

No. 20-5408

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IN THE  
**United States Court of Appeals for the Sixth Circuit**

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ADAMS & BOYLE, P.C., ET AL.,  
*Plaintiffs-Appellees,*

*v.*

HERBERT H. SLATERY, III, Attorney General of  
Tennessee, ET AL.,  
*Defendants-Appellants.*

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On Appeal from the United States District Court  
for the Middle District of Tennessee  
No. 3:15-cv-00705  
Hon. Bernard A. Friedman

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**BRIEF OF THE AMERICAN PUBLIC  
HEALTH ASSOCIATION AND EXPERTS IN  
PUBLIC HEALTH AS *AMICI CURIAE* IN  
SUPPORT OF PLAINTIFFS-APPELLEES**

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**DISCLOSURE OF CORPORATE AFFILIATIONS AND  
FINANCIAL INTEREST**

Pursuant to Sixth Cir. R. 26.1, the American Public Health Association and the individual *amici curiae* set forth at Appendix A make the following disclosures:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If Yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

**No. The American Public Health Association is a non-profit organization, with no parent corporation or publicly traded stock.**

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

**No.**

ORRICK, HERRINGTON & SUTCLIFFE LLP

*/s/ Lisa T. Simpson*

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## INTEREST OF AMICI CURIAE<sup>1</sup>

The American Public Health Association champions the health of all people and all communities, strengthens the public health profession, shares the latest research and information, promotes best practices, and advocates for evidence-based public health policies. APHA combines a nearly 150-year perspective and a broad-based membership working to improve the public's health.

The individual *amici* are leaders in public health: they include deans and professors, health commissioners, infectious disease experts, and directors of public health institutions. *Amici* have responded to SARS, Zika, Ebola, HIV/AIDS, tuberculosis, and other disease outbreaks, working as, or with, front-line public health practitioners, public health researchers, government advisory panels, legislators, global health security teams, and non-profit organizations to develop innovative solutions to emerging infectious diseases.

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<sup>1</sup> No party's counsel authored this brief in whole or in part. No party, party's counsel, or any person other than amicus or its counsel contributed money intended to fund preparing or submitting this brief. A complete list of amici is attached as Appendix A. All parties have consented to the filing of this brief.

*Amici* share a professional commitment to evidence-based research and public health. From that perspective, *amici* are deeply concerned by Tennessee’s decision to restrict access to abortions during the COVID-19 pandemic because it will endanger public health.

## ARGUMENT

### I. **Burdening Access To Essential Reproductive Healthcare During A Pandemic Is Not Justified Under Public Health Principles.**

Public health control measures must be “evidence-informed”: Pandemic response should be guided by the best available scientific evidence and respect for individual autonomy.<sup>2</sup> Any public health measure must be “proportional to the risk presented by those affected, scientifically sound, transparent to the public, the least restrictive means to protect public health, and regularly revisited to ensure that

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<sup>2</sup> Ethics Subcomm. of the Advisory Comm. to the Dir., Centers for Disease Control & Prevention (CDC), *Ethical Guidelines in Pandemic Influenza* 8-9 (2007) (“CDC, *Ethical Guidelines*”), <https://tinyurl.com/yam7f63u>; CDC, *Field Epidemiology Manual: Developing Interventions* (2018), <https://tinyurl.com/yc3bnr4d>; Yale Sch. of Pub. Health & Yale Law Sch., *Achieving a Fair and Effective COVID-19 Response* 4 (Mar. 2, 2020) (“Yale COVID-19 Letter”), <https://tinyurl.com/squkg6w>; Am. Med. Ass’n, *AMA Underscores Importance of Science, Data in COVID-19 Fight* (Apr. 7, 2020), <https://tinyurl.com/ya2wtccs>.

they are still needed as the epidemic evolves.”<sup>3</sup> Restrictions that are not evidence-informed and carefully tailored can cause the very harms to public health that the response to the pandemic intends to avoid.

