No. 04-1144

In The
Supreme Court of the United States

KELLY A. AYOTTE,
ATTORNEY GENERAL OF NEW HAMPSHIRE,
Petitioner,

V.

PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, *ET AL.*,
Respondents.

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

BRIEF *AMICI CURIAE* OF AMERICAN ASSOCIATION OF PRO LIFE OBSTETRICIANS AND GYNECOLOGISTS, CHRISTIAN MEDICAL ASSOCIATION, CATHOLIC MEDICAL ASSOCIATION, ALLIANCE DEFENSE FUND, NATIONAL ASSOCIATION OF EVANGELICALS, CONCERNED WOMEN FOR AMERICA AND CHRISTIAN LEGAL SOCIETY IN SUPPORT OF PETITIONER

Steven H. Aden *(Counsel of Record)*
CENTER FOR LAW &
RELIGIOUS FREEDOM
OF THE CHRISTIAN LEGAL SOCIETY
4208 Evergreen Lane, Suite 222
Annandale, Virginia 22003
Tel.: (703) 642-1070

Counsel for Amici Curiae

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

CONSTITUTIONAL AND STATUTORY PROVISIONS

MEDICAL AUTHORITIES

OTHER AUTHORITIES

STATEMENTS OF INTEREST OF *AMICI CURIAE*[1]

American Association of Pro Life Obstetricians and Gynecologists ("AAPLOG") is a national organization of over 2,500 obstetricians and gynecologists who reaffirm the unique value and dignity of individual human life in all stages of growth and development from conception onward.

The Christian Medical Association ("CMA") was founded in 1931 and today represents over 16,000 members—primarily practicing physicians representing the entire range of medical specialties. These members, who include physicians licensed to practice in the State of New Hampshire, share a common commitment to the principles of biblical faith and the integration of those principles with professional practice. Among other functions, the CMA Medical Ethics Commission coordinates member experts in the field of medical ethics who formulate positions on vital issues. These positions are subsequently voted upon for adoption, amendment, or rejection by over 100 elected representatives to the national convention of the Association. CMA's members have an interest in the case before the Court because it raises the prospect of a constitutional rule that may result in poorer access to family support structures necessary for providing medical care in the best interests of their patients.

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[1] *Amici curiae* file this brief by consent of the parties, and copies of the letters of consent are on file with the Clerk of the Court. Counsel for *Amici* authored this brief in its entirety. No person or entity, other than the *amici curiae*, their supporters, or their counsel, has made a monetary contribution to the preparation or submission of this brief. *Amici* wish to gratefully acknowledge the contributions of Steven R. Zielinski, M.D., J.D., who served as principal medical consultant for this brief.

The Catholic Medical Association is a professional association of American and Canadian physicians, who seek to respond to the unique responsibility which belongs to all health-care personnel as guardians and servants of human life and human dignity. Its members are conscious of the fact that their patients entrust themselves to the knowledge acquired by physicians. This suggests an important tension. As John Paul, II noted in *On Faith and Reason*, "On the one hand, the knowledge acquired through belief can seem an imperfect form of knowledge, to be perfected gradually through personal accumulation of evidence; on the other hand, belief is often humanly richer than mere evidence, because it involves an interpersonal relationship and brings into play not only a person's capacity to know but also the deeper capacity to entrust oneself to others...." This capacity to entrust oneself to others lies at the heart of the patient-physician relationship, and at the heart of this case. The Catholic Medical Association has an interest in assisting the Court in properly understanding that relationship.

Alliance Defense Fund ("ADF") is a not-for-profit public interest organization that provides strategic planning, funding, and training to attorneys and organizations to reform American law so that all human life will be respected and protected from conception to death. Its membership includes hundreds of lawyers and numerous public interest law firms. ADF has advocated for the rights of Americans in hundreds of significant cases throughout the United States, having been directly or indirectly involved in at least 500 cases and legal matters, including cases before this Court regarding life issues such as *Vacco v. Quill,* 521 U.S. 793 (1997), and *Washington v. Glucksberg,* 521 U.S. 702 (1997).

The National Association of Evangelicals ("NAE") is a nonprofit association of evangelical Christian denominations, local churches, para-church organizations, and individuals, and includes more than 50,000 local churches from 51 denominations, as well as over 250 other religious ministries. NAE serves a constituency of over 30 million people. The Association believes that human life is sacred, that civil government has no higher duty than to protect human life, and the duty is particularly applicable to the life of unborn children because they are helpless to protect themselves.

