

No. 19-1392

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**In the Supreme Court of the  
United States**

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THOMAS E. DOBBS, STATE HEALTH OFFICER OF THE  
MISSISSIPPI DEPARTMENT OF HEALTH, ET AL., PETITIONERS

*v.*

JACKSON WOMEN'S HEALTH ORGANIZATION, ET AL.

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*ON WRIT OF CERTIORARI  
TO THE UNITED STATES COURT OF APPEALS  
FOR THE FIFTH CIRCUIT*

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**BRIEF FOR MONIQUE CHIREAU WUBBENHORST,  
M.D., M.P.H., GRAZIE POZO CHRISTIE, M.D.,  
COLLEEN MALLOY, M.D., AND THE CATHOLIC  
ASSOCIATION FOUNDATION AS AMICI CURIAE  
IN SUPPORT OF PETITIONERS**

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**TABLE OF CONTENTS**

	Page
Table of authorities.....	III
Interest of amici curiae .....	1
Summary of argument.....	3
Argument.....	5
<b>I. <i>Roe</i> and <i>Casey</i>'s Viability Standard Is Incomplete and Outdated According to Current Science.....</b>	<b>5</b>
<b>A. "Viability" no longer means what it did at the time of <i>Roe</i> and <i>Casey</i>.....</b>	<b>5</b>
<b>B. Ultrasound technology has dramatically improved and provides a clear window into the womb to witness the humanity of the unborn child. ....</b>	<b>8</b>
<b>C. Improved imaging has provided greater information about fetal development. ....</b>	<b>14</b>
<b>D. Advancements in technology have led to recognition of the fetus as a patient by mainstream medicine. ....</b>	<b>18</b>
<b>E. Current science shows that the fetus is pain-capable much earlier than previously thought. ....</b>	<b>22</b>
<b>II. <i>Casey</i> Is Unworkable and Should Be Overruled. ....</b>	<b>26</b>
<b>A. <i>Casey</i> does not allow for restrictions based on increased knowledge of how the brutal abortion procedure affects the unborn child.....</b>	<b>27</b>

II

**B.** *Casey* is inconsistent with the Court’s  
recognition of other State interests that  
justify abortion restrictions..... 30

**C.** *Casey*’s standard is arbitrary and has had  
damaging effects..... 32

Conclusion ..... 36

### III

#### TABLE OF AUTHORITIES

	Page(s)
Cases:	
<i>Baze v. Rees</i> , 553 U.S. 35, 49 (2008).....	26
<i>Boer v. Planned Parenthood of Ind. &amp; Ky.</i> , 139 S. Ct. 1780 (2019).....	30
<i>City of Akron v. Akron Ctr. for Reprod. Health, Inc.</i> , 462 U.S. 416 (1983).....	27
<i>EMW Women’s Surg. Ctr., P.S.C. v. Friedlander</i> , 960 F.3d 785 (6th Cir. 2020) .....	31
<i>Gonzales v. Carhart</i> , 550 U.S. 124 (2007).....	<i>passim</i>
<i>Harris v. W. Alabama Women’s Ctr.</i> , 139 S. Ct. 2606 (2019).....	30, 31
<i>Jackson Women’s Health Org. v. Dobbs</i> , 945 F.3d 265 (5th Cir. 2019) .....	3, 33
<i>Janus v. Am. Fed’n of State, Cty., &amp; Mun. Emps., Council 31</i> , 138 S. Ct. 2448 (2018).....	21, 26
<i>June Med. Servs. LLC v. Russo</i> , 140 S. Ct. 2103 (2020).....	33, 34
<i>McCorvey v. Hill</i> , 385 F.3d 846 (5th Cir. 2004) .....	22, 33
<i>MKB Mgmt. Corp. v. Stenehjem</i> , 795 F.3d 768 (8th Cir. 2015) .....	33

IV

Page(s)

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*Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc v. Smith*,  
913 F.3d 551 (5th Cir. 2019) ..... 28

*Planned Parenthood of Se. Pa. v. Casey*,  
505 U.S. 833 (1992).....*passim*

*Roe v. Wade*,  
410 U.S. 113 (1973)..... 4, 5, 7, 30

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543 U.S. 551 (2005)..... 22

*S. Bay United Pentecostal Church v. Newsom*,  
141 S. Ct. 716 (2021)..... 4

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530 U.S. 914 (2000)..... 27, 33

*Thornburgh v. Am. Coll. Obst. & Gyns.*,  
476 U.S. 747 (1986)..... 31

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900 F.3d 1310 (11th Cir. 2018) ..... 31

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492 U.S. 490 (1989)..... 31, 34

*Whole Woman’s Health v. Paxton*,  
978 F.3d 896 (5th Cir. 2020) ..... 14, 28, 29, 30, 31

Statutes:

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No. 108-105, § 2(14)(M), 117 Stat. 1201 (2003)..... 32

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VI

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IX

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### INTEREST OF AMICI CURIAE

*Amici curiae* are Monique Chireau Wubbenhorst, M.D., M.P.H., Grazie Pozo Christie, M.D., Colleen Malloy, M.D., and The Catholic Association Foundation.<sup>1</sup>

Dr. Monique Chireau Wubbenhorst is a board-certified obstetrician-gynecologist. Dr. Wubbenhorst graduated from Mount Holyoke College and attended medical school at Brown University. She received a master's in public health from Harvard University. She completed her residency in obstetrics and gynecology at Yale-New Haven Hospital and her postdoctoral fellowship in health services research at the Sheps Center for Health Services Research at the University of North Carolina-Chapel Hill. She was on the faculty at Duke University School of Medicine from 2003-2018. She is a fellow of the American College of Obstetricians and Gynecologists (ACOG). Dr. Wubbenhorst recently served as the Senior Deputy Assistant Administrator in the Bureau of Global Health at the U.S. Agency for International Development (USAID). Dr. Wubbenhorst's clinical career has focused on caring for women in disadvantaged populations, especially the African-American community.

Dr. Grazie Pozo Christie is a practicing physician specializing in diagnostic radiology. Dr. Christie graduated from Columbia University and received her medical degree from the University of Miami Miller School of Medicine. She completed her residency in diagnostic radiology and a fellowship in orthopedic radiology at Jackson Memorial Hospital in Miami. She is a diplomate of the American Board of Radiology. For over two decades

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<sup>1</sup> Petitioner and Respondent provided blanket consent for the filing of *amicus* briefs. Rule 37.3(a). No counsel for any party authored this brief, in whole or in part. No person or entity other than *amici* contributed monetarily to its preparation or submission.

she has been in private practice as a general radiologist in Miami, working mainly in underserved communities. Using a variety of modalities, including ultrasound, magnetic resonance imaging and computed tomography, she works closely with referring physicians to diagnose disease in her patients. As part of her daily practice, Dr. Christie interprets ultrasounds of pregnant women and their developing babies.

Dr. Colleen Malloy is board-certified in both neonatal-perinatal medicine and pediatrics. She is an Assistant Professor of Pediatrics (Neonatology) at Northwestern University Feinberg School of Medicine in Chicago. Dr. Malloy graduated from the University of Notre Dame and received her medical degree from Northwestern University Feinberg School of Medicine. She completed her residency in pediatrics and her fellowship in neonatology at Loyola University Medical Center in Chicago. She maintains a clinical practice at Northwestern Memorial Hospital and the Ann & Robert H. Lurie Children's Hospital of Chicago. In her clinical practice, Dr. Malloy helps to manage high-risk pregnancies and cares for babies born prematurely as well as term babies with health issues.

