profit organizations involved in caring for women who encounter an unexpected pregnancy or its aftermath, including women considering late term abortions (after the twelfth week of gestation) for any reason, including women who would otherwise not be considering abortion if their physician(s) were not recommending the termination of pregnancy because of the possibility of fetal abnormality. As national organizations whose affiliated members, professional staff, and volunteers have collectively worked directly with the hundreds of thousands of women who encounter unplanned or otherwise difficult pregnancies, many of whom have experienced or will soon face harmful post-abortion symptoms or conditions harmful to their physical and psychological health, each of the *amicus* parties has a direct and vital interest in protecting women from the various harms abortion yields that were not known or considered by the

[1] As required by Rule 37.2(a) for the filing of this brief without motion, all parties, through their counsel of record, were given ten days' notice of the filing of this brief. The parties have consented to the filing of this brief. Pursuant to Rule 37.6, *Amici* represent that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. Printing costs for the brief were paid by the Jubilee Campaign.

Court when it rendered its related opinions in *Roe v. Wade*, 410 U.S. 113 (1973) and *Doe v. Bolton*, 410 U.S. 179 (1973).

Because *amici* have witnessed and care for the thousands of women who are now reporting how abortion has harmed them and because *amici* have every reason to believe that many more women will be coming forward to report the harm abortion has done and is doing to them, all *amici* urge this Court to grant *certiorari* so that Petitioner State of Arizona can demonstrate to this Court – as they did to the district court's satisfaction below, *Isaacson v. Horne*, 884 F. Supp. 961 (D. Ariz. 2012) – that in light of the medical evidence, legislatures have an interest in protecting maternal health all throughout the pregnancy, and thus may prohibit abortions after twenty weeks.

Individual *amici* explain their interest in this case in their own words:

Elisabeth Slotkin: Two of my children are in heaven. My daughter is in heaven because God took her home. Little Katie was born with a serious genetic disorder and lived for only two months. My son is in heaven because I aborted him. I am joining this brief because I want the Court to know which choice I regret and which choice I delight in.

I look back on my daughter's life with deep joy and satisfaction. I was not a perfect mom, even for those two months, but I have the satisfaction of knowing that I loved her deeply and cared for her as well as I could. I think of her often in God's presence

and my heart leaps. My son is in God's presence too, but that thought sends me to my knees. The law says it was my choice to make, but I know the truth: I made a decision no human has the right to make – the decision to end the life of an innocent child.

When I found out as a teenager that I was pregnant, I decided to abort for only one horrifically selfish and immature reason: I did not want to face the difficult discussion with my parents that would follow if they found out I was sexually active. My abortion was not the result of a well-thought out "informed decision" that I made after consulting with my physician. Although I was given papers to sign, I do not recall that anyone at the clinic spoke to me about the risks or potential negative side effects of abortion. I am certain no one asked me why I wanted to abort or challenged me to think through my decision. While being prepped for the procedure, I told the doctor that I believed abortion was wrong, but he said nothing to discourage me from going through with it.

Many years later, I was once again faced with the decision to abort: my husband and I were told that our baby had Trisomy 13, an incurable genetic disorder. The doctor urged us to make our decision quickly because I was already far along in my pregnancy and fast approaching our state's abortion deadline.

Once again, years after my abortion, I felt the tug of selfish thinking: I was afraid of the way a tiny, innocent baby might change my life. I knew that

some Trisomy 13 children live for many years, and I realized our daughter might need total care. I worried about the strain on our finances and on our marriage.

My husband and I also wrestled with the fear that our daughter might suffer. Maybe, we thought, the compassionate thing would be to abort her before she ever had to struggle. But then we remembered that plenty of people suffer and yet still want to live as long as they can. Who were we to decide that she should *die* so she might not *suffer*?

When I told the doctor we had decided not to abort, he urged me to reconsider: looking me in the eye, he warned that I might not be able to handle carrying a child that I knew was unlikely to live. We stood firm in our decision not to abort, but over the course of my pregnancy, I thought a lot about what he had said. What did his warning that I might not be able to "handle" it even *mean*? Did he mean there was a significant risk I would have a nervous breakdown? Did he mean the stress might kill me?