Concerned Women for America ("CWA") is the nation's largest public policy organization for women. Located in Washington, D.C., CWA is a non-profit organization that provides policy analysis to Congress, state and local legislatures and assistance to pro-family organizations through research papers and publications. CWA seeks to inform the news media, academic community, business leaders and the general public about marriage, family, cultural and constitutional issues that affect the nation. CWA has participated in numerous *amicus curiae* briefs in the United States Supreme Court, lower federal courts and state courts.

CWA's vision statement calls for women and like-minded men to come together to restore the family to its traditional purpose because this allows each family member to realize their God-given potential and be more responsible citizens. The inalienable right to life documented in the Declaration of Independence and shored up by strong families is a touchstone of liberty. CWA's defense of minors' ability to rely on the protection and wisdom of their parents is a long-standing part of CWA's educational and grassroots efforts.

The Christian Legal Society ("CLS"), founded in 1961, is a nonprofit interdenominational association of Christian attorneys, law students, judges, and law professors with chapters in nearly every state and most law schools. Since 1975, the Society's legal advocacy division, the Center for Law and Religious Freedom, has worked for the protection of human life from conception to natural death.

SUMMARY OF ARGUMENT

In imposing a constitutional standard for parental notice statutes that mandates a broadly interpreted "health" exception, the Circuit Court of Appeals has relied precipitously upon the testimony of one physician-Plaintiff in the case. The Court's *Amici* seek to bring to the Court's attention supplemental medical authority that suggests that none of the acute medical complications of pregnancy cited by the Court of Appeals or Respondents and their *amici* necessarily mandates immediate termination of pregnancy by abortion as the accepted standard of practice. Moreover, Respondents' assertion that abortion is a relatively "safe" medical procedure relies upon maternal mortality data that is unintended for that purpose and unsuitable to it.

ARGUMENT

i. INTRODUCTION.

In 2003, the New Hampshire legislature enacted the "Parental Notification Prior to Abortion Act" to require parental notification before abortions may be performed on unemancipated minors. 2003 N.H. LAWS 173, codified at N.H. REV. STAT. ANN. ("RSA") § 132:24-28 (2003); *see Planned Parenthood of Northern New England v. Heed*, 390

F.3d 53, 55 (1st Cir. 2004). The Act provides:

> No abortion shall be performed upon an unemancipated minor or upon a female for whom a guardian or conservator has been appointed pursuant to RSA 464-A because of a finding of incompetency, until at least 48 hours after written notice of the pending abortion has been delivered in the manner specified in paragraphs II and III.

RSA 132:25; 390 F.3d at 55. Written notice must be addressed to the parent at the usual place of residence; notification by certified mail is permitted. *Id*. However, notice is not required in the fashion provided by the statute if the person entitled to notice certifies they have received it, or if the physician certifies that abortion is necessary to prevent the minor's death and there is insufficient time to provide the requisite notice. RSA 132:26; 390 F.3d at 55.

The District Court held the Act facially invalid pursuant to this Court's decisions in *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833 (1992) and *Stenberg v. Carhart*, 530 U.S. 914 (2000). 390 F.3d at 56-57; *Planned Parenthood of Northern New England v. Heed*, 296 F. Supp.2d 59, 64-65 (D. N.H. 2003). The District Court found the Act unconstitutional due to the lack of an explicit exception to protect the health of the minor and the narrowness of the Act's exception for abortions necessary to prevent the minor's death. 390 F.3d at 56-57; 296 F.Supp.2d at 65 (health exception) and 67 (death exception). The lower court relied upon the affidavit of the only physician plaintiff in the case, Dr. Wayne Goldner, who listed five specific conditions that, in his view, could require abortion to protect a minor's health. 390 F.3d at 56, n.2; 296 F. Supp.2d at 56. Although the District Court did not discuss these conditions

in its opinion, they were cited by the Court of Appeals as examples of medical conditions that may require an abortion to preserve a minor's health:

> Dr. Wayne Goldner listed in his unopposed declaration five specific conditions that could require abortion to protect a minor's health: pre-eclampsia, eclampsia, premature rupture of the membranes surrounding the fetus, spontaneous chorioamnionitis, and heavy bleeding during pregnancy.

390 F.3d 53, 56, n.2. The Court's *Amici*, who include thousands of obstetricians, gynecologists, surgeons and internal physicians, respectfully take issue with the courts' reliance upon Dr. Goldner's assertions. In the case of each of these pregnancy complications, as well as in the case of most if not all other recognized complications, immediate termination by abortion is not only not indicated, in many cases it is actually contraindicated. *See* Appendix A to Brief of *Amici* ("Comparison Chart: Pregnancy Complications and Treatments"). *Amici* submit that the medical-legal issue for the Court to consider in the circumstances contemplated by the New Hampshire parental notification act is not whether a particular complication may necessitate consideration of termination as a therapeutic response generally, but whether Respondents have adequately demonstrated (primarily through Dr. Goldner's assertions) that immediate termination within 48 hours in the primary clinical setting of Respondent women's health centers is indicated for such complications. In *Amici*'s view, accepted medical authority directly contradicts Respondent's position.