As they care for both women and their unborn children as their patients, *amici* physicians have seen firsthand in their clinical practices how science has advanced dramatically since *Roe v. Wade* and *Planned Parenthood of Southeastern Pennsylvania v. Casey* were decided. These advancements not only affect when a fetus is viable, but also create new concerns that States should be able to consider when restricting abortion.

The Catholic Association Foundation (TCA) is a lay organization dedicated to being a faithful voice for Catholics in the public square. TCA has previously filed

*amicus curiae* briefs in this Court. TCA responds to the call of the Catholic Church for members of the lay faithful to apply Catholic teaching, wisdom, and principles to the issues of the day. TCA strives toward achieving a society in which the common good and the dignity of every human person—born or unborn—is upheld.

#### SUMMARY OF ARGUMENT

48 years after *Roe v. Wade*, innumerable advances in science and medicine now inform our understanding of pregnancy, fetal development, and viability in ways unimaginable in 1973. Mississippi prohibited abortions after 15 weeks' gestation because of that evidence. *See* Pet. App. 65a-70a, 75a-100a. But the lower court, relying on *Planned Parenthood of Southeastern Pennsylvania v. Casey*, held that “[n]o state interest is constitutionally adequate to ban abortions before viability, so the interests advanced here are legally irrelevant to the sole issue necessary to decide the Clinic’s constitutional challenge.” *Jackson Women’s Health Org. v. Dobbs*, 945 F.3d 265, 275 (5th Cir. 2019). Under *Casey*, Mississippi is *compelled* to permit doctors to kill living, pain-capable human fetuses—as science now shows—in a way that even an animal could not be legally killed.

As a practicing obstetrician-gynecologist, radiologist, and neonatologist, *amici* physicians have had front-row seats in witnessing the comprehensive scientific innovations over the last few decades. Advancing science has painted an intimate portrait of the fetus and its humanity. Science has told us volumes about the unborn child’s development and its capacity to feel pain, and mainstream medicine treats the unborn child as a patient. Yet *amici* physicians are also witness to the fruits

of abortion jurisprudence that is out-of-sync with the latest medical science. As they care for their unborn patients, they are confronted with the evidence of their undeniable humanity—evidence that *Casey* deems legally irrelevant. It is their professional view that in *Roe*'s own terms, we have arrived at a quite different “point in the development of man's knowledge” about life *in utero*. *Roe v. Wade*, 410 U.S. 113, 159 (1973), *holding modified by Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (plurality op.). The Court's jurisprudence should reflect—or, at least, leave room for—this new understanding. As it stands now, it does not.

If the Court's abortion jurisprudence purports to rely on science, it should at least rely on *modern* science. But *Casey* effectively declared all scientific developments irrelevant and the viability line absolute, even though *Casey* itself relied on evolving science in declaring *Roe*'s trimester framework rigid and unworkable. If there is no flexibility for States to consider scientific advancements in limiting abortion, *Casey* requires “science-based policy yield to judicial edict.” *S. Bay United Pentecostal Church v. Newsom*, 141 S. Ct. 716, 723 (2021) (Kagan, J., dissenting). *Roe* and *Casey*'s viability framework is outdated and unworkable. It must be overruled.

## ARGUMENT

**I. *Roe* and *Casey*'s Viability Standard Is Incomplete and Outdated According to Current Science.**

This Court reconsiders constitutional precedent “when it is convinced that its earlier decision rested on a dated or incorrect view of the facts or law.”<sup>2</sup> Current science makes clear that *Roe* and *Casey*'s viability standard is out-of-date. Since those cases were decided, scientific advancements have allowed both physicians and the public to learn more about the unborn child and its development, including its capacity to feel pain. Technology has allowed the fetus to be viable outside the mother's womb significantly earlier, and has allowed physicians to provide medical treatment, even surgery, to the fetus *in utero*. Mainstream medicine considers the unborn child a patient. These developments have revealed the human form of the fetus and undermine viability as the sole factor States may consider in limiting abortion. *Roe* and *Casey*'s fundamental premise is therefore outmoded and must be reconsidered because of current science.

**A. “Viability” no longer means what it did at the time of *Roe* and *Casey*.**

This Court's definition of viability is the point at which the fetus is “potentially able to live outside the mother's womb, albeit with artificial aid.” *Roe*, 410 U.S. at 160. In 1973, viability meant 28 weeks' gestation (the cusp of the third trimester), but by 1992, it was 23 or 24 weeks, well into the second trimester. *Casey*, 505 U.S. at 860. Those babies—previously at the very edge of possible survival—now survive at much higher rates.

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<sup>2</sup> Bryan A. Garner, et al., *The Law of Judicial Precedent* 367 (2016).



In 1993, the *New England Journal of Medicine* reported the survival rate at 22 weeks to be zero.<sup>3</sup> In 2009, the *Journal of the American Medical Association* reported the survival rate at 22 weeks' gestation was 9.8%.<sup>4</sup> In 2015, the *New England Journal of Medicine* reported the survival rate as 22.1%.<sup>5</sup> In 2016, *Pediatrics* reported a 31% survival rate.<sup>6</sup> And a 2017 Canadian study showed the survival rate at 22 weeks was 64.4%.<sup>7</sup> The NICU now commonly cares for infants born at these gestational ages. Babies born at only 21 weeks have now survived.<sup>8</sup> And a recent study suggested that artificial womb technology is feasible.<sup>9</sup> The supposed viability line has now

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<sup>3</sup> M. Allen, et al., *The Limit of Viability—Neonatal Outcome of Infants Born at 22 to 25 Weeks' Gestation*, N. E. J. Med. Vol. 329 no. 22, 1597–1601 (Nov. 25, 1993), <https://www.nejm.org/doi/pdf/10.1056/NEJM199311253292201?articleTools=true>.

<sup>4</sup> K. Marsal, et al., *One-Year Survival of Extremely Preterm Infants After Active Perinatal Care in Sweden*, J. of Am. Med. Assn. Vol. 301 no. 21, 2225–33, (June 3, 2009), <https://jamanetwork.com/journals/jama/fullarticle/184015>.

<sup>5</sup> C. Malloy, M. Chireau Wubbenhorst, T. Sander Lee, *The Perinatal Revolution*, Issues in L. & Med. 26 Vol. 34 no. 1, 15-41, 26 (Spring 2019), <https://heinonline.org/HOL/LandingPage?handle=hein.journals/ilmed34&div=6&id=&page=> (footnote omitted).

<sup>6</sup> *Id.* (footnote omitted).

<sup>7</sup> *Id.* (footnote omitted).

<sup>8</sup> Fox Television, *Extreme Premie*, 'About the Size of a Hand,' *Goes Home in Georgia* (July 2020), <https://fox6now.com/2020/07/01/extreme-preemie-comes-home-for-first-time/>; A. Pawlowski, 'Miracle baby': *Born at 21 Weeks, She May Be the Most Premature Surviving Infant* (Nov. 2017), <https://www.today.com/health/born-21-weeks-she-may-be-most-premature-surviving-baby-t118610>.

<sup>9</sup> See Malloy, *supra*, at 33 (footnote omitted).

moved at least a *month and a half* earlier than was contemplated in *Roe*.<sup>10</sup>

According to *Casey*, *Roe*'s "central holding" is "that viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions." 505 U.S. at 860. Because the plurality assumed that any movement in that line would be trivial, *Casey* was willing to accept the "imprecision" of the viability line as "within tolerable limits" because "there is no line other than viability which is more workable." *Id.* at 870. But as discussed above, the movements in the viability line, as defined by *Roe*, are significant.

