No. 06-3108

UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

JANE ROE, individually and on behalf of all others similarly situated,

Plaintiffs-Appellees,

v.

LARRY CRAWFORD, Director of the Missouri Department of Corrections, *et al.*,

Defendants-Appellants.

On Appeal from the United States District Court for the Western District of Missouri, Central Division

BRIEF FOR *AMICI CURIAE* THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL WOMEN'S ASSOCIATION, AND THE AMERICAN PUBLIC HEALTH ASSOCIATION IN SUPPORT OF PLAINTIFFS-APPELLEES

Kimberly A. Parker
Counsel of Record
Jessica L. Waters
WILMER CUTLER PICKERING
HALE AND DORR LLP
1875 Pennsylvania Ave., N.W.
Washington, D.C. 20006
(202) 663-6000

Counsel for Amici Curiae

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STATEMENT OF INTEREST OF AMICI CURIAE[1]

The **American College of Obstetricians and Gynecologists** (ACOG), a non-profit educational and professional organization founded in 1951, is the leading professional association of physicians who specialize in the health care of women. Its more than 50,000 members, including 974 physicians in Missouri, represent approximately 90% of all board-certified obstetricians and gynecologists practicing in the United States.

The **American Medical Women's Association** (AMWA), founded in 1915, is an organization of women physicians and medical students dedicated to women's health and the advancement of women in medicine. AMWA works to advance its goals at the local, national, and international level.

The **American Public Health Association** (APHA) is the oldest, largest, and most diverse organization of public health professionals in the world. The Association works to protect all Americans, their families, and communities from preventable, serious health threats, and strives to ensure that community-based health promotion and disease prevention activities and preventative health services are universally available.

Amici urge this court to affirm the judgment of the District Court for the

[1] Pursuant to Fed. R. App. P. 29(a), Counsel for *Amici* has contacted the parties and obtained consent to file this brief.

Western District of Missouri in favor of the plaintiffs.

SUMMARY OF ARGUMENT

As the United States District Court for the Western District of Missouri correctly found, the Missouri Department of Corrections' ("DOC") policy prohibiting pregnant inmates from choosing abortion by refusing to transport them off-site for this medical care violates the Eighth Amendment. *Roe v. Crawford*, 439 F. Supp. 2d 942, 953 (W.D. Mo. 2006). Abortion care, no less than other types of pregnancy-related care, is a serious medical need, and the intentional denial of such care constitutes unconstitutional deliberate indifference.

DOC's policy – which is, in essence, a policy of forced childbirth – prevents a woman from obtaining pregnancy-related care that can reduce the risks to her health and life, and ignores the unique health risks faced by pregnant incarcerated women. The health risks associated with continuing a pregnancy and childbirth, or of delaying abortion care, are significant for any pregnant woman, but, as DOC acknowledges of its own inmate population, the risks are often greater for incarcerated women. It is precisely because of these risks that expert professional medical groups, such as *amici*, leading medical schools, and other penal systems consider abortion care standard, essential health care that must be available to *all* women. DOC's policy ignores this medical expertise and is at odds with community standards. Finally, DOC's argument that "elective" abortion care

cannot constitute a serious medical need ignores the case law directly on point and erroneously conflates the Eighth Amendment "serious medical need" standard with a medical emergency standard.

ARGUMENT

It is well-settled and undisputed that the Missouri Department of Corrections is obligated to "provide medical care for those whom it is punishing by incarceration." *Estelle v. Gamble*, 429 U.S. 97, 103 (1976), and that a DOC policy or practice that fails to treat an inmate's "serious medical need" runs afoul of the Eighth Amendment. *Estelle*, 429 U.S. at 106; *Warren v. Fanning*, 950 F.2d 1370, 1373 (8th Cir. 1991). The DOC argues that abortion care is not a serious medical need. But, as the policies, practices, and clinical experience of *amici* medical and public health groups demonstrate, abortion care, no less than other pregnancy-related care, is a serious medical need and a basic component of health care for pregnant women.