I. NEW HAMPSHIRE'S PARENTAL NOTIFICATION LAW WILL NOT INCREASE MATERNAL MORBIDITY AND MORTALITY AMONG THE STATE'S

TEENAGERS.

Teenage pregnancy, while not desirable, does not result in excess maternal mortality provided the mother receives proper prenatal care. Numerous studies support the value of proper prenatal care as essential to the well-being of the adolescent mother and child.[2] "Women without any prenatal care were almost twofold at increased risk for maternal death

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[2] The quantity and quality of prenatal care have a direct and significant effect on the pregnant woman and her offspring. The most striking examples of the value of prenatal care occur in teenage pregnancies. The unique medical problems of the pregnant teenager can be controlled and the results of proper prenatal care prove to be no different from that in the general population. Israel and Woutersz, *Teenage Obstetrics*, 85 AM. J. OBSTET. GYNECOL. 869 (1963); Anderson, *Comprehensive Management of the Pregnant Teen-ager*, 7 CONTEMPORARY OB/GYN 75 (1976); Briggs, Herren, *et. al*., *Pregnancy in the Young Adolescent*, 84 AM. J. OBSTET. GYNECOL. 436 (1962); Dwyer, *Managing the Teenage Pregnancy*, 12 OB-GYN OBSERVER 2 (1975); Webb, Briggs, Brown, *A Comprehensive Adolescent Maternity Program in a Community Hospital*, 84 AM. J. OBSTET. GYNECOL. 442 (1962); Houde and Conway, *Teen-age Mothers: a Clinical Profile*, 7 CONTEMPORARY OB/GYN 71 (1976); Sarrel and Klerman, *The Young Unwed Mother*, 105 AM. J. OBSTET. GYNECOL. 575 (1969); Dott and Fort, *Medical and Social Factors Affecting Early Teenage Pregnancy*, 125 AM. J. OBSTET. GYN-ECOL. 532 (1976); Clark, Wong, *et al., The Pregnant Adolescent*, 142 ANN. N.Y. ACAD. SCI. 813 (1970); Zaeckler, Adelman, *et al*., *The Young Adolescent as an Obstetrical Risk*, 103 AM. J. OBSTET. GYNECOL. 305 (1969). These results show the benefits of proper pre-natal care for the pregnant teenager. There are no studies indicating any medical benefits of abortion for the pregnant teenager, nor is abortion recommended as the form of treatment. Many health problems prevalent among teenagers can be diagnosed and treated concurrently with pregnancy; such treatment may not occur should the patient choose abortion.

relative to those who received prenatal care."[3] Nothing in the growth or physiology of an adolescent specifically contraindicates pregnancy.[4] In fact, the opposite is true, as "women aged 35-39 years carry a 2.6-fold increased risk of maternal death and those $\geq$40 years have a 5.9 fold increased risk."[5] This is reflected in New Hampshire's own recent experience; State Health Department statistics demonstrate that for the period 1999 to 2002, New Hampshire has recorded no deaths due to pregnancy, childbirth and the puerperium for patients under 22 years of age. *See* Appendix B, Health Statistics and Data Management Section of the Bureau of Disease Control and Health Statistics, Department of Health and Human Services, Table, *NH Female Leading Causes of Deaths from 1999 to 2002*.

Physicians have long known that an excessive reliance on abortion as a treatment for adolescent pregnancy was unfounded. The Court should be extremely wary of abortion as a treatment for the health problems of teenagers since severe, long-term complications and handicaps have developed due to such abortions.[6] Further, since an individual's first pregnancy may also be her only one and existing health problems in an adolescent only tend to worsen over time,[7] an adolescent should not be hastily

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[3] Dildy, G. (Ed.), *et al*., CRITICAL CARE OBSTETRICS 6 (4th ed. 2003), citing Atrash, H.K., *et al*., *Maternal and Perinatal Mortality*, 4 CURR. OP. OBSTET. GYNECOL. 61 (1992).

[4] Seeley, *et al*., ANATOMY AND PHYSIOLOGY 937-955 (5th ed. 2000).

[5] CRITICAL CARE OBSTETRICS at 6.

[6] Bulfin, *A New Problem in Adolescent Gynecology*, 72 SOUTHERN MED. J. 967-968 (Aug. 1979).