Further, *Casey* accepted that "there may be some medical developments that *affect the precise point of viability*," but did not allow for "medical developments" that affect *other* aspects of the abortion issue. *Id.* (emphasis added). These developments, discussed below, are just as relevant to the "balance" *Casey* struck between the woman's liberty interest and the State's interest in "the life of the fetus that may become a child," *id.* at 846, 861. They show that the fetus is not merely a clump of tissue that "may become" a child—it *is* an "unborn child, a child assuming the human form." *Gonzales v. Carhart*, 550 U.S. 124, 160 (2007). The human form of the child, regardless of its viability, is unaccounted for by *Casey*.

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<sup>10</sup> *Roe*'s definition of viability no longer only describes a premature infant's survival. Even human zygotes can now survive "outside the mother's womb" with "artificial aid," *Roe*, 410 U.S. at 160. *See, e.g.,* Mayo Clinic, *In vitro fertilization*, <https://www.mayoclinic.org/tests-procedures/in-vitro-fertilization/about/pac-20384> 716.

**B. Ultrasound technology has dramatically improved and provides a clear window into the womb to witness the humanity of the unborn child.**

Even without ultrasound technology, doctors have long known that the baby was alive in the womb. In 1859, the American Medical Association unanimously approved a report deeming abortion the “unwarrantable destruction of human life.”<sup>11</sup> But the development of fetal ultrasound revolutionized our understanding of the fetus. Technological advances since *Roe* and *Casey* have allowed for widespread use and better-quality images, giving the public a growing appreciation of the fetus *in utero*.

1. Since *Roe*, ultrasound went from being infrequent, expensive, and cumbersome, to becoming part of the standard of care. Fetal ultrasound was pioneered in 1958.<sup>12</sup> For the first time, physicians could visually observe a living fetus.<sup>13</sup> But the first images were rudimentary, and the first machines enormous and expensive, making ultrasound largely inaccessible.<sup>14</sup> As technology advanced, smaller, less expensive ultrasound machines were developed, resulting in greater access and more routine use.<sup>15</sup> Once fetal ultrasound became

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<sup>11</sup> James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* 157 (1978).

<sup>12</sup> See S. Campbell, *A Short History of Sonography in Obstetrics and Gynaecology*, Facts, Views, & Visions: Issues in Obst., Gyn., & Repro. Health, Vol. 5 no. 3, 213–29, (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987368/>.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> Ultrasound machines are now as small as laptop computers; others are simply handheld transducers that transmit images to a

democratized, the public began to appreciate the undeniable humanity of the unborn child. One sure sign of this new cultural understanding: the ultrasound images posted on refrigerators and social media by expectant parents (and grandparents) across America. These black-and-white, baby-on-the-way images have informed the minds and hearts of lay people who have become increasingly aware that what is at issue in this legal debate are members of the human family, even when small and hidden in the haven of the womb.

Over the last decade, ultrasound has been widely used not only for medical purposes, but also for bonding with the unborn child. Ultrasound facilities are common in shopping malls, providing families with keepsake images.<sup>16</sup> The reliability of ultrasound to determine the baby's sex has also made "gender reveals" popular, and many families prepare gender-specific nurseries and layettes well in advance of the baby's arrival.<sup>17</sup>

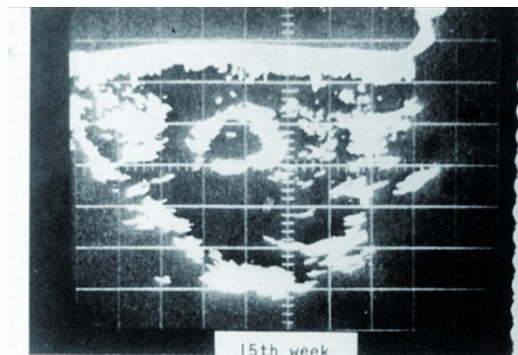
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smartphone. See, e.g., GE Healthcare, *Introducing Versana Active with an Advanced Cart* (July 8, 2020), <https://youtu.be/noMXN-iJjhw>; GE Healthcare, *Vscan Air*, <https://handheldultrasound.gehealthcare.com/>.

<sup>16</sup> See, e.g., Cari Romm, *FDA Warning: Stay Away From 'Keepsake' Ultrasounds*, *The Atlantic*, Dec. 14, 2014, <https://www.theatlantic.com/health/archive/2014/12/fda-warning-stay-away-from-keepsake-ultrasounds/383816/>.

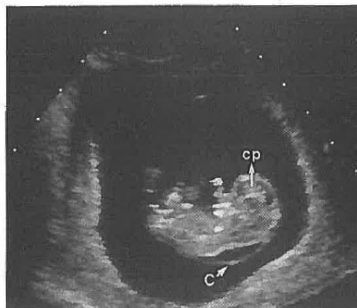
<sup>17</sup> See Elyse Samuels, *How do parents find out the sex of their baby today? Exploring the trend of gender-reveal parties*, *Wash. Post*, May 13, 2018, <https://www.washingtonpost.com/news/parenting/wp/2018/05/13/how-do-parents-find-out-the-sex-of-their-baby-today-exploring-the-new-trend-of-gender-reveal-parties/>.

2. The quality of ultrasound images has improved dramatically since *Roe* and *Casey*. Sonograms in the 1970s were rudimentary:<sup>18</sup>



Sonograms in the late 1980s<sup>19</sup> were still blurry and indefinite, as the below image illustrates. A sonographer's guess as to the baby's sex in those days was unreliable.

Figure 6 Abdominal ultrasound of a 10.5 week embryo with cystic hygromas (C, cystic hygroma; cp, choroid plexus).



Transvaginal ultrasound, a technological leap that occurred in the early 1990s, allowed for greater visibility of

<sup>18</sup> Campbell, *supra*, at Fig. 7.

<sup>19</sup> See M. Cullen, et al., *A Comparison of Transvaginal and Abdominal Ultrasound in Visualizing the First Trimester Conceptus* J. Ultrasound Med. Vol. 8, 565–69, 568 (1989), <https://perma.cc/778Q-BFCC>.

the fetus in early pregnancy.<sup>20</sup> This technique provided evidence destroying the argument that the fetus in early pregnancy was merely a “clump of cells.” In 1996, four years after *Casey*, ultrasound technology clear enough to reliably determine the fetus’s sex was so new that physicians still debated whether they should routinely tell parents this information.<sup>21</sup> Now, ultrasound technology allows for 3D and 4D real-time imaging.<sup>22</sup> The below 3D image of a first trimester fetus demonstrates the dramatic increase in imaging capability as compared to what was available around the time of *Casey*.<sup>23</sup>

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<sup>20</sup> See Campbell, *supra*.

<sup>21</sup> See F. Chervenak & L. McCullough, *Should Sex Identification Be Offered As Part of the Routine Ultrasound Examination?*, 8 J. Ultrasound Obstet. Gyn. 293–94 (1996), <http://onlinelibrary.wiley.com/doi/10.1046/j.1469-0705.1996.08050293.x/epdf>.

<sup>22</sup> See, e.g., Ultrasoundlink, *What is 4D ultrasound scan?*, <https://www.youtube.com/watch?v=OBV7i9zRAto> (demonstrating differences in current 2D, 3D, and 4D technology).

