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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.)

Appendix A

This appendix contains state criminal abortion statutes in effect in 1868, followed by state criminal abortion statutes enacted between 1868 and 1938. The statutes appear in chronological order of their enactment.

1. New York (1828):

Sec. 9. "Every person who shall administer to any woman pregnant with a quick child, any medicine, drug or substance whatever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose***, shall be deemed guilty of manslaughter in the second degree."

Sec. 21. "Every person who shall willfully administer to any pregnant woman, any medicine, drug, substance or thing whatever, or shall use or employ any instrument of 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, upon conviction, be punished by imprisonment in a county jail not more than one year, or by fine not exceeding five hundred dollars, or by both such fine and imprisonment."

N. Y. Rev. Stat., pt. 4, ch. 1, Tit. 2, § 9, Tit. 6, § 21 (1828) (emphasis added).

2. Ohio (1834):

Sec. 1. "Be it enacted by the General Assembly of State of Ohio, That 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, upon conviction, 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."

Sec. 2. "That any physician, or other person, who shall administer to any woman pregnant with a quick child, any medicine, drug, or substance whatever, or shall use or employ any instrument, or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose***, shall, in case of the death of such child or mother in consequence thereof, be deemed guilty of high misdemeanor, and, upon conviction thereof, shall be imprisoned in the penitentiary not more than seven years, nor less than one year."

1834 Ohio Laws pp. 20–21 (emphasis added).

3. Indiana (1835):

Sec. 3. "That every person who shall wilfully administer to any pregnant woman, any medicine, drug, substance or thing whatever, or shall use or employ 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***, shall upon conviction be punished by imprisonment in the county jail any term of [time] not exceeding twelve months and be fined any sum not exceeding five hundred dollars."

1835 Ind. Laws p. 66 (emphasis added).

4. Missouri (1835):

Sec. 10. "Every person who shall administer to any woman pregnant with a quick child, any medicine, drug, or substance whatsoever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by a physician to be necessary for that purpose***, shall be deemed guilty of manslaughter in the second degree."

Sec. 36. "Every physician, or other person, who shall willfully administer to any pregnant woman, any medicine, drug, substance or thing whatsoever, or shall use, or employ any instrument or means whatsoever, with intent thereby to procure abortion, or 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 a physician to be necessary for that purpose***, shall, upon conviction, be adjudged guilty of a misdemeanor, and be punished by imprisonment in a county jail not exceeding one year, or by fine not exceeding five hundred dollars, or by both such fine and imprisonment.

Act of Mar. 20, 1835, art. 2, §§ 10, 36, 1835 Mo. Rev. Stat. 165, 168, 172 (emphasis added).

5. Maine (1840):

Sec. 13. "Every person, who shall administer to any woman pregnant with child, whether such child be quick or not, any medicine, drug or substance whatever, or shall use or employ any instrument or other means whatever, with intent to destroy such child, and shall thereby destroy such child before its birth, ***unless the same shall have been done as necessary to preserve the life of the mother***, shall be punished by imprisonment in the state prison, not more than five years, or by fine, not exceeding one thousand dollars, and imprisonment in the county jail, not more than one year."

Sec. 14. "Every person, who shall administer to any woman, pregnant with child, whether such child shall be quick or not, any medicine, drug or substance whatever, or shall use or employ any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, ***unless the same shall have been done, as necessary to preserve her life***, shall be punished by imprisonment in the county jail, not more than one year, or by fine, not exceeding one thousand dollars."

Me. Rev. Stat., Tit. 12, ch. 160, §§ 13–14 (1840) (emphasis added).

6. Alabama (1841):

Sec. 2. "Every person who shall wilfully administer to any pregnant woman any medicines, drugs, substance or thing whatever, or shall use and employ any instrument or means whatever with intent thereby to procure the miscarriage of such woman, ***unless the same shall be necessary to preserve her life, or shall have been advised by a respectable physician to be necessary for that purpose***, shall upon conviction, be punished by fine not exceeding five hundred dollars, and by imprisonment in the county jail, not less than three, and not exceeding six months."

1841 Ala. Acts p. 143 (emphasis added).

7. Massachusetts (1845):

Ch. 27. "Whoever, ***maliciously or without lawful justification***, with intent to cause and procure the miscarriage of a woman then pregnant with child, shall administer to her, prescribe for her, or advise or direct her to take or swallow, any poison, drug, medicine or noxious thing, or shall cause or procure her with like intent, to take or swallow any poison, drug, medicine or noxious thing; and whoever ***maliciously and without lawful justification***, shall use any instrument or means whatever with the like intent, and every person, with the like intent, knowingly aiding and assisting such offender or offenders, shall be deemed guilty of felony, if the woman die in consequence thereof, and shall be imprisoned not more than twenty years, nor less than five years in the State Prison; and if the woman doth not die in consequence thereof, such offender shall be guilty of a misdemeanor, and shall be punished by imprisonment not exceeding seven years, nor less than one year, in the state prison or house of correction, or common jail, and by fine not exceeding two thousand dollars."

1845 Mass. Acts p. 406 (emphasis added).

8. Michigan (1846):

Sec. 33. "Every person who shall administer to any woman pregnant with a quick child, any medicine, drug or substance whatever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose***, shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of manslaughter."

Sec. 34. "Every person who shall wilfully administer to any pregnant woman any medicine, drug, substance or thing whatever, or shall employ 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, upon conviction, be punished by imprisonment in a county jail not more than one year, or by a fine not exceeding five hundred dollars, or by both such fine and imprisonment."

Mich. Rev. Stat., Tit. 30, ch. 153, §§ 33–34 (1846) (emphasis added).

9. Vermont (1846):

Sec. 1. "Whoever ***maliciously, or without lawful justification*** with intent to cause and procure the miscarriage of a woman, then pregnant with child, shall administer to her, prescribe for her, or advise or direct her to take or swallow any poison, drug, medicine or noxious thing, or shall cause or procure her, with like intent, to take or swallow any poison, drug, medicine or noxious thing, and whoever ***maliciously and without lawful justification***, shall use any instrument or means whatever, with the like intent, and every person, with the like intent, knowingly aiding and assisting such offenders, shall be deemed guilty of felony, if the woman die in consequence thereof, and shall be imprisoned in the state prison, not more than ten years, nor less than five years; and if the woman does not die in consequence thereof, such offenders shall be deemed guilty of a misdemeanor; and shall be punished by imprisonment in the state prison not exceeding three years, nor less than one year, and pay a fine not exceeding two hundred dollars."

1846 Vt. Acts & Resolves pp. 34–35 (emphasis added).

10. Virginia (1848):

Sec. 9. "Any free person who shall administer to any pregnant woman, any medicine, drug or substance whatever, or use or employ any instrument or other means with intent thereby to destroy the child with which such woman may be pregnant, or to produce abortion or miscarriage, and shall thereby destroy such child, or produce such abortion or miscarriage, ***unless the same shall have been done to preserve the life of such woman***, shall be punished, if the death of a quick child be thereby produced, by confinement in the penitentiary, for not less than one nor more than five years, or if the death of a child, not quick, be thereby produced, by confinement in the jail for not less than one nor more than twelve months."

Virginia, 1848 Va. Acts p. 96 (emphasis added).

11. New Hampshire (1849):

Sec. 1. "That every person, who shall wilfully administer to any pregnant woman, any medicine, drug, substance or thing whatever, or shall use or employ any instrument or 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, upon conviction, be punished by imprisonment in the county jail not more than one year, or by a fine not exceeding one thousand dollars, or by both such fine and imprisonment at the discretion of the Court."

Sec. 2. "Every person who shall administer to any woman pregnant with a quick child, any medicine, drug or substance whatever, or shall use or employ any instrument or means whatever, with intent thereby to destroy such child, ***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 such purpose***, shall, upon conviction, be punished by fine not exceeding one thousand dollars, and by confinement to hard labor not less than one year, nor more than ten years."

1849 N. H. Laws p. 708 (emphasis added).

12. New Jersey (1849):

"That if any person or persons, ***maliciously or without lawful justification***, with intent to cause and procure the miscarriage of a woman then pregnant with child, shall administer to her, prescribe for her, or advise or direct her to take or swallow any poison, drug, medicine, or noxious thing; and if any person or persons ***maliciously, and without lawful justification***, shall use any instrument or means whatever, with the like intent; and every person, with the like intent, knowingly aiding and assisting such offender or offenders, shall, on conviction thereof, be adjudged guilty of a high misdemeanor; and if the woman die in consequence thereof, shall be punished by fine, not exceeding one thousand dollars, or imprisonment at hard labour for any term not exceeding fifteen years, or both; and if the woman doth not die in consequence thereof, such offender shall, on conviction thereof, be adjudged guilty of a misdemeanor, and be punished by fine, not exceeding five hundred dollars, or imprisonment at hard labour, for any term not exceeding seven years, or both."

