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IN THE
SUPREME COURT OF PENNSYLVANIA

No. 26 MAP 2021

ALLEGHENY REPRODUCTIVE HEALTH CENTER, ET AL.,

Appellants,

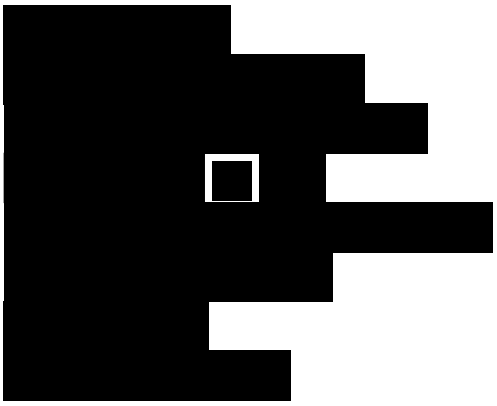
v.

PENNSYLVANIA DEPARTMENT OF HEALTH SERVICES, ET AL.,

Appellees.

On Appeal from the order of the Commonwealth Court of Pennsylvania, No. 26 M.D. 2019, entered March 26, 2021.

BRIEF OF *AMICI CURIAE* TEXAS RIGHT TO LIFE; STEPHEN J. HILGERS, MD IN OPPOSITION TO APPELLANTS' PETITION FOR REVIEW



Counsel for all Amici Curiae

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INTEREST OF AMICI CURIAE[1]

Amici Curiae are a Texas physician and a nonprofit organization, Texas Right to Life, who share a common interest in defending the sanctity of human life. The state of Texas has established the unconstitutionality of mandating taxpayer funding of abortions, and Texas Right to Life stands in defense of other states that do the same. Pennsylvania, like Texas, has repeatedly held that the state has an interest in natural childbirth but has no such interest in elective abortion. Petitioners' arguments ignore this traditional framework and attempt to reframe the argument about inaccurate medical risks.

The U.S. Supreme Court and the Pennsylvania Supreme Court have repeatedly held that a state may prioritize childbearing over elective abortions without violating any constitutional rights. *See Harris v. McRae*, 448 U.S. 297 (1980); *Fischer v. Dep't of Public Welfare*, 502 A.2d 134 (1985). Rather than address this long-held principle, Petitioners argue that abortion is less dangerous than childbirth and should therefore be funded by public funds. This argument is incorrect and misleading. Amici limits its arguments to refute this policy argument and to show that abortion has its own set of dangers and risks, both physical and mental.

Amici have a common interest in addressing incomplete claims about abortion

[1] No person or entity other than Amicus, its members, or counsel have authored or paid in whole or in part for the preparation of this brief. *See* 210 Pa.R.A.P. § 531(b)(2)(i).

and childbirth. Abortion supporters repeatedly misrepresent the *lack* of reporting and evidence about abortion as proof of its safety.

Amici submit this brief to oppose the petition for review filed by Appellants Allegheny Reproductive Health Center, et al. ("Reproductive Health Centers") and to affirm the Commonwealth Court's holding that the Coverage Ban found in Pennsylvania's Abortion Control Act is constitutional.

SUMMARY OF ARGUMENT

TO THE HONORABLE SUPREME COURT OF PENNSYLVANIA:

Amici Curiae submit this brief in opposition to the petition for review filed by the Reproductive Health Centers. Amici urge this Court to deny review and uphold the decision of the Commonwealth Court of Pennsylvania that the Coverage Ban under the Pennsylvania Abortion Control Act is constitutional and that the Reproductive Health Centers lack standing to challenge the coverage ban.