<sup>23</sup> A. Kurjak & A. Luetic, *Fetal neurobehavior assessed by three-dimensional/four-dimensional sonography*, Zdravniski Vestnik., Vol. 79, 790–99, 794 (Nov. 2010), [https://www.researchgate.net/publication/287702538\\_Fetal\\_neurobehavior\\_assessed\\_by\\_three-dimensionalfour-dimensional\\_sonography](https://www.researchgate.net/publication/287702538_Fetal_neurobehavior_assessed_by_three-dimensionalfour-dimensional_sonography).



Using a 3D ultrasound, clinicians can see a ten-week fetus moving its arms, and in the eleventh week, moving its tiny fingers.<sup>24</sup> The incredible detail in these images even allows one to see if the unborn child has her mother's nose or her father's chin, even in the second trimester, as below:<sup>25</sup>




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<sup>24</sup> *Id.* at 795.

<sup>25</sup> *Id.* at 796.

3D and 4D images, surface rendered, reveal the human face of the fetus: plump cheeks, delicately formed lips, and tiny noses:<sup>26</sup>



In 4D renderings, we can observe movement. The baby can be seen yawning, sucking her thumb, and kicking.<sup>27</sup> 4D technology also shows fleeting expressions: the grimace of a cry, a frown wrinkling the forehead, a curve of the lips into a smile.<sup>28</sup> The baby's mouth opens, and we can even see the tongue moving.<sup>29</sup> These detailed images

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<sup>26</sup> Campbell, *supra*, at Fig. 15.

<sup>27</sup> See GE Healthcare, *GE Healthcare Voluson HDlive Ultrasound Imaging Short Movie* (Dec. 5, 2011), <https://www.youtube.com/watch?v=BD7quHKgEuk>.

<sup>28</sup> See, e.g., M. Sato, et al., *4D ultrasound study of fetal facial expressions at 20–24 weeks of gestation*, *Int'l J. Gyn. Obstet.* Vol. 126 no. 3, 275–79, (Sept. 2014); <https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1016/j.ijgo.2014.03.036>.

<sup>29</sup> *Ultrasoundlink, supra*, at 1:24-1:29.



have opened a window into the womb, allowing us to witness the human form of the child.

**C. Improved imaging has provided greater information about fetal development.**

Increasing availability of ultrasound and sophisticated imaging of the fetus has provided now-vivid particulars of fetal development.

At 15 weeks' gestation—only three weeks into the second trimester, and over a month before the middle of pregnancy—the child is already well past the embryonic stage of development and into the fetal stage, which extends from 11 to 39 weeks.<sup>30</sup> At 15 weeks' gestation, the fetus is small, but looks unmistakably human, despite not yet being “viable” according to *Casey*. At 15 weeks, the child's average length is 4-6 inches from the crown of the head to the rump, and 4.1 ounces in weight.<sup>31</sup> The reproduced image below is close to scale.<sup>32</sup>

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<sup>30</sup> See Keith L. Moore, et al., *The Developing Human: Clinically Oriented Embryology* 85 (11th ed. 2020).

<sup>31</sup> See Mark A. Curran, *Fetal Development*, (Mar. 2019), <https://perinatology.com/Reference/Fetal%20development.htm#15>; see also Moore, *supra*, at 86.

<sup>32</sup> This image depicting a 15-week fetus is part of an exhibit admitted into evidence based on expert testimony in *Whole Woman's Health v. Paxton*, 978 F.3d 896 (5th Cir. 2020), *reh'g en banc granted, opinion vacated*, 978 F.3d 974 (5th Cir. 2020), and can be found at page 4268 of the record on appeal.



At 15 weeks' gestation, all major organs are formed and functioning, including the liver, kidneys, pancreas, and brain.<sup>33</sup> Although the child receives nutrients and oxygen through the umbilical cord, the digestive, urinary, and respiratory systems are practicing for extra-uterine life. At 15 weeks, the fetus swallows and urinates; she even "breathes," filling her lungs with amniotic fluid and expelling it.<sup>34</sup> The cardiovascular system is fully formed. Not only is the baby's heartbeat detectable, as it has been for nine weeks, but the four chambers of the fetal heart are visible.<sup>35</sup> So is the blood "whooshing" between the chambers on color doppler ultrasound.<sup>36</sup> At 15 weeks, the baby's head, starting with the brain, is a marvel of intricacy. The brain's large frontal lobes, ventricles, and thalamus fill most of the space.<sup>37</sup> The fetal profile is clear: the gently sloping nose, the distinct upper and lower lips and chin.<sup>38</sup>

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<sup>33</sup> See Curran, *supra*, at 13 weeks.

<sup>34</sup> Moore, *supra*, at 87; Curran, *supra*, at 11 weeks; *see also, e.g.*, Ultrasound Ireland, *15 Weeks Pregnant - Your 15th Week Of Pregnancy* (July 17, 2015), 0:03-1:29, <https://www.youtube.com/watch?v=mDjwNOeM3jE>.

<sup>35</sup> See Curran, *supra*, at 6 weeks; Philips Healthcare, *Advanced screening views of the fetal heart - Part 1 - 4-chamber color and PW Doppler*, (Sept. 13, 2016), <https://www.youtube.com/watch?v=UaC0S7W2OWM>.

<sup>36</sup> See Philips Healthcare, *supra*.

<sup>37</sup> Ultrasoundlink, *supra*, at 0:24.

<sup>38</sup> See Ultrasound Ireland, *supra*.



The external genitalia are visible, allowing sonographers to inform families whether their baby is a son or daughter.<sup>39</sup>

Although many women cannot yet feel movements,<sup>40</sup> a baby at 15 weeks' gestation is very active. Unless the baby is asleep, kicking and arm-waving are commonly seen during ultrasound evaluations.<sup>41</sup> The fetal spine is often gently curved as the fetus rests against the mother's uterine wall. But then the baby plants her feet against the wall in front of her and stretches vigorously.<sup>42</sup>

This is the living reality of what is at issue in this case: a tiny boy or girl who, at 15 weeks, kicks, breathes, and hiccups, who has little fingers that open and close—and who has undeniably “assum[ed] the human form.” *Gonzales*, 550 U.S. at 160.

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<sup>39</sup> Moore, *supra*, at 88; Curran, *supra*, at week 14.

<sup>40</sup> Moore, *supra*, at 86; Curran, *supra*, at week 15.

<sup>41</sup> Moore, *supra*, at 88; *see also*, Ultrasound Ireland, *Scan of the Week: 15 Weeks Pregnant (The Advanced Early Ultrasound)*, (July 17, 2020), <https://www.youtube.com/watch?v=PbIEmTq8UyQ> (2D ultrasound scan of 15-week baby).

<sup>42</sup> *See id.*

**D. Advancements in technology have led to recognition of the fetus as a patient by mainstream medicine.**

Science has not only plainly revealed the human *form* of the unborn child. It has led to the recognition of the fetus as a patient in her own right. Obstetricians have viewed the baby as a patient along with the mother.<sup>43</sup> But until recently, there was a limit to what doctors could do to confirm a problem with the fetus, and little that could be done about it. Sophisticated imaging, genetics, and the exploding field of fetal therapy have increased our knowledge of fetal life. Mainstream medicine now recognizes the fetus as a patient, capable of being treated and worthy of care. Clinicians also recognize that the fetus' environment in the womb can impact the rest of her life.<sup>44</sup>

When *Roe* was decided, perinatal medicine was a brand-new field.<sup>45</sup> The development of diagnostic technology like ultrasound and MRI, which allowed physicians to safely visualize the living fetus in real time throughout pregnancy, “shifted the focus from the newborn, with a severe disorder that could not be corrected after birth, to the possibility of prenatal medical or surgical intervention that could help ameliorate the clinical manifestations of disease ... these diagnostic capabilities led to further research ... and the realization that the fetus was, and is, a patient.”<sup>46</sup>

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<sup>43</sup> Cf. F. Gary Cunningham, et al., eds. *Williams Obstetrics* 181–343 (25th ed. 2018) (section in seminal obstetrics textbook titled “The Fetal Patient”).

