Case No. 17-1883

United States Court of Appeals

for the

Seventh Circuit

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC.,

Plaintiff-Appellee,

– v. –

COMMISSIONER OF THE INDIANA STATE DEPARTMENT OF HEALTH, in his official capacity, *et al*.,

Defendants-Appellants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF INDIANA, INDIANAPOLIS DIVISION
(THE HONORABLE TANYA WALTON PRATT)

BRIEF FOR AMICI CURIAE AMERICAN MEDICAL WOMEN'S ASSOCIATION, ASSOCIATION OF REPRODUCTIVE HEALTH PROFESSIONALS, NATIONAL PHYSICIANS ALLIANCE, AND PHYSICIANS FOR REPRODUCTIVE HEALTH IN SUPPORT OF APPELLEE AND AFFIRMANCE

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APPEARANCE & CIRCUIT RULE 26.1 DISCLOSURE STATEMENT

Appellate Court No: 17-1883

Short Caption: Planned Parenthood of Indiana and Kentucky, Inc. v. Commissioner of Indiana Dep't of Health, et al.

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

Amici Curiae American Medical Women's Association, Association of Reproductive Health Professionals, National Physicians Alliance, and Physicians for Reproductive Health

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Paul, Weiss, Rifkind, Wharton & Garrison LLP

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

None

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

None

Attorney's Signature: /s/ Roberto J. Gonzalez Date: August 3, 2017

Attorney's Printed Name: Roberto J. Gonzalez

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None

Attorney's Signature: /s/ Jane B. O'Brien Date: August 3, 2017

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Attorney's Signature: /s/ Michelle S. Kallen Date: August 3, 2017

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Attorney's Signature: /s/ Crystal M. Johnson Date: August 3, 2017

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None

Attorney's Signature: /s/ Jonathan Silberstein-Loeb Date: August 3, 2017

Attorney's Printed Name: Jonathan Silberstein-Loeb

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES & COURT RULES

OTHER AUTHORITIES

INTEREST OF AMICI CURIAE[1]

The American Medical Women's Association ("AMWA"), Association of Reproductive Health Professionals ("ARHP"), National Physicians Alliance ("NPA"), and Physicians for Reproductive Health ("Physicians") (collectively, "Amici") submit this brief as amici curiae in support of Plaintiff-Appellee Planned Parenthood of Indiana and Kentucky, Inc. ("PPINK").

- AMWA is an organization of women physicians, medical students, and residents whose mission is to support policies and programs that improve women's health. AMWA opposes efforts to overturn or weaken *Roe* v. *Wade*, either directly or indirectly, as in the case of legislation which burdens access to the abortion procedure.
- ARHP trains, supports, and advocates for the sexual and reproductive health professionals who impact patients' lives. ARHP's mission is to transform and improve sexual and reproductive health care and access through professional training and advocacy. ARHP believes that society benefits when individuals have the power and resources to make healthy decisions about their bodies, sexuality, and reproduction for themselves. Abortion care is a critical component of comprehensive reproductive health care, and ARHP supports a woman's right to choose to have an abortion.
- NPA is a non-partisan, nonprofit organization with members of a wide range of medical specialties. NPA is committed to advancing the core values of the medical profession: service, integrity, and advocacy. NPA believes that regulations governing reproductive

[1] Pursuant to Federal Rule of Appellate Procedure 29, the parties have consented to the filing of this brief. Also pursuant to Rule 29, undersigned counsel for amici curiae certify that: (1) no counsel for a party authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission this brief; and (3) no person or entity—other than amici curiae, their members, or their counsel—contributed money intended to fund the preparation or submission of this brief.

medical standards should be based on medical evidence and the input of trained medical experts and not on political opinion.

- Physicians is a doctor-led nonprofit that seeks to assure meaningful access to comprehensive reproductive health services, including contraception and abortion, as part of mainstream medical care. Founded in 1992, the organization currently has more than 6,000 members across the country, including more than 3,000 physicians who practice in a range of fields: obstetrics and gynecology, pediatrics, family medicine, emergency medicine, cardiology, public health, neurology, radiology, and more. These Physicians members, many of whom provide abortion care, include faculty and department heads at academic medical centers and top U.S. hospitals.

Amici have long held the position that access to the full range of reproductive health services, including abortion, is a fundamental right and integral to the health and well-being of individual women and to the broader public health. Comprehensive health care—including abortion—furthers the goals of public health, including preventing disease, promoting health, and prolonging life among the population as a whole. Abortion is an essential component of comprehensive reproductive care. Like other forms of health care, safe, legal abortion reduces the risk of a range of negative and even life-threatening outcomes, including psychological complications like maternal depression, maternal morbidity, and mortality overall. Amici therefore oppose legislation that makes abortion services more difficult to obtain or more likely to cause harm to the physical or mental health of individual women.