Both the Pennsylvania and the U.S. Supreme Courts have repeatedly held that a state may make a "value judgment favoring childbirth over abortion, and . . . implement that judgment by the allocation of public funds." *Fischer*, 502 A.2d at 140 (quoting *Harris*, 448 U.S. at 292). Further, such allocation does not violate the federal Constitution nor the state constitution, nothing in either document requires that a state affirmatively support a constitutional right, merely that it does not actively prevent it. *Id.*

Petitioners argue that these long-standing principles are flawed and should be overturned. As a part of that argument, they argue that abortion is safer than childbirth and is therefore healthcare worthy of taxpayer funding. Pet. Br. at 72. Amici seek to address this policy claim that induced elective abortion is safer than childbirth and therefore healthcare. Setting aside the death of the baby, abortion inflicts substantial physiological and psychological injuries upon its victims. Further, the violent act of abortion is not safer than childbirth, as is commonly but fallaciously argued. Reporting requirements are nearly nonexistent in most jurisdictions, making a scientific assessment of the medical consequences after an abortion extremely difficult to assess.

Finally, Pennsylvania has wide latitude to allocate its finite public funds as it sees fit. It has the right to prioritize funding for childbirth over funding for abortions. While current PA law has exceptions for abortions in cases of danger to the mother or in the case of rape, the state does not have the same kind of interest in elective induced abortions. *See* 62 Pa.C.S. § 453. Even assuming *arguendo* that Petitioners were correct and precedent should be reconsidered, the relative safety or danger of any given medical procedure has little to nothing to do with the state's decision to fund it with taxpayer funding. States and communities have always had an interest in the safe delivery of children and protection of mothers. Nothing Petitioners present in their brief challenges the current status quo nor gives a reason to overturn

longstanding precedent.

ARGUMENT

Neither state nor federal law recognize induced elective abortion as a form of healthcare mandating taxpayer funding.

I. Induced Elective Abortion Has Its Own Long List Of Dangers And Medical Risks.

Elective induced abortion involves violently killing and removing an otherwise healthy preborn child from an otherwise healthy mother, resulting in the death of a child and negligent harm to a woman. Contrary to Petitioners' assertions, abortions, whether surgical or medical, bring both physical and mental risks.[2]

A. The physical dangers associated with abortions are uncontested.

Induced elective abortions, whether medical or surgical, carry medical risks just like any other medical procedure. In this case, a woman's body goes through a massive interruption of a natural process, leaving the body to pick up the pieces and reset. A woman may bleed, pass large blood clots, and suffer severe cramps as her

[2] Surgical induced abortions include dilation and curettage or vacuum aspiration (D&C), as well as dilation and evacuation (D&E) for later abortions. Maarit Niinimäki et al., *Immediate Complications After Medical Compared With Surgical Termination of Pregnancy*, 144 Obstretrics and Gynecology 795, 796 (2009); Manjeet Kaur et al., *A Complication of Surgical Abortion: A Rare Presentation*, 6 Journal of South Asian Federation of Obstetrics and Gynaecology 33 (2014). The medical induced abortion, or medication abortion, involves high doses of oral contraceptives with combined use of mifepristone and misoprostol, or other prostaglandins, to kill a preborn child. Maarit Niinimäki et al., at 796.

body pushes the baby out of her womb. *See The physical process*, Miscarriage Association, https://www.miscarriageassociation.org.uk/information/miscarriage/the-physical-process/ (last visited Dec. 9, 2021). One of the only studies to date on the differences between induced abortion and miscarriage found that there were greater significant biological and behavioral impacts after an induced abortion than a miscarriage. Christina Camilleri, et al., *Biological, Behavioral and Physiological Consequences of Drug-Induced Pregnancy Termination at First-Trimester Human Equivalent in an Animal Model*, 13 Front. Neurosci. 1, 2-3, 6-7 (2019) [hereinafter Camilleri, *Biological, Behavioral and Psychological Consequences of Drug-Induced Pregnancy Termination*] (finding "a significant difference between induced pregnancy termination (medical abortion) and natural miscarriage").[3]

Further, despite the increased mortality rates associated with the death of a child in the womb, those mortality rates are significantly lower for a woman who has suffered a miscarriage than an abortion. David C. Reardon & John M. Thorp, *Pregnancy associated death in record linkage studies relative to delivery, termination of pregnancy, and natural losses: A systematic review with a narrative synthesis and meta-analysis*, 5 SAGE Open Medicine 1, 5, 7-8 (2017) [hereinafter "Reardon, *Pregnancy-Associated death*"]. With abortion, the natural processes that help a

[3] This study was conducted on rats and contains an interesting discussion on the lack of information on abortion outcomes and the difficulty in creating scientifically credible studies due to the lack of information. Camilleri, *Biological, Behavioral and Psychological Consequences of Drug-Induced Pregnancy Termination*, at 1-2.

woman's body prepare to carry a child, support a child, are traumatically and unnaturally cut short.