[7] Most constitutional illnesses, *e.g*., diabetes, hypertensive and vascular disorders, rheumatological disorders and genetic disorders tend to worsen an individual's health over time. *See*

rushed into an abortion when future child bearing may be placed at greater risk. As adolescents are not fully developed with regard to future planning and risk assessment,[8] parental notification, knowledge and involvement are essential to ensure positive overall outcomes.

II. MEDICAL COMPLICATIONS OF PREGNANCY DO NOT REQUIRE ABORTION AS A TREATMENT IN THE CIRCUMSTANCES CONTEMPLATED BY THE NEW HAMPSHIRE STATUTE.

Respondents evidence a fundamental misunderstanding of the proper role of the physician in the care of the high risk pregnant adolescent. Proper medical care mandates evaluation and diagnosis prior to undertaking life altering surgical procedures. Such action is not only prudent from the medical perspective, it is essential in the context of induced abortion, since the pregnant adolescent is likely to be at risk in any future pregnancies and the best opportunity to have offspring might be her first and only pregnancy.

All of the potentially catastrophic medical conditions cited by opponents would also mandate care in an advanced medical facility. Specialized units have been developed for the provision of such care.[9] Such care would, of necessity, go beyond the immediate abortion procedure and would likely involve complex decision-making. Prudent medical care and planning would therefore consistently involve parental involvement and consultation, if not outright

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generally Habermann, T. (Ed. in Chief), MAYO CLINIC INTERNAL MEDICINE BOARD REVIEW 2002-2003.

[8] See generally John J. Mitchell, THE NATURAL LIMITATIONS OF YOUTH: THE PREDISPOSITIONS THAT SHAPE THE ADOLESCENT CHARACTER (Ablex Pub. Co. 1998).

[9] CRITICAL CARE OBSTETRICS at 13-16.

consent. Encouraging parental knowledge and involvement at the earliest opportunity would serve to protect the adolescent in difficult circumstances, particularly when the adolescent cannot advocate for herself.[10]

The Court's *Amici* believe that the litany of complex medical complications of pregnancy cited as necessitating a health exception, including Eisenmenger's Syndrome,[11] Pulmonary Hypertension, Pre-Eclampsia/Eclampsia, Premature Rupture of the Membranes/Chorioamnionitis, Placenta Previa and Abruptio Placenta, and Marfan's Syndrome,12 do not necessarily warrant immediate abortion as the primary therapeutic response, for the reasons discussed herein.

Eisenmenger's Syndrome is a form of cyanotic heart disease which involves severe pulmonary hypertension originating from a left to right shunting of blood.[13] As the pulmonary hypertension worsens, the shunt reverses, forcing unoxygenated blood to bypass the heart. While Eisenmenger's Syndrome is considered a contraindication to

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[10] The confidentiality advocated by Respondents is designed to keep the information *only* from the parent. Since pregnancy in an otherwise unemancipated adolescent raises at least the question of statutory rape or child sexual abuse, the unnecessary allegiance to confidentiality may only serve to maintain the adolescent in an abusive situation or allow others with knowledge of the adolescent's history to use the threat of exposure for continued coercion or abuse.

[11] *See* Brief *Amici Curiae* of Society for Adolescent Medicine, *et al*., in Support of Appellees at 11.

[12] *Id*.

[13] Atrial septal defect, ventricular septal defect and patent ductus arteriosis can all be sources of the original left-to-right shunt. Epstein, P. (Ed. in Chief) and Foster, E. (Ed.), MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM 89 (13th ed. 2003).

pregnancy and some authorities might advocate termination early in a pregnancy, nothing in the medical literature requires emergent or even urgent termination. The vast majority of deaths occur peri-partum (*i.e*., during delivery) and post-partum.

The accepted treatment for Eisenmenger's Syndrome in pregnancy is supplemental oxygen, bed rest, early hospitalization with close hospital monitoring, decreased cardiac workload and maintenance of venous return, appropriate vascular volume and right ventricular filling.[14] In fact, some studies indicate increased maternal mortality with surgical intervention in the latter half of pregnancy compared to vaginal delivery.[15]

Several points regarding Eisenmenger's Syndrome are important to consider. First, the occurrence of late stage Eisenmenger's Syndrome with significant pulmonary hypertension in the adolescent population is extremely rare. Eisenmenger's syndrome does not develop spontaneously. "Over many years, the prolonged presence of high flow and pressure in the pulmonary arteries causes the pulmonary vessels to constrict and thicken."[16] "[T]hese are exceedingly rare conditions."[17]

Second, hormonal changes secondary to pregnancy may provide some protective effect by decreasing pulmonary

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[14] Burrow, *et al*. (Eds.), MEDICAL COMPLICATIONS DURING PREGNANCY 110-111 (6th ed. 2004); CRITICAL CARE OBSTETRICS at 257.