SUMMARY OF ARGUMENT

In the state of Indiana, when a woman seeks an abortion, at least three parties are present in the exam room: the physician, the patient, and the State. Indiana (the "State") has set forth a litany requirements it deems "necessary" for a woman to make an informed decision to

terminate her pregnancy. The State requires that medical providers tell a woman that "human physical life begins when a human ovum is fertilized by a human sperm," the estimated dimensions of a fetus at the same stage of development, and that "objective scientific information shows that a fetus can feel pain at or before twenty (20) weeks of postfertilization age," among other things. Ind. Code § 16-34-2-1(a). The State also requires the physician to provide the woman with a brochure developed by the state department of health with color pictures of embryos and fetuses at various gestational ages. *Id.* § 16-34-2-1.5(b)(1)(A).

Whether or not a physician believes it to be in the patient's best interest, Indiana Code § 16-34-2-1.1(a)(5) (the "Ultrasound Law") now forces a physician to perform an ultrasound on a pregnant woman at least 18 hours before an abortion and requires a woman to view the ultrasound and hear the auscultation of the fetal heart tones unless she certifies, on a form developed by Indiana's state department of health, that she does not want to view the ultrasound or listen to the fetal heart tones before the abortion is performed. In practice, the Ultrasound Law significantly limits where a pregnant woman can receive the state-mandated pre-abortion counseling because only a limited number of PPINK centers are capable of performing the necessary ultrasounds. The Ultrasound Law would require many women to travel great distances (and incur corresponding burdens such as cost of travel and sometimes lodging, missing work, paying for childcare, and, for some women, the risk being discovered by an abusive partner) to obtain the additional procedure required by the Ultrasound Law. This case presents the question of whether the added burden of requiring women to travel to and undergo a medically unnecessary ultrasound, which they may (and often do) decline to view, 18 hours before obtaining an abortion is disproportionate to the benefit that the State stands to gain.

The State argues that the Ultrasound Law promotes (1) fetal life and (2) women's mental health. However, the State failed to introduce any meaningful evidence in the district court that the Ultrasound Law indeed promotes either of these ends. In fact, the overwhelming medical evidence shows that the Ultrasound Law is more likely to harm women's mental health, impede the physician-patient relationship, and damage public health as a whole.

As part of an ongoing effort to undermine and ultimately overturn *Roe* v. *Wade*, abortion opponents promote laws (like the Ultrasound Law) that burden women with mandatory ultrasounds at medically unnecessary times and coerce women to listen to the fetal heart tones prior to an abortion under the guise of "informed consent." However, medical providers and reputable medical organizations (such as Amici) have been clear that such regulations do not, in fact, promote "informed consent" and that such regulations intrude on the physician-patient relationship in ways that are detrimental to public health.[2] Therefore, Amici support PPINK's request that this Court affirm the decision below.

ARGUMENT

I. The Ultrasound Law Places an Undue Burden on Women Seeking to Exercise their Constitutional Right to an Abortion.

Last term, the Supreme Court issued the landmark decision in *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292 (2016), which held that Texas's HB-2 abortion regulations

[2] Gayatri Devi et al., Am. Med. Women's Ass'n, *Position Statement on Abortion and Reproductive Rights*, 18 J. Women's Health 229, 229 (2009); Ass'n Reprod. Health Prof'l, *Position Statement, Access to Reproductive Health* (June 2012), http://www.arhp.org/about-us/position-statements#1; Nat'l Physicians Alliance, *Policy Statement on Protecting Free Speech Between Patients and Physicians* (Feb. 2013), http://npalliance.org/wp-content/uploads/NPA_Policy_Stmt-Protecting_Patient_Physician_Free_Speech-022713.pdf; *see also* Am. Coll. Obstetricians & Gynecologists, *ACOG Committee Opinion No. 424: Abortion Access and Training*, 113 Obstetrics & Gynecology 247, 247–50 (Jan. 2009); Am. Pub. Health Ass'n, *Policy Statement No. 20083–Need for State Legislation Protecting and Enhancing Women's Ability to Obtain Safe, Legal Abortion Services Without Delay or Government Interference* (Oct. 28, 2008), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/23/09/30/need-for-state-legislation-protecting-and-enhancing-womens-ability-to-obtain-safe-legal-abortion.

imposed an undue burden on the constitutional right to an abortion. The Ultrasound Law is similarly unconstitutional.

a. *Whole Woman's Health* Squarely Applies.

The State argues that the balancing test the Supreme Court applied to invalidate Texas abortion regulations in *Whole Woman's Health* does not apply here because the Ultrasound Law furthers the State's interest in the woman's *mental* health (rather than *physical* health) and is directed at the State's interest in promoting fetal life by convincing women to change their mind about the abortion. (Appellants' Br. at 10.) The State further purports to distinguish the Ultrasound Law on the ground that, like the statute that was upheld in *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), the Ultrasound Law furthers the State's interest in "informed consent." According to the State, courts should apply different levels of scrutiny depending on the State's purported interest. (*See* Appellants' Br. at 10–11.) Neither *Casey* nor *Whole Woman's Health* provides any basis for this approach.