Other potential physical consequences associated with abortions include:

- In 2009, the American Association for Cancer Research disclosed a higher risk of breast cancer in women who have a medical abortion. The study found an alarming "2.5-fold increased risk for triple-negative breast cancer," a significantly more aggressive and medically challenging form of breast cancer found in young women. Jessica Dolle, et al., *Risk Factors for Triple-Negative Breast Cancer in Women Under the Age of 45 Years*, 18 Cancer Epidemiology, Biomarkers & Prevention 1163, 1157 (2009). *See also* Janet R. Daling, et al., *Risk of Breast Cancer among White Women following Induced Abortion*, 144 American Journal of Epidemiology 373, 379 (1996) (finding that women of reproductive age with a history of induced abortion face a potential increase in breast cancer).

- Organ damage in the form of uterine perforation has been reported after medically induced abortion, as the abortion process can create ruptures and tears in the uterus. Daniel Grossman, et al., *Complications after Second Trimester Surgical and Medical Abortion*, 16 Reproductive Health Matters 173, 176-177 (2008).

- The performance of medically induced abortions creates an increased risk of ectopic pregnancies. Ectopic pregnancies, in turn, may serve as a risk factor for repeat ectopic pregnancies. Jean Bouyer et al., *Risk Factors for Ectopic Pregnancy: A Comprehensive Analysis Based on a Large Case-Control, Population-based Study in France*, 157 Am. J. of Epidemiology 185 (2003). An ectopic pregnancy is nonviable and, if undetected, can result in the destruction of the fallopian tube or even death.

- Post-abortive women may develop infections such as endometritis and pelvic inflammatory disease (PID), and this risk is significantly higher for women with chlamydia infections. Sharon L. Achilles and Matthew F. Reeves, *Prevention of Infection after Induced Abortion*, 83 Contraception 295, 299 (2011); Erik Qvigstad et al., *Pelvic inflammatory disease associated with Chlamydia trachomatis infection after therapeutic abortion*, 59 British J. of Vener. Dis. 189 (1983) (finding that PID is

the most significant complication of induced abortions).

- Many aborting women suffer from obstetric hemorrhage, a term used to describe any severe bleeding during the pregnancy. Research conducted in 2021 defined obstetric hemorrhage as a "common complication," revealing that in 25.6 percent of women experienced the condition during post-abortion pregnancies. Berhanu Elfu Feleke et al., *The effects of stillbirth and abortion on the next pregnancy: a longitudinal stud*y, 21 BMC Women's Health 1, 3, 6 (2021).

- Abortion may cause placenta previa[4] in subsequent pregnancies. A 2017 meta-analysis study of 872 publications found a drastic increase in the risk of placenta previa following induced abortions. Manoochehr Karami and Ensihyeh Jenabi, *Placenta previa after prior abortion: a meta-analysis*, 4 Biomed Res Ther 1441, 1443-1444, 1448 (2017). *See also* John M. Thorp et al., *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 72 The Linacre Quarterly Survey 44, 53 (2005) (finding that the risk of developing placenta previa, the "leading cause of uterine bleeding in the third trimester," is significantly higher for post-abortive women).

