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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

STACY SEYB, M.D., Plaintiff, v. MEMBERS OF THE IDAHO BOARD OF MEDICINE, in their official capacities; *et al*, Defendants, and ATTORNEY GENERAL RAÚL LABRADOR, Defendant-Intervenor.	)	Case No.: 1:24-cv-00244-BLW **PLAINTIFF'S POST-TRIAL PROPOSED FINDINGS OF FACT AND CONCLUSIONS OF LAW**

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I. Idaho's Abortion Bans

1. Two Idaho statutes banning abortion are currently in effect: a ban on abortion throughout pregnancy, Idaho Code § 18-622 ("Total Abortion Ban"), and a ban on abortion when embryonic or fetal cardiac activity has been detected, Idaho Code §§ 18-8801 to 18-8808 ("Fetal Heartbeat Act"), (collectively, the "Abortion Bans").[1]

A. The Total Abortion Ban

2. The Total Abortion Ban was enacted in 2020 as a trigger ban. *See Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1152 (Idaho 2023). It took effect on August 25, 2022, thirty days after the Supreme Court issued judgment in *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215 (2022). *See* Act of Mar. 24, 2020, ch. 284, § 1, 2020 Idaho Sess. Laws 827, 827 (S.B. No. 1385); *United States v. Idaho*, 623 F. Supp. 3d 1096, 1103 (D. Idaho 2022), *cert. before judgment granted sub nom. Moyle v. United States*, 144 S. Ct. 540 (2024) (mem.), *cert. dismissed as improvidently granted by* 603 U.S. 324 (2024) (per curiam), *appeal dismissed by* 131 F.4th 798, 804 (9th Cir. 2025).

3. In its original form, the Total Abortion Ban "ma[de] all 'abortions' a crime and include[d] a provision directing the appropriate professional licensing board to implement certain penalties against 'any health care professional' who violates it." *Planned Parenthood Great Nw.*, 522 P.3d at 1152 (citations omitted). Instead of exceptions, it allowed for "*legally justified abortions* through affirmative defenses to prosecution." *Id.* at 1152-53.

[1] For the sake of clarity and consistency, Plaintiff uses the designations given to these statutes by the Idaho Supreme Court. *See Planned Parenthood Great Nw., Hawaii, Alaska, Ind., Ky. v. State*, 522 P.3d 1132, 1152-53 (Idaho 2023).

4. "The two affirmative defenses, stated generally, [we]re: (1) "[t]he physician determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman"; and (2) in the case of rape or incest, prior to the abortion, the woman provided the physician with a copy of her report of rape or incest to law enforcement." *Id.* at 1153.

5. In 2023, the Idaho Supreme Court rejected a State constitutional challenge to the Abortion Bans, which included a claim that the first affirmative defense was unconstitutionally vague on its face. *Id.* at 1203-04. In construing that provision for purposes of its vagueness analysis, the Idaho Supreme Court held that:

> [T]he statute does not require *objective* certainty, or a particular level of immediacy, before the abortion can be "necessary" to save the woman's life. Instead, the statute uses broad language to allow for the "clinical judgment that physicians are routinely called upon to make for proper treatment of their patients."

Id. at 1203 (citation omitted). The Idaho Supreme Court further held that: "Of course, a prosecutor may attempt to prove that the physician's subjective judgment that an abortion was 'necessary to prevent the death of the pregnant woman' was not made in 'good faith' by pointing to other medical experts on whether the abortion was, in their expert opinion, medically necessary." *Id.* at 1204.

6. Later in 2023, the Idaho Legislature amended the Total Abortion Ban and the statutory definition of abortion applicable to it. Act of Apr. 4, 2023, ch. 298, §§ 1–2, 2023 Idaho Sess. Laws 906, 906-09 (H.B. No. 374). Those amendments took effect on July 1, 2023. *Id.* at 909.

7. As amended, the definition of abortion applicable to the Total Abortion Ban provides that:

> "Abortion" means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the unborn child except that, for purposes of this chapter, abortion shall not mean: (a) The use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization, or the implantation of a fertilized ovum within the uterus; (b) The removal of a dead unborn child; (c) The removal of an ectopic or molar pregnancy; or (d) The treatment of a woman who is no longer pregnant.

Idaho Code § 18-604(1).

8. As amended, the operative language in the Total Abortion Ban states that: "[E]very person who performs or attempts to perform an abortion as defined in this chapter commits the crime of criminal abortion." *Id.* § 18-622(1).

9. The 2023 statutory amendments converted the affirmative defenses to exceptions. The first exception currently exempts from liability a physician who "determined, in his good faith medical judgment and based on the facts known to the physician at the time, that the abortion was necessary to prevent the death of the pregnant woman" provided that the physician "performed or attempted to perform the abortion in the manner that, in his good faith medical judgment and based on the facts known to the physician at the time, provided the best opportunity for the unborn child to survive, unless, in his good faith judgment, termination of the pregnancy would have posed a greater risk of the death of the pregnant woman" from a cause other than self-harm. *Id.* § 18-622(2)(a). This exception does not apply when the pregnant person faces a risk of death from self-harm. *Id.*

10. The second exception now applies to survivors of rape or incest, but only if the survivor (or their parent or guardian if the survivor is a minor) reported the crime to a government agency and can furnish documentation of the report to the abortion provider. *See id.* § 18-622(2)(b).

11. Additionally, the Total Abortion Ban provides that criminal abortion does not encompass medical treatment that results in the accidental death of an embryo or fetus and does not "subject a pregnant woman on whom any abortion is performed or attempted to any criminal conviction and penalty." *Id.* § 18-622(4)-(5).

12. Criminal abortion constitutes a felony punishable by two to five years in prison. *Id.* § 18-622(1). Further, the license of any licensed healthcare provider who performs or attempts a criminal abortion or assists with such action "shall be suspended by the appropriate licensing board for a minimum of six (6) months upon a first offense and shall be permanently revoked upon a subsequent offense." *Id.* § 18-622(1).

B. The Fetal Heartbeat Act

13. The Fetal Heartbeat Act was originally enacted in 2021 as a trigger ban containing both a criminal enforcement provision and a private right of action for specified individuals. *See* Fetal Heartbeat Preborn Child Protection Act, ch. 289, § 1, 2021 Idaho Sess. Laws 867, 867-69 (H.B. No. 366).

14. In 2022, the Idaho Legislature amended the statute to, among other things, move the trigger language to the criminal enforcement provision and give the private right of action immediate effect. *See* Fetal Heartbeat Preborn Child Protection Act, ch.152, § 4, 2022 Idaho Sess. Laws 532, 534-35 (S.B. No. 1309) (codified as amended at Idaho Code § 18-8805); *Planned Parenthood Great Nw.*, 522 P.3d at 1153. The criminal enforcement provision was triggered by the Eleventh Circuit's decision in *SisterSong Women of Color Reproductive Justice Collective v. Governor of Georgia*, 40 F.4th 1320 (11th Cir. 2022). It took effect thirty days after the judgment issued in that case. *See* Idaho Code § 18-8805(1); *Planned Parenthood Great Nw.*, 522 P.3d at 1154.

15. In its current form, the Fetal Heartbeat Act prohibits abortion care when embryonic or fetal cardiac activity is detectable, subject to narrow exceptions for certain medical emergencies and survivors of rape or incest. *See* Idaho Code §§ 18-8801 to 18-8808.

16. For purposes of the Fetal Heartbeat Act, "'[a]bortion' means the use of any means to intentionally terminate the clinically diagnosable pregnancy of a woman with knowledge that the termination by those means will, with reasonable likelihood, cause the death of the preborn child," and "does not mean the use of an intrauterine device or birth control pill to inhibit or prevent ovulations, fertilization, or the implantation of a fertilized ovum within the uterus." *Id.* § 18-8801(1).

17. The operative language in the Fetal Heartbeat Act provides that: "A person may not perform an abortion on a pregnant woman when a fetal heartbeat has been detected …." *Id.* § 18-8804(1). The statute defines "fetal heartbeat" to mean "embryonic or fetal cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the gestational sac." *Id.* § 18-8801(2).

18. The statute contains an exception for cases of "medical emergency," *id.* § 18-8804(1), defined as "a condition that, in reasonable medical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function," *id.* § 18-8801(5).

19. The statute also contains an exception for survivors of rape or incest, but only if the survivor (or their parent or guardian if the survivor is a minor) reported the crime to a law enforcement agency or child protective services and can furnish documentation of the report to the abortion provider. *See id.* § 18-8804(1).

20. Under the criminal enforcement provision, violation of the Fetal Heartbeat Act constitutes a felony punishable by two to five years in prison. Idaho Code § 18-8805(2). The Idaho Board of Medicine may also suspend or revoke a healthcare provider's professional license. *Id.* § 18-8805(3).

21. The Fetal Heartbeat Act's criminal enforcement provision states that: "Nothing in this section shall be construed to conflict with the effectiveness of [the Total Abortion Ban] …. In the event both this section and [the Total Abortion Ban] are enforceable, [the Total Abortion Ban] shall supersede this section." *Id.* § 18-8805(4).

C. State Court Declaratory Judgment Concerning the Abortion Bans

22. Last year, an Idaho district court issued a declaratory judgment that the Abortion Bans

> do not make it a crime to perform an 'abortion' as defined in [Idaho Code § 18-604(1)] if, in the performing physician's good faith medical judgment (based on the facts known to the physician at the time of the abortion), the patient—because of an existing medical condition or pregnancy complication that would be alleviated by an abortion—faces a non-negligible risk of dying sooner without an abortion (even if her death is neither imminent nor assured), so long as (i) the risk of her death doesn't arise from a risk of self-harm, and (ii) the manner of pregnancy termination is the one that, without … increasing the risk of her death, best facilitates the unborn child's survival outside the uterus, if feasible.

Adkins v. State, No. CV01-23-14744, slip op. at 39 (Idaho 4th Dist. Ct. Apr. 11, 2025). The defendants, including the State of Idaho, the Idaho Attorney General, and the Idaho State Board of Medicine, did not appeal this judgment.

D. Federal Court Injunctions Against Enforcement of the Total Abortion Ban

23. On August 24, 2022, one day before the Total Abortion Ban took effect generally, this Court preliminarily enjoined its enforcement "to the extent that [the] statute conflicts with" care mandated by the Emergency Medical Treatment and Labor Act ("EMTALA"), 42 U.S.C. § 1395dd(a), in a case brought by the federal government. *Idaho*, 623 F. Supp. 3d at 1102. The

U.S. Supreme Court subsequently stayed that injunction. *Moyle v. United States*, 144 S. Ct. 540 (2024) (mem.). The Supreme Court treated the stay applications as petitions for a writ of certiorari before judgment and granted the petitions, *id.*, but it later dismissed them as improvidently granted and vacated the stays it had entered, *Moyle v. United States*, 603 U.S. 324, 325 (2024) (per curiam). After President Trump took office, the Government dismissed the case. *See* Stip. of Dismissal, *United States v. Idaho*, No. 1:22-cv-329-BLW (D. Idaho Mar. 5, 2025), ECF No. 182.

24. Following entry of a temporary restraining order on March 4, 2025, this Court on March 20, 2025, again entered a preliminary injunction barring enforcement of the Total Abortion Ban in circumstances that conflict with EMTALA's mandates, this time in a case brought by St. Luke's Health System. *St. Luke's Health Sys., Ltd. v. Labrador*, 782 F. Supp. 3d 953, 964, 987 (D. Idaho 2025). That preliminary injunction, which remains in effect, provides that:

> The Court orders that Attorney General Raúl Labrador—and his officers, employees, and agents—are preliminarily enjoined from enforcing Idaho Code § 18-622 against St. Luke's or any of its medical providers as applied to medical care required by the Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd. Specifically, the Attorney General, including his officers, employees, and agents, are prohibited from initiating any criminal prosecution against, attempting to suspend or revoke the professional license of, or seeking to impose any other form of liability on, St. Luke's or any of its medical providers based on their performance of conduct that is defined as an "abortion" under Idaho Code § 18-604(1), but that is necessary to "stabilize" a patient presenting with an "emergency medical condition" as required by EMTALA pursuant to 42 U.S.C. § 1395dd(e)(1)(A), (3)(A).

Id. at 987.

25. On July 31, 2023, this Court entered a preliminary injunction barring the Idaho Attorney General from enforcing the Total Abortion Ban against licensed healthcare providers who refer patients to out-of-state abortion providers or otherwise provide information that

facilitates out-of-state abortion care. *Planned Parenthood Greater Nw. v. Labrador*, 684 F. Supp. 3d 1062, 1070, 1095 (D. Idaho 2023). The Ninth Circuit affirmed that preliminary injunction. *Planned Parenthood Gr. Nw., Haw., Alaska, Ind., Ky. v. Labrador*, 122 F.4th 825, 833 (9th Cir. 2024). The Court subsequently entered a consent decree, which provides in relevant part:

> It is hereby ordered that the Attorney General of Idaho, the Ada County Prosecuting Attorney, and the Valley County Prosecuting Attorney shall not enforce Idaho Code § 18-622 against Plaintiffs for the conduct of referring a woman across state lines to an abortion provider, which includes, but is not limited to, informing about, counseling about, recommending, providing a referral for, scheduling an appointment for, informing about sources of funding for, or otherwise advising or assisting an individual in learning about or obtaining, an abortion or out-of-state consultation for abortion pills where that abortion will be performed or the out-of-state prescription will be filled outside the borders of Idaho where it is legal to obtain such abortion or prescription for abortion pills.

Consent Decree ¶ 22, *Planned Parenthood Gr. Nw., Haw., Alaska, Ind., Ky. v. Labrador*, No. 1:23-cv-142-BLW (D. Idaho July 17, 2025), ECF No. 193.

II. Parties and Witnesses

26. Stacy Seyb, M.D., is the Plaintiff in this action. He is qualified to provide expert testimony about the treatment of patients with high-risk pregnancies. Licensed to practice medicine in Idaho, Dr. Seyb is an attending physician in maternal-fetal medicine at St. Luke's Health System, where he has worked for twenty-six years. Tr. 105:20-106:3 (Seyb). Dr. Seyb served on Idaho's Maternal Mortality Review Committee ("MMRC") from 2019 to 2023, and he chaired the committee during the final two years of his tenure. *Id.* 109:7-15, 110:12-15, 110:25-111:2; Ex. 3 at 2; Ex. 4 at 2. He currently serves as Idaho's State Liaison to the Society for Maternal Fetal Medicine ("SMFM"). Tr. 108:1-8 (Seyb). During his time at St. Luke's, Dr. Seyb has delivered thousands of babies, and he has provided approximately 500 abortions, all of which were medically indicated. *Id.* 107:14-21. He would like to be able to offer abortion care

to all pregnant patients with serious medical needs, and he stands ready, willing, and able to do so should the Court grant him the relief he is seeking in this case. *Id.* 118:14-119:3.

27. The Members of the Idaho Board of Medicine ("Medical Board") are Defendants in this action. The Medical Board is the State agency responsible for overseeing the practice of medicine in Idaho, including the licensure of physicians. *See* Idaho Code §§ 54-1801 to 54-1821; Ex. 1074 at 11. It is required to suspend or revoke the license of any physician who violates the Total Abortion Ban or the Fetal Heartbeat Act. *See* Idaho Code §§ 18-622(1), 18-8805(3), 54-1806, 54-1806A. For a first violation of either statute, the Medical Board must impose a suspension "for a minimum of six (6) months" and has discretion to impose a longer suspension. *Id.* at §§ 18-622(1), 18-8805(3). The Medical Board's disciplinary process generally involves multiple investigatory and adjudicatory steps to determine the appropriate length of a suspension. Ex. 1074 at 14-25; Tr. 660:11-20 (Guzman). The Medical Board has eleven members. Idaho Code § 54-1805. Plaintiff sues each member in the member's official capacity. Guillermo Guzman, M.D., Chair of the Medical Board, testified at trial. Tr. 656:24-657:1 (Guzman).

28. The Ada County Prosecuting Attorney is a Defendant in this action. Idaho's County Prosecuting Attorneys have primary responsibility for "enforcing all the penal provisions of any and all statutes of [Idaho]," Idaho Code § 31-2227(1), including the Abortion Bans, *id.* §§ 18-622, 18-8805. Plaintiff sues the Ada County Prosecuting Attorney in the attorney's official capacity.

29. Plaintiff named additional County Prosecuting Attorneys as Defendants, Compl. ¶¶ 18-60, Dkt. No. 1, but the Court dismissed Plaintiff's claims against them, Mem. Decision & Order 18-19, 41, Dkt. No. 54.

30. The Attorney General of Idaho intervened in this case as a Defendant under Federal Rule of Civil Procedure 24(a)(2). Mem. Decision & Order 5, Dkt. No. 66.

31. Patricia Cline Cohen, Ph.D., is a witness for Plaintiff. She is qualified to provide expert testimony about the law's treatment of abortion—and the social context for that treatment—throughout American history as well as the historical literature concerning abortion and abortion regulation in the United States. She earned a Ph.D. in history from the University of California, Berkeley. Ex. 1001 at 1. She currently serves as the Edward A. Dickson Emerita Professor of History at the University of California, Santa Barbara ("UCSB"), and she previously served as a historian at UCSB from 1976 to 2014. *Id.* During 2012-2013, she was President of the Society for Historians of the Early American Republic ("SHEAR"). *Id.* at 2. She has conducted extensive research on the history of abortion and abortion regulation in the United States, and in 2025, she convened a research conference at the Huntington Library titled "Abortion in American History: Intimate Decisions, Medical Knowledge, and Legal Decrees in the Two Centuries Before *Roe v. Wade*." Tr. 929:1-19; Ex. 1001 at 2.

32. Carly Dahl, M.D., is a witness for Plaintiff. She is qualified to provide expert testimony about the treatment of patients with high-risk pregnancies. She is board certified in obstetrics and gynecology, board eligible in maternal-fetal medicine, and licensed to practice medicine in Utah and Wyoming. Tr. 167:16-22 (Dahl); Ex. 1002 at 1-2. In addition to her M.D., Dr. Dahl holds a Master of Science in Clinical Investigation ("M.S.C.I.") degree. Ex. 1002 at 1. She also serves as an Adjunct Assistant Professor of Maternal-Fetal Medicine at the University of Utah. *Id.*

33. Alexandra Grosvenor Eller, M.D., is a witness for Plaintiff. She is qualified to provide expert testimony about the treatment of patients with high-risk pregnancies. She is

board certified in obstetrics and gynecology; maternal-fetal medicine; and complex family planning, and she is licensed to practice medicine in Utah, Idaho, Wyoming, and Montana. Tr. 361:10-23 (Eller). Dr. Eller serves as an Assistant Professor of Obstetrics and Gynecology at the University of Utah School of Medicine. Ex. 1003 at 1. She also serves as Associate Medical Director for Women's Health at Intermountain Healthcare, a position that makes her responsible for systemwide approval of pregnancy terminations. Tr. 362:6-9 (Eller); Ex. 1003 at 1. In addition to her M.D., Dr. Eller holds a Master of Public Health ("M.P.H.") degree. Ex. 1003 at 1.

34. Monica Eppinger, J.D., Ph.D., is a witness for Plaintiff. She is qualified to provide expert testimony about the law's treatment of abortion—and the social context for that treatment—in the United States and England from medieval times through the twentieth century. She earned a J.D. from Yale Law School and a Ph.D. in Anthropology from the University of California, Berkeley. Ex. 1004 at 1. She serves as a Professor of Law and Anthropology at Saint Louis University School of Law. *Id.* She has conducted extensive research about Anglo-American law's treatment of abortion, and she authored an article about the history of therapeutic abortion that was published in the Georgetown Journal of Gender and the Law in 2016. Tr. 450:25-456:25 (Eppinger); Monica Eppinger, *The Health Exception*, 17 Geo. J. Gender & L. 665 (2016) [hereinafter Eppinger Article].

35. Jennifer Payne, M.D., is a witness for Plaintiff. She is qualified to provide expert testimony about reproductive psychiatry and the treatment of patients with perinatal psychiatric disorders. She is board certified in psychiatry and neurology, and she is licensed to practice medicine in Maryland and Virginia. Ex. 1005 at 1-2. At the University of Virginia ("UVA"), Dr. Payne serves as Director of the Perinatal Mental Health Clinic; Vice Chair of Research for

Psychiatry and Neurobehavioral Sciences; and Director of the Reproductive Psychiatry Research Program. *Id.* at 1, 5, 12; Tr. 246:18-22 (Payne). She also serves as a Professor in the Psychiatry and Neurobehavioral Sciences Department, and she supervises UVA's Resident's Clinic. Ex. 1005 at 6, 12. Prior to joining UVA, Dr. Payne was the founding Director of the Johns Hopkins Women's Mood Disorders Center, now called the Johns Hopkins Reproductive Mental Health Center. *Id.* at 12. She has authored dozens of articles in peer-reviewed journals, and she serves as the principal investigator for several ongoing clinical studies, including the Prospective Study of Pregnant Women With and Without Mood Disorders. *Id.* at 5-6.

36. Danielle Prentice, D.O., is a witness for Plaintiff. She is qualified to provide expert testimony about the treatment of pregnant patients with diabetes. She is board certified in obstetrics and gynecology and in maternal-fetal medicine, and she is licensed to practice medicine in Oregon and Washington State. Tr. 214:6-14 (Prentice); Ex. 1006 at 1. Dr. Prentice serves as the Co-Director of the Diabetes and Pregnancy Program at Oregon Health & Science University ("OHSU"). Ex. 1006 at 1. She also serves as an Assistant Professor of Obstetrics and Gynecology at the OHSU School of Medicine. *Id.* In addition, she serves as the Director of the Diabetes and Pregnancy Program at PeaceHealth Southwest Medical Center. *Id.* at 4.

37. Diana Romero, Ph.D., is a witness for Plaintiff. She is qualified to provide expert testimony about medical sociology and public health. At the City University of New York ("CUNY"), Dr. Romero is a Professor in the Department of Community Health and Social Sciences at the Graduate School of Public Health and Health Policy as well as the Director of the Maternal, Child, Reproductive, and Sexual Health Specialization. Ex. 1007. She earned a doctorate in Sociomedical Sciences from Columbia University and an M.A. in Scientific Journalism from New York University. *Id.*

38. Marcela Smid, M.D., is a witness for Plaintiff. She is qualified to provide expert testimony about the treatment of patients with high-risk pregnancies and about substance use disorder. She is board certified in obstetrics and gynecology; maternal-fetal medicine; complex family planning; and addiction medicine, and she is licensed to practice medicine in Nevada; North Carolina; Utah; and Wyoming. Ex. 1008 at 1. At the University of Utah, Dr. Smid serves as the Director of Perinatal Addiction Service; Medical Director of the Substance Use & Pregnancy—Recovery, Addiction, Dependence (SUPeRAD) Clinic; and Medical Director of the Obstetric AirMed service. *Id.* at 4. At the University of Utah School of Medicine, Dr. Smid serves as an Associate Professor in the Department of Obstetrics and Gynecology, Division of Maternal-Fetal Medicine; as an Adjunct Assistant Professor in the Department of Psychology; and as an Adjunct Associate Professor in the Department of Psychiatry. *Id.* at 1-2. Dr. Smid also serves on the Steering Committee of the Utah Department of Health Opioid Safety Bundle, and she chairs the State of Utah's Maternal Mortality Review Committee. *Id.* at 4-5. In addition to her M.D., Dr. Smid holds an M.S. in Health & Medical Science and an M.A. in Medical Anthropology. *Id.* at 1.

39. Dustan Hughes, M.D., is a witness for the State. Now retired, Dr. Hughes previously worked as a general obstetrician-gynecologist ("OB-GYN") in Idaho. Tr. 669:3-10 (Hughes). Dr. Hughes is not a maternal-fetal medicine specialist ("MFM"). *Id.* 737:6-7. While in practice, he referred patients with high-risk pregnancies to MFMs, including for abortion care. *Id.* 737:14-16, 742:5-7. Over the course of his career, he referred "many" patients to Dr. Seyb. *Id.* 742:18-19. Dr. Hughes never performed an abortion himself or counseled patients about abortion as an option because he has conscientious objections to the procedure. *Id.* 737:10-

738:15. He was not transparent about this with his patients, *id.* 738:16-18, a lack of candor relevant to the credibility of his testimony.

40. Dr. Elena Kraus, M.D., Ph.D., is a witness for the State. She is a board-certified MFM licensed to practice medicine in Missouri and Nebraska, and she has a doctoral degree in healthcare ethics. Tr. 1055:7-18 (Kraus). Dr. Kraus has conscientious objections to abortion and has never provided a first-trimester abortion or second-trimester dilation and evacuation ("D&E") procedure, although she has counseled patients with high-risk pregnancies about these options. *Id.* 1163:1-15, 1165:20-1166:25. Dr. Kraus does not consider previability induction of labor to be an abortion when performed to treat a serious health condition, even though it constitutes an abortion under Idaho law. *Id.* 1163:16-1164:11. When one of Dr. Kraus' high-risk patients decides to have an abortion, she refers the patient to another provider. *Id.* 1166:7-10, 1167:19-24. Those patients generally do not follow up with Dr. Kraus afterward. *Id.* 1166:14-16, 1167:25-1168:3.

41. Joseph Dellapenna is a witness for the State. He is a law professor with a research interest in the history of abortion regulation, though he holds no degree in history or anthropology. Tr. 758:7-759:8, 831:1-13 (Dellapenna). In 1979, he wrote a law review article about this history. *Id.* 837:19-838:7 (citing Joseph W. Dellapenna, *The History of Abortion: Technology, Morality, and Law*, 40 U. Pitt. L. Rev. 359, 406 (1979) [hereinafter Dellapenna Article]). In 1987, he wrote a book chapter on the topic for an anthology. *Id.* 832:25-833:25 (citing Joseph W. Dellapenna, *Abortion and the Law: Blackmun's Distortion of the Historical Record*, *in Abortion and the Constitution: Reversing* Roe v. Wade *Through the Courts* 137 (Dennis J. Horan, et al., eds., 1987) [hereinafter Dellapenna Chapter]). Later, he wrote a full-length book. *See* Ex. 10. The first edition was published in 2006, and a revised edition was

published in 2023. Tr. 836:4-10 (Dellapenna). The forward to the original edition characterizes the work as "an argumentative book," and it indeed reads more like a 1,000-plus page amicus brief than a traditional work of historical scholarship. Ex. 10 at xviii; *see* Tr. 837:4-12 (Dellapenna). Over the years, Professor Dellapenna has collaborated extensively with Americans United for Life, including participating in a conference focused on strategies to overturn *Roe v. Wade* through the courts and a confidential summit concerning national amicus brief strategy. *Id.* 831:25-833:25.

III. The Physiology of Pregnancy

42. When a person becomes pregnant, their body rapidly undergoes various physiological changes to accommodate the growing fetus, support fetal development, and prepare for delivery and postpartum needs. Tr. 13:25-18:1 (Smid). In fact, almost every organ system in the body changes during pregnancy. *Id.* 14:4-6.

43. Starting with the cardiovascular system, blood volume increases by 30% to 100% in order to supply oxygen and nutrients to the developing embryo or fetus and support the pregnant person's body. *See* Tr. 14:7-18 (Smid). This means the heart must pump more blood each minute, increasing cardiac output. *Id.* 14:11-13. For twins and higher-order gestations (e.g., triplets), the strain on the cardiovascular system is even greater. *Id*. 14:19-23. Blood pressure changes throughout pregnancy. *Id.* 14:14-16. Further, the growing uterus can compress the inferior vena cava—the large vein that returns blood from the lower body to the heart. *Id.* 14:16-18. Immediately post-partum, the body must transform again. *Id.* 14:24-15:5. The uterus compresses down, and all of the blood that was previously in the uterus returns to maternal circulation, placing a significant strain on the circulatory system. *Id.* 15:1-5.

44. With respect to the respiratory system, pregnancy increases the body's demand for oxygen, and the breathing rate often rises to meet the demand. Tr. 15:6-14 (Smid). The

expansion of the uterus pushes upward against the diaphragm, causing a feeling of shortness of breath. *Id.* 15:10-12. The oxygen disassociation curve causes a patient's entire pH (acid/base status) to change. *See id.* 15:13-14.

45. The renal system is impacted by pregnancy because the kidneys must work harder than before to filter the increased volume of blood flowing through the body. *See* Tr. 15:15-21 (Smid). This increased filtration rate leads to increased urine output. *Id.*

46. The endocrine system changes dramatically as pregnancy increases certain hormones in the body, fundamentally altering the pregnant person's neurobiology. Tr. 15:22-16:14, 55:24-55:4 (Smid). The placenta produces human chorionic gonadotropin, which supports embryonic and fetal development until the placenta begins massive production of progesterone and estrogen. *Id.* 15:22-16:2. These two hormones have a profound impact on every system in the body, including the brain. *Id.* 15:22–16:4. Pregnancy typically increases thyroid hormone production to help with metabolic changes. *See id.* 16:4-7. To ensure that the developing embryo or fetus receives adequate glucose, pregnancy can also induce insulin resistance. *Id.* 16:8-14. The dramatic increase in estrogen and progesterone continues as pregnancy progresses, rising from the first through the third trimester. *Id.* 82:8-10. Once pregnancy ends, the production ends abruptly, causing a dramatic decrease in estrogen and progesterone. *See id.* 82:11-13.

47. In the gastrointestinal system, progesterone slows the smooth muscles, including those inside the gastrointestinal tract, which can increase constipation. Tr. 16:16-20 (Smid). The liver increases its production of certain proteins, and there may be a slowing or cessation of bile acids moving from the liver to the gallbladder. *Id.* 16:20-24.

48. In the musculoskeletal system, hormones like relaxin soften ligaments and joints. Tr. 16:25-17:2 (Smid). Weight gain shifts the patient's center of gravity and increases stress on the musculoskeletal system, which can lead to pain, especially among those with pre-existing conditions. *Id.* 17:3-6.

49. In the skin system, there is an increase in blood flow, which can cause increased sweating. Tr. 17:7-10 (Smid). Pregnancy can also cause changes in facial pigmentation, some of which may be permanent. *Id*. 17:11-12. In addition, pregnancy can cause stretch marks on the abdomen and breasts, which may also be permanent. *Id*. 17:11-14.

50. The reproductive system experiences fundamental changes during pregnancy. Tr. 17:15-20 (Smid). The uterus grows from the size of a pear to the size of a watermelon. *Id.* 19-20. The cervix shortens and increases vascularity. *Id*. 17:18-19.

51. Pregnancy causes a complex modulation of the immune system to protect the pregnant person from disease while preventing the rejection of the fetus. Tr. 17:21-18:1 (Smid). This can change the body's response to infection. *Id*.

52. In addition, pregnant people experience numerous physical changes that profoundly impact their daily lives. Tr. 395:2-24, 428:9-431:24 (Eller). For example, many pregnant people experience frequent nausea and vomiting, especially during the first trimester. *Id*. 395:2-8. Because pregnancy causes weight gain, over time, a pregnant person's regular clothes will no longer fit, and they will have to buy new ones. *Id*. 395:9-16. Pregnancy causes a person's feet and ankles to swell. *Id*. 395:22-24. As pregnancy progresses, a pregnant person's abdomen expands and takes on a characteristic shape, announcing the pregnancy to others and making it difficult for the pregnant person to maintain privacy concerning their condition. *Id*.

428:14-429:12. The hormonal changes of pregnancy affect a pregnant person's emotions, memory, and concentration. *Id*. 429:13-20.

53. A person cannot remain pregnant indefinitely; absent a spontaneous or induced abortion, a pregnant person must give birth. Labor and delivery are extraordinarily painful processes. Tr. 429:21-431:24 (Eller). Although there are medications that can help to manage the pain, some people cannot utilize them due to contraindications or the circumstances of their labor. *Id*. 429:21-430:19. Vaginal childbirth entails risks of serious complications and death. Tr. 1181:20-1182:2 (Kraus). In addition, vaginal childbirth has long-term impacts on a pregnant person's body. Tr. 397:19-398:16, 430:20-431:24 (Eller). These may include chronic pelvic floor dysfunction, incontinence, and pain during sexual intercourse. *Id.* 397:19-398:1. Vaginal childbirth sometimes requires a clinician to perform an episiotomy—a painful surgical incision in the tissue between the vaginal opening and the anus—to facilitate delivery. *Id*. 430:20-431:10. The alternative to vaginal childbirth is Cesarean section. *Id*. 364:10-15, 398:2-7. This is a major abdominal surgery that entails significant risk of injury and death. *Id*. 398:2-7; Tr. 1182:3-9 (Kraus). A Caesarean section causes scarring, requires a weeks- or months-long recovery, and creates increased risk of complications in future pregnancies. Tr. 398:2-16, 431:13-24 (Eller).

IV. Maternal Morbidity and Mortality

54. The physiological changes brought about by pregnancy sometimes lead to serious complications that result in maternal morbidity or mortality. Tr. 18:2-21 (Smid).

55. Maternal morbidity refers to a nonfatal complication or medical condition resulting from pregnancy or childbirth. Tr. 1185:9-1186:1 (Kraus). Maternal morbidity can have serious, life-long impacts on a person's health. Tr. 18:9-15 (Smid).

56. Maternal mortality refers to the death of a pregnant or recently pregnant person. Tr. 18:20-21 (Smid).

57. The United States has the highest rate of maternal mortality among high-income nations. 2019 Idaho Sess. Laws 336, § 1, 336 (H.B. No. 109); Tr. 19:5-8 (Smid).

58. MMRCs are multidisciplinary groups that convene at the state or local level in the United States to systematically review deaths that occur during or within one year of the end of a pregnancy. Tr. 19:9-14 (Smid). The Centers for Disease Control and Prevention ("CDC") provides technical assistance to MMRCs and operates a data system, the Maternal Mortality Review Information Application ("MMRIA" or "Maria"), that is designed to assist MMRCs across the country by providing a common data language. Ex. 1 at 11.

59. In 2019, the Idaho legislature enacted a law that created a state-level MMRC in Idaho for the first time. 2019 Idaho Sess. Laws 336, 336-37 (codified at Idaho Code §§ 39-9601 to 39-9605). It was housed in the Idaho Department of Health and Welfare ("Health Department"). *Id.* That MMRC reviewed maternal mortality data for the years 2018 to 2021 and issued an annual report for each year summarizing its findings. Exs. 1-4. During that time, the MMRC was comprised of fourteen to sixteen members, including Dr. Seyb. Tr. 109:7-25 (Seyb); Ex. 2 at 1-2; Ex. 3 at 1-2; Ex. 4 at 1-2. The legislation that created this MMRC sunset on July 1, 2023, and the committee disbanded. 2019 Idaho Sess. Laws 336, 338; Tr. 110:12-15 (Seyb).

60. In 2024, the Idaho Legislature gave the Medical Board the power to "[c]ollect and review data and information concerning maternal mortality in the state of Idaho" and directed the Medical Board to "provide an annual summary report no later than January 31 each year to the legislature on the number of instances of maternal mortality and other information as determined

by the board." 2024 Idaho Sess. Laws 333, 334 (H.B. No. 399). The Medical Board used this authority to create a new MMRC that operates within the Idaho Division of Occupational and Professional Licenses. Ex. 6 at 10; Ex. 1074 at 26-30. The new MMRC has only eleven members, and Dr. Seyb was excluded from participation. Tr. 110:16-19 (Seyb); Ex. 5 at 2; Ex. 6 at 5; Ex. 7 at 2; Ex. 1074 at 35. The new MMRC first reviewed maternal deaths during 2023 and issued a report concerning its findings in 2025. Ex. 6 at 3, 10; Ex. 1074 at 31-33, 36. Subsequently, it reviewed maternal deaths during 2022 and 2024, and it issued reports concerning each of those years on January 27, 2026. Ex. 5 at 2, 9; Ex. 7 at 2; Ex. 1074 at 31-32.

61. Consistent with the CDC's MMRIA system, both Idaho MMRCs have distinguished between pregnancy-associated deaths and pregnancy-related deaths. Ex. 1 at 5; Ex. 5 at 3. A pregnancy-associated death is the death of a woman while pregnant or within one year of the end of the pregnancy, regardless of the cause. Ex. 1 at 5; Ex. 5 at 3. A pregnancy-related death is the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Ex. 1 at 5; Ex. 5 at 3.[2]

62. During the period 2018 to 2024, the leading underlying cause of pregnancy-related death in Idaho was mental health conditions, which includes both substance use disorders

[2] The Medical Board's MMRC admits that Idaho's pregnancy-related mortality ratio is "statistically insignificant" due to the small sample size, Ex. 5 at 10, 15; Ex. 7 at 4, which means that no meaningful information can be gained from comparing the ratios in successive years. As the 2022 report notes: "Since the inception of the Idaho MMRC in 2018, total maternal deaths, specifically pregnancy-related deaths, have remained variable. As additional review years are released, gross trends may emerge showing potential gaps in maternal care. Although each death is tragic, the small number of annual deaths relative to total live births is statistically insignificant, making it difficult to rely solely on annual data to draw broad conclusions about healthcare safety and delivery in Idaho." Ex. 5 at 10.

and other mental health conditions. Ex. 1009. In its 2023 Report, the Medical Board's MMRC noted that: "Idaho's 2023 Pregnancy-Related Death (PRD) findings highlight that women with pre-existing health conditions have a higher risk of dying during pregnancy and for a year after childbirth …. Three (3) of the five (5) Pregnancy-Related Deaths had a mental health condition as a pre-existing condition." Ex. 6 at 20.

63. The following year, however, when the Medical Board published the MMRC reports for 2022 (out of sequence) and 2024, *see* Ex. 5 at 9, it noted a change in the methodology for classifying deaths from suicide. The 2024 MMRC report states: "*Suicides are classified as pregnancy-associated but not related when there is a history of suicidal ideation or attempts prior to the pregnancy* or if the suicide is associated with an unrelated event." Ex. 7 at 12 (emphasis added); *see* Tr. 74:5-76:24 (Smid). This change in methodology is unsound and is causing the MMRC to undercount the number of pregnancy-related deaths from suicide that occur in Idaho. Tr. 79:9-13 (Smid); *see* Tr. 273:19-274:5 (Payne). The 2024 MMRC report classifies two maternal deaths from suicide as pregnancy associated but not related. Ex. 7 at 12.

64. Equally concerning, the 2022 MMRC report classifies two maternal deaths as pregnancy associated but not related because they "were attributable to pre-existing medical conditions" without indicating whether those deaths were from suicide or the pre-existing medical conditions were exacerbated by pregnancy. Ex. 5 at 10. The report does so despite earlier recounting a definition of pregnancy-related death derived from national public health standards and embodied in CDC guidance that encompasses not just deaths from complications of pregnancy itself, but the death of a pregnant person from "[a] chain of events initiated by the pregnancy" or "[a]ggravation of an unrelated condition by the physiological effects of pregnancy." *Id.* at 7; *see* Tr. 74:8-76:24 (Smid). Thus, subsequent to the filing of this lawsuit,

the Medical Board began departing from nationally recognized standards for the conduct of MMRCs, resulting in fewer pregnancy-related deaths being counted by Idaho's MMRC.

65. Data from the CDC and other state MMRCs shows that mental health conditions are also a leading cause of pregnancy-related death nationwide. Tr. 277:18-278:7 (Payne). Indeed, an SMFM guidance document relied on by Dr. Kraus reports that "maternal self-harm (suicide, injury, overdose) remains a leading, yet underappreciated, cause of maternal mortality." Tr. 1171:14-1172:13 (Kraus) (quoting SMFM, et al., *Society for Maternal-Fetal Medicine Consult Series No. 54: Assessing the risk of maternal morbidity and mortality*, 224 Am. J. Obstetrics & Gynecology B2, B4 (2021) [hereinafter SMFM Consult Series No. 54], https://doi.org/10.1016/j.ajog.2020.12.006); *see also id.* 1169:1-1170:3, 1176:21-1177:10.