In *Casey*, the Supreme Court established the "undue burden" standard as a limit on states' authority to regulate abortion in part because, before viability, the states' interests are "not strong enough to support . . . the imposition of a substantial obstacle to the woman's effective right to elect [an abortion]." *Casey*, 505 U.S. at 846, 877–79 (plurality opinion). *Whole Woman's Health* explicitly applied *Casey*'s undue burden standard and explained that "the rule announced in *Casey* . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." 136 S. Ct. at 2309. The Court reasoned that "unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to women seeking an abortion" impose an undue burden under *Casey*. *Id.* at 2309 (citing *Casey*, 505 U.S. at 878).

b. The Ultrasound Law Imposes an Undue Burden.

The State ties the Ultrasound Law to its interest in women's mental health generally and informed consent specifically by asserting that "[i]f the idea behind the waiting period is valid generally, there is no basis for questioning it with regard to one particular informed-consent component," here, the Ultrasound Law. (Appellants' Br. at 39–42.) That is not the law. "*Casey* stated, and *Karlin* [v. *Foust*, 188 F.3d 446, 484–88 (7th Cir. 1999)] reiterated, that an informed-consent statute may have effects that differ from the written terms, and that those effects could in principle demonstrate that an innocuous-appearing law actually imposes an undue burden on abortion." *A Woman's Choice-East Side Women's Clinic* v. *Newman*, 305 F.3d 684, 687–88 (7th Cir. 2002). *Casey* upheld certain regulations related to informed consent based on "evidence on th[e] record;" it did not, as the State suggests, hold that all waiting periods or any means of promoting fetal life is *per se* constitutional. *Casey*, 505 U.S. at 881–85; *id.* at 883, 851 (states may "express[] a preference for childbirth over abortion" but they "may not compel or enforce" their views about abortion or its implications).

To determine whether a burden is "undue," *Casey* "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." *Whole Woman's Health*, 136 S. Ct. at 2309. The State would have this Court blindly accept its claim that the Ultrasound Law has "a significant potential impact" without evaluating the legitimacy of that claim. (Appellants' Br. at 36.) That argument has been rejected by this Court and by the Supreme Court. *Whole Woman's Health*, 136 S. Ct. at 2309–10; *Planned Parenthood of Wisconsin, Inc.* v. *Schimel*, 806 F.3d 908, 916 (7th Cir. 2015). Courts "have 'an independent constitutional duty to review [a legislature's] factual findings where constitutional rights are at stake,'" *Schimel*, 906 F.3d at 916 (quoting *Gonzales* v. *Carhart*, 550 U.S. 124, 163–65 (2007)), and must "ask[] whether and to what extent the challenged regulation actually advances the

state's justification," *id.* at 919. "The feebler the medical grounds . . . , the likelier is the burden on the right to abortion to be disproportionate to the benefits and therefore excessive." *Id.* at 920.

Whole Woman's Health clarified that in determining whether a burden is undue, courts must examine the "existence or nonexistence of medical benefits" of a regulation in addition to the burdens it imposes. 136 S. Ct. at 2310; *see also Schimel*, 806 F.3d at 919 (explaining that courts "ask[] whether and to what extent the challenged regulation *actually* advances the state's interest" (emphasis added)). Moreover, courts should "give significant weight to evidence in the record" surrounding questions of medical uncertainty rather than deferring to the legislature. *Whole Woman's Health*, 136 S. Ct. at 2309; *see also Schimel*, 806 F.3d at 919 ("An abortion-restricting statute sought to be justified on medical grounds requires not only reason to believe . . . that the medical grounds are valid, but also reason to believe that the restrictions are not disproportionate . . . to the medical benefits that the restrictions are believed to confer . . . .").

Indeed, scientific evidence (and the lack thereof) was a central focus of the *Whole Woman's Health* analysis. The Court relied on numerous peer-reviewed studies as well as expert testimony and amicus briefs refuting the purported medical benefits of the Texas regulation. 136 S. Ct. at 2310–11; *see also id.* at 2310 (discussing the Court's reliance in *Casey* on the "research-based submissions of amici in declaring a portion of the law at issue unconstitutional"). Scientific and factual evidence is equally crucial here, where the evidence shows that the proposed regulation would harm, rather than promote, women's mental health and would do little (if anything) to promote fetal life. PPINK's evidence also demonstrates that the need to travel to a PPINK center that has the ability to perform an ultrasound 18 hours before an abortion

imposes significant burdens on the ability of a woman to exercise her right to choose an abortion. (Appellee's Br. at 9–16; App'x at 13–29.)

The burden imposed here is analogous to that in *Whole Woman's Health*. As in *Whole Woman's Health*, the Ultrasound Law would "force women to travel long distances" to obtain an abortion, burdening them with additional travel, lodging, and childcare expenses on top of the risk of missing multiple days of work. *Whole Woman's Health*, 136 S. Ct. at 2318. These burdens are particularly difficult for low-income women, a disproportionate subsection of the women seeking an abortion. (App'x at 14.)

