Nos. 20-1784, 20-1824, & 20-1970

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *et al.*,
Plaintiffs-Appellees,

v.

UNITED STATES FOOD AND DRUG ADMINISTRATION, *et al.*,
Defendants-Appellants.

On Appeal from the United States District Court for the District of Maryland

BRIEF *AMICI CURIAE* OF 102 MEMBERS OF CONGRESS IN SUPPORT OF DEFENDANT-APPELLANT FDA AND REVERSAL OF THE LOWER COURT

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INTEREST OF *AMICI CURIAE*

Amici are 102 Members of Congress, 24 Senators and 78 Members of the House of Representatives (herein "Members"), representing 34 States. A complete list of *Amici* Members is found in the Appendix to this brief.

Amici Members have a special interest in the correct interpretation, application, and enforcement of health and safety standards for elective abortion enacted by the People of the States they represent. *Amici* strongly urge the Court to reverse the District Court's decision and to provide clarity regarding the bounds of the Government's ability to safeguard the lives and health of their citizens.

SUMMARY OF ARGUMENT[1]

Amici curiae Members of Congress are charged with oversight of the U.S. Food and Drug Administration (FDA) under Art. I, Sec. 8 of the Constitution to ensure that this federal agency discharges its statutory duty to approve the marketing of drugs and devices only upon a demonstration that such drugs and devices are "safe and effective" for use by the American public. Twenty years ago, the FDA approved the marketing of the chemical abortion drug RU-486 (known as mifepristone)

[1] Amici have authority to file this brief under Fed. R. App. P. 29 because all parties have consented to its filing. A party's counsel has not authored the brief in whole or in part, nor contributed money that was intended to fund the preparation or submission of the brief. No person outside of *Amici* or their Counsel has contributed money intended to fund preparation of the brief.

subject to and conditional on a set of safeguards surrounding its use to protect women from known risks. *Mifeprex (Mifepristone) Information*, U.S. Food and Drug Admin. (Feb. 5, 2018), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information. The lower court substituted its own judgment, based on purported medical evidence presented by the plaintiffs, for the considered scientific judgment of the agency and imposed a nationwide injunction against the enforcement of certain Risk Evaluation and Mitigation Strategies (REMS). The court's *Amici* urge that this decision was contrary to the Supreme Court's recent direction to overturn an abortion regulation only if it operates as a substantial obstacle for a large fraction of women seeking abortion. Further, the court's order was contrary to the well-established safety concerns the FDA relied upon in adopting the REMS, and failed to take into account the important public interest in ensuring that women are not subject to intimidation and coercion in seeking abortion. For these reasons, *Amici* urge the court to reverse the decision of the district court.

ARGUMENT

I. THE DISTRICT COURT MISAPPLIED *CASEY*'S UNDUE BURDEN STANDARD.

By applying the cost-benefit test from *Whole Woman's Health v. Hellerstedt*, the district court erroneously overlooked the holding of *June Medical Services v. Russo*. As discussed below, *June Medical* reestablished the undue burden standard

of *Planned Parenthood v. Casey* as the proper standard for assessing the constitutionality of an abortion restriction. Under *Casey*, "a regulation that has 'the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus' is an 'undue burden' that is an unconstitutional infringement on a woman's fundamental right of privacy." *Am. Coll. of Obstetricians and Gynecologists v. U.S. Food and Drug Admin.* (hereinafter "ACOG"), No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017 at *52–53 (D. Md. July 13, 2020) (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992)). *Whole Woman's Health* subsequently suggested that the *Casey* standard includes a cost-benefit analysis which would require that "'courts consider the burdens a law imposes on abortion access together with the benefits those laws confer.'" *Id*. at *54 (citing *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016)).

Earlier this year, the Supreme Court again addressed *Casey*'s undue burden standard. In a splintered 4-1-4 decision in *June Medical Services*, the Supreme Court held unconstitutional a Louisiana admitting privileges regulation ("Act 620"). *June Med. Servs. L. L. C. v. Russo*, 140 S. Ct. 2103, 2113 (2020) (plurality). Notably, the four-Justice plurality first analyzed Act 620 under a substantial obstacle test, finding that Act 620 placed a substantial obstacle in the path of women seeking abortion in Louisiana. *Id*. at 2122–2130. The plurality then turned to a benefits-burdens analysis

of Act 620, finding that "the law offers no significant health-related benefits." *Id*. at 2130–2132. In turn, the plurality held Act 620 was an undue burden on a woman's constitutional right to an abortion. *Id*. at 2132.