Ultimately, my husband and I "handled" the challenges the same way anybody does: by walking through them one step at a time. During the two months our daughter was alive, we received an outpouring of support and love from family and friends. It was a difficult time, but my doctor's warning turned out to be completely erroneous: I was never unable to handle things. Yes, we grieved deeply when we lost Katie, but we would have also grieved if we

had aborted her – and *that* kind of grief would have been accompanied by shame and regret. Instead, we are able to hold our heads high, knowing we took care of her as well as we could, and the grief we experience is mitigated by the memories of all the sweet moments we enjoyed with her.

In both of my pregnancies, my doctors pointed me in the wrong direction. The doctor who performed my abortion never explained that I might have to deal with serious adverse consequences – grief, shame, and deep regret – for the rest of my life. Katie's doctor warned me of adverse consequences I might experience if I did *not* abort, but his warnings were entirely misguided: giving birth to Katie was one of my proudest moments, and one of the best choices I have ever made.

Michelle Geraci: I became pregnant when I was 21 years old. I did not want to have an abortion, but I was terrified and didn't have a clue how I could go through a pregnancy and have a baby. I was struggling financially. I worked several jobs with the elderly and also waitressed. My car had broken down. The father of this child turned out not to be in life where I thought he was. I was so ashamed.

Inside Planned Parenthood I was rushed through the consent paperwork to indicate that I knew what I was doing. I was in a state of shock as I numbly signed whatever paper they put in front of me without knowing what I was signing. When I was brought into the exam room they exposed my stomach and put

gel on it. I asked what they were doing. The doctor said she needed to see. Then I saw a little black and white figure moving on an ultrasound screen across the room. Something went through me like a wave. I asked the doctor what that was and she said it was nothing. She saw my face and quickly moved between me and the screen. Then she stopped and said that I didn't have to do this. I desperately told her my situation and that I didn't want to but didn't know what else to do. I said I felt like I was on a roller coaster and I wanted off. She looked at me, shrugged her shoulders, and said "fine." Next thing I knew a mask was over my face, and I was thinking I was trying to say that getting off the roller coaster didn't mean I wanted an abortion. I woke up in a room full of girls crying. The girl next to me tearfully reached out to hold my hand. I was crying, too. I took her hand, but I hated her and I hated myself.

The counselor had told me life would return to normal after the abortion. It mostly did, except for the part of me that died along with my baby – and that dead, empty place turned into a nightmarish, anguished black hole for the loss of my child's life that I sacrificed for me. A day has not gone by that I haven't felt grief and sorrow over the loss and horrific death of my baby. Every life milestone, I note how old my child would be. The full impact of what I'd done came when I became pregnant with my now almost ten-year-old child. When I saw her ultrasound picture at eight weeks, I knew that the baby I'd aborted was much more developed than the eight week old I was

looking at. I never forgot that split second image of my aborted baby bouncing around that black and white screen across the room. In those weeks I had heard the voice and felt the presence of my child.

In each of my two next pregnancies, I was told my child would have Down Syndrome. I resisted pressure to abort because I knew I could not go through that experience again. In both of those instances, the initial diagnosis had been wrong. The Down Syndrome tests had yielded false positives. If I had listened to the recommendation of my doctor, I would have aborted two healthy children.

My fourth child does have Down Syndrome. After the pre-natal diagnosis, I was told that life raising a baby with Down Syndrome would be difficult and was advised and encouraged to have an abortion. My son is not a cold, medical description. He is more than a diagnosis. He is a gift and a joy. Nine out of ten children with Down Syndrome are aborted. This is wrong. I have had an abortion, and I speak with personal experience when I say that giving birth to a child with a disability is far healthier – physically, spiritually, emotionally – than having an abortion. Children don't detract from or burden life, children add joy and worth and depth to life.

Christine Bridges: I had an abortion when I was nineteen years old. My boss insisted that I have the abortion and gave the money for the procedure to a co-worker, ordering him to drive me to the clinic. On the day of my abortion, I was in a stupor. I was over

four months pregnant. I know my baby was a boy. I remember that I was placed in a recovery room with three other girls. One was driven there by her father. Another girl had returned to the clinic because a twin was still in her womb. After the abortion, I suffered from a severe infection for months. The antibiotics were expensive. Worse than the immediate physical side effects, though, were the emotional ones about which I had never been warned. I was unable to speak without crying for a year after the abortion. I was in therapy for at least five years after that abortion.