V. Maternal-Fetal Medicine

66. Maternal-fetal medicine is a subspecialty of obstetrics and gynecology that focuses on the treatment of patients with high-risk pregnancies. Tr. 10:6-9; 29:9-19 (Smid); Tr. 363:18-364:5 (Eller). All pregnancies entail some risk of morbidity and mortality. Tr. 29:9-11 (Smid); Tr. 364:6-15 (Eller). But some patients face heightened risks because of complications, pre-existing medical conditions, or other factors. Tr. 29:12-19 (Smid); Tr. 366:7-14, 397:19-398:16 (Eller). MFMs treat patients facing risks of maternal morbidity and mortality that exceed the typical risks of pregnancy. Tr. 29:12-19 (Smid); Tr. 363:21-364:25 (Eller). Pregnant individuals are usually referred to MFMs by general OB-GYNs, other physicians, or midwives after these heightened risks are identified. Tr. 29:20-24 (Smid); Tr. 106:12-14 (Seyb).

67. After completing medical school and a four-year residency in obstetrics and gynecology, physicians who want to be MFMs must complete a three-year fellowship. Tr. 29:25-30:4 (Smid).

68. The leading professional organization for physicians in the United States is the American Medical Association ("AMA"). Tr. 31:22-31:1 (Smid). The leading professional organization for OB-GYNs in the United States is the American College of Obstetricians & Gynecologists ("ACOG"). Tr. 31:7-11 (Smid). The leading professional association for MFMs in the United States is the SMFM. *Id*. 31:12-17. Each of these organizations publishes standards and guidelines that help to define the standard of care for treating pregnant patients. *Id*. 32:2-5, 33:18-34:11.

VI. Medical Indications for Abortion

69. In medicine, an "indication" is a symptom, condition, or factor that makes a particular course of action advisable. Tr. 34:12-14 (Smid); Tr. 113:6-8 (Seyb); Ex. 1074 at 37-38. An abortion is "medically indicated" when there is a medical reason for terminating a patient's pregnancy. Tr. 34:12-17 (Smid); Tr. 113:9-16 (Seyb). Medical indications for abortion can be maternal or fetal in nature. Tr. 34:15-17 (Smid); Tr. 113:17-25 (Seyb). Maternal indications arise from the pregnant person's condition, whereas fetal indications arise from the condition of the embryo or fetus. Tr. 34:15-17 (Smid); Tr. 113:17-25 (Seyb).

70. The term medically indicated abortion is synonymous with the term therapeutic abortion. Tr. 113:14-16 (Seyb).

71. Given the sheer variety and diversity of patient health circumstances, it is impossible to catalog all maternal indications for abortion. Tr. 34:18-20 (Smid). A wide variety of complications can develop during pregnancy that pose serious threats to a patient's health but will not necessarily result in the patient's death. Tr. 35:3-13 (Smid). It is not possible to provide an exhaustive list of such complications, but some examples (discussed in more detail below) include preterm premature rupture of membranes ("PPROM"); hypertensive disorders in pregnancy ("HDPs"); placental abnormalities; gestational diabetes; and major depressive

disorder. *See infra* ¶¶ 117, 148-156. Likewise, pregnancy can exacerbate a wide variety of underlying conditions and/or interfere with their treatment. It is not possible to provide an exhaustive list of such conditions, but some examples (discussed in more detail below) include heart disease; chronic kidney disease; cancer; Type 1 and Type 2 diabetes; substance use disorder; and other mental health conditions. *See infra* ¶¶ 106-140, 157-172.

72. Similarly, it is not possible to catalog the wide range of conditions that constitute fetal indications for abortion. Tr. 172:23-25 (Dahl). Plaintiff is seeking relief from the Abortion Bans only as to embryonic and fetal conditions that are life-limiting. In this context, life-limiting is a medical term of art that encompasses fatal fetal conditions as well as conditions for which there is little or no prospect of long-term survival outside the uterus without severe morbidity, and for which there is no cure. Tr. 169:21-25, 171:15-20 (Dahl) (citing ACOG, *Perinatal Palliative Care: ACOG Committee Opinion No. 786*, 134 Obstetrics & Gynecology e84, e85 (2019) (reaffirmed in 2024), https://doi.org/10.1097/ aog.0000000000003425). Although it is not possible to provide an exhaustive list of these, some examples (discussed in more detail below) include anencephaly; achondrogenesis; bilateral renal agenesis; holoprosencephaly; Hypoplastic Left Heart Syndrome ("HLHS"); iniencephaly; Limb-Body Wall Complex ("LBWC"); Meckel-Gruber Syndrome; Osteogenesis Imperfecta Type II; sirenomelia; thanatophoric dysplasia; Triploidy; Trisomy 13; and Trisomy 18. *See infra* at ¶¶ 173-191. In addition, Plaintiff is seeking relief from the Abortion Bans as to multi-fetal pregnancy reductions. Tr. 115:11-14 (Seyb).

73. According to SMFM, "pregnancies complicated by pre-existing or new medical co-morbidities, including mental health conditions, present an even higher risk for dangerous complications, making access to abortion central to safe obstetric care." Tr. 57:5-57:9 (Smid)

(quoting SMFM, *Society for Maternal-Fetal Medicine Position Statement: Access to Abortion Care*, 231 Am. J. Obstetrics & Gynecology B7 (2024), https://doi.org/10.1016/j.ajog.2024.04.006).

74. Dr. Hughes's testimony that abortion is almost never medically indicated is given no weight. The Court finds that Dr. Hughes lacks the experience and expertise to opine on the provision of medically indicated abortion given that he has never performed an abortion, Tr. 679:24-25 (Hughes), and refers patients with high-risk pregnancies to MFMs, including Dr. Seyb, *id.* 742:12-19. In addition, Dr. Hughes' testimony conflicts with that of Dr. Kraus, who routinely counsels patients with high-risk pregnancies about the option of having an abortion. Tr. 1165:20-22 (Kraus). Notably, Dr. Kraus testified that an intervention can be medically indicated without being medically *necessary*, and that often patients have more than one option for how to respond to a medical condition, each entailing its own set of risks and benefits. *Id.* 1165:5-19.

75. The State contends that abortion is never medically indicated because it is unsafe. The Court finds that this position is not supported by the evidence.

76. In 2018, a Committee of the National Academies of Sciences, Engineering and Medicine ("National Academies") issued a Consensus Study Report on the Safety and Quality of Abortion Care in the United States after systematically reviewing the relevant evidence. Tr. 369:11-372:2 (Eller) (citing Nat'l Acads. of Scis., Eng'g & Med., *The Safety and Quality of Abortion Care in the United States* (Nat'l Acads. Press 2018) [hereinafter National Academies Report], https://doi.org/10.17226/24950). It concluded that abortion in the United States is safe; serious complications of abortion are rare; and abortion does not increase the risk of long-term physical or mental health disorders. *Id.* (citing National Academies Report at 10, 152-53).

77. A widely cited study published in 2012 compared the mortality rates associated with live births and legal induced abortions in the United States during 1998-2005. Tr. 372:20-374:6 (Eller) (citing Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215 (2012) [hereinafter Raymond & Grimes]). It concluded that the risk of death associated with childbirth was approximately fourteen times higher than the risk of death associated with abortion, and the overall morbidity associated with childbirth also exceeded that with abortion. *Id.* 373:20-374:6 (citing Raymond & Grimes at 1). As the authors noted:

> The disparity between abortion and childbirth safety is not surprising. Pregnancies ending in abortion are substantially shorter than those ending in childbirth, and thus entail less time for pregnancy-related complications, such as pregnancy-induced hypertension and placental abnormalities manifest themselves in late pregnancy; early abortion avoids these hazards. Moreover, in the United States in 2008, on-third of births occurred by cesarean delivery, an abdominal operation with substantial morbidity.

Tr. 1201:23-1202:14 (Kraus). The study likely underestimated the relative safety of abortion over continued pregnancy because it compared abortions to live births and omitted other pregnancy outcomes that entail greater risks of death such as stillbirths. *Id.* 1202:15-1203:7.

78. Recently, a group of researchers conducted a similar analysis using data from 2018-2021. Tr. 374:23-377:4 (Eller) (citing Maria W. Steenland, et al., *Pregnancy- and Abortion-Related Mortality in the US, 2018-2021*, 9 JAMA Network Open e2554793 (2026) [hereinafter Steenland], https://doi.org/10.1001/jamanetworkopen.2025. 54793). They found that the ratio of pregnancy- to abortion-related mortality during that period was between 44.3 and 69.6, at least three times higher than the ratio calculated using data from 1998 to 2005, reflecting higher rates of pregnancy-related mortality and lower rates of abortion-related mortality compared with the earlier study period. *Id.* 376:1-15 (citing Steenland at 1). Collectively, these

studies demonstrate that abortion does not increase the risks that a pregnant person faces and is medically safer than childbirth. *Id.* 377:5-9.

79. The Court finds that the Finnish study on which Dr. Kraus relied does not support her conclusion about the relative safety of abortion and childbirth. *See* Tr. 1082:15-1086:19, 1090:1-25 (Kraus); Tr. 1234:9-1236:2, 1236:11-1238:9, 1240:17-1241:1 (Eller). For one thing, the study compares the number of deaths from all causes, including homicide, among women who had abortions and women who gave birth. Tr. 1236:14-1237:14 (Eller). But the data on which it relies shows that, when non-medical causes are screened out, the mortality rate among women who gave birth is three times higher than the mortality rate among women who had abortions. *Id.* 1237:1-3. For another thing, findings about the population in Finland are not generalizable to findings about the population in the United States because the nations differ in key respects, including demographics and the existence of a national healthcare system, which impacts the accessibility of healthcare. *Id.* 1240:17-1241:1.

80. Similarly, the Court finds that Dr. Hughes' opinions about the safety of abortion, based on his anecdotal experience in a hospital emergency department, are entitled to little weight. Instead, the Court credits the findings of a well-designed study of more than 50,000 California patients receiving health insurance through the State's Medi-Cal program, which covers abortion care. Tr. 1215:8-1216:2, 1217:8-18, 1218:8-1219:5 (Eller) (citing Ushma D. Upadhyah, et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (2015) [hereinafter Upadhyah], https://doi.org/10.1097/AOG.0000000000000603). This study found that only 0.087% of all abortions resulted in a visit to a hospital emergency department for an abortion-related complication within six weeks of the procedure; the total abortion-related complication rate based on all sources of care, including

hospital emergency departments and the original abortion facilities was 2.1%, and the total rate of major complications was 0.23%. *Id.* 1219:11-1220:12 (citing Upadhyay at 175).

81. The State's contention that abortion poses a heightened risk of long-term mental health conditions is likewise unsupported by the evidence. Leading psychiatric authorities such as the American Psychiatric Association, the American Psychological Association, and the United Kingdom's Royal College of Psychiatrists have conducted robust scientific reviews of the relevant medical literature and uniformly concluded that there is no reliable evidence that abortion causes mental illness. Tr: 279:1-281:7 (Payne). The National Academies found that much of the published research on this topic suffers from serious methodological flaws. *Id*. 281:8-282:19. It explained that: "The utility of most of the published research on mental health outcomes is limited by selective recall bias, inadequate controls for confounding factors, and inappropriate comparators. More[over], systematic reviews and meta-analyses are not reliable if they do not assess the quality of the primary research they include." *Id*. 281:17-282:16 (citing National Academies Report at 149). The studies relied on by Dr. Kraus suffer from these methodological flaws. *Id.* 282:17-24. Well-designed studies, like the Turnaway Study, have found that having an abortion does not increase the likelihood that a person will experience depression, post-traumatic stress disorder, or other mental health conditions. *Id*. 282:25-283:17.

82. Further, Dr. Kraus failed to cite reliable evidence in support of her opinion that abortion increases mental health risks for pregnant people carrying an embryo or fetus with a life-limiting condition. Tr. 282:20-24 (Payne); Tr. 1194:24-1195:5 (Kraus) ("I don't think we have a ton of data or research on that specific topic, but that's what we have."). Of the two studies she relied on, one was based solely on semi-structured interviews with eleven women in Sweden, Tr. 1195:10-17 (Kraus) (citing Nina Asplin, et al., *Pregnancy Termination Due to Fetal*

Anomaly: Women's Reactions, Satisfaction and Experiences of Care, 30 Midwifery 620 (2014), https://doi.org/10.1016/j.midw.2013.10.013), and the other, by Dr. Kraus' own admission, had "significant limitations," *id.* at 1196:5-14.

83. Similarly, the Court finds that the evidence does not support the State's contention that a fetus can feel pain prior to viability. There is a broadly held consensus in the medical field based on neuroanatomy that, before twenty-four to twenty-six weeks' gestation, a fetus does not have the neurological structures needed to feel pain. Tr. 390:23-392:9 (Eller). A systematic, multidisciplinary review of the scientific literature supports this view. *Id.* 393:11-394:10 (citing Susan J. Lee et al., *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 294 JAMA 947 (2005), https://doi.org/10.1001/jama.294.8.947). In any event, analgesia can be administered to a pregnant patient during an abortion procedure to prevent any potential fetal pain. Tr. 1194:7-23 (Kraus).

84. The State's contention that being denied a therapeutic abortion is a net benefit for a patient's health because it enables the patient to maintain health insurance coverage—and specifically Medicaid coverage—for a longer period of time is also unsupported by the record. The State has presented no evidence that having Medicaid during pregnancy is associated with postpartum improvement of underlying chronic health conditions. In contrast, Dr. Romero's testimony identified substantial evidence that chronic or worsened health conditions treated during pregnancy persist after a patient gives birth and that patients who are unable to obtain desired abortion care experience adverse social outcomes. Tr. 338:16-22, 343:14-24, 345:1-346:18 (Romero).

85. Medicaid enrollees face particular challenges in accessing pregnancy-related care. Tr. 336:4-6 (Romero). National studies have documented reduced access to specialty care for

Medicaid enrollees compared to those with private insurance. *Id.* 336:7-16. Studies examining the wait time for a new patient appointment with an OB-GYN subspecialist, such as an MFM, found a statistically significant difference by type of insurance, with significantly longer wait times for Medicaid recipients. *Id.*

86. A recent study found that readmission rates were consistently higher for those with Medicaid than for those with private insurance, and patients covered by Medicaid at the time of delivery were more likely to become uninsured over time. *See* Tr. 338:13-22 (Romero). Thus, Medicaid coverage at the time of delivery was a significant predictor of being readmitted to a hospital within six months and being uninsured at the time of readmission. *See id.*

87. Idaho trails other states in Medicaid coverage for pregnant people. Idaho's income eligibility level for pregnant people seeking Medicaid coverage is capped at 138% of the Federal Poverty Line, which is substantially lower than the national average. Tr. 337:18-338:1 (Romero). And Idaho patients eligible for Medicaid coverage because of their pregnancy status lose coverage within a year after the pregnancy ends. *Id*. 338:8-12. As a result, many pregnant and postpartum people in Idaho lack health insurance and have inadequate access to health care. *See id.*

88. The federal Office of the Inspector General recently studied maternal health care access in Medicaid Managed Care, focusing on provider coverage rules and network adequacy standards. Tr. 341:10-342:2. (Romero). It identified forty-one states with comprehensive, risk-based managed care programs covering pregnant and/or postpartum enrollees; Idaho was not among them. *Id.*

89. Idaho also trails other states in the availability of medical services. Tr. 340:10-16. (Romero). The 2024 report of the American Association of Medical Colleges found that Idaho

had the lowest number of both active and direct patient care physicians in the country. *Id.* 340:17-22, 347:5-10, 347:24-348:1-3 (citing *U.S. Physician Workforce Data Dashboard*, AAMC (2026), https://www.aamc.org/data-reports/report/us-physician-workforce-data-dashboard [https://perma.cc/FXT7-X3JE]). Moreover, the number of practicing OB-GYNs in the State, which was low to begin with, has diminished significantly since the Abortion Bans took effect. *See id*. 340:17-22; *see infra* at ¶ 104.

VII. Shared Decision-Making

90. The dominant model of decision-making in contemporary medical practice is known as shared decision-making. Tr. 44:23-45:3 (Smid).

91. Shared decision-making is rooted in the four principles of medical ethics: autonomy, or respecting patients' ability to make their own medical decisions; beneficence, or acting in a way that benefits the patient; nonmaleficence, or avoiding harm to the patient; and justice, or treating all patients in a fair and equitable manner. Tr. 45:4-9 (Smid).

92. Shared decision-making entails a collaborative process in which physicians and patients engage in a dialogue about key decisions that includes consideration of evidence-based options and the patient's personal values, goals, and preferences. Tr. 45:10-19 (Smid). Shared decision-making stands in stark contrast to older models of decision-making in which a physician would make a unilateral assessment of the patient's best interests and guide the patient toward the physician's preferred treatment option. *See id*. 45:20-22; Tr. 367:11-368:15 (Eller).

93. According to SMFM: "Shared decision-making is the optimal counseling approach, and healthcare practitioners should utilize strategies that reduce barriers to informative, unbiased communication, prioritize patient values, and empower patients to make the best reproductive health choices for them." Tr. 46:3-17 (Smid) (quoting Anjali Kaimal, et al., *Society for Maternal-Fetal Medicine Consult Series No. 55: Counseling women at increased*

risk of maternal morbidity and mortality, 224 Am. J. of Obstetrics & Gynecology B16, B21 (2021) [hereinafter SMFM Consult Series No. 55], https://doi.org/10.1016/j.ajog.2020.12. 007).

94. For shared decision-making to be effective, physicians must provide patients with clear, accurate, and unbiased information that informs the patient about their diagnosis, treatment options, potential risks, and expected outcomes. Tr. 45:10-16 (Smid). Physicians must also inquire about the patient's values, goals, and preferences. *Id*. 45:10-16. A physician should never pressure a patient to choose a particular option. Tr. 1168:4-15 (Kraus). The physician must respect the patient's decision, even if the physician disagrees with it. Tr. 45:17-19 (Smid).

95. Idaho's current MMRC recommends use of "shared decision-making to plan for potential complications or emergency situations when a patient's religious, moral, or cultural beliefs may require accommodations to maintain compliance with standard of care." Ex. 7 at 7; *accord* Ex. 5 at 20.

96. SMFM advises that a pregnant person at heightened risk of maternal morbidity or mortality "should receive nondirective counseling regarding the potential risks and benefits of pregnancy continuation, including the short- and long-term implications of expectant management or medical intervention for the condition placing her at an increased risk and the risks and benefits of pregnancy termination." Tr. 46:3-9, 46:21-47:14 (Smid) (quoting SMFM Consult Series No. 55 at B19). It further advises that: "When indicated during pregnancy, counseling regarding pregnancy termination should be performed as expeditiously as possible to optimize choices and outcomes." *Id.* 46:3-9, 47:15-18 (quoting SMFM Consult Series No. 55 at B19-20).

97. When medical indications for abortion arise during pregnancy, patients face complex and often heart-wrenching decisions about how to proceed. Tr. 47:19-48:12 (Smid); Tr.

116:14-25 (Seyb). Patients generally do not take these decisions lightly and give strong consideration to their personal values and religious beliefs. Tr. 47:19-48:21 (Smid); Tr. 116:14-25 (Seyb). They take a variety of individualized factors into account, such as the nature and magnitude of the risks to their health; the likelihood that their pregnancy will result in a live birth; the degree to which their child may suffer after birth; the impact that their own death or disability would have on their loved ones, including any current children; their desired family size; risks to their future fertility; the strength of their social and emotional support systems; their financial resources and the medical resources available in their community; and their prior experiences with pregnancy. Tr. 47:19-48:21, 60:22-61:11 (Smid); Tr. 116:14-25 (Seyb).

98. Dr. Seyb engages in shared decision-making with his patients. Tr. 116:3-4 (Seyb). Not all of his patients with medical indications for abortion choose to have an abortion, but some do. Tr. 116:5-13 (Seyb); *see also* Tr. 48:17-21 (Smid); Tr. 229:1-3 (Prentice); Tr. 367:20-368:18 (Eller).

VIII. The Abortion Bans' Impact on Dr. Seyb's Practice

99. Dr. Seyb is not a high-volume abortion provider. *See* Tr. 117:1-15 (Seyb). Most of the patients he treats have wanted pregnancies. *Id.* 116:8-10. Nevertheless, throughout his more than twenty-five-year tenure as an MFM at St. Luke's, he has regularly performed ten to twenty therapeutic abortions each year for patients with serious medical needs. *Id.* 117:1-3.

100. Since Idaho's Abortion Bans have been in effect, Dr. Seyb has had to refer some patients with serious medical needs to out-of-state abortion providers. Tr. 117:4-7 (Seyb).[3]

101. But for the Abortion Bans, Dr. Seyb would continue to offer abortion care in Idaho to all patients with serious medical needs seeking such care, rather than refer them to out-of-state abortion providers. Tr. 118:14-119:3 (Seyb). That includes patients with serious medical needs arising from physical health conditions; patients with serious medical needs arising from mental health conditions; and patients with serious medical needs arising from embryonic and fetal conditions. *Id.*

A. Patients Facing a Risk of Death From Self-Harm

102. The Total Abortion Ban prohibits therapeutic abortion in cases where a patient faces a risk of death from self-harm. Idaho Code § 18-622(2)(a)(i) ("No abortion shall be deemed necessary to prevent the death of the pregnant woman because the physician believes that the woman may or will take action to harm herself."). The Fetal Heartbeat Act prohibits therapeutic abortion in a subset of such cases—when embryonic or fetal cardiac activity is detectable—unless the patient is experiencing a "medical emergency" that necessitates an "immediate abortion." Idaho Code §§ 18-8801(2), 18-8801(5), 18-8804(1).

103. But for the Abortion Bans, Dr. Seyb would provide therapeutic abortion care to all patients facing a risk of death from self-harm who sought abortion care from him. *See* Tr.

[3] Many of Plaintiff's expert witnesses are MFMs who practice in states bordering Idaho. *See supra* at ¶¶ 32-33, 36, 38. Since the Abortion Bans took effect, they have provided therapeutic abortion care to numerous Idaho patients referred to them by Dr. Seyb or his colleagues in Idaho. For example, Dr. Eller has provided therapeutic abortion care to at least five patients who traveled from Idaho, including one with preexisting heart failure, several with PPROM, and one seeking a multi-fetal pregnancy reduction. Tr. 398:17-399:21 (Eller). Similarly, Dr. Smid has provided therapeutic abortion care for one to three patients per year who traveled from Idaho. Tr. 48:22-23, 61:24-62:12 (Smid).

118:14-119:1 (Seyb). Dr. Seyb has treated pregnant patients with mental illness in the past, including one who died from suicide. *Id.* 119:23-25, 121:10-15. It is a regular part of his practice to screen patients for depression. *Id.* 122:7-12. It is within the scope of his current practice to provide abortion care in connection with a mental health condition. Tr.30:20-31:4, 35:6-19, 46:21-47:18, 55:5-9 (Smid); Ex 2010 at 158:22-159:2.

104. Before *Dobbs*, patients seeking abortion for mental health reasons would often obtain care in outpatient abortion clinics. Ex. 2010 at 66:6-67:17. Since the Total Abortion Ban took effect, all of Idaho's outpatient abortion clinics have closed, eliminating that option. *Id.* at 159:3-12; *see* Tr. 738:19-24 (Hughes). Now, any patient eligible to have an abortion in Idaho must have the abortion in a hospital. Moreover, since the Total Abortion Ban has been in effect, more than a third of Idaho's OB-GYNs have left the State or stopped treating pregnant people. Tr. 146:25-147:6 (Seyb). Given the closure of all outpatient abortion clinics and the massive reduction of OB-GYNs in the state, the share of patients seeking medically indicated abortion care from Dr. Seyb is going to be higher in the future than it has been in the past.

105. Pregnant patients with certain medical conditions are at a heightened risk of death from self-harm. Tr. 57:23-58:9 (Smid); Tr. 252:25-253:6 (Payne); *see* Tr. 678:15-19 (Hughes) (describing patients with depression, anxiety, and bipolar disorder as high risk).

1. Patients With Substance Use Disorder

106. One such condition is substance use disorder. Tr. 57:23-58:4 (Smid).

107. Substance use disorder is a chronic brain disease that results in the compulsive use of certain substances and negatively affects a patient's health and quality of life. Tr. 62:19-24 (Smid). Examples of such substances include alcohol, opioids, cocaine, and methamphetamine. *Id*. 64:4-8. About 50% of substance use disorder is attributable to genetic predisposition. *Id.* 63:25-64:1.

108. Using these substances alters how a patient's brain functions. Tr. 62:25-63:14 (Smid). It causes the brain to release the neurotransmitter dopamine, which can lead a patient to temporarily experience a pleasurable feeling or "high." *Id.* Over time, the brain perceives use of the substance as necessary to maintain well-being, and the patient seeks it out compulsively. *See id.* Substance use disorder ranges in severity from mild to severe. Tr. 64:9-16 (Smid).

109. Patients with substance use disorder are at risk of death from overdose. Tr. 64:17-21 (Smid). Substance use disorder can also result in motor impairment that places patients at increased risk of accidental injury. *Id.* 65:11-15. In addition, it can be difficult for patients with co-morbidities to follow treatment plans for those conditions. *Id.* 65:1-18. For example, patients may delay seeking medical care or struggle to take medications needed to manage their medical conditions. *Id*.

110. Pregnancy creates a higher risk of overdose and impairment for people with substance use disorder because the physiological changes caused by pregnancy affect the way that substances impact the body. Tr. 65:19-66:12 (Smid). Further, the stress of pregnancy and caring for a newborn makes it harder for a person with substance use disorder to abstain from using substances. *Id*. 66:7-12.

111. Moreover, people with alcohol use disorder face a Catch-22 when they become pregnant. Continuing to use alcohol is harmful to the developing embryo or fetus, but abrupt cessation of alcohol use poses a high risk of morbidity and mortality for the pregnant person. Tr. 66:13-19, 67:25-68:4 (Smid). Supervised withdrawal in a hospital setting is optimal, but there are not enough programs to meet patient need. *Id*. 66:20-67:24. Further, some patients face financial and/or logistical barriers to obtaining in-patient care. *Id.* Accordingly, this option is not available to everyone. *Id.*

112. Seizure disorders are disproportionately present in people with substance use disorder. Tr. 68:5-12 (Smid). Pregnant patients who have both an opioid use disorder and a seizure disorder have a heightened risk of morbidity and mortality during opioid withdrawal. *Id.*

113. Terminating a pregnancy reduces the risk that a pregnant person with substance use disorder will die during pregnancy or during the post-partum period from a cause related to the use of substances. Tr. 68:13-18 (Smid).

2. Patients With Other Mental Health Conditions

114. Pregnant patients with certain other mental health conditions are also at heightened risk of death from self-harm. Tr. 57:23-58:9 (Smid); Tr. 252:25-253:2, 256:7-20 (Payne).

115. Such conditions include major depressive disorder, bipolar disorder, schizophrenia, and schizoaffective disorder. Tr. 58:2-4 (Smid); Tr. 253:3-6 (Payne).

116. This is not an exhaustive list. Tr. 253:7-9 (Payne).

117. Major depressive disorder is a psychiatric illness that causes a patient, on a persistent or periodic basis, to experience severely low mood that results in functional impairment. Tr. 253:12-22 (Payne). Functional impairment refers to a significant difficulty or disruption in one or more areas of life, such as a person's ability to perform the activities of daily life like eating and drinking, showering, and paying bills, or a person's ability to perform their job responsibilities *Id*. 253:24-244:6. Major depressive disorder is distinct from adjustment disorder, a condition in which people experience low mood due to a stressful or traumatic life event. *Id*. 254:7-18. Whereas adjustment disorder calls for social support and talk therapy, major depressive disorder calls for psychiatric intervention. *Id*. 254:16-18.

118. Bipolar disorder is a serious mental health condition in which patients experience mood fluctuations between periods of abnormally elevated mood and energy and major

depressive episodes. Tr. 254:19-255:11 (Payne). There are different varieties of bipolar disorder, but all bipolar patients experience symptoms that can significantly impact their work, relationships, ability to carry out daily activities, and personal safety. *See id*.

119. Schizophrenia is a serious mental health condition that is characterized by some or all of the following symptoms: delusions; hallucinations; disorganized thought, behavior, or speech; difficulty talking; and difficulty maintaining employment or relationships. Tr. 255:13-21 (Payne).

120. Schizoaffective disorder is a serious mental health condition in which patients prominently exhibit mood symptoms (such as those found in people living with major depressive disorder or bipolar disorder) as well as symptoms found in people living with schizophrenia in between mood episodes. Tr. 255:22-256:6 (Payne).

121. Some patients with the foregoing conditions experience psychosis, suicidality, nonsuicidal self-injury, and catatonia, all of which create a risk of death. Tr. 256:7-258:5 (Payne).

122. Psychosis encompasses a range of psychiatric symptoms typically marked by a distorted perception of reality. Tr. 256:15-20 (Payne). Patients experiencing psychosis may present with hallucinations, delusions (including paranoia), disorganized thinking, or disorganized behavior, each indicative of a departure from typical mental function. *Id*. 256:15-20. A psychotic patient might act on their false perceptions and beliefs to engage in risky behavior, like running into traffic, injuring themselves, or attempting suicide. *Id*.

123. Suicidality refers to a heightened risk that a patient will take deliberate action to end their life that typically presents with suicidal ideation (intrusive thoughts or plans about ending one's life). Tr. 256:11-14, 278:16-25 (Payne).

124. Nonsuicidal self-injury refers to engaging in deliberate conduct with the intent of hurting oneself. Tr. 256:21-257:9 (Payne). This includes engaging in behaviors that cause bleeding, burns, or pain. *Id*. Nonsuicidal self-injury is distinct from suicidality; it can serve as a coping mechanism for emotional distress as well as a signal to others that the individual is distressed. *Id*. Nevertheless, nonsuicidal self-injury may result in significant consequences. *Id*. 257:4-9.

125. Catatonia is a serious condition that affects some patients with certain psychiatric and neurological disorders. Tr. 257:10-13 (Payne). Patients experiencing catatonia will often become mute; stop eating or drinking; and stop moving or interacting normally. *Id.* 257:13-16. Catatonia poses risks to a patient's health and life because it impairs their daily functioning. *Id*. 257:10-258:5. Patients with catatonia may also develop dehydration and malnutrition; autonomic nervous system instability, which can lead to dangerous fluctuations in blood pressure; and blood clots, which can cause stroke or pulmonary embolism. *Id*. 257:17-258:5.

126. Pregnancy exacerbates many mental health conditions and complicates their treatment. Tr. 262:2-21 (Payne). The dramatic hormonal fluctuations triggered by pregnancy fundamentally change the neurobiology of a pregnant person. *Id.* 262:9-12, 266:8-13, 273:19-274:5; Tr. 15:22-16:4, 82:8-13 (Smid). People living with mental health conditions that were well managed before pregnancy may experience recurrence or a worsening course of their condition after becoming pregnant or giving birth. Tr. 273:19-274:5, 274:23-275:9 (Payne).

127. In addition, pregnancy itself may trigger a sudden onset of mental health conditions that present with health- or life-threatening symptoms. Tr. 275:16-276:12 (Payne). For example, perinatal depression (depression during pregnancy or the postpartum period) is a type of major depressive disorder that is likely related to and caused by hormonal changes that

are associated with pregnancy and childbirth. *Id*. Dr. Payne has treated many patients with this condition and has also conducted extensive clinical research about it. *Id*. 275:22-276:12; Ex. 1005 at 5. Her research identified two biomarkers of heightened sensitivity to fluctuations in hormones such as estrogen and progesterone that predict which pregnant patients will experience perinatal depression. Tr. 276:1-12 (Payne). While the cause of this hormonal sensitivity is not yet fully understood, the presence of biomarkers makes clear that it has a biological basis. *Id*.

128. Compounding the challenges that pregnant patients face, the physiological changes of pregnancy, including increases in blood volume and changes in metabolism, affect the way that the body responds to medications. Tr. 262:5-17 (Payne). For some patients with serious mental health conditions, medications may not be as effective during pregnancy as they were before. *Id*.

129. Studies have found that, among women with major depressive disorder managing their condition with medication, approximately 25% experienced relapse during pregnancy despite continuing their medications. Tr. 263:4-9 (Payne). For women living with bipolar disorder, about 30% of those who continued their medications during pregnancy experienced relapse. *Id*. 263:10-13.

130. Furthermore, some medications used to treat serious mental health conditions have teratogenic effects, which means that they can cause profound and lasting harm to a developing embryo or fetus. Tr. 53:15-25 (Smid); Tr. 264:21-25 (Payne); *see* Tr. 687:14-18 (Hughes); Tr. 1115:21-24 (Kraus). Such medications include carbamazepine and valproic acid. Tr. 54:2-9 (Smid). Tr. 265:1-3 (Payne). Patients who become pregnant while taking these medications must consider the risks to the fetus of continuing to use the medication as well as the

risks to themselves of switching to a different medication, which may be less effective or cause greater side effects, or of ceasing medication entirely. Tr. 265:4-25 (Payne).

131. These patients cannot easily switch to a different psychiatric medication that is not teratogenic. Tr. 265:10-13 (Payne). Most pregnant patients who take carbamazepine or valproic acid, for example, have usually failed to respond to other, non-teratogenic mood stabilizing medication. *Id.* Given the risks, clinicians are reluctant to prescribe them to women of reproductive age except as a last resort. *Id.*; Tr. 687:19-24 (Hughes).

132. Research shows that, for many other psychiatric medications, the risk of harm to the fetus is less than the risk of harm to both the pregnant person and fetus of untreated psychiatric illness, but that does not mean that these medications are "safe" for the fetus in an objective sense. Tr. 289:22-290:10 (Payne). Despite the net risk, some patients are reluctant to continue taking prescribed medications during pregnancy—even if they have not been conclusively linked to teratogenic effects—because they are worried about exposing the fetus to harm, and some ob-gyns recommend that patients stop taking their psychiatric medications while pregnant. *See id.* 264:7-13; Tr. 687:14-18 (Hughes). Indeed, an SMFM guidance document cited by Dr. Kraus warns that: "Because of the fears of teratogenic or adverse neonatal effects, women may discontinue psychiatric pharmacotherapy during pregnancy." Tr. 1172:1-3, 1177:7-12 (Kraus).

133. Additionally, relapse causes some patients to stop taking their medications because the illness itself interferes with the patient's normal functioning in ways that make it hard for the patient to adhere to a medication regimen. Tr. 264:14-20 (Payne).

134. Seventy percent of patients with major depressive disorder and 80%-100% of patients with bipolar disorder or schizoaffective disorder who stop their psychiatric medications

for pregnancy experience a relapse of their psychiatric condition and can experience life- or health-endangering symptoms. Tr. 263:14-22 (Payne).

135. Dr. Seyb once treated a patient with bipolar disorder who became pregnant. Tr. 121:7-122:6 (Seyb). Before her pregnancy, the patient was taking medication to manage her condition. *Id.* She decided to continue the pregnancy and stop taking her medication to avoid risks to the fetus. *Id.* Subsequently, her mental health deteriorated. *Id.* She was able to carry the fetus to term and give birth, but she died from suicide during the postpartum period. *Id.*

136. Pregnant patients who experienced a serious mental health condition in connection with a prior pregnancy are likely to develop a serious mental health condition during their current pregnancy. Tr. 276:13-17 (Payne). For example, women who have experienced perinatal depression have about a 75% risk of developing depression in connection with a subsequent pregnancy. *Id*. As a result, a patient's psychiatric experience during a prior pregnancy provides useful information about the psychiatric risks the patient will face during their current pregnancy. *Id.* 276:18-277:14; Tr. 1111:24-1112:2 (Kraus) ("I would say people with a history of mental health conditions, and people with a history of postpartum depression are certainly at increased risk, and we'll discuss that ahead of time.").

137. For some patients experiencing the onset, recurrence, or worsening of mental health conditions because of pregnancy, life-threatening symptoms such as psychosis, suicidality, nonsuicidal self-injury, and catatonia cannot be effectively managed through psychotherapy, medication, or other psychiatric treatments. Tr. 252:25-253:6, 256:8-258:5, 267:18-270:23, 271:17-273:18, 318:18-319:3 (Payne). For these patients, terminating the pregnancy is the only way to eliminate the symptoms and corresponding risk to the patient's life. *Id.* 273:13-274:5; 283:18-20.

138. For example, Dr. Payne treated a patient with well-managed bipolar disorder who had a history of worsening major depressive episodes during pregnancy. Tr. 267:2-8 (Payne). When she became pregnant for the third time, she experienced life-threatening symptoms, including suicidality and non-suicidal self-injury, that did not improve with medication management and psychotherapy. *Id*. 267:9-17. The patient ultimately chose to have an abortion to eliminate the threat to her health and life. *Id*. 267:16-17.

139. The State contends that a patient at risk of death from self-harm can be hospitalized as an alternative to terminating the pregnancy. Not only would an unwanted hospitalization be a tremendous burden on a patient's liberty, the weight of the evidence shows that it is not a realistic or effective option for all patients. Hospital psychiatric beds are in short supply, and as a result, hospitalization is not available to every pregnant patient. Tr. 269:2-8 (Payne). Indeed, Dr. Hughes testified that the hospital to which he referred pregnant patients for inpatient care closed its labor and delivery unit in 2024 and relocated their psychiatric unit. Tr. 741:2-9 (Hughes). He does not know the hospital's current capacity to accept pregnant psychiatric patients. *Id.* Even if a hospital psychiatric bed is available, hospitalization is not appropriate for every patient. Dr. Payne testified that inpatient psychiatric care can be a "traumatic experience." Tr. 268:17-18 (Payne). Psychiatric units are locked down to prevent patients from leaving. *Id.* 268:19-20. Typically, visiting hours are strictly limited, and patients' cell phones and computers are confiscated, so patients have minimal, if any, contact with their loved ones and are not able to engage in remote work. *See id.* 268:20-24. There are likely to be other patients in the unit who are "very psychiatrically ill," *id.* 268:24-25, which can contribute to the traumatic nature of the experience. Moreover, hospitalization is not always effective in preventing patient suicide. *Id.* 268:14-16. Every year, some patients commit suicide while

hospitalized in a psychiatric unit. *Id.* The Court gives little weight to Dr. Kraus' testimony on this matter because her experience is limited to treating patients in hospital obstetrical wards, and she conceded that "[protocols] are somewhat different if [patients] are in an inpatient psychiatric ward." Tr. 1117:13-1118:2 (Kraus).

140. Similarly, the other alternatives to abortion identified by the State are not available or appropriate for all patients. For example, electroconvulsive therapy ("ECT") is contraindicated for some patients. Tr. 269:18-23 (Payne). Further, it is time and resource intensive, requiring treatment three days per week for several weeks at a time, and patients cannot drive while undergoing treatment. *Id.* 269:20-270:4. In addition, ECT entails significant side effects, including memory loss, headaches, nausea, vomiting, anxiety, and elevated blood pressure. *Id.* 269:24-270:14. Likewise, transcranial magnetic stimulation ("TMS") is not widely available in the United States. *Id.* 270:22-23, 271:20-22.

3. Comparability to Patients Facing a Risk of Death from Other Medical Causes

141. The State contends that pregnant people facing a risk of death from self-harm are dissimilar to pregnant people facing a risk of death from other medical causes in four respects: (1) self-harm is not limited to any specific physical condition; (2) determining the risk of self-harm depends on self-reporting, which is unreliable; (3) whether a person experiences suicidal ideation or attempts suicide can be unpredictable; and (4) unlike risks from other medical conditions, self-harm causes injury only through an affirmative action by the patient. The record does not support these contentions. To the contrary, it demonstrates that the people in each group are similarly situated in all respects.

142. First, the risk of death from self-harm, like the risk of death from other medical causes, arises from specific, diagnosable medical conditions. Tr. 252:25-253:6, 256:7-258:5

(Payne); *see supra* at ¶¶ 105-06, 114-16. These illnesses involve physiological processes affecting brain function. Tr. 54:24-55:9, 58:5-9 (Smid); Tr. 262:5-17, 266:18-24 (Payne). Pregnancy causes shifts in neurotransmitter systems and other physical changes to the body that can trigger or exacerbate psychiatric illness and complicate its treatment. Tr. 54:24-55:9, 58:5-9 (Smid); Tr. 262:5-17, 266:17-24 (Payne). Indeed, researchers have identified epigenetic biomarkers associated with sensitivity to hormonal changes that predict the development of depression during pregnancy and postpartum. Tr. 276:1-12 (Payne).