This Court has held that a medical need is "serious" if it is "one that has been diagnosed by a physician as requiring treatment, or one that is so obvious that even a layperson would easily recognize the necessity for a doctor's attention." *Camberos v. Branstad*, 73 F.3d 174, 176 (8th Cir. 1995) (quoting *Johnson v. Busby*, 953 F.2d 349, 351 (8th Cir. 1991)); *see also Gutierrez v. Peters*, 111 F.3d 1364, 1373 (7th Cir. 1997) (a serious medical need is one "a reasonable doctor or

patient would find important and worthy of comment or treatment"). Abortion care clearly meets this standard. This Court has recognized that medical conditions that are far from emergent or life threatening can amount to serious medical needs. *See, e.g.*, *Ellis v. Butler*, 890 F.2d 1001, 1003 n.1 (8th Cir. 1989) ("We note that a medical condition need not be an emergency in order to be considered serious under *Estelle*."). And, as the Third Circuit has held, "An elective, nontherapeutic abortion may . . . constitute a 'serious medical need' where denial or undue delay in provision of the procedure will render the inmate's condition 'irreparable.'" *Monmouth County Correctional Institutional Inmates v. Lanzaro*, 834 F.2d 326, 349 (3d Cir. 1987); *see also Doe v. Barron*, 92 F. Supp. 2d 694, 696-697 (S.D. Ohio 1999) (enjoining correctional facility from denying inmate access to abortion services and citing *Lanzaro* with approval). This Court should adopt the same standard.

I. Access to Abortion Care, No Less Than Other Pregnancy-Related Care, is a Serious Medical Need for Pregnant Women

Unless she miscarries, a pregnant woman faces two options: carrying her pregnancy to term or ending it. Just as a woman who plans to continue her pregnancy needs medical treatment – to care for herself and her fetus *in utero*, as well as to deliver safely at term – a woman who chooses to terminate her pregnancy likewise needs medical attention. There is no medical basis for treating pregnancy termination as less serious than other pregnancy-related care.

A. Denying Access to Abortion Care Prevents a Woman from Obtaining Pregnancy-Related Care that Can Reduce Risks to Her Health and Life

Preventing a woman from accessing abortion services denies her care that can significantly reduce the risks to her health and life that are posed by continuing a pregnancy through childbirth. Expert Report of Robert James Sokol, M.D., Civ. No. 05-4333-CV-C-DW (W.D. Mo., Feb. 9, 2006) (Sokol Report) ¶ 6 (JA 425). Pregnancy causes increased risk of serious medical complications and even, in some cases, death. American Medical Women's Association, Policy Statement: *Abortion* (2000), *available at* http://www.amwa-doc.org/index.cfm?objectId=0A5BF4D4-D567-0B25-58C7E8584C98D43B (AMWA Policy Statement: *Abortion*) ("Pregnancy . . . involves medical risk for a patient, ranging from minor physical inconveniences to death itself."); Sokol Report ¶ 1 (JA 423). The risk of death associated with carrying a pregnancy through childbirth is substantially higher than the risk of death associated with induced abortion: a woman is at least 10 times more likely to die from continuing a pregnancy through childbirth than from an induced abortion. Laurie D. Elam-Evans et al., *Abortion Surveillance-United States, 1999,* in *Surveillance Summaries*, 51 MMWR (No. SS-9) 3, 7, 28 (Table 19) (Centers for Disease Control and Prevention, Nov. 29, 2002), *available at* http://www.cdc.gov/mmwr/PDF/SS/SS5109.pdf (for period 1991 to 1997, average case-fatality rate for known legal abortion was 0.6 deaths per 100,000

legal abortions); *Pregnancy-Related Deaths Among Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native Women - United States, 1991-1997*, 50 MMWR (No. 18) 361, 361, 362 (Table 1) (Centers for Disease Control and Prevention, May 11, 2001), *available at* http://www.cdc.gov/mmwr/PDF/WK/MM5018.pdf (for period 1991 to 1997, pregnancy-related mortality ratio for overall population of 11.5 deaths per 100,000 live births); *see also* Grimes, D., *Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991-1999*, 194 Obstetrics & Gynecology 92-94 (2006) (using national statistics to estimate mortality risk of various pregnancy outcomes from 1991-99 and finding that the "relative risk associated with live birth was 12.4 times higher" than the risk of death "associated with legal abortion"); Guttmacher Institute, *Facts on Induced Abortion in the United States* (May 2006), *available at* http://www.guttmacher.org/pubs/fb_induced_abortion.pdf ("The risk of death associated with childbirth is about 12 times as high as that associated with abortion"); Sokol Report ¶ 4 (JA 424).

While the risk of serious medical complications associated with induced abortion is low, the risk of health complications from continuing a pregnancy to term is considerably higher. A woman planning to give birth has roughly forty times the risk of hospitalization for a complication compared to a woman undergoing abortion. H.J. Jiang et al., *Care of Women in U.S. Hospitals*, *2000*,

HCUP Fact Book No. 3, AHRQ Publication No. 02-0044, at 9, 36, 37 (Agency for Healthcare Research and Quality, 2002), *available at* http://www.ahrq.gov/data/hcup/factbk3/factbk3.pdf (in 2000, nearly four million women gave birth, and there were about 374,000 hospitalizations for complications separate from delivery among women with pregnancies going to term, a rate of about 9%; in contrast, there were about 1.3 million abortions and about 3,100 hospitalizations for complications from abortions, a rate of 0.2%); Guttmacher Institute, *Facts on Induced Abortion, supra*, at 2 ("fewer than 0.3% of abortion patients experience a complication that requires hospitalization."); Sokol Report ¶ 4 (JA 424).