1849 N. J. Laws pp. 266–267 (emphasis added).

13. California (1850):

Sec. 45. "And every person who shall administer or cause to be administered or taken, any medicinal substances, or shall use or cause to be used any instruments whatever, with the intention to procure the miscarriage of any woman then being with child, and shall be thereof duly convicted, shall be punished by imprisonment in the State Prison for a term not less than two years, nor more than five years: ***Provided, that no physician shall be affected by the last clause of this section, 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 (emphasis added).

14. Texas (1854):

Sec. 1. "If any person, with the intent to procure the miscarriage of any woman being with child, ***unlawfully and maliciously*** shall administer to her or cause to be taken by her any poison or other noxious thing, or shall use any instrument or any means whatever, with like intent, every such offender, and every person counselling or aiding or abetting such offender, shall be punished by confinement to hard labor in the Penitentiary not exceeding ten years."

1854 Tex. Gen. Laws p. 58 (emphasis added).

15. Louisiana (1856):

Sec. 24. "Whoever shall ***feloniously*** administer or cause to be administered any drug, potion, or any other thing to any woman, for the purpose of procuring a premature delivery, and whoever shall administer or cause to be administered to any woman pregnant with child, any drug, potion, or any other thing, for the purpose of procuring abortion, or a premature delivery, shall be imprisoned at hard labor, for not less than one, nor more than ten years."

La. Rev. Stat. § 24 (1856) (emphasis added).

16. Iowa (1858):

Sec. 1. "That every person who shall willfully administer to any pregnant woman, any medicine, drug, substance or thing whatever, or shall use or employ any instrument or other means whatever, with the intent thereby to procure the miscarriage of any such woman, ***unless the same shall be necessary to preserve the life of such woman***, shall upon conviction thereof, be punished by imprisonment in the county jail for a term of not exceeding one year, and be fined in a sum not exceeding one thousand dollars."

1858 Iowa Acts p. 93 (codified in Iowa Rev. Laws § 4221) (emphasis added).

17. Wisconsin (1858):

Sec. 11. "Every person who shall administer to any woman pregnant with a child any medicine, drug, or substance whatever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose***, shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of manslaughter in the second degree."

Sec. 58. "Every person who shall administer to any pregnant woman, or prescribe for any such woman, or advise or procure any such woman to take, any medicine, drug, or substance or thing whatever, or shall use or employ any instrument or other means whatever, or advise or procure the same to be used, with intent thereby to procure the miscarriage of any such woman, shall upon conviction be punished by imprisonment in a county jail, not more than one year nor less than three months, or by fine, not exceeding five hundred dollars, or by both fine and imprisonment, at the discretion of the court."

Wis. Rev. Stat., ch. 164, § 11, ch. 169, § 58 (1858) (emphasis added).

18. Kansas (1859):

Sec. 10. "Every person who shall administer to any woman, pregnant with a quick child, any medicine, drug or substance whatsoever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by a physician to be necessary for that purpose***, shall be deemed guilty of manslaughter in the second degree."

Sec. 37. "Every physician or other person who shall wilfully administer to any pregnant woman any medicine, drug or substance whatsoever, or shall use or employ any instrument or means whatsoever, with intent thereby to procure abortion or 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 a physician to be necessary for that purpose***, shall, upon conviction, be adjudged guilty of a misdemeanor, and punished by imprisonment in a county jail not exceeding one year, or by fine not exceeding five hundred dollars, or by both such fine and imprisonment."

1859 Kan. Laws pp. 233, 237 (emphasis added).

19. Connecticut (1860):

Sec. 1. "That any person with intent to procure the miscarriage or abortion of any woman, shall give or administer to her, prescribe for her, or advise, or direct, or cause or procure her to take, any medicine, drug or substance whatever, or use or advise the use of any instrument, or other means whatever, with the like intent, ***unless the same shall have been necessary to preserve the life of such woman***, or of her unborn child, shall be deemed guilty of felony, and upon due conviction thereof shall be punished by imprisonment in the Connecticut state prison, not more than five years or less than one year, or by a fine of one thousand dollars, or both, at the discretion of the court."

1860 Conn. Pub. Acts p. 65 (emphasis added).

20. Pennsylvania (1860):

Sec. 87. "If any person shall ***unlawfully*** administer to any woman, pregnant or quick with child, or supposed and believed to be pregnant or quick with child, any drug, poison, or other substance whatsoever, or shall ***unlawfully*** use any instrument or other means whatsoever, with the intent to procure the miscarriage of such woman, and such woman, or any child with which she may be quick, shall die in consequence of either of said unlawful acts, the person so offending shall be guilty of felony, and shall be sentenced to pay a fine not exceeding five hundred dollars, and to undergo an imprisonment, by separate or solitary confinement at labor, not exceeding seven years."

Sec. 88. "If any person, with intent to procure the miscarriage of any woman, shall ***unlawfully*** administer to her any poison, drug or substance whatsoever, or shall ***unlawfully*** use any instrument, or other means whatsoever, with the like intent, such person shall be guilty of felony, and being thereof convicted, shall be sentenced to pay a fine not exceeding five hundred dollars, and undergo an imprisonment, by separate or solitary confinement at labor, not exceeding three years."

1861 Pa. Laws pp. 404–405 (emphasis added).

21. Rhode Island (1861):

Sec. 1. "Every person who shall be convicted of wilfully administering to any pregnant woman, or to any woman supposed by such person to be pregnant, anything whatever, or shall employ any means whatever, with intent thereby to procure the miscarriage of such woman, ***unless the same is necessary to preserve her life***, shall be imprisoned not exceeding one year, or fined not exceeding one thousand dollars."

1861 R. I. Acts & Resolves p. 133 (emphasis added).

22. Nevada (1861):

Sec. 42. "[E]very person who shall administer, or cause to be administered or taken, any medicinal substance, or shall use, or cause to be used, any instruments whatever, with the intention to procure the miscarriage of any woman then being with child, and shall be thereof

duly convicted, shall be punished by imprisonment in the Territorial prison, for a term not less than two years, nor more than five years; ***provided, that no physician shall be affected by the last clause of this section, who, in the discharge of his professional duties, deems it necessary to produce the miscarriage of any woman in order to save her life***."

1861 Nev. Laws p. 63 (emphasis added).

23. West Virginia (1863):

West Virginia's Constitution adopted the laws of Virginia when it became its own State:

"Such parts of the common law and of the laws of the State of Virginia as are in force within the boundaries of the State of West Virginia, when this Constitution goes into operation, and are not repugnant thereto, shall be and continue the law of this State until altered or repealed by the Legislature."

The Virginia law in force in 1863 stated:

Sec. 8. "Any free person who shall administer to, or cause to be taken, by a woman, any drug or other thing, or use any means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and shall thereby destroy such child, or produce such abortion or miscarriage, shall be confined in the penitentiary not less than one, nor more than five years. ***No person, by reason of any act mentioned in this section, shall be punishable where such act is done in good faith, with the intention of saving the life of such woman or child***."

1848 Va. Acts p. 96; W. Va. Const., Art. XI, § 8 (1862) (emphasis added).

24. Oregon (1864):

Sec. 509. "If any person shall administer to any woman pregnant with child, any medicine, drug or substance whatever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, ***unless the same shall be necessary to preserve the life of such mother***, such person shall, in case the death of such child or mother be thereby produced, be deemed guilty of manslaughter."

Ore. Gen. Laws, Crim. Code, ch. 43, § 509 (1865) (emphasis added).

25. Nebraska (1866):

Sec. 42. "Every person who shall ***willfully and maliciously*** administer or cause to be administered to or taken by any person, any poison or other noxious or destructive substance or liquid, with the intention to cause the death of such person, and being thereof duly convicted, shall be punished by confinement in the penitentiary for a term not less than one year and not more than seven years. And every person who shall administer or cause to be administered or taken, any such poison, substance or liquid, with the intention to procure the miscarriage of any woman then being with child, and shall thereof be duly convicted, shall be imprisoned for a term not exceeding three years in the penitentiary, and fined in a sum not exceeding one thousand dollars."

Neb. Rev. Stat., Tit. 4, ch. 4, § 42 (1866) (emphasis added).

26. Illinois (1867):

Sec. 1. "*Be it enacted by the People of the State of Illinois, represented in the General Assembly*, If any person shall, by means of any instrument or instruments, or any other means whatever, cause any pregnant woman to miscarry, or shall attempt to procure or produce such miscarriage, the person so offending shall be deemed guilty of a high misdemeanor, and, upon conviction thereof, shall be confined in the penitentiary for a period not less than two nor more than ten years."