[15] CRITICAL CARE OBSTETRICS at 257.

[16] http://tchin.org/resource_room/c_art_06.htm (emphasis added).

[17] T. Murphy Goodwin, M.D., *Medicalizing Abortion Decisions*, 61 FIRST THINGS 33-36 (March 1996).

vascular resistance.[18] The loss of these protective hormones by surgical abortion may have significant adverse consequences.

Third, since the vast majority of complications are peri- and post partum, the existence of Eisenmenger's Syndrome is highly unlikely to produce adverse health consequences during the period when parental notification, under the New Hampshire law, will be at issue.

Fourth, no responsible physician would undertake the care of a pregnant Eisenmenger's patient, whether for surgical abortion or delivery, outside of the hospital setting. For an adolescent patient, close contact and consultation with the parents or other responsible guardian would be essential for appropriate immediate treatment, case management and follow-up care.

Finally, delivery of an adolescent mother, while problematic, may be preferable from a health standpoint compared to the risk of a later pregnancy which is likely to occur in the same mother only with a worsened cardiovascular status. Complex decisions regarding potential termination in a setting where future pregnancy is contraindicated are best done in a careful, well planned manner with appropriate familial and medical support. The New Hampshire law is consistent with such appropriate parental involvement.

Pulmonary Hypertension in pregnancy carries with it similar concerns to those noted for Eisenmenger's Syndrome. Recent medical advances (*e.g.*, epoprostenol,[19]

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[18] CRITICAL CARE OBSTETRICS at 257.

[19] *See generally* http://www.nlm.nih.gov/medlineplus/druginfo/uspdi/203429.html.

inhaled nitric oxide[20]) may prove beneficial in decreasing morbidity and mortality in these patients regardless of the planned clinical outcome. For both Eisenmenger's Syndrome and Pulmonary Hypertension, appropriate clinical evaluation and initial stabilization therapy will provide more than ample time for either parental notification or judicial bypass.

Cardiac surgery during pregnancy is not absolutely contraindicated, but should be optimized as to time, place, gestation and level of care.[21] However, surgical abortion as a treatment for certain cardiovascular conditions, such as congestive heart failure, has long been known to carry severe inherent risks:

> *For the patient who is not in cardiac failure there is no need to terminate* and if she is in failure termination is next door to manslaughter . . .
>
> *On no account may obstetrical intervention be undertaken until the patient's cardiac failure is under control*, although the situation may seem so grim that one may be tempted to interfere. To do so would simply seal the patient's fate. *Once failure has been controlled, however, the need to intervene in the pregnancy has passed*.[22]

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[20] CRITICAL CARE OBSTETRICS at 258.

[21] MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM at 96-97. For peripartum cardiomyopathy, "Treatment is supportive and includes standard treatment for congestive heart failure." MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM at 100. *See generally id*., at 99 (discussing benefits and risks of continuing or interrupting pregnancy in cardiac patients).

[22] Donald, I., PRACTICAL OBSTETRIC PROBLEMS 169-170 (5th ed. 1979) (emphases added).

Pre-eclampsia is a disease unique to pregnancy and pregnancy related conditions.[23] Pre-eclampsia is defined as maternal hypertension, proteinuria and edema beginning after the 20th week of gestation.[24] Optimal treatment consists of bed rest, blood pressure monitoring and control, regulation of fluid intake and output, close hospital monitoring and medication for neurologic indications.[25] Treatment for pre-eclampsia has been fairly standardized for decades,[26] and newer anti-hypertensive medications have improved treatment and control.[27] Early delivery, not necessarily abortion, is considered if the condition worsens *after* attempts at medical control.[28]

While some authorities advocate outpatient monitoring and expectant management for pre-eclampsia,[29] such care is not likely to be appropriate in the setting of adolescent pregnancy, particularly in the absence of parental notice and

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[23] MEDICAL COMPLICATIONS DURING PREGNANCY at 45. Eclampsia, which involves maternal seizures in the setting of pre-eclampsia, is included here. "The incidence of eclampsia has declined since the 1920s, largely because of the greater availability of prenatal care." MEDICAL COMPLICATIONS DURING PREGNANCY at 46.

[24] MEDICAL COMPLICATIONS DURING PREGNANCY at 45-47.

[25] MEDICAL COMPLICATIONS DURING PREGNANCY 54-56; CRITICAL CARE OBSTETRICS at 438.