In his concurrence, Chief Justice Roberts provided the necessary fifth vote to affirm the Court's judgment and hold Act 620 unconstitutional. *Id*. at 2134 (Roberts, C.J., concurring in the judgment). Notably, Chief Justice Roberts agreed with the plurality's holding that Act 620 was a substantial obstacle, relying on the fact that the language of Act 620 was virtually identical to the statute struck down in *Hellerstedt* and the principal of stare decisis. *Id*. However, the Chief Justice expressly rejected the plurality's reliance on a cost-benefit analysis. *Id*. at 2135–2139. According to the Chief Justice, a cost-benefit analysis requires Justices to act as legislators with an "'unanalyzed exercise of judicial will' in the guise of a 'neutral utilitarian calculus.'" *Id*. at 2136 (citing *New Jersey v. T.L.O.*, 469 U.S. 325, 369 (1985) (Brennan, J., concurring in part and dissenting in part)). In this regard, Chief Justice Roberts reaffirmed that *Casey* "look[s] to whether there was a substantial burden, not whether benefits outweighed burdens." *Id*. at 2137.

At issue here is the application of the *Marks* rule to *June Medical*. In *Marks v. United States*, the Supreme Court held "[w]hen a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who

concurred in the judgments on the narrowest grounds.'" 430 U.S. 188, 193 (1977) (citing *Gregg v. Georgia*, 428 U.S. 153, 169 n.15 (1976) (opinion of Stewart, Powell, and Stevens, JJ.). As the district court noted, "the holding of *June Medical Services* is fairly limited to the reasoning that represents a 'common denominator' that [Chief Justice Roberts] shared with the plurality." *ACOG*, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017 at *59. The district court also referenced *A.T. Massey Coal Co. v. Massanari*, in which the Fourth Circuit held the *Marks* rule does not apply to a decision "'unless the narrowest opinion represents a common denominator of the Court's reasoning' and embodies a position 'implicitly approved by at least five Justices who support the judgment.'" *Id*. at *60. (referencing *A.T. Massey Coal Co. v. Massanari*, 305 F.3d 226, 236 (4th Cir. 2002)). In this regard, Fourth Circuit precedent directs district courts to look at the common reasoning shared by the plurality and concurrences.

As the district court indicated, "the [*June Medical*] plurality did not agree with the Chief Justice's criticism of the balancing test, and neither the plurality nor the Chief Justice predicated the decision on an overruling of *Whole Woman's Health*." *Id*. In turn, the district court held "*June Medical Services* is appropriately considered to have been decided without the need to apply or reaffirm the balancing test of *Whole Woman's Health*, not that *Whole Woman's Health* and its balancing test have been overruled." *Id*. at *61.

Unfortunately, instead of analyzing the narrowest holding of *June Medical*, the district court applied the *June Medical* plurality's benefits-burdens analysis as if it was the standard of the Court. *Id*. at *65–99; *see also id*. at *61 (explaining that "*Whole Woman's Health* remains the most recent majority opinion delineating the full parameters of the undue burden test" which is "binding on this Court.") But at best, the Supreme Court is split over whether it can be said there is "no controlling opinion" under the *Marks* rule, and, thus, whether lower courts may be allowed to disregard the opinions. *Ramos v. Louisiana*, 140 S. Ct. 1390, 1403 (2020) (plurality); *id*. at 1416 n.85 (Kavanaugh, J., concurring in part); *id*. at 1431 (Alito, J., with Roberts, C.J., and Kagan, dissenting). In the narrowest terms, under *Marks* and *Massanari*, *June Medical* held only that Act 620 was a substantial obstacle to women seeking abortion in Louisiana. *June Med. Servs*, 140 S. Ct. at 2134 (Roberts, C.J., concurring); *id.* at 2130 (plurality). In this regard, precedent does not support the district court's decision to disregard the holding of *June Medical* in favor of the plurality's reasoning.