**A. Essential healthcare must be maintained during a pandemic.**

An effective public health response must contain the spread of the contagion and maintain access to essential healthcare services.<sup>4</sup> One category of pandemic-mitigation measures, referred to as “nonpharmaceutical interventions,” reduces the effective rate of human-to-human viral transmission through community hygiene, surveillance and diagnostic measures, isolation of the sick, and social distancing.<sup>5</sup> These interventions can help maintain healthcare capacity until pharmaceutical interventions—vaccines and antiviral drugs—become

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<sup>3</sup> Yale COVID-19 Letter, *supra* n.2, at 1; *see also* CDC, *Ethical Guidelines*, *supra* n.2, at 5.

<sup>4</sup> World Health Organization, COVID-19 Strategic Preparedness and Response Plan 2 (Feb. 12, 2020), <https://tinyurl.com/yadtahgu>.

<sup>5</sup> Julia E. Aledort et al., *Non-pharmaceutical Public Health Interventions for Pandemic Influenza: An Evaluation of the Evidence Base*, 7 BMC Pub. Health 208, 210 (2007), <https://tinyurl.com/y7b39dwz>.

available.<sup>6</sup> But because nonpharmaceutical interventions can limit individual freedom and cause unintended negative consequences, they must be approached with “great care” and carefully tailored to avoid outsized social harm.<sup>7</sup>

Restricting access to healthcare services during a pandemic should only be undertaken if there is evidence that it will improve public health and not endanger the health of patients who require access to those services. Guidance on nonpharmaceutical interventions discusses restrictions on social gatherings by closing schools, encouraging workplace telecommuting, and cancelling mass gatherings, not the restriction of access to essential healthcare.<sup>8</sup>

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<sup>6</sup> A. Wilder-Smith & D.O. Freedman, *Isolation, Quarantine, Social Distancing and Community Containment: Pivotal Role for Old-Style Public Health Measures in the Novel Coronavirus (2019-nCoV) Outbreak*, 27 *J. of Travel Med.* 1, 3 (2020), <https://tinyurl.com/yd4xx8hj>; CDC, *Ethical Guidelines*, *supra* n.2, at 2 n.8.

<sup>7</sup> CDC, *Ethical Guidelines*, *supra* n.2, at 4.

<sup>8</sup> *E.g.*, CDC, *Community Mitigation Guidelines to Prevent Pandemic Influenza—United States, 2017*, 66 *Morbidity & Mortality Wkly. Rep.* 1, 1-2, 6 (2017) (“CDC, *Community Mitigation*”), <https://tinyurl.com/y7fotw5d>; Joseph Barbera et al., *Large-Scale Quarantine Following Biological Terrorism in the United States*, 286 *J. Am. Med. Ass’n* 2711, 2711, 2716 (2001); Howard Markel et al., *Nonpharmaceutical Interventions Implemented by US Cities During the*

When considering postponing nonessential healthcare in a pandemic, one of the key questions is which health services are essential and “time-sensitive” and which are not.<sup>9</sup> In evaluating particular procedures, officials should seek guidance from public health experts who can apprise them of the likely consequences of postponement based on evidence and sound medical judgment.

Without essential health services, many will suffer serious medical consequences or even die from conditions that were otherwise treatable. Experience in past epidemics has shown that lack of access to essential health services can result in increases in morbidity and mortality that outlast the epidemic and can result in more deaths than those caused by the epidemic itself.<sup>10</sup>

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*1918-1919 Influenza Pandemic*, 298 J. Am. Med. Ass’n 644, 645 (2007), <https://tinyurl.com/r2sbucg>; Aledort, *supra* n.5, at 213.

<sup>9</sup> World Health Organization, COVID-19: Operational Guidance for Maintaining Essential Health Services During an Outbreak 4 (Mar. 25, 2020), <https://tinyurl.com/razyn78>.

<sup>10</sup> Inter-Agency Working Grp. on Reproductive Health in Crises, Programmatic Guidance for Sexual and Reproductive Health in Humanitarian and Fragile Settings During the COVID-19 Pandemic 1 (Apr. 10, 2020), (“IAWG, COVID-19 Guidance”), <https://tinyurl.com/y99jxnlc>; cf. Nishant Kishore et al., *Mortality in Puerto Rico after Hurricane Maria*, 379 New Eng. J. Med. 162, 168 (2018).

