No. 19-1392

In the
SUPREME COURT OF THE UNITED STATES

THOMAS E. DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, et al.,
Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, et al.,
Respondents.

On Writ of Certiorari to the United States
Court of Appeals for the Fifth Circuit

BRIEF OF THE PENNSYLVANIA PRO-LIFE FEDERATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICUS[1]

The Pennsylvania Pro-Life Federation is a state-wide nonprofit prolife organization that is committed to promoting the dignity and value of human life from conception to natural death and to restoring legal protection for unborn children. Through legislation, political action, education and other legal means, including submitting *amicus* briefs in appropriate cases, the Federation proclaims the truth about abortion.

The *Amicus* seeks an overturn of *Roe v. Wade,* 410 U.S. 113 (1973) so that States may once again provide protection for vulnerable unborn human life.

SUMMARY OF THE ARGUMENT

In modern obstetrical practice, the physician treats two patients—the mother and her unborn baby—and strives to maximize and protect the health and well-being of both. Good medical practice requires this. It is rare that the interests of one of these patients, from a medical standpoint, conflicts with the other. Even in those instances where the

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[1] No counsel for any party authored this brief in whole or in part, and no party, person or entity other than the *amici*, their members and counsel have made any monetary contribution intended to fund the preparation or submission of this brief. Counsel for all parties have filed blanket consents.

mother's condition may place her physical health at greater risk, the pregnancy can generally be managed satisfactorily with a successful outcome for both the mother and baby. In those very rare circumstances when this cannot be done, laws like Mississippi's allow pregnancy terminations to take place in order to protect the mother.

Claims that abortion must be allowed on demand because abortion is statistically safer than childbirth should be rejected. The relative risk of death is negligible in both abortion and childbirth. Moreover, although abortion is a medical *procedure*, it is rarely a medical *decision*. In the vast majority of cases, abortions are sought for socio-economic reasons; not for medical reasons. Therefore, discussing maternal mortality in relation to elective abortion simply is not relevant in any practical or meaningful sense.

Contrary to what some suggest, *Roe* was not a significant cause of reduced maternal mortality and morbidity from abortion. Such reductions correspond more closely with medical advances such as the development of effective antibiotics to manage infections and advances in medical technology allowing for blood transfusions and better administration of anesthesia.

These medical advances were unrelated to the legalization of abortion, having occurred well before *Roe* was handed down. So, overturning *Roe* will not

affect those advances, nor will it preclude the application of future medical advances in the treatment of pregnant women and an overall reduction in maternal mortality from all causes.

Roe was a radical decision that overrode the legislative judgments of all 50 states. It was based on a flawed understanding of the humanity of the unborn child and views of obstetrical practice that are outdated because they fail to treat unborn children as second patients in pregnancy. Additionally, it may have been based on false claims regarding the number of women supposedly dying from illegal abortion. It should be overturned.

ARGUMENT

Well before *Roe* was decided, the abortion controversy was infused with many false claims and much misinformation. It is likely that these politically motivated claims had some influence on the Court in rendering its decision in *Roe*.

The impression frequently was given (and still is) that childbirth is extremely risky and that women need abortion because it is much safer than childbirth. Likewise, based on made up and grossly inflated numbers of maternal deaths prior to *Roe*, it has been erroneously suggested that *Roe* was the reason for a dramatic reduction in maternal mortality from abortion, and that its overturn would return the country to a time when "thousands" of women died from "back-alley" abortions. None of this is true.

I. THERE ARE TWO PATIENTS THAT MUST BE CARED FOR IN MODERN OBSTETRICAL PRACTICE, AND IT IS RARE THAT AN ABORTION WOULD BE NEEDED TO MANAGE A PREGNANCY SUCCESSFULLY.

1. Basic medical texts, for decades, have made it clear that there are two patients that must be cared for in modern obstetrical practice. For example, in explaining the need for significant revisions to the 1980 edition of *Williams Obstetrics,* the authors stated:

> Happily, we have entered an era in which the fetus can be rightfully considered and treated as our *second patient*. . . Fetal diagnosis and therapy have now emerged as legitimate tools the obstetrician must possess. Moreover, the number of tools the obstetrician can employ to address the needs of the fetus increases each year.