In light of Chief Justice Roberts's concurrence in *June Medical*, the Eighth Circuit recently reversed and remanded an abortion case for reconsideration. *Hopkins v. Jegley*, 968 F.3d 912 (8th Cir. 2020). In its analysis of *June Medical*, the Eighth Circuit emphasized that Chief Justice Roberts "concurred in the judgment, not the plurality's reasoning." *Id*. at 914 (internal citation omitted). The Eighth

Circuit noted that Chief Justice Roberts discussed *Casey*'s undue burden standard at length while rejecting the benefits-burdens test from *Whole Woman's Health*. *Id.* at 914. In this regard, "Chief Justice Robert's [*sic*] vote was necessary in holding unconstitutional Louisiana's admitting-privileges law, so his separate opinion is controlling." *Id.* at 915 (referencing *Marks*, 430 U.S. at 193). The Eighth Circuit further explained that "[i]n light of Chief Justice Roberts's separate opinion, 'five Members of the Court reject[ed] the *Whole Woman's Health* cost-benefit standard.'" *Id.* (internal citation omitted). Since the *Jegley* district court had analyzed the case under the *Whole Woman's Health* cost-benefit standard, the Eighth Circuit vacated and remanded the case for consideration in light of Chief Justice Robert's concurrence, "which is controlling." *Id.* at 916. For these reasons, and to avoid an unnecessary conflict with the Eighth Circuit Court of Appeals over the application of *June Medical*, the court should reverse and remand this case for further consideration in light of Chief Justice Roberts' concurrence in *June Medical Services*.

II. THE PRELIMINARY INJUNCTION REMOVES HEALTH AND SAFETY SAFEGUARDS FOR WOMEN SEEKING CHEMICAL ABORTIONS.

The preliminary injunction permits an untested form of telemedicine in chemical abortions and puts at risk women's health and safety. The recent use of telemedicine for chemical abortion "closely resembles the in-person process for the

procedure." Y. Tony Yang & Kathy B. Kozhimannil, *Medication Abortion Through Telemedicine: Implications of a Ruling by the Iowa Supreme Court*, 127 Obstetrics & Gynecology 313 (Feb. 2016). A woman will go into an abortion clinic, receive an ultrasound, and have her vital signs measured by a nurse or trained technician. *Id*. The woman then consults with a physician via video chat, and if she is determined to be a medically appropriate candidate for the drug, the doctor remotely unlocks a drawer and sees her take the pills from it. *Id*.; *see also* Comm. on Practice Bulletins—Gynecology and the Soc'y of Family Planning, *Medical Management of First-Trimester Abortion*, Practice Bulletin No. 143, at 11 (reaffirmed 2016) (describing the telemedicine model in which abortion patients are seen in-clinic but have a video consultation with an off-site physician). One to three weeks after taking the pills, the woman returns to her provider for a follow up visit. In fact, the Mayo Clinic states that: "Medical abortion isn't an option if you . . . *[c]an't make follow-up visits to your doctor* or don't have access to emergency care." *Medical Abortion*, Mayo Clinic (May 14, 2020), https://www.mayoclinic.org/tests-procedures/medical-abortion/about/pac-20394687; *see also Medical Management of First-Trimester Abortion*, *supra*, at 3 (noting that chemical abortion "[r]equires follow-up to ensure completion of abortion").

In contrast, the preliminary injunction allows women to receive a chemical abortion entirely remotely. The FDA already allows the determination of a patient's

eligibility and informed consent counseling via telemedicine. *ACOG*, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 122017, at *11–13. The FDA also does not require a follow-up visit to check that the chemical abortion completed. *Id*. The temporary injunction thus strips away the remaining in-person protections for dispensing and signature requirements. *Id*. at *132. As the district court noted, abortion providers indicate they can, and will, use telemedicine entirely remotely for chemical abortions. *Id*. at *26–27 (internal citations omitted). However, abortion providers cannot remotely assess whether chemical abortion is medically appropriate for a woman.

The FDA requires certain healthcare provider qualifications, including the "[a]bility to assess the duration of pregnancy accurately" and the "[a]bility to diagnose ectopic pregnancies." *Prescriber Agreement Form: Mifeprex (Mifepristone)*, U.S. Food and Drug Admin. (Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifeprex_2016-03-29_Prescriber_Agreement_Form.pdf. To fulfill these requirements, the district court noted that abortion providers can determine remotely the length of pregnancy, whether it is ectopic, and if there are contraindications. *ACOG*, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 112017, at *84 (internal citation omitted). Yet, the district court's finding is contrary to established medicine. Mayo Clinic indicates that a physician can only diagnose an ectopic pregnancy by blood tests and an ultrasound.