II. The Ultrasound Law Does Not Advance the State's Purported Interests.

The State claims that the Ultrasound Law advances two state interests: (1) protecting fetal life and (2) protecting women's mental health. The State failed to introduce any meaningful evidence supporting either of those interests—let alone evidence sufficient to justify the significant additional burdens the Ultrasound Law would impose on women seeking to obtain an abortion.

a. The Ultrasound Law Does Not Advance the State's Interest in Protecting Fetal Life.

The State claims that its purpose for the Ultrasound Law is to give women additional time to contemplate the ultrasound image in hopes of "persuading" women not to follow through with an abortion, thus "promoting" fetal life. (Appellants' Br. at 25–26, 31–33.) However, the State failed to present credible evidence that advancing the ultrasound requirement by 18 hours would in fact persuade any women to forgo abortion, as opposed to merely creating additional obstacles to obtaining one due to added burden and expense.

The State cites a study of women who viewed ultrasounds directly prior to a scheduled abortion for its conclusion that the Ultrasound Law could potentially change the minds

of 2.3% of the 7% of women with medium or low decisional certainty if an ultrasound is viewed during their visit to a PPINK center at least 18 hours prior to the scheduled abortion. (*Id.* at 32–33 (citing Mary Gatter et al., *Relationship Between Ultrasound Viewing and Proceeding to Abortion*, 123 Obstetrics & Gynecology 81, 85 (2014)).) As an initial matter, the State mischaracterizes the results of the study. (*See* Appellee's Br. at 35–36, 36 n.17.) Moreover, PPINK introduced evidence that when given the option to view the ultrasound and hear the fetal heart tones, 75% of PPINK patients decline to do so. (Appellee's Br. at 8.) Thus, even assuming the results of the Gatter study accurately reflected the potential efficacy of the Ultrasound Law—an unwarranted assumption—the State's interest of reaching a maximum of 4 out of 10,000 women who attend a pre-abortion consultation is wholly disproportionate to the burdens imposed on all 10,000 women (and those who are unable to overcome the additional burden).

Finally, and most importantly, the study is not probative of the issue in this case: whether the *additional 18 hours* to ruminate on the ultrasound would in fact impact a woman's decision to have an abortion, given that every woman already has the opportunity to view the ultrasound prior to the procedure if she so chooses. For that, the State relied on one doctor's recollection of a single patient who said she *might* have changed her mind if she had viewed her ultrasound during the first consultation. (Appellants' Br. at 5–6, 31–32, 36.) The district court correctly concluded that this one piece of speculation did not justify the burdens imposed by the Ultrasound Law—travel, expense, and inconvenience to make an additional trip to a potentially distant PPINK center that could perform the required ultrasound 18 hours before the abortion. (App'x at 13–29.)

b. The Ultrasound Law Does Not Benefit Women's Mental Health.

The State argues that the Ultrasound Law's mandatory 18-hour period between the ultrasound and the abortion facilitates "informed consent" and, by convincing them not to

follow through with the abortion, protects women from psychological ailments that stem from regret. (Appellants' Br. at 39–42.) The State's suggestion that women are unable to make sufficiently informed decisions without a mandatory 18-hour period to ruminate on the ultrasound is grounded in a now-familiar narrative of regret advanced by abortion opponents.[3] This narrative, which has no valid scientific basis, fuels the cultural stigma surrounding abortion. It is this stigma, not the abortions themselves, that threatens women's mental health.

In stark contrast to the absence of evidence supporting the State's position, is the mountain of evidence showing that there is *no* causal link between abortion and negative mental health outcomes. Despite numerous studies intended to find that abortion leads to negative mental health outcomes,[4] the overwhelming majority of valid scientific research has failed to find any such link.[5] The State cites a literature review by Priscilla K. Coleman in support of its

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[3] The anti-abortion movement appropriated the language of informed consent as part of a paternalistic women-protective rhetoric ultimately aimed at challenging *Roe* v. *Wade* and finally eliminating a woman's agency over her reproductive choices. *See* Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 Yale L.J. 1694, 1712–33 (2008) (describing the history and evolution of the "Women Protective Antiabortion Argument" within the pro-life movement); Clarke D. Forsythe, *Can* Roe *v.* Wade *Be Overturned After 40 Years?*, Defending Life 2013 at 41 (Americans United for Life 2013) (explaining that laws "such as informed consent requirements and abortion clinic regulations" are part of "a larger and broader assault" by the pro-life movement "on the target [*Roe* v. *Wade*] and its foundation. . . . as a means to ultimately eliminate[e] [abortion]."), http://aul.org/featured-images/AUL-1301_DL13%20Book_FINAL.pdf. Amici ask that this Court not turn a blind-eye to the strategy of layering regulation upon regulation in an effort to dismantle *Roe*.

