THOMAS SZOTT
Wyoming Bar No. 7-5139
Thomas Szott Law LLC
P.O. Box 4042
Cheyenne, WY 82003
(307) 275-8038
thomas@szottlaw.com
*Attorney for Amici Curiae*

IN THE DISTRICT COURT OF THE NINTH JUDICIAL DISTRICT

IN AND FOR TETON COUNTY, WYOMING

| | |
|---|---|
| **DANIELLE JOHNSON; KATHLEEN DOW; GIOVANNINA ANTHONY, M.D.; RENE R. HINKLE, M.D.; CHELSEA'S FUND; and CIRCLE OF HOPE HEALTHCARE d/b/a Wellspring Health Access,**<br><br>Plaintiffs,<br><br>v.<br><br>**STATE OF WYOMING; MARK GORDON, Governor of Wyoming; BRIDGET HILL, Attorney General for the State of Wyoming; MATTHEW CARR, Sheriff Teton County, Wyoming; and MICHELLE WEBER, Chief of Police, Town of Jackson, Wyoming,**<br><br>Defendants. | Civil Action No. 18853 |

**Amicus Brief of Wyoming Physicians in Support of State Defendants**

## Table of Contents

## Table of Authorities

### Wyoming Cases



### Other Cases



### Statutes



### Other Authorities

## Interest of *Amici Curiae*

*Amici curiae* Timothy P. Hallinan, MD (retired); David M. Lind, MD, FACOG (retired); Samantha Michelena, MD, FACOG (active OB/GYN); and Michael R. Nelson, DO, FACOOG (active OB/GYN) are Wyoming physicians who support the Life is a Human Right Act passed by the Wyoming Legislature in 2023. The *amici* adhere to the first principle of medical ethics in the Hippocratic tradition: "First, do no harm." The *amici* oppose abortion on demand and believe no Wyoming physician has the professional duty to harm an unborn baby or any other patient.

## Introduction and Summary of Argument

Obstetric care is unique in the realm of medicine. Like other doctors in clinical practice, obstetricians care for patients. However, in almost every case, an obstetrician is caring for two patients simultaneously: a mother and her unborn child. Under this two-patient paradigm, an obstetrician's goal is to maximize the health and chances of survival for both patients.

Even before the advent of modern obstetric care, Wyoming law enshrined this two-patient paradigm. Except while bound by *Roe v. Wade* and its progeny from 1973 to 2022, the territorial and state legislatures of Wyoming persistently prohibited most abortions dating back to 1869, with varying allowances to preserve mothers' lives.[1]

[1] The earliest abortion prohibition in Wyoming dates from 1869, one year after Congress established Wyoming Territory in 1868. COMP. LAWS OF WYO. Ch. 35, § 25 (1876). This prohibition contained an allowance for an abortion "procured or attempted by, or under advice of a physician or surgeon, with intent to save the life of such woman, or to prevent serious and permanent bodily injury to her," although this allowance might have been limited to a criminal charge involving a pregnant woman's death, not an unborn child's. The territorial legislature revised the abortion

After *Roe*'s demise in 2022, *see Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228 (2022), a "trigger law" once again prohibited many abortions in Wyoming. *See* WYO. STAT. § 35-6-102(b) (2022). And in 2023, the legislature passed two new laws prohibiting many abortions in Wyoming: (1) the "Life is a Human Right Act," which generally prohibits many abortions; and (2) a separate prohibition of many chemical abortions. Thus, for more than 150 years, Wyoming law has enshrined the two-patient paradigm that guides obstetricians in real-world clinical practice.

Meanwhile, obstetric care has improved dramatically in that timeframe. In the early 20th century, most maternal deaths were preventable, the result of poor obstetric education and delivery practices. Centers for Disease Control and Prevention (CDC), *Achievements in Public Health, 1900-1999: Healthier Mothers and Babies*, Morbidity and Mortality Weekly Report (Oct. 1 1999), *available at* bit.ly/3SPuPq3. However, between 1900 and 1997, the maternal mortality rate in the United States declined almost 99%. *Id.* Furthermore, the decline of infant mortality in the 20th century was "unparalleled by [any] other mortality reduction." *Id.* Early decreases in infant mortality were due to a combination of advances in public health, social welfare, and medicine. *Id.* Reductions later in the 20th century, however—such as a 41% decline in neonatal mortality during the 1970s—can be attributed to

---

provision in 1884, and again in 1890. REV. STAT. OF WYO. § 879 (1887); 1890 WYO. SESS. LAWS Ch. 73, § 31. Each allowed abortions "necessary to preserve [the woman's] life." The 1890 prohibition (and a companion provision) remained unchanged until repealed in 1977, four years after the U.S. Supreme Court's decision in *Roe v. Wade*. *See Doe v. Burk*, 513 P.2d 643, 645 (Wyo. 1973). Subsequently, Wyoming's 1977 statutory regime remained the law until the U.S. Supreme Court decided *Dobbs v. Jackson Women's Health Organization* in 2022.

technological advances in neonatal medicine and wider availability of perinatal services. *Id.* Today, well-trained obstetricians nationwide and in Wyoming routinely and expertly care for mothers and their unborn children.