Sec. 2. "If any person shall, in the attempt to produce the miscarriage of a pregnant woman, thereby cause and produce the death of such woman, the person so offending shall be deemed guilty of murder, and shall be punished as the law requires for such offense."

Sec. 3 "***The provisions of this act shall not apply to any person who procures or attempts to produce 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) (emphasis added)

27. Maryland (1868):

Sec. 2. "And be it enacted, That any person who shall knowingly advertise, print, publish, distribute or circulate, or knowingly cause to be advertised, printed, published, distributed or circulated, any pamphlet, printed paper, book, newspaper notice, advertisement or reference containing words or language, giving or conveying any notice, hint or reference to any person, or to the name of any person real or fictitious, from whom; or to any place, house, shop or office, when any poison, drug, mixture, preparation, medicine or noxious thing, or any instrument or means whatever; for the purpose of producing abortion, or who shall knowingly sell, or cause to be sold any such poison, drug, mixture, preparation, medicine or noxious thing or instrument of any kind whatever; or where any advice, direction, information or knowledge may be obtained for the purpose of causing the miscarriage or abortion of any woman pregnant with child, at any period of her pregnancy, or shall knowingly sell or cause to be sold any medicine, or who shall knowingly use or cause to be used any means whatsoever for that purpose, shall be punished by imprisonment in the penitentiary for not less than three years, or by a fine of not less than five hundred nor more than one thousand dollars, or by both, in the discretion of the Court; and in case of fine being imposed, one half thereof shall be paid to the State of Maryland, and one-half to the School Fund of the city or county where the offence was committed; provided, however, 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 (emphasis added).

28. Florida (1868):

Ch. 3, Sec. 11. "Every person who shall administer to any woman pregnant with a quick child any medicine, drug, or substance whatever, or shall use or employ any instrument, or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose***, shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of manslaughter in the second degree."

Ch. 8, Sec. 9. "Whoever, with intent to procure miscarriage of any woman, ***unlawfully*** administers to her, or advises, or prescribes for her, or causes to be taken by her, any poison, drug, medicine, or other noxious thing, or unlawfully uses any instrument or other means whatever with the like intent, or with like intent aids or assists therein, shall, if the woman does not die in consequence thereof, be punished by imprisonment in the State penittentiary not exceeding seven years, nor less than one year, or by fine not exceeding one thousand dollars."

1868 Fla. Laws, ch. 1637, pp. 64, 97 (emphasis added).

29. Minnesota (1873):

Sec. 1. "That any person who shall administer to any woman with child, or prescribe for any such woman, or suggest to, or advise, or procure her to take any medicine, drug, substance or thing whatever, or who shall use or employ, or advise or suggest the use or employment of any instrument or other means or force whatever, with intent thereby to cause or procure the miscarriage or abortion or premature labor of any such woman, ***unless the same shall have been necessary to preserve her life***, or the life of such child, shall, in case the death of such child or of such woman results in whole or in part therefrom, be deemed guilty of a felony, and upon conviction thereof, shall be punished by imprisonment in the state prison for a term not more than ten (10) years nor less than three (3) years."

Sec. 2. "Any person who shall administer to any woman with child, or prescribe, or procure, or provide for any such woman, or suggest to, or advise, or procure any such woman to take any medicine, drug, substance or thing whatever, or shall use or employ, or suggest, or advise the use or employment of any instrument or other means or force whatever, with intent thereby to cause or procure the miscarriage or abortion or premature labor of any such woman, shall upon conviction thereof be punished by imprisonment in the state prison for a term not more than two years nor less than one year, or by fine not more than five thousand dollars nor less than five hundred dollars, or by such fine and imprisonment both, at the discretion of the court."

1873 Minn. Laws pp. 117–118 (emphasis added).

30. Arkansas (1875):

Sec. 1. "That it shall be unlawful for any one to administer or prescribe any medicine or drugs to any woman with child, with intent to produce an abortion, or premature delivery of any foetus before the period of quickening, or to produce or attempt to produce such abortion

by any other means; and any person offending against the provision of this section, shall be fined in any sum not exceeding one thousand ($1000) dollars, and imprisoned in the penitentiary not less than one (1) nor more than five (5) years; ***provided, that this section shall not apply to any abortion produced by any regular practicing physician, for the purpose of saving the mother's life."***

1875 Ark. Acts p. 5 (emphasis added).

31. Georgia (1876):

Sec. 2. "That every person who shall administer to any woman pregnant with a child, any medicine, drug, or substance whatever, or shall use or employ any instrument or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother, or shall have been advised by two physicians to be necessary for such purpose***, shall, in case the death of such child or mother be thereby produced, be declared guilty of an assault with intent to murder."

Sec. 3. "That any person who shall wilfully administer to any pregnant woman any medicine, drug or substance, or anything whatever, or shall employ any instrument or means whatever, with intent thereby to procure the miscarriage or abortion 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, upon conviction, be punished as prescribed in section 4310 of the Revised Code of Georgia."

1876 Ga. Acts & Resolutions p. 113 (emphasis added).

32. North Carolina (1881):

Sec. 1. "That every person who shall wilfully administer to any woman either pregnant or quick with child, or prescribe for any such woman, or advise or procure any such woman to take any medicine, drug or substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy said child, ***unless the same shall have been necessary to preserve the life of such mother***, shall be guilty of a felony, and shall be imprisoned in the state penitentiary for not less than one year nor more than ten years, and be fined at the discretion of the court."

Sec. 2. "That every person who shall administer to any pregnant woman, or prescribe for any such woman, or advise and procure such woman to take any medicine, drug or any thing whatsoever, with intent thereby to procure the miscarriage of any such woman, or to injure or destroy such woman, or shall use any instrument or application for any of the above purposes, shall be guilty of a misdemeanor, and, on conviction, shall be imprisoned in the jail or state penitentiary for not less than one year or more than five years, and fined at the discretion of the court."

1881 N. C. Sess. Laws pp. 584–585 (emphasis added).

33. Delaware (1883):

Sec. 2. "Every person who, with the intent to procure the miscarriage of any pregnant woman or women supposed by such person to be pregnant, ***unless the same be necessary to preserve her life***, shall administer to her, advise, or prescribe for her, or cause to be taken by her any poison, drug, medicine, or other noxious thing, or shall use any instrument or other means whatsoever, or shall aid, assist, or counsel any person so intending to procure a miscarriage, whether said miscarriage be accomplished or not, shall be guilty of a felony, and upon conviction thereof shall be fined not less than one hundred dollars nor more than five hundred dollars and be imprisoned for a term not exceeding five years nor less than one year."

1883 Del. Laws, ch. 226 (emphasis added).

34. Tennessee (1883):

Sec. 1. "That every person who shall administer to any woman pregnant with child, whether such child be quick or not, any medicine, drug or substance whatever, or shall use or employ any instrument, or other means whatever with intent to destroy such child, and shall thereby destroy such child before its birth, ***unless the same shall have been done with a view to preserve the life of the mother***, shall be punished by imprisonment in the penitentiary not less than one nor more than five years."

Sec. 2. "Every person who shall administer any substance with the intention to procure the miscarriage of a woman then being with child, or shall use or employ any instrument or other means with such intent, ***unless the same shall have been done with a view to preserve the life of such mother***, shall be punished by imprisonment in the penitentiary not less than one nor more than three years."

1883 Tenn. Acts pp. 188–189 (emphasis added).

35. South Carolina (1883):

Sec. 1. "That any person who shall administer to any woman with child, or prescribe for any such woman, or suggest to or advise or procure her to take, any medicine, substance, drug or thing whatever, or who shall use or employ, or advise the use or employment of, any instrument or other means of force whatever, with intent thereby to cause or procure the miscarriage or abortion or premature labor of any such woman, ***unless the same shall have been necessary to preserve her life***, or the life of such child, shall, in case the death of such child or of such woman results in whole or in part therefrom, be deemed guilty of a felony, and, upon conviction thereof, shall be punished by imprisonment in the Penitentiary for a term not more than twenty years nor less than five years."

Sec. 2. "That any person who shall administer to any woman with child, or prescribe or procure or provide for any such woman, or advise or procure any such woman to take, any medicine, drug, substance or thing whatever, or shall use or employ or advise the use or employment of, any instrument or other means of force whatever, with intent thereby to cause or procure the miscarriage or abortion or premature labor of any such woman, shall,

upon conviction thereof, be punished by imprisonment in the Penitentiary for a term not more than five years, or by fine not more than five thousand dollars, or by such fine and imprisonment both, at the discretion of the Court; but no conviction shall be had under the provisions of Section 1 or 2 of this Act upon the uncorroborated evidence of such woman."