[26] CRITICAL CARE OBSTETRICS at 438-39; MAYO CLINIC INTERNAL MEDICINE BOARD REVIEW 2002-2003 at 553.

[27] CRITICAL CARE OBSTETRICS at 441-444.

[28] "When severe pre-eclampsia is diagnosed, immediate delivery, regardless of gestational age, has generally been recommended." National High Blood Pressure Education Program Working Group (1990), quoted in CRITICAL CARE OBSTETRICS at 438.

[29] *E.g.*, CRITICAL CARE OBSTETRICS at 438-439.

involvement.[30] It would be difficult, if not impossible, to imagine a situation where the adolescent would receive appropriate medical management in a suitable clinical setting,[31] regardless of the intended pregnancy outcome, without parental notice and parental involvement. Further, the health risks and concerns for the adolescent do not terminate merely because the pregnancy does[32] and follow-up in a supportive environment would be essential to prevent any late complications.

Placenta Abruptio and *Placenta Previa* are conditions that often present with significant vaginal hemorrhage. Placental abruption is defined as the premature separation of a normally situated placenta, and may be partial or complete.[33] In *placenta previa*, a portion of the placenta may partially or completely cover the internal cervical os.[34] In the setting of vaginal blood loss, appropriate initial management includes bed rest, close hospital monitoring, fluid resuscitation, and transfusion as needed. "Resuscitation with fluid, blood, and correction of coagulopathy must be urgently undertaken, and invasive monitoring may be necessary."[35] Should the clinical condition of the mother permit, ultrasound evaluation and testing for pregnancy

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30 MEDICAL COMPLICATIONS DURING PREGNANCY at 55. Optimal outpatient management would include twice weekly fetal monitoring, ultrasound evaluations and frequent laboratory and clinical evaluations.

31 *See* CRITICAL CARE OBSTETRICS at 438-439 ("…intensive maternal and fetal monitoring in a tertiary care center").

32 MEDICAL COMPLICATIONS DURING PREGNANCY at 56 ("Late postpartum eclampsia has also been observed, the seizures occurring after the first postpartum week.").

33 CRITICAL CARE OBSTETRICS at 298.

34 ANATOMY AND PHYSIOLOGY at 964.

35 CRITICAL CARE OBSTETRICS at 298.

viability may be considered. But the appropriate treatment is *not* abortion, since "…prompt delivery prevents further decompensation of both mother and fetus."[36] "If the fetus is alive and of viable gestational age at presentation, urgent delivery by caesarean section is indicated unless vaginal delivery is imminent."[37]

To undertake such care in anything less than a full service hospital would be risky. To undertake such care in a free-standing clinic or with mid-level health practitioners would be unthinkable.[38] Parental notification can be easily accomplished as part of transfer to an appropriate medical care facility or during the period of stabilization at that facility. Parental consultation may be essential, since the distressed adolescent may be unable to advocate for herself or provide for the needs of her newborn.

Premature Rupture of Membranes surrounding the unborn child may lead to an infectious condition known as Chorioamnionitis. Most infections are caused by bacteria in the cervical and vaginal flora.[39] Treatment requires prompt administration of antibiotics and delivery.[40] Since the required antibiotics are administered intravenously and would be required regardless of intended pregnancy outcome, hospitalization, monitoring of drug levels and close

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[36] CRITICAL CARE OBSTETRICS at 298.

[37] CRITICAL CARE OBSTETRICS at 298.

[38] *Amici* note with concern that Respondent Planned Parenthood of Northern New England admits that "Using mid-level practitioners reduces costs for patients and enables us to reach more women." http://www.ppnne.org/site/PhotoAlbumUser?view=UserPhotoDetail&PhotoID=68499&position=3&AlbumID=7528 (last viewed 08/06/05).

[39] MEDICAL COMPLICATIONS DURING PREGNANCY at 314.

[40] MEDICAL COMPLICATIONS DURING PREGNANCY at 315.

observation are mandatory.[41] As noted throughout this brief, parental notification, consultation and support would be essential to a positive outcome for the adolescent.

Marfan's Syndrome is an autosomal dominant genetic disease that produces abnormalities in connective tissue. Individuals with Marfan's Syndrome are at risk for aortic dissection and other cardiovascular complications.

> Pregnancy should be discouraged in these individuals. Maternal activity should be limited, and prophylactic B-adrenergic blocking therapy should be applied during pregnancy. Ideal monitoring includes blood pressure analysis and serial echocardiographic studies. If there is progressive aortic root dilation or if the aortic root diameter exceeds 5.5 cm, necessary surgical repair can be carried out during pregnancy with good outcomes.[42]

Cesarean section is advised in certain circumstances.[43]

In summary, pregnancy complications in the adolescent do not require a rush to abortion. Prudent medical management requires an appropriate evaluation and an effort at stabilization which would allow for beneficial parental notification and involvement. *See* Appendix A to Brief of *Amici* ("Comparison Chart: Pregnancy Complications and Treatments").