143. Second, clinicians do not rely solely on patient self-reporting to determine whether a patient faces a risk of death from self-harm. Tr. 70:25-72:9 (Smid); Tr. 258:6-259:2 (Payne). As with all health conditions, clinicians identify psychiatric symptoms and diagnose mental health conditions through a comprehensive clinical evaluation process. Tr. 70:25-72:9 (Smid); Tr. 252:12-24, 259:3-261:21 (Payne); Tr. 1111:14-19 (Kraus) ("Q. What do you do when a pregnant woman indicates that she is suicidal or has had suicidal ideations?/ A. Again, after asking questions, if I can confirm that, you know, she has a plan, that this is a real risk, then I generally recommend evaluation in an emergency department or with, you know, psychiatry to evaluate for potential admission."). When evaluating patients for mental health conditions, clinicians reference the Diagnostic and Statistical Manual of Mental Disorders, also known as the DSM-5-TR, which provides standardized criteria to define and diagnose psychiatric conditions. Tr. 71:9-12 (Smid); Tr. 259:3-18 (Payne); Tr. 1110:15-17 (Kraus). In addition, clinicians draw from other medical literature, their training, clinical experience, and professional expertise to observe patients' behavior, appearance, thought processes, demeanor, interactions, and communication patterns; obtain information from family members or friends; consider the patient's medical and family history; and, when appropriate, use laboratory testing, imaging, and

diagnostic instruments. Tr. 59:21-25, 71:13-24 (Smid); Tr. 258:6-260:21 (Payne); *see* Tr. 1110:12-14 (Kraus) ("You know, it's still important to talk with the patient, observe the patient. There are certainly lots of pieces of information that help us."). A clinician cannot predict with 100% certainty that a patient will die from self-harm if an underlying medical condition is left untreated, just as a clinician cannot predict with 100% certainty that a patient will die from an infection if the cause of the infection is left untreated. Tr. 83:10-17 (Smid); Tr. 261:2-16 (Payne). Nevertheless, the diagnostic criteria that clinicians use to determine whether a patient faces a risk of death from self-harm are reliable. Tr. 70:25-71:8 (Smid); Tr. 261:12-21 (Payne); Tr. 740:15-741:1 (Hughes).

144. Third, clinicians can make *reasonable* predictions about whether a patient will experience suicidal ideation or attempt suicide based on the patient's diagnosis, prior medical history, and other symptoms, just as clinicians can make *reasonable* predictions about whether a patient will experience hemorrhage or organ failure. Tr. 258:6-260:21 (Payne). Clinicians can rarely, if ever, make predictions with 100% certainty. Tr. 83:11-13 (Smid); Tr. 261:2-4; (Payne); Tr. 368:12-15 (Eller). Psychiatry is no different than other areas of medicine in that regard. Tr. 260:23-261:11 (Payne).

145. Fourth, self-harm is not volitional. Tr. 70:18-24 (Smid); Tr. 278:16-25 (Payne). It is the result of pathological conditions that affect patients' brain chemistry and function. Tr. 278:16-25 (Payne). A patient cannot rely on willpower to overcome a serious mental health condition like major depressive disorder or substance use disorder any more than a patient can rely on willpower to overcome cancer or diabetes. Tr. 70:18-24 (Smid); Tr. 318:1-4 (Payne) ("There is a mythology that people with depression should just pull their socks up and get on with it. And that is because most people haven't seen what real psychiatric illness can do."). For

all of these conditions and many others, a patient's own actions (e.g., diet, physical activity level, adherence to treatment plan) may contribute to the progression of the disease. Tr. 72:10-73:5 (Smid). But none of these mental or physical health conditions are the result of a conscious choice, and none can be effectively managed without medical intervention. Tr. 70:18-24 (Smid); Tr. 278:8-25 (Payne). The notion that the risk of death from self-harm is a patient's fault or could be eliminated if only the patient exhibited more grit or determination is rooted in stigma against psychiatric illness and a fundamental misunderstanding of mental health. Tr. 278:8-25 (Payne); Tr. 69:3-17 (Smid).

B. Patients Facing a Risk of Serious Morbidity That is Not Necessarily Life-Threatening

146. The Total Abortion Ban prohibits therapeutic abortion in cases where continued pregnancy poses a risk of serious morbidity to the pregnant person that is not necessarily life-threatening. Idaho Code § 18-622(1), (2)(a). The Fetal Heartbeat Act prohibits therapeutic abortion in a subset of such cases—when embryonic or fetal cardiac activity is detectable—unless the patient is experiencing a "medical emergency" that necessitates an "immediate abortion of her pregnancy … for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function." Idaho Code §§ 18-8801(2), 18-8801(5), 18-8804(1).

147. But for the Abortion Bans, Dr. Seyb would provide therapeutic abortion care to all patients who sought abortion care from him for whom continued pregnancy posed a risk of serious morbidity. Tr. 118:14-119:3 (Seyb).

1. Patients Who Develop Pregnancy-Related Complications

148. As explained above, a wide range of pregnancy-related complications pose a risk of serious morbidity to a pregnant person. *Supra* at ¶ 71. It is not possible to provide an exhaustive list of such complications and conditions. *Id.*

149. PPROM, cervical insufficiency, HDPs, and placental abnormalities are illustrative examples of pregnancy-related complications that pose a risk of serious morbidity to a pregnant person but are not necessarily life-threatening. Tr. 35:3-13 (Smid); Tr. 122:13-125:15 (Seyb); Tr. 218:10-13, 231:1-6 (Prentice); Tr. 399:5-11, 400:9-16 (Eller). Mental health conditions whose onset is triggered by pregnancy can also pose such a risk, *supra* at ¶ 127, as can gestational diabetes, *infra* at ¶¶ 169, 197.

150. PPROM occurs when a patient's gestational sac ruptures before the pregnancy reaches full term, allowing amniotic fluid to leak out, disrupting the barrier between the fetus and normal bacteria on our bodies. Tr. 35:24-36:4 (Smid); Tr. 123:5-11 (Seyb). A pregnant person who experiences PPROM is at risk of developing an infection, which can lead to sepsis. Tr. 36:20-37:3 (Smid); Tr. 123:5-19 (Seyb). Sepsis can cause death in some cases. Tr. 37:4-8 (Smid). More often, it causes permanent organ damage, cognitive impairment, and an increased risk of developing future infections. *Id*. 37:9-21. A severe intraamniotic infection can require a hysterectomy, which renders the patient infertile. Tr. 1222:25-1223:8 (Eller). PPROM may occur before viability, and the earlier in pregnancy that PPROM occurs, the lower the likelihood of fetal survival. *Id.* 35:24-36:16. ACOG and SMFM both recommend that, when PPROM occurs prior to fetal viability, patients should be offered the option of immediate pregnancy termination. *Id.* 42:1-10. (citing SMFM, *Society for Maternal-Fetal Medicine Consult Series No. 71: Management of previable and periviable preterm prelabor rupture of membranes*, 231 Am. J. Obstetrics & Gynecology B2, B5 (2024), https://doi.org/10.1016/j.ajog.2024.07.016).

Terminating a pregnancy reduces the risk that a pregnant person with PPROM will experience serious morbidity as a result of that condition. *Id.* 43:14-16.

151. The State's medical experts, however, testified that, under the Abortion Bans, when previable PPROM occurs, a physician may not terminate the pregnancy immediately; instead, the physician must wait until the patient is no longer medically stable. Tr. 739:11-17 (Hughes); Tr. 1189:19-1190:18 (Kraus). Dr. Kraus takes this position despite acknowledging that, once a complication occurs, it can escalate quickly, and an infection can escalate to sepsis in a short period of time. *Id.* 1190:19-24. Similarly, Dr. Hughes takes this position despite acknowledging that an intraamniotic infection "starts first with no signs." Tr. 705:20-22 (Hughes); *see also* Tr. 1220:24-1222:16 (Eller) (discussing ACOG guidelines concerning intraamniotic infection).

152. After the Abortion Bans took effect but before the St. Luke's EMTALA injunction was in place, Dr. Seyb saw a patient who was approximately eighteen weeks' pregnant and presented with grossly ruptured membranes. Tr. 123:5-19 (Seyb). Dr. Seyb's assessment led him to conclude that the patient had an early intrauterine infection and, unless her pregnancy was terminated, she would develop a worsening infection. *Id.* He could not make a good faith determination that the infection would be fatal, however. *Id.* She wanted to terminate the pregnancy immediately, so Dr. Seyb referred her to an MFM in Utah and arranged for air transport. *Id.* By the time the patient arrived in Utah, she met the criteria for sepsis. *Id.*

153. Placental abnormalities include placenta previa (when the placenta covers the cervix) and placental abruption (when the placenta prematurely detaches from the uterus). Tr. 48:24-49:5 (Smid). These conditions may cause hemorrhaging or disseminated intravascular coagulation ("DIC"), a blood clotting disorder, both of which can lead to organ damage, organ

failure, loss of future fertility, and in some cases, death. *Id*. 49:6-25, 50:4-10. Serious morbidity is a more common outcome than death. *Id*. 50:1-3. Terminating a pregnancy reduces the risk that a pregnant person with a placental abnormality will experience serious morbidity as a result of that condition. *Id*. 50:11-19.

154. Before the Abortion Bans took effect, Dr. Seyb treated a patient who started to experience vaginal bleeding from a placental abnormality at approximately twelve weeks of pregnancy. Tr. 124:19-125:15 (Seyb). By approximately seventeen weeks of pregnancy, the patient required a blood transfusion for anemia. *Id.* Tr. 125:4-10. The bleeding continued unpredictably, and it was unlikely that the pregnancy would be able to reach viability. *Id.* Tr. 125:1-10. The maternal health risks were high. *Id.* Tr. 125:4-10. At approximately nineteen weeks, the patient decided to terminate the pregnancy, and Dr. Seyb performed an abortion procedure for her in Idaho. *Id.* If Dr. Seyb encountered a patient in the same situation today, he would refer her out of state to obtain abortion care because of the Abortion Bans. *Id.* Tr. 125:11-15.

155. Hypertensive diseases of pregnancy are common pregnancy-related complications such as pre-eclampsia and eclampsia that entail persistently high blood pressure. Tr. 51:4-12 (Smid). They can lead to organ damage, organ failure, stroke, seizures, and in some cases, death. *Id*. 51:13-52:1. While HDPs can lead to death, they are more likely to cause serious maternal morbidity that may result in lifelong health complications. *Id.* 51:18-1. HDPs typically occur after twenty weeks of pregnancy, but some cases of pre-eclampsia have been reported at seventeen to nineteen weeks of pregnancy. *Id*. 52:2-5. Terminating a pregnancy reduces the risk that a pregnant person with an HDP will experience serious morbidity as a result of that condition. *Id*. 52:6-9.

156. Before the Abortion Bans took effect, Dr. Seyb treated a patient at approximately twenty weeks of pregnancy who presented with pre-eclampsia. Tr. 126:1-25 (Seyb). Her blood pressure progressively increased, and after ruling out other potential causes, it became clear she was developing preeclampsia. Tr. 126:1-12. Continued pregnancy would have put her at high risk, and the only way to reverse pregnancy-related hypertension is to remove the placenta. *Id.* 126:8-12. The patient chose to terminate the pregnancy and Dr. Seyb was able to treat her immediately in Idaho. *Id.* 126:1-25. Since the Abortion Bans took effect, Dr. Seyb's colleagues at St. Luke's have had to refer several patients with HDPs to out-of-state physicians. *Id.* 126:22-25.

2. Patients with Underlying Conditions That Are Complicated by Pregnancy

157. As explained above, pregnancy can exacerbate a wide range of underlying medical conditions and/or interfere with the treatment of those conditions, posing a risk of serious morbidity to a pregnant person that is not necessarily life-threatening. *See* Tr. 52:12-53:18 (Smid); Tr. 366:7-14 (Eller). Although it is not possible to provide an exhaustive list of such conditions, illustrative examples include heart disease, chronic kidney disease, cancer, and diabetes. *See infra* at ¶¶ 157-172.

158. Pre-existing mental health conditions may also be complicated by pregnancy. *Supra* at ¶¶ 110, 126.

159. For people with preexisting heart disease, the physiological changes of pregnancy can lead to severe cardiac decompensation. Tr. 377:15-378:5 (Eller). Indeed, pregnancy sometimes "unmasks" a preexisting but previously undiagnosed cardiac condition. *Id*. 382:8-23. Pregnant patients with congenital heart disease, valvular heart disease, arrhythmias, pulmonary hypertension, and cardiomyopathy face heightened risks of serious morbidity and mortality during pregnancy. *Id*. 378:8-382:7.

160. Maternal cardiac conditions are commonly classified according to four levels of risk, known as the World Health Organization Risk Classes I-IV. Tr. 383:3-8 (Eller). Class I includes patients with a relatively low risk of serious morbidity or mortality; whereas Class IV includes patients with an extremely high risk of serious morbidity or mortality. *Id.* Some doctors and hospitals use alternative classification systems. *Id.* 383:9-15.

161. For someone with a preexisting history of cardiac arrhythmia, or irregular heartbeats, pregnancy can prompt more frequent and dangerous arrhythmias to occur. Tr. 379:10-381:1 (Eller).

162. For someone with cardiomyopathy, a condition characterized by a weakened heart muscle, pregnancy can exacerbate the condition, potentially causing heart failure. Tr. 381:22-382:7 (Eller).

163. In cases where a patient has a serious cardiac condition exacerbated by pregnancy, it is not possible to predict whether the patient will die. Tr. 383:16-19 (Eller). But carrying the pregnancy to term will substantially increase the patient's risk of serious, long-term morbidity. *See id*. 377:10-21. In some cases, the progression of heart failure will necessitate surgical implantation of an assistive device or a heart transplant. *See, e.g., id.* 1231:10-1233:4. Terminating the pregnancy reduces the risk that a pregnant person with a cardiac condition will experience serious morbidity as a result of that condition. *Id.* 400:6-16 (Eller).

164. Before the Abortion Bans took effect, Dr. Seyb treated a pregnant patient who suffered from severe heart failure. Tr. 127:25-128:17 (Seyb). The pregnancy exacerbated her condition. *Id.* Dr. Seyb worked with her cardiologist to assess her level of risk. *Id.* After engaging in a shared decision-making process, the patient ultimately decided to terminate the pregnancy. *Id.* Dr. Seyb provided her abortion in Idaho. *Id.* If he encountered a patient with the

same condition today, he would refer her to an out-of-state physician because of the Abortion Bans. *Id.*

165. For patients with chronic kidney disease, pregnancy poses high risks to both the pregnant person and fetus. Tr. 128:21-129:23 (Seyb); Tr. 366:7-14 (Eller). Moreover, patients are generally not eligible for a kidney transplant while pregnant, and the American Society of Transplantation and the American Society of Transplant Surgeons recommend waiting at least one year after receiving a kidney transplant before becoming pregnant. Tr. 129:14-23 (Seyb); Tr. 384:14-385:21 (Eller). For patients with a prior kidney transplant (or other solid organ transplant), many immunosuppressive drugs used to prevent organ rejection are teratogenic. Tr. 384:14-385:21 (Eller). Continuing use of those drugs during pregnancy poses a serious risk of birth defects, but ceasing use or altering medications poses a serious risk of organ rejection. *See id.*

166. A recent study examined health outcomes in a cohort of pregnant people with chronic kidney disease and found that providing abortion care resulted in significantly fewer cases of stage progression, fewer cases of end-stage renal disease requiring dialysis, and nine fewer deaths per year. Tr. 343:14-24 (Romero) (citing Sydney McCarthy, et al., *The impact of denying abortion access to patients with chronic kidney disease: a cost-effectiveness analysis*, 146 Contraception 110863 (2025)). Thus, terminating a pregnancy reduces the risk that a pregnant person with chronic kidney disease will experience serious morbidity as a result of that condition. *Id.*; Tr. 344:1-5 (Romero).

167. Dr. Seyb recently treated a patient with end-stage renal disease who was undergoing peritoneal dialysis and was on the kidney transplant list. Tr. 128:18-129:13 (Seyb); Tr. 1157:20-1158:14 (Kraus). She became pregnant unintentionally following a contraceptive

failure. *Id.* After being counseled about the risks of pregnancy and her treatment options, the patient decided that an abortion would be in her best interest. *Id.* Dr. Seyb could not provide the abortion for her without facing prosecution for violating the Abortion Bans, so he referred her out of state. *Id.*

168. Pregnancy complicates the treatment of cancer. Tr. 52:18-19 (Smid). It is a contraindication for many routine cancer treatments, including radiation and some chemotherapies, because those treatments carry a high risk of fetal death or serious birth defects. *See id*. 52:18-25. Alternative treatments are generally far less effective. *Id.* 53:1-3. While delaying radiation and chemotherapy until the conclusion of a pregnancy will not necessarily result in a patient's death, doing so may allow the cancer to progress to a stage that entails more serious morbidity, requires more invasive treatment, or has a diminished likelihood of long-term survival. *See id.* 53:9-12. Terminating the pregnancy reduces the risk that a pregnant person with cancer will experience serious morbidity as a result of that condition. *Id.* 53:6-12.

169. Pregnancy complicates the treatment of diabetes, and in some cases may cause the onset of diabetes. Tr. 217:19-24, 223:17-225:16 (Prentice). Diabetes refers to a set of chronic conditions where the body is unable to process glucose correctly or utilize it effectively. *Id.* 216:2:4. Type 1 diabetes is an autoimmune condition in which the body's immune system attacks and destroys the insulin-producing beta cells in the pancreas. *Id.* 216:8-13. As a result, the pancreas produces little to no insulin. *Id.* People with Type 1 diabetes need to administer exogenous (i.e., laboratory-made) insulin in order to survive. *Id.* Type 2 diabetes is a chronic condition in which the body's cells become resistant to insulin; the pancreas may still produce insulin but the body stops responding effectively to it. *Id.* 216:18-22. Over time, the pancreas may no longer be able to produce enough insulin to keep blood glucose levels in the normal

range. *Id.* 216:23-25. Gestational diabetes is a type of diabetes that occurs during pregnancy when hormones produced by the placenta cause insulin resistance. *Id.* 217:19-24.

170. When blood sugar levels are not well controlled, patients with diabetes can develop a wide range of serious complications, including hypertension, cardiovascular disease, kidney disease, neuropathy, and retinopathy, which in turn can lead to heart attack, stroke, kidney failure, limb amputation, blindness, and death. Tr. 219:4-220:18 (Prentice). Patients with diabetes, especially those with Type 1, can also develop diabetic ketoacidosis ("DKA") when a lack of insulin prompts the body to begin breaking down fat cells as fuel, causing a buildup of acids, called ketones, in the blood. *Id.* 220:21-221:3. Untreated DKA causes cerebral edema, or swelling in the brain, which can lead to coma and death or long-term cognitive impairments. *Id.* 221:4-10. A patient's level of blood-sugar control is measured by a hemoglobin A1c ("HbA1c") test, a blood test that determines the patient's average blood sugar level over a three-month period. *Id.* 218:14-21.

171. Poorly controlled blood sugar also has a significant impact on fetal development, creating a risk of pregnancy loss or major congenital abnormalities. Tr. 231:10-14 (Prentice). Spine and heart development are particularly sensitive to increased blood sugar. *Id.* 229:4-17. The higher a patient's HbA1c level, the greater the risk of harm to a developing embryo or fetus. *Id.* 233:10-13.

172. Pregnancy makes it harder for people with diabetes to control their blood sugar and increases the risk that a patient will experience serious, long-term morbidity. Tr. 224:4-225:16 (Prentice). For example, pregnancy has been shown to accelerate the progression of diabetic retinopathy, which can cause blindness in working-age Americans. *Id.* 225:6-10. Some pregnant patients—particularly those who struggle to adequately control their blood sugar or

have a history of diabetic complications or hospitalizations—decide to have an abortion after considering the risks that continued pregnancy would pose to their own health as well as the likelihood of miscarriage or severe fetal harm. *Id.* 229:4-230:23. Terminating a pregnancy reduces the risk that a pregnant person with diabetes will experience serious morbidity as a result of that condition. *See id.* 231:1-6.

C. Patients With Fetal Indications for Abortion

1. Patients Carrying an Embryo or Fetus With a Life-Limiting Condition

173. The Total Abortion Ban prohibits therapeutic abortion in cases where a developing embryo or fetus has a life-limiting condition—i.e., a condition that is fatal or for which there is little or no prospect of long-term survival outside the uterus without severe morbidity, and for which there is no cure—unless the abortion is necessary to prevent the death of the pregnant person from a cause other than self-harm. Idaho Code § 18-622(1)-(2); Tr. 171:15-20 (Dahl) (citing ACOG, *Perinatal Palliative Care: ACOG Committee Opinion No. 786*, 134 Obstetrics & Gynecology e84, e85 (2019) (reaffirmed in 2024), https://doi.org/10.1097/aog.0000000000003425). The Fetal Heartbeat Act prohibits therapeutic abortion in a subset of such cases—when embryonic or fetal cardiac activity is detectable—unless the patient is experiencing a "medical emergency" that necessitates an "immediate abortion." Idaho Code §§ 18-8801(2), 18-8801(5), 18-8804(1).

174. But for the Abortion Bans, Dr. Seyb would provide therapeutic abortion care to all patients seeking abortion care from him carrying an embryo or fetus with a life-limiting condition. Tr. 114:1-115:22 (Seyb).

175. It is not possible to provide an exhaustive list of life-limiting embryonic and fetal conditions. Tr. 172:23-25 (Dahl). Illustrative examples include anencephaly; achondrogensis; bilateral renal agenesis; holoprosencephaly; HLHS; iniencephaly; LBWC; Meckel-Gruber

Syndrome; Osteogenesis Imperfecta Type II; sirenomelia; thanatophoric dysplasia; Triploidy; Trisomy 13; and Trisomy 18. *See infra* at ¶¶ 176-190.

176. Anencephaly is a neural tube defect where the fetal skull and scalp fail to fully develop, exposing fetal brain tissue to amniotic fluid, which causes it to degenerate. Tr. 174:17-22 (Dahl). It is a fatal condition with no available treatment. *Id.* 174:23-24. Fetuses with anencephaly have a higher rate of miscarriage or stillbirth, and neonates born with the condition can be expected to live only hours or days. *Id.* 175:2-4.

177. Achondrogenesis is a skeletal dysplasia in which the fetus's bones fail to develop properly. Tr. 175:17-25 (Dahl). The chest wall is abnormally small and compressed, which prevents the fetal lungs from developing properly. *Id.* This condition is fatal, and there is no available treatment. *Id.* 176:1-6.

178. Bilateral renal agenesis occurs when the fetus fails to develop kidneys, which causes anhydramnios or the complete absence of amniotic fluid. Tr. 176:10-20 (Dahl). Amniotic fluid is essential for fetal lung development. *Id.* Without it, a fetus develops pulmonary hypoplasia. *Id.* Bilateral renal agenesis is fatal, and only experimental treatments are available. *Id.* 176:21-177:9.

179. HLHS occurs when the left side of a fetal heart does not develop correctly, impairing normal blood flow throughout the body. Tr. 177:13-178:3 (Dahl). This condition, if untreated, is lethal within days to weeks due to the inability to pump blood from the left side of the heart to the remainder of the brain and body. *Id.*, 181:13-14. Treatment, which is palliative in nature, entails multiple cardiac surgeries that require extensive hospitalization and medical intervention as well as significant financial and post-surgery resources. *See id.* 178:10-181:8. These surgeries cannot correct the dysfunction of the heart but attempt to improve heart function

using one, instead of two, ventricles. *Id.* 178:6-9, 178:17-25. The mortality rate with palliative treatment is about 40%. *Id.* 181:9-12.

180. Iniencephaly is a neural tube defect that entails extreme and fixed retroflexion of the neck with the orbits permanently displaced upwards. Tr. 183:7-11 (Dahl). The chin is contiguous with the chest. *Id.* 183:11-12. There is a high rate of Caesarean delivery for fetuses with iniencephaly. *Id.* 183:13-18. Iniencephaly is a fatal condition, and there is no available treatment. *See Id.* 183:19-23.

181. LBWC, also known as body stalk anomaly, is a fetal malformation characterized by the attachment of fetal visceral organs to the placenta. *See* Tr. 184:8-11 (Dahl). It is associated with limb defects, deformity of the spine, and neural tube defects. *See id.* 184:11-12. Most people with LBWC terminate the pregnancy. *Id.* 184:17-18. If they do not, vaginal delivery is very difficult to achieve because there is nothing compressing the cervix, which is an essential component of labor. *Id.* 184:18-22. LBWC is a fatal condition, and there is no available treatment. *See id.* 184:13-15, 185:1-4.

182. Meckel-Gruber Syndrome is a genetic syndrome comprised of renal cystic dysplasia, abnormal brain development outside of the skull or other central nervous system abnormalities, and postaxial polydactyly (extra fingers or toes). Tr. 185:12-18 (Dahl). Due to the renal cystic dysplasia, the kidneys do not develop properly, leading to a deficiency in amniotic fluid or complete anhydramnios. *Id.* 185:13-16, 185:24-186:3. The condition is fatal, and there is no available treatment. *Id.* 185:19-186:3.

183. Holoprosencephaly is a birth defect where there is abnormal formation of the brain tissue. Tr. 186:6-8 (Dahl). Instead of two separate hemispheres of the brain, there is a connection between the two, which cause significant abnormalities in brain development. *Id.*

186:8-12. Holoprosencephaly causes severe intellectual disability, seizures, inability to perform any daily functions of living or achieve early milestones, hypotonia, and feeding issues. *Id.* 186:13-18. There are no treatments available for holoprosencephaly. *Id.* 186:19-20. Fifty percent of infants with holoprosencephaly die within the first few months of life, and 80% die within the first year of life. *Id.* 186:21-24.

184. Osteogenesis Imperfecta, also known as brittle bone disease, is a genetic disorder that leads to low bone mineral density, which causes extremely fragile bones that fracture easily. *See* Tr. 187:3-7 (Dahl). Type II is most severe form of the disease, causing severe bone deformities, a soft skull, and pulmonary hypoplasia. *See id.* 187:8-15. Osteogenesis Imperfecta Type II is fatal, and there is no available treatment. *Id.* 187:16-22.

185. Sirenomelia, also known as mermaid syndrome, entails fetal malformation characterized by having a single lower extremity. Tr. 188:2-5 (Dahl). There is also abnormal intraabdominal organ development and abnormal kidney function. *Id.* 188:6-7. It is commonly associated with bilateral renal agenesis or bilateral cystic dysplastic kidneys, leading to anhydramnios. *Id.* 188:6-10. There are no treatments available for sirenomelia, and death can be expected within hours of being born due to respiratory failure. *Id.* 188:11-15.

186. Thanatophoric dysplasia is a severe skeletal disorder that is associated with very short limbs, a small chest cavity leading to underdeveloped lungs, and central nervous system abnormalities. *See* Tr. 188:19-189:4 (Dahl). It is also associated with disproportionately large head development, which can cause cervical spine instability and brain stem compression. *Id.* 188:22-23, 189:2-4. There are no treatments available for thanatophoric dysplasia, and death is anticipated within hours of birth from respiratory failure. *Id.* 189:5-11.

187. Triploidy is a genetic condition in which an embryo has three complete sets of chromosomes instead of two. Tr. 189:14-17 (Dahl). Triploidy is associated with congenital heart conditions, abnormal brain development, cystic kidney disease, growth abnormalities, musculoskeletal abnormalities, facial abnormalities, cognitive impairment, and seizures. *See id.* 189:18-21. The condition is fatal, and there is no available treatment. *Id.* 189:22-190:1. There is an elevated risk of miscarriage or stillbirth with triploidy as well as an increased risk of pregnancy complications. *Id.* 189:25-190:4.

188. Trisomy 13 is a genetic condition in which an embryo has three copies of chromosome 13, instead of two. Tr. 190:7-9 (Dahl). Trisomy 13 is associated with multiple fetal anomalies, including brain anomalies, cardiac defects, renal abnormalities, and fetal growth restriction. *See id.* 190:10-13. Approximately 50% of cases will result in miscarriage or stillbirth if managed expectantly. *Id.* 190:16-20. Less than 50% of neonates with Trisomy 13 survive one week of life, and there is a 90% mortality rate in the first year of life. *Id.* 190:20-23.

189. Trisomy 18 is a genetic condition in which an embryo has three copies of chromosome 18, instead of two. Tr. 191:1-3 (Dahl). Trisomy 18 is associated with multiple fetal anomalies, including cardiac defects, musculoskeletal anomalies, omphalocele, congenital diaphragmatic hernia, spina bifida, and brain anomalies. *See id.* 191:4-9. Approximately 50% of cases will result in intrauterine fetal demise if managed expectantly. *Id.* 191:12-15. Ninety percent of babies born with Trisomy 18 die within the first month of life. *Id.* 191:16-18.

190. Before the Abortion Bans took effect, Dr. Seyb regularly provided abortion care to patients diagnosed with life-limiting embryonic or fetal conditions. Tr. 115:2-117:7 (Seyb). Now, he must refer those patients to out-of-state doctors when they want to terminate their pregnancies. *See id.* 117:1-7. Last fall, for example, he referred two patients with fatal fetal

conditions out of state. *Id.* 130:7-131:6. One was approximately twelve weeks' pregnant and carrying a fetus with anencephaly. *Id.* The other was approximately fourteen weeks' pregnant and carrying a fetus with LBWC. *Id.* Since the start of this year, he and his colleagues have referred approximately ten patients carrying an embryo or fetus with a life-limiting condition out of state, including another patient carrying a fetus with LBWC and one carrying a fetus with HLHS. *Id.* 131:7-14.

191. The Court does not credit Dr. Hughes's testimony that all "ladies" respond the same way to receiving a diagnosis that the embryo or fetus they are carrying has a life-limiting condition. Tr. 695:8-696:8 (Hughes). Likewise, the Court does not credit Dr. Hughes' testimony that all women react with nonchalance to the suffering and deaths of their newborns and then immediately resume their daily lives as if nothing happened. *Id.* 696:2-12 ("They take pictures. It's a wonderful event, and then the baby will die …. They have ceremonies, and they go on with their routine."). It appears that Dr. Hughes is projecting his own nonchalance onto his patients, without any real appreciation for the depth of anguish that some in this circumstance feel. The weight of the evidence demonstrates that there is no one-size-fits-all approach to dealing with the grief that accompanies the diagnosis of a life-limiting fetal condition. Tr. 1229:13-16, 1230:5-1231:3 (Eller). As discussed above, pregnant people wrestle with a number of highly individualized factors when deciding whether to terminate the pregnancy or carry it to term. *Supra* at ¶ 97. Some patients feel that there would be no point in enduring the risks and burdens of pregnancy if their baby would not survive after birth, while others feel an obligation to carry the pregnancy to term. *See* Tr. 116:11-25 (Seyb).

2. Patients Seeking a Multi-Fetal Pregnancy Reduction

192. The Medical Board takes the position that a multi-fetal pregnancy reduction "might" satisfy the definition of abortion under Idaho Code § 18-604(1). Ex. 1010 at 9-10.

None of the other Defendants have disavowed that multi-fetal pregnancy reduction is prohibited by the Abortion Bans. Accordingly, Dr. Seyb faces a credible threat of enforcement of the Total Abortion Ban for providing a multi-fetal pregnancy reduction unless it is necessary to prevent the death of the pregnant person from a cause other than self-harm. Idaho Code § 18-622(1)-(2). Dr. Seyb faces a credible threat of enforcement of the Fetal Heartbeat Act for providing a multi-fetal pregnancy reduction in a subset of such cases—when embryonic or fetal cardiac activity is detectable—unless the patient is experiencing a "medical emergency" that necessitates an "immediate abortion." Idaho Code §§ 18-8801(2), 18-8801(5), 18-8804(1).

193. But for the Abortion Bans, Dr. Seyb would provide a multi-fetal pregnancy reduction to all patients who sought that care from him. Tr. 115:11-22 (Seyb).

194. Multifetal pregnancies pose serious risks to both the pregnant patient and the developing embryos and fetuses, especially in cases of higher-order multiples. Tr. 115:11-22 (Seyb); Tr. 385:24-386:14 (Eller). Performing a pre-viability procedure to reduce the total number of gestations both decreases the risk of serious injury and death for the patient and increases the likelihood of survival for the remaining embryos or fetuses. Tr. 134:10-23 (Seyb); Tr. 386:15-387:11 (Eller).

195. Patients sometimes have multi-fetal pregnancies where one or more fetuses are affected by serious anomalies that put the other fetuses at risk. Tr. 134:17-23 (Seyb); Tr. 387:12-389:1 (Eller). For example, twin pregnancies can be affected by a developmental or genetic anomaly in one twin while the other twin is healthy. Tr. 136:14-22 (Seyb); Tr. 387:12-389:1 (Eller). Reducing the pregnancy to a single fetus can provide significant benefits to the unaffected fetus, significantly increasing its chance of survival. Tr. 387:12-389:1 (Eller).

196. Over the course of his career, before the Abortion Bans took effect, Dr. Seyb performed several reduction procedures for patients with multiple gestations. Tr. 134:6-138:6 (Seyb). For example, he treated a patient carrying quadruplets and reduced the pregnancy to twins. *Id.* 135:7-16. The patient subsequently delivered near term without complication. *Id.* Dr. Seyb also had a case where he was not able to provide intervention soon enough. *Id.* 135:17-136:4. The patient was pregnant with septuplets and wanted to reduce the pregnancy, but she ultimately miscarried all the fetuses at ten weeks of pregnancy, before he was able to perform the procedure. *Id.*

197. Recently, Dr. Seyb treated a patient carrying twins. Tr. 136:14-138:6 (Seyb). One twin was healthy and the other had a fatal condition. *Id.* Absent intervention, the patient would have faced a heightened risk of miscarriage as well as pre-eclampsia, gestational diabetes, and postpartum hemorrhage. *See id*. 136:18-22; Tr. 386:25-387:19 (Eller). She wanted to reduce the pregnancy, but the Abortion Bans prevented Dr. Seyb from performing the procedure in Idaho. Tr. 136:14-137:3 (Seyb). Instead, he referred the patient to a practice group in Utah. *Id.* Dr. Eller performed a reduction procedure for the patient, who ultimately delivered a healthy baby at full term. Tr. 399:12-21 (Eller). The patient sent Dr. Eller a copy of her birth announcement, which acknowledged both the pain she experienced at the loss of the co-twin and the joy she experienced at welcoming her first child. *Id.*

D. Chilling Effect

198. The Abortion Bans also have a chilling effect on the provision of abortion care even in cases where continued pregnancy would pose life-threatening risks to the patient. Tr. 139:3-142:22 (Seyb). That is because it is often impossible for Dr. Seyb and his colleagues to determine that an abortion is *necessary* to prevent a patient's death. *See id.* Medical outcomes are rarely certain. Tr. 153:6-16 (Seyb); Tr. 261:2-11 (Payne); Tr. 368:12-15 (Eller). At best,

doctors can assess the probability of an outcome based on clinical evidence and prior experience, but every patient's circumstances are unique, and such assessments are not mathematically precise. *See id*; Tr. 83:11-17 (Smid).

199. Because of the uncertainty inherent in predicting patient outcomes, it is possible for reasonable doctors to disagree about whether an abortion is necessary to prevent a patient's death. Tr. 83:11-17 (Smid); Tr. 1199:19-22 (Kraus); Ex. 1010 at 15. Dr. Seyb fears that, even if he believes that an abortion is necessary to prevent the death of one of his patients, another doctor will second-guess his judgment, and a prosecutor will file charges against him on that basis. *See id*; Tr. 165:3-11, 142:16-22, 148:5-9 (Seyb). The Idaho Supreme Court has confirmed that this fear is reasonable, holding that: "a prosecutor may attempt to prove that the physician's subjective judgment that an abortion was 'necessary to prevent the death of the pregnant woman' was not made in 'good faith' by pointing to other medical experts on whether the abortion was, in their expert opinion, medically necessary." *Planned Parenthood Great Nw.*, 522 P.3d at 1204.

200. The State's own medical experts disagree with one another about circumstances in which abortion is necessary to save a pregnant person's life, as well as with Dr. Seyb. Dr. Hughes thinks that no pregnancy-related medical condition is truly life threatening, while Dr. Kraus thinks that most conditions that pose a serious risk to a pregnant person's health also threaten their life. *Compare* Tr. 682:6-20, 732:17-19; 733:7-23; 741:10-13 (Hughes), *with* Tr. 1208:3-10, 1211:4-13 (Kraus).

201. During her direct examination, Dr. Kraus second-guessed many of the judgment calls that Dr. Seyb has made over the past three years, claiming it was clear that abortion was necessary to save the patient's life in cases where Dr. Seyb thought the risk of death was too attenuated to satisfy the Abortion Ban's exceptions. Tr. 1152:2-1160:10 (Kraus). On cross,

however, Dr. Kraus admitted that not all cases of pregnancy-related risk are clear cut. *Id.* 1201:2-11 ("And so, Dr. Kraus, what if the prior instance of postpartum cardiomyopathy wasn't class IV? What if it was a different class? Do you still think an abortion would have been necessary to save the patient's life? / A. I think it would be a harder argument to make. You know, in those cases where there was a history of cardiomyopathy and then there was a recovery of normal heart function, the risks are significantly less. Certainly there's a higher risk of it happening again. But again, that would be—that would be more gray."). This admission accords with testimony she previously provided to the Nebraska legislature, explaining that physicians encounter "many difficult and complex medical situations … whether it be an acute emergency, as in hemorrhage or sepsis, or a chronic medical condition that puts a mother at high risk for morbidity and even mortality, in pregnancy." *Id.* 1183:14-1184:3, 1185:2-10.

202. Moreover, Idaho's Attorney General has openly expressed hostility to abortion and abortion providers in both court filings and public statements. Tr. 140:21-141:25 (Seyb); *see* Raúl R. Labrador, *Labrador Letter: Defending Idaho's Pro-Life Laws*, Idaho Off. Att'y Gen. (Oct. 27, 2025), https://www.ag.idaho.gov/newsroom/labrador-letter-defending-idahos-pro-life-laws/ [https://perma.cc/89ZE-6VMT] (criticizing Dr. Seyb in a newsletter for bringing this lawsuit and alleging that "[p]atients suffered" because "Dr. Seyb failed to understand Idaho law and neglected to educate himself on his professional duties and responsibilities"); Br. for Pet'r at 3, 5, *Moyle v. United States*, 603 U.S. 324 (2024) (No. 23-727) (discussing Idaho's 150-year commitment to prohibiting abortion). Additionally, Idaho's legislature has declined to expand or clarify the medical exception in the statute to provide doctors with a manifest safe harbor for providing abortion care to patients with serious medical needs. *See* Tr. 142:1-4 (Seyb); *see* H.B.

374, 2023 Idaho Sess. Laws 906. These governmental actions and omissions exacerbate the statute's chilling effect on doctors who treat pregnant patients. *Id.* 142:5-7 (Seyb).

203. Further, violating either one of the Abortion Bans constitutes a felony that is punishable by two to five years in prison, as well as grounds for a doctor's medical license to be suspended or revoked. Idaho Code §§ 18-622(1), 18-8805(2)-(3). Such high stakes cause doctors to err on the side of denying care to patients. Tr. 139:3-140:20 (Seyb).

204. In recent years, Dr. Eller has provided therapeutic abortion care in Utah for some Idaho patients facing a high risk of pregnancy-related mortality because no doctor in Idaho was willing to do so. Tr. 398:17-400:16 (Eller).