1883 S. C. Acts pp. 547–548 (emphasis added).

36. Kentucky (1910):

Sec. 1. "It shall be unlawful for any person to prescribe or administer to any pregnant woman, or to any woman whom he has reason to believe pregnant, at any time during the period of gestation, any drug, medicine or substance, whatsoever, with the intent thereby to procure the miscarriage of such woman, or with like intent, to use any instrument or means whatsoever, ***unless such miscarriage is necessary to preserve her life***; and any person so offending, shall be punished by a fine of not less than five hundred nor more than one thousand dollars, and imprisoned in the State prison for not less than one nor more than ten years."

Sec. 2. "If by reason of any of the acts described in Section 1 hereof, the miscarriage of such woman is procured, and she does miscarry, causing the death of the unborn child, whether before or after quickening time, the person so offending shall be guilty of a felony, and confined in the penitentiary for not less than two, nor more than twenty-one years."

Sec. 3. "If, by reason of the commission of any of the acts described in Section 1 hereof, the woman to whom such drug or substance has been administered, or upon whom such instrument has been used, shall die, the person offending shall be punished as now prescribed by law, for the offense of murder or manslaughter, as the facts may justify."

Sec. 4. "The consent of the woman to the performance of the operation or administering of the medicines or substances, referred to, shall be no defense, and she shall be a competent witness in any prosecution under this act, and for that purpose she shall not be considered an accomplice."

1910 Ky. Acts pp. 189–190 (emphasis added).

Appendix B

This appendix contains criminal abortion statutes in effect in 1868 in United States Territories, followed by criminal abortion statutes enacted between 1868 and 1938 in the Territories and District of Columbia. The statutes appear in chronological order of their enactment.

1. Hawaii (1850):

Sec. 1. "Whoever ***maliciously***, ***without lawful justification***, administers, or causes or procures to be administered any poison or noxious thing to a woman then with child, in order to produce her mis-carriage, or ***maliciously*** uses any instrument or other means with like intent, shall, if such woman be then quick with child, be punished by fine not exceeding one thousand dollars and imprisonment at hard labor not more than five years. And if she be then not quick with child, shall be punished by a fine not exceeding five hundred dollars, and imprisonment at hard labor not more than two years."

Sec. 2. "***Where means of causing abortion are used for the purpose of saving the life of the woman, the surgeon or other person using such means is lawfully justified***."

Haw. Penal Code, ch. 12, §§ 1–2 (1850) (emphasis added).

2. Washington (1854):

Sec. 37. "Every person who shall administer to any woman pregnant with a quick child, any medicine, drug, or substance whatever, or shall use or employ any instrument, or other means, with intent thereby to destroy such child, ***unless the same shall have been necessary to preserve the life of such mother***, shall, in case the death of such child or of such mother be thereby produced, on conviction thereof, be imprisoned in the penitentiary not more than twenty years, nor less than one year."

Sec. 38. "Every person who shall administer to any pregnant woman, or to any woman who he supposes to be pregnant, any medicine, drug, or substance whatever, or shall use or employ any instrument, or other means, thereby to procure the miscarriage of such woman, ***unless the same is necessary to preserve her life***, shall on conviction thereof, be imprisoned in the penitentiary not more than five years, nor less than one year, or be imprisoned in the county jail not more than twelve months, nor less than one month, and be fined in any sum not exceeding one thousand dollars."

Terr. of Wash. Stat., ch. 2, §§ 37–38, p. 81 (1854) (emphasis added).

3. Idaho (1864):

Sec. 42. "[E]very person who shall administer or cause to be administered, or taken, any medicinal substance, or shall use or cause to be used, any instruments whatever, with the intention to procure the miscarriage of any woman then being with child, and shall be thereof duly convicted, shall be punished by imprisonment in the territorial prison for a term not less than two years, nor more than five years: ***Provided, That no physician shall be effected by***

the last clause of this section, who in the discharge of his professional duties, deems it necessary to produce the miscarriage of any woman in order to save her life."

1863–1864 Terr. of Idaho Laws p. 443 (emphasis added).

4. Montana (1864):

Sec. 41. "[E]very person who shall administer, or cause to be administered, or taken, any medicinal substance, or shall use, or cause to be used, any instruments whatever, with the intention to produce the miscarriage of any woman then being with child, and shall be thereof duly convicted, shall be punished by imprisonment in the Territorial prison for a term not less than two years nor more than five years. ***Provided, That no physician shall be affected by the last clause of this section, who in the discharge of his professional duties deems it necessary to produce the miscarriage of any woman in order to save her life***."

1864 Terr. of Mont. Laws p. 184 (emphasis added).

5. Arizona (1865):

Sec. 45. "[E]very person who shall administer or cause to be administered or taken, any medicinal substances, or shall use or cause to be used any instruments whatever, with the intention to procure the miscarriage of any woman then being with child, and shall be thereof duly convicted, shall be punished by imprisonment in the Territorial prison for a term not less than two years nor more than five years: ***Provided, that no physician shall be affected by the last clause of this section, who in the discharge of his professional duties, deems it necessary to produce the miscarriage of any woman in order to save her life.***"

Howell Code, ch. 10, § 45 (1865) (emphasis added).

6. Colorado (1867):

Sec. 42. "Every person who shall wilfully and maliciously administer, or cause to be administered to, or taken by any person, any poison or other noxious or destructive substance, or liquid, with the intention to cause the death of such person, and being thereof duly convicted, shall be punished by confinement in the penitentiary for a term not less than one year, and not more than ten years; and every person who shall administer, or cause to be administered or taken, any such poison, substance or liquid, or who shall use, or cause to be used, any instrument of whatsoever kind, with the intention to procure the miscarriage of any woman then being with child, and shall thereof be duly convicted, shall be imprisoned for a term not exceeding three years, in the penitentiary, and fined in a sum not exceeding one thousand dollars; and if any woman by reason of such treatment shall die, the person, or persons, administering or causing to be administered, such poison, substance, or liquid, or using or causing to be used, any instrument, as aforesaid, shall be deemed guilty of manslaughter, and if convicted, be punished accordingly, ***unless it appear that such miscarriage was procured or attempted by or under 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***."

Rev. Stats. of Colo., § 42 (1867) (emphasis added).

7. Wyoming (1869):

Sec. 25. "[A]ny person who shall administer, or cause to be administered, or taken, any such poison, substance or liquid, or who shall use, or cause to be used, any instrument of whatsoever kind, with the intention to procure the miscarriage of any woman then being with child, and shall thereof be duly convicted, shall be imprisoned for a term not exceeding three years, in the penitentiary, and fined in a sum not exceeding one thousand dollars; and if any woman by reason of such treatment shall die, the person, or persons, administering, or causing to be administered such poison, substance, or liquid, or using or causing to be used, any instrument, as aforesaid, shall be deemed guilty of manslaughter, and if convicted, be punished by imprisonment for a term not less than three years in the penitentiary, and fined in a sum not exceeding one thousand dollars, ***unless it appear that such miscarriage was procured or attempted by, or under 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***."

1869 Terr. of Wyo. Gen. Laws p. 104 (emphasis added).

8. Utah (1876):

Sec. 142. "Every person who provides, supplies, or administers to any pregnant woman, or procures any such woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, ***unless the same is necessary to preserve her life***, is punishable by imprisonment in the penitentiary not less than two nor more than ten years."

Terr. of Utah Comp. Laws § 1972 (1876) (emphasis added).

9. North Dakota (1877):

Sec. 337. "Every person who administers to any pregnant woman, or who prescribes for any such woman, or advises or procures any such woman to take any medicine, drug or substance, or uses or employs any instrument, or other means whatever with intent thereby to procure the miscarriage of such woman, ***unless the same is necessary to preserve her life***, is punishable by imprisonment in the territorial prison not exceeding three years, or in a county jail not exceeding one year."

Dakota Penal Code § 337 (1877) (codified at N. D. Rev. Code § 7177 (1895)) (emphasis added).

10. South Dakota (1877):

Same as North Dakota.

S. D. Rev. Penal Code Ann. § 337 (1883).

11. Oklahoma (1890):

Sec. 2187. "Every person who administers to any pregnant woman, or who prescribes for any such woman, or advises or procures any such woman to take any medicine, drug or substance, or uses or employs any instrument, or other means whatever, with intent thereby to procure the miscarriage of such woman, ***unless the same is necessary to preserve her life***, is punishable by imprisonment in the Territorial prison not exceeding three years, or in a county jail not exceeding one year."