III. STATISTICAL COMPARISONS OF ABORTION RISKS

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41 *Id*.

42 MEDICAL COMPLICATIONS DURING PREGNANCY at 112, citing Elkayam, U., *et al*., *Cardiovascular Problems in Pregnant Women with the Marfan Syndrome*, 123 ANN. INTERN. MED. 117 (1995).

43 *Id.*

AND MATERNAL MORTALITY RISKS MAY GIVE A FALSE IMPRESSION OF ABORTION SAFETY.

Respondents urge that abortion is "an extremely safe medical procedure." Declaration of Wayne Goldner 2, ¶ 3. Dr. Goldner claimed in the District Court that "Both in terms of mortality (death) and morbidity (serious complications short of death) abortion is many times safer than continuing pregnancy through to childbirth." *Id*. Complaint at 7. However, this argument depends upon a fallacious comparison of maternal mortality and live birth data. While defining maternal mortality relative to live births may be statistically convenient, it improperly represents the true population at risk while including deaths from unrelated groups. According to the Centers for Disease Control and Prevention,

> The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 abortions. These measures are conceptually different and used by CDC for different public health purposes.

Appendix C, Letter of July 20, 2004 from Julie L. Gerberding, M.D., M.P.H., Director, to Walter M. Weber, American Center for Law & Justice, p. 1.

Moreover, the Maternal Mortality Rate (MMR) is commonly defined as the Total Maternal Deaths (TMD) divided by the number of Live Births (LB). Each component suffers from multiple defects that make the overall MMR an inappropriate means for comparison to the Abortion Mortality Rate (AMR).

First, the TMD is defined as all deaths attributable to pregnant women during the period of their pregnancy and for a year after delivery.[44] Such deaths might occur in women of all races,[45] across the entire age range in which pregnancy can occur,[46] in all states of underlying health conditions,[47] by all causes[48] and without regard to whether or not the woman is under a physician's care. Each element noted above has implications that make the TMD number increase, thereby increasing the MMR, but which are not considerations as likely to occur in a population of women seeking abortion. Women seeking induced abortions tend to be younger, healthier, from favorable socioeconomic circumstances, of white (Caucasian) race and all, by definition, are under a physician's care. Those with underlying medical conditions who succumb, in whole or in part, to the stresses of an induced abortion procedure, may have their deaths attributed to the underlying medical condition or a subsequent condition which developed, rather than the abortion procedure.[49] Being under a physician's care during a pregnancy has been shown to be a significant factor in the

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[44] Centers for Disease Control and Prevention, *Pregnancy Related Mortality Surveillance – United States, 1991-1999* (MMWR), February 21, 2003, available at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm.

[45] Minorities are more commonly represented in the population of women continuing their pregnancies and have poorer outcomes. CRITICAL CARE OBSTETRICS at 4 ("Black maternal race confers a relative risk of 3.7 fold for maternal death compared to White women."); CRITICAL CARE OBSTETRICS at 6.

[46] *Id*. ("women aged 35-39 years carry a 2.6-fold increased risk of maternal death and those $\geq$40 years have a 5.9 fold increased risk").

[47] *See generally* MEDICAL COMPLICATIONS DURING PREGNANCY; CRITICAL CARE OBSTETRICS.

[48] CRITICAL CARE OBSTETRICS at 6.

[49] CRITICAL CARE OBSTETRICS at 6.

prevention of maternal mortality.[50]

Second, the calculation of MMR based on the number of live births falsely underestimates the population of women who are at risk for the complications of pregnancy either wholly or in part. Women who experience miscarriages, stillbirths, pre-partum intrauterine deaths and deaths from other causes may be added to the TMD without ever having the likelihood of a live birth.

Confidentiality issues also impact the accuracy of reporting of maternal deaths, since a pregnant or recently pregnant woman may have the evidence of her pregnancy objectively determined, but whether her abortion is natural or induced cannot so easily be assumed. Many women withhold the fact of their induced abortion. Should such women suffer severe morbidity or mortality, prior to disclosure, their deaths might be attributed to complications of pregnancy instead of the true cause, which is induced abortion.[51] Further, confidentiality issues preclude the proper and objective collection and interpretation of morbidity and mortality data in induced abortion.[52] While

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[50] *Id*. ("Women without any prenatal care were almost twofold at increased risk for maternal death relative to those who received prenatal care.").