[4] *See* Reva B. Siegel, *The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 Duke L.J. 1641, 1662–64 (2008) (explaining that the anti-abortion movement has been attempting—and failing—to gin up evidence that abortion leads to negative health outcomes since the 1980s).

[5] *See, e.g.*, Nat'l Collaborating Ctr. for Mental Health, *Induced Abortion and Mental Health*, London Acad. of Med. Royal Colls., Dec. 2011 (concluding, after a systematic literature review, that "rates of mental health problems for women with an unwanted pregnancy were the same whether they had an abortion or gave birth"); Trine Munk-Olsen et al., *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 New Eng. J. Med. 332 (2011) (findings of population-based cohort study did not support hypothesis that there is an increased risk of mental disorders after a first-trimester induced abortion); Am. Psychological Ass'n, Task Force on Mental Health and Abortion, *Report of the Task Force on Mental Health and Abortion* (2008) (concluding, in an exhaustive review of valid research on abortion, that "among adult women who have unplanned pregnancy the relative risk of mental

assumption that women who have abortions may suffer psychological problems, but that study failed to follow well-accepted scientific methodologies and has been widely discredited. (Appellants' Br. at 40 (citing Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199 Brit. J. Psychiatry 180, 186–86 (2011)).)[6] *But see, e.g.*, Ronald C. Kessler & Alan F. Schatzberg, *Commentary on Abortion Studies of Steinberg and Finer and Coleman*, 46 J. Psychiatric Res. 410 (2012); Louise M. Howard et al., Commentary, *Abortion and Mental Health: Guidelines for Proper Scientific Conduct Ignored*, 200 Brit. J. Psychiatry 74, 74–78 (2012). Indeed, Coleman's analysis was so flawed and the criticism from the scientific community so strong that it prompted the editors of the British Journal of Psychiatry to "give new guidance for the preparation of reviews in [their] authors' instructions." Commentary, *Abortion and Mental Health*, 200 Brit. J. Psychiatry at 78 (Editors' response). Even if it were credible, however, Coleman's study does not address the relevant question here: whether imposing an 18-hour waiting period after an ultrasound improves mental health outcomes.

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health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy"); V.E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 Contraception 436, 436–50 (2008) (concluding that "the highest quality research available does not support the hypothesis that abortion leads to long-term mental health problems"). Of course, proving a negative is nearly impossible.

[6] Coleman's review is a "meta-analysis" of scientific literature published between 1995 and 2009. *See* Coleman, *Abortion and Mental Health*, 199 Brit. J. Psychiatry at 74. There are several flaws with her methodology. First, Coleman provided no explanation why certain articles were included in her analysis and others were not. Nat'l Collaborating Ctr. for Mental Health, *supra* note 5, at 14. Second, Coleman included studies that did not control for mental health problems prior to the abortion. *Id.* Third, Coleman relied on multiple studies that used the same dataset, but failed to account for potential interdependence between studies and the impact it would have on her analysis. *Id.* at 18. Most importantly, however, her results used an invalid comparison group. Instead of comparing the mental health outcomes of women who had an unwanted pregnancy and carry it to term to those who chose to abort, Coleman's review used the general population of women who did not have an abortion—regardless of whether the pregnancy was wanted, unwanted, planned, or unplanned—as a comparator to measure the mental health outcomes of women who have had abortions. This led to manifestly skewed results. *Id.* at 14, 17.

The State seeks to bolster Coleman's conclusions by citing two additional sources that purportedly link abortion to women's mental health, but these sources suffer the same flaws as the Coleman review and likewise lack any logical nexus between the 18-hour waiting period and the supposed mental health benefit. (*See* Appellants' Br. at 41 (citing Carlo V. Bellieni & Giuseppe Buonocore, *Abortion and Subsequent Mental Health: Review of Literature*, 67 Psychiatry & Clinical Neurosciences 301, 301–10 (2013); Donald P. Sullins, *Abortion, Substance Abuse and Mental Health in Early Adulthood: Thirteen-Year Longitudinal Evidence from the United States*, 4 Sage Open Med. 1 (2016)).) None of the State's sources controlled for whether the woman wanted to become pregnant, leading to unreliable results about the existence or nonexistence of a causal link between abortion and mental health problems. In any event, none is probative of the issue in this case: whether requiring an ultrasound 18 hours in advance of an abortion—rather than the day of the abortion—could alleviate some threat to a woman's mental health.

Finally, the State faults the district court for discounting Coleman's study on the ground that the court should have considered the "full picture of the academic discussion on the issue." (Appellants' Br. at 41 n.2.) However, the studies the district court cited were comprehensive reviews of all scientific literature on the subject and were conducted by leading professional organizations with expertise in this area.[7] The strength of these reviews and their conclusions appropriately outweighed the discredited and distinguishable studies upon which the State relies and reflect the consensus among public health organizations, like Amici. *See generally Whitaker By Whitaker* v. *Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d

[7] Declaration of John William Stutsman, M.D., FACOG ¶¶ 7–10, *Planned Parenthood of Indiana and Kentucky Inc.* v. *Comm'r, Indiana State Dep't of Health*, No. 1:16-cv-1807-TWP-DML (Oct. 24, 2016), ECF No. 38-3.