Okla. Stat. § 2187 (1890) (emphasis added).

12. Alaska (1899):

Sec. 8. "That if any person shall administer to any woman pregnant with a child any medicine, drug, or substance whatever, or shall use any instrument or other means, with intent thereby to destroy such child, ***unless the same shall be necessary to preserve the life of such mother***, such person shall, in case the death of such child or mother be thereby produced, be deemed guilty of manslaughter, and shall be punished accordingly."

1899 Alaska Sess. Laws ch. 2, p. 3 (emphasis added).

13. District of Columbia (1901):

Sec. 809. "Whoever, with intent to procure the miscarriage of any woman, prescribes or administers to her any medicine, drug, or substance whatever, or with like intent uses any instrument or means, ***unless when necessary to preserve her life or health and under the direction of a competent licensed practitioner of medicine***, shall be imprisoned for not more than five years; or if the woman or her child dies in consequence of such act, by imprisonment for not less than three nor more than twenty years."

§ 809, 31 Stat. 1322 (1901) (emphasis added).

14. New Mexico (1919):

Sec. 1. "Any person who shall administer to any pregnant woman any medicine, drug or substance whatever, or attempt by operation or any other method or means to produce an abortion or miscarriage upon such woman, shall be guilty of a felony, and, upon conviction thereof, shall be fined not more than two thousand ($2,000.00) Dollars, nor less than five hundred ($500.00) Dollars, or imprisoned in the penitentiary for a period of not less than one nor more than five years, or by both such fine and imprisonment in the discretion of the court trying the case."

Sec. 2. "Any person committing such act or acts mentioned in section one hereof which shall culminate in the death of the woman shall be deemed guilty of murder in the second degree; ***Provided, however, an 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***."

Sec. 3. "For the purpose of the act, the term "pregnancy" is defined as that condition of a woman from the date of conception to the birth of her child."

1919 N. M. Laws p. 6 (emphasis added).

Appendix C

IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT

OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF ADA

JENNIFER ADKINS; JILLAINE ST.MICHEL; KAYLA SMITH; REBECCA VINCEN-BROWN; EMILY CORRIGAN, M.D., on behalf of herself and her patients; JULIE LYONS, M.D., on behalf of herself and her patients; and IDAHO ACADEMY OF FAMILY PHYSICIANS, on behalf of itself, its members, and its members' patients,

Plaintiffs,

vs.

STATE OF IDAHO; BRAD LITTLE, in his official capacity as Governor of the State of Idaho; RAÚL LABRADOR, in his official capacity as Attorney General of the State of Idaho; and IDAHO STATE BOARD OF MEDICINE,

Defendants.

Case No. CV01-23-14744

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022), the United States Supreme Court overruled *Roe v. Wade*, 410 U.S. 113 (1973), and, by doing so, gave effect to two Idaho statutes that severely restrict abortion (collectively, "Idaho's Abortion Laws"). One of them is the "General Abortion Ban," I.C. § 18-622, which broadly criminalizes abortion, but not when performed by 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," so long as the reason it was necessary wasn't to

avert a risk of self-harm by the pregnant woman and the manner of performing it "provided the best opportunity for the unborn child to survive, unless . . . termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman." I.C. § 18-622(2)(a)(i)–(ii). The other is the "Fetal Heartbeat Law," I.C. §§ 18-8801 to -8805, which criminalizes abortion performed after fetal cardiac activity is present, I.C. § 18-8804(1), unless, according to a "reasonable medical judgment," an "immediate abortion" is necessary to "avert [the pregnant woman's] death" or "a delay [in performing the abortion] will create serious risk of substantial and irreversible impairment of a major bodily function" of hers, I.C. § 18-8801(5).

Plaintiffs are four women prevented by Idaho's Abortion Laws from obtaining abortion care in Idaho during complicated or nonviable pregnancies, two physicians prevented from providing medically appropriate abortion care, and a medical association concerned about implications for patient care. On September 11, 2023, they sued the State of Idaho, Governor Brad Little, Attorney General Raúl Labrador, and the Idaho State Board of Medicine to challenge the constitutionality of Idaho's Abortion Laws and seek guidance concerning the medical circumstances in which abortion is still legal. After two dispositive motions, Claims I and III, as asserted against only the State, are Plaintiffs' surviving claims. (*See* Mem. Decision & Order Mot. Dismiss 9–22; Mem. Decision Order Mot. Summ J. 7–18.)

Claim I isn't a constitutional claim. It just seeks a declaratory judgment concerning the medical circumstances in which Idaho's Abortion Laws allow

abortion. (Compl. ¶¶ 315–21.) Plaintiffs contend that, despite their restrictive language, Idaho's Abortion Laws allow physicians to perform abortion when they determine in good faith that, for reasons other than hedging a risk of self-harm, it is within the medical standard of care to treat a high-risk or complicated pregnancy. (Pls.' Proposed Findings Fact & Conclusions Law ¶¶ 202, 206.)

Claim III seeks a declaratory judgment that the Idaho Constitution—by recognizing "enjoying and defending life" and "pursuing happiness and securing safety" as "inalienable rights," Idaho Const. art. I, § 1—grants pregnant women a constitutional right of access to abortion care if a physician determines that abortion is within the medical standard of care to treat their high-risk or complicated pregnancies. (Pls.' Proposed Findings Fact & Conclusions Law ¶ 137.) Plaintiffs say this constitutional right applies when abortion would alleviate (i) "a pre-existing or underlying physical or mental health condition that cannot effectively be treated during pregnancy, is exacerbated by pregnancy, requires recurrent invasive intervention, or otherwise makes continuing the pregnancy unsafe for the pregnant patient"; (ii) "a physical or mental health condition caused by pregnancy or a complication of pregnancy that poses a risk of infection, bleeding, or organ damage, or otherwise makes continuing the pregnancy unsafe for the pregnant patient"; or (iii) "a lethal fetal diagnosis, regardless of whether the fetal diagnosis increases the pregnant patient's health risks of continuing the pregnancy and giving birth." (*Id.*) They also say it applies when abortion would preserve the ability to procreate. (*Id.* ¶¶ 152–53.)

A six-day bench trial was held from November 12–21, 2024. Twenty-two witnesses testified: all six individual plaintiffs (Jennifer Adkins, Jilliane St.Michel, Kayla Smith, Rebecca Vincen-Brown, Dr. Emily Corrigan, and Dr. Julie Lyons), Kaelyn Coltrin, Caleb McInnis, Dr. Nichole Aker, Dr. Loren Colson, Dr. Katherine Wenstrom, Dr. Ali Raja, Dr. John Werdel, Dr. Duncan Harmon, Elizabeth Woodruff, Dr. Shannon Withycombe, Dr. Jennifer Payne, Jennifer Liposhak, Elke Shaw-Tulloch, Dr. Dustan Hughes, Dr. Rod Story, and Dr. Ingrid Skop. Additionally, the following exhibits were admitted into evidence: Plaintiffs' Exhibits 6, 10, 14–19, 39, 44, 104, 111, 112, 114, 117, 122, 127, 137, 138, 143, 146, 148, 153, 154, 155, 157, 213–18, 226, 245, 318, 486, 491, 565, and 582–86 and the State's Exhibits 1011, 1017, 1022, 1046, 1047, 1049, 1051, 1052, and 1056–58.[1]

On February 19, 2025, the parties filed timely proposed findings of fact and conclusions of law. The State's filing was accompanied by a request for judicial notice of the 2023 Idaho Maternal Mortality Review Committee Annual Report, to which Plaintiffs objected in filings on February 24, 2025, and February 28, 2025. Then, on April 7, 2025, Plaintiffs filed a request for judicial notice of a court order issued on March 20, 2025, in a federal case alleging that Idaho's Abortion Laws are unenforceable to the extent they conflict with a federal statute requiring hospitals

[1] Some of these exhibits were admitted only in part. Additionally, some of them some of them were admitted provisionally, as was some testimony, subject to relevance objections to be decided in rendering these findings of fact and conclusions of law. All such objections are overruled, so all provisionally admitted evidence stands as part of the trial record. The Court relies on no such evidence, however, unless it is expressly cited in these findings of fact and conclusions of law.

that receive Medicare funds to provide stabilizing treatment to patients with emergent medical conditions. This new filing reset the under-advisement date, which had been February 28, to April 7. In any event, judicial notice may be taken "at any stage of the proceeding," I.R.E. 201(d), so the parties' post-trial requests for judicial notice aren't necessarily untimely. Judicial notice may be taken, however, of only "a fact that is not subject to reasonable dispute," I.R.E. 201(b), so long as it is a relevant fact, *see* I.R.E. 402. The State's request is denied; the 2023 Idaho Maternal Mortality Review Committee Annual Report's issuance isn't subject to reasonable dispute, but the report is offered for conclusions, which, even if relevant, are subject to reasonable dispute. Plaintiffs' request is denied because the federal court order isn't relevant.