Some women have preexisting conditions, such as heart, kidney, or liver disease, which can be exacerbated by pregnancy. Other women's health is threatened by conditions caused by the pregnancy itself. For example:

- It is estimated that over 3% of live births in the United States are complicated by diabetes, with over 90% of these women having gestational diabetes (defined as having high blood sugar (glucose) levels during pregnancy without a prior history of diabetes). F. Gary Cunningham, et al., *Williams Obstetrics* 1170 (22d ed. 2005); American Diabetes Association, *Gestational Diabetes*, *available at* http://www.diabetes.org/gestational-diabetes.jsp (last visited Dec. 6, 2006) (estimating that gestational diabetes affects 4% of pregnant women). Women with gestational diabetes are at increased risk for health complications, such as postpartum cardiovascular complications. *Williams Obstetrics* 1176. They also face an increased lifetime risk of diabetes.

- Approximately 5% of pregnancies are complicated by preeclampsia, a hypertensive disorder of pregnancy. *Id.* at 765. Women with severe preeclampsia can face serious deterioration of a number of organs and organ systems, including renal failure, blindness, severe cardiovascular

disturbances, pulmonary edema (fluid accumulation and swelling in the lungs), rupture of the liver, seizures, and stroke. *Id.* at 770-778.

- Approximately 1 in 200 deliveries result in placental abruption, the complete or partial separation of the placenta from the uterine wall. *Id.* at 811. Maternal risks associated with abruption include massive blood loss, disseminated intravascular coagulation (the failure of the clotting mechanism at the site of bleeding), and renal failure. *Id.* at 811-816.

Incarcerated pregnant women, because of their disadvantaged backgrounds, may face even greater risks during pregnancy than women in the general population. ACOG, *Special Issues in Women's Health*, *Health and Health Care of Incarcerated Adult and Adolescent Females* 89 (2005); Jennifer G. Clarke, MD, et al., *Reproductive Health Care and Family Planning Needs Among Incarcerated Women*, 96 Am. J. of Public Health 834, 836 (May 2006) (finding that 54% of incarcerated women in study did not have health insurance and 11.1% were homeless when they entered the correctional facility); *see also* Marian Knight & Emma Plugge, *The Outcomes of Pregnancy Among Imprisoned Women: A Systematic Review*, 112 BJOG: An International Journal of Obstetrics & Gynecology 1467 (2005) (imprisoned pregnant women considered a high risk group due to deprived socioeconomic backgrounds, and to greater likelihood of smoking, excessive alcohol use, and abuse of illegal drugs than general population); National Commission on Correctional Health Care, *Position Statement: Women's Health Care in Correctional Settings* (2005), *available at* http://www.ncchc.org/resources/statements/womenshealth2005.html ("Owing to

their past medical histories, incarcerated women tend to have complicated and high-risk pregnancies.").[2] Indeed, DOC admits that many of the pregnant inmates at its facility have high-risk pregnancies. SF ¶¶ 71-72, 106-108 (JA 66, 70-71).

B. DOC's Policy Increases Health Risks to Women Who Decide to Terminate Their Pregnancies, Even If They Are Released While Still Pregnant

DOC's policy denying incarcerated women access to abortion increases health risks for all inmates who decide to end their pregnancies, including those who leave prison still pregnant. Many such inmates will be too advanced in pregnancy to obtain an abortion by the time they are released. But even for those women who are able to end their pregnancies upon release, DOC's policy would necessarily force treatment delays. Such delay significantly increases the medical risk associated with abortion. While abortion is, as noted above, very safe, the

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[2] Women of color may face even greater risks, as they comprise a disproportionate percentage of the incarcerated population and are also at increased risk of some pregnancy-related complications such as preeclampsia, eclampsia, and pre-term birth – all of which are associated with increased lifetime risks to the woman's health. *See* Nicholas Freudenberg, *Adverse Effects of U.S. Jail and Prison Policies on the Health and Well-Being of Women of Color*, 92 Am. J. of Public Health 1895 (2002) (women of color are disproportionately more likely to be incarcerated than white women); Andrea P. MacKay et al., *Pregnancy-Related Mortality From Preeclampsia and Eclampsia*, 97 Obstetrics & Gynecology 533 (2001) (finding that black women were 3.1 times more likely to die from preeclampsia or eclampsia than white women); D. Ashton, *Prematurity–Infant Mortality: the Scourge Remains*, 16 Ethn. Dis. 58 (2006) (finding that African-American women are disproportionately likely to experience pre-term birth).

risks associated with abortion increase as the pregnancy advances; for each week the procedure is delayed, the risk of serious medical complications increases, and the risk of death increases by nearly 40%. Sokol Report ¶ 5 (JA 424-25); *see also* Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729 (2004) (increased risk of maternal death associated with abortions at increased gestational age).[3] Thus, for those women who are not able to end their pregnancies until after they are released from prison, DOC's policy imposes additional unwarranted and unnecessary health risks as a result of the forced delay in care.

