South Dakota Mandatory Visit to "Pregnancy Help Center"

The first brief, due March 9th, is in *Planned Parenthood of Minnesota, North Dakota, and South Dakota v. Noem* (21-2913), currently before the 8th Circuit. The case challenges a 2011 South Dakota law requiring patients to visit a "Pregnancy Help Center" (PHC) during the period between when they receive pre-abortion counseling from their physician and the abortion itself. The law was enjoined in 2011 and in 2020 the state and the intervenor-defendant PHCs asked the court to dissolve the injunction. The District Court denied the request to dissolve and the defendants have appealed that decision to the Eighth Circuit.

Under the law, PHCs are charged with interviewing patients to screen for coercion and providing them with information about alternatives to abortion and that abortion terminates "the life of a whole, separate, unique, living human being." In order to qualify as a PHC under the law, an organization cannot have referred a patient to obtain an abortion since at least 2008. Defendants argue that the information and screening patients receive at the PHC is an aspect of informed consent for the abortion procedure. Plaintiffs argue that the required visit to the PHC is invasive, harmful, and constitutes an undue burden on access to abortion. Moreover, the PHCs are not uniquely qualified to screen for coercion and their definitions of what constitutes coercion are biased and well outside the mainstream.

The brief in this case will rebut the defendants' argument about the role of the PHCs with information and clinical guidance about how informed consent works in the context of abortion care. ACOG's Committee Opinion 819, discusses how the process of informed consent (which would be completed by the physician and/or clinic providing the abortion) includes the opportunity to decline a procedure and how, in a shared decision making framework, the informed consent process "involves discussion of the benefits and risks of available treatment options in the context of a patient's values and priorities." Thus, it is unethical and contrary to the principles of informed consent and shared decision making to require a patient who has already sought out abortion care to visit a PHC to discuss that care with a third-party, over the patient's expressed objections. While the South Dakota law is unique in its approach, ACOG and members of this coalition have filed numerous briefs that discuss the role of informed consent in the ethical practice of medicine and this brief would be in keeping with that prior work. Relatedly, one of the major concerns about this law is that, if it is allowed to stand, it could serve as a blueprint for similar requirements in other states seeking to restrict access to abortion and clinically accurate information about abortion.

Montana Abortion Restrictions

The second brief ACOG will be filing is in the Montana Supreme Court and concerns three separate restrictions on abortion care in the state. The case (*Planned Parenthood of Montana v. Montana*, DA 21-0521) challenges three abortion restrictions passed by the legislature and signed by the governor in 2021 (the laws are currently enjoined and not in force). In the 1999 *Armstrong* decision, the Montana Supreme Court found that the state constitution guaranteed the right to abortion. Thus, prior to the passage of these laws, Montana had essentially no restrictions on abortion. These laws are viewed as a direct attempt to overturn the *Armstrong* decision. Given developments in the federal courts related to abortion access, especially the pending Supreme Court decision in the *Jackson Women's Health Organization v. Dobbs*, state restrictions on abortion like the ones at issue here take on additional weight and importance. Cases like this one may well be the future of litigation over access to abortion across the country.

The first restriction at issue is a ban on abortion after 20 week's gestation and provides criminal penalties for anyone violating the ban aside from a few exceptions for medical emergencies and serious

health risks. Planned Parenthood of Montana currently provides abortions up to 21 weeks 6 days gestation. The second law requires medication abortion to be an in-person procedure. In addition to requiring the documentation of verification of intrauterine pregnancy and determination of blood type, the law also requires that the clinician schedule a follow-up visit within 7 to 14 days to confirm termination of the pregnancy. Medications to complete the abortion cannot be provided by mail or courier. Finally, the law creates an additional informed consent process, to be completed 24 hours in advance of receiving the drugs, that includes a compulsory state-created form and the provision of medically inaccurate information about medication abortion reversal. The final law requires clinicians to tell the patient that they can view an ultrasound of the fetus and listen to the fetal cardiac tones. The patient must sign a state form attesting that they were given the option to view the ultrasound and the clinician must document whether the patient viewed the images.

ACOG's brief will outline for the court that abortion is a safe medical procedure and that these sorts of restrictions on abortion are an interference in the patient-physician relationship. Clinical guidance from ACOG and other organizations does not support arbitrary gestational age bans and this coalition has previously filed amicus briefs in numerous cases challenging these restrictions, arguing that it is scientific evidence and medical judgement, not state legislatures, that should drive decisions about provision of abortion. Additionally, the FDA's guidance along with that of many medical societies is clear that medication abortion can be provided safely via telemedicine and the type of in-person examination outlined in the Montana law is not medically necessary in most cases. Members of this coalition have long been on the record about the safety of remote provision of medications for abortion, most recently by acting as amici in the suit ACOG and others brought against the FDA over the in-person dispensing requirement for mifepristone. This brief would also convey to the court that the information about abortion reversal in the required informed consent documentation is medically inaccurate; there is no evidence that treatment with progesterone after taking mifepristone will increase the likelihood of continuing the pregnancy (see ACOG PB 225). Finally, the requirement that the patient be offered an ultrasound and their decision documented is not only intrusive in the relationship between the patient and their physician, but is also medically unnecessary and requires that the abortion has an in-clinic component, when one is not needed.