This Court is now considering challenges to the legislature's 2023 abortion restrictions. But the Plaintiffs are not only challenging these statutes. The Plaintiffs are challenging the entire two-patient paradigm of obstetric care, which they seek to replace with a one-patient paradigm. Under this one-patient paradigm, the wellbeing of the unborn baby is irrelevant, every abortion is medically indicated, and every obstetrician would have a legal and ethical duty to provide (or at least facilitate) abortion on demand, regardless of the circumstances.

In this brief, the *amici* argue in favor of the traditional two-patient paradigm of obstetric care, confining their analysis to the Life is a Human Right Act (or "the Act"). As discussed below, the Plaintiffs' one-patient paradigm is an ideological fantasy. It does not reflect clinical reality, and it would radically change the practice of obstetrics in Wyoming. Conversely, although it is not a perfect law, the Life is a Human Right Act generally reflects the two-patient paradigm of obstetric care. It allows physicians to provide life-preserving treatment for pregnant women experiencing dangerous physical complications of pregnancy, while simultaneously offering many unborn babies a chance to survive. And it is consistent with real-world obstetric practice, in which competent physicians, directed by training, experience, and expert clinical guidance, routinely diagnose and treat life-threatening pregnancy complications. This Court should allow the Act to take effect.

## Argument

### I. Abortion on demand is not essential healthcare, because obstetricians practice under a two-patient paradigm.

#### a. The Plaintiffs' one-patient paradigm of obstetric care does not reflect clinical reality.

To achieve their one-patient paradigm of obstetric care, the Plaintiffs begin by characterizing abortion as a safer pregnancy outcome than childbirth. To this point, the Plaintiffs cite data from the United States that purportedly show "[t]he risk of mortality from pregnancy and childbirth is over 12 times greater than for legal pre-viability abortion." (Plaintiffs' Summary Judgment Memorandum at 14).

However, as a simple matter of statistical analysis, this is a false comparison. As Dr. Julie L. Gerberding, then-Director of the CDC, explained in 2004, the maternal mortality rate is computed per 100,000 live births, because underlying information about live births is reliable and allows analysis of long-term trends and international comparisons. Letter of July 20, 2004 from Louise Gerberding, Director, CDC, to Walter M. Weber *available at* bit.ly/3CErJzL. Dr. Gerberding notes that the second ratio, which evaluates maternal deaths from abortion, relies on a case-fatality rate computed per 100,000 legal abortions. *Id.* "These measures are conceptually different and are used by CDC for different public health purposes." *Id.* Moreover, accurate information on the cause of death may not be available. *Id.* In short, comparing the two ratios is inherently fallacious.

Statistics from countries with more accurate data on maternal mortality may tell a different story. For example, a study of first pregnancies among Danish women reported the risk of death within 180 days after an early abortion was about 244%

higher than the risk of death after childbirth; the risk of death within 180 days after a late-term abortion (after 12 weeks gestation) was about 705% higher than after childbirth. David C. Reardon & Priscilla K. Coleman, *Short and long term mortality rates associated with first pregnancy outcome: Population register based study for Denmark 1980-2004*, 18 Med. Sci. Monitor PH71–PH76 (2012) *available at* bit.ly/3rEOCg8.

The Plaintiffs also catalog various health risks associated with pregnancy and childbirth. They include not only complications like pulmonary diseases and preeclampsia, and not only risks inherent in labor and delivery, but even garden-variety circumstances that occur in uncomplicated pregnancies: increased "blood volume, a faster heart rate, increased production of clotting factors, breathing changes, digestive complications, substantial weight gain[,] and a growing uterus." (Plaintiffs' Summary Judgment Memorandum at 13).

Combining questionable statistics with the risks inherent in pregnancy, the Plaintiffs leap to their one-patient paradigm for obstetric practice. According to the Plaintiffs, "[g]iven that pregnancy and childbirth carry much higher risks to a woman's health than abortion, there is no circumstance where a woman will not obtain a medical benefit from an abortion." (Plaintiffs' Summary Judgment Memorandum at 33). The Plaintiffs' proposed expert is blunter, claiming "any abortion that a pregnant person requests - for any reason - is medically necessary." (Exhibit 7 ¶ 51). Thus, "[e]very abortion is life-saving healthcare." (*Id.* ¶ 52).