<sup>44</sup> Malloy, *supra*, at 15 (footnote omitted).

<sup>45</sup> *Id.* at 16.

<sup>46</sup> *Id.*

Improved diagnostic capability has allowed for many conditions to be treated medically while the fetus is still *in utero*.<sup>47</sup> One of the most common interventions is the preventative treatment of neural-tube defects. Doctors routinely advise women to take folic acid starting before conception and throughout their pregnancy, as it reduces neural-tube defects like spina bifida.<sup>48</sup> Magnesium sulfate has been examined extensively as a means to reduce the risk of cerebral palsy.<sup>49</sup> Congenital adrenal hyperplasia can be diagnosed very early in pregnancy and treated starting at 7-9 weeks' gestation.<sup>50</sup> Other fetal problems that can be medically prevented or treated are HIV infection and thyroid disease.<sup>51</sup>

Aside from diagnosis of the fetus, imaging has also made it possible for interventional surgical procedures to be performed *in utero*. Using ultrasound for guidance, doctors can safely perform amniocentesis, biopsies, surgery and sampling.<sup>52</sup> As imaging technology advanced, better visualization led to “drastically improved” screening for certain conditions and an explosion in possible treatments.<sup>53</sup>

Laparoscopic-type techniques, known as fetoscopy, have “revolutionized” fetal procedures.<sup>54</sup> These procedures use endoscopes (small, fiber-optic guided instruments) within the uterus. Using ultrasound guidance, fetoscopy enables doctors to place shunts (to treat

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<sup>47</sup> *See id.* at 17–19.

<sup>48</sup> *Id.* at 17.

<sup>49</sup> *Id.* at 18.

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 18–19.

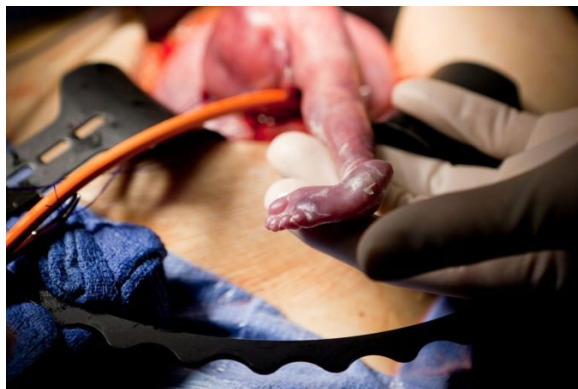
<sup>52</sup> *Id.* at 17.

<sup>53</sup> *See id.* at 16–17.

<sup>54</sup> *Id.* at 19.

problems like bladder obstruction), and correct blood vessel abnormalities.<sup>55</sup> Life-saving interventions are now available for fetuses diagnosed with congenital heart disease. Fetal hemolytic disease, often fatal if untreated, may be treated *in utero* through fetal blood transfusions.<sup>56</sup>

Advancing technology also allows doctors to perform open fetal surgery as early as 15 weeks' gestation.<sup>57</sup> Over the last decade, fetal surgeries have “soared as never before.”<sup>58</sup> During these surgeries, physicians will open the uterus and operate directly on the fetus, producing images like the one below, which reinforce the human form of the child in the womb.<sup>59</sup>



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<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> Shawn Shinneman, *The Surgeon Who Works On Babies Before They're Born*, Dallas Mag., Oct. 2018, <https://www.dmagazine.com/publications/d-magazine/2018/october/timothy-crombleholme-works-on-babies-before-theyre-born/>.

<sup>58</sup> Carlo V. Bellieni, *Analgesia for fetal pain during prenatal surgery: 10 years of progress*, *Pediatric Res.* 1612-18, 1 & Fig. 1 (Sept. 24, 2020), <https://www.nature.com/articles/s41390-020-01170-2>.

<sup>59</sup> Malloy, *supra*, at 21; *see also* Shinneman, *supra*.

The below image was taken during a surgery to repair open spina bifida.<sup>60</sup>



During open fetal surgery, surgeons can remove tumors and repair congenital diaphragmatic hernias.<sup>61</sup> Other conditions successfully treated in open fetal surgery include large lung tumors, severe kidney obstruction, low amniotic fluid, and twin-to-twin transfusion syndrome.<sup>62</sup>

The rapidly developing field of fetal therapies and surgery—completely undeveloped at the time of *Roe* and still largely futuristic at the time of *Casey*—is significant for purposes of evaluating whether the “underpinnings” of those cases have been “eroded.” *Janus v. Am. Fed’n of State, Cty., & Mun. Emps., Council 31*, 138 S. Ct. 2448, 2482 (2018) (citation omitted). These new technologies have confirmed that in the view of mainstream medicine,

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<sup>60</sup> Miriam Falco, *Study: Major benefits for spina bifida surgery in the womb*, CNN, Feb. 10, 2011, <http://edition.cnn.com/2011/HEALTH/02/09/surgery.spina.bifada/index.html> (image of a 22-week fetus grasping the surgeon’s finger).

<sup>61</sup> Malloy, *supra*, at 21–23.

<sup>62</sup> *Id.* at 23–24.



“the fetus has truly become a patient.”<sup>63</sup> That only changes if *the same child* is unwanted by its mother and slated for abortion.<sup>64</sup> At minimum, the same ethical principles governing the medical treatment of the fetus should govern elective abortion of the fetus. As the Court acknowledged in the death penalty context, human dignity is not dependent on whether that human is slated to die. *See Roper v. Simmons*, 543 U.S. 551, 560 (2005) (“By protecting even those convicted of heinous crimes, the Eighth Amendment reaffirms the duty of the government to respect the dignity of all persons.”)

**E. Current science shows that the fetus is pain-capable much earlier than previously thought.**

“[N]eonatal and medical science ... now graphically portrays, as science was unable to do [at the time of *Roe*], how a baby develops sensitivity to external stimuli and to pain much earlier than was then believed.” *McCorvey v. Hill*, 385 F.3d 846, 852 (5th Cir. 2004) (Jones, J., concurring) (footnote omitted). With the development of fetal surgery, it was necessary for physicians to consider fetal pain, and anesthesia to prevent it, to ensure treatment is done humanely. After reviewing scientific evidence from the last decade, researchers have now concluded that “the human fetus can feel pain when it undergoes surgical interventions and direct analgesia must be provided to it.”<sup>65</sup> Advancing technology also provides more information about how the fetus experiences the brutal abortion procedure that ends its life. The

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<sup>63</sup> *Id.* at 36 (footnote omitted).

<sup>64</sup> *See id.* at 33 (“The fetus is considered a ‘person’ when carried by a woman who plans to continue the pregnancy, but the fetus is not considered a person when the mother plans abortion.”)