I was also not advised that an abortion can cause premature delivery in subsequent pregnancies. I have since given birth to five children, three of whom were born prematurely. My second child – but first birth – was my son, Patrick, who weighed only one pound, nine ounces when he was born. He died five days after birth. My third child (second birth) was born prematurely without hips fully formed and with severe jaundice. He has stomach problems to this day. My oldest daughter was also born prematurely and has very low blood pressure and serious immune problems and poor eyesight. Before she was born, I was told she would be mongoloid and encouraged to abort her. However, this turned out to be a wrong diagnosis. I do not regret giving birth to any of my children, despite the challenges caused by their illnesses. Every day, though, even after all these years, I still regret my abortion.

Contrary to the expressed presumption in *Roe v. Wade*, 410 U.S. 113 (1973) that abortion helps women, the *amici* have first-hand experience and knowledge of the fact that abortion poses significant and grave risks to the health of women far exceeding the health risks and other concerns posed by carrying their children to term.

SUMMARY OF THE ARGUMENT

Amici argue in support of the State of Arizona's petition for writ of certiorari. In the forty years since this Court decided *Roe* and *Doe*, new information has come to light which contradicts those cases' underlying factual assumptions which have never been reexamined by this Court. *First*, contrary to the expressed presumption in *Roe* that abortion helps women, the *amici* have first-hand experience that abortion poses significant and grave risks to the health of women far exceeding the health risks and other concerns posed by carrying their children to term. *Second*, *amici* know that while a prenatal diagnosis of disease or disability can be devastating, it is far healthier to bring that child to term rather than aborting it. Among the *amici* are post-abortive women who every day regret their abortions and every day are grateful they chose to carry to term their disabled child. Third, since *Roe* and *Doe* were decided, an infrastructure of care has developed, offering a variety of practical and compassionate alternatives to abortion for women that simply did not exist in 1973.

Amici Heartbeat International, Care Net, and NIFLA are among a network of thousands of pregnancy centers that provide much needed care and support to women facing unplanned pregnancies.

The Ninth Circuit relied exclusively upon this Court's justifiably criticized viability framework, first enunciated in *Roe* without an adequate factual record, to justify ignoring the uncontroverted medical facts that formed the foundation for the District Court's judgment below to uphold the constitutionality of Arizona's challenged regulation of abortion after the twentieth week of gestation. This viability framework should be revisited by this Court for many reasons, particularly for the sake of advancing the state's compelling interest in protecting women's health.

ARGUMENT

Confronted with documented evidence about the threat that abortion poses to the health of women and the pain that late term abortions cause to unborn children, the utter gruesomeness of late-term abortion (however performed), and the threats it poses to the integrity of the medical profession, the State of Arizona, through its duly constituted legislative authority, duly enacted a law (H.B. 2036) to protect the health of the mother and the dignity of the unborn child to be free from excruciating pain by allowing

abortions after twenty weeks only when necessary to avert death or serious health risks to the mother.

Amici argue that, in light of this evidence, a ban on abortions after twenty weeks is rational and reasonable. Because the physical risks of abortion increase significantly after twelve weeks and because the medical evidence demonstrates that a fetus that fully developed suffers great pain as a result of the abortion procedure, *amici* argue that Arizona's abortion restriction not only does not present an undue burden on women's access to abortion, but indeed, saves women from a great deal of negative physical, psychological, and emotional consequences.

I. This Court Should Reconsider the Viability Framework Established in *Roe* and *Doe*, As It Has No Logical Nexus to the Health and Safety of Women.

It is time for this Court to officially abandon the viability framework laid out in previous abortion cases. As this Court has previously noted,

> Viability is reached when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support. Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability – be it weeks of gestation or fetal

> weight or any other single factor – as the determinant of when the State has a compelling interest in the life or health of the fetus.

Colautti v. Franklin, 439 U.S. 379, 388-89 (1979). *Amici* know firsthand that the effects of abortion, particularly the emotional and psychological ones, exist regardless of whether the fetus was viable at the time of the abortion or not. Viability is a fluid construct which focuses solely on the fetus. Some fetuses might be viable at twenty-two weeks whereas others may not. The risks to women of having an abortion at twenty-two weeks, however, remain the same, regardless of whether the fetus was viable.