C. Denying Pregnant Women the Ability to Decide Whether or Not to Terminate a Pregnancy is Inconsistent with Good Medical Judgment and with Standard Medical Care

DOC's policy is inconsistent with generally accepted principles of reproductive health care, as well as its own standards. By DOC's own admission, it strives to provide "the level of care that is comparable to [the] community standard of practice." SF ¶¶ 47-48 (JA 63). The applicable "community

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[3] *See also H.L. v. Matheson*, 450 U.S. 398, 412 (1981) ("Time is likely to be of the essence in an abortion decision."); *Zbaraz v. Hartigan*, 763 F.2d 1532, 1537 (7th Cir. 1985) ("[D]elays of a week or more . . . increase the risk of abortion to a statistically significant degree[.]" (quoting *Women's Medical Center of Providence, Inc. v. Roberts*, 530 F. Supp. 1136, 1146 (D.R.I. 1982)), *aff'd*, 484 U.S. 171 (1987); *Doe v. Barron*, 92 F. Supp. 2d 694, 696 (S.D. Ohio 1999) (delay in abortion care for incarcerated woman "will unnecessarily increase the health risks imposed on Plaintiff").

standards" for both non-incarcerated and incarcerated women – demonstrated by the policies of major medical groups, medical school curricula, and the polices of other penal institutions – establish that abortion care is a serious medical need. Abortion care is simply a basic part of pregnancy-related care, and it is recognized as such by the major medical groups and institutions that treat pregnant women and train others to do so.

1. Major Medical Groups Support Access to Abortion Care for Incarcerated Women

As reflected in their recommendations, the major medical groups dedicated to women's health recognize abortion care as essential, standard health care for pregnant women. *Amicus* ACOG, the leading professional organization of physicians who provide health care for women, has long supported access to abortion care for all women. *See* ACOG Statement of Policy, *Abortion Policy* 2 (reaffirmed July 2004) ("ACOG supports access to care for all individuals, irrespective of financial status, and supports the availability of all reproductive options."). *Amicus* AMWA, an organization of women physicians, medical students, and residents whose mission is to support policies and programs that improve women's health, likewise supports access to abortion care for all women: "[T]he American Medical Women's Association has adopted the position that the decision to continue or interrupt a pregnancy belongs to the pregnant woman, in consultation with her physician." AMWA Policy Statement: *Abortion, supra*.

Likewise, *amicus* APHA, the oldest and largest organization of public health professionals in the world, has continually reaffirmed its "commitment to . . . the right of women to choose abortion" and "accessible, affordable, and safe abortion services for all women." APHA Policy Statement: *Safeguarding the Right to Abortion as Reproductive Choice* (1989); APHA Policy Statement: *Support for Sexual and Reproductive Health and Rights in the United States and Abroad* (2003), *available at* http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=view&id=1251 (2003) (reaffirming 1989 policy).

These same expert groups have recognized that incarcerated women, no less than non-incarcerated women, need access to a full range of reproductive health care. For example, ACOG recommends that "pregnancy counseling and abortion services" be available for all incarcerated women and that "incarcerated females of all ages should receive reproductive health care, including adequate prenatal or abortion services, per ACOG guidelines." ACOG, *Special Issues in Women's Health: Health and Health Care of Incarcerated Adult and Adolescent Females* 89, 97 (2005). The APHA has also authored guidance for the reproductive health treatment of incarcerated women. Stating that "jail and prison health programs must provide the services and facilities necessary to meet women's health care needs," and noting the prevalence of high risk pregnancies among incarcerated women, APHA's position is that "women prisoners must have access to . . .

abortion counseling and services upon request." APHA, *Standards for Health Services Correctional Institutions* 108 (2003).

DOC's policy of prohibiting access to abortion care is thus wholly inconsistent with the recommendations of the expert medical groups dedicated to women's health.