- Abortion drastically increases the risk of low birth weight in newborns following subsequent pregnancies. Birgit Reime et al., *Reproductive outcomes in adolescents who had a previous birth of an induced abortion compared to adolescents' first pregnancies*, 8 BMC Pregnancy and Childbirth 4 (2008). In 2012, the International Organizations Research Group cited 127 published studies that found a clear tie between abortion and premature delivery or abortion and low birthweight. Byron Calhoun, *Abortion and Preterm Birth: Why Medical Journals Aren't Giving Us The Real Picture*, 9 International Organizations Research Group 1, 10 (2012).

- Post-abortive adolescents are more likely to suffer a stillbirth or preterm birth than young women who have never had an abortion.[5] Birgit Reime

[4] Placenta previa is a condition during pregnancy in which the baby's placenta develops at the lowest part of the uterus, covering all or part of the mother's cervix. Symptoms may include acute bleeding and contractions, and a C-section is required if the condition persists. *Placenta previa*, Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/placenta-previa/symptoms-causes/syc-20352768 (last visited Dec. 9, 2021).

[5] Stillbirth was defined as "a birth of an infant without live-signs weighing...more than 499 grams." *See* Birgit Reime et al., *Reproductive outcomes in adolescents who had a previous birth of an*

et al. at 5-6.

- Women who choose induced elective abortion are sixty percent more likely to suffer a miscarriage in subsequent pregnancies. N. Maconochie et al., *Risk factors for first trimester miscarriage — results from a UK population-based case-control study*, 114 BJOG: An Int'l J. of Obstetrics & Gynecology 170, 175 (2007).

- Approximately twenty percent of women who undergo a medical abortion suffer at least one of multiple complications, the worst of which are hemorrhaging, infection, and incomplete abortion, followed closely by thromboembolic diseases and injuries such as cervical laceration and uterine perforation.[6] Maarit Niinimaki et al., *Immediate Complications After Medical Compared With Surgical Termination of Pregnancy*, 114 Obstetrics & Gynecology 795, 796, 799 (2009). Excessive hemorrhage presents a particular risk in medical abortions due to the common use of mifepristone. Ralph P. Miech, *Pathopharmacology of Excessive Hemorrhage in Mifepristone Abortions*, 41 Annals of Pharmacotherapy 2002, 2002-2005 (2007).

- A 2011 study found that 20.3 percent of patients with medical abortions required a procedure called a ostabortion suction curettage to complete the abortion. H Liao et al., *Repeated medical abortions and the risk of preterm birth in the subsequent pregnancy*, 284 Arch Gynecol Obstet 579, 583-584 (2011). This means that if a woman takes a pill to interrupt the pregnancy and kill the baby in her womb, she may still not deliver the baby naturally. In those cases, a D&C procedure is necessary to remove the baby in order to prevent further complications. There is no evidence available for how often women are told of these risks or how often this additional procedure is required.

- Similarly to medical abortions, surgical abortions, particularly D&E pose a risk of uterine perforation and infection, cervical laceration, and incomplete abortion. These risks increase with the progression of the pregnancy. Manjeet Kaur et al., *A Complication of Surgical Abortion: A Rare Presentation*, 6 Journal of South Asian Federation of Obstetrics

induced abortion compared to adolescents' first pregnancies, 8 BMC Pregnancy and Childbirth 4, 6 (2008).

[6] Potential infections include "pelvic inflammatory disease, endometritis, cervicitis, wound infections, pyrexia of unknown origin, urinary tract infections, and septicemia." Maarit Niinimäki et al. at 796.

and Gynaecology 33 (2014).

These are only a few of the physical dangers associated with abortions, whether medical or surgical.

Medical intervention in natural processes always carries with it the risk of physical consequences. Abortion is no different. The invasion of the womb through surgical or medical abortion in order to kill a growing child and traumatically interrupt the natural processes of childbirth leaves the woman open to severe consequences and risks.

B. Abortion inflicts psychological injuries upon the mother.

Studies indicates that a large portion of women who undergo an abortion have adverse mental health outcomes. A meta-analytic review of twenty-two abortion studies revealed that women who choose abortion face a eighty-one percent higher risk of decreased mental health than those who do not. Priscilla K. Coleman, *Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009*, 199 Brit. J. of Psychiatry 180, 182-183 (2011) [hereinafter Coleman, *Abortion and mental health*] (finding that "abortion is a statistically validated risk factor for the development of various psychological disorders").