By this reasoning, pregnancy is no different than a dangerous disease. Any abortion at any stage of pregnancy will cure the disease, so every abortion is medically necessary.

However, the Plaintiffs' one-patient paradigm is not based on medical evidence or reality. Instead, it rests upon the ideological conclusion that abortion and childbirth are comparable outcomes because the unborn child has no relevance to the physician's treatment recommendations. If this were a valid medical conclusion, then every competent obstetrician would recommend abortion as a first line treatment for every pregnant woman, and an overwhelming majority of obstetricians would perform abortions. But the former premise is absurd. As for the latter, a national survey showed 93% of obstetrician-gynecologists in private practice did not provide abortions in 2013 or 2014. Sheila Desai, *Estimating Abortion Provision and Abortion Referrals Among United States Obstetrician-Gynecologists in Private Practice*, 97 Contraception 297-302 (2018). In short, the Plaintiffs' one-patient paradigm does not reflect the reality of obstetric practice.

In reality, obstetricians practice under a two-patient paradigm. And under this two-patient paradigm, comparing the relative maternal risks of abortion and childbirth is irrational, because the two outcomes are categorically different. Whatever their relative risks for a pregnant mother, the overall risk of death (mother or child) is thousands of times higher in abortion cases than live-birth cases. Even if medically necessary to save one patient's life, an abortion is never a good outcome in any case, because it results in the death of another patient.

And by definition, an unborn baby qualifies as an obstetrician's "patient," because the obstetrician is providing medical diagnosis or treatment to the unborn baby. *See, e.g.*, WYO. STAT. § 33-26-102(a)(xx) (defining "Physician-patient relationship"). Indeed, various medical treatments and diagnostics given or performed in pregnancy are exclusively for the unborn baby's benefit. Some of these occur early in pregnancy, such as dietary changes, folic acid taken by the mother to prevent neural tube defects in the baby, and ultrasounds performed to detect abnormalities in the baby. Tests and interventions continue as pregnancy progresses.

Expectant mothers sometimes endure great hardship, and medical risk, to protect the lives of the children in their wombs. Under a one-patient paradigm, this would be medically irrational. But in reality, it is medically appropriate, because multiple lives are involved.

**b. The Plaintiffs' one-patient paradigm would radically change obstetric practice in Wyoming.**

To their credit, the Plaintiffs are logically consistent. They press their one-patient paradigm to its inevitable, albeit radical conclusion.

Specifically, the Plaintiffs argue abortion on demand is ethically and legally mandatory. Relying on their premise that every abortion is necessary healthcare, the Plaintiffs argue any prohibition of abortion would "place physicians in an ethical dilemma of choosing between their obligation to provide the best available medical care and substantial legal (sometimes criminal) penalties." (Plaintiffs' Summary Judgment Memorandum at 35). Complying with the Life is a Human Right Act could cause physicians "to violate their oath." (*Id.* at 36). Indeed, complying with the Act

could result in physicians receiving professional discipline for "[p]racticing medicine below the applicable standard of care." (*Id.*).

If the Plaintiffs' logic were valid, it would radically alter obstetric practices in Wyoming. If an obstetrician could receive professional discipline for refusing to perform an abortion, and if every abortion were life-saving healthcare, then the logical conclusion would be inescapable: every obstetrician would have a professional duty to perform (or at least facilitate) any abortion a woman might request, regardless of the circumstances. Admittedly, the Plaintiffs seem to offer a slight allowance: "[I]f performing a particular abortion is not consistent with the applicable medical standard of care, then there is nothing that requires a physician to perform it." (Plaintiffs' Summary Judgment Memorandum at 36). But by the Plaintiffs' own logic, this allowance is illusory. As discussed above, the Plaintiffs claim <u>every</u> abortion is medically necessary. Therefore, under the Plaintiffs' paradigm, every obstetrician in Wyoming would have the legal and ethical duty to perform or facilitate abortion on demand, whatever the circumstances.

Fortunately, the Plaintiffs' logic is not valid. They are ignoring reality, and they are ignoring the law.

The question of professional discipline is easily settled. For decades, Wyoming law has explicitly guaranteed that no person may be subject to any sanction, including a professional sanction by a governing board, for refusing to perform or participate in any abortion. WYO. STAT. § 35-6-130. The reason for the refusal does

not matter. *See id.* Therefore, contrary to what the Plaintiffs argue, no physician in Wyoming may face professional discipline for refusing to perform an abortion.