2. Major Medical Schools and Professional Associations Teach Medical Professionals the Importance of Abortion Care as Part of the Standard of Care for Pregnant Women

Medical schools and professional associations charged with training the next generation of health care providers teach students that abortion is part of standard medical care for women. A 2003 survey found that one-third of medical schools include abortion training in their pre-clinical curricula, and over 40 percent of schools offered a clinical abortion experience. Association for Reproductive Health Professionals (ARHP) Model Curriculum, Module 1, at 13 (2d ed. 2004).

Likewise, model medical school curricula developed by expert medical associations underscore that abortion training is a core part of medical school training precisely because it is part of basic pregnancy-related health care for women. For example, the Association for Reproductive Heath Professionals (ARHP) Model Curriculum, recognizing that 34 percent of women will have an abortion before 45 years of age, includes an entire module on abortion training. ARHP Model Curriculum, Module 7, at 7 (2d ed. 2004). Students are expected to

be able to conduct counseling sessions on pregnancy options, including abortion, and to be able to perform abortion procedures. *Id.*, Module 7, at 6. This model curriculum has become well accepted; the first edition of the curriculum was authored by AMWA, and was ultimately incorporated into elective courses and clerkships[4] in at least 24 medical schools in the United States. *Id.*, Module 1, at 11. The *Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Residency Education in Obstetrics and Gynecology* likewise state that, unless a resident has religious or moral objection, "access to experience with induced abortion must be part of residency education." *ACGME Program Requirements for Residency Education in Obstetrics and Gynecology* (2005), *available at* http://www.acgme.org/acWebsite/downloads/RRC_progReq/220pr705.pdf .

Other professional organizations have issued guidelines or model curricula recommending that students and physicians be able to counsel and refer women for the full range of pregnancy options. For example, the Association of Professors of Gynecology and Obstetrics (APGO), an academic medicine organization dedicated to women's health care education and faculty development in medical schools, has developed the *Women's Health Care Competencies for Medical Students: Taking*

[4] A clerkship is a part of medical school training that allows students to work directly with patients under the supervision of a faculty member.

Steps to Include Sex and Gender Differences in the Curriculum. Designed to be used as a template for medical schools when implementing curricula, the *Competencies* recommend that students be able to describe methods of pregnancy termination, discuss complications, and perform non-directive counseling. APGO, *Women's Health Care Competencies for Medical Students: Taking Steps to Include Sex and Gender Differences in the Curriculum* (2005), *available at* http:// wheocomp.apgo.org/competency-topic.cfm?topicid=32. Likewise, the *Council on Resident Education in Obstetric and Gynecology* (CREOG) *Core Curriculum in Obstetrics and Gynecology* recommends that physicians be able to counsel pregnant women on all options available to them, and if they themselves do not perform abortions, refer patients for abortion care. CREOG, *Educational Objectives: A Core Curriculum in Obstetrics and Gynecology* (8th ed. 2005), *available at* http://www.gynob.emory.edu/pdf/creogeducationalobjectives.pdf (last visited Dec. 6, 2006).

3. Leading Penal Standards Treat Abortion Care as a Serious Medical Need

DOC's policy prohibiting abortion access is also at odds with the policies of prison health care accreditation groups and other penal systems. For example, the National Commission on Correctional Health Care (NCCHC), whose mission is to "improve the quality of health care in jails, prisons and juvenile confinement facilities," has established standards for health care in prisons and jails. NCCHC

takes the position that "Correctional institutions should be required to meet recognized community standards for women's services as promoted by standards set by NCCHC." NCCHC, *Position Statements: Women's Health Care in Correctional Settings* (2005), *available at* http://www.ncchc.org/resources/statements/womenshealth2005.html. NCCHC recognizes the expertise of professional associations such as ACOG, and recommends that prisons and jails develop policies based on the recommendations of these expert groups. *Id.* With respect to reproductive health specifically, NCCHC has said, "Considering women's special reproductive health needs, the frequency of repeating certain tests, exams, and procedures (e.g., Pap smears, mammograms) *should be based on guidelines established by professional groups such as . . . the American College of Obstetricians and Gynecologists*, and should take into account age and risk factors of the female correctional population." *Id.* (emphasis added). In keeping with ACOG guidance, NCCHC standards on pregnancy counseling state: "Pregnant women are given comprehensive counseling and assistance in accordance with their expressed desires regarding their pregnancy, whether they elect to keep the child, use adoption services, or have an abortion." *Pregnancy Counseling*, NCCHC P-G-10 (JA 261-62).

The Missouri DOC contracts with Correctional Medical Services ("CMS") for the provision of care to all inmates, and CMS is, as mandated by contract with

DOC, NCCHC accredited. CMS states that, to the "best of [its] ability," it adheres to NCCHC standards, SF ¶¶ 42-45 (JA 62-63), and yet it flatly denies pregnant women abortion care.