Seven years after Coleman's study, medical doctor David Reardon reiterated these concerns with the finding that at least some women suffer "significant mental health issues that are caused, triggered, aggravated, or complicated by their abortion

experience." David C. Reardon, *The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities*, 6 SAGE Open Medicine 1, 29 (2018) [hereinafter Reardon, *The abortion and mental-health controversy*]. Additional risks of psychological harm associated with induced abortions include:

- Induced elective abortion poses an increased risk of suicide and suicidal thoughts. Morgan CL, Evans M and Peters JR, *Suicides after pregnancy, Mental health may deteriorate as a direct effect of induced abortion*, 314 BMJ 899, 902 (1997) (finding a trend in post-abortion attempted suicides and a potential link to the abortions themselves). One report found that suicide attempts declined after both delivery and miscarrage, yet increased dramatically after abortion. Reardon, *The abortion and mental-health controversy*, at 17.

- A post-abortive woman may experience depression and anxiety, which often stems from feelings of shame or remorse over the self-inflicted loss of her baby. Alarmingly, it is not unusual for these emotions to give way to neglect or abuse of later children. Priscilla Coleman et al., *Induced Abortion and Child-Directed Aggression Among Mothers of Maltreated Children*, 6 Internet Journal of Pediatrics and Neonatology 1, 2 (2006).

- In one analysis, seventy-eight percent of women experienced depression and 80 percent experienced guilt post abortion. These women also suffered PTSD, grief, and anxiety. Anne Speckhard and Natalia Mufel, *Universal Responses to Abortion? Attachment, Trauma, and Grief Responses in Women Following Abortion*, 18 Journal of Prenatal & Perinatal Psychology & Health 3, 9, 13, 26, 28-29 (2003). *See also* Priscilla K. Coleman, *Induced Abortion and Increased Risk of Substance Abuse: A Review of the Evidence*, 1 Current Women's Health Reviews 21, 23-24 (2005) [hereinafter Coleman, *Induced Abortion and Increased Risk of Substance Abuse*] (finding that induced abortion trigger high levels of stress, PTSD, anxiety, and psychological distress).

- Many women see the effects of induced abortion in their personal lives

and interpersonal relationships. Tragically, some mothers avoid exposure to other babies following their abortion, "even trying to avoid their own lives." In a desperate attempt to cope with the emotional pain, they may pass the blame for the abortion on their doctors or loved ones. Speckhard, *Universal Responses in Women Following Abortion*, at 17-19.

- One study found that aborting women "avoided conception and sexual intercourse," and some even grew to develop a "negative opinion of gynecologists." Magdalena Szymanska and Bogdan Chazan, *Differences between behaviours of female patients from Poland and Belarussia after natural miscarriage and induced abortion*, 24 Ethics & Medicine: An International Journal of Bioethics 29, 38 (2008).

- Substance abuse and alcoholism are additional concerns, as abortion increases the risk that women will use marijuana or abuse alcohol twofold. One 1978 study found that alcoholism was more common after than before abortion, and similar studies have evidenced higher rates of cocaine, methamphetamine, and opiate use. Coleman, *Induced Abortion and Increased Risk of Substance Abuse*, at 22-23.

- The Guttmacher Institute observed that approximately half of all abortions in the U.S. are repeat abortions. Susan A. Cohen, *Repeat Abortion, Repeat Unintended Pregnancy, Repeated and Misguided Government Policies*, 10 Guttmacher Policy Review (2007). This staggering statistic strongly suggests that aborting women are likely to seek additional abortions. A New York study found similar results, with repeat abortions comprising well over fifty percent of all abortions committed in the state. This analysis revealed that "the majority of abortion patients are at high risk for repeat unintended pregnancy and abortion." Amita Toprani, *Repeat abortions in New York City, 2010*, 92 Journal of Urban Health 593, 601 (2015).