205. Many OB-GYNs, including some of Dr. Seyb's colleagues at St. Luke's, have ceased practicing medicine in Idaho rather than face the risk of criminal prosecution for providing medically indicated care to their patients. Tr. 140:2-144:1. (Seyb). Indeed, on July 31, 2025, the medical journal JAMA Network Open published a study assessing changes in the number of OB-GYNs practicing obstetrics in Idaho after the Abortion Bans took effect. *Id.* 144:2-23, 146:23-147:6 (citing J. Edward McEachern, et al., *Change in Number of OB/GYN Physicians Practicing Obstetrics After the Dobbs Decision*, 2025 JAMA Network Open e2524893 [hereinafter McEachern], https://doi.org/10.1001/jamanetworkopen.2025.24893). It concludes that, between August 2022 and December 2024, Idaho had a net loss of ninety-four OB-GYNs practicing obstetrics, more than one-third of the total number of such doctors practicing in the state. *Id.* (citing McEachern at 2).

206. Dr. Hughes's testimony that he is not "scared of prosecution" under Idaho Code § 18-622, Tr. 713:15-18 (Hughes), that Dr. Seyb's concerns about prosecution are unreasonable, *id.* 713:19-714:2, and that physicians do not need to be afraid of criminal prosecution under either

Abortion Ban, *id.* 735:23-737:1, is given no weight. Dr. Hughes is retired. *Id.* 669:3-5. He testified that, for conscientious reasons, he never provided abortion care when he was a practicing OB-GYN, and he never counseled a patient about abortion as an option. *Id.* 737:10-14, 738:2-4, 8-15. In fact, Dr. Hughes testified that there are no maternal or fetal medical conditions for which he would counsel a patient that abortion is an option. *Id.* 738:25-739:3. He referred his high-risk patients to MFMs, including many to Dr. Seyb. *Id.* 737:14-16, 742:5-19. Only once in his career did he think a patient under his own care needed a life-saving abortion, and he handed that patient off to other doctors to perform the procedure. *Id.* 726:20-728:7, 741:14-22. A physician who is no longer in practice, who never provided abortion care when he was in practice, and who passed the potential liability for providing abortions onto other doctors has no reason to fear prosecution under the Abortion Bans and is not in the same position as doctors who actually provide therapeutic abortions.

IX. Historical Treatment of Therapeutic Abortion in American Law and Society

A. Fundamental Rights to Life and Health

207. The right to therapeutic abortion is a specific application of the fundamental rights to life and health, both of which are deeply rooted in this nation's history and tradition and implicit in the concept of ordered liberty.

208. Blackstone reports that first among the "absolute rights of every Englishman" is the "right of personal security." 1 William Blackstone, *Commentaries on the Laws of England* 127–128 (Thomas M. Cooley ed., Callaghan & Cockcroft, 1871) (1765) [hereinafter 1 Blackstone], https://repository.law.umich.edu/books/100/. "The right of personal security consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation." *Id.* at 129. "Both the life and limbs of a man are of such high value, in the estimation of the law of England, that it pardons even homicide if committed *se*

defendendo, or in order to preserve them." *Id.* at 130. "Besides those limbs and members that may be necessary to a man, in order to defend himself or annoy his enemy, the rest of his person or body is also entitled, by the same natural right, to security from the corporal insults of menaces, assaults, beating, and wounding; though such insults amount not to destruction of life or member." *Id.* at 134. Blackstone further says that the "preservation of a man's health from such practices as may prejudice or annoy it" is an established component of the right to personal security." *Id.*

209. The right of self-defense is a corollary of the right of personal security described by Blackstone. 4 William Blackstone, *Commentaries on the Laws of England* 183-84 (Thomas M. Cooley ed., Callaghan & Co., 3d ed. rev., 1884) (1769) [hereinafter 4 Blackstone], https://repository.law.umich.edu/books/98/. The Supreme Court has recognized that "[s]elf-defense is a basic right, recognized by many legal systems from ancient times to the present day." *McDonald v. City of Chicago*, 561 U.S. 742, 767 (2010). Further, it is "the *central component*" of the Second Amendment right to bear arms. *Id.* (quoting *District of Columbia v. Heller*, 554 U.S. 570, 599 (2008)). Today, every state allows use of deadly force against threats of death or serious bodily injury to oneself or a third party. Paul H. Robinson et al., *The American Criminal Code: General Defenses*, 7 J. Legal Analysis 37, 49–53 (2015).

210. The necessity doctrine is closely related to the right of self-defense. At common law, "the defense of necessity, or choice of evils, . . . covered the situation where physical forces beyond the actor's control rendered illegal conduct the lesser of two evils." *United States v. Baily*, 444 U.S. 394, 410 (1980). Blackstone illustrates this doctrine by recounting a case of two shipwrecked men. 4 Blackstone at 186. They both seek refuge from the sea on the same piece of driftwood, but it is too small to support both of them, so "one of them thrusts the other from it,

whereby he is drowned." *Id.* "He who thus preserves his own life at the expense of another man's is excusable through unavoidable necessity, and the principle of self-defen[s]e: since their both remaining on the same weak plank is a mutual, though innocent, attempt upon, and an endangering of each other's life." *Id.*

211. The right to bodily integrity is likewise a corollary of the right of personal security. As the Supreme Court has explained, "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

212. The right to health is intertwined with the right to life. Its fundamental nature is reflected in the Eighth Amendment requirement that the government "provide medical care for those whom it is punishing by incarceration." *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).[4] Deliberate indifference to the "serious medical needs of prisoners" violates the Eighth Amendment prohibition on cruel and unusual punishment. *Id.* at 104. The fundamental nature of the right to health is further reflected in the law's historical treatment of the practice of medicine, consistently affording immunity from criminal liability to practitioners who act with therapeutic intent and exercise due care. *See infra* at ¶¶ 237-40.

213. In accordance with these deeply rooted rights, therapeutic abortion enjoyed consistent legal protection from the medieval period through the early twentieth century. *See infra* at ¶¶ 241-47, 258-260, 263-65, 273, 276, 278, 287-94, 303-304, 314.

[4] The Due Process Clause likewise requires the government to provide medical care to individuals who are in governmental custody for reasons other than a criminal conviction. *See Gordon v. County of Orange*, 888 F.3d 1118, 1122-23 (9th Cir. 2018).

B. Abortion and Related Medical Treatments During the Medieval and Early Modern Periods

214. In England, the medieval period began in approximately 600 and continued to approximately 1500. Tr. 457:21-23 (Eppinger). To the best of our knowledge, there were no English people living in North America during the medieval period. *Id.* 458:2-4. The early modern period began in approximately 1500 and continued to 1776. *Id.* 457:24-458:1, 458:10-12. English colonists first began to inhabit North America during this period. *Id.* 458:6-9. After a failed attempt in Roanoke, they established the first permanent English settlement in North America at Jamestown in 1607. *Id.* The American colonies declared their independence from England in 1776, ushering in the start of a new historical era in both England and the United States. *See id.* 457:24-458:1, 458:10-12.

215. There is substantial evidence in the form of medical treatises, medical practice manuals, medical textbooks, diaries, letters, and biographies that, throughout the medieval and early modern periods, health practitioners in England and the American colonies administered both emmenagogic treatments, which were intended to restore menstruation in a woman who had ceased menstruating and were known to pose a risk of miscarriage, and abortifacient treatments, which were intended to terminate a diagnosed pregnancy for therapeutic reasons. Tr. 451:9-455:23, 466:12-467:25, 468:12-470:11 (Eppinger). In disputing the safety and efficacy of these treatments, the State misses the point. What matters is that members of medieval and early modern society *believed* that these treatments were safe and effective by the standards of the day and regularly utilized them. *See id.* 466:20-467:8, 471:10-472:10; Tr. 879:8-15 (Dellapenna). Certain methods of restoring menstruation and inducing abortion were considered unduly risky, however, and were disfavored by health practitioners. Tr. 473:1-8 (Eppinger). The law treated

emmenagogic and abortifacient practices differently depending on contemporaneous understandings of their therapeutic value. *See* Eppinger Article at 694-97.

216. To understand the therapeutic significance of emmenagogic and abortifacient treatments in medieval and early modern England and the American colonies, it is necessary to understand the paradigm of health that prevailed in those times and places. During the medieval and early modern periods of history, humoral theory was the prevailing paradigm for understanding health in Europe, and European colonizers carried it to North America. Tr. 459:3-5, 460:15-25 (Eppinger). Humoral theory is heavily influenced by the Hippocratic tradition of ancient Greece and the work of Claudius Galen, a physician who practiced in ancient Rome. *Id.* 460:3-10.

217. According to humoral theory, good health depends on maintaining a proper balance of four humors associated with bodily fluids—blood, phlegm, black bile, and yellow bile. Tr. 459:6-23 (Eppinger); Eppinger Article at 676-77. An imbalance of the humors causes illness and requires medical intervention. Tr. 459:24-460:2 (Eppinger); Eppinger Article at 677. Bloodletting, also known as venesection, is a classic example of a humoral intervention. Eppinger Article at 677.

218. New paradigms of medicine began to emerge in the eighteenth century and gradually replaced humoral theory, but its influence persisted through the early twentieth century. *See* Tr. 461:1-462:2, 542:20-543:13, 545:8-19 (Eppinger); Eppinger Article 701-03, 723-24; *infra* at ¶¶ 309-12.

219. In the humoral health regime, menstruation was thought to play an important role in women's health by purging excess blood and thereby regulating the blood humor. Tr. 463:18-464:20 (Eppinger); Eppinger Article at 678-79. Amenorrhea, or the absence of menstruation,

was understood to cause a dangerous build-up of waste materials in a woman's body that any responsible medical practitioner would find incumbent to address. Tr. 464:21-25, 465:23-466:11 (Eppinger); Eppinger Article at 679-80. Indeed, the most commonly prescribed medications for women in medieval medical texts were intended to treat amenorrhea. Tr. 466:20-467:8 (Eppinger). People generally understood that a connection exists between pregnancy and cessation of menstruation. Tr. 465:15-22 (Eppinger); Eppinger Article at 679. But "retained menses" and "pregnancy" were not synonyms; these two conditions were thought to exist in parallel. *See* Tr. 465:1-2, 465:15-466:11 (Eppinger); Eppinger Article at 679.

220. Evidence indicates that amenorrhea remained a significant cause of medical concern through the early years of the twentieth century. For example, Professor Dellapenna notes that:

> From the nineteenth century, we find the diary of Mary Poor (wife of the founder of Standard and Poor's), who birthed seven children and had at least two miscarriages during a period of 22 years, yet her diary shows her frequently fretting for months even near the end of her childbearing years over whether a missed period signaled another pregnancy or some other problem.

Ex. 10 at 191; Tr. 877:14-17 (Dellapenna). And the Oregon medical board exam administered in July 1911 asked test-takers to describe the treatment for amenorrhea, demonstrating that the subject was still a part of medical school curriculum at that time. Tr. 985:1-3, 985:19-986:8 (Cohen).

221. During the medieval and early modern periods, there was no objective way to diagnose pregnancy. *See* Tr. 465:4-8 (Eppinger). Hormonal pregnancy tests and prenatal imaging were not developed until the twentieth century. *Id.* 468:4-5; Eppinger Article at 670 & n.28. Instead, society relied on a woman's perception of fetal movement to diagnose pregnancy. Tr. 465:4-8 (Eppinger). The point in pregnancy when a woman feels movement for the first time is known as quickening. *Id.* It typically occurs at four to five months' gestation. *Id.* 465:10-14.

Before quickening, pregnancy might be suspected, but it could not be confirmed. *See id*. 465:18-466:5, 468:1-11.

222. The most common emmenagogic treatments involved medications derived from plants, administered either orally or vaginally through use of a pessary, a ball of cotton or other tampon-like object that could be soaked in a medicinal liquid. Eppinger Article at 683-84. In the hands of unskilled practitioners, these substances could result in injury and death. Tr. 472:11-25 (Eppinger); Eppinger Article at 700. In the hands of skilled practitioners, they were understood to be generally safe, at least by contemporaneous standards of care, which relied heavily on purgatives and bloodletting. *Id.* 462:3-10, 471:10-472:10; Eppinger Article at 677, 686-87. Medical practitioners were aware that emmenagogic medications had the potential to cause a miscarriage if a woman were pregnant. *See id.* 467:9-19.

223. Medical practitioners did sometimes seek to terminate a known pregnancy for therapeutic reasons, and plant-based medications were the primary method they employed for this purpose, too. Tr. 468:12-469:6 (Eppinger); Eppinger Article at 684-85. Medical texts distinguished between emmenagogic and abortifacient medications, but there was overlap between the two categories. Tr. 467:9-25 (Eppinger); Eppinger Article at 682-83.

224. During the medieval and early modern periods, abortifacient interventions involving uterine intrusion, such as inserting a sharp object through the vagina, were discussed but generally disfavored because they posed a greater risk of injury or death to the patient. Tr. 471:3-9, 473:1-5 (Eppinger); Eppinger Article at 686-87.

C. Abortion Under the Common Law

1. Influences on the Early Common Law

225. English common law was not sui generis. Its development, beginning in 1066 with the Norman Conquest of England, was influenced by a wide variety of sources, including ancient cultures and legal traditions. Tr. 473:11-24 (Eppinger).

226. In ancient Greece, Aristotle expounded a doctrine known as "mediate animation," which influenced Western thought for centuries.[5] *See* Tr. 474:23-475:3 (Eppinger); Tr. 846:21-847:3, 849:19-850:7 (Dellapenna); Ex. 10 at 158-59. The doctrine holds that a developing embryo and fetus, conceived with a vegetative soul, does not become a sensitive animal until forty days after conception if it is male or eighty to ninety days after conception if it is female, and does not become a rational human being until shortly before birth. *See* Ex. 10 at 158; 1 Aristotle, *Generation of Animals*, *in The Complete Works of Aristotle* 1111, 1142-43 (Jonathan Barnes ed., A. Platt trans., Princeton Univ. Press 1995) (1984).

227. Ancient Greek law permitted and sometimes even required infanticide for population control and eugenic purposes. Ex. 10 at 155. To the extent that Greek law regulated abortion, it did so not out of regard for fetal life, but to optimize eugenic practices. *Id.*

228. The ancient Romans treated abortion as a legal offense, but only against the husband of a pregnant woman if he neither commanded nor consented to the abortion. Ex. 10 at

[5] Twentieth-century theologian Joseph Doncheel argued that this terminology is misleading and the term mediate or delayed "hominization" would be more apt. *See, e.g.*, Joseph F. Donceel, S.J., *Immediate Animation and Delayed Hominization*, 31 Theological Studies 76, 76 (1970) ("Animation means that an organism is animated, has a soul (*anima*), is alive. Thus the term 'delayed animation' seems to imply that the partisans of this theory hold that the embryo is not alive immediately after conception. Such is not their position. They claim that the embryo is alive, that it is animated from the very start, but the soul which animates it is not yet a human soul, is a vegetative or animal soul; the human soul comes later. Animation is immediate, hominization is delayed.").

156. In Roman society, a fetus was not viewed as a living person distinct from its mother until it was born. *Id.* According to Professor Dellapenna: "All in all, Roman law appears to disclose a culture in which abortion law was designed to protect the rights of the father rather than the fetus." *Id.* at 157.

229. Early Jewish tradition distinguished between consensual and non-consensual abortion. It permitted consensual abortion if continued pregnancy "posed a threat to the mother's well-being." Ex. 10 at 154. It prohibited non-consensual abortion, but similar to Roman law, treated it as an offense against the putative father. A well-known passage from the Old Testament states: "When men have a fight and hurt a pregnant woman, so that she suffers a miscarriage, but no further injury, the guilty one shall be fined as much as the woman's husband demands of him, and he shall pay in the presence of the judges." Exodus 21:22 (New Am. Bible rev. ed. 2011).[6]

230. Early Canon Law and influential Catholic thinkers in the medieval period such as Augustine of Hippo and Thomas Aquinas adopted Aristotle's view of mediate animation. Ex. 10 at 159. Medieval Canon Law nevertheless condemned abortion, at least in some circumstances, for reasons unrelated to fetal personhood, just as it condemned contraception. *Id.* at 154, 158-59.

231. During the medieval and early modern periods, there was no societal consensus on when a developing embryo[7] or fetus acquired the essential attributes of human personhood. Tr. 479:16-24 (Eppinger).

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[6] The passage continues: "But if injury ensues, you shall give life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, stripe for stripe." Exodus 21:23-25 (New Am. Bible rev. ed. 2011).

[7] During the medieval period, the Latin term "conceptus" was generally used to describe the products of human conception during the early stages of development. Tr. 478:16-20 (Eppinger). The term "embryo" began to enter the English lexicon in the early modern period. Tr. 478:21-479:15 (Eppinger).

2. Features of the Common Law Relevant to Therapeutic Abortion

232. The principal evidence concerning the common law's treatment of abortion during the medieval and early modern periods comes from treatises summarizing the common law. Tr. 484:10-13 (Eppinger). There are few records of actual court proceedings concerning abortion from this time, and those that do exist are incomplete and ambiguous. *See* Ex. 10 at 135-36 (describing medieval court records concerning abortion as "terse" and noting that they often lack information about the outcome of a proceeding); *id.* at 137 ("Records finding 'not guilty,' … often contain more detail than records for which we do not know the outcome, yet we still do not know the arguments that were made about the law or the theories that the court relied on in the case."); *id.* at 152 (explaining that most early legal proceedings involving ingestion abortions were actually prosecutions for witchcraft in ecclesiastical courts); *id.* at 170 ("During the fifteenth century, there are almost no records of prosecutions for abortion in the royal courts ….").

233. Professor Dellapenna claims that his research unearthed scores of cases from these periods concerning criminal prosecutions for abortions. But shockingly, none of these cases involves a prosecution under the common law of England for a consensual abortion. The cases on which Professor Dellapenna relies fall into two groups. The first group concerns prosecutions in royal courts under the common law for violent assaults against pregnant women that caused miscarriages. *See* Ex. 10 at 135-38, 172; Tr. 852:2-6 (Dellapenna). The second group concerns prosecutions in ecclesiastical courts under Canon law for witchcraft. *See* Ex 10. at 152-53, 159-68, 172; Tr. 856:10-18 (Dellapenna). Professor Dellapenna states:

> The division of responsibility between lay and church courts fell more or less, albeit imperfectly, along these lines: The royal courts focused on keeping the King's peace; the church courts focused on crimes against conscience that did not involve violence or a threat of major social disruption. The division in itself would account for the royal courts' concern with violent injury abortions, and the

> church courts' concern with the perhaps voluntary ingestion abortions. Indeed, the apparently voluntary attempts at abortion through injury techniques were prosecuted in a church court rather than in a royal court. In addition to the likelihood that an ingestion abortion was voluntary rather than coerced, when abortion was sought through ingesting a potion it seemed to smack of magic sufficiently to seem devil's work.

Ex. 10 at 172. Notably, witchcraft was neither a synonym nor a euphemism for abortion. Tr. 855:3-11 (Dellapenna). A broad array of conduct was punished by Church authorities as witchcraft. *See* Ex. 10 at 168-69. The witchcraft prosecutions at the core of Professor Dellapenna's opinions in this case happened to include some form of pregnancy loss in the fact pattern, but they were not prosecutions for abortion *per se*. *See* Tr. 853:21-23, 855:3-11 (Dellapenna). Neither the assault cases nor the witchcraft cases support the claim that English common law treated therapeutic abortion—or any consensual abortion—as a crime.

234. Several major treatises contribute to our understanding of English common law. Henry de Bracton's *On the Laws and Customs of England* (1220-1230) is regarded as the authoritative statement of English common law from the medieval period. Tr. 485:13-486:8 (Eppinger). Sir Edward Coke's *Institutes of the Lawes of England* (1628-1644) and Sir Matthew Hale's *The History of the Pleas of the Crown* (1736) are comprehensive statements of English common law written in the seventeenth century.[8] Tr. 486:17-487:17 (Eppinger). William Blackstone's *Commentaries on the Laws of England* (1765-1769) is a comprehensive statement of English common law written in the eighteenth century. Tr. 487:18-488:6 (Eppinger). Each of these treatises was generally well known by courts and legal practitioners in colonial America and the early American republic. Tr. 488:7-17 (Eppinger); *see* Tr. 873:24-874:12, 876:17-25 (Dellapenna).

[8] Professor Dellapenna believes that Hale reported the law with more historical accuracy than Coke, and Plaintiff does not dispute this. Tr. 874:13-15 (Dellapenna); Ex. 10 at 206.

235. Three key features of the common law relevant to therapeutic abortion emerge from these treatises: (1) the common law granted immunity from criminal liability to health practitioners acting with therapeutic intent; (2) the common law took a nuanced approach to regulating abortion that varied based on the stage of pregnancy, the method employed, and the reason for ending a pregnancy; (3) the common law did not accord personhood status to prenatal life. *See infra* at ¶¶ 236-56.

a. Legal Immunity for Acts Done with Therapeutic Intent

236. Although Bracton did not discuss the law's treatment of medical practice per se, his discussion of homicide has implications for medical practice. Tr. 488:25-489:6 (Eppinger). Bracton's treatise, written in the thirteenth century, contains a complex taxonomy of homicide. *See* Henry de Bracton, 2 *On the Laws and Customs of England* 340-42 (Samuel E. Thorne trans., Harv. Law Sch. Libr. online ed. 2003) (1210-1268) [hereinafter Bracton], https://amesfoundation.law.harvard.edu/Bracton/Common/SearchPage.htm. According to Bracton, homicide may be classified as spiritual or corporal. *Id.* at 340. Corporal homicide may be committed by word or by deed. *Id.* Homicide by word may be committed by precept, by counsel, and by denial or restraint. *Id.* Homicide by deed may be committed in the administration of justice, of necessity, by chance, and by intention. *Id.*

237. Of these, homicide by chance is the most relevant to medical practice. *See* Tr. 489:11-490:2 (Eppinger). Bracton reports that a person is liable for homicide by chance if they unintentionally cause a person's death while (1) engaging in an unlawful activity or (2) failing to exercise due care while engaging in a lawful activity. Bracton at 341. In contrast, a person engaged in a lawful activity who exercises due care is not liable for unintentional deaths caused by their actions. *Id.* Although Bracton does not expressly discuss this doctrine's application to medical practice, logically it would have shielded a healthcare provider acting within the

prevailing standard of care from liability for the unintentional death of a patient. *See id.*; Tr. 489:11-490:2 (Eppinger).

238. By the time Coke writes in the early seventeenth century, the common law had evolved to provide explicit protection for healthcare providers. Coke states: "If one that is of the mysterie of a physician take a man in cure and giveth him such physick as within three days he dye thereof, without any felonious intent, and against his will, it is no homicide." Edward Coke, *The Fourth Part of the Institutes of the Laws England, Concerning the Jurisdiction of Courts* 251 (Leon E. Bloch Law Library, UMKC Sch. Of Law, digital ed.) (1648), https://irlaw.umkc.edu/cgi/viewcontent.cgi?article=1001&context=coke_institutes_lawes. Hale describes the immunity the common law afforded a healthcare provider even more broadly: "If a phy[si]cian gives a person a potion without any intent of doing him any bodily hurt, but with an intent to cure or prevent a di[seas]e, and contrary to the expectation of the physician it kills him, this is no homicide, and the like of a chiurgeon." 1 Matthew Hale, *The History of the Pleas of the Crown* 429 (1736) [hereinafter Hale], https://wythepedia.wm.edu/library/HaleHistoryOfThePleasOfTheCrown1736Vol1.pdf. Blackstone writes: "If a physician or surgeon gives his patient a potion or plaster to cure him, which contrary to expectation, kills him, this is neither murder nor manslaughter, but misadventure; and he shall not be punished criminally, however liable he might formerly have been to a civil action for neglect or ignorance".[9] 4 Blackstone at 196-97.

[9] Blackstone addresses medical malpractice in the section of the Commentaries dealing with civil, rather than criminal wrongs. 3 William Blackstone, *Commentaries on the Laws of England* 122 (Thomas M. Cooley, ed., Callaghan & Co., 3d ed. rev., 1884) (1768) ("3 Blackstone"), https://repository.law.umich.edu/books/98/. He states that "injuries affecting a man's *health*" caused by "the neglect or unskilful management of his physician, surgeon, or apothecary" may serve as the basis for an action to recover damages. *Id.* In the course of this discussion, he notes that "*mala praxis*," Latin for malpractice, *see Mala Praxis*, Black's Law Dictionary (12th ed. 2024), "is a great misdemeanor and offense at common law, whether it be for curiosity and experiment or by neglect; because it breaks the trust which the party had placed in his physician,

239. Thus, from the thirteenth century to the eighteenth century, the common law shielded medical practitioners acting with due care and therapeutic intent from liability for any death they caused.[10] *See* Tr. 489:11-490:2, 490:8-491:16, 492:5-493:4, 493:7-495:14 (Eppinger).

240. Nineteenth-century American courts followed this common law tradition. *See, e.g.*, *Rice v. State*, 8 Mo. 561, 563 (1844) (reversing a physician's conviction for manslaughter in connection with the death of a pregnant patient) ("We are not aware of the existence of a law which prohibits any man from prescribing for a sick person with his consent, if he honestly intended to cure him by his prescription, however ignorant he may be of medical science.");

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and tends to the patient's destruction." 3 Blackstone at 122. He does not, however, discuss medical malpractice further in the section of his treatise dealing with crimes, and his discussion of homicide suggests that medical malpractice could not serve as the basis for a manslaughter indictment. *See* 4 Blackstone at 197.

[10] There was disagreement in the legal community about whether this immunity extended only to licensed physicians and surgeons or to unlicensed healthcare providers, such as midwives, as well. *See* Hale at 429-30. Hale says: "And I hold their opinion to be erroneous, that think, if he be no licensed chiurgeon or physician, that occasioneth this mischance, that then it is felony, for physic and salves were before licensed physicians and chirurgeons." *Id.* at 429; *see also id.* at 430 ("This doctrine therefore, that if any die under the hand of an unlicensed physician, it is felony is apocryphal, and fitted, I fear, to gratify and flatter doctors and licentiates in physic …."). He takes the view that unlicensed healthcare providers may be subject to statutory penalties for practicing medicine without a license, but not to criminal liability. *Id.* at 429-30. And he believes that there are good reasons for the law to take this approach, particularly with respect to midwives: "And certainly if that opinion should obtain, that is one not licensed a physician should be guilty of felony, if his patient miscarry, we should have many of the poorer sort of people, especially remote from London, die for want of help, lest their intended helpers might miscarry. *Id.* at 430. Hale's reasoning suggests that at least one purpose in granting medical practitioners immunity from liability was to ensure that the common law did not interfere with people's access to vital health services. Blackstone notes the disagreement but does not take a position. 4 Blackstone at 197 ("[B]ut it hath been holden, that if it be not a *regular* physician or surgeon, who administers the medicine, or performs the operation, it is manslaughter at the least. Yet, Sir Matthew Hale very justly questions the law of this determination.").

The tension between—and the relative political power of—*regular* physicians and *irregular* healthcare providers goes on to play a significant role in the regulation of medicine generally and abortion specifically in the nineteenth century both in England and the United States. *See infra* at ¶¶ 268, 271-72.

Commonwealth v. Thompson, 6 Mass. 134, 134 (1809) (acquitting a physician of homicide in connection with the death of a patient) ("If one, assuming the character of a physician, through ignorance administer medicine to his patient, with an honest intention and expectation of a cure, but which causes the death of the patient, he is not guilty of felonious homicide."). They were open to the possibility of criminal liability for healthcare providers only when they engaged in extreme recklessness or had reason to know that the treatment they administered was likely to be fatal. *See Rice*, 8 Mo. at 564 ("Although a physician cannot be indicted for murder or manslaughter, if a patient die under his prescriptions when his intentions were honest, yet it has been held that *mala praxis* is a great misdemeanor, and an offense at common law, whether it be for curiosity or experiment, or by neglect." (citing Blackstone and other English authorities)); *Thompson*, 6 Mass. at 140-41 ("The death of a man, killed by voluntarily following a medical prescription, cannot be adjudged felony in the party prescribing, *unless* he, however ignorant of medical science in general, had so much knowledge, or probable information of the fatal tendency of the prescription, that it may be reasonably presumed by the jury to be the effect of obstinate, wilful rashness, at the least, and not of an honest intention and expectation to cure." (emphasis added)).

b. Nuanced Treatment of Abortion

241. Bracton specifically addresses abortion in two sections of his treatise. The first reference to abortion comes in the section on homicide: "If one strikes a pregnant woman or gives her poison in order to procure an abortion, if the foetus is already formed or quickened, especially if it is quickened, he commits homicide." Bracton at 341. The second reference to abortion comes in a section on "woundings committed in breach of the peace": "If anyone forcibly interferes with a woman's internal organs in order to produce abortion, he is liable."

Bracton at 406, 408. Thus, under the common law as reported by Bracton, abortion was not unlawful per se. Rather, it was unlawful only in certain circumstances.

242. To properly contextualize Bracton's discussion of abortion, it is important to note two things. First, nonconsensual abortion—and specifically, the practice of beating a pregnant woman to cause her to miscarry against her will—was a cause of concern in the medieval period. Tr. 495:17-22 (Eppinger). Professor Dellapenna explains that the legal system's interaction with abortion during this time was predominantly if not exclusively focused on violent attacks against pregnant women. Ex. 10 at 135 ("One … will search in vain during the period before 1400 for a record of a prosecution for abortion that was not also a crime against the mother in the most graphic terms."). Second, Bracton (as well as other commentators and jurists from this time period) "drew freely from Roman and Canon Law to fill gaps in the common law as they described it." Ex. 10 at 152-53.

243. With these undisputed facts in mind, the best way to interpret Bracton's passage on homicide and abortion is that he is referring to the unintentional death of a pregnant woman from an attempted abortion, even though some have assumed a different meaning. Tr. 496:25-497:6 (Eppinger); *but see Roe v. Wade*, 410 U.S. 113, 134 & n.23 (1973), *overruled by Dobbs*, 597 U.S. at 231. With respect to abortion, medieval common law's focus was on nonconsensual violence against pregnant women, which sometimes resulted in their deaths. *See supra* at 242. And subsequent common law authorities that build on Bracton's foundation are unequivocal that a fetus cannot be the victim of a homicide. *See infra* at ¶¶ 251-55. Thus, Bracton's discussion of abortion as homicide is best understood as an example of homicide by chance. Tr. 498:6-16 (Eppinger). The upshot is that, when someone beats or poisons a pregnant woman for the purpose of causing her to miscarry and they end up killing her, they are criminally liable for her

death. *Id.* 499:10-23; Eppinger Article at 690-91. In contrast, when a healthcare provider administers a humoral treatment for amenorrhea in accordance with the prevailing standard of care, they would face no liability if their patient died, nor if she lived and miscarried her pregnancy, regardless of quickening. Tr. 499:10-23 (Eppinger); Eppinger Article at 690-91.

244. It is notable that Bracton's discussion of abortion as an example of unlawful wounding follows a discussion of castration. Immediately before the sentence about abortion, Bracton states: "But what is to be said where a man cuts off another's testicles and castrates him on account of debauchery or in order to sell him. He is liable whether he does it with his consent or against his will. Sometimes capital punishment follows, sometimes permanent exile with the forfeiture of all property." Bracton at 408. Subsequently, Bracton notes: "The jews are allowed to circumcise their sons but those of other religions are not; if they do so the punishment for castration is imposed." *Id.* The juxtaposition of castration and abortion and subsequent discussion of immunity from liability when circumcision is performed as a Jewish rite suggests that medieval common law punishment for abortion by wounding was connected to violation of sexual mores or religious law, and not to views about the value of fetal life. Further, like beating or poisoning a pregnant woman, interfering with her internal organs using a sharp object would have posed a high risk of injury or death and was not part of accepted medical practice at the time. Tr. 502:9-503:5; Eppinger Article at 691-92.

245. Both Coke and Hale report that abortion after quickening is a common law crime that does not rise to the level of a felony. Coke, *Third Institute*, at 50; Hale at 433. Hale characterizes abortion as "a great crime, and by the judicial law of Moses … punishable by death." Hale at 433. Professor Dellapenna acknowledges ambiguity in this characterization; it is not clear whether Hale is reporting that abortion is a great crime under the common law, or

instead, under Canon law. Tr. 875:23-876:15 (Dellapenna). Given the protection English common law afforded healthcare providers, *supra* at ¶¶ 237-39, and the allowance by Jewish law (i.e., the judicial law of Moses) of abortion in cases where pregnancy posed a threat to the pregnant woman's well-being, *supra* at ¶ 229, it can be inferred that post-quickening abortion was not a crime when performed for therapeutic reasons. Neither Coke nor Hale report any liability for pre-quickening abortion. Coke, *Third Institute*, at 50; Hale at 433. Hale does report, however, that regardless of quickening, if a pregnant woman dies as the result of a *non-therapeutic abortion*, her death is a murder: "But if a woman be with child, and any gives her a potion to destroy the child within her, and she take it, and it works so strongly, that it kills her, this is murder, for it was not given to cure her of a disease, but unlawfully to destroy her child within her, and therefore he, that gives a potion to this end, must take the hazard, and if it kill the mother, it is murder …." Hale at 429-30. This discussion parallels Bracton's discussion of homicide by chance, and it expressly distinguishes between acts intended to cure a pregnant woman of a disease and acts intended to terminate an unwanted pregnancy. *See* Tr. 500:24-501:12 (Eppinger); *see* Tr. 799:13-17 (Dellapenna); Eppinger Article at 692-93.

246. Blackstone describes post-quickening abortion as "merely a heinous misdemeanor" and does not report any liability for pre-quickening abortion. 1 Blackstone at 130.

247. Overall, medieval and early modern common law regulated abortion in nuanced ways designed to protect pregnant women from violent or otherwise dangerous practices and perhaps also to enforce religious precepts. The common law did not regulate abortion in ways that would have restricted a medical practitioner's ability to administer accepted emmenagogic and abortifacient treatments for therapeutic purposes. Eppinger Article at 695-97.

248. Before 1850, no American court recognized abortion as a common law crime before quickening. Tr. 507:18-508:11 (Eppinger); *see Mitchell v. Commonwealth*, 78 Ky. 204, 210 (1879) ("The limit of our duty is to determine what the law is, and not to enact or declare it as it should be. In the discharge of this duty, and after a patient investigation, we are forced to the conclusion that it never was a punishable offense at common law to produce, with the consent of the mother, an abortion prior to the time when the mother became quick with child. It was not even murder at common law to take the life of the child at any period of gestation, even in the very act of delivery."); *Smith v. Gaffard*, 31 Ala. 45, 51 (1857) ("In this case [seeking damages for slander], it does not appear from the words themselves, nor from any part of the complaint, that the imputation of an abortion, procured when the woman was 'quick with child,' was conveyed, or intended to be conveyed. Unless the words convey that imputation, or were intended to convey that imputation, they do not charge an offense punishable by law under indictment, and, therefore, are not, *per se*, actionable."); *Abrams v. Foshee*, 3 Iowa 274, 279 (1856) ("These authorities agree in holding, that to cause, or procure an abortion, *before* the child is quick, is not a criminal offence at common law, whatever it may be after the child is quick."); *Smith v. State*, 33 Me. 48, 55 (1851) ("At common law, it was no offence to perform an operation upon a pregnant woman by her consent, for the purpose of procuring an abortion, and thereby succeed in the intention, unless the woman was 'quick with child.'"); *State v. Cooper*, 22 N.J.L. 52, 58 (N.J. 1849) ("We are of opinion that the procuring of an abortion by the mother, or by another with her assent, unless the mother be quick with child, is not an indictable offence at the common law, and consequently that the mere attempt to commit the act is not indictable. There is neither precedent nor authority to support it."); *Commonwealth v. Parker*, 50 Mass. 263,

265-66 (1845) ("And the court are of opinion that, at common law, no indictment will lie, for attempts to procure abortion with the consent of the mother, until she is quick with child.").

249. In 1850, the Pennsylvania Supreme Court held that abortion was a common law crime throughout pregnancy. *See Mills v. Commonwealth*, 13 Pa. 631, 633 (1850). Notably, the court held that abortion was a crime against nature, and not a crime against the developing embryo or fetus. *Id.* ("It is a flagrant crime, at common law, to attempt to procure the miscarriage or abortion of the woman; because it interferes with and violates the mysteries of nature, in that process by which the human race is propagated and continued. It is a crime against nature, which obstructs the fountain of life, and therefore it is punished."); *id.* ("It is not the murder of a living child, which constitutes the offence, but the destruction of gestation, by wicked means and against nature. The moment the womb is instinct with embryo life, and gestation has begun, the crime may be perpetrated."). Recently, the Pennsylvania Supreme Court acknowledged that its earlier opinion was an outlier, and one that came late in the development of the common law. *Allegheny Reprod. Health Ctr. v. Penn. Dep't of Human Servs.*, 309 A.3d 808, 909 (Pa. 2024) ("[A]t the time our Charter was adopted [in 1776], abortions were available and performed and the government did not interfere in a woman's pregnancy until quickening."). Only one other American court—the North Carolina Supreme Court—held that abortion was a common law crime before quickening, and not until 1880. *See State v. Slagle*, 83 N.C. 630, 632 (1880) ("In some of the states it has been held that in the absence of any statute the offence can only be perpetrated upon a woman so far advanced in gestation as to be quick with child, and this requirement is met in the present bill. But we are not disposed thus to restrict the criminal act, but to hold that it may be committed at any stage of pregnancy."). *Slagle* endorsed *Mills*' reasoning that abortion is a crime against nature and not

against the embryo or fetus. *Id.* (quoting *Mills*, 13 Pa. at 633). There is no evidence that either jurisdiction viewed therapeutic abortion as a crime before quickening or that any American jurisdiction viewed therapeutic abortion as a crime after quickening. *See* Tr. 508:12-15 (Eppinger).

250. Among other things, the record contains no evidence of any conviction under the common law, either pre- or post-quickening, for an abortion performed in good faith for medical reasons in either England or America. Tr. 508:16-509:8 (Eppinger); Tr. 842:7-25 (Dellapenna).

c. Rejection of Prenatal Personhood

251. From at least the sixteenth century onward, the common law expressly and consistently held that a fetus is not a person. Sir William Staunford, one of the best known writers on criminal pleadings in sixteenth-century England, reported that a child *in utero* could not be the victim of homicide because it is not *in rerum natura*. Ex. 10 at 187; Tr. 857:23-858:14, 859:17-19 (Dellapenna). The Latin phrase *in rerum natura* signifies that something is in existence—a part of the physical world as opposed to something abstract or fictitious. *See In Rerum Natura*, Black's Law Dictionary (12th ed. 2024); Tr. 505:8-9 (Eppinger).

252. Coke explains that an essential element of the crime of murder is a victim who is a "reasonable creature in rerum natura." Edward Coke, *The Third Part of the Institutes of the Laws England Concerning High Treason, and Other Pleas of the Crown and Criminal Causes* 47 (Leon E. Bloch Law Library, UMKC Sch. of Law, digital ed.) (1644) [hereinafter Coke, *Third Institute*], https://irlaw.umkc.edu/cgi/viewcontent.cgi?params=/context/coke_institutes_lawes/article/1000/&path_info=klc000008.pdf. He discusses abortion in a passage explaining what this element means: "If a woman be quick with childe, and by a [p]otion or otherwise killeth it in her wombe; or if a man beat her, whereby the childe dieth in her body, and she is delivered of a dead childe, this is a great misprision, and no murder; but if the childe be born

alive, and dieth of the potion, battery, or other cause, this is murder: for in law it is accounted a reasonable creature, *in rerum natura*, when it is born alive." *Id.* at 50. Thus, Coke reports that a fetus cannot be the object of murder until after it is born because the common law does not recognize its existence as a rational creature—or in other words, because it is not yet a person.

253. Hale agrees with Coke that a fetus cannot be the object of murder because it is not a person in the eyes of the common law, but he disagrees that a newborn who dies from injuries sustained *in utero* can be the object of murder. He states: "If a woman be quick or great with child, if she take, or another give her any potion to make an abortion, or if a man strike her, whereby the child within her is kild, it is not murder nor manslaughter by the law of *England*, because it is not yet *in rerum natura*, tho it be a great crime, and by the judicial law of Moses was punishable with death, nor can it legally be known, whether it were kild or not, so it is, if after such child were born alive, and baptized, and after die of the stroke given to the mother, this is not homicide." Hale at 433 (citations omitted).