Jack A. Pritchard & Paul C. MacDonald, *Williams Obstetrics,* vii (16th Ed. 1980) (emphasis supplied). A later edition made it even more obvious that obstetricians must be cognizant of the unborn baby as a separate entity when managing a pregnancy. It stated:

> Obstetrics is an unusual specialty of medicine. Practitioners of this art and science must be concerned simultaneously with the lives and

> well-being of two persons; indeed, the lives of two who are interwoven.

F. Gary Cunningham, et al., *Williams Obstetrics*, vii (18th ed. 1989). In a chapter entitled "Techniques to Evaluate Fetal Health," it was stated:

> Until relatively recently, the intrauterine sanctuary of the fetus was held to be inviolate. The mother was the patient to be cared for; the fetus was but another albeit transient, maternal organ. . . Indeed, the fetus is no longer regarded as a maternal appendage. . . . Instead, the fetus has achieved the status of the second patient, a patient who usually faces much greater risks of serious morbidity and mortality than does the mother.
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> The many advances in diagnosis and treatment that now clearly establish the fetus as a patient have also contributed remarkably to legal considerations involving the fetus. Fetal legal rights are emerging; for example, in some courts, the fetus has been allowed to file suit.

Id at 277.

Obstetric ultrasound technology was in its infancy at the time of *Roe,* and was not widely used in the United States until well into the 1970's. Malcolm Nicolson & John E.E. Fleming, *Imaging and Imagining the Fetus* 233 (2013). It has since given

rise to whole new fields of medicine and top pediatric hospitals across the country regularly perform surgery on this second patient.[2]

Abortion proponents disregard these basic facts when they ignore the existence of the second patient within the womb and suggest that unborn children are just appendages of the mother to be discarded upon her request. In so doing, they suggest a return to an outmoded and discredited approach to pregnancy and obstetrical practice.

2. It is rare that the interests of one of these patients, from a medical standpoint, conflicts with the other. And, on those rare occasions when it does, the pregnancy can generally be successfully managed. So, medically speaking, abortion is almost never needed to manage a pregnancy. Honest abortion proponents long ago admitted to the overall safety of pregnancy and the lack of a need for abortion for medical reasons.

In 1956, when maternal mortality rates were much higher than today,[3] the namesake of Planned

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[2] See e.g., the website of Children's Hospital of Philadelphia: "Today, fetal therapy is recognized as one of the most promising fields in pediatric medicine, and prenatal surgery is becoming an option for a growing number of babies with birth defects." *Fetal Surgery*, Children's Hospital of Philadelphia., https://www.chop.edu/treatments/fetal-surgery (last visited July 26, 2021).

[3] The maternal death rate in 1946 was 11.6/10,000 (or 116/100,000) and, by 1956, had declined to 4.0/10,000 (or

Parenthood's Guttmacher Institute highlighted the overall safety of pregnancy and childbirth. He stated that in more than 30 years of obstetrical practice, during which he had delivered about 6,000 babies, he had seen only 3 patients die—two from cancer and one from a blood clot. He stated that "[p]regnancy and labor have little to do with any of the three." A.F. Guttmacher, *Pregnancy and Birth* 271 (1956).

Likewise, in a paper published in 1960, Dr. Mary Calderone, then Medical Director of Planned Parenthood Federation of America, admitted: "medically speaking, that is, from the point of view of diseases of the various systems, cardiac, genitourinary, and so on, it is hardly ever necessary today to consider the life a mother as threatened by pregnancy." Mary S. Calderone, *Illegal Abortion as a Public Health Problem*, 50 Am. J. Pub. Health 948 (1960) ("*Illegal Abortion*").

Obstetrics texts from the seventies also confirm the safety of pregnancy and childbirth and the ability to manage it successfully without abortion. One such textbook states: "abortion for purely medical reasons, i.e., vascular, renal or heart disease and so forth is rarely indicated in current medical practice." Duncan E. Reid, et al., *Principles in*

40/100,000). Milton C. Klein & Jacob Clahr, *Factors in the Decline of Maternal Mortality,* 168 JAMA 237 (1958) ("*Factors*").

Management of Human Reproduction 274 (1972). *See also*, J.P. Greenhill & Emanuel A. Friedman, *Biological Principles in Modern Practice of Obstetrics* 385 (1974) (noting that the number of induced abortions "on demand" had been rising astronomically, "while medical reasons appear to be almost vanishing" due to improved medical therapies).