Ectopic Pregnancy, Mayo Clinic (Feb. 28, 2020), https://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/diagnosis-treatment/drc-20372093. In other words, a physician cannot determine via telemedicine whether a pregnancy is ectopic.

Determining gestational age usually is done in-person by ultrasound. Ultrasound is the most accurate method to establish or confirm gestational age in the first trimester. Comm. on Obstetric Practice Am. Inst. of Ultrasound in Med. Soc'y for Maternal-Fetal Medicine, *Methods for Estimating the Due Date*, Comm. Op. No. 700, at 1 (May 2017). Dating a pregnancy by using a woman's last menstrual period ("LMP") is less accurate. The American College of Obstetricians and Gynecologists (ACOG) indicates only one half of women accurately recall their LMP. *Id*. at 2. In one study, forty percent of women had more than a five-day discrepancy between their LMP dating and the ultrasound dating. *Id*. In this regard, LMP dating is not as precise as an ultrasound. But an accurate measurement of gestational age is required to show that a woman is even a candidate for a chemical abortion.

Without an in-person requirement, abortion providers also cannot test for Rh negative blood type. During pregnancy, if a woman has Rh negative blood while her fetus is Rh positive, the woman's body may produce antibodies after exposure to fetal red blood cells. *Rh Factor Blood Test*, Mayo Clinic (June 17, 2020), https://www.mayoclinic.org/tests-procedures/rh-factor/about/pac-20394960.

Abortion can cause maternal exposure to fetal blood. *Id*. Therefore, a healthcare provider must give a woman with Rh negative blood a Rh immune globulin injection. Without the injection, antibodies can damage future pregnancies by creating life-threatening anemia in fetal red blood cells. *Id*. ACOG describes that "Rh testing is standard of care in the United States, and RhD immunoglobulin should be administered if indicated" during abortions. *Medical Management of First-Trimester Abortion*, at 6. Rh negative blood typing is thus a medically necessary test but it cannot occur during medical abortions that are done entirely via telemedicine.

Regrettably, the district court put little weight on the FDA's scientific judgment that the in-person requirements are necessary for women's health and safety. *ACOG*, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 112017, at *97–99, 116–119. The district court indicated that the FDA in 2016 characterized the risk of a "major adverse event[]" from mifepristone use as "'exceedingly rare, generally far below 0.1% for any individual adverse event.'" *Id*. at *98 (internal citation omitted). Even so, the district court noted that "the degree of risk associated with mifepristone is relevant here only to the extent it provides a basis to require advanced counseling of patients." *Id*. In this regard, the district court presumed the safety of Mifeprex while ignoring the underlying issues of informed consent and whether a chemical abortion is medically appropriate.

The district court neatly sidestepped the underlying issue of informed consent. As discussed above, a woman needs an in-person visit to show that she is a medically appropriate candidate for a chemical abortion. Ultrasonography and Rh negative blood typing cannot be done remotely. Telemedicine also is inefficient in identifying domestic violence or reproductive control. In other words, the lower court approved a procedure under which the abortion provider has not determined that a woman is a medically appropriate candidate for a chemical abortion and that she has given uncoerced, informed consent. The district court arbitrarily limited the discussion to "advanced counseling." However, but for a determination that chemical abortion is medically appropriate, and a woman has given uncoerced, informed consent, a woman may not receive a chemical abortion.

The district court also erroneously presumed the safety of RU-486, or "Mifeprex". The FDA statistics are only for the safety of Mifeprex as dispensed pursuant to the REMS. In other words, the district court speculated when it determined that Mifeprex is safe even after severing the underlying REMS safeguards through its temporary injunction.

As the FDA notes,

> A medication is considered safe for purposes of medication approval if the benefits of using the medication are greater than the risks. However, there still may be serious risks associated with the medication. A REMS can help to ensure that the medications are used safely and allow FDA to approve medications that have these risks and would otherwise not be available.