254. Like Coke and Hale, Blackstone reports that, for either murder or manslaughter to occur, "the person killed must be '*a reasonable creature in being, and under the king's peace*,' at the time of the killing," and therefore the death of a fetus is "no murder, but a great misprision."[11] 4 Blackstone at 197-98. He adopts Coke's view that, "if the child be born alive, and dieth by reason of the potion or bruises it received in the womb, it seems, by the better opinion, to be murder in such as administered or gave them." *Id.* at 198.

255. American courts in the nineteenth and early twentieth centuries likewise held that a fetus was not a person under the common law, nor under state statutes incorporating common

[11] In this context, a misprision is a crime that does not rise to the level of a felony. Tr. 488:18-21 (Eppinger).

law principles. For example, in an 1876 criminal case, the Iowa Supreme Court reversed the conviction of a physician for manslaughter in connection with the death of a fetus during childbirth. *State v. Winthrop*, 43 Iowa 519, 523 (Iowa 1876). The court held that an instruction given to the jury was faulty because it failed to make clear that, for the elements of the crime to be satisfied, the child must have been born alive before it died, establishing independent circulation and an existence separate from its mother. *Id.* at 519-23.

256. A line of civil cases beginning with *Dietrich v. Inhabitants of Northampton*, 138 Mass. 14, 17 (1884) (Holmes, J.), held that neither a fetus nor its representative could recover in tort for prenatal injuries or wrongful death *even if* the fetus was born alive. *See, e.g.*, *Magnolia Coca Cola Bottling Co. v. Jordan*, 78 S.W.2d 944, 950 (Tex. Comm'n App. 1935), *overruled by Leal v. C.C. Pitts Sand & Gravel*, 419 S.W.2d 820, 822 (Tex. 1967); *Stanford v. St. Louis-S.F. Ry. Co.*, 108 So. 566, 566 (Ala. 1926) ("The authorities … are unanimous in holding that a prenatal injury affords no basis for an action in damages, in favor either of the child or its personal representative."), *overruled by Huskey v. Smith*, 265 So. 2d 596, 598 (Ala. 1972); *Drobner v. Peters*, 133 N.E. 567, 568 (N.Y. 1921), *overruled by Woods v. Lancet*, 102 N.E.2d 691, 695 (N.Y. 1951); *Lipps v. Milwaukee Elec. Ry. & Light Co.*, 159 N.W. 916, 917 (Wis. 1916); *Buel v. United Rys. Co. of St. Louis*, 154 S.W. 71, 72 (Mo. 1913) ("We have not been able to find any precedent at common law establishing the right of a child injured while en ventre sa mere, but subsequently born alive, to bring an action thereafter for the injuries so received."),[12] *overruled by Steggall v. Morris*, 258 S.W.2d 577, 582 (Mo. 1953); *Gorman v. Budlong*, 49 A. 704, 707 (R.I. 1901), *overruled by Sylvia v. Gobeille*, 220 A.2d 222, 223 (R.I. 1966); *Allaire v.*

[12] "*En ventre sa mere*" means in utero or in the mother's womb. *En Ventre Sa Mere*, Black's Law Dictionary (12th ed. 2024).

St. Luke's Hosp., 76 Ill. App. 441, 450 (1898); *Dietrich*, 138 Mass. at 15 ("Some ancient books seem to have allowed the mother an appeal for the loss of her child by a trespass upon her person. But no case, so far as we know, has ever decided that, if the infant survived, it could maintain an action for injuries received by it while in its mother's womb." (citations omitted)).[13] Many of these cases distinguished doctrines concerning prenatal property rights, which are rooted in civil rather than common law, on the ground that they embody a legal fiction. *See, e.g.*, *Jordan*, 78 S.W.2d at 948 ("The decisions which protect unborn children in property and property rights but undertake by the indulgence of a fiction of existence to save to the child property which in fairness belongs to it. They do not support the imposition of liability upon others for torts indirectly committed against a prospective human being, one unseen and unknown, and who may never have an independent existence."). A Queen's Bench decision from Ireland in 1890, cited by many of the American cases, likewise denied recovery to a plaintiff for prenatal injuries. *Walker v. Great N. Ry. Co. of Ir.*, 28 L.R. Ir. 60, 69 (1890); *see id.* at 80 (Harrison, J.) ("When the accident occurred … the plaintiff was still unborn, and had no existence apart from her mother …."); *id.* at 83 (O'Brien, J.) ("There is no person and no duty."); *id.* at 84 (Johnson, J.) ("As a matter of fact, when the act of negligence occurred the plaintiff was not *in esse*, was not a person, or a passenger, or a human being.").

257. The common law's rejection of prenatal personhood is deeply rooted in American history and tradition, spanning a period of more than four centuries. This means that the original public meaning of the term "person" as used in the Fifth and Fourteenth Amendments did not encompass prenatal life; developing embryos and fetuses were not guaranteed a right to life by

[13] Although today, most American jurisdictions allow recovery for prenatal torts, the law did not begin to change in this respect until after World War II. *See*, American Law of Torts § 9:27 (2025).

those constitutional provisions; and the law assigned greater value to the interests of pregnant women than to the interests of prenatal life.

D. Statutory Regulation of Abortion in the Nineteenth Century

1. In England

258. In 1803, Parliament adopted Lord Ellenborough's Act, the first English statute to regulate abortion.[14] 43 George 3 c. 58 (U.K.) (1803); Tr. 509:9-13 (Eppinger); Eppinger Article at 703. The statute criminalized abortion throughout pregnancy, but only when done "wilfuly and maliciously" or "wilfuly, maliciously, and unlawfully." 43 George 3 c. 58 (1803). These mens rea elements preserved and incorporated common law doctrine on therapeutic intent, and they were retained in subsequent revisions of the criminal statute throughout the nineteenth century. Tr. 510:3-11, 511:24-512:3 (Eppinger); Eppinger Article at 704-06. For example, sections 58 and 59 of the Offenses Against the Person Act of 1861 provide that, to be punishable, an abortion or attempted abortion at any stage of pregnancy must be done "unlawfully." 24 & 25 Vict. C. 100 §§ 58-59 (U.K.) (1861); Tr. 515:3-24 (Eppinger).

259. The mens rea elements *unlawful* and *malicious* were well-known under the common law; both signified an act done without justification. *See* Tr. 511:9-19 (Eppinger); Eppinger Article at 704-706. For example, Blackstone explains that unlawfulness and malice aforethought are elements of murder. 4 Blackstone at 194, 200. He states that "unlawfulness arises from the killing without warrant or excuse." *Id.* at 194-95. Similarly, with respect to malice, he states that:

[14] It has been reported that: "Lord Ellenborough was renowned for his strict Christian morality. Contemporaries commended him not only as a wise reformer of the law, but also as 'a [f]earless advocate of religion, and a determined assertor of public and private morals.'" Ex. 8 at 20 (quoting Lord Ellenborough's obituary in *The Courier*, Oct. 18, 1818).

> [A]ll homicide is malicious, and, of course, amounts to murder, unless where *justified* by the command or permission of the law; *excused* on the account of accident or self-preservation; or *alleviated* into manslaughter, by being either the involuntary consequence of some act, not strictly lawful, or if voluntary, occasioned by some sudden and sufficiently violent provocation.

Id. at 200. From this, it can be inferred that unlawful or malicious abortion is abortion performed without justification. Abortion performed to preserve a pregnant woman's life or health would have been justified and therefore not subject to penalty under Lord Ellenborough's Act. Tr. 511:20-23 (Eppinger).

260. During the nineteenth and early twentieth centuries, both the legal community and the medical community in England understood therapeutic abortion to be protected by law at all stages of pregnancy. *See infra* at ¶¶ 261-65. Lawyers and judges as well as doctors distinguished between unlawful abortion and therapeutic abortion. *See id.*

261. English lawyer and bioethicist John Keown conducted an extensive review of obstetrical textbooks published in England between 1794 and 1937, as well as medical journal articles, lectures, and proceedings of medical conferences. Ex. 8 at 59-83; Tr. 632:1-9 (Eppinger). He concluded that: "[T]he evidence of obstetrical writings … indicate that therapeutic abortion was performed even before Ellenborough's Act and that, well before [*Rex v. Bourne*, discussed below], was being undertaken for increasingly extensive indications, including the preservation of mental health." Ex. 8 at 59. Although there were some dissenting voices within the medical community, Dr. Keown described the "orthodox position," reflected in Francis Ramsbotham's 1867 text on obstetrics, as embracing therapeutic abortion for a wide range of medical indications threatening a pregnant woman's health or life. *Id.* at 61-62 ("Explaining the greater esteem in which the life and health of the mother were held, [Ramsbotham] pointed out that she, unlike her unborn child, was bound to the world by many

social, moral and religious ties; had feelings, affections, hopes and fears; and was involved in relationships or interdependency.").

262. Dr. Keown highlighted use of a procedure during the eighteenth and nineteenth centuries called craniotomy, which entailed crushing the fetal skull during vaginal childbirth, resulting in fetal death. Ex. 8 at 60; Tr. 522:9-14 (Eppinger). When successful vaginal delivery was not possible due to an anomaly in the structure of the woman's pelvis or the development of the fetus, there were two options—craniotomy or Caesarean section. *See* Ex. 8 at 60. Before twentieth-century medical advances like the development of anti-hemorrhagic and antibiotic medications, craniotomy posed fewer risks to the pregnant woman. *See* Ex. 8 at 60; Ex. 9 at 14; Tr. 522:6-8 (Eppinger). Dr. Keown reported that physicians frequently performed craniotomies for this reason, prioritizing the welfare of the pregnant woman over the welfare of the fetus. Ex. 8 at 60. He stated:

> [T]he evidence indicates that medical men were quite prepared to sacrifice the fetus to protect the life of the mother. This was so even at delivery: the destruction of the child during labour by lessening its skull was far from uncommon. In the eighteenth and nineteenth centuries many women suffered from pelvic deformity, whether as a result of fracture or poor diet, which rendered natural delivery at full term hazardous. Two alternatives were the Caesarian section and craniotomy. The dangers of the former to the women were, until the beginning of the present century, considerable. This left craniotomy as the safer option, and it was performed with such frequency that some practitioners expressed concern at the number of children thereby destroyed. Nevertheless, professional opinion appears, almost universally, to have regarded the life of the mother as more valuable than that of the child. In cases of irreconcilable conflict, therefore, the welfare of the mother prevailed.

Id.

263. Dr. Keown also surveyed a wide array of English legal documents, including court decisions, transcripts of legal proceedings, formal legal correspondence, and extra-judicial statements in lectures and public meetings. Ex. 8 at 52-59. Regarding the law, he explained that: "[E]ven before *Bourne* therapeutic abortion to preserve the woman's life was lawful. The

evidence suggests that the preservation of health would also have constituted a lawful cause, and there is no evidence that health was confined to the patient's physical as opposed to her mental condition." *Id.* at 57. Dr. Keown noted that he could find no evidence of a prosecution for therapeutic abortion prior to *Rex v. Bourne*, *id.* at 78, and the lack of such prosecutions in the face of the open and common practice of therapeutic abortion is further evidence that the legal authorities understood it to be lawful, *id.* at 162 ("The absence of any reported prosecution of a practitioner for the performance of the operation, according to professionally approved criteria, from the late eighteenth century to 1938, suggests the tacit approval of this discretion by the state."); *see also* Tr. 525:6-12 (Eppinger). He concluded that the law afforded physicians broad discretion to provide abortions that they believed were medically indicated. Ex. 8 at 162 ("[The medical profession has] historically been allowed a broad discretion in determining what constitutes 'therapeutic' abortion and in acting upon that determination."); *see* Tr. 526:7-527:5 (Eppinger).

264. The landmark English case *Rex v. Bourne*, (1938) 3 All E.R. 615 (Eng.), [1939] 1 K.B. 687 (Macnaghten, J.), confirms that Lord Ellenborough's Act and its successors preserved common law immunity for therapeutic abortion. *See* Tr. 537:15-538:17 (Eppinger). It concerns a physician charged with unlawful abortion under the Offences Against the Person Act of 1861 in connection with providing an abortion to a fourteen-year-old girl who had been raped. *Id.* 530:5-14. The reported opinion is comprised of the judge's instructions to the jury, who ultimately acquitted the doctor. *Id.* 530:24-531:1. The judge explained that, although the statute did not contain any express exceptions, use of the term "unlawful" implied an exception for acts "done in good faith for the purpose only of preserving the life of the mother." *Bourne*, 3 All E.R. at 617 ("Those words express what, in my view, has always been the law with regard to the

procuring of an abortion, and, although not expressed in sect. 58 of the Act of 1861, they are implied by the word 'unlawful' in that section."). The judge further instructed the jury that there is not a firm boundary between preserving a person's life and preserving a person's health. *Id.* ("Life depends upon health, and it may be that health is so gravely impaired that death results."). He explained that, when a patient faces a risk of death, a physician need not wait until death is imminent to provide an abortion. *Id.* at 618. The judge then went a step further and instructed the jury that, if continuing the pregnancy would cause serious harm to the pregnant person's physical or mental health, the implied exception is satisfied. *Id.* at 619 ("[I]f the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor, who, in those circumstances, and in that honest belief, operates, is operating for the purpose of preserving the life of the woman."). The judge also instructed the jury to take the risk of suicidal ideation into account. *Id.* at 619-20 ("Here you have the evidence of Dr. Rees, a gentleman of eminence in the profession, that, from his experience and his knowledge, the mental effect produced by pregnancy brought about by the terrible rape which Dr. Gorsky described to you must be most prejudicial …. So far as danger to life is concerned, you cannot, of course, be certain of the result unless you wait until a person is dead. Nobody suggests that the operation only becomes legal when a patient is dead.").

265. Thus, *Bourne* established that the abortion ban enacted by Parliament in 1861 contained an implied exception for abortions provided in good faith to preserve the life or physical or mental health of the pregnant person, including to mitigate the risk of suicide. Dr. Keown concluded that *Bourne* did not effect a change in the law but simply confirmed what the law had always been. Ex. 8 at 79 ("The Bourne case of 1938 did not … liberate medical

discretion from an uncompromising law. In fact, this was recognised by Bourne himself. Writing shortly after his trial he conceded that his aim had not been to reform the law but to ensure its declaration.").

2. In the United States

a. Statutes Enacted Before 1857

266. In the United States, the codification of abortion law in the nineteenth century occurred in waves. Tr. 538:24-539:10 (Eppinger). The first wave began in 1821 and focused on patient protection as part of a broader trend of regulating medical practice. *Id.* 539:6-7; Ex. 9 at 43-44. Historian James C. Mohr, who wrote a seminal account of abortion regulation in nineteenth-century America, explained that: "The first wave of abortion legislation in American history emerged from the struggles of both legislators and physicians to control medical practice rather than from public pressure to deal with abortion per se." Ex. 9 at 43.

267. The second wave began in 1840 as a reaction to scandalous press coverage of commercial (i.e., nontherapeutic) abortion resulting in pregnant women's deaths. Tr. 539:7-8, 551:7-552:16 (Eppinger); Eppinger Article at 714-17; Ex. 9 at 47-50, 119-20.

268. The earliest American abortion statutes were enacted against a backdrop of acute change in medical thinking and medical practice. Tr. 541:13-543:13 (Eppinger); Eppinger Article at 717-18. There was an explosion of new medical schools during the nineteenth century, producing a wave of formally trained "regular" physicians who began to abandon the tenets of humoral health in favor of new theories of medicine and new surgical techniques. Tr. 542:1-4 (Eppinger). The educational rigor of these new medical schools varied greatly, and so did the competence of the doctors they produced. Ex. 9 at 33. The regular physicians were almost exclusively male as most medical schools during this period excluded female students. Tr. 543:14-544:6 (Eppinger). They competed for patients with "irregular" healthcare providers such

as midwives, apothecaries, and people who called themselves doctors but had no formal medical education. Tr. 545:8-19, 553:21-554:9 (Eppinger); Ex. 9 at 32-34. The irregulars were more steeped in traditional humoral practices. Tr. 545:14-18 (Eppinger).

269. Public alarm at the perceived proliferation of "quack" practitioners who lacked fundamental knowledge and skills as well as those who—whether due to incompetence, hubris, or economic motivation—engaged in "rash" practices that subjected patients to unreasonable risks became a recurrent theme in in the first half of the nineteenth century, leading to calls for regulation. *See* Tr. 545:20-546:21 (Eppinger); s*ee also Thompson*, 6 Mass. at 142 ("It is to be exceedingly lamented, that people are so easily persuaded to put confidence in these itinerant quacks, and to trust their lives to strangers without knowledge or experience. If this astonishing infatuation should continue, and men are found to yield to the impudent pretensions of ignorant empiricism, there seems to be no adequate remedy by a crimina[l] prosecution, without the interference of the legislature, if the quack, however weak and presumptuous, should prescribe, with honest intentions and expectations of relieving his patients."); 3 N.Y. Rev. Stat. Appendix: Revisers' Reports and Notes, pt. 4, ch. 1, tit. 6, § 28, 811, 829-30 (1828-1835) ("The rashness of many young practitioners in performing the most important surgical operations for the mere purpose of distinguishing themselves, has been a subject of much complaint, and we are advised by old and experienced surgeons, that the loss of life occasioned by such practice is alarming.").[15] As Dr. Mohr explained: "During the middle decades of the nineteenth century, legislators felt a special obligation to protect the public from an occupational group that was …

[15] Although the New York revisors' commentary concerned a provision criminalizing the performance of unnecessary surgery that was ultimately stricken from the final legislation before its enactment, it shows that concern about changing medical paradigms and the use of risky new techniques was part of the zeitgeist. Tr. 548:10-549:25 (Eppinger); *see* Ex. 9 at 28.

reaching something of a nadir. By the late 1820s physicians, with a good deal of justification, were viewed by many Americans as menaces to their society." Ex. 9 at 31.

270. Beginning in the 1830s, well publicized accounts of the deaths of young women in connection with nontherapeutic abortions contributed to public concern and increased momentum for regulation. Tr. 539:7-8, 551:7-552:16 (Eppinger); Eppinger Article at 714-17; Ex. 9 at 47-50, 119-20.

271. Perhaps surprisingly, regular physicians were at the forefront of efforts to regulate medical practice during this time period, perceiving that such regulation would afford them a competitive advantage over their irregular counterparts. Tr. 553:21-554:14 (Eppinger); Ex. 9 at 32-34. Because regulars tended to have ideological objections to abortion, and nontherapeutic abortion was a financial boon for irregulars, the regulation of abortion became bound up in the regulation of medical practice more generally. Ex. 9 at 32-34. Dr. Mohr reported that:

> In the face of such crises many regular physicians in the United States decided to try to defend both their medical theories and their material livelihoods in the best way they could: through state legislatures. The regulars perceived that their generally well-established social backgrounds would, in the long run, give them something of an advantage over their rivals in those public forums. Their ongoing and ultimately successful efforts to influence medical-related legislation of all kinds became crucial to the evolution of abortion policy at the state level because, unlike most of their irregular rivals and unlike a majority of the American people, regular physicians opposed abortion not only after quickening, but before quickening as well.

Ex. 9 at 34; *see also* Ex. 10 at 355 ("There is no denying that allopathic physicians were in the lead in the fight for stricter abortion laws, including seeking to foster public recognition that non-allopathic medical practitioners were responsible for a good deal of the growing incidence of abortion."); *id.* at 356 (explaining that statements in committee reports, medical journal articles, and newspaper op-eds "do indicate the allopaths' belief that irregular physicians comprised the bulk of the professional abortionists; similar statements argued that these "irregulars" could

exploit this practice to build a relationship that could allow the irregulars to obtain the entire medical business of the patients and their families.").

272. Dr. Keown described a similar dynamic at play in England. Ex. 8 at 39-47. Discussing the enactment of sections 58-59 of the Offences Against the Person Act of 1861, he explained:

> That the legislature was not influenced by that opinion to the extent of prohibiting all unqualified medical practice reflects, as had the Medical Act, the strength of the prevailing ethos which favoured a *laissez-faire* approach to the regulation of medical practice, and suggests limits to professional influence, particularly when the profession's motives were not wholly disinterested. However, the legislature's enactment of ss. 58 and 59 can be seen as a response to the profession's demand that, if the law was not going to suppress irregular practitioners, then it ought at least to check their growing trade in abortion. Even this more modest response to the problem would, of course, redound to the benefit of the regulars, for while it would not proscribe their competitors it would at least throw a further obstacle in their way by extending the prohibition on a procedure which, according to the regulars, they were finding increasing profitable.

Ex. 8 at 46.

273. The first statutory regulation of abortion in the United States came in 1821 when the Connecticut legislature amended a section of the state criminal code dealing with death by poison to include a prohibition against "wilfully and maliciously" administering "any deadly poison, or other noxious and destructive substance" with the intent to "cause or procure the miscarriage of any woman, then being quick with child" as part of a comprehensive revision of its criminal code. Conn. Gen. Stat. tit. 22, §§ 14, 16, at 151-53 (1821); Tr. 554:18-25, 556:13-557:6 (Eppinger). As in Lord Ellenborough's Act and its successors, the mens rea element served to exempt therapeutic abortion from punishment. Tr. 557:3-6 (Eppinger); Eppinger Article at 706.

274. Missouri and Illinois adopted similar poison control measures in 1825 and 1827, respectively. Eppinger Article at 707; Ex. 9 at 25-26.

275. In 1827, the New York legislature made the unauthorized practice of medicine a crime. Tr. 557:10-22 (Eppinger); Ex. 9 at 37-38. The following year, New York adopted abortion legislation as part of a comprehensive revision of its criminal code. Tr. 557:23-558:1 (Eppinger). The omnibus statute included three provisions concerning abortion. *See* Eppinger Article at 707-09; Ex. 9 at 26-27. The first provision made the "wilful killing" of a quick fetus first-degree manslaughter if accomplished by an injury to the pregnant woman that would constitute murder if it caused her death. 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 8, at 659, 661 (1828). The second provision made any intervention with the intent to "destroy" a quick fetus second-degree manslaughter. 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 9, at 659, 661 (1828).

276. The third provision contained the first express therapeutic exception in any English or American abortion statute. Tr. 559:9-15 (Eppinger). It made intentionally procuring a miscarriage at any stage of pregnancy a misdemeanor "unless the same shall have been necessary to preserve the life of such woman, or shall have been advised by two physicians to be necessary for that purpose." 2 N.Y. Rev. Stat. pt. 4, ch. 1, tit. 6, § 21, at 689, 694 (1828). Dr. Mohr explained that the influence of lobbying by regulars is clearly reflected in this provision:

> One of the cardinal points of the New York regulars' code of ethics was the principle of mandatory consultation in difficult cases; the regulars had given that principle a great deal of attention when they drafted their ethics in 1823. In 1828, by persuading the [New York] revisers to make explicit something that might well have been left implicit as before, they were able to introduce their cherished principle of consultation into the state code. They also, of course, placed themselves in the position of deciding when the law would be applied to its letter and when it would be bent on behalf of a patient.

Ex. 9 at 38.

277. New Jersey enacted its first abortion statute in 1849, which like New York's statute, criminalized abortion before quickening. 1849 N. J. Laws pp. 266-267. Interpreting this

law nine years later, the New Jersey Supreme Court explained that its purpose was to protect the health and lives of pregnant women:

> The design of the statute was not to prevent the procuring of abortions, so much as to guard the health and life of the mother against the consequences of such attempts. The guilt of the defendant is not graduated by the success or failure of the attempt. It is immaterial whether the *fœtus* is destroyed, or whether it has quickened or not. In either case the degree of the defendant's guilt is the same. The only gradation recognized by the statute in the defendant's guilt, is made to depend upon the effect of the act upon the mother, viz., whether she died in consequence of it.

State v. Murphy, 27 N.J.L. 112, 114 (N.J. 1858).[16]

278. Between 1821 and 1857, several other states and territories enacted abortion statutes aimed at protecting pregnant women from unsafe practices and unscrupulous abortion providers. Tr. 559:19-560:4 (Eppinger); Ex. 9 at 39-45, 145-46. Mohr noted that: "Legislators had been annoyed at the flagrant commercialization of abortion that arose during the 1840s and continued into the 1850s, and were fearful about the possibility of incompetent abortionists wreaking serious harm, even death, to the nation's women. But these factors by themselves had not produced forceful new policies." Ex. 9 at 145. No evidence from the historical record suggests that the statutes enacted during this time period were intended to restrict the ability of regular physicians to provide abortions for medical reasons. Tr. 559:22-560:4 (Eppinger). To the contrary, all of the statutes enacted during this period contained either mens rea requirements that served to exempt therapeutic abortions from liability or express therapeutic exceptions. Tr. 560:5-19 (Eppinger); *see* Eppinger Article at 717-23; apps. A-B.

[16] At the time of the decision, Daniel Haines, who had signed the legislation at issue into law when he served as New Jersey's governor, was a justice on New Jersey's Supreme Court. Ex. 9 at 137.

b. Statutes Enacted After 1857

279. The next stage of abortion regulation followed the formation of the AMA in 1847. Tr. 561:3-13 (Eppinger); Tr. 942:18-943:4 (Cohen); Ex. 9 at 147-48, 200-201. The regulars' campaign against nontherapeutic abortion gained steam after the AMA formed a Committee on Criminal Abortion a decade later. Tr. 561:14-19 (Eppinger); Tr. 943:5-8 (Cohen); Ex. 9 at 154-55. Formation of the committee was the result of organizing by Horatio Robinson Storer, a doctor from Boston who specialized in women's health and was staunchly opposed to abortion, and he became its chair. Tr. 561:20-24 (Eppinger); Tr. 943:9-944:3, 945:1-15 (Cohen); Ex. 9 at 154-55. It is undisputed that: "Storer was the dominant personality in the early stages of the American Medical Association's campaign against abortion, and thus perhaps the most important leader of the anti-abortion movement in nineteenth-century America." Ex. 10 at 358-59; *accord* Tr. 561:25-562:2 (Eppinger).

280. At the AMA's national convention in Louisville in 1859, the organization adopted a committee report and series of resolutions drafted by Dr. Storer opposing criminal abortion and calling on state legislatures to ban it. Tr. 945:8-15, 946:25-947:11 (Cohen); Ex. 9 at 156-57. Dr. Mohr explained that:

> From the Louisville convention of 1859 through the rest of the nineteenth century, the steadily growing AMA would remain steadfastly and officially committed to outlawing the practice of abortion in the United States, both inside and outside that organization, and the vigorous efforts of America's regular physicians would prove in the long run to be the single most important factor in altering the legal policies toward abortion in this country.

Ex. 9 at 157. The regulars directed their efforts at so-called "criminal abortion," which was distinct in their minds from therapeutic abortion. Tr. 562:8-13 (Eppinger).

281. It is undisputed that, in the nineteenth century, many regular physicians held sincere moral objections to abortion based on their understanding of prenatal development.[17] *See* Ex. 9 at 35-36. This does not mean, however, that they viewed a developing embryo or fetus as a person; many argued that prenatal life deserved protection because of its *potential* for personhood. An 1873 address by an Illinois regular to his county medical society is illustrative of this view:

> Many, indeed, argue, that the practice is not, in fact, criminal, because, they argue, that the child is not viable until the seventh month of gestation, hence there is no destruction of life. The truly professional man's morals, however, are not of that easy caste, because he sees in the germ the probable embryo, in the embryo the rudimentary foetus, and in that, the seven months viable child and the prospective living, moving, breathing men or women, as the case may be.

Ex. 9 at 165-66 (quoting James S. Whitmire, *Criminal Abortion*, 31 Chi. Med. J. 385, 392 (1874)). This distinction is important. Like the common law and their English counterparts, American physicians in the nineteenth century assigned greater value to the health of a pregnant woman than to the preservation of prenatal life. *See infra* at ¶¶ 295-97, 300-02, 310-12.

282. During the second half of the nineteenth century, the regulars joined their moral objections to abortion and their economic interest in gaining an advantage over the irregulars in the competition for patients with a commitment to enforcing women's traditional roles as wives

[17] Evidence indicates that regular physicians in the nineteenth century did not universally hold such objections. The record demonstrates that many regulars themselves provided nontherapeutic abortions. *See* Tr. 979:9-981:15, 1044:11-1045:4 (Cohen). Evidence further indicates that most Americans did not share the regulars' views about the value of life at conception, instead ascribing significant value to prenatal life only after it reaches certain developmental milestones, like quickening or viability, later in pregnancy. *See* Tr. 976:23-977:16, 1043:6-22 (Cohen), Ex. 9 at 114-18, 166; Aaron Tang, *After Dobbs: History, Tradition, and the Uncertain Future of a Nationwide Abortion Ban*, 75 Stan. L. Rev. 1091, 1129, 1154 (2023) [hereinafter Tang]; *infra* at ¶ 304. Likewise, most American religious leaders declined to speak out against abortion in the nineteenth century, despite frequent urging by the regulars. Ex. 9 at 182-96.

and mothers and nativist concerns about the increasing abortion rate among married white Protestant women. Ex. 9 at 166-70.

283. As a group, regulars were staunchly committed to enforcing women's traditional roles as wives and mothers. Ex. 9 at 168-70. Professor Dellapenna notes that: "Physicians and their allies made little secret about their concerns. They openly stated goals such as promoting proper female behavior in the home and elsewhere. Supporters of proper female behavior certainly at the time were unashamed of such views." Ex. 10 at 343. Dr. Storer, for example, "described marriage without children as legalized prostitution." Ex. 10 at 369.

284. In 1868, AMA members voted down a recommendation of their national committee on ethics to permit female doctors to consult with regulars, and they rejected an 1871 charter amendment that would have permitted delegates from medical schools that admitted women. Ex. 9 at 169. Many argued that women's biological attributes made them unfit for higher education or work outside the home. Ex. 10 at 363-64; *id.* at 366 ("The great majority of male physicians on both sides of the Atlantic considered women congenitally unfit to be physicians."). Dr. Storer, who supported a resolution opposing the admission of women to Harvard Medical School and wrote numerous articles proclaiming the unfitness of women to be medical practitioners, "argued that women are appendages of their reproductive systems, unlike men in whom, according to Storer, the reproductive system was 'merely subsidiary.'" Ex. 10 at 363-64 (quoting Horatio R. Storer, *The Causation, Course and Treatment of Reflex Insanity in Women* 150 (1871), and Horatio R. Storer, *Why Not? A Book for Everywoman* 74-75 (1866) [hereinafter Storer, *Why Not?*]).

285. Beginning in the mid-nineteenth century, the United States underwent a significant demographic transition. Tr. 930:18-20 (Cohen). Birthrates among women born in the

United States plummeted; there was a large influx of European immigrants; and the industrial revolution fueled the growth of cities and a decline in rural populations. *See id.* 930:21-932:21. Amplifying nativist anxiety among the upper classes, Dr. Storer and his allies frequently repeated the claim that abortion was far more common among native-born Protestant women than among Catholic immigrants. Ex. 9 at 167; Ex. 10 at 364 ("[Storer] apparently shared the nativist fears that abortion among middle class (*i.e.* white) American women would open the nation to settlement by foreigners (*i.e.* darker skinned southern Europeans …), and in this vein was not above … Catholic-bashing."). Dr. Mohr reported: "There can be little doubt that Protestants' fears about not keeping up with the reproductive rates of Catholic immigrants played a greater role in the drive for anti-abortion laws in nineteenth-century America than Catholic opposition to abortion did." Ex. 9 at 167. Professor Dellapenna explained:

> In the United States, the nineteenth-century opponents of the emerging practice of abortion did raise the demographic transition as a reason for banning both abortion and contraception. Their arguments expressed fear that whites in general, and middle-class Anglo-Saxons in particular, would be outbred by the lesser classes. The phrase "race suicide" came into use after 1901 to describe a fear that the traditionally dominant culture would be swamped by faster-breeding "races." The notion of race at that time was applied broadly to link prejudices against Jews and Catholics with prejudices against darker-skinned people in a grand fear of "mongrelization." Fueling these fears in the United States were not only falling birthrates of upper- and middle-class whites, but also an enormous influx of eastern and Southern Europeans.

Ex. 10 at 492-93.

286. Evidence indicates that the legislatures enacting stricter abortion laws in the late nineteenth century shared the regulars' concerns not only about prenatal life, but also about the role of women in society, the relative birthrates of American-born and immigrant women, and the safety of commercial abortion. For example, in 1867, a special committee of the Ohio Senate with three regular-physician members issued a report endorsing abortion legislation that was ultimately enacted by the full legislature. Ex. 9 at 206-10. The report, which echoed language

from Dr. Storer's polemics, made five main points: (1) abortion occurred with alarming frequency in Ohio; (2) the Ohio public supported broad abortion access; (3) emerging scientific evidence concerning *in utero* development demonstrated that quickening was not a biologically significant milestone; (4) abortion was dangerous for pregnant women; and (5) American-born women had abortions much more frequently than immigrant women, shirking their duties both to their husbands and to society at large. *Id.* at 207. On this last point, the committee report stated:

> Do [our native women] realize that in avoiding the duties and responsibilities of married life, they are, in effect, living in a state of legalized prostitution? Shall we permit our broad and fertile prairies to be settled only by the children of aliens? If not, we must, by proper legislation, and by the diffusion of a correct public sentiment, endeavor to suppress a crime which has become so prevalent.

Id. at 207-08 (quoting Journal of the Senate of the State of Ohio, 1867, app., 233-25).

287. On the other hand, there is no evidence that legislatures of this period were concerned with physicians' discretion to provide therapeutic abortions. With a qualification concerning Nebraska discussed below, *see infra* at ¶ 292, all of the state abortion statutes enacted between 1857 and 1919 authorized therapeutic abortions either through express exceptions from criminal liability or mens rea requirements that served to exclude therapeutic abortions, Tr. 564:6-25 (Eppinger). *See also* Eppinger Article at 731-35; app. A-B.

288. When the Fourteenth Amendment was ratified in 1868, of the twenty-eight states with statutes criminalizing abortion,[18] nineteen statutes contained express exceptions for abortions necessary to preserve the pregnant person's life: Alabama, 1841 Ala. Acts p. 143; California, 1850 Cal. Stats. p. 233; Connecticut, 1860 Conn. Pub. Acts p. 65; Florida, 1868 Fla.

[18] Professor Aaron Tang argues that *Dobbs* was incorrect in concluding that all of these statutes banned abortion before quickening. Tang at 1128 ("Substantial evidence suggests that as many as 12 of the 28 states on the majority's list actually continued the centuries-old common law tradition of permitting pre-quickening abortions."); *contra Dobbs*, 597 U.S. at 248.

Laws, ch. 1637, pp. 64, 97; Indiana, 1835 Ind. Laws p. 66; Iowa, 1858 Iowa Acts p. 93 (codified in Iowa Rev. Laws § 4221); Kansas, 1859 Kan. Laws pp. 233, 237; Maine, Me. Rev. Stat., Tit. 12, ch. 160, §§ 13–14 (1840); Michigan, Mich. Rev. Stat., Tit. 30, ch. 153, §§ 33–34 (1846); Missouri, Act of Mar. 20, 1835, art. 2, §§ 10, 36, 1835 Mo. Rev. Stat. 165, 168, 172; Nevada, 1861 Nev. Laws p. 63; New Hampshire, 1849 N. H. Laws p. 708; New York, N. Y. Rev. Stat., pt. 4, ch. 1, Tit. 2, § 9, Tit. 6, § 21 (1828), 1829 N. Y. Laws p. 19 (codifying these provisions in the revised statutes); Ohio, 1834 Ohio Laws pp. 20–21; Oregon, Ore. Gen. Laws, Crim. Code, ch. 43, § 509 (1865); Rhode Island, 1861 R. I. Acts & Resolves p. 133; Virginia, 1848 Va. Acts p. 96; West Virginia, W. Va. Const., Art. XI, § 8 (1862); and Wisconsin, Wis. Rev. Stat., ch. 164, § 11, ch. 169, § 58 (1858); *see also* app. A. None of these statutes distinguished self-harm from other threats to a pregnant person's life. App. A. Six of these statutes included a safe harbor for physician consultation: New York, Ohio, Michigan, New Hampshire, Wisconsin, and Florida. *Id.*

289. Two statutes had therapeutic exceptions that were worded differently: Illinois and Maryland. Illinois's statute exempted from liability "any person who procures or attempts to procure the miscarriage of any pregnant woman for bona fide medical or surgical purposes." 1867 Ill. Pub. Laws, 25th Gen. Assembly 1st Sess. §§ 2, 3, at 89 (Act of Feb. 28, 1867). Maryland's statute provided that

> nothing herein contained shall be construed so as to prohibit the supervision and management by a regular practitioner of medicine of all cases of abortion occurring spontaneously, either as the result of accident, constitutional debility, or any other natural cause, or the production of abortion by a regular practitioner of medicine when, after consulting with one or more respectable physicians, he shall be satisfied that the foetus is dead, or that no other method will secure the safety of the mother.

1868 Md. Laws p. 315.

290. The State has presented no evidence that these different formulations had different legal consequences. It appears that neither medical practice nor enforcement patterns varied among states based on the specific formulations of their therapeutic exceptions.

291. Six statutes contained mens rea requirements such as "feloniously," "maliciously," or "unlawfully" that excluded therapeutic abortions from the definition of the offense: Louisiana, La. Rev. Stat. § 24 (1856); Massachusetts, 1845 Mass. Acts p. 406; New Jersey, 1849 N. J. Laws pp. 266–267; Pennsylvania, 1861 Pa. Laws pp. 404–405; Texas, 1854 Tex. Gen. Laws p. 58; and Vermont, 1846 Vt. Acts & Resolves pp. 34–35; *see also* app. A.

292. The remaining state, Nebraska, adopted a life exception when it codified its laws in 1873. Neb. Rev. Stat. pt. 3, ch. 4, § 39 (1873). As codified, the statute provided:

> Any physician, or other person, who shall wilfully administer to any pregnant woman any medicine, drug, substance, or thing whatever, or shall use any instrument or other means whatever, with intent thereby to procure the miscarriage of any such woman, *unless the same shall have been necessary to preserve the life of such woman, or shall have been advised by two physicians to be necessary for that purpose*, shall be punished by imprisonment in the county jail, not more than one year, or by fine, not exceeding five hundred dollars, or by both such fine and imprisonment.

Id. (emphasis added).

293. In 1868, only six of the thirteen territories that would eventually become states had statutes that criminalized abortion in at least some circumstances: Arizona; Colorado; Hawaii; Idaho; Montana; and Washington. *See* app. B. Five of these statutes included express life exceptions that did not distinguish self-harm from other threats to a pregnant person's life: Arizona, Howell Code, ch. 10, § 45 (1865); Hawaii, Haw. Penal Code, ch. 12, §§ 1–2 (1850); Idaho, 1863–1864 Terr. of Idaho Laws p. 443; Montana, 1864 Terr. of Mont. Laws p. 184; and Washington, Terr. of Wash. Stat., ch. 2, §§ 37–38, p. 81 (1854); *see also* app. B. Colorado's statute exempted from liability abortions "procured or attempted by or under the advice of a

physician or surgeon, with intent to save the life of such woman, or to prevent serious and permanent bodily injury to her." Gen. Laws Colo. Terr. ch. 22, § 42, p. 202 (1868).

294. All criminal abortion statutes enacted between 1868 and 1900 contained express therapeutic exceptions, *see* app. B, as did a District of Columbia statute enacted in 1901, § 809, 31 Stat. 1322 (1901) (immunizing abortion from liability "when necessary to preserve [a woman's] life or health and under the direction of a competent licensed practitioner of medicine"), and a New Mexico statute enacted in 1919, 1919 N. M. Laws p. 6 ("[A]n abortion may be produced when two physicians licensed to practice in the State of New Mexico, in consultation, deem it necessary to preserve the life of the woman, or to prevent serious and permanent bodily injury.").