3. In those rare instances where the mother's life is at risk, state laws allow an abortion to take place to preserve the mother's life. *See*, Miss. Code Ann. §41-41-191; Appendix at 65a (allowing abortion when "necessary to preserve the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury, including a life endangering physical condition arising from the pregnancy itself, or when the continuation of the pregnancy will create a serious risk of substantial and irreversible impairment of a major bodily function").

II. CLAIMS THAT ELECTIVE ABORTIONS MUST BE ALLOWED BECAUSE ABORTION IS STATISTICALLY SAFER THAN CHILDBIRTH SHOULD BE REJECTED.

Despite the above facts regarding the safety of childbirth and the lack of a medical indication for induced abortion, abortion proponents often claim

that the risk of death due to abortion is less than the risk of death in childbirth. Because of this, they argue that abortions are "medically necessary." And they then assert that abortion must be allowed on demand because abortion is statistically "safer" than childbirth. A common claim is that abortion is 14 times safer than childbirth. [4]

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[4] Elizabeth G. Raymond and David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States,* 119 Obstet. Gynecol. 215 (2012). This number is based on data from 1998-2005 using a "pregnancy-associated" mortality rate of 8.8 deaths per 100,000 live births, and a mortality rate of .6 deaths per 100,000 abortions.

A more recent maternal mortality rate mentioned for 2019 is about 20/100,000 live births. Donna L. Hoyert, *Maternal Mortality Rates in the United States, 2019, NCHS Health E-Stats*. 2021. DOI: https://doi.org/10.15620/cdc:103855. Given that the maternal mortality rate was 7.2/100,000 in 1987, (see data table PMSS) one can understand that there is a fair amount of ongoing dispute over the accuracy of the claims regarding "pregnancy-associated" death rates and abortion death rates. Some scholarly articles suggest that the reported pregnancy/childbirth mortality rate is inflated while the reported rate of abortion deaths is much lower than it actually is due to significant underreporting of abortion deaths. See e.g., Brian Clowes, *The Role of Maternal Deaths in the Abortion Debate*, 13 St. Louis Univ. Public Law Rev. 327, 349-360 (1993) ("*Role of Maternal Deaths*"); Byron Calhoun, *The Maternal Mortality Myth in the Context of Legalized Abortion,* 80 Linacre Q. 264 (2013); Patrick J. Marmion & Ingrid Skop, *Induced Abortion the Increased Risk of Maternal Mortality,* 87 Linacre Q. 302 (2020).

There are many complicating factors causing concern and some confusion regarding the accuracy of the data. 1) The CDC Pregnancy Mortality Surveillance System ("PMSS") changed the reporting criteria in 1987. Prior to that time,

A. The Risk of Dying from Abortion or Childbirth Is Negligible.

Claiming that abortion is statistically safer than childbirth makes a point. But, it is a point that has no practical significance. Assuming, arguendo, that the data upon which these claims rely is accurate, the risk of dying from *either* abortion *or* childbirth is still negligible. For example, comparing the worst-case scenario for childbirth (about 20/100,0000) and the best-case scenario for abortion (about 1/100,000), the risk of dying in childbirth is (.00020 or (.02%)) and the risk of dying in abortion is

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maternal deaths only included deaths that occurred during pregnancy or within 42 days of birth. (This was similar to the reporting method for the World Health Organization (WHO)). The new reporting criteria now include deaths that occur during pregnancy or *within 1 year of birth.* Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, www.cdc.gov/reproductivehealthmortality/pregnancy-mortality-surveillance-system.htm. "PMSS") (The notes from the PMSS state: "Whether the actual risk of a woman dying from pregnancy-related causes has increased is unclear.") 2) The "pregnancy-related" deaths include deaths from abortion. So, those deaths get counted twice and inflate the overall "pregnancy-related" mortality rate. 3) This is not to say that there isn't any increase in maternal mortality happening. Given rising obesity with its concomitant morbidities, increased use of C-sections for non-emergency situations, and an increased number of women trying to conceive later in life, it is very possible that there are more women who are placing themselves at higher risk of death, but that does not mean that they are seeking an abortion or that an abortion would not be available to them if necessary to save their lives.