<sup>65</sup> Bellieni, *supra*, at 1.

possibility of fetal pain warrants the same consideration given in the context of medical treatment as it does in the context of abortion, yet *Casey*'s rigid framework makes no allowance for it.<sup>66</sup>

Generally, pain is perceived after receptors transmit the pain message to the spinal cord, which carries the message into the deeper parts of the brain—the thalamus and cortex—for processing. These structures are developing in the baby well before “viability.” By 12 weeks’ gestation, sensory fibers have grown into the spinal cord and connected with the thalamus, which is the “essential organ of the affective side of our sensation, especially pain,” and has “pivotal importance” for “fetal pain.”<sup>67</sup> Also by 12 weeks, the first projections from the thalamus connect with the cortical subplate.<sup>68</sup> The subplate is a transient developmental structure that forms underneath the cortical plate proper.<sup>69</sup> Neurons first migrate into the subplate until the cortical plate above is sufficiently mature; the neurons then migrate to the cortex.<sup>70</sup> The subplate gradually becomes white matter.<sup>71</sup>

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<sup>66</sup> See S. Derbyshire & J. Bockmann, *Reconsidering fetal pain*, *J. Med. Ethics* Vol. 46, no. 1, 3–6, 4 (2020), <https://jme.bmj.com/content/46/1/3> (“[W]hile all the evidence suggests that surgeons performing therapeutic fetal interventions routinely consider pain relief for the fetus, surgeons performing abortions have their focus on the pregnant woman as their patient. Consequently they more rarely consider fetal pain relief during the preparation and execution of abortion. Whether or not the fetus feels pain, therefore, is relevant to current medical practice surrounding abortion and could motivate changes in practice.” (footnote omitted)).

<sup>67</sup> Bellieni, *supra*, at 2.

<sup>68</sup> Derbyshire, *supra*, at 4.

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

The fact that the fetus lacks a fully functional cortex before 24 weeks' gestation led some scientists to believe that fetal pain perception was impossible before then, despite evidence showing that the fetus will respond to noxious stimuli much earlier.<sup>72</sup> In 2010, the Royal College of Obstetricians and Gynaecologists (RCOG) issued a report making this conclusion,<sup>73</sup> and the American College of Obstetricians and Gynecologists (ACOG) recently relied on it to make the same argument.<sup>74</sup>

But researchers now criticize the RCOG report as ill-founded: “We could rewrite this [report] as ‘in theory they can’t feel pain, therefore they don’t.’”<sup>75</sup> And more recent research “call[s] into question the necessity of the cortex for pain and demonstrat[es] functional thalamic connectivity into the subplate.”<sup>76</sup> Further, “even if the cortex is deemed necessary for pain experience, there is now good evidence that thalamic projections into the subplate, which emerge around 12 weeks’ gestation, are functional and equivalent to thalamocortical projections that emerge around 24 weeks’ gestation.”<sup>77</sup> Researchers now believe that “current neuroscientific evidence

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<sup>72</sup> See, e.g., V. Glover & N. Fisk, *Fetal pain: implications for research and practice*, Brit. J. Obstet. Gyn. Vol. 106, 881–86, 882 (Sept. 1999), <https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1111/j.1471-0528.1999.tb08424.x>.

<sup>73</sup> See Royal Coll. of Obstet. and Gyns., *Fetal awareness review of research and recommendations for practice: report of a working party* (Mar. 2010), <https://www.rcog.org.uk/globalassets/documents/guidelines/rcogfetalawarenesswpr0610.pdf>.

<sup>74</sup> Am. Coll. of Obstet. & Gyns., *Facts are Important: Fetal Pain*, <https://www.acog.org/advocacy/facts-are-important/fetal-pain> (undated but referencing the Trump Administration).

<sup>75</sup> Bellieni, *supra*, at 5 (footnote omitted).

<sup>76</sup> *Id.* at 3.

<sup>77</sup> *Id.* at 4.

undermines the necessity of the cortex for pain experience. Thus, current neuroscientific evidence supports the possibility of fetal pain before the ‘consensus’ cut-off of 24 weeks.”<sup>78</sup>

Review of the last decade’s research shows that science has also disproved other theories arguing that fetal pain is impossible before 24 weeks.<sup>79</sup> In fact, “one of the most prominent researchers” in the field of fetal pain, “who had always excluded” its eventuality, “has changed his conclusions, due to the new evidence.”<sup>80</sup> He now concludes that “[o]verall, the evidence, and a balanced reading of that evidence, points towards *an immediate and unreflective pain experience* mediated by the developing function of the nervous system from *as early as 12 weeks*.”<sup>81</sup>

The relevance to abortion was not lost on the prominent researcher who reconsidered his views due to new science. Even though he is pro-choice, he and his co-author (who is pro-life) noted that their personal views “should not interfere with discussion of whether fetal pain is possible and whether the science of fetal development can rule out the possibility of fetal pain.”<sup>82</sup>

It is still unknown exactly how the fetus experiences pain. But even if it does not experience pain like an adult with a fully formed cortex, fetal pain is still worthy of consideration.<sup>83</sup> In fact, evidence suggests that the

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<sup>78</sup> *Id.* at 4.

<sup>79</sup> *Id.* at 1–7.

<sup>80</sup> *Id.* at 1.

<sup>81</sup> Derbyshire, *supra*, at 6 (emphasis added).

<sup>82</sup> *Id.* at 3.

<sup>83</sup> *Id.* at 4–6; see also, e.g., *Baze v. Rees*, 553 U.S. 35, 49 (2008) (plurality op.) (“Our cases recognize that subjecting individuals to a

unborn child, like infants, may even experience pain more severely than mature people.<sup>84</sup> Medicine already recognizes this, and physicians avoid suffering in even pre-viable fetuses. Fetal anesthesia is the standard of care for any fetal procedure.<sup>85</sup> And the standard of care for babies born alive that are too young to be resuscitated still includes palliative care: pain medication, warmth, and swaddling for comfort.<sup>86</sup> Yet when those same babies are subjected to abortion, their suffering is deemed irrelevant because they are destined to die. That this Court’s precedent requires this perverse result is more than sufficient to require its reversal.

## II. *Casey* Is Unworkable and Should Be Overruled.

Aside from changes in fact or law, other factors the Court considers in deciding to overrule precedent, *see Janus*, 138 S. Ct. at 2478–79, favor overruling the viability standard because it has proven unworkable.

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risk of future harm—not simply actually inflicting pain—can qualify as cruel and unusual punishment.”)

<sup>84</sup> Glover, *supra*, at 882 (“The last pathways in the nociceptive system ... do not form until after birth, raising the possibility that the fetus may actually be more sensitive to noxious stimuli than the older child, and may explain why the newborn shows exaggerated behavioural responses to sensory provocation.”).

<sup>85</sup> *See* Bellieni, *supra*, at 1 (“[T]he human fetus can feel pain when it undergoes surgical interventions and direct analgesia must be provided to it.”); Derbyshire, *supra*, at 4 (“Currently ... we are not aware of any procedures where invasive fetal intervention proceeds without anaesthesia or analgesia, except for abortion.”)

<sup>86</sup> *See, e.g.,* ACOG, *Obstetric Care Consensus: Periviable Birth* (2019), <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2017/10/periviable-birth>.

**A. *Casey* does not allow for restrictions based on increased knowledge of how the brutal abortion procedure affects the unborn child.**

Since *Roe*, medicine has developed new ways to treat the fetus as a patient and is addressing the impact those treatments have on the fetus with respect to pain. But over the same period, abortion providers have employed increasingly brutal abortion methods.