- Most statistical analyses on the topic of abortion and mental health demonstrate an association between abortion and higher rates of sleep disorders. Reardon, *The abortion and mental health controversy*, at 6. The risk of sleep disorders is considerably higher for women who have had an abortion compared to those who deliver their babies naturally. Reardon, *Pregnancy associated death*, at 2.

- Women post-abortion often continue to gain weight, sometimes developing eating disorders, up to the delivery date of their aborted baby.

> Others quickly lose weight due to depression and anxiety post-abortion. Speckhard, *Universal Responses in Women Following Abortion*, at 28.

As demonstrated above, elective induced abortions have dramatic negative consequences—both physical and mental.

II. Petitioners And Other Pro-Abortion Advocates Repeat, Without Evidence, That Abortion Is Safer Than Childbirth Even Though The Abortion Evidence Remains Severely Lacking.

Petitioners repeat the common fallacy that it is safer for a woman to have her unborn child stripped from her womb than to deliver the child into the world.

Petitioners' claim that "the risk of death associated with childbirth is fourteen times higher that with abortion." Pet. Br. at 54 (citing R.133a, ¶ 67). Their petition then cites to the record and an unsworn declaration from obstetrician/gynecologist Courtney Anne Schreiber that declares:

> Abortion . . . is almost always safer for a woman than carrying a pregnancy to term. This is especially true for first trimester procedures, but this margin of safety extends even into the second trimester. While the risks associated with abortion increase as the pregnancy progresses, overall legal induced abortion is markedly safer than childbirth. The risk of death associated with childbirth is approximately 14 times higher than that with abortion, and the overall morbidity associated with childbirth exceeds that with abortion.

Dr. Schreiber's testimony repeats a dubious argument about the safety of abortion that proponents of abortion have promulgated for decades. She then cites a 2012 paper from Elizabeth Raymond and David Grimes, which found higher mor-

bidity in pregnancy-associated complications than in abortion. Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstet Gynecol 215 (2012).

Amici were unable to find any other source for this statistic and in fact, Dr. Bryan Calhoun, an obstetrician/gynecologist and professor at West Virginia University-Charleston, responded to the Raymond/Grimes claim less than a year after they published their paper. *See* Byron Calhoun, *The Maternal Mortality Myth in the Context of Legalized Abortion*, 80 The Linacre quarterly 264, 265 (2013). Dr. Calhoun denies that the 14 times statistic is supported by any scientific literature and "there is no credible scientific basis to support it." *Id.* He goes on to say that a valid scientific assessment of abortion is extremely difficult because of "incomplete reporting, definitional incompatibilities, voluntary data collection, research bias, reliance upon estimations, political correctness, inaccurate and/or incomplete death certificate completion, incomparability with maternal mortality statistics, and failing to include other causes of death such as suicides." *Id.*

By the admission of the Centers for Disease Control and Prevention (CDC), "there is no national requirement for [abortion] data submission or reporting." *CDCs Abortion Surveillance System FAQs*, Centers for Disease Control and Prevention, https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm (last visited Dec. 10, 2021). Some states do not even report abortions or abortion-related deaths.

Guttmacher Institute, *Abortion Reporting Requirements* (2021), https://www.guttmacher.org/state-policy/explore/abortion-reporting-requirements. The CDC itself, the very federal agency tasked with compiling abortion statistics, only occasionally conducts abortion surveys. Even the Guttmacher Institute, a pro-abortion research organization tasked with advancing reproductive rights in the United States, has admitted that abortion reporting is often incomplete and unreliable. Joerg Dreweke, *Abortion Reporting: Promoting Public Health, Not Politics*, 18 Guttmacher Policy Review (2015). European countries have prioritized abortion reporting through companies like Exelgyn, a global pharmaceutical company that collects abortion data. Exelgyn is able to show statistics on who is seeking abortions, where, and how the abortions are paid for. *European Data*, Exelgyn (Dec. 6, 2021, 8:30pm), https://abort-report.eu/europe/#ar6. They are also able to better understand outcomes after the procedures because it is in the normal course of business to follow up and keep records of outcomes. In stark contrast, the United States has adopted the careless practice of not requiring any reporting on abortions, a catastrophe that is yielding a sorely insufficient understanding of the dangers of abortion.