Roles of Different Participants in REMS, U.S. Food and Drug Admin. (Mar. 24, 2020), https://www.fda.gov/drugs/risk-evaluation-and-mitigation-strategies-rems/roles-different-participants-rems. Even when the REMS are followed, there are still serious risks with Mifeprex.

State reporting of adverse events from Mifeprex is voluntary. Even so, the FDA has received Mifeprex reports of 24 deaths, 4,195 adverse events, 1,042 hospitalizations (excluding deaths), 599 blood loss requiring transfusions, 412 infections, and 69 severe infections. *Mifepristone U.S. Post-Marketing Adverse Events Summary Through 12/31/2018*, U.S. Food and Drug Admin. https://www.fda.gov/media/112118/download. Again, these adverse events occurred under the REMS. By dismantling REMS safeguards, the district court severs the FDA's scientifically backed safeguards. Under the preliminary injunction, the district court cannot ensure the safety or informed consent of women seeking chemical abortions.

III. THE PRELIMINARY INJUNCTION SUBVERTS THE PUBLIC INTEREST IN PREVENTING DOMESTIC VIOLENCE.

The district court failed to identify, let alone analyze, the issue of domestic violence. In turn, the district court erroneously analyzed the balance of equities and public interest in this case. A court analyzes four factors for a preliminary injunction: (1) whether the moving party is likely to succeed on the merits; (2) whether the moving party is likely to suffer irreparable harm in the absence of preliminary relief; (3) whether the balance of equities tip in the moving party's favor; and (4) whether an injunction is in the public interest. *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 21 (2008). When the United States is a party, a court considers the balance of equities and public interest factors together. *Nken v. Holder*, 556 U.S. 418, 435 (2009). Notably, "[a] preliminary injunction is an extraordinary remedy never awarded as of right." *Winter*, 555 U.S. at 24 (internal citation omitted). As the Supreme Court describes, "[c]rafting a preliminary injunction is an exercise of discretion and judgment, often dependent as much on the equities of a given case as the substance of the legal issues it presents." *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). "In exercising their sound discretion, courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction." *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 312 (1982) (internal citation omitted). Here, the district court failed to identify the

public interest of preventing domestic violence and, in turn, improperly analyzed the medical interest of an in-person requirement.

There are two incommensurable public policy concerns underlying plaintiff's claim: the use of telemedicine to prevent the spread of COVID-19 and in-person medical requirements to address systematic domestic violence. In its decision, the district court analyzed at length the use of telemedicine for chemical abortions during the COVID-19 pandemic. *ACOG*, No. TDC-20-1320, 2020 U.S. Dist. LEXIS 112017, at *17–27. In this regard, the court concluded that temporary enjoinment of the in-person requirements aligned "with the public health guidance to eliminate unnecessary travel and in-person contact." *Id*. at *118. But the district court failed to identify, let alone analyze, the public interest concern of domestic violence. *Id*. at 115–119.

Intimate partner violence ["IPV"] and reproductive control are domestic violence concerns for women seeking an abortion. IPV includes physical violence, sexual violence, stalking, and psychological aggression by a current or former intimate partner. *Preventing Intimate Partner Violence*, Ctrs. For Disease Control and Prevention (Feb. 26, 2019), https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html. The Centers for Disease Control and Prevention (CDC) notes that "IPV is a significant public health issue that has many individual and societal costs." *Id*. IPV may produce

chronic health conditions affecting survivors' heart, digestive, reproductive, muscle and bones, and nervous systems. *Id*. IPV survivors may experience depression and post-traumatic stress disorder. Survivors also are at higher risk for engaging in health risk behaviors, such as smoking, binge drinking, and sexual risk behaviors. *Id*. The CDC estimates the lifetime medical, lost work productivity, and criminal justice costs are $3.6 trillion. *Id*. The lifetime cost for a female victim of IPV is $103,767. *Id*. Thus, there are steep individual and societal costs for IPV.