295. As in England, during the nineteenth century, regular physicians in America performed therapeutic abortions for a wide range of medical indications to preserve patient health as well as life. *See infra* at ¶¶ 295-97, 300-07. American doctors were generally aware of developments in the British medical community during this time period and were engaged in dialogue with their counterparts in the United Kingdom. Tr. 944:4-25 (Cohen). It was not unusual for young American doctors with sufficient financial resources to study or apprentice in the United Kingdon. *Id.* 943:20-944:10. American doctors also had access to professional literature produced in the United Kingdom. *Id.* 944:15-17. Indeed, a major Philadelphia publishing house called Blanchard & Lea, which specialized in publishing medical texts, reprinted many books by English authors. *Id.* 944:18-25, 987:10-11.

296. Throughout the nineteenth and early-twentieth centuries, American doctors commented on therapeutic abortion in medical journals, textbooks, and public lectures. For example, in 1847, Dr. Gunning Bedford, a prominent New York City obstetrician, was called to

examine a patient believed to be pregnant, who was suffering from extreme nausea. Tr. 948:9-19, 949:2-950:10 (Cohen). After completing his examination, he used an instrument to empty her uterus. *Id.* 950:13-15. He spoke in detail about his decision in a lecture to medical students. *Id.* 949:25-950:4 (citing Gunning S. Bedford, *A Lecture Introductory to a Course on Obstetrics and the Diseases of Women and Children in the University of New York*, New York University Medical Department, 1847, at 17-18 [hereinafter Bedford]). Dr. Bedford reported that the procedure he performed caused hydatids to emerge from the woman's uterus, the result of abnormal development that today is called a molar pregnancy. *Id.* 950:16-23 (citing Bedford at 17-18). This demonstrated that he made the right judgment call, and he reported it to his students with pride. *Id.* 950:24-25 (citing Bedford at 17-18). His lecture was reprinted in the *New York Herald*, then an irreverent and sensationalist two-penny paper. *Id.* 951:4-12, 17-24 (citing *Medical*, New York Herald, Feb. 13, 1848, at 1). Other doctors raised objections to the detailed description of how to perform an abortion appearing in a publication with such wide circulation, but no one questioned Dr. Bedford's medical judgment, and he did not face any legal consequences for his actions. *Id.* 951:13-952:20. He continued to recount the episode in subsequent lectures and publications. *Id.* 952:18-20.

297. Dr. Storer, the architect of the AMA's campaign against criminal abortion, wrote about what he thought were justifiable reasons to perform an abortion on multiple occasions. Tr. 953:25-954:2 (Cohen). In a professional publication, he focused on conditions that would make vaginal childbirth difficult or impossible, such as "malformation or monstrosity of the foetus"; pelvic contraction; and uterine cancer, as well as "severe obstetric complications" in the current pregnancy or in prior pregnancies, including "obstinate vomiting"; "puerperal convulsions" (*i.e.*, postpartum seizures caused by eclampsia); "dropsies" (*i.e.*, edema); "irreducible displacements

of the uterus" (*i.e.*, permanent descension of the uterus due to pelvic floor weakening); and "varix of the external labial vessels" (*i.e.*, swollen or twisted veins on the labia). *See id.* 954:5-956:20 (citing Horatio R. Storer, *On Criminal Abortion* 64-65 (Philadelphia, J.B. Lippincott & Co. 1860), https://wellcome collection.org/works/r37g29ar) [https://perma.cc/W993-7CRW]. In a publication intended for a general audience, he emphasized two broader considerations: "cases of insanity, of epilepsy, or other mental lesion, where there is fear of transmitting the malady to a line of offspring," and "general ill-health, where there is perhaps a chance of a patient becoming an invalid for life." *Id.* 957: 2-19, 958:11-959:8 (quoting Storer, *Why Not?*, at 25, https://archive.org/details/whynotbookforeve00stor) [https://perma.cc/P65J-24MD].

298. Dr. Storer lived in Massachusetts where the abortion statute criminalized abortions that were "malicious[]" and "without lawful justification." 1845 Mass. Acts p. 406; *see* Tr. 939:20-940:6 (Cohen). The line between malicious and lawful abortion was made apparent in a case appealed to Massachusetts' highest court in 1858. *See Commonwealth v. Wood*, 77 Mass. 85, 90 (1858). A physician was charged with violating Massachusetts' 1845 abortion statute. *Wood*, 77 Mass. at 86-87. At trial, the judge instructed the jury "that if the defendant, a practising physician, in the exercise of his best skill and judgment, honestly believed that the act was necessary to preserve the mother from great peril to life or health, and in good faith procured a miscarriage with that view, he could not be convicted." *Id.* at 90. The jury nonetheless found him guilty, likely based on evidence that he had an ongoing sexual relationship with the unmarried abortion patient that was the cause of her pregnancy. *Id.*; Tr. 938:6-9 (Cohen). On appeal, the Massachusetts Supreme Court held that the jury instructions were proper and that, if the jury concluded that the physician performed the abortion "to screen [the patient] or himself from exposure and disgrace," the statute's mens rea element

would be satisfied. *Wood*, 77 Mass. at 92. Thus, although the case resulted in a conviction, it shows that terminating a pregnancy for the purpose of preserving a woman's health was understood to be lawful in Massachusetts. Tr. 939:10-22 (Cohen).

299. Subsequent decisions of the Massachusetts Supreme Court confirm this understanding of the law. *See, e.g.*, *Commonwealth v. Wheeler*, 53 N.E.2d 4, 5 & n.1 (Mass. 1944) (citing *Rex v. Bourne*, [1939] 1 K.B. 687) ("[A] physician may lawfully procure the abortion of a patient if in good faith he believes it to be necessary to save her life or to prevent serious impairment of her health, mental or physical, and if his judgment corresponds with the general opinion of competent practitioners in the community in which he practices."); *Commonwealth v. Nason*, 148 N.E. 110, 112 (Mass. 1925) (upholding a jury charge that included the following instruction: "[A] physician has a right to commit an abortion and if it is done upon the best judgment of that doctor and his judgment corresponds with the average judgment of the doctors in the community in which he practices, that can cease to be illegal and becomes legal, just as legal as if he were delivering a woman with forceps five days before the period of gestation"); *Commonwealth v. Brown*, 121 Mass. 69, 76 (1876) (upholding a jury charge that included the following instruction: "[T]he jury are instructed that a physician may lawfully procure the miscarriage of a woman pregnant with child, by any means appropriate and reasonable for that purpose, directly or indirectly applied, if in so doing he acts in good faith for the preservation of the life or health of such pregnant woman").

300. Whereas Dr. Storer contended that, when a pregnant patient suffered from mental illness, abortion was justified on eugenic grounds, *see supra* at ¶ 297, other doctors cited preservation of the patient's life and health as a basis for providing abortion care to those with mental illness. For example, in 1894, Dr. Robert C. Eve of Augusta, Georgia, wrote that

abortion is "justifiable" and "recommended" to preserve a patient's life "in some cases of pregnancy complicated with insanity." Tr. 959:11-961:4 (Cohen) (quoting Robert C. Eve, *The Medico-Legal, Legal, and Moral Aspects of Criminal Abortion and Infanticide*, 11 Atlanta Med. & Surgical J., no. 9, Nov. 1894, at 520). Similarly, a doctor writing in a prominent North Dakota medical journal in 1914 included among a list of cases "in which an abortion is imperative: the mentally unfit who might become deranged." *Wrigley v. Romanick*, 988 N.W.2d 231, 241 (N.D. 2023) (quoting *Criminal Abortions*, 34 Journal-Lancet 81, 82 (1914)) (citing this as evidence that "it was common knowledge that an abortion could be performed to preserve the life or health of the woman").

301. Dr. T. Gaillard Thomas delivered a series of lectures at New York City's College of Physicians and Surgeons in 1889-90 urging a broad view of therapeutic abortion to the students. Tr. 961:6-24 (Cohen) (citing T. Gaillard Thomas & P. Brynberg Porter, *Abortion and its Treatment, from the Stand-Point of Practical Experience: A Special Course of Lectures Delivered at the College of Physicians and Surgeons, New York, Session of 1889-90*, at 99-104 (New York: Appleton and Co. 1896) [hereinafter Thomas]). Anything that threatens "to destroy the life or intellect, or to permanently ruin the health of a patient," is an indication for abortion, he said. *Id.* 962:12-24 (quoting Thomas at 99). The "vomiting of pregnancy," which he believed to be responsible for the death of Charlotte Brontë, topped his list. *Id.* 963:4-9 (Cohen) (quoting Thomas at 100). Another danger was a kidney condition called puerperal nephritis; the doctor called it "cruel" to subject a patient to the risk of dying in labor of puerperal convulsions, or surviving it with the doom of chronic Bright's disease. *Id.* 963:10-20 (Cohen) (quoting Thomas at 101). Cardiac disease, cancer, chorea, and contracted pelvis, along with placenta praevia and convulsions rounded out his list of indications for abortion. *Id.* 963:21-964:1

(Cohen) (citing Thomas at 101-104). He told the students that this list was not meant to be exhaustive: "In this enumeration, I do not pretend to give you all the conditions which may, from time to time, call for this measure. I only aim to show you some of the principal ones as they have been met with by me in actual practice …." *Id.* 965:1-8 (quoting Thomas at 104).

302. Dr. Thomas acknowledged advancements in the performance of Caesarian sections, including the advent of Porro's operation, a Caesarean section followed immediately by a hysterectomy. Tr. 964:2-14 (citing Thomas at 102-03). Porro's operation was safer than traditional Caesarean section because it reduced the risk of serious hemorrhaging, but it left the patient infertile. *Id.* 964:15-22. Dr. Thomas said: "I still do not believe that when we can avoid it by inducing abortion, we are justified in subjecting our patient to the great risk attending these operations, even under the most favorable conditions." *Id.* 964:2-10 (quoting Thomas at 102-03). He concluded his lecture series with a detailed description of how to perform an abortion safely, in contrast to the methods used by commercial abortion providers. *Id.* 965:25-966:4 (citing Thomas at 104-112).

303. Even those who believed that therapeutic abortion was justified only in narrow circumstances acknowledged that the law gave physicians broad discretion in the matter. For example, Dr. William H. Parish of Philadelphia reported with apparent dismay that some regulars performed therapeutic abortions for indications he did not think warranted them. Tr. 969:24-970:20 (Cohen) (citing William H. Parish, *Criminal Abortion*, 14 Proceedings of the Philadelphia County Medical Society, 1893, at 154-55 [hereinafter Parish], https://www.google.com/books/edition/Proceedings_of_the_Philadelphia_County_M/eWweyrg519MC?hl=en&gbpv=0). As an illustration, he discussed a case in which, after he rendered an opinion that a particular patient's abortion would not be justified on therapeutic grounds, a regular

physician in a different city reached the opposite conclusion and performed the abortion. *Id.* 970:24-971:10 (citing Parish at 155). Both the patient and her husband were concerned, based on the patient's prior experiences with pregnancy, that carrying this pregnancy to term would cause her to develop insanity. *Id.* 971:1-5 (citing Parish at 154-55). Dr. Parish acknowledged that "there is room for difference of opinion in the medical profession as to what conditions justify the production of abortion," and "[t]he law leaves it quite entirely to the medical profession to determine what constitutes justifiable abortion, either early or late [in gestation]." *Id.* 971:11-23 (quoting Parish at 154).

304. In 1907, Dr. Montgomery Russell of Seattle similarly wrote that: "The law leaves it entirely to the judgment of the medical profession to determine when it is necessary and warrantable to produce abortion." Tr. 972:14-974:1 (Cohen) (quoting Montgomery Russell, *Criminal Abortion*, 5 Nw. Med., Jan.-Dec. 1907, at 303, https://archive.org/details/northwestmedicin5190nort) [https://perma.cc/EUN5-PJJ5https://perma.cc/6WKG-4UDX]. Dr. Russell noted that even criminal abortionists seldom faced legal consequences, calling the law concerning criminal abortion "practically a dead letter." *Id.* 974:5-14 (quoting Russell at 303). He observed that criminal abortionists are seldom prosecuted or convicted unless their patient dies. *Id.* 974:15-975:4 (quoting Russell at 303). He attributed the lack of legal accountability to overly permissive laws and public sympathy for those who seek and provide abortions, stating: "Abortionists are sheltered by the words of the law and the sympathy of the community." *Id.* (quoting Russell at 303).

305. The original edition of Williams' *Obstetrics* was published in 1903. Tr. 981:23-982:7 (Cohen). It posited a duty to provide therapeutic abortion prior to fetal viability in the following circumstances: "(1) as a direct means of saving the life of the mother; (2) to do away

with a condition which may threaten her life if gestation continues; and (3) to avoid certain dangers which may supervene if pregnancy is allowed to progress to full term." *Id.* 982:17-983:2 (quoting J. Whitridge Williams, *Obstetrics,* 338 (1st ed. 1903) (https://wellcomecollection.org/works/e7 r6bqzt) [https://perma.cc/8XE2-GXY8]).

306. In the 1910-20s, journals of state and regional medical societies followed a custom of printing the prior year's board exams as a study aid. Tr. 983:4-12 (Cohen). In the Northwest Medicine Journal (published jointly by state medical societies in Idaho, Washington and Oregon), an essay exam question in 1911 asked, "[u]nder what circumstances may a physician be justified in producing an abortion, and how is the operation performed." *Id.* 983:13-20, 984:25-985:10 (quoting Examination Questions, 3 Nw. Med. 266, 269 (1911), https://archive.org/details/northwestmedicin1019nort/page/268/mode/2up?q=%22Examination+Questions%22 [https://perma.cc/648F-ZA3S]). This tells us that the distinction between criminal and therapeutic abortions was a standard part of the medical schools' curriculum, along with instruction in how to accomplish a safe abortion. *Id.* 985:11-15.

307. An article written for the Journal of the Catholic Medical Association in 1952 by a pair of doctors who believed that "[t]herapeutic abortion is legalized murder," Roy J. Heffernan & William A. Lynch, *Is Therapeutic Abortion Scientifically Justified?*, 19 Linacre Q. 11, 25 (1952), https://epublications.marquette.edu/lnq/vol19/iss1/5/, reported that:

> Twenty-five or thirty years ago [1922-1927], therapeutic abortions were performed with deplorable frequency in most of the leading non-Catholic clinics. Tuberculosis, heart disease, diabetes, hyperemesis gravidarum, neoplasms, chronic nephritis, hypertension, various types of anemia, chorea, thyroid disfunction, disturbances of the nervous system and psychiatric disorders, in fact in almost any complication of early pregnancy which did not promptly respond to conservative therapy, evacuation of the uterus would be considered.

Id. at 11. Thus, although these doctors deplored therapeutic abortion, they understood the practice to be "legalized" and widespread in the early decades of the twentieth century.

308. The formalization of the discipline of psychiatry in the United States paralleled that of medicine more broadly, with institutionalization accelerating in the mid-nineteenth century. Eppinger Article at 739. Benjamin Rush, for example, published his first American textbook on psychiatry in 1812. Tr. 563:3-11 (Eppinger) (citing Benjamin Rush, *Medical Inquiries and Observations upon Diseases of the Mind* (1812)). The founding of the American Psychiatric Association in 1844 and Dorothea Dix's post-Civil War campaign for specialized treatment hospitals helped to establish psychiatry as part of the emerging medical mainstream. Tr. 562:24-563:2, 563:12-564:2 (Eppinger); Eppinger Article at 739-40. Regulars sometimes cited mental illness as an indication for therapeutic abortion. *Supra* at ¶¶ 300, 303, 307.

309. In addition to providing therapeutic abortions in the nineteenth and early twentieth centuries, doctors continued to provide emmenagogic treatments that they knew entailed a serious risk of causing miscarriage. Tr. 986:9-16 (Cohen). Many engaged in routine use of intra-uterine probes to restore patients with blocked menses to health. Tr. 986:24-987:1, 989:8-22, 990:11-15, 996:5-11 (Cohen).

310. For example, Dr. Henry Miller, a doctor in Louisville, Kentucky, who served as President of the AMA in 1859, and thus the designated backer of its campaign against criminal abortion, described making "free use of the uterine sound," an intrauterine probe that initially caused little pain but soon after caused "severe hypogastric suffering" lasting for a day or more. Tr. 986:17-987:14, 988:11-989:1 (Cohen) (quoting Henry Miller, *Principles and Practices of Obstetrics* (Blanchard and Lea, 1858), at 96-97, https://www.google.com/books/edition/The_Principles_and_Practice_of_Obstetric/PSE1AQAAMAAJ?hl=en&gbpv=1 [https://perma.cc/M8BA-2JD3]). Miller believed the humoral theory that "menstruation is, as all experience testifies, so essential to female health; why, when it is morbidly suppressed, the

whole system suffers, and when it is restored, the flow of health revisits the cheeks." *Id.* 987:22-988:9 (quoting Miller at 82). He acknowledged that using the tool to probe the uterus created a risk of abortion: "In truth, this is a misfortune which can only be avoided by perpetual vigilance. It occurred once in my own hands." *Id.* 989:23-990:8 (quoting Miller at 98).

311. In 1864, Dr. Storer dedicated an entire article to the topic of treating amenorrhea with a uterine probe. Tr. 990:11-991:3 (Cohen). In it, he warned of "unintentionally, and so far innocently, committing malpractice, and thereby of adding confirmation to an opinion already but too prevalent, that the profession directly, or by implication, sanction the induction of criminal abortion." *Id.* 991:12-992:1 (quoting Horatio R. Storer, *The Surgical Treatment of Amenorrhea*, 47 Am. J. Med. Sci., Jan. 1864, at 81, https://library.si.edu/digital-library/book/americanjournalo47thor) [hereinafter Storer, *Amenorrhea*]. Candidly, Dr. Storer admitted to having "more than one direct occurrence of the accident against which I would now guard the profession." *Id.* 992:16-24 (citing Storer, *Amenorrhea* at 87).

312. Dr. Henry I. Bowditch of Boston was Dr. Storer's colleague and a fellow member of the Suffolk County Medical Society. Tr. 993:12-23 (Cohen). He provided written feedback to Storer on an early report advocating for stricter abortion laws. *Id.* 993:24-994:6, 995:10-14. Among other things, he expressed concern that such laws would eliminate his unchecked prerogative to use the probe. *Id.* 995:15-996:11. In a private letter to Dr. Storer, he wrote:

> Are there not cases where a physician would be justified in suggesting a course [of?] med as he would use in Amenorrhoea, even when he might *suspect*, but not be able to *know* of the evidence of pregnancy? Suppose a mother of several children which she has in rapid succession & the physician feels assured that health & possible life will be endangered if another pregnancy occurs, would he be criminal if he were to use common means for amenorrhoea if the menses have been absent six weeks? Are the cases always so plain that a man can decide & may he not balance a choice of evils?

Id. 995:18-996:4 (quoting Letter from Henry I. Bowditch to H.R. Storer (Apr. 20, 1857) (original at the Countway Library, Harvard University), https://horatiostorer.net/letters-to/) .

313. Despite the enactment of so many abortion statutes in response to the AMA's campaign, successful prosecutions for criminal abortion in the nineteenth and early twentieth centuries were rare, and successful prosecutions for therapeutic abortion were non-existent. Tr. 565:4-7 (Eppinger); Tr. 936:22-937:2 (Cohen); Tr. 842:17-25 (Dellapenna); Ex. 10 at 431 ("Acquittals or dismissals do predominate among reported cases.").

314. Many jurisdictions afforded doctors a *presumption* that they were acting with therapeutic intent, requiring prosecutors to prove otherwise beyond a reasonable doubt. *See, e.g.*, *People v. Davis*, 200 N.E. 334, 425-26 (Ill. 1936); *State v. DeGroat*, 168 S.W. 702, 706 (Mo. 1914) (collecting cases); *id.* at 707 ("[W]e conclude that by the great weight of the ruled cases, and from the logic of the case, and for reasons to be deduced from rules on cognate matters, the burden is on the state to prove the nonnecessity of the abortion to save the life of the mother or the life of an unborn child."); *State v. Wells*, 100 P. 681, 686-87 (Utah 1909), *overruled by State v. Crank*, 105 Utah 332 (1943); *State v. Clements*, 14 P. 410, 415 (Or. 1887) ("The experience of mankind shows that cases have often arisen in which such treatment has necessarily been resorted to, and, in the absence of other proof, the law, in its benignity, would presume that it was performed in good faith, and for a legitimate purpose."); *Moody v. Ohio*, 17 Ohio St. 110, 111-12 (1866). Some jurisdictions afforded the presumption only to regular physicians. *See, e.g.*, *State v. Dunklebarger*, 221 N.W. 592, 594 (Iowa 1928) ("This presumption, as applied to a regular physician, was recognized in [*State v. Rowley*, 198 N.W. 37 (Iowa 1924)], where we refused to recognize such presumption in favor of one who was not a regular physician.").

315. Few, if any, cases from this time period discuss the scope of express therapeutic exceptions. *See* Tr. 933:3-15, 936:22-2 (Cohen). The Court is aware of an ambiguous case from 1891 in which the Wisconsin Supreme Court upheld the convictions of a doctor and his wife in connection with an abortion that caused the death of the pregnant woman. *Hatchard v. State*, 48 N.W. 380, 382 (Wis. 1891). The wife—but not the doctor—alleged that the abortion was therapeutic because the pregnant woman had threatened to commit suicide, and that the jury should have been instructed accordingly. *Id.* There was no evidence that the pregnant woman was suffering from a mental illness, and no evidence that the doctor believed that the abortion was necessary to save her life. *See id.* ("[T]here is no testimony tending to show that Dr. Hatchard thought anything of the kind."). The court held that the wife was not entitled to a jury instruction on therapeutic abortion for three reasons: (1) there was no evidence that the doctor believed the abortion was therapeutic; (2) the doctor failed to consult with any other physician concerning the patient; and (3) the statute was only intended to apply in cases where a pregnant woman's death was anticipated to result from "natural causes." *Id.* It is not clear from the decision whether the court viewed all suicidal ideation as outside the scope of the therapeutic exception or only suicidal ideation not linked to a medical diagnosis.[19] *Id.*

316. After World War II, for a variety of reasons, the practice of therapeutic abortion largely moved to hospitals, where review boards were established to weigh the medical justifications for a patient's abortion to determine if they met legal criteria. Tr. 565:8-566:8 (Eppinger); *see* Reva B. Siegel & Mary Ziegler, *Abortion's New Criminalization: A History-and-*

[19] There is evidence that early American law distinguished between suicidal acts by those who are sane and suicidal acts by those who are mentally ill. *See Washington v. Glucksberg*, 521 U.S. 702, 712-13 (1997) (discussing a colonial Rhode Island law that the Court viewed as representative).

Tradition Right to Health-Care Access After Dobbs, 111 Va. L. Rev. 413, 447 (2025) [hereinafter Siegel & Ziegler] ("After allowing greater access to abortion during the Great Depression of the 1930s, many jurisdictions seemed to have increased prosecutions in the 1940s, targeting not only negligent physicians but also skilled providers. Hospitals seeking to defuse the threat of prosecution and stabilize practice created therapeutic abortion committees that deliberated about the permissibility of abortion in individual cases." (footnotes omitted)). Risk averse institutions operating in an increasingly hostile environment, hospitals were generally more wary of providing care based on implied statutory exceptions than individual doctors had been a century earlier. *See* Tr. 566:9-15 (Eppinger).

317. The Finkbine case in 1962 illustrates this dynamic. Sherri Chessen Finkbine was a local television personality in Arizona, pregnant with her fifth child, when she took thalidomide pills that her husband had obtained while traveling in Europe. *See* Tr. 999:10-14 (Cohen); Sherri Chessen Finkbine, *The Lesser of Two Evils*, *in Before* Roe v. Wade*: Voices That Shaped the Abortion Debate Before the Supreme Court's Ruling* 11, 12-14 (Linda Greenhouse & Reva Siegel eds., 2012) [https://perma.cc/D3K3-9DT9] [hereinafter Finkbine]. After learning that the medication had teratogenic effects, she sought advice from her doctor, who recommended a therapeutic abortion. Finkbine at 13. Based on the risk that her baby would be born with serious birth defects, Finkbine decided to proceed with the abortion. *Id.* at 13-14. Her doctor sought approval from his hospital's review board, which initially granted it. *Id.* But after Finkbine shared her story with a local reporter, international publicity ensued, and the review board got cold feet. *Id.* ("The surgery, they felt at that point, could be challenged by any citizen. Anyone could have gone to the prosecuting attorney and the doctor, the hospital and myself could face criminal prosecution no matter how noble or how right we felt our justification

was."). Finkbine and the hospital filed a declaratory judgment action in state court seeking judicial determination that the abortion was permitted under Arizona law, but the case was dismissed on jurisdictional grounds. *Id.* at 14-15; *Mother Loses Round in Legal Battle for Abortion: Arizona Court Dismisses Suit for Prosecution Immunity*, N.Y. Times, July 31, 1962, at 9. Finkbine ultimately traveled to Sweden to obtain an abortion. Tr. 999:15-21 (Cohen); Finkbine at 17.

318. Situations like this prompted a new campaign to reform abortion laws, this time to close the gap between statutory language and standard medical practice. *See* American Law Institute Abortion Policy, 1962, *in Before* Roe v. Wade*: Voices That Shaped the Abortion Debate Before the Supreme Court's Ruling* 24, 24-25 (Linda Greenhouse & Reva Siegel eds., 2012) [https://perma.cc/D3K3-9DT9] (discussing the Model Penal Code's introduction of a provision concerning therapeutic abortion); *Doe v. Bolton*, 410 U.S. 179, 182 (1973) (noting that the Model Penal Code provision "has served as the model for recent legislation in approximately one-fourth of our States"), *abrogated by Dobbs*, 597 U.S. at 231.

319. In the midst of this campaign, various stakeholders across the country brought cases concerning the scope and constitutionality of therapeutic exceptions in state abortion statutes. Courts deciding these cases generally did not employ originalist methodologies, so the extent to which they can inform our knowledge of the public's understanding of these statutes at the time of their enactment is limited. In any event, their outcomes vary widely.

320. For example, in the 1950s and 60s, California appellate courts applying the state's 1850 abortion statute, which exempted from liability any physician "who, in the discharge of his professional duties, deems it necessary to produce the miscarriage of any woman in order to save her life," 1850 Cal. Stats. p. 233, held that credible evidence of mental illness satisfied the

exception. *See People v. Abarbanel*, 48 Cal. Rptr. 336, 339 (Cal. Dist. Ct. App. 1965) ("[H]ere the record discloses that two qualified psychiatrists recommended the therapeutic abortion and there is no evidence that appellant disbelieved or doubted the validity of these recommendations."); *People v. Ballard*, 335 P.2d 204, 206 (Cal. Dist. Ct. App. 1959) ("It may be well to say at the outset in this case that a great deal of misunderstanding would be avoided in abortion matters if they were considered in the light of the fact that an abortion is not necessarily, in and of itself, an illegal procedure or act. In other words, not all abortions are illegal."); *id.* at 211 ("In this case it is admitted, at the very least, that Mrs. Gresham was *extremely nervous*. She apparently was *upset, had headaches*, was *unable to sleep*, and *thought that she was pregnant*. She was *agitated, disturbed* and *had many problems* …. Such a showing would not seem to prove beyond a reasonable doubt and to a moral certainty that she was in good health and that treatment of some sort was not necessary."). The California Supreme Court had earlier indicated that liability could not be imposed under the statute on a doctor who, "acting in good faith … attempted to empty the uterus in the interest of the health or for the preservation of the life of the patient." *People v. Darrow*, 298 P. 1, 6 (Cal. 1931). In 1969, however, the California Supreme Court held that the therapeutic exception was unconstitutionally vague by contemporary medical standards and invalidated the entire statute as a result. *People v. Belous*, 458 P.2d 194, 197 (Cal. 1969).

321. In 1971, the U.S. Supreme Court considered the meaning of the word "health" as used in the 1901 District of Columbia abortion statute's therapeutic exception. *United States v. Vuitch*, 402 U.S. 62, 71-72 (1971). It held, based on "the general usage and modern understanding of the word 'health,'" that the term encompassed both physical and mental health. *Id.* at 72.

322. In contrast, in 1972, the Illinois Supreme Court held that the therapeutic exception in Illinois' 1961 abortion statute, which was substantially similar to its nineteenth-century abortion statute, did not permit abortion for mental health reasons. *People ex rel. Hanrahan v. White*, 285 N.E.2d 129, 130-31 (Ill. 1972). The court relied heavily on the fact that statutory amendments proposed in 1969 and 1971, which would have expressly authorized abortion for mental health reasons, were not enacted. *Id.*

323. Some state court cases from this period held that therapeutic exceptions authorized abortions only in cases where death was reasonably certain to occur during pregnancy. *Sasaki v. Commonwealth*, 485 S.W.2d 897, 901 (Ky. App. 1972) ("The court is of the opinion that the phrase 'necessary to preserve her life' is not unconstitutionally vague, albeit perhaps technically imprecise. The phrase means, and is generally understood to mean, that an abortion is unavailable except if it is reasonably certain that a woman's continued pregnancy will result in her death." (quoting *Crossen v. Att'y Gen.*, 344 F. Supp. 587, 590 (E.D. Ky. 1972)), *vacated*, 410 U.S. 951 (1973) (mem.); *Nelson v. Planned Parenthood Ctr. of Tucson, Inc.*, 505 P.2d 580, 584-85 (Ariz. App. 1973) (quoting *Crossen*, 344 F. Supp. at 590). Yet state court cases from other periods construing similar statutory language held that death need not be certain or imminent. *See, e.g.*, *Planned Parenthood Gr. Nw.*, 522 P.3d at 1203 ("[T]he statute does not require *objective* certainty, or a particular level of immediacy, before the abortion can be 'necessary' to save the woman's life."); *Dunklebarger*, 221 N.W. at 596 (Iowa 1928) (reversing a conviction for procuring a miscarriage) ("In order to justify the act of Dr. Wallace, it was not essential that the peril to life should be imminent. It was enough that it be potentially present, even though its full development might be delayed to a greater or less extent. Nor was it essential

that the doctor should believe that the death of the patient would be otherwise *certain* in order to justify him in affording present relief.").

324. In 1972, the Indiana Supreme Court held that the therapeutic exception in Indiana's abortion statute permitted abortion "only when the continuation of the pregnancy will directly and proximately result in the death of the mother." *Cheaney v. State*, 285 N.E.2d 265, 271 (Ind. 1972). In 2023, however, the court abrogated its prior decision, holding that Indiana's therapeutic exceptions have always encompassed serious, nonfatal health risks. *Members of Med. Licensing Bd. of Ind. v. Planned Parenthood Gr. Nw., Haw., Alaska, Ind., Ky.*, 211 N.E.3d 957, 976 (Ind. 2023) ("[I]t is a relatively uncontroversial legal proposition that the General Assembly cannot prohibit an abortion procedure that is necessary to protect a woman's life or to protect her from a serious health risk. Reflecting that understanding, all of Indiana's abortion statutes since 1851 have recognized an exception for abortions that are required to protect a woman's life." (citations omitted)).

325. In addition to California, the Supreme Courts of Florida and Vermont invalidated their state abortion statutes on vagueness and substantive due process grounds, respectively, after analyzing the scope of protection for therapeutic abortion. *State v. Barquet*, 262 So.2d 431, 435 (Fla. 1972); *Beecham v. Leahy*, 287 A.2d 836, 840 (Vt. 1972).

326. Lower federal courts split on the scope and constitutionality of state abortion statutes during this period. *See, e.g.*, *Abele v. Markle*, 342 F.Supp. 800, 801 (D. Conn. 1972) (invalidating statute on substantive due process grounds), *vacated*, 410 U.S. 951 (1973) (mem.); *Babbitz v. McCann*, 310 F.Supp. 293, 302 (E.D. Wis. 1970) (invalidating statute on substantive due process grounds); *Steinberg v. Brown*, 321 F.Supp. 741, 742 (N.D. Ohio 1970) (upholding statute) ("This is another in a series of cases which have been and are being filed in various

courts throughout the United States attacking the constitutionality of state statutes forbidding abortions."); *Rosen v. Louisiana State Board of Medical Examiners*, 318 F.Supp. 1217, 1219 (E.D. La. 1970) (upholding statute), *vacated*, 412 U.S. 902 (1973) (mem.).

327. The Supreme Court's 1973 decisions in *Roe v. Wade* and *Doe v. Bolton* settled questions about the circumstances in which doctors may lawfully provide therapeutic abortions until *Dobbs* overturned them in 2022.

PROPOSED CONCLUSIONS OF LAW

I. Standing

A. Article III Standing

328. "One need not violate a criminal law and risk prosecution in order to challenge the law's constitutionality." *Peace Ranch, LLC v. Bonta*, 93 F.4th 482, 487 (9th Cir. 2024). A plaintiff in a pre-enforcement challenge has Article III standing if (1) the plaintiff has alleged "an intention to engage in a course of conduct arguably affected with a constitutional interest;" (2) the conduct is "arguably proscribed by statute;" and (3) "there exists a credible threat of prosecution." *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 159-64 (2014). Dr. Seyb satisfies this test.

329. When analyzing the first prong of the *Driehaus* test, "courts must ask whether the plaintiff would have the intention to engage in the proscribed conduct, were it not proscribed." *Peace Ranch*, 93 F.4th at 488. "Intention," in this context, is a counterfactual construct: it asks not what the plaintiff has done, but what he would do if the law did not forbid it. *Id.* Here, Dr. Seyb's testimony demonstrates that he would like to offer abortion care to all pregnant patients with serious medical needs, and he stands ready, willing, and able to do so should the Court grant him the relief he is seeking in this case. *Supra* at ¶¶ 8, 101, 193. This conduct arguably enjoys constitutional protection under the Fourteenth Amendment's Due Process and Equal Protection

Clauses, so the first prong of the test is satisfied. *See infra* at ¶¶ 349-446; *Peace Ranch*, 93 F.4th at 488 (explaining that the inquiry into constitutional interest "does not require [a court] to engage in a mini litigation of the claims" or determine that the plaintiff's claims are meritorious); *Isaacson v. Mayes*, 84 F.4th 1089, 1099 (9th Cir. 2023) (holding that the plaintiff physicians satisfied the first *Driehaus* prong in a challenge to abortion restrictions because their claim was rooted in the Due Process Clause).

330. The second prong of the *Driehaus* test is satisfied because the Abortion Bans prohibit abortion care that Dr. Seyb would like to provide in many circumstances, including when a patient is facing a risk of death from self-harm; when a patient is facing a risk of serious morbidity that is not necessarily life threatening; when a patient is carrying an embryo or fetus with a life-limiting condition, and when a patient is seeking a multi-fetal pregnancy reduction. *Supra* at ¶¶ 101, 193; *cf. Isaacson*, 84 F.4th at 1099 (concluding that the second *Driehaus* factor was satisfied where "many abortions [the plaintiff physicians] would otherwise perform could be deemed violations of the statute").

331. The State implies—though it studiously avoids taking an explicit position—that the middle category is an empty set. Through the testimony of Dr. Kraus, the State seeks to establish that any medical condition that poses a serious threat to a pregnant person's health also poses a serious threat to the person's life. Dr. Kraus' testimony failed to establish this, however. She acknowledged that "there is an area of significant or severe morbidity that's going to also overlap with mortality. But it's a subset of morbidity, not all of it." Tr. 1211:4-7 (Kraus). Further, the weight of the evidence demonstrates that some complications of pregnancy and some medical conditions exacerbated by pregnancy can cause serious nonfatal complications, such as blindness, infertility, and progression of chronic disease. *Supra* at ¶¶ 150, 163, 166, 168,

172; Tr. 1170:21-1171:5, 1177:4-12 (Kraus); Tr. 1223:9-25 (Eller). In addition, some pregnancy-related complications can cause such rapid decompensation that, if a doctor waits to intervene until a patient is no longer medically stable, as Dr. Kraus testified the Abortion Bans require, Tr. 1189:19-1190:18 (Kraus), it may be too late to prevent the patient from experiencing serious complications or death, *id.* at 1190:19-24.

332. In any event, this issue goes to the scope of relief that the Court should award if Plaintiff establishes a constitutional violation, and not to whether Dr. Seyb has standing to seek relief in the first instance. It is undisputed that the Abortion Bans prohibit *some* abortions that Dr. Seyb would like to provide, such as in cases where a patient faces a risk of death from self-harm, is carrying an embryo or fetus with a life-limiting condition, or seeks a multi-fetal pregnancy reduction. Tr. 1196:18-25 (Kraus); Ex. 1010 at 9-10. Plaintiff's inability to lawfully provide these abortions satisfies Article III's injury requirement and vests the Court with jurisdiction to consider Plaintiff's claims for declaratory and injunctive relief. Should Dr. Seyb prevail on those claims, the Court will limit any relief awarded to circumstances in which a patient *does not* face a risk of death from a cause other than self-harm.

333. The third prong of the *Driehaus* test is satisfied because Dr. Seyb would face a credible threat of enforcement were he to provide medically indicated abortions not covered by the Abortion Bans' exceptions. "This final prong often rises or falls with the enforcing authority's willingness to disavow enforcement." *Peach Ranch*, 93 F.4th at 490. Here, the State has not disavowed enforcement against Dr. Seyb for providing abortions that are prohibited by the Abortion Bans. This case is therefore distinguishable from *Idaho Federation of Teachers. v. Labrador*, No. 1:23-cv-00353-DCN, 2024 WL 3276835, at *1 (D. Idaho July 2, 2024), where the State had "*specifically and emphatically*" disavowed enforcement of the challenged statute

against the plaintiffs for the activities they wished to pursue. Moreover, in *Isaacson*, a vagueness challenge to Arizona abortion regulations, the Ninth Circuit pointed to statements that Arizona officials had made in other litigation as evidence of a credible threat of enforcement. *See, e.g.*, 84 F.4th. at 1101 ("Although this was a general statement …, Plaintiffs could reasonably interpret it as a threat to investigate physicians who run afoul of those Regulations."). Here, the State of Idaho expressed a general intention to enforce the Total Abortion Ban against physicians providing medically indicated abortions in litigation concerning whether the ban is pre-empted by EMTALA. *See supra* at ¶¶ 23-24; Br. for Pet'r at 39-40, *Moyle v. United States*, 603 U.S. 324 (2024) (No. 23-727) (arguing that Idaho would be irreparably harmed if it could not enforce the Total Abortion Ban); *id.* at 3, 5 (discussing Idaho's 150-year commitment to prohibiting abortion).

334. Despite the State's arguments, the Members of the Medical Board have not disavowed enforcement of the Abortion Bans. To the contrary, the Medical Board takes the position that exercise of the enforcement authority delegated to it by statute is "mandatory." Tr. 654:13-16, 655:2-9, 15-17 (Guzman); *supra* at ¶¶ 12, 20 (discussing the Board's statutory enforcement authority). The Medical Board merely claims that it will not commence administrative enforcement proceedings against a doctor who violates the Abortion Bans until criminal enforcement proceedings have concluded. But the sequence of enforcement actions is a distinct issue from whether the threat of enforcement is credible. Because the Medical Board admits that it will certainly take enforcement action against any doctor who is convicted of violating the Abortion Bans, Tr. 654:13-16, 655:2-9, 15-17 (Guzman), Dr. Seyb faces a credible threat of enforcement by the Medical Board should he perform an unlawful abortion. It is worth noting, nevertheless, that the Medical Board's position concerning the sequence of enforcement

actions is not recorded in any official way—not in rulemaking, not in written guidance, not even in meeting minutes, Tr. 659:15-660:2 (Guzman)—and it is not binding. The Medical Board is free to change its position at any time in the future. *Id.* 660:3-8.