Examination of the Justices' notes and memoranda from the *Roe* and *Doe* decisions reveal that the decision to prohibit restrictions on abortion before viability was a completely arbitrary decision. But for some artful maneuvering on the part of pro-abortion justices and law clerks, *Roe v. Wade* could just as likely drawn the line at the end of the first trimester rather than viability. *See* CLARK D. FORSYTHE, ABUSE OF DISCRETION 133-40 (2013) (discussing Justice Blackmun's initial notes and Justice Powell's clerk's memo). Indeed,

> [s]everal countervailing considerations should have weighed against viability . . . including the simple fact that viability, and its implications, were never argued in the lower courts, never briefed in the Supreme Court, and never mentioned, even once, during the four

> hours of oral argument in December 1971 and October 1972.

Id. at 141.

The idea that the viability framework was put into place to protect the health and safety of women is erroneous.

> The seven medical sources that Blackmun relied upon did no more than suggest that abortion might be safe in the first trimester. The Justices had absolutely no data that suggested abortion was safe *after* the first trimester. In fact, extending the abortion "right" to viability contradicted the arguments of the abortion attorneys who said that the risk to women rose significantly after the first trimester. The little medical data that were contained in the briefs and the arguments contradicted any expansion beyond twelve weeks.

Id. at 144. As *amici* know, the negative physical, emotional, and psychological effects of abortion occur regardless of the fetus' viability outside the womb. Decades of experience counseling post-abortive women have proven that abortion has far more ramifications for the health and safety of women than the *Roe* and *Doe* Court ever dreamed possible. The scant medical evidence used as a foundation in *Roe* (and subsequently by the Ninth Circuit in its decision below) not only provides no justification for the viability framework but also demonstrates that this Court should

reconsider abortion restrictions, using all available medical evidence.

II. Abortion Causes Long-Lasting Physical, Emotional, and Psychological Harms to Women.

The Ninth Circuit's opinion in this case rested on the assumptions of fact laid out by this Court in *Roe* and *Doe*. Those cases were founded largely upon several essential factual assumptions: (1) that an unwanted pregnancy presents a short-term crisis; (2) that an abortion will provide a "health" benefit to the woman facing such a crisis by allowing her to return to a normal life; and (3) that abortion is a relatively rare and safe procedure without lasting harmful effects on the woman. With the dramatic increase of abortions since those 1973 decisions, the unexpected and tragic consequences of abortion are emerging and establish the need to reexamine these assumptions.

Consistent throughout this Court's abortion jurisprudence has been an underlying concern and regard for the health of women. The *Doe* and *Roe* Court assumed that a woman's decision to obtain an abortion would be a medical decision made by or in conjunction with the woman's physician and that such relationship of professional medical care would alleviate any health or safety issues. *See Roe*, 410 U.S. at 149-50; *Doe*, 410 U.S. at 190-91. The *Roe* Court acknowledged that the "compelling" State interest in

maternal health past the first trimester meant that the State could regulate abortion after that point "to the extent that the regulation reasonably relates to the preservation and protection of maternal health." 410 U.S. at 163; *see also id.*, at 149-50 ("[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient").

In 1973, neither this Court nor the women who have since undergone abortions could have known of the psychological and physiological harms that legalized abortion would cause such women. The presumption communicated by *Doe*, *Roe*, and their progeny is that "abortion is legal and therefore it must be safe as well." However, the experience of *amici*, in working with hundreds of thousands of women yearly since the *Doe* decision, parallels the extensive factual findings cited by the State in its Petition regarding the complications and ill-effects of abortion.[2] The harmful

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[2] The Petition for Certiorari states:

> The more recent advances in medical knowledge relied upon by the Arizona legislature here cut the other direction, however. We now know, as the Arizona legislature found, that the risk to maternal health increases significantly, even exponentially, with each passing week of pregnancy. Chapter 250, Laws of 2012 § 9(A)(2) (citing L. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103:4 OBS. & GYN. 729-737 (2004)); Priscilla K. Coleman et al., *Late-Term Elective Abortion and Susceptibility to Posttraumatic Stress Symptoms*, 2010 J.

(Continued on following page)

psychological effects include post-abortion traumatic stress disorder; suicide, suicidal attempts, and suicidal ideation requiring psychiatric care and/or the use of psychotropic drugs; sleep disturbance (including recurring nightmares); sexual dysfunction; increased smoking, alcohol and drug abuse; eating disorders; abuse and/or neglect of their living children; chronic relationship problems (including divorce); and repeat abortions.