In addition, denying access to essential health services undermines the effectiveness of public health guidance to self-isolate and practice social distancing. People are less likely to cooperate with public health directives if they need to seek other means of obtaining medical services.<sup>11</sup>

**B. Abortion is essential healthcare.**

“Abortion is an essential health service.”<sup>12</sup> Access to abortion must be maintained during the COVID-19 pandemic because abortion is time-sensitive. While abortion is safe, potential health risks increase as it is delayed and gestation progresses.<sup>13</sup>

Restricting abortion means that delay can render abortion unavailable to women whose pregnancies are at later gestational ages when fetal abnormalities are diagnosed, or who face barriers in

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<sup>11</sup> Yale COVID-19 Letter, *supra* n.2, at 3-5; Robert J. Blendon et al., *Public Response to Community Mitigation Measures for Pandemic Influenza*, 14 *Emerging Infectious Diseases* 778, 780 tbl.1 (2008), <https://tinyurl.com/y8mfxt5>.

<sup>12</sup> Michelle J. Bayefsky et al., *Abortion During The Covid-19 Pandemic—Ensuring Access to an Essential Health Service*, *New Eng. J. Med.* (Apr. 9, 2020), <https://tinyurl.com/ycgyv7qw>.

<sup>13</sup> Int’l Fed. of Gynecology and Obstetrics, *Abortion Access and Safety With COVID-19* (Mar. 31, 2020), <https://tinyurl.com/y7q897dn>.

reaching a clinic. Births have far higher rates of maternal mortality and morbidity than abortions.<sup>14</sup> The recent Ebola outbreaks in West Africa demonstrated the importance of maintaining reproductive health services during an epidemic, as obstacles in obtaining essential reproductive healthcare there led to dramatic increases in maternal morbidity and mortality.<sup>15</sup>

Given these risks, public health officials must ensure that the expected impact of any nonpharmaceutical intervention during a pandemic, such as restricting access to essential healthcare like abortion, will advance and not endanger public health.

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<sup>14</sup> Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 *Obstetrics & Gynecology* 215, 216-17 (2012), <https://tinyurl.com/ybph5ujz>.

<sup>15</sup> See, e.g., Benjamin Black & Gillian McKay, Covid-19 and Reproductive Health: What Can We Learn From Previous Epidemics? (Mar. 19, 2020), <https://tinyurl.com/yad4mdp6>; Patricia A. McQuilkin et al., *Health-Care Access During the Ebola Virus Epidemic in Liberia*, 97 *Am. J. of Tropical Med. & Hygiene* 931, 934 (2017), <https://tinyurl.com/y7phxy65>.

## **II. Tennessee’s Restriction Of Abortions Will Exacerbate This Public Health Crisis With No Corresponding Benefit.**

### **A. Interstate travel increases when abortions are not available locally.**

Effective public health measures account for the negative consequences of interventions used to curtail a health crisis.<sup>16</sup>

Tennessee contends that it is necessary to restrict abortion to reduce social contact and control transmission of COVID-19. But the consequences of restricting local abortion access will likely be to increase social contact by forcing women to travel out of state for care.

To slow transmission of COVID-19, it is vital to reduce interstate travel,<sup>17</sup> as the disease is more likely to spread by daily and interstate

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<sup>16</sup> Kathryn Oliver et al., *Understanding the Unintended Consequences of Public Health Policies: The View of Policymakers and Evaluators*, 19 *BMC Pub. Health* 1, 1-2 (2019), <https://tinyurl.com/y6wg7o8w>.

<sup>17</sup> See, e.g., CDC, *Public Health Recommendations for Community-Related Exposures*, <https://tinyurl.com/t7fnvba>; CDC, *Community Mitigation*, *supra* n.8, at 1; Scott Gottlieb et al., *Am. Enter. Inst.*, *National Coronavirus Response* 3-4 (Mar. 28, 2020), <https://tinyurl.com/vldomvg>; World Health Org. Writing Grp., *Nonpharmaceutical Interventions for Pandemic Influenza, National and Community Measures*, 12 *Emerging Infectious Diseases* 88, 92 (2006), <https://tinyurl.com/y8u53zbz>.

travel than from international sources.<sup>18</sup> For pregnant women, travel is unavoidable whether for pregnancy-related care or abortion care. But Tennessee’s abortion restriction will further increase interstate travel, as women in states with more restricted abortion access are likely to travel farther to obtain an abortion.<sup>19</sup> Under Tennessee’s restriction, 75% of women seeking procedural abortions will need to travel more than 100 miles to access abortion care in another state.<sup>20</sup>

Because pregnant women who travel out of state for abortions will interact with more people—for gas, food, or bathrooms along the way—increasing interstate travel will increase contacts,<sup>21</sup> and Tennessee’s abortion restriction is likely to increase transmission of COVID-19.