(.00001 or (.001%). In other words, your chance of surviving childbirth is 99.99980% and your chance of surviving abortion is 99.99999%. In either case, it is just the difference of a fraction of a fraction of 1 percent and is akin to comparing a 0% risk of dying with a 0% risk of dying.

B. Although Abortion Is a Medical Procedure, It Is Rarely a Medical Decision.

Any increased statistical risk, then, is largely theoretical and, in any event, is irrelevant to a discussion of elective abortion. It is true that abortion is a medical *procedure*. Equally true, however, is the fact that abortion is rarely a medical *decision*.

Pennsylvania has a comprehensive reporting requirement regarding the existence of pre-existing medical conditions that would complicate a pregnancy. For the last reporting year, there were 161 reports of women with pre-existing medical conditions out of a total of about 31,000 abortions performed. Abortion Statistics (2019), *"Pre-existing Medical Conditions Which Would Complicate a Pregnancy,"* Table 15, at 12, Pennsylvania Department of Health (Dec. 2020). That is 161/31,000, or .005 (.5%). So only one half of one percent of women who sought abortions in Pennsylvania had an underlying medical condition that would complicate the pregnancy.

Although a limited number of studies have been done to determine the reasons that women have abortions, the data has been relatively consistent over the years and shows that the vast majority of abortions are performed for socio-economic reasons; not medical reasons. The top three reasons usually mentioned are: concern about how a baby would change their life; inability to afford a child; and single parent/relationship problems. See e.g., Aida Torres and Jacqueline Darroch Forrest, *Why Do Women Have Abortions?,* 20 Fam. Planning Perspectives 169 (1988) ("Torres"); M. Antonia Biggs, *et al.*, *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC Women's Health 29 (2013) ("Biggs").

The Torres study reported that only 7% (133 women), based on a self-administered questionnaire, indicated that their own health had *contributed* to their decision to have an abortion. 20 Fam. Planning Perspectives at 170, Table 1. Of these 133 women, 67 women (53%) said that they were told by their doctors that "their condition would be made worse by being pregnant." *Id.* at 172. Thus, at most, about 3.5% of the women surveyed suggested that they had been advised to get an abortion due to health reasons. Only 3% listed a health problem as their most important reason for seeking abortion. *Id.* at 170 Table 1. The Biggs study has similar results.[5]

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[5] The Biggs study was based on data from the Turnaway Study. Although the study states that 12% of women mentioned health

C. Discussing Maternal Mortality Rates in Relation to Elective Abortion Has No Practical Relevance.

Somewhere between 93% and 99.5% of abortions are performed for reasons unrelated to health. So, the minuscule difference between the risk of dying from abortion or childbirth rarely, if ever, registers on the minds of women seeking elective abortions.

Since very few women decide to have abortions because they wish to avoid risks to their physical health, it is disingenuous to suggest that abortion must be kept available on demand because it is statistically "safer" for women. This simply is not a consideration that informs their decisions. Nor should it be, given the exceedingly low rate of mortality from either course of action.

Moreover, for those few whose lives are at risk, current laws in Mississippi and every other state allow abortions when it is necessary to prevent the mother's death. Thus, the relative risks of *death* from abortion and childbirth should be disregarded in any serious discussion about the "need" for abortion on

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reasons, only 6% mentioned "concern for her own health." Biggs, at 7. This study, unlike Torres, does not indicate whether any of these women had been told by a doctor that they had a physical health condition which could be made worse by pregnancy.

demand. Likewise, the negligible difference in the safety of abortion and childbirth cannot support a claim that abortion is always "medically necessary" because it is statistically safer.

III. AN OVERTURN OF *ROE* WOULD NOT LIKELY INCREASE MATERNAL MORTALITY BECAUSE *ROE* WAS NOT RESPONSIBLE FOR THE REDUCTION IN MATERNAL MORTALITY FROM ABORTION.

Abortion proponents frequently make grossly erroneous assertions with respect to the number of women supposedly dying from back-alley and self-induced abortions prior to *Roe*. For example, in briefs submitted to this Court in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), Petitioners claimed that in the 1950's and 1960's as many as "5,000 to 10,000 women died each year" from "back-alley and self-induced abortions." Pet. Br. at 32. They then noted that the maternal mortality rate was substantially lower than it was long ago. *Id.* And, from these "facts" they argued that *Roe* and legalized abortion on demand were the cause of this dramatic reduction in maternal mortality. *Id.*

In *Roe*, the Court referred to the "prevalence of high mortality rates at illegal 'abortion mills.'" 410 U.S. at 150. Thus, the Court may have been influenced by similar outlandish claims regarding the number of deaths that allegedly were occurring.