The dilation and evacuation (D&E) procedure currently used after 15 weeks' gestation was not used for second-trimester abortions at the time of *Roe*. *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 436 & n.23 (1983); *see also Stenberg v. Carhart*, 530 U.S. 914, 924 (2000). The Court described this brutal procedure before based on the testimony of late-term abortionist Dr. Leroy Carhart:

The Supreme Court described the D&E procedure in gruesome “technical detail” in *Stenberg v. Carhart*, acknowledging that its description “may seem clinically cold or callous to some, perhaps horrifying to others.” As the Supreme Court explained, abortion doctors use D&E in the second trimester because at that stage of fetal development, “the fetus is larger”—“particularly the head”—and the “bones are more rigid,” meaning “dismemberment or other destructive procedures” are required. . . . A physician extracts from the womb what moments before had been a living “unborn child”—using forceps, scissors, or a similar instrument that “slices, crushes, or grasps” fetal body parts one at a time. Piece by piece. Arm by arm. Leg by leg. And as the abortion doctor “cut[s] or rip[s] the piece from the body”—a torso,

a spine, a rib cage—he places each body part on a tray (or in a dish)<sup>87</sup> to keep inventory and ensure that nothing is left behind. *Sometimes the heart is still beating on the tray.* The fetus dies just as an adult experiencing corporal dismemberment would—by bleeding to death as his or her body is torn apart.

*Whole Woman’s Health*, 978 F.3d at 913 (Willett, J., dissenting) (emphasis added) (citations omitted).<sup>88</sup> “As one bioethicist testified, it’s ‘self-evident that it’s brutal and inhumane to tear a living organism limb from limb alive.’” *Id.* at 930. And “[n]o one would dispute that, for many, D&E is a procedure itself laden with the power to devalue human life.” *Gonzales*, 550 U.S. at 158.<sup>89</sup>

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<sup>87</sup> See *Planned Parenthood of Greater Tex. Fam. Plan. & Preventative Health Servs., Inc v. Smith*, 913 F.3d 551, 556 (5th Cir. 2019), *on reh’g en banc sub nom. Planned Parenthood of Greater Texas Fam. Plan. & Preventative Health Servs., Inc. v. Kauffman*, 981 F.3d 347 (5th Cir. 2020) (photograph of aftermath of D&E abortion).

<sup>88</sup> See also Testimony of Dr. Anthony Levatino, C-SPAN, “Planned Parenthood Medical Procedures,” <https://www.youtube.com/watch?v=j0tQZhEisaE>.

<sup>89</sup> Abortion providers do not dispute this. See W. Hern & B. Corrigan, *What About Us? Staff Reactions to D&E*, Adv. In Planned Parenthood Vol. 15 no. 1, 3–8, 7 (Jan. 1980), <https://www.drhern.com/wp-content/uploads/2018/05/staff-reaction-de.pdf> (“[T]here is no possibility of denying an act of destruction. It is before one’s eyes. The sensations of dismemberment flow through the forceps like an electric current.”); L. Harris, *Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse*, *Repro. Health Matters*, Vol. 16 no. supp. 31, 74–81, 76 (2008), <https://www.tandfonline.com/doi/pdf/10.1016/S0968-8080%2808%2931396-2?needAccess=true> (“There is violence in abortion, especially in second trimester procedures.”)

Given the recent evidence showing the fetus may experience pain as early as 12 weeks, researchers have directly concluded that “a D&E procedure will deliver repeated nociceptive events that may involve fetal pain before fetal death.”<sup>90</sup> Fetal pain is so likely that the same researchers advocate for fetal analgesia to be used in abortions, even before less outwardly brutal procedures causing fetal death, such as feticidal injections.<sup>91</sup> But the D&E procedure is inherently brutal and inhumane regardless of whether the fetus can feel it. We would never countenance dismembering a person (or even an animal) as a means of causing death, even if the person were anesthetized first.<sup>92</sup>

Researchers note that even among the general public, “concerns about what the fetus might experience or feel have increased, and women considering an abortion express concern about the welfare of the fetus.”<sup>93</sup> No doubt, this is because of the advancements in ultrasound technology described above. As *Casey* recognized, “most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision.” 505 U.S. at 882. Yet because of *Casey*, Mississippi is *compelled* to permit doctors to kill living, pain-capable human children—because they are “preivable” according to *Roe* and *Casey*—in a way that “someone could not legally

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<sup>90</sup> Derbyshire, *supra*, at 5.

<sup>91</sup> *Id.*

<sup>92</sup> Moreover, a scientific disagreement about whether the fetus feels pain at that age should not foreclose the State from “err[ing] on the side of caution.” *Whole Woman’s Health*, 978 F.3d at 930 (Willett, J., dissenting). “Medical uncertainty does not foreclose the exercise of legislative power in the abortion context any more than it does in other contexts.” *Gonzales*, 550 U.S. at 164.

<sup>93</sup> Derbyshire, *supra*, at 5. (footnotes omitted).



kill an animal.” *Whole Woman’s Health*, 978 F.3d at 930 (Willett, J., dissenting).

**B. *Casey* is inconsistent with the Court’s recognition of other State interests that justify abortion restrictions.**

By locking in “viability” as the only legally sufficient reason a State may prohibit abortions, *Casey* is also out-of-step with the Court’s own recognition of other state interests justifying regulation of previability abortion. Some examples: preventing the coarsening of society to the humanity of newborns, *Gonzales*, 550 U.S. at 157; the integrity and ethics of the medical profession, who must simultaneously treat the unborn child as a patient in some contexts and as mere “tissue” in others,<sup>94</sup> *id.*; protection of minors, *Casey*, 505 U.S. at 899–900; and maternal health, *Roe*, 410 U.S. at 154.

Because of advancements in genetic testing, it is now possible to know the child’s sex soon after fertilization and whether it has any genetic disorders, like Down Syndrome. Justice Thomas recently explained abortion’s ties to the eugenics movement, noting that “technological advances have only heightened the eugenic potential for abortion.” *Box v. Planned Parenthood of Ind. & Ky.*, 139 S. Ct. 1780, 1784 (2019) (Thomas, J., concurring). Thus, there is a “compelling interest in preventing abortion from becoming a tool of modern-day eugenics.” *Id.* at 1783 & n.2 (Thomas, J., concurring). But *Casey* does not permit those interests to be considered in limiting abortion.

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<sup>94</sup> See Harris, *supra*, at 77 (“I thought to myself how bizarre it was that I could have legally dismembered this fetus-now-newborn if it were inside its mother’s uterus – but that the same kind of violence against it now would be illegal, and unspeakable.”)

Of particular relevance, multiple Justices that joined *Roe* agreed that fetal pain and development are important considerations. Justice Blackmun, the author of *Roe*, found it “obvious” that “the State’s interest in the protection of an embryo ... increases progressively and dramatically as the organism’s capacity to feel pain, to experience pleasure, to survive, and to react to its surroundings increases day by day.” *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 552 (1989) (Blackmun, J., joined by Brennan and Marshall, JJ., concurring in part) (cleaned up); *see also id.* at 569 (Stevens, J., concurring in part) (stating that the interest in protecting a “developed fetus” from “physical pain or mental anguish” is “valid”). As Justice Stevens wrote in *Thornburgh v. ACOG*: “The development of a fetus—and pregnancy itself—are not static conditions, and the assertion that the government’s interest is static simply ignores this reality.” 476 U.S. 747, 778 (1986) (Stevens, J., concurring).