This endangers the health of the pregnant women who are exposed to

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<sup>18</sup> Joseph R. Fauver et al., *Coast-to-Coast Spread of SARS-CoV-2 in the United States Revealed By Genomic Epidemiology* 7 (Mar. 26, 2020), <https://tinyurl.com/yabr7wt9>.

<sup>19</sup> Rachel K. Jones & Jenna Jerman, *How Far Did US Women Travel for Abortion Services in 2008?*, 22 *J. Women’s Health* 708, 708 (2013); Jonathan Bearak et al., *COVID-19 Abortion Bans Would Greatly Increase Driving Distances for Those Seeking Care*, *Guttmacher Inst.* 1 & tbl. 1 (updated Apr. 8, 2020) <https://tinyurl.com/y7u299dn>.

<sup>20</sup> Bearak et al., *supra* n.19.

<sup>21</sup> *See, e.g.*, Emergency Application, App.14, 151-52, 163, 233, 307-08, *Planned Parenthood Center for Choice v. Abbott*, No. 19A1019 (U.S. Apr. 11, 2020).

SARS-CoV-2 during their out-of-state travel and creates additional potential transmission events during their time away and when they return home. These consequences run counter to an evidence-informed approach to controlling the current pandemic.

**B. When abortion is restricted, longer pregnancies require more healthcare contacts and use more PPE.**

Restricting abortion access will also require more women to carry their pregnancies longer, including to term, leading to an increased risk to pregnant women and a likely increase in healthcare contacts and PPE use.

Women who remain pregnant longer because of restrictions on access to abortion will likely have more contacts with the healthcare system. First, forcing women to wait until the directive expires or until they can arrange out-of-state travel to obtain a procedural abortion will impose delay.<sup>22</sup> Delaying a procedural abortion can necessitate a two-

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<sup>22</sup> See Kari White et al., *Experiences Accessing Abortion Care in Alabama among Women Traveling for Services*, 26 *Reproductive Health* 298 (2016).

day procedure, which is more complex and requires more clinic visits than a one-day procedure.<sup>23</sup>

Second, pregnant women attend an average of 11.4 prenatal visits during their pregnancy.<sup>24</sup> And a substantial proportion of pregnant women seek emergency care.<sup>25</sup> In one recent study, 49% visited the emergency department at least once, and 23% visited twice or more.<sup>26</sup> Pregnant women with a comorbid condition—about 27% of pregnant women in the United States—are even more likely to seek emergency care due to complications.<sup>27</sup> Restricting or delaying access to abortion increases risks to maternal health and the frequency of healthcare

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<sup>23</sup> Pltfs.' Opp. 4-5, 8.

<sup>24</sup> Urania Magriples et al., *Prenatal Health Care Beyond the Obstetrics Service: Utilization and Predictors of Unscheduled Care*, 198 Am. J. Obstetrics Gynecology 1, 5 (2008), <https://tinyurl.com/ydb2xq27>.

<sup>25</sup> Shayna D. Cunningham et al., *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant Women*, 24 Acad. Emergency Med. 940, 940-41 (2017), <https://tinyurl.com/yan96osp>.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at 943.

contacts, thereby undermining the effectiveness of social distancing policies in reducing viral transmission.<sup>28</sup>

Women who receive timely abortions, in contrast, use and interact with fewer healthcare resources. Abortions generally do not require hospital facilities—most take place at an outpatient facility.<sup>29</sup> Major complications from procedural abortions are rare—occurring in only 0.21% of abortions—and rarely require hospitalization, with its attendant PPE usage and contacts with healthcare workers.<sup>30</sup>

Restricting access to abortion during the COVID-19 pandemic not only fails to conserve PPE and limit contacts, it causes women to carry their pregnancies further than they otherwise would and results in increased contacts and PPE use.