OF PREGNANCY 1, 7 (citing S.V. GAUFBERG, ABORTION COMPLICATIONS (2008); Bartlett, *Risk Factors*). The incidence of major complications from an abortion is highest after twenty weeks. Chapter 250, Laws of 2012 § 9(A)(3) (citing J. Pregler & A. DeCherney, WOMEN'S HEALTH: PRINCIPLES AND CLINICAL PRACTICE 232 (2002)). The risk of death from an abortion is about thirty-five times greater at sixteen to twenty weeks than it is before eight weeks gestation, and nearly *one hundred times greater after twenty weeks*. Chapter 250, Laws of 2012 § 9(A)(4) (citing Bartlett, *Risk Factors*). Risks to the woman's mental health also increases significantly with later-term abortions. Chapter 250, Laws of 2012 § 9(A)(1) (citing, *e.g.*, P. K. Coleman, *Abortion and Mental Health: Quantitative Syntheses and Analysis of Research Published 1995-2009*, 199 BRIT. J. OF PSYCHIATRY 180-86 (2011)).

These findings are well supported by peer-reviewed scientific studies and the legislative record here. *See*, *e.g.*, SER at 0094-96; Coleman, *Late-Term Elective Abortion*, at 7 (finding that women who underwent later abortions (thirteen weeks and beyond) reported "more disturbing dreams, more frequent reliving of the abortion, and more trouble falling asleep").

Brief for Petitioner at 23-24, *Horne et al. v. Isaacson et al.*, No. 13-402 (Sept. 27, 2013).

The viability line established by *Roe* and *Casey* do not afford the legislature the same flexibility as *Gonzales v. Carhart*, 550 U.S. 124 (2007) to take into account other considerations about regulating abortion such as increased risk to maternal health. As the State's petition for certiorari points out,

> the significance of *Gonzales* is that factors other than viability matter to this Court's abortion jurisprudence. As with the congressional statute upheld in *Gonzales*, Arizona has not banned all previability abortions. It continues to allow them prior to twenty weeks gestational age when, as even abortion proponents acknowledge, the overwhelmingly large majority of second trimester abortions are performed.

Brief for Petitioner at 13, *Horne et al. v. Isaacson et al.*, No. 13-402 (Sept. 27, 2013).

Now, however, "the one fact that seems nearly axiomatic in psychological literature on abortion is that the later in pregnancy one aborts, the greater the woman's risk for negative emotional sequelae." Brian D. Wassom, *The Exception That Swallowed the Rule?:* Women's Professional Corp. v. Voinovich *and the Mental Health Exception to Post-Viability Abortion Bans*, 49 CASE W. RES. L. REV. 799, 853 (1999). Since the founding of Heartbeat International in 1971, its affiliates have also worked with many thousands of women who suffer emotionally from having undergone abortions. Although the term "post abortion syndrome" had not yet been coined in the

early 1970s, the Heartbeat International affiliate pregnancy centers quickly began to see suffering women who had one or more abortions. In consulting with professionals to develop programs to help these women, the centers were advised on the one hand that abortion did not have any damaging effects on women. Yet, on the other hand, the centers were cautioned that volunteers ("nonprofessionals") should not get involved for fear that post-abortive women might become suicidal. This advice only confirmed what the centers were experiencing – that for a significant number of women, the choice to abort their unborn children left them deeply psychologically harmed. *See* Peggy Hartshorn, *Pregnancy Help Centers: Prevention, Crisis Intervention, Healing: Putting It All Together*, published in BACK TO THE DRAWING BOARD: THE FUTURE OF THE PRO-LIFE MOVEMENT (Teresa R. Wagner ed., 2003).[3]

One peer-reviewed study led by a pro-abortion researcher demonstrates that the risk of suicide was

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[3] Indeed, numerous peer-reviewed studies have found an increased risk of mental trauma after abortion. *See*, *e.g.*, P.K. Coleman, *Abortion and Mental Health: Quantitative Syntheses and Analysis of Research Published 1995-2009*, 199 BRIT. J. OF PSYCHIATRY 180 (2011); D.M. Fergusson et al., *Does Abortion Reduce the Mental Health Risks of Unwanted or Unintended Pregnancy? A Re-Appraisal of the Evidence*, 47 AUST. & N.Z. J. PSYCH. 819-27 (2013). *See also* J.M. Thorp, Jr., et al., *Long Term Physical and Psychological Health Consequences of Induced Abortion: A Review of the Evidence*, 58 OBS. AND GYN. SURVEY 67 (2003).