Unfortunately, IPV is common. *Id*. One in four women have experienced IPV. *Id*. Nearly one in five women have experienced severe physical violence by an intimate partner. *Id*. "Unintended" pregnancy, which may be a reason to seek an abortion, raises the risk of IPV. Women with unintended pregnancies are four times as likely to experience IPV as women with intended pregnancies. Comm. on Health Care for Underserved Women, *Reproductive and Sexual Coercion*, Comm. Op. No. 554, at 2 (Feb. 2013) (internal citation omitted). Notably, half of all pregnancies are characterized as "unintended". Comm. on Gynecologic Practice Long-Acting Reversible Contraception Working Group, *Increasing Access to Contraceptive Implants and Intrauterine Devices to Reduce Unintended Pregnancy*, Comm. Op. No. 645, at 1 (reaffirmed 2018).

Abortion also increases the risk of IPV. There are "[h]igh rates of physical, sexual, and emotional IPV . . . among women seeking a[n abortion]." Megan Hall et

al., *Associations Between Intimate Partner Violence and Termination of Pregnancy: A Systematic Review and Meta-Analysis*, 11 PLoS Med. 1, 15 (Jan. 2014). For women seeking abortion, the prevalence of IPV is nearly three times greater than women continuing a pregnancy. *Reproductive and Sexual Coercion* at 2. Post-abortive IPV victims also have a "significant association" with "psychosocial problems including depression, suicidal ideation, stress, and disturbing thoughts." Hall, *supra*, at 11.

Notably, a survey in the American Journal of Public Health indicated IPV perpetrators are more likely than nonabusive men to be involved in a pregnancy that ended in abortion. Jay G. Silverman et al., *Male Perpetration of Intimate Partner Violence and Involvement in Abortions and Abortion-Related Conflict*, 100 Am. J. of Pub. Health 1415, 1416 (Aug. 2010). The surveyed male IPV perpetrators were likely to be in conflict with their female partner particularly over her abortion decision when the violence occurred. *Id*.

With the prevalence of IPV, ACOG acknowledges that "[b]ecause of the known link between reproductive health and violence, health care providers should screen women and adolescent girls for intimate partner violence and reproductive and sexual coercion at periodic intervals." *Reproductive and Sexual Coercion* at 1. Intimate partner violence is therefore a grave concern for women seeking abortion.

Reproductive control, which overlaps IPV, is also a public policy concern for women seeking abortion. Reproductive control describes "actions that interfere with a woman's reproductive intentions." Sam Rowlands & Susan Walker, *Reproductive Control by Others: Means, Perpetrators and Effects*, 45 BMJ Sexual & Reprod. Health 61, 62 (2019). Reproductive control occurs over "decisions around whether or not to start, continue or terminate a pregnancy, including deployment of contraception, and may be exercised at various times in relation to intercourse, conception, gestation and delivery." *Id.* Reproductive control includes intimate partners, family members, and sex traffickers asserting control over a woman's reproductive decisions. *Id*. at 65. Thus, in the context of abortion, reproductive control not only produces coerced abortions or continued pregnancies, it also affects whether the pregnancy was intended in the first place. *Id*. at 61–62.

Reproductive control is a prevalent issue for women. "As many as one-quarter of women of reproductive age attending for sexual and reproductive health services give a history of ever having suffered [reproductive control]." *Id*. at 62. In the United States, African-American and multiracial women disproportionately experience reproductive control. Charvonne N. Holliday et al., *Racial/Ethnic Differences in Women's Experiences of Reproductive Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 26 J. of Women's Health 828 (2017). Younger women also are more at risk for reproductive control. Elizabeth Miller et al., *Recent Reproductive*

Coercion and Unintended Pregnancy Among Female Family Planning Clients, 89 Contraception 122 (2014). Coerced abortion particularly is a problem for victims, including minor victims, of sex trafficking in the United States. Rowlands, *supra*, at 64.

Women seeking abortion are susceptible to domestic violence in the forms of IPV and reproductive control. In turn, IPV and reproductive control may impair a woman's ability to provide consent to an abortion. Telemedicine only reduces the safeguards against domestic violence and coercion.

The American Medical Association describes:

> While social distancing and quarantine measures are in place to protect the general public, domestic violence situations are likely to worsen as victims may be limited in seeking care or leaving the unsafe situation. Domestic violence is also a contributing factor to adverse health outcomes such as increased risk of chronic disease, depression, post-traumatic stress disorder, and substance use behaviors.