An evidence-informed evaluation based on data and sound medical judgment leads *amici* to the exact opposite conclusion from that of the

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<sup>28</sup> See Sonja A. Rasmussen et al., *Pandemic Influenza and Pregnant Women*, 14 *Emerging Infectious Diseases* 95, 97 (2008), <https://tinyurl.com/ybkkch67>.

<sup>29</sup> Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *Obstetrics & Gynecology* 175, 175, 177 & tbl.1 (2015), <https://tinyurl.com/y74qp2dg>; Grace Shih & Robin Wallace, *First-Trimester Pregnancy Termination: Uterine Aspiration*, UpToDate (Jan. 2020).

<sup>30</sup> Upadhyay, *supra* n.30, at tbl.3 178-79.

State: There is no public health benefit to restricting access to abortion during the COVID-19 pandemic. The State’s directive forecloses access to an essential healthcare service, reduces the effectiveness of social distancing by increasing travel and contacts, and requires more healthcare resources. Restricting access to abortion needlessly endangers the welfare of pregnant women and the general public.

### **III. Tennessee’s Restriction Of Abortions Will Exacerbate Deeply Rooted Health Inequities.**

Effective public health responses minimize the risk of morbidity and mortality by accounting for existing inequity in healthcare access.<sup>31</sup> Restricting access to abortion worsens preexisting inequalities by placing disproportionate burdens on low-income women and women of color.<sup>32</sup>

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<sup>31</sup> See Sandra Crouse Quinn & Supriya Kumar, *Health Inequalities and Infectious Disease Epidemics*, 12 *Biosecurity and Bioterrorism* 263, 265-67 (2014) (“*Health Inequalities*”), <https://tinyurl.com/y8kal3wv>.

<sup>32</sup> See Human Rights Watch, *US: Address Impact Of Covid-19 On Poor* (Mar. 19, 2020) (“HRW, *Covid-19 On Poor*”), <https://tinyurl.com/y8wbv4w7>; *Health Inequalities*, *supra* n.31, at 265-67.

Three out of four pregnant women who seek abortions are low-income.<sup>33</sup> And the children of women who are denied abortions are more likely to live in poverty.<sup>34</sup> Low-income pregnant women are also unlikely to have the means to travel out of state to seek medical care, which may lead to an increase in unsafe abortions,<sup>35</sup> and their serious and life-threatening complications.<sup>36</sup>

Even when Tennessee’s restriction is lifted, low-income women will suffer disproportionately in obtaining abortion healthcare due to economic hardship,<sup>37</sup> the difficulty of scheduling appointments,<sup>38</sup> and a likely shortage in treatment capacity as demand for treatment surges when clinics reopen.<sup>39</sup>

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<sup>33</sup> Guttmacher Institute, *Induced Abortion in the United States* (Sept. 2019), (“*Induced Abortion*”), <https://tinyurl.com/l789emu>.

<sup>34</sup> ANSIRH, *Women’s Access to Abortion Improves Children’s Lives* (Jan. 2019), <https://tinyurl.com/y9xjtkwg>.

<sup>35</sup> Kari White et al., *The Potential Impacts of Texas’ Executive Order on Patients’ Access to Abortion Care* 3, Tex. Pol’y Evaluation Project, Mar. 2020, <https://tinyurl.com/y7krvh8f>.

<sup>36</sup> Susheela Singh et al., *Abortion Worldwide 2017: Uneven Progress and Unequal Access* 4 (2018).

<sup>37</sup> Alan Berube & Nicole Bateman, *Who Are the Workers Already Impacted by the COVID-19 Recession?*, Brookings (Apr. 3, 2020), <https://tinyurl.com/ydcx5vbl>.

<sup>38</sup> *E.g.*, White, *Potential Impacts*, *supra* n.36, at 3.

<sup>39</sup> *Id.* at 2.

\* \* \*

Allowing Tennessee's flawed public health rationales to justify restricting abortion will lead to profound consequences on women's ability to access timely, safe abortion and will negatively impact the public's health.

### CONCLUSION

The Court should deny the motion for a stay.

Respectfully submitted,

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## CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 29(a)(5) and 27(d)(2)(A) because this brief contains 2574 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word in Century Schoolbook 14-point font.

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## CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Sixth Circuit by using the appellate CM/ECF system on April 23, 2020.

I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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