Furthermore, the Plaintiffs' arguments rely on the faulty premise that states must permit physicians to offer any "treatment" they, their patients, or elements of the medical establishment may deem appropriate. But to the contrary, governments routinely prohibit or regulate "treatments," from assisted suicide, *e.g.*, WYO. STAT. § 35-22-509, to controlled substances, *e.g.*, *id.* § 35-7-1030, to various forms of abortion, *e.g.*, 18 U.S.C. § 1531 (prohibiting partial-birth abortion). Patients in a given state have no right to such "treatments," and physicians who unlawfully provide them may properly face discipline or liability under the law. These limitations do not violate medical ethics.

Finally, no physician would violate his oath by refusing to perform an abortion. "Medical ethics in the Hippocratic tradition entreat doctors to 'First, do no harm.'" *Nieto v. Kapoor*, 268 F.3d 1208, 1222 n.12 (10th Cir. 2001). Consistent with this first principle, obstetricians under the two-patient paradigm work to save their patients, not kill them. No physician has an ethical duty to destroy one of his patients, regardless of how it might benefit the other.

## II. The Life is a Human Right Act reasonably reflects the two-patient paradigm of obstetric care, protecting unborn babies while allowing Wyoming physicians to provide life-preserving treatment to pregnant mothers.

Having dispensed with the Plaintiffs' radical one-patient paradigm of obstetric care, it remains to discuss how the Life is a Human Right Act reflects the two-patient paradigm that governs real-world obstetric practice. The *amici* begin by summarizing

the law's provisions and continue by explaining how the law allows life-preserving treatment for pregnant women in Wyoming.

**a. The Life is a Human Right Act offers a straightforward framework for physicians in Wyoming.**

For a physician contemplating a particular procedure involving a pregnant woman, the Life is a Human Right Act provides a straightforward framework:

*First*, does the physician intend to terminate a known, non-ectopic pregnancy in a manner reasonably likely to cause an unborn baby's death, without intending to save the unborn baby? Unless these elements are present, the procedure is not "abortion" and is allowed. WYO. STAT. §§ 35-6-122(a)(i), -123(a).

*Second*, is the physician treating the woman for cancer or another disease requiring treatment that may kill or harm the unborn baby? If so, then the procedure is not "abortion" and is allowed. WYO. STAT. §§ 35-6-122(a)(i)(D), -123(a).

*Third*, did the pregnancy result from a reported act of incest or sexual assault, or has the physician reasonably diagnosed a molar pregnancy or a substantial likelihood of a lethal fetal anomaly? If so, then the physician may terminate pregnancy at any stage by any means, including "abortion." WYO. STAT. §§ 35-6-123(a); -124(a)(iii), (iv).

*Fourth*, in the physician's reasonable medical judgment, is termination of pregnancy necessary to prevent the woman's death, a substantial risk of death, or the serious and permanent impairment of a life-sustaining organ? If so, then the physician may terminate the woman's pregnancy, but he must make any medically reasonable effort to preserve the lives of the pregnant woman and the unborn baby.

WYO. STAT. §§ 35-6-123(a), -124(a)(i). If the baby is not viable, then the physician may terminate the pregnancy via "abortion." If the baby is or may be viable, then the physician must terminate pregnancy by induction or caesarian section, not "abortion." *See id.*[2]

An important clarification is necessary. The Plaintiffs claim physicians at this stage of the analysis must delay "treatment . . . until a woman is at imminent risk of serious injury or death." (Plaintiffs' Summary Judgment Memorandum at 38). But the Plaintiffs are wrong. The law allows termination of pregnancy not only "to prevent the death of the pregnant woman," but also "to prevent . . . a substantial risk of death for the pregnant woman because of a physical condition or the serious and permanent impairment of a life-sustaining organ." WYO. STAT. § 35-6-124(a)(i). Because the law authorizes preventative care, a physician need not wait for a medical emergency before providing life-preserving treatment. Rather, a physician may provide

[2] Wyoming Statutes § 35-6-124(a)(i) allows a "a pre-viability separation procedure necessary in the physician's reasonable medical judgment to prevent the death of the pregnant woman, a substantial risk of death for the pregnant woman because of a physical condition or the serious and permanent impairment of a life-sustaining organ of a pregnant woman, provided that . . . the physician makes all reasonable medical efforts under the circumstances to preserve both the life of the pregnant woman and the life of the unborn baby in a manner consistent with reasonable medical judgment." Section 35-6-124(a)(i) says nothing about terminating pregnancies post-viability. However, any termination where the unborn baby has a reasonable chance to survive, WYO. STAT. § 35-6-122(a)(i), or where the physician intends to save the unborn baby's life, *id.* § 35-6-122(a)(i)(A), is not an "abortion" under the law. In short, if the unborn baby is or may be viable, a physician may terminate a woman's pregnancy to preserve her life or health, but he must do so with the intent to save the unborn baby as well.

treatment as soon as it is medically advisable, thereby preventing an emergency in the first instance.