335. Accordingly, Dr. Seyb satisfies the requirements for Article III standing.

B. Third-Party Standing

336. It is well-settled that a plaintiff has "standing to litigate the rights of third parties when enforcement of the challenged restriction against the litigant would result indirectly in the violation of third parties' rights." *Warth v. Seldin*, 422 U.S. 490, 510 (1975); *accord Kowalski v. Tesmer*, 543 U.S. 125, 130 (2004). Indeed, when this criterion is met, a plaintiff need not demonstrate a close relationship with the third parties at issue nor that they face a hindrance to asserting their own rights. *Kowalski*, 543 U.S. at 130. Thus, the Supreme Court has allowed third-party standing in cases involving a variety of fact patterns and interests. *Powers v. Ohio*, 499 U.S. 400, 415 (1991) (holding that a criminal defendant had third-party standing to assert the rights of potential jurors excluded from jury service); *Carey v. Pop. Servs. Int'l*, 431 U.S. 678, 684 (1977) (holding that a company selling non-medical contraceptives had third-party standing to assert the rights of potential customers, including minors); *Craig v. Boren*, 429 U.S. 190, 194-95 (1976) (holding that a beer vendor had third-party standing to assert the rights of potential customers where the statute prohibited vendors from distributing beer to young men rather than directly prohibiting young men from drinking beer); *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965) (holding that healthcare providers had third-party standing to assert the rights of patients seeking to use contraception); *Barrows v. Jackson*, 346 U.S. 249, 258 (1953) (holding that white property owners had third-party standing to assert the rights of potential black purchasers).

337. Consistent with these precedents, the Supreme Court and Ninth Circuit have held that abortion providers have third-party standing to assert the rights of their patients in cases

challenging abortion restrictions. *See, e.g.*, *June Med. Servs. L.L.C. v. Russo*, 591 U.S. 299, 318-20 (2020) (plurality opinion) (collecting cases) ("We have long permitted abortion providers to invoke the rights of their actual or potential patients in challenges to abortion-related regulations."), *abrogated on other grounds by Dobbs*, 597 U.S. at 215; *accord June Med. Servs. L.L.C.*, 591 U.S. 299 at 354 n.4 (Roberts, C.J., concurring in the judgment) ("For the reasons the plurality explains, I agree that the abortion providers in this case have standing to assert the constitutional rights of their patients." (citation omitted));[20] *Isaacson v. Horne*, 716 F.3d 1213, 1221 (9th Cir. 2013) ("Recognizing the confidential nature of the physician-patient relationship and the difficulty for patients of directly vindicating their rights without compromising their privacy, the Supreme Court has entertained both broad facial challenges and pre-enforcement as-applied challenges to abortion laws brought by physicians on behalf of their patients.").

338. The Supreme Court's decision in *Dobbs* did not overrule these precedents. *See* 597 U.S. at 233. To the contrary, the *Dobbs* Court decided constitutional claims asserted by "an abortion clinic, Jackson Women's Health Organization, and one of its doctors" on behalf of their patients. *Id.*

339. Accordingly, Dr. Seyb has standing to assert the constitutional rights of his patients.

II. Statutory Jurisdiction, Venue, and Right of Action

340. The Court has jurisdiction over Plaintiff's claims pursuant to 28 U.S.C. § 1331 because this case is a civil action "arising under the Constitution, laws, or treaties of the United

[20] Because the four-Justice plurality and Chief Justice Roberts agreed on the third-party standing analysis in *June Medical*, it constitutes the opinion of a majority of the Court.

States," and 28 U.S.C. § 1343(a)(3) because this case seeks to redress the deprivation of federal constitutional rights under color of state law.

341. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(1) because Defendants, who are government officers sued in their official capacities, operate and perform their official duties in this district. Venue is also proper pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events and omissions giving rise to Plaintiff's claims occurred in this district.

342. 42 U.S.C. § 1983 grants Plaintiff a right of action to redress the deprivation, under color of state law, of rights secured by the U.S. Constitution.

343. Declaratory relief is authorized by 28 U.S.C. §§ 2201–2202 and Federal Rule of Civil Procedure 57.

III. Eleventh Amendment Immunity

344. The Eleventh Amendment generally precludes federal courts from hearing suits brought by a state citizen against the state or its instrumentality in the absence of consent. *Matsumoto v. Labrador*, 122 F.4th 787, 802 (9th Cir. 2024).

345. By voluntarily intervening in this lawsuit, the Attorney General has consented to the Court's jurisdiction and waived any claim to Eleventh Amendment immunity. *Clark v. Barnard*, 108 U.S. 436, 447 (1883) ("The immunity from suit belonging to a state, which is respected and protected by the constitution within the limits of the judicial power of the United States, is a personal privilege which it may waive at pleasure; so that in a suit, otherwise well brought, in which a state had sufficient interest to entitle it to become a party defendant, its appearance in a court of the United States would be a voluntary submission to its jurisdiction."); *accord Lapides v. Bd. of Regents of Univ. Sys. of Ga.*, 535 U.S. 613, 619 (2002) (declaring, in a case concerning removal, that "it is not surprising that more than a century ago this Court

indicated that a State's voluntary appearance in federal court amounted to a waiver of its Eleventh Amendment immunity.").

346. Notably, the Attorney General intervened "on behalf of the State of Idaho," not for a limited purpose like challenging the Court's jurisdiction or seeking to quash a subpoena, but "to defend the constitutionality of the State of Idaho's duly enacted laws regulating abortion" from the merits of Plaintiff's claims. Mem. in Supp., Dkt. No. 61-1 at 1; *accord id.* at 3 ("The Attorney General's timely motion under Rule 24(a)(2) should be granted so that he can represent the unique interests of the State in defending the constitutionality of the laws challenged by Plaintiff."); *id.* at 4 ("The Attorney General, as the elected attorney of the people of the State of Idaho, seeks to intervene to defend the same laws that Plaintiff challenges."); *id.* at 6 ("[T]he Attorney General, as the elected attorney for the people of the entire State of Idaho, seeks to intervene so as to defend and make known the State's position on its laws at issue.").

347. Because Eleventh Amendment immunity belongs to the State and not to individual officers, the Attorney General's waiver "on behalf of the State of Idaho," *id.* at 1, precludes any other state officer from asserting immunity on behalf of the State.

348. The Members of the Board of Medicine contend that they are not proper Defendants under *Ex parte Young*'s limited exception to Eleventh Amendment immunity. *See Ex parte Young*, 209 U.S. 123 (1908). Although this contention is dubious in light of *Matsumoto*'s holding that, to satisfy *Ex parte Young*, a state officer need not have primary or unconditional authority to enforce a challenged statute and enforcement need not be imminent, 112 F.4th at 803, the Court need not reach the issue. *Ex parte Young* became irrelevant when the Attorney General intervened in the lawsuit, waiving the State's Eleventh Amendment immunity.

IV. Substantive Due Process

A. Access to Therapeutic Abortion is a Fundamental Right

1. The Court Must Carefully Examine the Historical Record to Determine Whether the Right to Therapeutic Abortion is Deeply Rooted in American History and Tradition

349. Although the Bill of Rights enumerates certain individual rights, the Framers did not intend it to create an exhaustive list. The Ninth Amendment thus states: "The enumeration in the Constitution of certain rights shall not be construed to deny or disparage others retained by the people." U.S. Const. amend IX. The Supreme Court has long recognized that the Due Process Clause of the Fourteenth Amendment provides substantive protection for both enumerated and unenumerated rights against infringement by the states. *See McDonald*, 561 U.S. at 758.

350. In recent years, the Supreme Court has favored an originalist approach to identifying the nature and scope of both enumerated and unenumerated rights that focuses on whether a right is "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty." *Dobbs*, 597 U.S. at 231 (2022); *accord McDonald*, 561 U.S. at 767; *see also Kennedy v. Bremerton Sch. Dist.*, 597 U.S. 507, 536 (2022) (holding that analysis of Establishment Clause claims must focus on "original meaning and history"). As lower courts have identified challenges in implementing this methodological shift, *see United States v. Rahimi*, 602 U.S. 680, 742 n.1 (2024) (Jackson, J., concurring) (collecting cases), the Supreme Court has acknowledged the difficulties inherent in making history the touchstone for constitutional analysis and endeavored to provide guidance, most notably in its recent Second Amendment cases. *See, e.g.*, *N.Y. State Rifle & Pistol Assoc., Inc. v. Bruen*, 597 U.S. 1, 25 (2022) ("To be sure, '[h]istorical analysis can be difficult; it sometimes requires resolving

threshold questions, and making nuanced judgments about which evidence to consult and how to interpret it.'" (citation omitted)).

351. In *Bruen*, for example, the Supreme Court explained that courts must engage in case-by-case determination of historical questions and may rely on evidence presented by the parties:

> The job of judges is not to resolve historical questions in the abstract; it is to resolve *legal* questions presented in particular cases or controversies. That "legal inquiry is a refined subset" of a broader "historical inquiry," and it relies on "various evidentiary principles and default rules" to resolve uncertainties. For example, "[i]n our adversarial system of adjudication, we follow the principle of party presentation." Courts are thus entitled to decide a case based on the historical record compiled by the parties.

597 U.S. at 25 n.6 (citations omitted); *accord United States v. Hemani*, No. 24-1234, 608 U.S. ___, 2026 WL 1751710, *6 (June 18, 2026) ("We decide cases 'based on the historical record' and arguments 'compiled by the parties' before us." (citation omitted)).

352. The State's contention that the Court may not consider expert testimony about the historical record because the historical record constitutes a "legislative fact" is contrary to the Supreme Court's guidance and based on caselaw from other jurisdictions that the Court finds unpersuasive.

353. Drawing on the writings of Professor Kenneth Davis, the Advisory Committee note to Federal Rule of Evidence 201(a) defines the terms adjudicative facts and legislative facts. *See* F.R.E. 201(a) advisory committee's note to 1972 proposed rules. "Adjudicative facts are simply the facts of the particular case." *Id.* "Legislative facts, on the other hand, are those which have relevance to legal reasoning and the lawmaking process, whether in the formulation of a legal principle or ruling by a judge or court or in the enactment of a legislative body." *Id.* Legislative facts are essentially facts known by logic, common sense, or cultural immersion. *See id.* As an example, the Advisory Committee note offers that:

> When a witness in an automobile accident case says "car," everyone, judge and jury included, furnishes, from non-evidence sources within himself, the supplementing information that the "car" is an automobile, not a railroad car, that it is self-propelled, probably by an internal combustion engine, that it may be assumed to have four wheels with pneumatic rubber tires, and so on.

Id. Thus, legislative facts are facts that are commonly known or inferable from facts that are commonly known, but they do not require acknowledgement through the formal process of judicial notice. *See id.* "In conducting a process of judicial reasoning, as of other reasoning, not a step can be taken without assuming something which has not been proved; and the capacity to do this with competent judgment and efficiency, is imputed to judges and juries as part of their necessary mental outfit." *Id.* (quoting James Bradley Thayer, *Preliminary Treatise on Evidence* 279-80 (1898)).

354. According to the Advisory Committee note, judges should have broad discretion in the methods they use to determine legislative facts. *See id.* By way of analogy, the note states:

> In determining the content or applicability of a rule of domestic law, the judge is unrestricted in his investigation and conclusion. He may reject the propositions of either party or of both parties. He may consult the sources of pertinent data to which they refer, or he may refuse to do so. He may make an independent search for persuasive data or rest content with what he has or what the parties present.

Id. (quoting Edmund M. Morgan, *Judicial Notice*, 57 Harv. L. Rev. 269, 270-71 (1944)). It continues: "This is the view which should govern judicial access to legislative facts." *Id.* "It renders inappropriate any limitation in the form of indisputability, any formal requirements of notice other than those already inherent in affording opportunity to hear and be heard and exchanging briefs, and any requirement of formal findings at any level." *Id.* "It should, however, leave open the possibility of introducing evidence through regular channels in appropriate situations." *Id.*

355. Paradoxically, some courts of appeals have leveraged the concept of legislative facts to limit the types of evidence on which a court may rely, particularly in constitutional cases. For example, in *Moore v. Madigan*, 702 F.3d 933, 942 (7th Cir. 2012) (Posner, J.), upon reversing the dismissal of a Second Amendment lawsuit, the Seventh Circuit declined to remand the case for factfinding, instead, remanding with instructions to enter relief for the plaintiffs. The court held that "[t]he constitutionality of the challenged statutory provisions does not present factual questions for determination in a trial." *Id.* It reasoned that: "Only adjudicative facts are determined in trials, and only legislative facts are relevant to the constitutionality of the Illinois gun law. The key legislative facts in this case are the effects of the Illinois law; the state has failed to show that those effects are positive." *Id.* The Fifth Circuit built on this logic in *Nathan v. Alamo Heights Ind. Sch. Dist.*, 173 F.4th 576, 607-08 & n.57 (5th Cir. 2026), a case concerning the Establishment Clause. It held that, "[w]hat the founding generation understood as an establishment of religion is a legal question to be decided by a court, not a 'fact' question to be decided by experts, no matter how credentialed." *Id.* at 607. "To be sure, courts must make a determined effort to grasp the relevant history bearing on that legal question." *Id.* "They do so by consulting articles, books, and historical sources and bringing their own independent judgment to bear on them—not by appointing an 'expert,' whose 'findings' are insulated by clear-error review on appeal." *Id.* at 607-08. Both of these cases rely only on F.R.E. 201(a) as the authority for their holdings, even though the rule indicates that judges should be afforded broad discretion in legislative factfinding.

356. The Supreme Court has not addressed this topic specifically, although, as noted above, it has endorsed reliance on party presentation of evidence in cases requiring a history-and-tradition analysis. *See supra* at ¶ 351.

357. The Ninth Circuit has discussed the distinction between legislative facts and adjudicative facts on a few occasions, but none of its opinions on the subject are precedential. *See Teter v. Lopez*, 76 F.4th 938, 946–47 (9th Cir. 2023) ("At oral argument, Hawaii's counsel argued that further *historical* research is needed in light of *Bruen.* But the historical research required under *Bruen* involves issues of so-called 'legislative facts' … rather than adjudicative facts …. Because the issue does not require further development of adjudicative facts to apply *Bruen*'s new standard, it does not trigger our 'standard practice' in favor of remanding when an intervening change in law requires additional inquiry concerning adjudicative facts. And even when that presumption in favor of remand applies, we need not do so when 'we can confidently decide [the issue] ourselves.' This is such a case." (citations omitted)), *opinion vacated on reh'g*, 93 F.4th 1150 (9th Cir. 2024); *Jones v. Bonta*, 34 F.4th 704, 726 n.24 (9th Cir. 2022) ("Defendants argue that we may not consider Plaintiffs' facts about these categories of guns, because they were not submitted below. But these facts are legislative facts, 'which have relevance to legal reasoning and the lawmaking process,' rather than adjudicative facts, which 'are simply the facts of the particular case.' We have previously considered this kind of fact in a Second Amendment challenge, even over a defendant's challenge that it was not in the record below." (citations omitted)), *opinion vacated on reh'g*, 47 F.4th 1124 (9th Cir. 2022); *Perry v. Brown*, 671 F.3d 1052, 1075 (9th Cir. 2012) ("It is debatable whether some of the district court's findings of fact concerning matters of history or social science are more appropriately characterized as 'legislative facts' or as 'adjudicative facts.' We need not resolve what standard of review should apply to any such findings, however, because the only findings to which we give any deferential weight … are clearly 'adjudicative facts' concerning the parties and 'who

did what, where, when, how, why, with what motive or intent.'") (citation omitted), *vacated and remanded sub nom. Hollingsworth v. Perry*, 570 U.S. 693 (2013).

358. District courts in the Ninth Circuit have taken a pragmatic approach to the issue, in line with the original intent of F.R.E. 201(a). *See United States v. Yates*, No. 1:21-CR-116-DCN, 2023 WL 5016971, *2 (D. Idaho Aug. 7, 2023) (holding that, to carry its burden of proof in a Second Amendment case, the Government may, but need not, retain historical experts); *Or. Firearms Fed'n v. Kotek*, 682 F. Supp. 3d 874, 885-86 & n.2 (D. Or. 2023) (declining to consider thirteen documents proffered as "legislative facts" after a lengthy trial) ("While legislative facts are often considered by appellate courts deciding Second Amendment challenges, this Court is a trial court. It is the function of the trial court to receive evidence and testimony that has been tested through the adversarial process." (citations omitted)).

359. This Court will similarly take a pragmatic approach to factfinding in this case, consistent with the original intent of F.R.E. 201(a) and the Supreme Court's guidance in *Bruen* and *Hemani*. The Court will consider the expert testimony and other evidence presented at trial, and it may consider additional evidence concerning the historical record as needed to aid its decision-making. The Court will not, however, rely uncritically on the testimony of any expert witness. It retains for itself the sole prerogative to make the findings of fact and conclusions of law necessary to resolve the issues presented here.

360. The Supreme Court has advised courts analyzing the meaning and scope of constitutional provisions to take a cautious approach to pre- and post-ratification history. On one hand, it explained that pre-ratification history—from both England and the American colonies—is a critical component of history-and-tradition analysis. *See Bruen*, 597 U.S. at 20; *Heller*, 554 U.S. at 595-601. On the other hand, it has cautioned that not all pre-ratification legal authority is

probative evidence of the Constitution's meaning. In *Bruen*, it declared: "As with historical evidence generally, courts must be careful when assessing evidence concerning English common-law rights. The common law, of course, developed over time. And English common-law practices and understandings at any given time in history cannot be indiscriminately attributed to the Framers of our own Constitution." 597 U.S. at 35 (citations omitted). "Even 'the words of *Magna Charta*'—foundational as they were to the rights of America's forefathers—'stood for very different things at the time of the separation of the American Colonies from what they represented originally.'" *Id.* (citation omitted); *see also Rahimi*, 602 U.S. at 694 ("Through these centuries, English law had disarmed not only brigands and highwaymen but also political opponents and disfavored religious groups. By the time of the founding, however, state constitutions and the Second Amendment had largely eliminated governmental authority to disarm political opponents on this side of the Atlantic."); *id.* at 722 n.3 (Kavanaugh, J., concurring) ("[R]eflexively resorting to English law or history without careful analysis can sometimes be problematic because America had fought a war—and would soon fight another in 1812—to free itself … of tyrannical British rule." (citations omitted)); *id.* at 723 ("The Equal Protection Clause provides another example. Ratified in 1868, that Clause sought to reject the Nation's history of racial discrimination, not to backdoor incorporate racially discriminatory and oppressive historical practices and laws into the Constitution."). Similarly, while the Supreme Court has explained that "'examination of a variety of legal and other sources to determine *the public understanding* of a legal text in the period after its enactment or ratification' [i]s 'a critical tool of constitutional interpretation,'" *Bruen*, 597 U.S. at 20 (quoting *Heller*, 554 U.S. at 605), it has also said that litigants and courts must "guard against giving postenactment history more weight than it can rightly bear, *id.* at 35.

361. Further, the Supreme Court has warned that some historical precedents are simply outliers that should be ignored. *See, e.g.*, *id.* at 65 ("We acknowledge that the Texas cases support New York's proper-cause requirement …. But the Texas statute, and the rationales set forth in [the Texas cases], are outliers.").

362. Here, the Court's legal analysis must begin with *Dobbs*. Although the Supreme Court held that the Constitution does not confer a "broad right" to obtain a pre-viability abortion in all circumstances, it did not address whether the Due Process Clause of the Fourteenth Amendment confers a right to abortion for the purpose of preserving a pregnant woman's life or health. *Dobbs*, 597 U.S. at 225, 231; *see id.* at 234 (noting that the Court granted certiorari "to resolve the question whether 'all pre-viability prohibitions on elective abortions are unconstitutional'"); *id.* at 380 (Breyer, Sotomayor, & Kagan, JJ., dissenting) ("The majority does not say … whether a State may prevent a woman from obtaining an abortion when she and her doctor have determined it is a needed medical treatment."); *see also Planned Parenthood Great Nw., Haw., Alaska, Ind., & Ky., Inc. v. Cameron*, 624 F. Supp. 3d 739, 748 (W.D. Ken. 2022) (holding, after *Dobbs*, that the plaintiffs' substantive due process claim against a Kentucky statute restricting abortion access "remains likely to succeed based on the right to a nonelective, emergency abortion, for the life and health of the pregnant woman"), *vacated as moot by* No. 22-5832, 2023 WL 3620977 (6th Cir. May 24, 2023).

363. Overturning *Roe*, 410 U.S. 113, and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), *Dobbs* held that substantive due process rights must be "deeply rooted in [our] history and tradition" and "essential to our Nation's 'scheme of ordered liberty,'" *id.* at 237 (citations omitted). Although the Court did not identify a precise test or methodology to determine whether this standard is satisfied, it concluded that the broad right

to pre-viability abortion recognized in *Roe* and *Casey* did not qualify because abortion had been a crime in certain circumstances under early English and American common law, and there was a trend toward increased criminalization of abortion in the nineteenth and early twentieth centuries. *See id.* at 242-50. In making this historical assessment, the Court relied principally on treatises about the common law from the thirteenth through eighteenth centuries; nineteenth century caselaw holding that post-quickening abortion was a crime under the common law; Lord Ellenborough's Act; nineteenth century American statutes criminalizing abortion to varying degrees; and published works by contemporary scholars examining the history of U.S. abortion laws. *Id.*

364. The same authorities demonstrate that abortion was never subject to criminal penalties when performed in good faith for medical reasons. To the contrary, the law has always distinguished between criminal abortion and therapeutic abortion, affording therapeutic abortion legal protection.

2. The Right to Therapeutic Abortion is a Specific Application of Broader Rights to Life and Health

a. The Right to Life is Deeply Rooted

365. The right to therapeutic abortion is a specific application of broader rights to life and health.

366. The Due Process Clause of the Fourteenth Amendment, like the Due Process Clause of the Fifth Amendment, expressly protects the right to life. U.S. Const. amend. XIV, § 1; U.S. Const. amend. V. There can be no doubt that the right to life is deeply rooted in American history and tradition and essential to the nation's scheme of ordered liberty. Indeed, Professor Dellapenna concedes this point. Tr. 843:1-3 (Dellapenna). As explained below, while this right extended to pregnant women at common law as well as in the nineteenth and early

twentieth centuries, the record is crystal clear that it did not extend to prenatal life. *Infra* at ¶¶ 380-83.

b. The Right to Health is Deeply Rooted

367. This nation's history and traditions show that the right to life is inextricably intertwined with the right to health. First, Blackstone identifies both life and health as essential components of the right to personal security, which he describes as a natural right on which the law should not encroach without a compelling reason. 1 Blackstone at 125, 129. He explains that this right informs the doctrine of self-defense, which permits an individual to use lethal force to protect themself not just from death but also from bodily harm. *Supra* at ¶¶ 208-09. The Supreme Court has described self-defense as a "basic right" and explained that it is the central component of the Second Amendment right to bear arms. The doctrine of necessity, which justifies an act that would otherwise be criminal, including homicide, when it constitutes the lesser of two evils, is closely related. *Supra* at ¶ 210. Therapeutic abortion can be understood as a means of self-defense and an act of necessity. *See* Siegel & Ziegler at 444-45 (explaining that, in the nineteenth and early twentieth centuries, some medical commentators connected therapeutic abortion with the right of self-preservation). It would make no sense for the law to permit individuals to protect their lives and bodies with arms but not with medical care.

368. The State's arguments concerning self-defense and necessity are unpersuasive for two reasons. First, they evince a fundamental misunderstanding of the right to self-defense. At its core, it is not a right to punish bad actors, although that may sometimes be a consequence of its exercise. It is a right to engage in acts of self-preservation, derivative of the rights to life and health. Indeed, Blackstone reported that it encompassed the right to drown a fellow shipwreck victim—who engaged in no wrongful conduct—if the plank that would serve as a life raft was only big enough for one. *Supra* at ¶ 210. Second, the State wrongly assumes that history and

tradition accorded equal value to the life of a pregnant woman and the life of a developing embryo or fetus. They did not. Throughout Anglo-American history, both law and society accorded greater weight to the woman's life.[21] *Supra* at ¶¶ 251-57, 262, 277, 281 & n.17, 302.

369. Second, the importance historically ascribed to the right of bodily integrity, *supra* at ¶ 211, demonstrates that the law attributed great value to the sanctity and well-being of a person's body independent of the value it attributed to a person's life. In the twentieth century, courts have invoked the right of bodily integrity to deny compelled organ donation, recognizing that the law may not compel an individual to put their body at risk to save the life of another. *See, e.g.*, *Curran v. Bosze*, 566 N.E.2d 1319, 1323 (Ill. 1990) (citing *Botsford*, 141 U.S. at 251); *McFall v. Shimp*, 10 Pa. D & C.3d 90, 90-91 (Pa. Com. Pl. 1978) (holding that society may not infringe on an individual's "absolute right to his 'bodily security'" even to save another person's life). In *McFall*, the court refused to compel a bone marrow donation necessary to save another person's life, explaining that "[o]ur society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another." 10 Pa. D & C.3d at 91. The court held that, even though in its view the defendant's refusal to participate in a life-saving bone marrow transplant was "morally indefensible," it was legally protected. *Id.* ("For our law to *compel* defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual ….") In *Curran*, the court

[21] In addition, the State's references to duress are inapposite. At common law, duress had a specific meaning that was distinct from self-defense or necessity. It signified a threat of violence from a third party aimed at coercing an individual to perform a specific bad act. *See* 4 Blackstone at 30. When that act was murder, the common law held that the individual would be justified in killing the person making the threat against his own life, rather than the intended victim. *Id.* Given the triangulation, the concept does not map onto therapeutic abortion as well as self-defense and necessity do.

rejected efforts to compel three-and-a-half-year-old twins to undergo a bone marrow harvesting procedure for the benefit of their half-brother, even though, "without the transplant, Jean Pierre will almost certainly die." 566 N.E.2d at 1345. It explained that, despite the sympathy it felt for the half-brother's "tragic situation," "it neither would be proper under existing law nor in the best interests of the 3½–year–old twins for the twins to participate in the bone marrow harvesting procedure." *Id.* These authorities reflect a longstanding legal tradition: the right to protect one's own body from the risk of harm is fundamental and cannot be subordinated to the interests of others.

370. Third, the Eighth Amendment's requirement that the government provide medical care to the people it incarcerates demonstrates that medical care—at least for serious medical needs, *Estelle*, 429 U.S. at 104—is a corollary of the rights to life and health—such that the government cannot prohibit it without a compelling reason. That is because it cannot constitute "cruel and unusual punishment," U.S. Const. amend. VIII, to deny an incarcerated person access to something that the government could otherwise prohibit.

371. Fourth, the protection that the common law historically afforded to the practice of medicine did not distinguish between life-saving medical care and care aimed at promoting health more broadly. *Supra* at ¶¶ 237-40 & n.10.

372. It is true that the law has long regulated the practice of medicine, but that does not undermine the status of health as a fundamental right. "[M]ost rights" are "not unlimited." *Heller*, 554 U.S. at 626. For example, notwithstanding the Second Amendment right to bear arms, "[a]t the founding, the bearing of arms was subject to regulations ranging from rules about firearm storage to restrictions on gun use by drunken New Year's Eve revelers." *Rahimi*, 602 U.S. at 691. "Some jurisdictions banned the carrying of 'dangerous and unusual weapons.'" *Id.*

(citation omitted). "Others forbade carrying concealed firearms." *Id.* (citation omitted). Similarly, notwithstanding the First Amendment right to free speech, a handful of "well-defined and narrowly limited classes of speech" are exempt from First Amendment protection, *Chaplinsky v. New Hampshire*, 315 U.S. 568, 571-72 (1942), most notably: fighting words, *id.* at 572; speech integral to criminal conduct, *Giboney v. Empire Storage & Ice Co.*, 336 U.S. 490, 498 (1949); defamation, *Beauharnais v. Illinois*, 343 U.S. 250, 254-55 (1952); obscenity, *Roth v. United States*, 354 U.S. 476, 485 (1957); true threats, *Watts v. United States*, 394 U.S. 705, 707-08 (1969) (per curiam); incitement, *Brandenburg v. Ohio*, 395 U.S. 444, 447-48 (1969) (per curiam); fraud, *Va. Bd. of Pharmacy v. Va. Citizens Consumer Council, Inc.*, 425 U.S. 748, 771-72 (1976); and child pornography, *New York v. Ferber*, 458 U.S. 747, 763-64 (1982). And the government may subject even protected speech to content-neutral time, place, and manner restrictions in appropriate circumstances. *See Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989).

373. Historically, medical regulation was limited to ensuring that medical practitioners were competent to provide care and avoided treatments that were unduly risky or far outside prevailing standards of care. *See supra* at ¶¶ 237-40 & nn.9-10. Laws banning competent practitioners from providing safe and accepted treatments are of relatively recent vintage.

374. *Washington v. Glucksberg*, 521 U.S. 702 (1997), and *United States v. Skrmetti*, 605 U.S. 495 (2025), are not to the contrary. In *Glucksberg*, the Supreme Court held that there is no fundamental right to physician-assisted suicide. 521 U.S. at 728. Notably, physician-assisted suicide is not performed for the purpose of preserving life and health. Rather, its goal is to end life, and impairing health is a necessary byproduct of that. *See id.* at 731 ("[P]hysician-assisted suicide could, it is argued, undermine the trust that is essential to the doctor-patient relationship

by blurring the time-honored line between healing and harming."). Thus, it is distinguishable from medical treatments, like therapeutic abortion, aimed at preserving a pregnant patient's life and health.

375. Although *Skrmetti* upheld a state statute banning minors from receiving treatment for gender dysphoria, it did not consider whether the statute infringed on a fundamental right. 605 U.S. at 522. The Supreme Court was "asked" only to decide whether the statute discriminated on the basis of gender in violation of the Equal Protection Clause. *Id.* at 510-11. Accordingly, it did not reach the issue presented here.

376. *Carnohan v. United States*, 616 F.2d 1120 (9th Cir. 1980), and *Mitchell v. Clayton*, 995 F.2d 772 (7th Cir. 1993), are likewise inapposite. In *Carnohan*, the Ninth Circuit held that the plaintiff had to exhaust his administrative remedies before he could pursue constitutional claims in federal court. 616 F.2d at 1122 ("If Carnohan wishes to obtain laetrile, he must exhaust his administrative remedies before seeking judicial relief."). In *Mitchell*, the Seventh Circuit rejected a constitutional challenge to a state law requiring licensure for acupuncturists. 995 F.2d at 775-76. In support of the statement that "most federal courts have held that a patient does not have a constitutional right to obtain a particular type of treatment or to obtain treatment from a particular provider if the government has reasonably prohibited that type of treatment or provider," the court cited *Roe v. Wade*, 410 U.S. at 165. Clearly, in 1993, *Roe* did not stand for the proposition that abortion lacked constitutional protection. It did, however, hold that states could limit the performance of abortions to licensed physicians. *Id.* Here, Dr. Seyb is a licensed physician, *supra* at ¶ 26, and he is not disputing that the State can limit the performance of therapeutic abortions to licensed clinicians.

3. From the Earliest Days of the Common Law Through World War II, Anglo-American Law Consistently Authorized Therapeutic Abortion

377. The record demonstrates that English common law generally shielded healthcare providers acting with due care and therapeutic intent from liability. *Supra* at ¶¶ 237-39 & nn.9-10. American courts followed this tradition. *Supra* at ¶¶ 240. Over time and on both sides of the Atlantic, the common law never interfered with the ability of a healthcare providers to administer standard emmenagogic or abortifacient treatments for therapeutic purposes.

378. Whereas during the nineteenth century, statutes in both England and the United States took an increasingly restrictive approach to regulating nontherapeutic abortions, these statutes consistently protected therapeutic abortions, exempting them from criminal liability through mens rea requirements or express exceptions. *See supra* at ¶¶ 259, 264-65, 273, 276, 278, 287-94. Many jurisdictions applied a *presumption* that abortion providers acted with therapeutic intent, at least when they were regular physicians, well into the twentieth century, requiring prosecutors to prove beyond a reasonable doubt that an abortion was not performed for a therapeutic reason. *See supra* at ¶ 314. Further, it was widely understood in the medical community that physicians had broad discretion to determine what constituted justifiable grounds for performing an abortion. *See supra* at ¶¶ 263, 303-04. Physicians in both England and the United States routinely provided therapeutic abortions and openly wrote and lectured about them. *Supra* at ¶¶ 261-63, 295-97, 300-07.

379. There is no evidence in the record of a single prosecution anywhere in England or the United States before 1938 of a doctor who provided an abortion in good faith for medical reasons. *Supra* at ¶¶ 250, 313. In 1938, a famous test case concerning therapeutic abortion resulted in an acquittal. *Supra* at ¶ 264.

4. From the Earliest Days of the Common Law Through World War II, Anglo-American Law and Society Consistently Gave the Interests of Pregnant People Precedence Over the Interests of Pre-Natal Life

380. Notably, and contrary to the State's arguments, the law never equated prenatal life with a woman's life at any stage of gestation. *See supra* at ¶¶ 249, 251-57. It clearly and consistently accorded greater value to women's lives. *See supra* at ¶¶ 247-48, 277, 287, 303-04. Even as the quickening doctrine began to recede in the face of emerging scientific recognition that an embryo is alive from the start of its development, no societal consensus developed in favor of prenatal personhood. *See supra* at ¶¶ 261-62, 281 & n.17, 304. Instead, the regular physicians who led the campaign for stricter abortion laws, the legislators who enacted the laws, and the judges who enforced them typically described the embryo or fetus as an inchoate being with the *potential* to develop into a person. *See supra* at ¶¶ 249, 255-56, 261, 281. This understanding may have supplied a rationale for prohibiting nontherapeutic abortion, but it did not supply a rationale for subordinating a pregnant woman's health to the well-being of the developing entity. So too with the other interests motivating the enactment of stricter abortion laws—the desire to enforce traditional gender roles and to prevent the birthrates of immigrant women from outpacing those of American-born women.[22] *See supra* at ¶¶ 282-86. Abortions performed for medical reasons were simply not the object of nineteenth-century abortion legislation.

381. In prioritizing a pregnant woman's interests over those of prenatal life, nineteenth-century statutes followed the common law tradition. *See supra* at ¶¶ 251-56. As

[22] In any event, these rationales, embodying sexist and racist stereotypes and discriminatory motives, are undeniably a part of American history, but they are not part of our constitutional tradition. The Equal Protection Clause of the Fourteenth Amendment rejected this part of our history; thus, it is not probative evidence of the Constitution's meaning. *See supra* at ¶ 360.

explained above, the common law did not treat a fetus as *in rerum natura* until it was born. *See id.* Before that, it was simply part of its mother. *See id.* In the United States, that common law tradition extended well into the twentieth century. *Supra* at ¶¶ 255-56.

382. Before becoming a witness for the State, Professor Dellapenna wrote that: "[T]he 19th century abortion statutes never treated abortion as the equivalent of murder. Either fetuses were not seen as fully human, or the sanctity-of-life ethic was never as fully accepted as its proponents claim …." Tr. 835:11-15 (Dellapenna) (quoting Dellapenna Chapter at 144).

383. The consistent statements in both the English treatises and the American caselaw over a period of several hundred years that a fetus is not in being and is not vested with the rights of personhood until it is born, *supra* at ¶¶ 251-56, leads the Court to conclude that the right to life protected by the Fourteenth Amendment does not extend to prenatal life.

5. The Right to Therapeutic Abortion Encompasses Abortion for Maternal Indications

a. The Risk of Death From Self-Harm

384. Unlike Idaho's Total Abortion Ban, none of the nineteenth-century abortion statutes expressly excluded the risk of death from self-harm as a legal basis for a therapeutic abortion, *see supra* at ¶¶ 288-94, and the record shows that doctors were openly providing therapeutic abortions for mental health reasons, including suicidal ideation, during the nineteenth and early twentieth centuries without fear of prosecution, *see supra* at ¶¶ 300, 303, 307. Although one American court questioned whether suicidal ideation could provide a legal justification for abortion, *see supra* at ¶ 315, its opinion appears to be an outlier. Importantly, there was no evidence in that case that the patient's threat to end her life was the result of mental illness, and the doctor who performed the abortion did not claim to have a therapeutic intent. *Id.* The Court is aware of no doctor being convicted of criminal abortion in any American

jurisdiction where the record demonstrated a good-faith intent to prevent the patient's suicide. On the other hand, *Rex v. Bourne*, interpreting the English Offences Against the Person Act of 1861, squarely held that a good-faith belief that a pregnant patient was at risk of death by suicide negated the criminal intent element of the statute. *See supra* at ¶¶ 264-65. The doctor who performed the abortion at issue in that case was acquitted. *Supra* at ¶ 264.

385. The weight of the evidence, viewed in light of the nation's deeply rooted efforts to discourage suicide—*see Glucksberg*, 521 U.S. at 710-16; *id.* at 730 ("The State has an interest in preventing suicide … and treating its causes.")—leads the Court to conclude that the prevention of suicide was generally viewed as a lawful reason for providing an abortion in the nineteenth and early twentieth centuries. Given the primacy that the Anglo-American legal tradition gives to the right of life, *supra* at ¶¶ 207-08, 366, the Court concludes that the Fourteenth Amendment guarantees pregnant people a fundamental right to obtain abortion care to mitigate a risk of death, including in cases where a mental health condition puts the pregnant person at risk of death from suicide, overdose, or other means of self-harm. The right to therapeutic abortion, and the right to life from which it derives, would mean little if it could not be asserted to protect a pregnant person from the leading cause of pregnancy-related death. *See supra* at ¶¶ 62, 65.

b. The Risk of Serious, Non-Fatal Complications

386. Likewise, the weight of the evidence leads the Court to conclude that the Fourteenth Amendment guarantees pregnant people a fundamental right to obtain abortion care to mitigate a risk of serious harm to their physical or mental health. As Judge Macnaghten explained in *Rex v. Bourne*, "[l]ife depends upon health." 3 All. E.R. at 617; *supra* at ¶ 264. The two are so intertwined that the right to life necessarily encompasses the right to health. Thus, nineteenth-century statutes authorizing abortion "when necessary to preserve a woman's life"

should be understood as authorizing abortion when necessary to preserve a woman's health. That is how a nineteenth-century American would have understood them. Notably, in *M'Culloch v. Maryland*, Chief Justice Marshall explained that the word "necessary" in the Constitution's Necessary and Proper Clause, does not require "absolute physical necessity," but instead requires a reasonable fit between means and ends. 17 U.S. 316, 413-14 (1819) ("If reference be had to [use of the word necessary] in the common affairs of the world, or in approved authors, we find that it frequently imports no more than that one thing is convenient, or useful, or essential to another. To employ the means necessary to an end, is generally understood as employing any means calculated to produce the end, and not as being confined to those single means, without which the end would be entirely unattainable."). This nineteenth-century understanding of the term "necessary" supports a broad reading of the life exceptions in abortion statutes from that era as encompassing all abortions performed in cases of serious medical need, and not just those that are strictly required to avoid death.

387. So does the medical literature of the time period. *See supra* at ¶¶ 295-97, 300, 312; Siegel & Ziegler at 445 ("In the medical profession's understanding, life exceptions in abortion bans gave regular physicians latitude to respond to a wide array of conditions."). Both the medical literature and the caselaw from this era indicate that doctors had broad discretion to perform medically indicated abortions based on the exercise of their professional judgment. *See supra* at ¶¶ 303-04, 313-14. The most ardent anti-abortion doctors expressed dismay about the broad range of indications for which their peers considered abortion justified. *See supra* at ¶ 303, 307. There is no evidence in the record that regular physicians' judgment about what constituted justifiable abortion was ever questioned by prosecutors, judges, or juries. Indeed, there is no evidence that any nineteenth-century doctor was ever convicted of criminal abortion

on the ground that, although medically indicated, it was not necessary to save the patient's life. *See supra* at ¶ 313.