1034, 1044 (7th Cir. 2017) ("Substantial deference is given to the district court's weighing of evidence and balancing of the various equitable factors.").

c. Rather than Promoting Women's Mental Health, the Ultrasound Law Undermines Women's Mental Health and Wellbeing.

The scientific literature indicates that the circumstances surrounding abortion—societal disapproval, shame, and stigma—and not the procedure itself threaten to undermine the mental health and wellbeing of a woman facing an unwanted pregnancy. The Ultrasound Law exacerbates social stigma surrounding terminating an unwanted pregnancy and negative attitudes toward a woman's experience of the abortion, both of which can contribute to negative mental health outcomes following an abortion.[8]

By asserting that a woman must be compelled to ruminate for 18-hours over the sights and sounds of "*her own fetus*" (Appellants' Br. at 4, 23) in order to make an informed decision, the State fuels the flawed assumption that women are incapable of making autonomous, informed decisions about their own healthcare. This rationale for the State's encroachment into patient decision-making invokes the same putatively benign purpose of "protecting women" that in fact deprives women of agency and that the Supreme Court has rejected in *Casey*. *See Casey*, 505 U.S. at 897–98 (rejecting the "common-law" view that deprived women of legal autonomy as "repugnant" to the Constitution).[9] The State's argument that women will be dissuaded from

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[8] Nat'l Collaborating Ctr. for Mental Health, *supra* note 5, at 8, 97–101, 111–12, 121 (finding that factors "associated with poorer mental health outcomes following abortion" include "the stigma associated with abortion[,] the need for secrecy regarding the abortion, personal characteristics, interpersonal concerns, level of social support and previous mental health problems").

[9] *See also Frontiero* v. *Richardson*, 411 U.S. 677, 684 (1973) (recognizing that "our Nation has had a long and unfortunate history of sex discrimination" that "was rationalized by an attitude of 'romantic paternalism' which, in practical effect put women, not on a pedestal, but in a cage"); Siegel, *supra* note 3, at 1773–80 (discussing evolution of women's legal status under the Constitution in the context of reproductive rights).

an abortion upon seeing and hearing "*her own fetus*" (Appellants' Br. at 4, 23) is also pernicious in its attempt to compel her to "bond" with the fetus (*id*. at 4).

A State-compelled, medically unnecessary (and often burdensome and expensive) trip to obtain an ultrasound at least 18 hours before the abortion contributes to the perception that the State disapproves of a woman's decision to obtain an abortion and adds an unnecessary layer of shame to that decision.[10] Research shows that women reporting these kinds of negative attitudes towards abortion at the time of the procedure had significantly more anxiety following the abortion as compared with those who had no negative attitude.[11] The cultural stigma surrounding abortion that is fueled by the State's abortion regulations—not the lack of a State-imposed 18-hour waiting period for a woman to ruminate over her decision—increases the likelihood of negative mental health outcomes following an abortion.[12]

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[10] *See* Jenna Jerman et al., *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 Perspectives on Sexual & Reprod. Health 95, 98 (Dec. 2017) (describing that travel "exacerbated the negative impact of barriers [women] faced" in qualitative study); Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 U.C.L.A. L. Rev. 351, 351–52 (2008) ("[T]he mandatory ultrasound requirement replaces consent with coercion—not about the ultimate decision, but about how a woman chooses to get there."); *see also* Clare Huntington, *Familial Norms and Normality*, 59 Emory L.J. 1103, 1135–36 (2010) ("[Ultrasound laws] contribute to the creation of a social norm that a fetus is a human being, that pregnant women are mothers who must conform to maternal norms, and that having an abortion is a shameful act. Without this emotional component, these laws would not be nearly as effective in contributing to a social norm that stigmatizes the choice to have an abortion.").

[11] A. Norda Broen et al., *Predictors of Anxiety and Depression Following Pregnancy Termination: A Longitudinal Five-year Follow-up Study*, 85 Acta Obstetricia et Gynecologica Scandinavica 317, 322 (2006) ("A negative attitude towards induced abortion was a significant predictor at six months and fives after the pregnancy termination. Previous studies have found that a restrictive, negative attitude toward induced abortion may be a risk factor for negative psychological responses after the abortion.").

[12] Franz Hanschmidt et al., *Abortion Stigma: A Systematic Review*, 48 Perspectives on Sexual & Reprod. Health 169, 169 (Dec. 2016) (discussing the "negative attribute ascribed to women who seek to terminate a pregnancy that makes them, internally or externally, as inferior to the ideals of womanhood") (quoting A. Kumar et al., *Conceptualizing Abortion Stigma*, 11 Culture, Health & Sexuality 625, 628 (2009)); *see* Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law*, 26 Women's Health Issues 63, 63–65 (Jan.–Feb. 2016) ("The majority of participants reported anticipating at least one negative outcome from the two-visit, 24-hour waiting

III. The Ultrasound Law Is Damaging To Public Health.

Abortion is an essential component to comprehensive reproductive care which, in turn, furthers the goals of public health (including preventing disease promoting health, and prolonging life among the population as a whole). Without safe, legal abortion, women of reproductive age face significantly increased risks to their health, including risks of major physical and mental health, complications from pregnancy and childbirth, and increased risks of death. Like other forms of healthcare, safe, legal abortion reduces the risk of a range of negative and even life-threatening outcomes.