The Life is a Human Right Act relies on two familiar touchstones, beginning with intent. An act is not "abortion" unless the physician intends to terminate a pregnancy without intending to save the unborn baby's life, treat an ectopic pregnancy, or provide necessary treatment for cancer or another disease. *See* WYO. STAT. §§ 35-6-122(a)(i), -123(a). Moreover, any "medical treatment to a pregnant woman that results in the accidental or unintentional injury to, or the death of, an unborn baby" is not prohibited. *Id.* § 35-6-124(a)(ii). And an "abortion" is not prohibited unless the physician specifically intended to cause or abet the abortion. *Id.* § 35-6-123(a). *See generally Cox v. State*, 829 P.2d 1183, 1185 (Wyo. 1992) ("[O]nly those crimes which refer to an intent to do a further act or achieve a future consequence are specific intent crimes."). In short, the Act only holds physicians accountable for their intentional acts.

As its second touchstone, the Life is a Human Right Act incorporates the standard of "reasonable medical judgment," defined as "a medical judgment that would be made by a reasonably prudent physician who is knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved." WYO. STAT. § 35-6-122(a)(iii). Under the Act, this standard informs physician determinations of whether termination is necessary to protect a woman's life or health or because of a molar pregnancy or lethal fetal anomaly. WYO. STAT. § 35-6-124(a)(i), (iv).

This touchstone of "reasonable medical judgment" is a familiar standard for Wyoming physicians. In practicing medicine, every "physician or surgeon must exercise the skill, diligence and knowledge, and must apply the means and methods, which would reasonably be exercised and applied under similar circumstances by members of his profession in good standing and in the same line of practice." *Vassos v. Roussalis*, 625 P.2d 768, 772 (Wyo. 1981). This standard "is an ascertainable and comprehensible standard that provides physicians with more than fair warning as to what conduct is expected of them in order to avoid the imposition of liability . . . because this is the same standard by which all of their medical decisions are judged under traditional theories of tort law." *See Karlin v. Foust*, 188 F.3d 446, 464 (7th Cir. 1999) (construing Wisconsin law) (quotation marks omitted). Moreover, this standard endorses a range of professional discretion. *Cf. id.* ("In any given medical situation there [are] likely to be a number of reasonable medical options and disagreement between doctors over the appropriate course of action does not, of course, render one option reasonable and another unreasonable.").

In sum, the Life is a Human Right Act reasonably reflects the two-patient paradigm of obstetric care. It protects the lives of most unborn babies while allowing physicians to provide life-preserving treatment for pregnant women.

**b. The Life is a Human Right Act reflects the two-patient paradigm that governs real-world obstetrics. It allows obstetricians to provide life-saving interventions, consistent with clinical guidance and reasonable medical judgment.**

The Plaintiffs criticize the Life is a Human Right Act on various fronts, some of which are beyond the scope of this *amicus* brief. However, under the two-patient

paradigm that governs real-world clinical obstetrics, the Plaintiffs' most fundamental criticisms are twofold and interrelated. *First*, the Plaintiffs claim the Act will prevent physicians from providing timely life-saving treatment to pregnant women as a matter of law. (*E.g.*, Plaintiffs' Summary Judgment Memorandum at 38-39). *Second*, the Plaintiffs predict physicians or hospitals will delay life-saving treatment because they cannot determine what is permissible under the Act. (*E.g.*, *id.* at 39). As discussed below, however, the Plaintiffs are wrong in both respects.

As a preliminary observation, practicing obstetricians have years of professional training (and their own experience) that enables them to identify dangerous pregnancy complications and when life-saving interventions are appropriate. As exemplified below, they also have clinical guidance from entities like the American College of Obstetricians and Gynecologists (ACOG), which provides clinical guidance to practicing obstetricians through practice bulletins, clinical practice guidelines, and other obstetric care consensus documents.[3] Along with

[3] In discussing ACOG's clinical guidance, one must understand the organization's two distinct roles. On one hand, ACOG issues position statements and statements of policy. ACOG Policy & Position Statements, *available at* bit.ly/3SJfh7c (last visited Oct. 16, 2023). Various position statements and statements of policy appear to be approved by the Board of Directors or Executive Board for ACOG; it is unclear to what extent the statements reflect the ideological views of ACOG's membership.