[51] *Id.* ("…infections were the leading cause of abortion related maternal deaths").

[52] In fact, New Hampshire is one of only 5 states that do not mandate abortion providers to submit epidemiologically valuable reports relative to abortion and, of course, its complications. Planned Parenthood, among other organizations, has opposed efforts by the New Hampshire State Department of Health and Human Services to require abortion providers to report such data. Saul, Rebekah, "Abortion Reporting in the United States: An Examination of the Federal-State Partnership," in *Family Planning*

maternal deaths, whether from pregnancy or induced abortion, generally occur in the hospital setting, induced abortions are performed in freestanding clinics not subject to reporting laws.[53] Death and injury following an induced abortion procedure often occurs at another location without complete knowledge of the previous induced abortion. Follow-up on induced abortion morbidity and mortality is incomplete and haphazard. Provider bias, including concerns about potential malpractice or public image, may significantly impact what is reported.

Respondents and their *amici* raise claims of increased mortality and morbidity from any restriction of immediate access to abortions for adolescents. Past claims of increased morbidity and mortality, including claims by allegedly impartial government agencies, have proven groundless. With regard to the Hyde Amendment, which restricted governmental funding for abortions, Dr. Willard Cates, representing the Centers for Disease Control Abortion Surveillance Branch, predicted a total of 77 excess deaths to women who would seek illegal abortions and an additional 5 excess deaths due to delays in seeking abortion.[54] The same department would later admit that no such increase in mortality or morbidity had occurred.[55] Even Dr. Cates would later admit, "The 'bloodbath' many predicted simply is not happening…"[56] The Court should not be swayed by

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Perspectives, Vol. 30, Number 5, Sept./Oct. 1998.

[53] *See Thornburgh v. Amer. College of Obstet. & Gyn.*, 476 U.S. 747 (1986).

[54] Pettiti and Cates, *Restricting Medicaid Funds: Projection of Excess Mortality*, 67 AMER. J. PUB. HEALTH 860-62 (Sept. 1977).

[55] Centers for Disease Control, *Morbidity and Mortality Weekly Report*, Vol. 28, No. 4, Feb 2, 1979.

[56] Cates, Willard, M.D., Centers for Disease Control, Interview in *The Washington Post*, February 16, 1978.

false claims of abortion safety compared to pregnancy or statistical claims of excess mortality or morbidity.

CONCLUSION

Parental involvement in a teenager's decision to continue or terminate her pregnancy is not only desirable, but beneficial to the overall mental and physical health of the teenage mother.

> In this case, however, we are concerned only with minors who according to the record range in age from children of twelve years to 17-year-old teenagers. Even the latter are less likely than adults to know or be able to recognize ethical, qualified physicians, or to have the means to engage such professionals. Many minors who bypass their parents probably will resort to an abortion clinic, without being able to distinguish the competent and ethical from those that are incompetent or unethical.

Bellotti v. Baird, 443 U.S. 622, 641 (1979). Moreover,

> The medical, emotional, and psychological consequences of an abortion are serious and can be lasting; this is particularly so when the patient is immature. An adequate medical and psychological case history is important to the physician. Parents can provide medical and psychological data, refer the physician to other sources of medical history, such as family physicians, and authorize family physicians to give relevant data.

H.L. v. Matheson, 450 U.S. 398, 411 (1981); *accord Ohio v. Akron Ctr. for Reproductive Health*, 497 U.S. 502, 518-19

(1990).

The teenager may have significant medical needs following the abortion procedure that further validate the desirability and benefits of early parental involvement. (Risks of infection, mental and physical trauma, hemorrhage, perforation, undetected ectopic pregnancy, etc.) Further, parental involvement can ensure the continued involvement and responsible management of qualified health professionals who might otherwise be unaware of or unavailable for the continuing medical needs of the teenager.

New Hampshire's plan for parental certification is a safe and effective means of assuring that the mother receives treatment in a timely manner without risking exposure to dangerous procedures and unscrupulous providers. Should the parents be notified and fail to act in the best interest of their teenage child, the physician has ample recourse either through emergency bypass or through termination of parental rights in a child welfare proceeding.

For the reasons set forth hereinabove, the Court's *Amici* respectfully submits that the decision of the First Circuit Court of Appeals should be reversed.

Respectfully submitted,

Steven H. Aden
(Counsel of Record)
CENTER FOR LAW
& RELIGIOUS FREEDOM OF
THE CHRISTIAN LEGAL SOCIETY
4208 Evergreen Lane, Suite 222
Annandale, Virginia 22003
Tel.: (703) 642-1070

Counsel for Amici Curiae

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