The Federal Bureau of Prisons' ("BOP") policies also recognize that the decision of whether to continue a pregnancy is one that belongs to the woman. BOP policies therefore reflect that inmates must have access to counseling about all pregnancy options, and can be transported for abortion services, if that is their decision. *See* BOP Policy*: Birth Control, Pregnancy, Child Placement, and Abortion* 6070.05(2)c (1996), *available at* http://www.bop.gov/DataSource/execute/dsPolicyLoc ("A pregnant inmate will be offered medical, religious, and social counseling to aid her in making a decision whether to carry the pregnancy to full term or to have an elective abortion."); Policy 6070.05(7)a ("The inmate has the responsibility to decide either to have an abortion or to bear a child."); Policy 6070.05(7)c ("In all cases, however, whether the Bureau pays for the abortion or not, the Bureau may expend funds to escort the inmate to a facility outside the institution to receive the procedure.").

Thus, Appellants' policy of denying abortion care for inmates flies in the face of the recommendations of the medical associations dedicated to women's health, and is inconsistent with community standards of basic reproductive health care.

II. DOC's and Its *Amici*'s Characterization of Abortion as "Elective" Does Nothing to Undermine the Fact That It is a Serious Medical Need

DOC and its *amici* argue that "elective, medically unnecessary abortions" are not serious medical needs because "there is no medical need for a procedure that is not medically necessary." Appellants' Br. 38; *see also* Br. of *Amici Curiae* Senator Chuck Gross and Senator Delbert Scott (*Amici* Senators Br.) 16, 19. In doing so, they ignore the case law directly on point and seemingly confuse the Eighth Amendment "serious medical need" standard with a medical emergency standard.

A. Abortion Care is a Serious Medical Need

DOC attempts to distinguish abortion care from other pregnancy-related care, arguing that abortion is an elective, medically unnecessary procedure, and "by definition, there is no medical need for a procedure that is not medically necessary." Appellants' Br. 38. This position is, however, flatly contradicted by applicable precedent: this Circuit has explicitly held that "a medical condition *need not be an emergency* in order to be considered serious under *Estelle*," *Ellis,* 890 F.2d at 1003 n.1 (emphasis added), and that the mere characterization of a medical need as "elective" does not negate the serious nature of a medical need. *Johnson v. Bowers*, 884 F.2d 1053, 1056 (8th Cir. 1989). Other Circuits have also made clear that an inmate need not "demonstrate that he or she experiences pain that is at the limit of human ability to bear, nor do we require a showing that his or

her condition will degenerate into a life-threatening one." *Brock v. Wright*, 315 F.3d 158, 163 (2d Cir. 2003); *id.* at 164, n.3 ("Merely because a condition might be characterized as 'cosmetic' does not mean that its seriousness should not be analyzed using the kind of factors enumerated in our jurisprudence and employed here."); *Washington v. Dugger*, 860 F.2d 1018, 1021 (11th Cir. 1988) (stating that "it is clear" that under *Estelle*, "the medical need of the prisoner need not be life threatening" to state an Eighth Amendment claim); *Delker v. Maass*, 843 F. Supp. 1390, 1399 (D. Or. 1994) ("[P]rison officials may not systematically ignore more subtle conditions merely because those conditions are not imminently life-threatening.").

Demonstrating this principle, this Circuit has repeatedly found that non-emergency care can constitute a serious medical need because the condition resulted in pain or loss of function. *See, e.g.*, *Hartsfield v. Colburn*, 371 F.3d 454, 456-458 (8th Cir. 2004) (reversing grant of summary judgment for prison officials on inmate's claim that nearly two-month delay in dental care violated Eighth Amendment); *Roberson v. Bradshaw*, 198 F.3d 645, 646 (8th Cir. 1999) (reversing grant of summary judgment for prison official and contract physician on inmate's claim that defendants were deliberately indifferent to serious medical need of special diet and medication to treat diabetes mellitus); *Boyd v. Knox*, 47 F.3d 966, 969 (8th Cir. 1995) (affirming denial of summary judgment on qualified immunity