388. Before he was retained as an expert witness for the State, Professor Dellapenna acknowledged that the therapeutic exceptions in nineteenth-century abortion statutes protected both life and health and afforded doctors broad discretion in providing therapeutic abortions. Tr. 891:16-25 (Dellapenna) (quoting Dellapenna Article at 406) ("In summary, the 19th century was a period of considerable legislative activity designed to make clear that abortion, by any means at any stage of pregnancy for any reason, except to preserve the *life or health* of the mother, was a serious crime." (emphasis added)); *id.* 892:20-893:3 (quoting Dellapenna Article at 413) ("Since therapeutic abortions were generally legal [between the mid-nineteenth and mid-twentieth centuries], such research could occur throughout this period without the researcher necessarily engaging in criminal conduct."); Ex. 10 at 517 ("The common therapeutic exceptions did give physicians some measure of control over authorizing abortions, although that authority was used sparingly in England and America before the 1930s."); Ex. 10 at 539 ("At the end of World War II, abortion generally was illegal across the planet, usually condemned as the murder of unborn children. In almost every nation, abortion was allowed only to protect the *life or health* of the mother." (emphasis added)).

389. Two state supreme courts—those of Indiana and North Dakota—recently concluded that the life exceptions adopted by their state's respective legislatures in the nineteenth century encompassed all abortions performed to preserve a pregnant woman's health. *Members of the Med. Licensing Bd. of Ind. v. Planned Parenthood Gr. Nw., Haw., Alaska, Ind., Ky.*, 211 N.E. 3d 957, 976 (Ind. 2023) (equating abortions necessary to protect a woman's life with abortions necessary to protect a woman from serious health risks); *Wrigley*, 988 N.W.2d at

241 (finding that, during the late-nineteenth and early twentieth centuries, "North Dakota recognized and approved abortions performed to preserve the life or health of the woman."). The North Dakota Supreme Court noted that: "Medical journals published shortly after statehood indicate it was common knowledge that an abortion could be performed to preserve the life or health of the woman." *Wrigley*, 988 N.W. 2d at 241.

390. The State's reliance on cases from the 1970s to support its interpretation of nineteenth-century abortion statutes is misplaced. The cases do not seek to ascertain the original meaning of the statutes they construe, and they come too late in time to constitute contemporaneous evidence. *See supra* at ¶¶ 319, 321-36. By the 1970s, abortion politics in the United States had changed significantly from the nineteenth century, and the practice of therapeutic abortion largely moved into hospitals, where it was governed by hospital review boards. *See supra* at ¶¶ 316-18. Moreover, to the extent the State relies on federal cases, those cases cannot provide a definitive interpretation of state laws. *Arizonans for Off. Eng. v. Arizona*, 520 U.S. 43, 48 (1997) (""Federal courts lack competence to rule definitively on the meaning of state legislation ….").

391. Accordingly, the Court concludes that the Fourteenth Amendment guarantees pregnant people a fundamental right to obtain abortion care to mitigate a risk of serious harm to their physical or mental health.

6. The Right to Therapeutic Abortion Encompasses Abortion for Fetal Indications

a. Life-Limiting Fetal Conditions

392. The centuries-long tradition of prioritizing a pregnant woman's life and health over the preservation of prenatal life supports recognition of a right to abortion in cases of life-limiting embryonic and fetal conditions. *See supra* at ¶¶ 247-49, 251-57, 261-62, 277, 287, 302.

All pregnancies entail health risks and impose significant burdens on pregnant people that impact their quality of life. *See supra* at ¶¶ 42-57. The historical record shows that the State is not justified in subjecting pregnant people to those risks when there is little to no chance of neonatal survival. Although diagnosis of life-limiting conditions as we understand them today was not possible in the nineteenth century, doctors of that era did understand that certain conditions made successful delivery of a child unlikely. *See supra* at 262, 267. In such cases, they believed that early abortion was justified to spare the pregnant woman from further risk exposure. *See supra* at ¶ 302. Dr. Storer himself wrote that, "[i]f the child must necessarily be lost, the [pre-viability induction of] labor should not be long delayed." Tr. 956: 7-8 (Cohen) (quoting Storer, *Criminal Abortion*, at 65). Similarly, Dr. Gaillard wrote that, despite improvements in the safety of Caesarean section and related procedures, "I still do not believe that, when we can avoid it by inducing abortion, we are justified in subjecting our patient to the great risk attending these operations even under the most favorable conditions." *Supra* at ¶ 302. Dr. Keown's research shows that English doctors likewise made medical decisions with the goal of minimizing risks to their pregnant patients. *See supra* at ¶¶ 261-62.

393. In addition, the law afforded nineteenth-century physicians broad discretion to provide abortions in accordance with prevailing medical standards. *See supra* at ¶¶ 263, 303-04. Today's prevailing standards recognize life-limiting embryonic and fetal conditions as a clear indication for abortion. *See supra* at ¶ 72. Even Dr. Kraus counsels patients about abortion when they receive this kind of diagnosis. Tr. 1166:17-25 (Kraus).

394. Accordingly, the Court concludes that the Fourteenth Amendment guarantees pregnant people a fundamental right to terminate their pregnancy when the embryo or fetus they are carrying has a life-limiting condition.

b. Multi-Fetal Pregnancy Reductions

395. As with life-limiting embryonic and fetal conditions, the technology needed to diagnose multi-fetal pregnancies and perform multi-fetal pregnancy reductions did not exist until relatively recently in our history. The doctrine of necessity, however, has ancient roots. *See supra* at ¶ 210. And multi-fetal pregnancy reduction is a quintessential example of the lesser of two evils. A pregnant person, faced with the likelihood that all of the embryos or fetuses she is carrying will miscarry, takes steps to maximize the odds that at least one will survive. *See supra* at ¶¶ 194-97. The Court concludes that the Fourteenth Amendment guarantees pregnant people a fundamental right to reduce a multi-fetal pregnancy to maximize the likelihood that at least one fetus survives.

7. The Weight of State Constitutional Authority Broadly Protects Therapeutic Abortion

396. It appears that only two state supreme courts—those of Idaho and Texas—have expressly declined to hold that their respective state constitutions guarantee a right to life-saving abortion care in all circumstances. *See Planned Parenthood Gr. Nw.*, 522 P.3d at 1193 (rejecting a dissenting Justice's argument that, "because Idaho statutes historically contained an exception to the criminalization of abortion to 'save' (later changed to 'preserve') the life of a mother, this statutory exception warrants the conclusion that there is an implicit fundamental right to abortion to prevent the death of the mother and to protect her health from injury, harm, or destruction."); *State v. Zurawski*, 690 S.W.3d 644, 653 (Tex. 2024) (holding that a Texas law authorizing life-saving abortion care only when needed to address a "physical condition" is not constitutionally deficient).

397. The Oklahoma Supreme Court has held that the Oklahoma Constitution "creates an inherent right of a pregnant woman to terminate a pregnancy when necessary to preserve her

life," meaning that "continuation of the pregnancy will endanger the woman's life due to the pregnancy itself or due to a medical condition that the woman is either currently suffering from or likely to suffer from during the pregnancy." *Okla. Call for Reprod. Just. v. Drummond*, 526 P.3d 1123, 1130 (Okla. 2023).

398. Using originalist methodologies, the supreme courts of Indiana and North Dakota have held that their respective constitutions guarantee a right to medically indicated abortion to protect both life and health. *Members of the Med. Licensing Bd. of Ind.*, 211 N.E. 3d at 976 ("Because this fundamental right of self-protection—whether considered as an exercise of the right to life, an exercise of the right to liberty, a limitation on the scope of the police power, or as a matter of equal treatment—is so firmly rooted in Indiana's history and traditions, it is a relatively uncontroversial legal proposition that the General Assembly cannot prohibit an abortion procedure that is necessary to protect a woman's life or to protect her from a serious health risk."); *Wrigley*, 988 N.W.2d at 242 ("After review of North Dakota's history and traditions, and the plain language of article 1, section 1 of the North Dakota Constitution, it is clear the citizens of North Dakota have a right to enjoy and defend life and a right to pursue and obtain safety, which necessarily includes a pregnant woman has a fundamental right to obtain an abortion to preserve her life or her health.").

399. At least nine other state supreme courts have held, in decisions that remain controlling, that their respective state constitutions guarantee a broad right to abortion, at least until viability, or treat restrictions on abortion as gender-based discrimination. *See, e.g.*, *Women of State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 19 (Minn. 1995); *Am. Acad. of Pediatrics v. Lungren*, 940 P.2d 797, 819 (Cal. 1997); *Valley Hosp. Ass'n, Inc. v. Mat-Su Coal. for Choice*, 948 P.2d 963, 968-69 (Alaska 1997); *Armstrong v. State*, 989 P.2d 364, 377 (Mont. 1999); *Right*

to Choose v. Byrne, 450 A.2d 925, 934 (N.J. 1982); *Hodes & Nauser, MDs, P.A. v. Schmidt*, 440 P.3d 461, 466 (Kan. 2019); *Allegheny Reprod. Health Ctr.*, 309 A.3d at 867; *State v. Johnson*, 582 P.3d 380, 396-97 (Wyo. 2026); *New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841, 855 (N.M. 1999).[23] Collectively, these courts employed an array of methodologies, not all of which centered history and tradition. But their decisions mean that therapeutic abortions enjoy constitutional protection in these states, alongside abortions performed for nontherapeutic reasons.

* * *

400. In sum, therapeutic abortion is a specific application of the deeply rooted rights to life and health, and it has enjoyed consistent legal protection from the medieval period through the early twentieth century. The Court concludes that the right to have an abortion for medical reasons, either maternal or fetal in nature, is deeply rooted in American history and tradition and essential to the nation's scheme of ordered liberty.

B. As Applied to Therapeutic Abortions, Idaho's Abortion Bans Fail Strict Scrutiny

401. Laws that burden fundamental rights are generally subject to strict scrutiny. *Dep't of State v. Muñoz*, 602 U.S. 899, 910 (2024) ("When a fundamental right is at stake, the Government can act only by narrowly tailored means that serve a compelling state interest."). Strict scrutiny puts the burden on the State to prove that, as applied to medically indicated abortion, the Abortion Bans are narrowly tailored to serve a compelling state interest. *See Reed v. Town of Gilbert*, 576 U.S. 155, 171 (2015). The State has failed to meet this burden.

[23] For a comprehensive, state-by-state analysis of the current status of state abortion law and state constitutional protection of abortion see *After Roe Fell: U.S. Abortion Laws by State*, Ctr. for Reprod. Rts., https://reproductiverights.org/maps/abortion-laws-by-state/ (last visited June 30, 2026).

402. The State contends that the Abortion Bans serve the following state interests:

> [R]espect for and preservation of prenatal life at all stages of development, … the protection of maternal health and safety; the elimination of particularly gruesome or barbaric medical procedures; the preservation of the integrity of the medical profession; the mitigation of fetal pain; and the prevention of discrimination on the basis of race, sex, or disability.

Ex. 1010 at 5, 9.

403. But these interests pertain to banning abortion generally, not to banning medically indicated abortions specifically. The State does not have a compelling interest in preserving prenatal life at the expense of a pregnant person's life or health. To the contrary, it concedes that it has a compelling interest in protecting maternal health and safety. But this interest is undermined, not advanced, by denying pregnant people access to medical care that would protect their health and safety. Moreover, the Abortion Bans are not aimed at "particularly gruesome or barbaric medical procedures"; they ban *all* abortion procedures in cases where pregnant individuals face a risk of death from self-harm, face a risk of serious harm to their health, or are carrying an embryo or fetus with a life-limiting condition. Further, the Abortion Bans are not narrowly tailored to mitigate fetal pain, which the State's own expert concedes could be accomplished through use of analgesia during an abortion procedure. Tr. 1194:7-23 (Kraus). Finally, terminating a pregnancy in which the embryo or fetus has little to no chance of survival is not discrimination on the basis of disability; it is medical treatment to obviate gratuitous health risks to the pregnant person as well as neonatal suffering and death.

404. To the extent that the State has a compelling interest in preventing abortions that are not provided in good faith, the Total Abortion Ban is not narrowly tailored to serve that interest. Prohibiting all abortions performed to mitigate a risk of death from self-harm is an overly broad solution to the problem the State is trying to solve, particularly when the leading underlying cause of pregnancy-related death in Idaho—and nationwide—is mental health

conditions. Without opining on the constitutionality of any particular alternative, the Court finds that less restrictive means of furthering the State's interest are possible. These include requiring a physician to document the indications for an abortion and requiring a physician to consult with another physician or mental health professional before performing an abortion for mental health indications.

405. Because the Abortion Bans are not narrowly tailored to serve a compelling state interest, they fail strict scrutiny and are therefore unconstitutional.

C. As Applied to Therapeutic Abortions, Idaho's Abortion Bans Fail Rational Basis Scrutiny

406. As an alternative basis for its judgment, the Court concludes that the interests asserted by the State are not rationally advanced in cases where a pregnant person faces a risk of death from self-harm. First, the leading underlying cause of pregnancy-related death in Idaho is mental health conditions, encompassing deaths related to suicide, substance-use disorder, and other types of self-harm. *Supra* at ¶ 62. It is not rational for Idaho to deny life-saving abortions to those most at risk of pregnancy-related death in the interest of preserving life. This is especially true given that, if a person dies while pregnant, the embryo or fetus they are carrying is likely to die as well. Tr. 18:22-19:1 (Smid). Second, forcing doctors to deny life-saving care to patients at risk of self-harm is not rationally related to preserving the integrity of the medical profession. This interest is served by enacting laws that reduce the risk of suicide, not laws that force doctors to turn a blind eye to it. *See Glucksberg*, 521 U.S. at 731.

407. Nor are the State's asserted interests advanced in cases where an embryo or fetus does not have a realistic chance of surviving past childbirth. The State has contended that the Abortion Bans are rational because they permit doctors to remove an embryo or fetus that dies in utero. This argument misses the point. The record establishes that weeks or months may elapse

between the time when a life-limiting condition is diagnosed and the time when miscarriage or stillbirth occurs. Tr. 191:19-24 (Dahl). It is arbitrary and irrational to force a pregnant person to endure the risks of pregnancy during that interval when the embryo or fetus has little chance of survival.

408. Likewise, these interests are not rationally advanced in cases where a multifetal pregnancy reduction would give one or more embryos or fetuses a meaningful chance of survival when they would otherwise have none. *See supra* at ¶¶ 194-97. The State contends that its interest in preserving prenatal life permits it to condemn all developing embryos and fetuses to death rather than allowing some to have a chance at life. But this is the very definition of irrational. Nor is it rational to hope that a miracle will enable some embryos or fetuses to survive when all available evidence demonstrates that a medical intervention is necessary. *See Nordlinger v. Hahn*, 505 U.S. 1, 11 (1992) (explaining that a statute may withstand rational basis scrutiny only if the legislative facts on which it is based "rationally may have been considered to be true by the governmental decisionmaker"). In these heartbreaking cases, the State simply has no legitimate interest in overriding the decision of parents of a wanted pregnancy about how best to maximize the chances that at least one child will survive.

409. Finally, the State misses the mark in arguing that the interests cited above support application of the Abortion Bans in cases where an embryo or fetus has a condition that, although incompatible with sustained life, may allow it to live for a brief time after birth. The State may not advance its interests in a way that differentiates between the welfare of an embryo or fetus and the welfare of a pregnant person because such differentiation is not rational. For instance, the State's interest in respect for and preservation of prenatal life is a subset of a broader interest in life. The State cannot rationally advance that interest in a way that disrespects

or fails to preserve postnatal life; the insistence that pregnant people endure the risks, burdens, and long-term health consequences of full-term pregnancy and childbirth knowing that the child they deliver is likely to die within hours or days of birth is the epitome of arbitrary state action. *See supra* at ¶¶ 42-57. Similarly, the State's interest in mitigating fetal pain is a subset of a broader interest in mitigating pain; the State cannot rationally advance that interest in a way that augments a pregnant person's physical pain or mental anguish.

410. The State cannot seriously contest what common sense and the evidentiary record make clear: When someone with a wanted pregnancy receives the devastating news that their embryo or fetus has a life-limiting condition, forcing them to remain pregnant for weeks or months against their will and go through childbirth only to watch their child experience intense suffering and death in infancy subverts the very interests the State seeks to advance. It disrespects maternal life, undermines maternal health, and imposes extraordinary pain and suffering on those already experiencing loss. Likewise, it is beyond dispute that forcing doctors to turn their backs on pregnant patients' pain and suffering and ignore their pleas for help is a gruesome and barbaric medical practice that undermines the integrity of the medical profession. Further, it is undeniable that the practice has a disparate impact on women and gender minorities, compelling them to endure physical and psychological torment because of their gender-specific capacity for pregnancy.

411. In sum, banning abortion in cases where a developing embryo or fetus has a life-limiting condition, or a multifetal pregnancy reduction would give one or more embryos or fetuses a meaningful chance of survival, fails to rationally advance any legitimate state interest.

V. Equal Protection

A. Pregnant People with Life-Threatening Mental Health Conditions Are Similarly Situated to Pregnant People with Other Life-Threatening Medical Conditions

412. The Total Abortion Ban distinguishes between pregnant people at risk of death from self-harm and pregnant people at risk of death from other causes. Idaho Code § 18-622(2)(a).

413. The Equal Protection Clause provides that "all persons similarly situated should be treated alike." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439 (1985).

414. Groups "need not be similar in all respects," but they must be alike in those respects relevant to the State's policy. *Ariz. Dream Act Coal. v. Brewer*, 757 F.3d 1053, 1064 (9th Cir. 2014).

415. The inquiry into whether groups are similarly situated is guided by the State's asserted objective and the characteristics that bear on that objective. *Olson v. California*, 104 F.4th 66, 77 (9th Cir. 2024) (citing *Ariz. Dream Act Coal.*, 757 F.3d at 1063).

416. Here, the State has defined the relevant category through its own statute: pregnant patients for whom abortion is "necessary to prevent the death" of the patient. Idaho Code § 18-622(2)(a). Within that category, the law prohibits physicians from providing life-saving abortion care to patients facing a risk of death from self-harm while authorizing physicians to provide life-saving abortion care to patients facing a risk of death from all other causes. *Id.*

417. The risk of death from self-harm arises from mental health conditions that cause suicidal ideation, substance use, and/or pathological behaviors that create a risk of accidental death. *Supra* at ¶¶ 105, 09, 121-125; *see also Glucksberg*, 521 U.S. at 730 ("Those who attempt suicide … often suffer from depression or other mental disorders.").

418. Patients with life-threatening mental health conditions are similarly situated to patients with other life-threatening medical conditions in the only respect that matters under the statute: both groups face a risk of death that would be mitigated by having an abortion.

419. In the Eighth Amendment context, the Ninth Circuit and many of its sister circuits have held that serious medical needs arising from mental health conditions are comparable to serious medical needs arising from other medical conditions and must be treated alike. *See Doty v. County of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994) ("In accordance with the other courts of appeals that have examined this issue, we now hold that the requirements for mental health care are the same as those for physical health care needs."); *see also Disability Rts. Mont., Inc. v. Batista*, 930 F.3d 1090, 1101 (9th Cir. 2019) ("[A]n Eighth Amendment claim is made out if prisoners with serious mental illnesses face a substantial risk of serious harm, and this is met with deliberate indifference to their condition."); *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) ("The extension of the eighth amendment's protection from *physical* health needs … to *mental* health needs is appropriate because, as courts have noted, there is '[n]o underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.'" (citations omitted)). Further, the Ninth Circuit has expressly held that the risk of death by suicide constitutes a serious medical need. *Conn v. City of Reno*, 572 F.3d 1047, 1055 (9th Cir. 2009) ("A heightened suicide risk or an attempted suicide is a serious medical need."), *amended by* 591 F.3d 1081 (9th Cir. 2010), *cert. granted, judgment vacated, and remanded*, 563 U.S. 915 (2011), *reinstated in relevant part by* 658 F.3d 897 (9th Cir. 2011); *see also Colburn v. Upper Darby Township*, 946 F.2d 1017, 1023 (3d Cir. 1991) ("[A] 'particular vulnerability to suicide' represents a 'serious medical need.'" (citation omitted)).

420. The features identified by the State—such as the availability of alternative treatments, the role of patient behavior, and the inherent uncertainty of prediction—do not distinguish these patient groups in a constitutionally meaningful way. The record demonstrates that all medical risk assessment, whether psychiatric or somatic, relies on individualized clinical judgment, probabilistic evaluation, and evolving treatment options. *Supra* at ¶¶ 90-98; 198. None of these features are unique to pregnant patients with life-threatening mental health conditions, and none provides a principled basis for categorically withholding life-saving care.

421. In particular, the existence of alternative treatments does not render the two groups of patients dissimilar. Not all treatments are effective for all patients, and every potential treatment requires an individualized assessment of potential risks and benefits. *Supra* at ¶¶ 53, 96-97, 168. This is equally true of treatments for physical health conditions as it is of treatments for mental health conditions. Tr. 52:18-53:3, 97:19-98:8 (Smid); Tr. 267:18-270:23, 318:18-319:3 (Payne); *compare supra, e.g.*, at ¶ 168 , *with supra, e.g.*, at ¶¶ 140.

422. Further, the record reflects that many physical health conditions involve patient behavior as a component of disease management and risk. The risks faced by patients with diabetes, for example, may vary based on their adherence to medication, diet, and exercise regimens, Tr. 225:17-226:15 (Prentice), yet those risks are universally understood as arising from a medical condition requiring clinical treatment, not as grounds for withholding life-saving care, *see* Tr. 72:19-73:5 (Smid). The presence of a behavioral component in the manifestation or progression of a condition does not distinguish the risk of death by self-harm from the risk of death by other medical causes.

423. Although psychiatric diagnosis often does not turn on a single laboratory or imaging result, it is not unreliable or meaningfully more subjective. Psychiatrists do not rely

solely on a patient's self-report, but rather apply standardized diagnostic criteria; observe the patient's speech, affect, thought process, behavior and other clinical signs; obtain collateral information from family members and others; review medical and family history; and where appropriate, use laboratory testing, imaging, and standardized instruments. *Supra* at ¶ 143. In fact, the DSM criteria were developed to standardize psychiatric diagnosis and application of the criteria ordinarily leads different psychiatrists to the same or substantially similar diagnosis. *Supra* at ¶ 143.

424. Nor is the legally relevant inquiry whether the underlying condition can be displayed on an X-ray or confirmed through blood tests. Section 18-622 requires a physician to determine whether abortion is necessary to prevent death. *Supra* at ¶¶ 4-5. That is a prospective assessment of risk and causation. Yet, physicians cannot predict with absolute certainty whether an untreated infection or psychiatric illness will result in death. *Supra* at ¶ 144. Psychiatrists nevertheless assess suicide risk every day in emergency, inpatient, and outpatient settings using established, reliable, clinical methods. Tr. 260:23-261:21 (Payne).

425. Importantly, the statutory classification does not track the degree of diagnostic or predictive certainty. It excludes every risk of death from self-harm, including risks corroborated by a longstanding diagnosis, observable psychosis or catatonia, prior acts of self-harm, collateral witnesses, hospitalization, treatment failure, or the agreement of multiple clinicians. At the same time, it permits abortion for other causes of death without requiring objective certainty or a particular degree of immediacy. *See Planned Parenthood Great Nw.*, 522 P.3d at 1203. The statutory line therefore turns on the anticipated mechanism of death, not on the objectivity or reliability of the evidence support the physician's judgment.

426. Accordingly, patients facing a risk of death from self-harm and those facing a risk of death from other medical causes are similarly situated with respect to the State's chosen objective, and the differential treatment of the two groups demands scrutiny under the Equal Protection Clause. *See Ariz. Dream Act Coal.*, 757 F.3d at 1064-65.

B. The Statutory Classification Fails Strict Scrutiny

427. Classifications that burden the exercise of a fundamental right are subject to strict scrutiny. *City of Cleburne*, 473 U.S. at 432 (explaining that strict scrutiny applies "when state laws impinge on personal rights protected by the Constitution"); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942) (subjecting a law to strict scrutiny because, in authorizing sterilization for one class of offenders but not another class of offenders with similar culpability, it burdened "one of the basic civil rights of man").

428. Here, this Court has found that medically indicated abortion is a fundamental right. *Supra* at 400. Because the Total Abortion Ban classifies patients in a manner that burdens one group's ability to exercise this right, the classification is subject to strict scrutiny.

429. Under strict scrutiny, the State must demonstrate that the challenged classification is narrowly tailored to serve a compelling governmental interest. *See City of Cleburne*, 473 U.S. at 440.

430. The interests asserted by the State to justify the challenged classification fall into three categories: (1) an interest in preserving fetal life; (2) an interest in regulating medical practice, including determining when abortion is an appropriate or necessary treatment; and (3) an interest in preventing the performance of abortions in bad faith. *See* Ex. 1010 at 4-5.

431. Assuming the State has a compelling interest in protecting fetal life, the challenged classification is not narrowly tailored to serve that interest. The statute is underinclusive with respect to the State's asserted interest because it permits abortion care when

necessary to prevent death from some life-threatening conditions, while prohibiting identical care when necessary to prevent death from life-threatening mental health conditions. Moreover, where the State's interest is the preservation of life, excluding a subset of patients who face a substantial risk of death undermines, rather than advances, that interest.

432. The statute is also overinclusive because it categorically prohibits physicians from providing abortion care in cases involving risk of death from self-harm, regardless of the severity, imminence, or medical certainty of that risk, and regardless of whether abortion is the only effective means of preventing the patient's death.

433. Even assuming that regulating the medical profession constitutes a compelling governmental interest in this context, the challenged classification is not narrowly tailored to serve that interest.

434. As the record establishes, physicians diagnose and assess the risk of death from self-harm using established medical standards, including clinical criteria, diagnostic frameworks, and professional judgment, in the same manner they assess other life-threatening conditions. *Supra* at ¶¶ 143-44. A law that categorically prohibits physicians from acting on that judgment in one subset of cases is fatally underinclusive.

435. Finally, for the same reasons expressed above, the classification is not narrowly tailored to serve the State's interest in preventing the performance of abortions in bad faith. *Supra* at ¶ 404.

436. Accordingly, the statute's differential treatment of pregnant patients facing a risk of death from self-harm fails strict scrutiny because it is not narrowly tailored to serve a compelling governmental interest.

C. The Statutory Classification Fails Rational Basis Scrutiny

437. While strict scrutiny is the appropriate standard to analyze the classification the State imposes on pregnant patients with life-threatening mental health conditions, the classification also fails rational basis review.

438. Under the Equal Protection Clause, a statutory classification must bear a rational relationship to a legitimate governmental interest. *See City of Cleburne*, 473 U.S. at 446; *Zobel v. Williams*, 457 U.S. 55, 60–61 (1982); *United States Dep't of Agric. v. Moreno*, 413 U.S. 528, 533 (1973).

439. Although rational basis review is deferential, it is not toothless. "Deference is not abdication," and rational-basis scrutiny requires that a justification for the challenged classification in fact exist. *See Silveira v. Lockyer*, 312 F.3d 1052, 1088-89 (9th Cir. 2002) (citations omitted), *abrogated on other grounds by Heller*, 554 U.S. at 570. A classification fails rational basis review where its relationship to an asserted governmental interest is "so attenuated as to render the distinction arbitrary or irrational." *See City of Cleburne*, 473 U.S. at 446.

440. Rational basis review requires a court to ask two questions. First, "[d]oes the challenged legislation have a legitimate purpose?"; and second, "[w]as it reasonable for the lawmakers to believe that use of the challenged classification would promote that purpose?" *W. & S. Life Ins. Co. v. State Bd. of Equalization*, 451 U.S. 648, 668 (1981).

441. Applying these principles, the challenged classification fails rational basis review. First, disdain for people with mental illness is an improper purpose that cannot serve as a legitimate basis for state action. *See City of Cleburne*, 473 U.S. at 450 (finding an equal protection violation where state action "appears to us to rest on an irrational prejudice against" people with developmental disabilities). The State's claim that suicidality can be "professed by

anyone" reflects precisely the kind of irrational animus and ignorance of psychiatry condemned in *Cleburne*.

442. Second, it was not reasonable for lawmakers to believe that the challenged classification is rationally related to any legitimate state interest. The State's interest in preserving life cannot rationally justify denying life-saving treatment to pregnant people suffering from mental illness. Idaho's own MMRC found that the most common underlying cause of pregnancy-related death in Idaho in recent years was mental health conditions, encompassing deaths related to suicide, substance-use disorder, and other types of self-harm. *Supra* at ¶¶ 62- 65; Ex. 1009. It is the height of irrationality for Idaho to exclude from the class of people authorized to obtain life-saving abortions those most at risk of pregnancy-related death. And if a person dies while pregnant, in many cases, the embryo or fetus they are carrying will die as well. Tr. 18:20-19:1 (Smid). Moreover, denying life-saving care to patients at risk of self-harm is not rationally related to the State's interest in regulating medicine. This interest is served by enacting laws that reduce the risk of suicide, not laws that force doctors to turn a blind eye to it. *See Glucksberg*, 521 U.S. at 731.

443. Notably, the asserted greater difficulty of psychiatric assessment does not rationally justify the categorical "self-harm" exclusion here. Rational basis review is deferential, but the classification must have "some footing in the realities of the subject addressed by the legislation." *Heller v. Doe*, 509 U.S. 312, 321 (1993).

444. In *Heller*, the Court concluded that a claimed difference in the ease of diagnosis could justify differing burdens of proof for civil commitment, where those differing burdens were in place to account for a corresponding difference in the risk of error. *Id.* at 321-328 (providing different burdens between developmental conditions and other psychiatric illnesses).

But unlike Kentucky's scheme in *Heller*, Idaho's statute does not calibrate the proof required to the claimed uncertainty. Instead, it makes that uncertainty irrebuttable. A patient is categorically excluded even when the psychiatric condition and risk of death are supported by observable symptoms, medical history, collateral sources, prior self-harm, treatment failure, and agreement among clinicians. Conversely, a patient facing another cause of death may qualify based on a physician's good-faith judgment without objective certainty. The line drawn, therefore, does not correspond to the State's asserted concern of uncertainty.

445. The anticipated mechanism of death is not a rational proxy for the reliability of the physician's assessment. If the concern is that a patient could falsely profess suicidality, the exclusion applies even when the risk is independently corroborated. If the concern is the difficulty of predicting future behavior, the exclusion applies even when the risk is acute, documented, and resistant to available treatment. And it applies regardless of whether any physician could in good faith regard the case as uncertain. The categorical rule, thus, rests on a generalized assumption about psychiatric illness rather than the actual reliability of the medical determination.

446. Accordingly, the Court concludes that the statutory classification is arbitrary and irrational in violation of the Equal Protection Clause.

VI. Remedy

447. District courts are not bound by a party's request for relief. Instead, they have broad discretion to award any relief to which a party is entitled based on the evidentiary record and applicable legal standards. *See* Fed. R. Civ. P. 54(c) ("Every … final judgment [other than a default judgment] should grant the relief to which each party is entitled, even if the party has not demanded that relief in its pleadings."); *Citizens United v. Fed. Election Comm'n*, 558 U.S. 310,

329-31 (2010) (holding that a court may grant facial invalidation of a statute even if a party expressly disclaims such relief).

448. The Attorney General argues that the Court should not enter relief against him because Plaintiff did not name him in the complaint. It is well-settled, however, that "[i]ntervenors under Fed. R. Civ. P. 24(a)(2) … enter the suit with the status of original parties and are fully bound by all future court orders." *United States v. Oregon,* 657 F.2d 1009, 1014 (9th Cir. 1981). In *California Chamber of Commerce v. Council for Education & Research on Toxics,* 29 F.4th 468, 483 (9th Cir. 2022), the Ninth Circuit affirmed a preliminary injunction against a defendant-intervenor. The Court held that the defendant-intervenor had the same obligations and rights as the defendant in the case, including "the duty to be bound by the district court's injunction order." *Id.* Further, the Attorney General cannot escape the consequences of his intervention by retroactively claiming to have intervened for a limited purpose. *See supra* at ¶ 346 (describing the purpose for which the Attorney General intervened). Only when a court imposes specific limitations or conditions upon an intervening party is that party's status so limited. *Cahill v. Insider Inc.*, 131 F.4th 933, 937-38 (9th Cir. 2025) (rejecting an intervenor's "attempts to dull the effect of its party status by arguing it is only a limited-purpose intervenor that should not be subject to the Protective Order or the district court's discovery orders"). In *Cahill*, the Ninth Circuit explained that, "by entering into the litigation here, [the intervenor] obtained the same rights and obligations that any other party would obtain." *Id.* at 938.

449. The Attorney General's reliance on *Pacific Radiation Oncology, LLC v. Queen's Medical Center*, 810 F.3d 631 (9th Cir. 2015), is misplaced. That opinion does not involve intervention. The plaintiff sought a preliminary injunction against the original defendants based on a purported likelihood of success on a set of claims that were unrelated to the claims asserted

in its complaint. *Id.* at 637 ("PRO fails to explain how the privacy claims underlying the motion for injunctive relief relate to the unfair trade practices claims in its complaint."). Here, Plaintiff is seeking a final judgment on precisely the claims asserted in his complaint, and he is entitled to relief on those claims from both the Defendants named in the complaint and the Attorney General who intervened as a Defendant and answered the complaint. *See* Att'y Gen. Raúl Labrador's Answer, Dkt. No. 61-2. Notably, as explained above, when entering a final judgment, a court "should grant the relief to which each party is entitled, even if the party has not demanded that relief in its pleadings." Fed. R. Civ. P. 54(c). For that reason, the First Circuit recently distinguished *Pacific Radiation Oncology* on the ground that "[i]t and the precedent it cited spoke only to preliminary injunctions, which are governed by a different set of considerations [than permanent injunctive relief]." *See Colón v. State Ins. Fund Corp.,* 169 F.4th 13, 22 n.2 (1st Cir. 2026).

450. The Ninth Circuit has held that Idaho's Attorney General has sufficient connection to enforcement of Idaho's criminal abortion laws to make him a proper defendant in a lawsuit challenging their constitutionality. *Planned Parenthood of Idaho, Inc. v. Wadsen*, 376 F.3d 908, 919-20 (9th Cir. 2004) (holding that the Attorney General's statutory authority to assist a county prosecutor or stand in their shoes if deputized by the Governor "demonstrates the requisite causal connection for standing purposes"); *accord Matsumoto*, 122 F.4th at 802-03. It explained that "[a]n injunction against the attorney general could redress plaintiff's alleged injuries, just as an injunction against the Ada County prosecutor could." *Wadsen*, 376 F.3d at 920. Thus, here, entry of relief against the Attorney General in his official capacity would neither be hollow nor in vain. Accordingly, the Court will enter relief against the Attorney

General, as a Defendant-Intervenor, on the same terms as it enters relief against the original Defendants.

451. The Declaratory Judgment Act provides that, "[i]n a case of actual controversy within its jurisdiction," except in circumstances not relevant here, "any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a). "Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such." *Id.*

452. Here, Plaintiff is entitled to a declaration that:

a. The Due Process Clause of the Fourteenth Amendment protects the right to obtain an abortion for medical reasons;

b. Insofar as the Total Abortion Ban, Idaho Code § 18-622, prohibits abortion in cases where a pregnant person faces a risk of death from self-harm, it violates the Due Process Clause of the Fourteenth Amendment;

c. Insofar as the Total Abortion Ban, Idaho Code § 18-622, treats pregnant people who face a risk of death from mental health conditions differently than pregnant people who face a risk of death from other medical conditions, it violates the Equal Protection Clause of the Fourteenth Amendment;

d. Insofar as the Total Abortion Ban, Idaho Code § 18-622, or Fetal Heartbeat Act, Idaho Code §§ 18-8801 to 18-8808, prohibits abortion in cases where a pregnant person faces a risk of serious harm to their physical or mental health, it violates the Due Process Clause of the Fourteenth Amendment;

e. Insofar as the Total Abortion Ban, Idaho Code § 18-622, or Fetal Heartbeat Act, Idaho Code §§ 18-8801 to 18-8808, prohibits abortion in cases where a pregnant person is carrying an embryo or fetus with a life-limiting condition, it violates the Due Process Clause of the Fourteenth Amendment; and

f. Insofar as the Total Abortion Ban, Idaho Code § 18-622, or Fetal Heartbeat Act, Idaho Code §§ 18-8801 to 18-8808, prohibits multi-fetal pregnancy reduction when performed for the purpose of improving the chances of long-term survival for at least one embryo or fetus, it violates the Due Process Clause of the Fourteenth Amendment.

453. Plaintiff is further entitled to permanent injunctive relief from unconstitutional applications of Idaho's Abortion Bans. The Supreme Court has explained that, "when confronting a constitutional flaw in a statute, [federal courts should] try to limit the solution to the problem." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006) (citations omitted). "We prefer, for example, to enjoin only the unconstitutional applications of a statute while leaving other applications in force, or to sever its problematic portions while leaving the remainder intact." *Id.* at 328-29. At the same time, a federal court must avoid rewriting state law to conform it to constitutional requirements because that is quintessentially legislative work. *Id.*

454. The Court is mindful that a State court has previously construed the therapeutic exceptions in Idaho's Abortion Bans as authorizing abortion care when

> in the performing physician's good faith medical judgment (based on the facts known to the physician at the time of the abortion), the patient—because of an existing medical condition or pregnancy complication that would be alleviated by an abortion—faces a non-negligible risk of dying sooner without an abortion (even if her death is neither imminent nor assured), so long as (i) the risk of her death doesn't arise from a risk of self-harm, and (ii) the manner of pregnancy

> termination is the one that, without … increasing the risk of her death, best facilitates the unborn child's survival outside the uterus, if feasible.

Adkins, slip op. at 39; *see supra* at ¶ 22. In crafting injunctive relief in this case, the Court will retain as much of this construction as possible while striking the portions that are incompatible with the Fourteenth Amendment.

455. Accordingly, the Court will permanently enjoin Defendants and Defendant-Intervenor, as well as their agents and successors in office, from enforcing the Total Abortion Ban, Idaho Code § 18-622, in the following circumstances:

a. When a physician concludes, based on good-faith medical judgment and the facts known to the physician at the time, that an abortion would mitigate a non-negligible risk that a pregnant person will die from self-harm;

b. When a physician concludes, based on good-faith medical judgment and the facts known to the physician at the time, that an abortion would mitigate a non-negligible risk of serious harm to a pregnant person's physical or mental health and an abortion is not otherwise necessary to prevent the death of the pregnant person;

c. When a physician concludes, based on good-faith medical judgment and the facts known to the physician at the time, that a pregnant person is carrying an embryo or fetus with a life-limiting condition;

d. When a physician concludes, based on good-faith medical judgment and the facts known to the physician at the time, that a multi-fetal pregnancy reduction would significantly improve the likelihood of long-term survival for at least one embryo or fetus.

456. Further, the Court will permanently enjoin Defendants and Defendant-Intervenor, as well as their agents and successors in office, from enforcing the Fetal Heartbeat Act, Idaho Code §§ 18-8801 to 18-8808, in the following circumstances:

a. When a physician concludes, based on good-faith medical judgment and the facts known to the physician at the time, that an abortion would mitigate a non-negligible risk of serious harm to a pregnant person's physical or mental health;

b. When a physician concludes, based on good-faith medical judgment and the facts known to the physician at the time, that a pregnant person is carrying an embryo or fetus with a life-limiting condition;

c. When a physician concludes, based on good-faith medical judgment and the facts known to the physician at the time, that a multi-fetal pregnancy reduction would significantly improve the likelihood of long-term survival for at least one embryo or fetus.

Dated: June 30, 2026

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CERTIFICATE OF SERVICE

I hereby certify that, on June 30, 2026, the foregoing document was electronically filed with the Clerk of the Court using the CM/ECF system, which will cause a copy to be served on all counsel of record.

/s/ Stephanie Toti
Stephanie Toti

APPENDICES

Appendix A: Criminal Abortion Statutes, U.S. States

Appendix B: Criminal Abortion Statutes, U.S. Territories & the District of Columbia

Appendix C: *Adkins v. State*, No. CV01-23-14744, slip op. (Idaho 4th Dist. Ct. Apr. 11, 2025)

Appendix D: *Walker v. Great N. Ry. Co. of Ir.*, 28 L.R. Ir. 60, 69 (1890)

Appendix E: *Rex v. Bourne*, (1938) 3 All E.R. 615 (Eng.)