COVID-19 Resource Guide: Women in Medicine, Am. Med. Ass'n (Aug. 3, 2020), https://www.ama-assn.org/practice-management/physician-health/covid-19-resource-guide-women-medicine. ACOG echoes the concern of COVID-19's impact on domestic violence. According to ACOG, "The risk of intimate partner violence is increased in the context of recommendations to shelter in place, physical distancing, financial hardships, and potential isolation and quarantine. The severity of intimate partner violence may escalate during pregnancy or the postpartum

period." *COVID-19 FAQs for Obstetrician-Gynecologists, Obstetrics*, Am. Coll. of Obstetricians and Gynecologists, https://www.acog.org/. Notably, ACOG recommends healthcare providers screen patients multiple times because patients may not be able to disclose abuse each time they are screened. *Id*. In other words, although domestic violence screening may occur by telehealth, "screening for intimate partner violence by telehealth may not allow women the privacy or safety needed to disclose abuse." *Id*. By overlooking domestic violence, the district court improperly balanced the equities and misanalyzed the public interest of a preliminary injunction.

CONCLUSION

For the reasons set forth above, *Amici* respectfully urge the Court to reverse the district court and vacate the temporary injunction.

Respectfully submitted,

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DATED: This 2nd day of November, 2020.

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CERTIFICATE OF SERVICE

I certify that on November 2, 2020, I electronically filed the foregoing brief with the Clerk of Court through the CM/ECF system, which shall send notification of such filing to any CM/ECF participants.

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APPENDIX

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Brian Babin, D.D.S. (TX-36)

Jim Banks (IN-03)

Dan Bishop (NC-09)

Ted Budd (NC-13)

Michael C. Burgess, M.D. (TX-26)

Ben Cline (VA-06)

Doug Collins (GA-09)

Warren Davidson (OH-08)

Neal Dunn, M.D. (FL-02)

Bill Flores (TX-17)

Russ Fulcher (ID-01)

Louie Gohmert (TX-01)

Garret Graves (LA-06)

Glenn Grothman (WI-06)

Jim Hagedorn (MN-01)

Vicky Hartzler (MO-04)

Ralph Abraham, M.D. (LA-05)

Rick W. Allen (GA-12)

James R. Baird (IN-04)

Andy Biggs (AZ-05)

Larry Bucshon, M.D. (IN-08)

Tim Burchett (TN-02)

Steve Chabot (OH-01)

Michael Cloud (TX-27)

K. Michael Conaway (TX-11)

Jeff Duncan (SC-03)

Tom Emmer (MN-06)

Jeff Fortenberry (NE-01)

Greg Gianforte (MT-AL)

Paul A. Gosar, D.D.S. (AZ-04)

H. Morgan Griffith (VA-09)

Michael Guest (MS-03)

Andy Harris, M.D. (MD-01)

Kevin Hern (OK-01)

Jody B. Hice (GA-10)

Michael Johnson (LA-04)

John Joyce, M.D. (PA-13)

Trent Kelly (MS-01)

Doug LaMalfa (CA-01)

Debbie Lesko (AZ-08)

Roger Marshall, M.D. (KS-01)

Cathy McMorris Rodgers (WA-05)

Alex X. Mooney (WV-02)

Pete Olson (TX-22)

Greg Pence (IN-06)

Guy Reschenthaler (PA-14)

John Rose (TN-06)

John Rutherford (FL-04)

Christopher H. Smith (NJ-04)

Lloyd Smucker (PA-11)

W. Gregory Steube (FL-17)

Tim Walberg (MI-07)

Michael Waltz (FL-06)

Brad Wenstrup, D.P.M. (OH-02)

Dusty Johnson (SD-AL)

Jim Jordan (OH-04)

Fred Keller (PA-12)

Steve King (IA-04)

Doug Lamborn (CO-05)

Billy Long (MO-07)

Tom McClintock (CA-04)

Carol D. Miller (WV-03)

Ralph Norman (SC-05)

Steven Palazzo (MS-04)

Scott Perry (PA-10)

Martha Roby (AL-02)

David Rouzer (NC-07)

Adrian Smith (NE-03)

Jason Smith (MO-08)

Ross Spano (FL-15)

William Timmons (SC-04)

Jackie Walorski (IN-02)

Randy K. Weber (TX-14)

Roger Williams (TX-25)

Joe Wilson (SC-02)

Ted S. Yoho, D.V.M. (FL-03)