grounds for prison dentist who delayed oral surgery referral for inmate suffering from impacted wisdom tooth). The Eighth Circuit is not alone: non-emergency medical care is routinely recognized to constitute a serious medical need. *See, e.g.*, *Farrow v. West*, 320 F.3d 1235, 1243-1245, 1249 (11th Cir. 2003) (reversing grant of summary judgment for prison defendants on inmate's claim that 15 month delay in provision of dentures constituted deliberate indifference to serious medical need); *Hewett v. Jarrard*, 786 F.2d 1080, 1086-1087 (11th Cir. 1986) (three day refusal to provide medical attention for injured shoulder was a "reckless disregard" of medical needs); *Harrison v. Barkley*, 219 F.3d 132, 137 (2d Cir. 2000) ("because a tooth cavity will degenerate with increasingly serious implications if neglected over sufficient time, it presents a 'serious medical need' within the meaning of our case law."); *Koehl v. Dalsheim*, 85 F.3d 86, 87-88 (2d Cir. 1996) (reversing district court's dismissal of inmate's claim that deprivation of his prescription eyeglasses and denial of medical attention for deteriorating eye condition constituted Eighth Amendment violation); *Boretti v. Wiscomb*, 930 F.2d 1150, 1154-1156 (6th Cir. 1991) (holding that physical and mental suffering experienced by inmate denied dressings for wound that did not become infected and healed properly could constitute Eighth Amendment violation); *Henderson v. Harris*, 672 F. Supp. 1054, 1059 (N.D. Ill. 1987) (treatment for hemorrhoids was a

serious medical need because "Plaintiff's medical needs were diagnosed by a physician as requiring treatment (medication, ointment and daily sitz baths.)").

Abortion care, as a standard component of pregnancy-related care, likewise constitutes a serious medical need. The "characterization of the treatment necessary for the safe termination of an inmate's pregnancy as 'elective' is of little or no consequence in the context of the *Estelle* 'serious medical needs' formulation. An elective, nontherapeutic abortion may nonetheless constitute a 'serious medical need' where denial or undue delay in provision of the procedure will render the inmate's condition 'irreparable.'" *Lanzaro*, 834 F.2d at 349.[5] This Circuit, relying on *Lanzaro*, has likewise held that "classification of . . . surgery as

[5] *Amici* Senators, relying on a Guttmacher Institute study, argue that because not all women base their decisions to have an abortion on health reasons, abortion cannot be a serious medical need. *Amici* Senators' Br. 27-32. As an initial matter, *amici* mischaracterize the results of the study. *Amici* Senators state that 7% of women cited personal health or fetal problems as one reason for choosing abortion. In fact, 7% cited health or fetal problems as the *most important reason for choosing abortion*, whereas 13% cited problems with fetal health and 12% cited problems with their own physical health as one of the reasons for choosing abortion. *See* Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives*, 37 Perspectives on Sexual and Reproductive Health 110 (2005), *available at* http://www.guttmacher.org/pubs/journals/3711005.pdf. Even putting aside this inaccuracy, however, *amici*'s argument still falls flat. Whether or not women cited a medical complication or problem as motivating their decision to terminate a pregnancy, abortion care has a major impact on the woman's health and thus constitutes a serious medical need.

'elective' . . . does not abrogate the prison's duty, or power, to promptly provide necessary medical treatment for prisoners." *Johnson v. Bowers*, 884 F.2d at 1056.

The denial of abortion care forces a woman to continue a pregnancy to term. Even complication-free pregnancies place a severe strain on a woman's health for the duration of the pregnancy and beyond, as her body undergoes intense physiological changes during pregnancy, labor, and delivery; it is a "medical condition that significantly affects an individual's daily activities." *McGuckin v. Smith*, 974 F.2d 1050, 1059-1060 (9th Cir. 1992), *overruled on other grounds by WMX Techs., Inc. v. Miller*, 104 F.3d 1133 (9th Cir. 1997). Moreover, as discussed *supra*, pregnancy complications can lead to increased risks to women's health and have life-long medical implications. Forcing a woman who wants to terminate a pregnancy to bear these risks cannot be tolerated under the Eighth Amendment. *See Todaro v. Ward*, 565 F.2d 48, 51 (2d Cir. 1977) ("the Eighth Amendment forbids not only deprivations of medical care that produce physical torture and lingering death, but also less serious denials which cause or perpetuate pain. To assert otherwise would be inconsistent with contemporary standards of human decency").

B. Providing Access for Abortion Care Does Not Afford Incarcerated Women Greater Rights than Non-Incarcerated Women

DOC's *amici* rely heavily on cases involving denials of public funding for abortion for *non-incarcerated women* to argue that granting incarcerated women abortion access affords them greater rights than non-incarcerated women. *Amici* Senators' Br. 20-23. But this argument ignores the reality of incarceration. As the Supreme Court has recognized, it is precisely *because* an inmate has been deprived of her liberty that she "*must* rely on prison authorities to treat [her] medical needs; if the authorities fail to do so, those needs will not be met." *Estelle*, 429 U.S. at 103 (emphasis added); *see also DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 199-200 (1989) ("when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs – e.g., food, clothing, shelter, medical care, and reasonable safety – it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause"). The state's obligations to incarcerated women thus differ sharply from its obligations to women in the free world. *Lanzaro*, 834 F.2d at 341 ("Whatever the government's constitutional obligations to the free world, those obligations often differ radically in the prison context.")