Having carefully reviewed the evidentiary record and the parties' proposed findings of fact and conclusions of law, the Court issues its findings of fact and conclusions of law.

I.

FINDINGS OF FACT

Patient Plaintiffs

1. Plaintiffs Jennifer Adkins, Jillaine St.Michel, Kayla Smith, and Rebecca Vincen-Brown initially sought pregnancy-related medical care in Idaho. (Tr. 73:24–74:7 (Adkins), 98:20–25 (St.Michel), 121:8–13 (Smith), 143:3–22 (Vincen-Brown).) Maternal-health concerns, grave fetal anomalies, or both complicated their pregnancies. (Tr. 79:16–80:11 (Adkins), 100:22–101:25 (St.Michel), 123:12–16, 124:4–20, 125:7–18 (Smith), 146:6–19 (Vincen-Brown).) Each wanted abortion care,

but Idaho's Abortion Laws—by broadly criminalizing abortion, *see* I.C. §§ 18-622, -8801 to -8805—relegated them to leaving Idaho to get it. (Tr. 85:1–6 (Adkins), 102:16–22 (St.Michel), 130:8–131:4 (Smith), 148:5–23 (Vincen-Brown).)

Physician Plaintiffs

2. Plaintiff Emily Corrigan is a board-certified, licensed physician who has practiced medicine in Idaho for five years and works as an obstetric hospitalist at Saint Alphonsus Regional Medical Center in Boise. (Tr. 159:2–12, 160:20–161:15; Pls.' Ex. PX019.) Dr. Corrigan specializes in treating patients with complicated pregnancies, including by performing no more than a few abortions per year, both before and after Idaho's Abortion Laws took effect. (Tr. 161:7–15, 162:25–163:2, 311:12–15, 313:11–14, 318:4–6.) Some of her patients experience treatment delays and poorer-quality healthcare because of Idaho's Abortion Laws, including because of confusion about when abortion is still legal. (Tr. 172:12–21, 177:7–22, 180:7–20, 182:9–183:19).

3. Plaintiff Julie Lyons is a board-certified, licensed physician who has practiced rural family medicine in Hailey since 2009. (Tr. 807:19–25, 810:15–16; Pls.' Ex. PX015.) In that capacity, she provides obstetrical and gynecological care, (Tr. 815:5–816:1), but hasn't performed abortions, (Tr. 855:11–22).

Plaintiff Idaho Academy of Family Physicians

4. Plaintiff Idaho Academy of Family Physicians ("IAFP") is an organization whose members are physicians (including Dr. Lyons), medical residents, and medical students. (Tr. 725:21–727:19.) IAFP sees Idaho's Abortion

Laws as a source of member confusion and an impediment to providing high-quality healthcare to pregnant women in Idaho. (Tr. 736:14–738:6, 741:4–16, 744:6–19.)

Expert witnesses

5. Plaintiffs presented testimony by five expert witnesses: Dr. Corrigan; Dr. Jennifer Payne, a board-certified, licensed psychiatrist, (Tr. 1015:15–18; Pls.' Ex. PX017); Dr. Ali Raja, a board-certified emergency medicine physician and professor of emergency medicine at Harvard Medical School, (Tr. 583:19–25; Pls.' Ex. PX014); Dr. Katharine Wenstrom, a board-certified obstetrician-gynecologist, maternal-fetal medicine specialist, and clinical geneticist (Tr. 485:8–19; Pls.' Ex. PX016); and Dr. Shannon Withycombe, a professor of history at University of New Mexico, (Tr. 861:10–22; Pls.' Ex. PX018). The State presented expert testimony by one witness: Dr. Ingrid Skop, a licensed obstetrician-gynecologist and the Charlotte Lozier Institute's Director of Medical Affairs. (Tr. 1201:22–1203:12.)

Other physicians testifying as fact witnesses

6. Plaintiffs also called three Idaho physicians to testify as fact witnesses concerning the on-the-ground application of Idaho's Abortion Laws. Dr. Nichole Aker is a board-certified family medicine physician practicing in Mountain Home and Boise, where she performed abortions before Idaho's Abortion Laws took effect. (Tr. 421:5–8, 422:3–5, 423:22–23.) Dr. Loren Colson is a board-certified family physician practicing in Idaho who also performed abortions before Idaho's Abortion Laws took effect. (Tr. 441:10–11, 442:12–20.) Dr. Duncan Harmon is a board-certified obstetrician-gynecologist and maternal-fetal medicine specialist practicing

at St. Luke's Regional Medical Center in Boise. (Tr. 698:21–25.) The State called two Idaho physicians to try to impeach the testimony of physicians called by Plaintiffs (including Drs. Aker, Colson, and Harmon) that Idaho's Abortion Laws aren't well understood by physicians. Dr. Dustan Hughes is an obstetrician-gynecologist who practices in Nampa. (Tr. 1154:10–14.) Dr. Rod Story is a family physician who practices in Moscow. (Tr. 1174:17–21.)

Some pregnancies involve medical complications
that imperil the health and lives of pregnant women

7. Healthy pregnancies are common, but some women suffer grave pregnancy-related health complications or experience worsening of preexisting health conditions during pregnancy. (Tr. 247:12–20 (Corrigan), 426:17–427:7 (Aker), 499:1–9, 545:2–12 (Wenstrom).)

8. Preexisting health conditions that can worsen during pregnancy and pose significant health risks to pregnant women include hypertension, cardiac disease, renal insufficiency, diabetes, autoimmune diseases, vascular problems, coagulation disorders, sickle-cell disease, cancer, or susceptibility to stroke. (Tr. 197:7–9, 231:6–24 (Corrigan).) Denying or delaying abortion care in these instances not only imperils the patient's health but also can shorten her lifespan. (Tr. 235:15–24 (Corrigan), 498:22–500:4 (Wenstrom).)

9. Some pregnancy-related conditions imperil a pregnant woman's health without necessarily posing an imminent risk of her death, including PPROM (preterm premature rupture of membranes), advanced cervical dilation or cervical incompetence, placental abruption, preeclampsia, HHELP (hemolysis, elevated liver

enzymes, and low platelets) syndrome, and hyperemesis gravidarum (characterized by severe nausea and vomiting). (Tr. 199:1–204:8, 231:6–233:3, 235:4–24 (Corrigan), 611:3–22 (Raja), 499:1–19 (Wenstrom).)

10. Plaintiffs' witnesses presented on-the-ground examples of pregnant women denied essential emergency care because their medical conditions weren't an imminent death risk. (Tr. 179:22–180:6 (Corrigan), 429:8–432:1 (Aker), 703:9–715:6 (Harmon).)

11. Take Dr. Harmon's testimony as an example. He recounted a patient who presented with previable PPROM at approximately fifteen weeks of gestation. (Tr. 703:9–704:11.) PPROM is a condition in which the amniotic sac ruptures and amniotic fluid leaks from the vagina before the onset of labor. (Tr. 198:11–25 (Corrigan).) According to both sides' experts, if left untreated, previable PPROM can cause a pregnant woman to suffer infection, sepsis, hemorrhage, infertility, and, ultimately, death. (Tr. 199:12–200:12, 204:2–8, 204:23–205:4 (Corrigan), 501:15–502:7 (Wenstrom), 1248:17–25, 1357:14–18, 1375:15–19 (Skop).) Because Dr. Harmon's patient presented with "no signs of bleeding, labor, no vital sign abnormalities and no clinical signs of infection," he considered her "clinically stable" and, at that moment, "an abortion was not necessary to prevent her death," so he believed Idaho's Abortion Laws prohibited performing an abortion, despite the apparent nonviability of the pregnancy. (Tr. 705:5–25, 709:11–15, 718:15–719:4.) Consequently, the patient was transferred out of state. (Tr. 706:20–24.)

12. Dr. Harmon also told of a woman pregnant with triplets, one of which had anencephaly, a lethal fetal diagnosis. (Tr. 713:1–24.) Dr. Harmon advised a selective-reduction procedure, in which that fetus would be removed to decrease gestational risks to the other two fetuses. (Tr. 714:8–22.) Because selective reduction is an abortion, however, Idaho's Abortion Laws relegated the patient to leaving Idaho to obtain abortion care, even though selective reduction would improve her chances of birthing healthy twins. (Tr. 714:23–715:6.)