The Ultrasound Law directly impacts two critical components of public health: informed consent and the physician-patient relationship. Forcing a woman to receive a medically unnecessary ultrasound 18 hours before a medical procedure is antithetical to informed consent, particularly when she may choose not to receive any information from the ultrasound. Moreover, forcing physicians to perform unnecessary medical procedures and require their patients to travel great distances to obtain such procedures improperly wedges the State between the physician and patient.

a. The Ultrasound Law Undermines Informed Consent.

The State-compelled ultrasound and waiting period are inconsistent with the doctrine of informed consent. Informed consent is an ethical doctrine rooted in the concepts of self-determination and autonomy, and it is based on the principle that patients have the right to

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period, and felt that the law would negatively impact their well-being."); Am. Psychological Ass'n, Task Force on Mental Health and Abortion, *supra* note 5, at 85 ("Examination of perceived stigma revealed that almost half of the 442 women in the multisite sample (Sample 1) felt that they would be stigmatized if others knew about the abortion, and over 45% felt a need to keep it secret from family and friends. Secrecy was associated with increases in psychological distress (anxiety and depression) over time, via the mediators of increased thought suppression and decreased emotional disclosure.").

make decisions regarding their own bodies free from coercion or manipulation.[13] It "consists of two essential elements: comprehension and free consent." *See Stuart* v. *Camnitz*, 774 F.3d 238, 251 (4th Cir. 2014). As the Fourth Circuit explained in *Stuart*:

> Comprehension requires that the physician convey adequate information about the diagnosis, the prognosis, alternative treatment options (including no treatment), and the risks and likely results of each option. Physicians determine the "adequate" information for each patient based on what a reasonable physician would convey, what a reasonable patient would want to know, and what the individual patient would subjectively wish to know given the patient's individualized needs and treatment circumstances. Free consent, as it suggests, requires that the patient be able to exercise her autonomy free from coercion. It may even include at times the choice *not* to receive certain pertinent information and to rely instead on the judgment of the doctor. The physician's role in this process is to inform and assist the patient without imposing his or her own personal will and values on the patient. The informed consent process typically involves a conversation between the patient, fully clothed, and the physician in an office or similar room before the procedure begins.

Id. at 251–52 (internal citations omitted).

Existing Indiana law, as well as general principles of medical ethics, ensure that women are more than adequately informed and made aware of the availability of information about fetal development to make an informed decision whether to have an abortion. Even though the State does not claim that the Ultrasound Law adds new information to inform a woman's decision, it requires physicians to perform certain additional acts before a patient is

[13] Am. Coll. of Obstetricians & Gynecologists, *ACOG Committee Opinion No. 439: Informed Consent*, 114 Obstetrics & Gynecology 401, 401–408 (Aug. 2009) ("Seeking informed consent . . . respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to support of the patient's freedom to make decisions. . . . Informed consent should be looked on as a process rather than a signature on a form. This process includes a mutual sharing of information over time between the clinician and the patient."); Howard Minkoff & Mary Faith Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, Hastings Ctr. Report 39, No. 5 (2009), at 21 (informed consent demands that the physician provide a patient with adequate information about her diagnosis, prognosis, and alternative treatment choices, including foregoing treatment).

legally deemed to have provided informed consent to an abortion.[14] This is antithetical to informed consent because a patient's decision about medical care should be voluntary—not coerced by government—and no aspect of it should be done without the patient's consent. The Ultrasound Law thus violates patient autonomy and creates unwarranted obstacles to her ability to receive care.[15]

Nor does the State claim that the 18-hour waiting period after receiving an ultrasound is medically necessary.[16] Instead, the State argues that it is "common" to delay major medical procedures "to enable proper medical consent." (Appellants' Br. at 34–36.) The State does not, however, impose a similar waiting period for any other medical procedure, including the procedures described by its expert Dr. Francis (e.g., hysterectomies, tubal ligation, or other forms of permanent sterilization). (App. App'x at 44–45.)[17] Those decisions are trusted to the judgment of the patient and her physician. A waiting period following an ultrasound is not uniquely justified here. Legal abortion is among the safest routine medical procedures (safer, in

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[14] Moreover, when given the option to view the ultrasound and listen to the auscultation of the fetal heart tone on the day of the scheduled abortion, 75% of PPINK patients decline to do so, a fact that belies any asserted state interest in informed consent that would justify forcing these women to travel additional distances, and suffer the expense and delay by doing so, in order to have an ultrasound at least 18 hours before their abortion procedure. (Appellee's Br. at 8.) When a "woman does not receive the information, [] it cannot inform her decision." *Stuart*, 774 F.3d at 252.