On the other hand, ACOG provides medical guidance to practicing obstetricians through practice bulletins, clinical practice guidelines, and other obstetric care consensus documents. In contrast to policy statements and position statements, this ACOG clinical guidance provides reliable information that physicians regularly use to identify life-threatening pregnancy complications and determine which medical interventions are medically appropriate.

multidisciplinary teams and other assets, obstetricians in Wyoming have the necessary tools to diagnose and treat dangerous pregnancy complications.

For her part, although the Plaintiffs' proposed expert opines that every pregnancy is life-threatening, she also posits various particularly dangerous conditions in her declaration. (Exhibit 7). Some are physical conditions within an obstetrician's scope of expertise and the scope of this *amicus* brief, while some (*e.g.*, systemic racism) are not. (Exhibit 7 ¶¶ 15-16, 55). However, for dangerous pregnancy complications within the scope of an obstetrician's expertise, the Life is a Human Right Act authorizes obstetricians to provide life-saving interventions.

**i. Ectopic Pregnancy**

The Act defines "ectopic pregnancy" as "a pregnancy that occurs when a fertilized egg implants and grows outside the main cavity of the uterus." WYO. STAT. § 35-6-122(a)(v). But according to the Plaintiffs' proposed expert, this statutory definition is too simple, because various ectopic pregnancies—*e.g.*, caesarean scar ectopic pregnancies—would not satisfy the definition. (Exhibit 7 ¶ 15).

However, assuming *arguendo* the Plaintiffs' proposed expert is correct, the Act nevertheless allows life-saving treatment for any ectopic pregnancy. As the Plaintiffs' proposed expert correctly observes, "Ectopic pregnancies are life-threatening[,] and immediate intervention should be offered when diagnosed to prevent severe morbidity and mortality." (Exhibit 7 ¶ 15). Therefore, regardless of whether a particular ectopic pregnancy satisfies the statutory definition in Section 35-6-122(a)(v), all ectopic pregnancies necessarily would qualify for immediate life-saving treatment to prevent the pregnant woman's death or a substantial risk thereof. WYO.

STAT. § 35-6-124(a)(i). Therefore, any lack of precision in the statutory definition of "ectopic pregnancy" is immaterial.

### ii. Molar Pregnancy

The Plaintiffs' proposed expert similarly criticizes the Act's statutory definition of "molar pregnancy." (Exhibit 7 ¶ 16). But as with ectopic pregnancies, even if a particular molar pregnancy does not meet the statutory definition, it nevertheless would qualify for any indicated life-saving treatment to prevent the woman's death or a substantial risk thereof. WYO. STAT. § 35-6-124(a)(i).

In discussing molar pregnancy, the Plaintiffs' proposed expert unaccountably fails to grasp the Act's plain language. She relates the anecdote of a woman in Oklahoma diagnosed with a partial molar pregnancy involving fetal cardiac activity, who apparently was directed to remain in the hospital parking lot, hemorrhaging, until fetal cardiac activity ceased. (Exhibit 7 ¶ 16). Apparently, the Plaintiffs' expert believes (or wants this Court to believe) the same thing would happen in Wyoming. But at the time, Oklahoma law apparently required a "medical emergency," *i.e.*, for "a woman to be in actual and present danger in order for her to obtain a medically necessary abortion." *Okla. Call for Reprod. Just. v. Drummond*, 526 P.3d 1123, 1131 (Okla. 2023). By contrast, as discussed above, the Act requires no such emergency. *See supra* § II(a). Apart from unaccountable misunderstanding, no competent Wyoming obstetrician or hospital would construe the Act otherwise.

### iii. Cancer

The Plaintiffs' proposed expert lists breast cancer, cervical cancer, gastric cancer, and melanoma as dangerous pregnancy conditions. (Exhibit 7 ¶ 55(iii), (xi),

(xii), (xiii)). She opines that abortion is necessary in such cases, because radiation therapy is not offered to pregnant women. (*Id.*)

Undeniably, cancer may be a life-threatening condition for an expectant mother.

> Treatment considerations and concerns for maternal and fetal health can vary depending on the type of cancer, the degree of spread, the likelihood of recurrence, the proximity of the cancer to the uterus, the possibility of cancer promotion due to pregnancy hormones, and the toxicity of treatment options for the unborn child (which may include surgery, radiation and chemotherapy), so there is not a standard recommendation on how cancer treatment should be addressed in pregnancy.[4]

However, as a general rule, "if a multidisciplinary team concludes that ending the pregnancy would benefit a woman undergoing cancer treatment, this management would . . . fall under [legal] exemptions for the 'life of the mother.'" *Id.* (emphasis omitted).