While the state can erect policies that prefer or encourage childbirth, it is well-settled that the state cannot, pre-viability, *prohibit* abortion. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992) ("Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure."). DOC's policy, of course, does exactly that: because inmates must rely on DOC for medical care, the policy denying access to abortion care *prohibits* inmates' access to pre-viability abortions, and essentially forces pregnant inmates who remain incarcerated throughout their pregnancy (or who are released too late to obtain abortions) to carry their pregnancies to term. While the state may "prefer" childbirth for all women, the policy's ban on pre-viability abortion results in forced childbirth for inmates, which goes well beyond the constitutionally permissible expression of a state preference for that outcome. *See Casey*, 505 U.S. at 878-879 (while a state may "promote the State's profound interest in potential life . . . a State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability").

Moreover, for incarcerated women, a policy that "prefers" childbirth by banning abortion not only subjects them to the health risks outlined above, but also has significant health consequences precisely because they reside in the penal system. It is well accepted that prenatal care and an enhanced, healthy diet during

pregnancy are critical for ensuring a healthy outcome for both the woman and the baby she will eventually deliver. *See* American Academy of Pediatrics and ACOG, *Guidelines for Perinatal Care* 77-82 (5th ed. 2002); *see also* ACOG, *You and Your Baby: Prenatal Care, Labor and Delivery, and Postpartum Care*, *available at* http://www.acog.org/publications/patient_education/ab005.cfm (last visited Dec. 6, 2006); APHA, *Standards for Health Services Correctional Institutions*, *supra*, at 108 (noting importance of prenatal care, including appropriate screening tests, and diet for incarcerated women). Yet, incarcerated women are forced to depend on the limited prenatal care and the poor nutritional diet available in prisons. *See* Marian Knight & Emma Plugge, *Risk Factors for Adverse Perinatal Outcomes in Imprisoned Pregnant Women: A Systematic Review*, 5 BMC Public Health 11(2005) (more than 30% of imprisoned pregnant women received inadequate prenatal care). Finally, being forced to continue a pregnancy while incarcerated often means that women will not be allowed to breast-feed and bond with the baby beyond the few hours immediately after childbirth, nor will they receive the postpartum physical and psychological care they may need. APHA, *Standards for Health Services Correctional Institutions*, *supra*, at 108 (recommending that prisons and jails provide an inmate time with her infant after delivery); NCCHC, Position Statement: *Women's Health Care in Correctional Settings* (2005), *available at*

http://www.ncchc.org/resources/statements/womenshealth2005.html ("Pregnant inmates have high levels of psychological distress, yet often do not receive counseling and support services. Likewise, screenings for postpartum physical and psychiatric complications often are not performed.").

Thus, DOC's argument that abortion care is not medically necessary ignores both existing precedent – making clear that a condition need not be emergent to amount to a serious medical need – and the medical realities of incarceration for pregnant women.

CONCLUSION

For the foregoing reasons, and those stated in the briefs of Appellees and its other *amici*, the decision of the United States District Court for the Western District of Missouri should be affirmed.

Respectfully submitted.

Kimberly A. Parker
Jessica L. Waters
WILMER CUTLER PICKERING
HALE AND DORR LLP
1875 Pennsylvania Ave., N.W.
Washington, D.C. 20006
(202) 663-6000

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C)(i) and Local Rule 32A(c), (d)(2), I hereby certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type-style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface, 14-point Times New Roman. I further certify that this brief was prepared using Word 2000 (9.0.3821 SR-1), that this brief text, including footnotes and excluding the Table of Contents, Table of Authorities, Certificate of Service, and this Certificate of Compliance, contains 5,925 words as calculated by its automated word count feature, and that the CD-ROM submitted with the instant brief has been scanned for viruses by Symantec Antivirus (version 10.0.2.2000; virus definition file 12/10/2006 rev. 7) and is virus-free.

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Jessica L. Waters
December 11, 2006

CERTIFICATE OF SERVICE

I, Jessica L. Waters, hereby certify that I have on this 11th day of December, 2006, caused two copies of the foregoing Brief For *Amici Curiae* The American College of Obstetricians and Gynecologists, The American Medical Women's Association, and The American Public Health Association in Support of Plaintiffs-Appellees to be served upon the following parties by overnight courier at the following addresses:

Diana Kasden
ACLU Foundation
125 Broad Street, 18th Floor
New York, New York 10004

Michael Pritchett
Missouri Assistant Attorney General
Missouri Office of the Attorney General
Post Office Box 899
Jefferson City, MO 65102

_____
Jessica L. Waters