[15] *ACOG Committee Opinion No. 439*, *supra* note 13 (explaining that the doctrine of informed consent requires that the physician respect the patient's "capacity to set one's own agenda"); Am. Med. Ass'n Code of Med. Ethics, *Opinion 8.08 - Informed Consent* ("The patient should make his or her own determination about treatment.").

[16] Indeed, "[t]here are no circumstances in which a patient's viewing of the fetus is medically necessary." Henry Minkoff & Jeffrey Ecker, *When Legislators Play Doctor: The Ethics of Mandatory Preabortion Ultrasound Examinations*, 120 Obstetrics & Gynecology 647, 649 (2012).

[17] While federally-funded insurance program restrict certain procedures, *see* 42 C.F.R. § 441.257, Indiana does not impose a similar requirement for privately-insured or uninsured patients.

fact, than childbirth),[18] and unlike permanent sterilization, there is no long-term impact on a woman's fertility.[19]

The Ultrasound Law misuses the practice of informed consent by requiring a patient to undergo an unnecessary medical procedure to further the State's goal of persuading the woman not to go through with an abortion. This is a violation of medical ethics and, by extension, detrimental to public health.

b. The Ultrasound Law Undermines the Physician-Patient Relationship.

A well-functioning public health system requires that physicians be able to act in accordance with their medical ethics and judgment and not undertake actions they believe will harm their patients—including legislatively compelled actions.[20] Physicians—not the State—are in the best position to determine how and when to treat their patients, and should be permitted to deliver care that meets the patient's needs, not the State's. *See Stuart*, 774 F.3d at 253 (mandatory ultrasound law "commandeered the doctor-patient relationship to compel the physician to express [the state's] preference to the patient"). Subverting the trust that is central to the physician-patient relationship threatens collective public healthcare.

Physicians must be permitted sufficient discretion to use their judgment and to provide individualized care based on each patient's needs. *See Roe* v. *Wade*, 410 U.S. 113, 114 (1973) ("The abortion decision and its effectuation must be left to the medical judgment of the

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[18] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012) ("[L]egal induced abortion is safe. Mortality and serious acute complications are extremely rare.").

[19] *Id.* (noting that "serious acute complications" resulting from abortions "are extremely rare"); Kristina Gemzel-Danielsson et al., *Contraception Following Abortion and the Treatment of Incomplete Abortion*, 126 Int'l J. Gynecology & Obstetrics S52, S52 (2014) ("An uncomplicated abortion has no negative consequences on a woman's future fertility.").

[20] *See* Am. Pub. Health Ass'n, *Policy Statement No. 20083–Need for State Legislation Protecting and Enhancing Women's Ability to Obtain Safe, Legal Abortion Services Without Delay or Government Interference* (Oct. 2008), http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1369.

pregnant woman's attending physician"). By mandating a physician perform a medically unnecessary procedure to satisfy purported "informed consent" requirements, the Ultrasound Law disrupts the physician-patient relationship and interferes with the ability and discretion of a doctor to counsel, advise, and assist patients. *See Doe* v. *Bolton*, 410 U.S. 179, 192 (1973) (noting that licensed physicians are "recognized by the State as capable of exercising acceptable clinical judgment" and "will know when a consultation is advisable").

Because it commandeers the physician's judgment, imposes unnecessary burdens on the administration of a medical procedure, undermines the doctor-patient relationship, and inhibits the delivery of care he or she believes is medically appropriate for each patient, Amici oppose the Ultrasound Law.

CONCLUSION

The Ultrasound Law reduces access to abortion, negatively impacts mental health outcomes, undermines informed consent, and interferes with the physician-patient relationship. For these reasons, Amici join PPINK in urging the Court to affirm the district court's decision.

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CERTIFICATE OF COMPLIANCE WITH FEDERAL RULE OF APPELLATE PROCEDURE 32(g)

Pursuant to Federal Rule of Appellate Procedure 32(g), I certify the following:

This brief complies with the type-volume limitation of Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure and Circuit Rule 29 because this brief contains 6593 words, excluding the parts of the brief exempted by Rule 32(f) of the Federal Rules of Appellate Procedure. This brief also complies with the typeface requirements of Rule 32(a)(5) of the Federal Rules of Appellate Procedure and Circuit Rule 32(b) and the type style requirements of Rule 32(a)(6) of the Federal Rules of Appellate Procedure because this brief has been prepared in a proportionally spaced typeface using the 2010 version of Microsoft Word in 12 point Times New Roman font for the body and 11 point Times New Roman font for footnotes.

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CERTIFICATE OF SERVICE

I hereby certify that on this 3rd day of August, 2017, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the CM/ECF system. All participants in this case are registered CM/ECF users and service will be accomplished by the CM/ECF system.

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