Current science strengthens these interests, yet *Casey* precludes States from taking it into account when limiting abortions. But “[t]he notion that anything in the Constitution prevents States from passing laws prohibiting the dismembering of a living child is implausible.” *Harris v. W. Alabama Women’s Ctr.*, 139 S. Ct. 2606, 2607 (2019) (Thomas, J., concurring). Based on *Casey*, multiple lower courts have rejected even modest measures to lessen suffering, like requiring feticide before D&E abortion.<sup>95</sup> Plainly, *Casey* goes too far in

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<sup>95</sup> *See, e.g., EMW Women’s Surg. Ctr., P.S.C. v. Friedlander*, 960 F.3d 785 (6th Cir. 2020), *cert. granted in part sub nom. Cameron v. EMW Women’s Surg. Ctr., P.S.C.*, 141 S. Ct. 1734 (2021); *Whole Woman’s Health*, 978 F.3d 896; *W. Alabama Women’s Ctr. v. Williamson*, 900 F.3d 1310 (11th Cir. 2018).

limiting the ability of States to restrict abortion based on compelling interests like fetal pain.

**C. *Casey*'s standard is arbitrary and has had damaging effects.**

*Casey* acknowledged that while “legislatures may draw lines which appear arbitrary without the necessity of offering a justification ... courts may not.” 505 U.S. at 870. But as time and science has revealed, *Casey*'s viability line is both arbitrary and unjustified. It requires the Court to usurp a role that the Constitution gives to the legislative branch and make decisions no court is equipped to make. The Court's adventure in abortion policymaking has had damaging effects on our political system. It is time to correct course.

1. The arbitrariness of the viability standard is demonstrated through the Court's own later precedent. In 2003, the federal Partial-Birth Abortion Ban was enacted by Congress, citing the “medical fact” that “unborn infants at this stage can feel pain when subjected to painful stimuli and that their perception of this pain is even more intense than that of newborn infants and older children when subjected to the same stimuli.” Pub. L. No. 108-105, § 2(14)(M), 117 Stat. 1201 (2003) (noting that “during a partial-birth abortion procedure, the child will fully experience the pain associated with piercing his or her skull and sucking out his or her brain”).

*Gonzales* upheld the Act. But because of *Casey*'s rigid framework, it did so only because the typical D&E procedure described above was still permitted, enabling the continued provision of previability second-trimester abortion. As Justice Ginsburg noted, it is nonsensical that the legality of a ban on an indisputably brutal procedure depended on the availability of an “equally”

brutal procedure. 550 U.S. at 181–82 (Ginsburg, J., dissenting). And as Justice Stevens noted, “[t]he notion that either of these two equally gruesome procedures ... is more akin to infanticide than the other ... is simply irrational.” *Stenberg*, 530 U.S. at 946–47 (Stevens, J., concurring). Yet this is the contradiction that *Casey*’s standard requires.

2. As lower courts have recognized, “because the Court’s rulings have rendered basic abortion policy beyond the power of our legislative bodies, the arms of representative government may not meaningfully debate’ medical and scientific advances.” *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 774 (8th Cir. 2015) (quoting *McCorvey*, 385 F.3d at 852 (Jones, J., concurring)). The very fact that science dates the Supreme Court’s abortion jurisprudence highlights an underlying problem: In *Casey*, unelected judges evaluated scientific evidence and “weigh[ed] the State’s interests in ‘protecting the potentiality of human life’ and the health of the woman, on the one hand, against the woman’s liberty interest” in obtaining an abortion. *June Med. Servs. LLC v. Russo*, 140 S. Ct. 2103, 2136 (2020) (Roberts, C.J., concurring in the judgment) (quoting *Casey*, 505 U.S. at 878). In other words, in holding that States cannot prohibit abortion for any reason before viability, *Casey* “has already balanced the State’s asserted interests and found them wanting.” *Dobbs*, 945 F.3d at 274. Based on their professional knowledge, *amici* physicians submit that the Court has empirically—and emphatically—struck the wrong balance.

But “[t]here is no plausible sense in which anyone, let alone this Court, could objectively assign weight to such imponderable values and no meaningful way to compare them if there were.” *June Med.*, 140 S. Ct. at 2136

(Roberts, C.J., concurring in the judgment). “Pretending that [the Court] could pull that off would require us to act as legislators, not judges, and would result in nothing other than an ‘unanalyzed exercise of judicial will’ in the guise of a ‘neutral utilitarian calculus.’” *Id.* (citation omitted). The Court has become the national “*ex officio* medical board” it did not want to be. *Gonzales*, 550 U.S. at 164 (quoting *Webster*, 492 U.S. at 518–19. It should relinquish that role.

3. The Court’s foray into medical regulation may not merely be stagnating the legal standard despite advancing science—it may be *impeding* science. Researchers fear that acknowledging science on fetal pain may lead to restriction on abortion.<sup>96</sup> ACOG’s clinging to decade-old research illustrates this point.<sup>97</sup> It also illustrates how ACOG’s views<sup>98</sup> are based less on science and more on the politics of protecting *Roe* and *Casey*. It is unconscionable to think that the “medical” community shapes “the science” to fit its political goals. But this is the division the Court’s abortion jurisprudence inflames.

4. Abortion is one of the most controversial issues in the United States and is likely so *because of* this Court’s intervention. The Court’s gambit in attempting to

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<sup>96</sup> See Derbyshire, *supra*, at 3 (“Fetal pain has long been a contentious issue, in large part because fetal pain is often cited as a reason to restrict access to termination of pregnancy or abortion.”); see also Harris, *supra*, at 77 (abortion providers are “silen[t]” about the violence of abortion because “frank talk like this is threatening to abortion rights.”)

<sup>97</sup> See ACOG, *Facts are important*, *supra*.

<sup>98</sup> Most practicing obstetrician-gynecologists do not share this view, as over 85% do not perform abortions. D. Stulberg, et al., *Abortion provision among practicing obstetrician-gynecologists*, *Obstet. Gyn.*, Vol. 118 no. 3, 609–14 (Sept. 2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3170127/>.

answer the question for all time and remove the issue from public debate, *see Casey*, 505 U.S. at 867, has had the opposite effect. Confirmations to this Court are now political bloodsport because of abortion. At least half of the American public is still as intensely opposed to abortion as it was in 1973.<sup>99</sup>

The most democratic solution would be for this Court to stop acting as “*ex officio* medical board” and permit State legislatures, which are politically accountable if they strike the wrong balance, and can nimbly respond to current science, to take its place. The Court should not be tempted to simply draw another arbitrary line, as that will result in yet more intense litigation and the issue repeatedly returning to the Court. Nor should the Court hold blindly to principles of *stare decisis* in retaining unworkable, outdated precedent. Judges “may have compulsions to revere past history and accept what was once written. But he [or she] remembers above all else that is *the Constitution* which he swore to support and defend, not the gloss which his predecessors may have put on it.”<sup>100</sup>

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This brief ends where *Casey* began: “Liberty finds no refuge in a jurisprudence of doubt.” 505 U.S. at 843. “Yet [48] years after ... holding that the Constitution protects a woman’s right to terminate her pregnancy in its early stages, that definition of liberty is still questioned.” *Id.* (citation omitted). Scientific advancements over the last

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<sup>99</sup> See, e.g., *Americans’ Opinions on Abortion: Knights of Columbus/Marist Poll Nat’l Survey* 7 (Jan. 2021), <https://www.kofc.org/en/resources/news-room/polls/kofc-national-survey-with-tables012021.pdf>.

<sup>100</sup> Garner, *supra*, at 354 (quoting William O. Douglas, *Stare Decisis*, 49 Colum. L. Rev. 735, 736 (1949)) (emphasis added).

48 years have multiplied, not reduced, those doubts, as the humanity of the unborn child is undeniable. The Court should relinquish its role as nationwide abortion regulator and return the job to States and elected officials where it belongs.

**CONCLUSION**

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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