13. Dr. Aker provided another example: a pregnant woman with bulging membranes before fetal viability—a condition that inevitably results in a miscarriage—who, it was believed, couldn't be offered abortion care under Idaho's Abortion Laws because a fetal heartbeat was detected. (Tr. 429:8–432:1.) The woman was sent home, only to return within the hour because, by then, her water had broken and, as it turned out, fetal cardiac activity had ceased. (*Id.*)

14. Additionally, Dr. Corrigan has on occasion treated pregnant women "denied stabilizing abortion care at other hospitals in Idaho," resulting in "increased complications" to their health. (Tr. 179:22–180:6.)

15. As these examples illustrate, Idaho's Abortion Laws have caused women with nonviable or health-threatening pregnancies to be denied abortion care because a physician couldn't conclude it was then necessary to prevent the patient's death. (Tr. 703:9–706:24, 708:3–710:23.) Dr. Harmon recalled "six or seven" instances in 2024 alone where patients in need of non-life-saving emergency

abortion care were transported out of state from St. Luke's Regional Medical Center in Boise to get that care elsewhere. (Tr. 710:12–23.)

Pregnant women who receive lethal fetal diagnoses face a terrible choice: continue with hopeless pregnancies or leave Idaho for abortion care

16. A lethal fetal diagnosis is a condition known to have "no significant chance of sustained life after delivery" and a "very high risk of fetus demise in-uteri or during birth. (Tr. 280:8–20 (Corrigan).)

17. Examples of lethal fetal diagnoses include certain chromosomal disorders, such as triploidy, trisomies 13 and 18, and those causing hydrops fetalis (profound edema) or anasarca of the fetus; anencephaly and acrania; and combinations of anatomical disorders, such as limb body wall complex (also known as body stalk anomaly). (Tr. 235:25–236:21 (Corrigan), 507:16–508:17, 525:10–15, 1455:1–1468:18 (Wenstrom).)

18. A lethal fetal diagnosis means not only that the pregnancy isn't viable but also that the pregnant woman's health is imperiled by continuing it. The longer women with certain lethal fetus diagnoses are pregnant, "the higher likelihood they [have] of developing further pregnancy complications, which can lead to things like future infertility and damage of other parts of their body." (Tr. 841:20–842:5.) These complications include the mental-health risks associated with appearing to the world to have a viable pregnancy while knowing otherwise. (Tr. 1441:7–19 (Payne) & Pls.' Ex. 35, at 6.)

19. For example, a pregnant woman treated by Dr. Harmon received a lethal fetal diagnosis of body stalk anomaly. (Tr. 710:24–712:6.) Body stalk anomaly is a rare, severe congenital malformation where the "fetal abdominal wall is fused to the placenta" and, though the fetus can survive to term, the result is "incompatible with life." (Tr. 1462:4–19 (Wenstrom).) Dr. Harmon advised the patient that expectant management was an option but, if she chose that option, she "may require . . . a [cesarean] section . . . to deliver the fetus that will not survive." (Tr. 711:19–712:6.) The patient chose to terminate her pregnancy but had to travel out of state to do so because an abortion wasn't considered necessary to prevent her death. (Tr. 712:7–13, 722:16–20.)

Some pregnancies jeopardize future fertility

20. Previable PPROM, if not treated with abortion care, risks a patient's future fertility because it could lead to an intrauterine infection that progresses to sepsis and necessitates a hysterectomy. (Tr. 199:12–201:4 (Corrigan), 1248:17–25 (Skop), 466:5–16 (Aker), 598:25–599:10 (Raja).)

21. In all three of the Dr. Harmon examples recounted above—patients with previable PPROM, anencephaly, and body stalk anomaly—pregnant women risked grave harm to their health and future fertility, though their lives weren't in imminent danger. (Tr. 703:9–706:24, 710:24–712:13, 716:1–24.)

Physicians are unsure when performing an abortion might jeopardize their freedom and livelihood

22. Confusion about Idaho's Abortion Laws is common among physicians for several reasons: (i) the use of non-medical terminology—"necessary to prevent

the death of the pregnant woman," I.C. § 18-622(2)(a)—to establish the legal standard for when abortion is allowed; (ii) the legal standard's imprecision; (iii) the mismatch between the legal standard and the way physicians are trained to address medical problems (they are trained to identify and provide the healthcare the patient wants and needs, life-saving or not); and (iv) the difficulty of ascertaining whether the legal standard is met. (Tr. 241:2–6, 246:18–247:17 (Corrigan), 610:10–611:2 (Raja), 701:12–703:5 (Harmon).)

23. Physician confusion about Idaho's Abortion Laws sometimes delays needed and wanted abortion care, (Tr. 243:19–25, 851:24–853:5), with potentially tragic implications. Consider, for example, a pregnant woman with previable PPROM. A physician may not know when abortion care becomes "absolutely necessary to prevent that patient's death," and the patient can progress quickly from merely facing a "health risk" to facing a "significant risk of . . . dying," but by then "it may be too late because the disease has progressed basically past the point of no return." (Tr. 248:21–249:1, 245:4–20.)

II.

CONCLUSIONS OF LAW

Idaho's Abortion Laws

1. Subject to two exceptions, the General Abortion Ban, I.C. § 18-622, makes performing an abortion a felony punishable by prison time and, if the defendant is a licensed healthcare provider, a mandatory license suspension (for a first offense) or revocation (for a subsequent offense). I.C. § 18-622(1).

2. The first exception is that an abortion performed by a physician isn't a crime if "[t]he physician determined, in his good faith medical judgment and based on the facts known to [him] at the time, that the abortion was necessary to prevent the death of the pregnant woman," so long as the reason it was necessary wasn't to avert a risk that the pregnant woman will "take action to harm herself" and the manner of performing it "provided the best opportunity for the unborn child to survive, unless . . . termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman." I.C. § 18-622(2)(a)(i)–(ii) (emphasis added). The second exception is that an abortion isn't a crime if performed by a physician during a pregnancy's first trimester and the patient had reported to authorities that she was a victim of rape or incest. I.C. § 18-622(2)(b).

3. The Fetal Heartbeat Law, I.C. §§ 18-8801 to -8805, criminalizes performing abortions after fetal cardiac activity is present, making them punishable like those prohibited by the General Abortion Ban, I.C. §§ 18-8804(1), -8805(2)–(3), unless, according to a "reasonable medical judgment," an "immediate abortion" is necessary to "avert [the pregnant woman's] death" or "a delay [in performing the abortion] will create serious risk of substantial and irreversible impairment of a major bodily function" of hers, I.C. § 18-8801(5).

4. The General Abortion Ban has primacy over the Fetal Heartbeat Law; the Fetal Heartbeat Law says that "[i]n the event both [laws] are enforceable," it is "supersede[d]" by the General Abortion Ban. I.C. § 18-8805(4); *see also Planned Parenthood Great Nw. v. State*, 171 Idaho 374, 403, 522 P.3d 1132, 1161 (2023).

Standing

5. The State contends that Claims I and III should be dismissed because Plaintiffs lack standing to assert them. (Def. State of Idaho's Proposed Findings Fact & Conclusions Law ¶¶ 1–103.) "Concepts of justiciability, including standing, identify appropriate or suitable occasions for adjudication by a court." *Associated Press v. Second Jud. Dist.*, 172 Idaho 113, 118, 529 P.3d 1259, 1264 (2023) (quoting *Coeur d'Alene Tribe v. Denney*, 161 Idaho 508, 513, 387 P.3d 761, 766 (2015)). "[S]tanding is a threshold determination that must be addressed before reaching the merits." *Zeyen v. Pocatello/Chubbuck Sch. Dist. No. 25*, 165 Idaho 690, 698, 451 P.3d 25, 33 (2019) (citing *Martin v. Camas Cty. ex rel. Bd. Comm'rs*, 150 Idaho 508, 513, 248 P.3d 1243, 1248 (2011)).

6. "Idaho courts have, again and again, reaffirmed a commitment to the federal standards for Idaho's standing doctrine." *Tidwell v. Blaine Cnty.*, 172 Idaho 851, 860, 537 P.3d 1212, 1221 (2023) (collecting cases). Under federal standards, "[t]he standing inquiry focuses on whether the plaintiff is the proper party to bring this suit." *Raines v. Byrd*, 521 U.S. 811, 818 (1997). As the Idaho Supreme Court recently put it, "[w]hen an issue of standing is raised, the focus is not on the merits of the issues raised, but upon the party who is seeking the relief," because "a party can have standing to bring an action, but then lose on the merits." *Midtown Ventures, LLC v. Capone*, 173 Idaho 172, 180, 539 P.3d 992, 1000 (2023) (quoting *Bagley v. Thomason*, 149 Idaho 806, 808, 241 P.3d 979, 981 (2010)).