The Life is a Human Right Act follows this general rule. Life-preserving cancer treatment is permissible under the Act, including any associated termination of pregnancy, either because such termination does not constitute "abortion" at all, WYO. STAT. § 35-6-122(a)(i)(D), or because it is necessary to prevent a substantial risk of the pregnant woman's death (or the permanent impairment of a life-sustaining organ); *id.* § 35-6-124(a)(i). At most, a physician might need to terminate pregnancy

---

[4] Ingrid Skop, M.D., F.A.C.O.G., & Mary E. Harned, J.D., *Pro-Life Laws Protect Mom and Baby: Pregnant Women's Lives are Protected in All States*, On Point, Issue 86, Sept. 2023, at 7, *available at* https://lozierinstitute.org/pro-life-laws-protect-mom-and-baby-pregnant-womens-lives-are-protected-in-all-states/ (hereafter "Skop & Harned").

via induction or caesarian section if the baby is viable. *See id.* But any accidental or unintentional harm to an unborn baby from cancer treatment would not be prohibited. *Id.* § 35-6-124(a)(ii). In short, the Act contemplates and authorizes life-preserving cancer treatment for pregnant women.

### iv. Other Dangerous Pregnancy Complications

Other dangerous pregnancy complications, including those referenced by the Plaintiffs' proposed expert, are not specifically identified in the Life is a Human Right Act. Nonetheless, the Act similarly authorizes life-preserving treatment for those complications, as discussed at the end of this section.

#### 1. Previable Prelabor Rupture of Membranes

According to the Plaintiffs' proposed expert, "previable rupture of membranes can lead to sepsis or hemorrhage, both of which are leading causes of maternal death globally." (Exhibit 7 ¶ 55(i)). This condition presents a substantial risk of death for a pregnant woman. Accordingly, along with expectant management, ACOG's clinical guidance recommends offering immediate "termination of pregnancy by induction of labor or dilation and evacuation." Skop & Harned at 5.

Significantly, ACOG's inclusion of "expectant management" (watchful waiting) as an alternative reflects its recognition of the two-patient paradigm of obstetric care. This same recognition resounds throughout various ACOG clinical guidance materials.

#### 2. Hypertensive Emergency

According to the Plaintiffs' proposed expert, "[p]ulmonary hypertension in pregnancy results in a 30-56% maternal mortality rate." (Exhibit 7 ¶ 55(ii)) A

hypertensive emergency during pregnancy may threaten the mother's life, and ACOG has clinical guidance to assist physicians in this circumstance. Skop & Harned at 5. Among other things, ACOG's clinical guidance again reflects the two-patient paradigm of obstetric care: "Because expectant management is intended to provide neonatal benefit at the expense of maternal risk, expectant management is not advised when neonatal survival is not anticipated." *Id.*

### 3. Placenta Accreta Spectrum

According to the Plaintiffs' proposed expert, placenta accreta spectrum disorder, which she describes as "when a placenta does not detach normally from a uterus, . . . confers a mortality risk of about 7% and an 18-fold increase in maternal morbidity." (Exhibit 7 ¶ 55(vi) (footnote omitted)). Undeniably, placenta accreta spectrum may be life-threatening to a pregnant woman. ACOG's clinical guidance provides:

> When the diagnosis of placenta accreta spectrum is made in the previable period, it is important to include counseling about the possibility of pregnancy termination for maternal indications given the significant risk of maternal morbidity and mortality. However, there are currently no data to support the magnitude of risk reduction, if any. Further, pregnancy termination in the setting of placenta accreta spectrum also carries risk, and the complexities of counseling should be undertaken by health care providers who are experienced in these procedures[.]

Skop & Harned at 6.

### 4. Maternal Heart Disease

The Plaintiffs' proposed expert lists ischemic heart disease as a dangerous pregnancy complication. Exhibit 7 ¶ 55(ix). Undeniably, maternal heart disease may be life-threatening during pregnancy. ACOG's clinical guidance provides,

> Patients should be counseled to avoid pregnancy or consider induced abortion if they have severe heart disease, including an ejection fraction below 30% or class III/IV heart failure, severe valvular stenosis, Marfan Syndrome with aortic diameter more than 45 mm, bicuspid aortic valve with aortic diameter more than 50 mm, or pulmonary arterial hypertension.

Skop & Harned 6. Furthermore, ACOG's guidance recommends employing a "multidisciplinary Pregnancy Heart Team" and "[a] personalized approach estimating the maternal and fetal hazards related to the patient's specific cardiac disorder and the patient's pregnancy plans." *Id.* Again, this guidance reflects the two-patient paradigm of obstetric care.