Prior pro-abortion literature reviews are plagued with scientific inaccuracies. *See* Coleman, *Abortion and mental health*, at 183. First, many of these studies did not include proper control groups or carefully defined terms; *see* Coleman, at 180; second, several of the reviews did not include relevant studies, with no explanation;

Id.; and third, the literature reviews lacked sufficient methodologically based selection criteria. *Id.* Coleman points out that because of the controversy surrounding abortion, researchers need to be more careful when creating their studies to avoid accusations of sloppiness or bias. *Id.*

But even if abortion statistics were more readily available and honestly recorded, Petitioners' arguments and the submitted affidavits draw misleading conclusions. Dr. Schreiber describes the physiological effects of pregnancy—hormonal changes, stress to the organs, morning sickness, the weakening of the immune system—as if the routine hardships of pregnancy justify abortion and its risks. No childbirth is without risks and side effects, and that has been true from the beginning of time. To give a grim depiction of the physiological effects standard in every pregnancy, without grappling with the guaranteed danger of killing the child or the potential dangers of violently ending the pregnancy with abortion as laid out above, is both contradictory and misleading.

In fact, researchers from the Department of Psychology at Franciscan University of Steubenville and the School of Medicine at San Sebastián University found evidence supporting the benefits of carrying a pregnancy to full term. *See* Camilleri, *Biological, Behavioral and Psychological Consequences of Drug-Induced Pregnancy Termination* (2019). Their peer-reviewed study, done on rats, illuminates a fact often ignored by the pro-abortion side—that a pregnancy carried to full-term,

with a healthy baby at the end, brings with it both psychological and mental benefits. The study also emphasized that the physiological, neurophysiological, and biobehavioral impacts of abortion have not been adequately examined. *Id*. In an outspoken endorsement of the study, Dr. Donna Harrison of the American Association of Prolife Obstetricians and Gynecologists declared:

> Elective abortion was thrust on American women without regard to the safety of this procedure or the long-term effects on a woman's body or mind . . . Medical abortion researchers focused on how fast the drug could kill the baby, and how much effort it would take on the part of the abortionists to handle complications. This study (the first not performed by the abortion industry) raises serious concerns about mental health effects of drug-induced abortions and the differences between spontaneous and induced abortion. Such studies should have been performed long before drug-induced abortion was allowed on the market.

Donna Harrison, *PRESS RELEASE: New Research Shows Potential for Mental and Physical Harm to Women Who Undergo Drug Induced Elective Abortions*, AAPLOG, May 2019.

The natural result of childbirth is a healthy mother and baby; the natural, intended result of abortion is a dead baby, which even the abortionists who testified in the United States Supreme Court hearings over the Partial-Birth Abortion Ban Act of 2003 acknowledged. *Fact checking the Fact checkers: Abortionists misrepresent the facts*, AAPLOG, https://aaplog.org/fact-checking-the-fact-checkers-abortionists-misrepresent-the-facts/ (last visited Dec. 10, 2021). A woman's body is designed to carry her pregnancy to term and give birth to her child; it is not designed to have

this natural process violently cut short.

If abortion research has revealed anything, it has revealed that we need more research. The limited abortion reporting has proven wholly insufficient to determine the safety of abortion in comparison to childbirth.

III. Pennsylvania Has Wide Latitude To Decide What Healthcare To Fund.

Petitioners try to argue that induced elective abortion is safer than childbirth and must therefore be funded with public funds. This argument ignores the longstanding legal framework for deciding what receives public medical funding in the United States. *See Fischer*, 502 A.2d at 119. Petitioners' arguments about the dangers of childbirth ignore the most important and incontrovertible reality of abortion v. childbirth—a "successful" abortion results in a dead baby and an unpregnant and physically and mentally fragile mother, a successful childbirth results in a healthy baby and a healthy mother.