three times greater for women who aborted than for women who carried their pregnancies to term. D.M. Fergusson et al., *Abortion in Young Women and Subsequent Mental Health*, 47 J. CHILD PSYCHOLOGY & PSYCHIATRY 16 (2006). Another peer-reviewed study demonstrates that women whose first pregnancies ended in abortion were sixty-five percent more likely to score in the "high risk" range for clinical depression than women whose first pregnancies resulted in a birth – even after controlling for age, race, marital status, divorce history, education, income, and pre-pregnancy psychological state. J.R. Cougle et al., *Depression Associated with Abortion and Childbirth: A Long-Term Analysis of the NLSY Cohort*, 9 MED. SCI. MONITOR 157 (2003).

Abortion causes severe and real mental health effects in women. Contrastingly,

> Dr. Fred Mecklenburg, a member of the American Association of Planned Parenthood physicians stated: "There are no known psychiatric diseases which can be cured by abortion. In addition there are none that can be predictably improved by abortion. . . . (Instead), it may leave unresolved conflicts coupled with guilt and added depression which may be more harmful than the continuation of the pregnancy." Therefore, even for the women whose mental or emotional health may suffer by giving birth, their mental

> health will suffer by knowingly aborting their viable child.

Michael J. Tierney, *Post-Viability Abortion Bans and the Limits of the Health Exception*, 80 NOTRE DAME L. REV. 465, 473-74 (2004) (citing Henry P. David et al., *Postpartum and Postabortion Psychotic Reactions*, 13 FAM. PLAN. PERSP. 88 (1981)). *Amici* Heartbeat International, Care Net, and NIFLA assist women every day who are suffering from the effects of abortion. *Amici* Slotkin, Geraci, and Bridges have themselves experienced these negative consequences in their own lives.

III. A Pre-Natal Diagnosis of Disease or Disability Does Not Mean Abortion Is The Best or Only Option.

A diagnosis of a fetal abnormality or disease does not mean that abortion is the only option to preserve the mother's health. "Indeed, although the Court has described the health exception as a core principle of *Roe v. Wade*, 'the evidence . . . is undisputed that except for the extremely rare (one in a million) case of partial hydatidiform mole, there are no fetal abnormalities which cause more risk to the mother by continuing the pregnancy to term than aborting the fetus.'" Brian D. Wassom, *The Exception That Swallowed the Rule?:* Women's Medical Professional Corp. v. Voinovich *and the Mental Health Exception to Post-Viability Abortion Bans*, 49 CASE W. RES. L. REV. 799, 840 (1999) (citing Brief for Defendants-Appellants at 13,

Women's Med. Prof'l Corp. v. Voinovich, 130 F.3d 187 (6th Cir. 1997)).

Many people argue that women should be able to access late-term abortions so as to alleviate distress that results from an unfavorable fetal diagnosis. However, as is frequently pointed out, these, very often, are wanted children, and thus it must be determined whether an abortion will help remove the source of the distress.

> In addition to being seen as a reason for abortion, the parents' distress over a fetal defect diagnosis is largely inevitable whether the child is born or aborted. To be sure, "(t)here are few if any more ego-involving phenomena than being part of producing a child." When that child is wanted, it becomes a focal point for a couple's hopes and dreams, catalyzing their inherent desire for immortality, personal pride and appreciation for each other. When the fetus turns out to be severely malformed or on the brink of inevitable death, the plunge from this "special emotional high . . . to an emotional low is immediate and devastating." Aborting the fetus cannot alleviate the psychological pain. Indeed, some doctors have said that they will refuse to abort a defective but viable fetus solely on the grounds that its defects cause distress to the parents.

Id. at 841-42 (citing M. Neil MacIntyre, *The Impact of an Abnormal Fetus or Child on the Choice for Prenatal Diagnosis and Selective Abortion*, *in* ABORTION,

MEDICINE & THE LAW 536 (J. Douglas Buster & David F. Walbert eds., 1992).

Abortions for fetal defects have been justified on other grounds beyond emotional trauma to women, such as the belief the deformed child will never be capable of contributing to society, and the pain and suffering the baby will endure during its shortened life span outweighs the state interest in preserving its life. However, this is akin to the arguments rejected by this Court when it held that there is no constitutionally protected right to physician-assisted suicide. *See Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).