**5. The Life is a Human Right Act authorizes life-preserving treatments for such conditions.**

For any dangerous physical complication of pregnancy not specifically referenced by the Life is Human Right Act, including those discussed above, the Act nevertheless permits physicians to provide medically reasonable life-preserving treatments. Before viability, assuming there is no medically reasonable chance to save the unborn baby's life, these would include indicated abortions by dilation and evacuation. *See* WYO. STAT. § 35-6-124(a)(i). After viability, consistent with the two-patient paradigm of obstetric care, a physician would need to terminate pregnancy by induction or caesarian section, not by any procedure designed to kill the unborn baby. *See id.*

**v. The Life is a Human Right Act will not impede Wyoming obstetricians from saving patients' lives.**

Life-threatening obstetric complications are one reason why obstetricians are so important within the medical community. For obstetricians, the concern is not that

pregnancy itself is life-threatening. Rather, pregnancy can become life-threatening in mere moments and require an immediate medical response. In turn, obstetricians rely upon peer-reviewed clinical guidance to inform their treatment decisions, including guidance from ACOG. And in the rare cases when the indicated treatment is unclear, multi-disciplinary committees within each hospital system can provide guidance to the physician as well as documentation for the hospital. Given this guidance, obstetricians have sufficient information to make reasonable medical judgments when presented with pregnancy complications.

The Life is a Human Right Act will not impede the quality of obstetric care for women in Wyoming. As outlined above, the law allows life-preserving treatments for dangerous physical complications of pregnancy. The law also incorporates specific intent and protects the diagnosis and treatment of pregnancy complications by physicians exercising "reasonable medical judgment." Competent obstetricians are accustomed to exercising such judgment and intervening to protect the lives of their patients when necessary. That will not change under the Act.

Finally, it is worth emphasizing what the Act does not do. Depending on the circumstances, the Act may require a physician to make medically reasonable efforts to save an unborn baby's life, including delivery by induction or caesarian section after viability. This should not be controversial. But otherwise, the Act does not distinguish between alternatives on moral or ethical grounds. The Act does not require any woman to continue a pregnancy that would endanger her life or the function of a life-sustaining organ. Nor does it require a physician to allow any

woman's health to deteriorate to the point of a medical emergency. The Act is not perfect, but it generally expresses and implements the two-patient paradigm of obstetric care in Wyoming.

## III. Conclusion

The Plaintiffs' one-patient paradigm of obstetric care is motivated by ideology, not medical reality. By contrast, a two-patient paradigm reflects the realities of obstetric care. And the Life is a Human Right Act reflects this two-patient paradigm. It requires what obstetricians are already doing: working to preserve the lives and health of mothers and babies in Wyoming.

DATED this 16th day of October, 2023.

Respectfully submitted,

*/s/ Thomas Szott*
THOMAS SZOTT[5]
Wyoming Bar No. 7-5139
Thomas Szott Law LLC
P.O. Box 4042
Cheyenne, WY 82003
(307) 275-8038
thomas@szottlaw.com
*Attorney for Amici Curiae*

[5] I hereby attest that I have on file an original signature corresponding to any signature indicated by a conformed signature /s/ within the electronically filed version of this document.

## Certificate of Service

I hereby certify that, on the 16th day of October, 2023, a copy of the foregoing was or will be served by email and U.S. Mail (and eService if applicable) as follows, consistent with WYO. R. CIV. P. 5(b):

John H. Robinson
Marci C. Bramlet
Robinson Bramlet LLC
P.O. Box 3189
Jackson, WY 83001
john@jrmcb.com
marci@jrmcb.com

Erin E. Weisman
Teton County Attorney's Office
P.O. Box 4068
Jackson, WY 83002
eweisman@tetoncountywy.gov

Megan M. Cooney
Gibson, Dunn & Crutcher, LLP
3161 Michelson Drive
Irvine, CA 92612
mcooney@gibsondunn.com

Lea M. Colasuonno
Carly K. Anderson
Town of Jackson
P.O. Box 1687
Jackson, WY 83001
lcolasuonno@jacksonwy.gov
canderson@jacksonwy.gov

Peter S. Modlin
Gibson, Dunn & Crutcher, LLP
555 Mission Street, Suite 3000
San Franciso, CA 94105
pmodlin@gibsondunn.com

Jay Jerde
Wyoming Attorney General's Office
109 State Capitol
Cheyenne, WY 82002
jay.jerde@wyo.gov

*/s/ Thomas Szott*
THOMAS SZOTT
*Attorney for Amici Curiae*