This Court should not be misled by any similar erroneous claims that might be repeated here.

A. Women Were Not Dying in Large Numbers from Illegal Abortion Prior To *Roe*.

In an article published in 1960, Planned Parenthood's Medical Director stated: "In 1957, there were only 260 deaths in the whole country attributed to abortions of any kind." Calderone, *Illegal Abortion,* 50 Am. J. Pub. Health at 948. Dr. Calderone noted that the number included "therapeutic abortions" and "so-called illegal abortions." *Id.*

Other supporters of legalized abortion also refused to give any credence to the outrageous claims of thousands of women dying from illegal abortions prior to *Roe*. Dr. Christopher Tietze, a medical statistician for the Population Council, was quoted in an article in the *New York Times* as stating that only 247 deaths from illegal abortions were reported in the United States in 1964 and calling the figures being bandied about "unmitigated nonsense." Fred P. Graham, "Fetus Defects Pose Abortion Dilemma," *The New York Times*, (Sept. 7, 1967), at 38. *See also*, B.N. Nathanson, *Aborting America* 193 (1979) (admitting that as co-founder of the National Abortion Rights Action League he and his organization knowingly falsified the number of "back-alley" abortion deaths they were claiming had occurred.)

Dr. Calderone also noted that there had been a dramatic decrease in abortion deaths in the past 30 years. "In New York City in 1921, there were 144 abortion deaths, in 1951 there were only 15." *Id. See*

also, Irvine Loudon, *Maternal Mortality in the Past and its Relevance to Developing Countries Today*, 72 Am.J. of Clin. Nutr., 241S, 243S (2000) (Describing the "sudden decline in maternal mortality rates in the 1930's," and noting that the greatest decreases in maternal mortality were due to the introduction of antibiotics, the use of blood transfusions, better medical training, and better anesthesia. The article also noted: "The decline in maternal mortality occurred at very much the same rate throughout the developed world.")

Obviously, these dramatic reductions in maternal mortality which *preceded Roe* and legalized abortion on demand by several decades could not have been due to *Roe*.

B. Reduction in Maternal Mortality Was Primarily Due to the Advent of Antibiotics and Blood Transfusions And Improvement in Administration Of Anesthesia.

Many of the major risks for childbirth-associated maternal mortality are the same as those for abortion-related maternal mortality. These include: infection, hemorrhage, and complications from anesthesia. Christopher Tietze & John Bongaarts, *The Demographic Effect of Induced Abortion*, 31 Obstet.& Gynecol. Survey 699, 708 (1976) ("Two of the major fatal complications of induced abortions are infection and hemorrhage

which are also important causes of non-abortion maternal mortality.")

As noted in *Williams Obstetrics*, maternal deaths from all causes have decreased markedly, in large part due to basic advances in medicine.

> Obviously there has been a general improvement in medical practice. The wide-spread use of blood transfusions and antibiotics and the maintenance of fluid, electrolyte, and acid-base balance in the serious complications of pregnancy and labor have materially changed obstetric practices. Equally important is the development of wide-spread obstetric training and education programs which have provided more and better qualified specialists.

F. Gary Cunningham, et al., *Williams Obstetrics*, 3 (18th ed. 1989).

These medical advances were unrelated to the legalization of abortion, and many occurred well before *Roe* was handed down. And they apply to all pregnancy related complications—whether or not related to abortion. So, overturning *Roe* will not affect those past advances that were responsible for decreasing maternal mortality, nor will it preclude the application of those and future medical advances in the treatment of all pregnant women, including those with complications from abortion.

CONCLUSION

Roe was a radical decision that overrode the considered judgments of the legislatures in all 50 states. It was based on outmoded views of the humanity of the unborn child, outdated views of obstetrical practice (which failed to treat the baby within the womb as a second patient) and, arguably, on false claims regarding the number of women supposedly dying from illegal abortion. It should be overturned.

Respectfully submitted,

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