Additionally, resources exist now to support the parents of disabled babies that did not exist at the time of *Roe* and *Doe*. Along with hundreds of online blogs and support groups[4] for parents whose baby is

[4] *See*, *e.g.*, Anencephaly Blessings from Above – ABFA, http://groups.yahoo.com/neo/groups/anencephalyblessingsfromabove/info (last accessed Oct. 23, 2013) (a support group for parents whose children have been diagnosed with anencephaly); Be Not Afraid, www.benotafraid.net (last accessed Oct. 23, 2013) (a private non-profit corporation whose mission is to provide comprehensive, practical, and peer-based support to parents experiencing a prenatal diagnosis and carrying to term); Carrying to Term, http://www.janelebak.com/ctt/index.html (last accessed Oct. 23, 2013) (an online resource for parents who have received a "devastating prenatal diagnosis"); Living with Trisomy 12, www.livingwithtri13.org (last accessed Oct. 23, 2013) (an online support center for parents whose children have been diagnosed with Trisomy 13 or 18); Miss Foundation, http://www.missfoundation.org/ (last accessed Oct. 23, 2013) (a volunteer based organization committed

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diagnosed with a disability or fatal disease, there is a growing perinatal hospice movement across the country, which supports parents of stillborn babies or children expected to die soon after birth. It offers nurses, chaplains, neonatologists, social workers, bereavement counselors and even a photographer to capture brief moments. *See* Julia Duin, *Choosing Not to Abort Babies with Disabilities*, WASH. TIMES (May 10, 2009), http://www.washingtontimes.com/news/2009/may/10/mothers-choosing-not-abort-children-disabilities/#ixzz2iTvh59BN. Parents of children with disabilities, including *amici*, state over and over that the pressure from the medical community to abort is severe. In response, these individuals are speaking out, pushing back on this pressure, by explaining that they either regret their decision to abort their children or celebrate their decision to give birth.

IV. There Are Pregnancy Centers Available to Women Now, Which Is a Changed Circumstance from 1973, Warranting a Re-Evaluation of This Court's Abortion Jurisprudence.

In 1973, neither this Court nor the women who have undergone abortions since then could have known of the psychological and physiological harm legalized abortion would cause them to suffer. The presumption communicated by *Roe* and its progeny is

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to providing crisis and long term support to families after the death of a baby or child).

that "abortion is legal, and therefore it must be safe as well." However, the experience of *amici*, in working with thousands of women yearly since the *Roe* decision, and in their own personal experiences, parallel the harmful psychological effects of abortion documented in the medical literature. See *supra* Part II.

There are a myriad of practical and compassionate alternatives to abortion that simply did not exist in 1973. An extensive infrastructure of care is now available to women in difficult pregnancies throughout Arizona and the United States. This care network allows women to avoid the grave emotional and financial hardships that some women once faced in giving birth, while at the same time allowing them to avoid the emotional harms of an abortion.

Amici Heartbeat International, Care Net, and NIFLA are three such care organizations. Currently, there are over 4,000 pregnancy centers across the nation. Naral: Pro-Choice America, *Crisis Pregnancy Centers*, http://www.prochoiceamerica.org/what-is-choice/abortion/abortion-crisis-pregnancy-centers.html (last accessed Oct. 25, 2013). As of 2010, 1,969 of those pregnancy centers were associated with *amici*. FAMILY RESEARCH COUNCIL, A PASSION TO SERVE (2010), *available at* http://downloads.frc.org/EF/EF12A47.pdf. Today, most pregnancy centers offer to women facing an undesired pregnancy a wide range of services completely free of charge. Typical services include pregnancy tests, crisis intervention for deciding among alternatives, peer or professional counseling, support groups, adoption support, parenting classes, shelter,

material aid, community referrals, and community education programs. Many also offer professional services needed for adoption, medical care, childbirth classes, legal assistance, financial assistance, housing, and similar services. Some affiliated centers now offer a wide range of medical and health services including sexually transmitted disease testing, pap smears, prenatal care, abuse recovery, post-abortion programs, and ultrasound technology.

CONCLUSION

For all the aforementioned reasons, *amici* urge this Court to grant the petition for writ of certiorari.

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