The state and public have the right to prefer one of those outcomes and to direct tax dollars accordingly. In fact, the Supreme Court has repeatedly held that a state may make a "value judgment favoring childbirth over abortion, and . . . implement[ing] that judgment by the allocation of public funds." *Maher v. Roe*, 432 U.S. 646, 474 (1977); *Harris*, 448 U.S. at 314. In *Maher*, the Court carefully distinguished between the state's constitutionally permissible power to encourage certain policy choices over others and the impermissible step to forbid unfavored policy

choices. 432 U.S. at 477. Using *Myer v. Nebraska*, 262 U.S. 390 (1923) as an example, the Court concluded that it is "abundantly clear that a State is not required to show a compelling interest for its policy choice to favor normal childbirth any more than a State must so justify its election to fund public but not private education." *Maher*, 432 U.S. 477.

In their petition for review, Petitioners described the harm suffered by some women who are "forced to carry their pregnancies to term." Amici do not deny those harms, nor do they seek to discount them for the sake of argument. Instead, amici seek to demonstrate that the harm caused by the unnatural act of abortion is at the very least equally alarming. To deliberately subsidize abortion through government funding is to deliberately subsidize this harm without any hope of healthy children and families.

Finally, an act that injures mothers and kills future mothers is not healthcare. The phrase "healthcare" presupposes the provision of legitimate care, the act of tending, nursing, watching over a patient attentively, prudently, and vigilantly to ensure that she does not suffer harm. The very act of abortion inflicts physical and psychological injuries upon the mother. Such an act should not be classified as healthcare.

Each of the foregoing arguments is secondary to the fundamental truth that every unborn child is a human person with a God-given, constitutional right to life. That right not only is protected by the United States Constitution, but also is inherent

in the laws of the state of Pennsylvania. Each unborn child is counted as a member of the household for purposes of public welfare. 55 Pa. Code § 181.453. Abortion is defined as an act likely to "cause the death of the unborn child." 28 Pa. Code § 29.31. Grave penalties are imposed for the murder of unborn children. 18 Pa.C.S.A. § 2604. The very laws of Pennsylvania, like those of Texas, recognize the personhood of an unborn child.

The natural result of childbirth is a healthy mother and baby; the natural, intended result of abortion is a dead baby. A woman's body is designed to carry her pregnancy to term and give birth to her child; it is not designed to have this natural process violently cut short. A society has an interest in encouraging the growth of its citizens and supporting that growth. Pennsylvania therefore has broad latitude to deny taxpayer support to elective abortions and instead fund natural childbirth.

CONCLUSION

Amici Curiae urge this Court to deny review and uphold the findings of the Commonwealth Court of Pennsylvania; namely, that the Coverage Ban under the Pennsylvania Abortion Control Act is constitutional, and that the Reproductive Health Centers lack standing to challenge the coverage ban.

Respectfully Submitted,

/s/ *Emily K. Cook*
Emily K. Cook
[redacted]
TEXAS RIGHT TO LIFE
[redacted]
Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that I am this day serving a true and correct copy of the foregoing Brief of Amici Curiae upon the parties via first class mail and/or electronic mail, which service satisfies the requirements of 210 Pa. Code Rule § 121:

Dated: December 13, 2021

/s/ *Emily K. Cook*
Emily K. Cook, Attorney

CERTIFICATE OF COMPLIANCE WITH WORD LIMIT

I hereby certify that based on a word count run in Microsoft Word 2016, this brief complies with the 7,000-word limit mandated by 210 Pa.R.A.P. § 531.

I further certify that this filing complies with the provisions of the *Case Records Public Access Policy of the Unified Judicial System of Pennsylvania* that require filing confidential information and documents differently than non-confidential information and documents.

Dated: December 13, 2021

/s/ *Emily K. Cook*
Emily K. Cook, Attorney