7. To establish standing, a plaintiff must show "(1) an injury in fact, (2) a sufficient causal connection between the injury and the conduct complained of, and (3) a likelihood that the injury will be redressed by a favorable decision." *Planned Parenthood*, 171 Idaho at 401, 522 P.3d at 1159. An injury sufficient to satisfy the requirement of an injury in fact must be concrete and particularized and actual or imminent, not conjectural or hypothetical. *Id.*

8. When multiple plaintiffs seek the same relief, the case may proceed so long as at least one plaintiff has standing to seek that relief. *E.g.*, *Farrell v. Bd. of Comm'rs, Lemhi Cnty.*, 138 Idaho 378, 383, 64 P.3d 304, 309 (2002) ("That all appellants may not have standing as to all issues in a brief written on behalf of all appellants is of no consequence if at least one appellant, as is the case, has standing for each issue argued."), *overruled on other grounds by City of Osburn v. Randel*, 152 Idaho 906, 277 P.3d 353 (2012); *Gibbons v. Cenarrusa*, 140 Idaho 316, 318, 92 P.3d 1063, 1065 (2002) (rejecting lack-of-standing defense because "[r]egardless of whether [Plaintiff A] has standing, it is clear that [Plaintiff B] has standing"); *Town of Chester v. Laroe Ests., Inc.*, 581 U.S. 433, 439 (2017) ("At least one plaintiff must have standing to seek each form of relief requested in the complaint."). The Court concludes below that Dr. Corrigan has standing to assert Claims I and III. That conclusion leaves no need to determine whether other plaintiffs also have standing; either way, Claims I and III may not be dismissed on standing grounds.

9. Dr. Corrigan, a board-certified OB-GYN whose work includes providing abortion care, testified that uncertainty about the meaning of Idaho's Abortion

Laws—when, precisely, is abortion still legal in Idaho?—and the resulting fear of criminal prosecution has negatively affected her ability to practice her profession. (Tr. 180:15–181:3.) This testimony isn't just credible but predictable. Idaho's Abortion Laws use medically imprecise language in dramatically changing the legal landscape under which obstetrical physicians like Dr. Corrigan practice medicine, creating uncertainty and fear as unintended byproducts of the legislative goals they seek to achieve. That's an injury in fact caused by Idaho's Abortion Laws (the first two elements of the standing test described in Conclusion of Law 3). Indeed, in *Planned Parenthood*, the same injury gave a physician standing to challenge the constitutionality of the Fetal Heartbeat Law's civil-liability provisions. 171 Idaho at 401, 522 P.3d at 1159. It follows that a physician whose practice is affected by the criminal-liability provisions of Idaho's Abortion Laws has standing to seek certainty as to their meaning. Further, Dr. Corrigan's injury will be redressed by deciding Claim I on the merits (the third and last element of the standing test); a decision will give her greater certainty about the meaning of Idaho's Abortion Laws, helping her navigate practicing her profession under the restrictive regime they create. Dr. Corrigan has standing to pursue Claim I.

10. The premise of Claim III is that pregnant women have a constitutional right to obtain abortion care in circumstances in which Idaho's Abortion Laws prohibit providing it. Hence, in pursuing Claim III, Dr. Corrigan seeks to vindicate the constitutional rights of women in need of abortion care, implicating the doctrine of third-party standing. Under that doctrine, a litigant has standing to assert the

rights of third parties if three elements are satisfied: "(1) the litigant suffered injury in fact, providing a significantly concrete interest in the outcome of the matter in dispute; (2) a sufficiently close relationship to the party whose rights are being asserted; and (3) a bar to the third parties' ability to protect their interests." *Id.* at 402, 522 P.3d at 1160.

11. *Planned Parenthood* is instructive here as well. There, the Idaho Supreme Court held that a physician had standing to assert the constitutional rights of Idaho women in challenging Idaho's Abortion Laws. *Id.* Dr. Corrigan's case for third-party standing isn't materially different.

12. In *Planned Parenthood*, the first element of the test for third-party standing—the litigant suffered an injury fact—was satisfied "[b]ased on the severe consequences of performing abortions after the enactment of these laws, the potential financial liabilities, and the governmental control on an allegedly constitutionally protected activity." *Id.* Likewise, Idaho's Abortion Laws cause an injury in fact to Dr. Corrigan by preventing her from providing abortion care in situations in which she otherwise would provide it to pregnant women she contends have a constitutional right to it. (Tr. 177:7–9, 181:4–8, 183:9–19.)

13. The second element of the test—a sufficiently close relationship between the plaintiff and the third party whose rights are being asserted—was satisfied in *Planned Parenthood* because "the doctor-patient relationship has long been held to be a sufficiently close relationship to meet the requirements for third-party standing in the abortion context," and "[t]he *Dobbs* decision did not . . .

abrogate the basic third-party standing principle that aside from the woman herself the physician is uniquely qualified to litigate the constitutionality of the State's interference with, or discrimination against, th[e] decision to get an abortion." 171 Idaho at 402, 522 P.3d at 1160 (internal quotation marks, brackets, and ellipsis points omitted). So too it is satisfied here.

14. Finally, the test's third element was satisfied in *Planned Parenthood* based on privacy and stigmatization concerns "in a post-*Dobbs* world." *Id.* Those same concerns are equally present here. Further, "the inherent time limitation in which a woman may obtain an abortion" is a serious impediment, even if not an absolute bar, to the woman's assertion of her constitutional rights. *Kootenai Med. Ctr. ex rel. Teresa K. v. Idaho Dep't of Health & Welfare*, 147 Idaho 872, 879, 216 P.3d 630, 637 (2009) (citing *Singleton v. Wulff*, 428 U.S. 106, 117 (1977)). For these reasons, the third element is satisfied here.

15. Dr. Corrigan has standing to pursue Claim III on behalf of Idaho women in need of abortion care.

Ripeness

16. Ripeness is another justiciability doctrine. *E.g.*, *Tucker v. State*, 162 Idaho 11, 18, 394 P.3d 54, 61 (2017). The State invokes it, saying Claims I and III are unripe because Plaintiffs don't include (or even identify) a pregnant woman now in need of an abortion that might or would be prohibited by Idaho's Abortion Laws. (Def. State of Idaho's Proposed Findings Fact & Conclusions Law ¶¶ 103–16.) For the reasons explained below, the Court disagrees.

17. The ripeness doctrine keeps courts from "entangling themselves in purely abstract disagreements," *Tucker*, 162 Idaho at 27, 394 P.3d at 70, or, in other words, "deciding cases which are purely hypothetical or advisory," *ABC Agra, LLC v. Critical Access Grp., Inc.*, 156 Idaho 781, 783, 331 P.3d 523, 525 (2014) (quoting *Bettwieser v. N.Y. Irrigation Dist.*, 154 Idaho 317, 326, 297 P.3d 1134, 1143 (2013)). To that end, it "asks whether a case is brought too early." *Tucker*, 162 Idaho at 27, 394 P.3d at 70. An asserted injury "too contingent or remote" doesn't "support present adjudication." *State v. Philip Morris, Inc.*, 158 Idaho 874, 883 n.6, 354 P.3d 187, 196 n.6 (2015) (quoting 13B Charles A. Wright et al., *Federal Practice & Procedure* § 3532.1 (3d ed. 2014)).

18. A three-pronged test is used to assess ripeness: "[A] claim is ripe when '(1) the case presents definite and concrete issues; (2) a real and substantial controversy exists (as opposed to hypothetical facts); and (3) there is a present need for adjudication.'" *PHH Mortg. v. Nickerson*, 164 Idaho 33, 40, 423 P.3d 454, 461 (2018) (quoting *State v. Manley*, 142 Idaho 338, 342, 127 P.3d 954, 958 (2005)). The test applies to cases seeking a declaratory judgment no differently than others. *E.g.*, *Paddison Scenic Props., Family Tr., L.C. v. Idaho Cnty.*, 153 Idaho 1, 4, 278 P.3d 403, 406 (2012) ("Idaho courts will only issue declaratory judgments in actions that are ripe for adjudication.").

19. Under this test, Claim I is ripe. Dr. Corrigan treats obstetrical patients, some of whom, her experience shows, need abortion care. To do her work the best she can, she needs the best information she can get concerning the medical

circumstances in which Idaho's Abortion Laws allow abortion. The declaratory judgment Plaintiffs seek is that Idaho's Abortion Laws, despite their restrictive language, allow physicians to perform abortion when they determine in good faith that, for reasons other than hedging a risk of self-harm, it is within the medical standard of care to treat a high-risk or complicated pregnancy. (Pls.' Proposed Findings Fact & Conclusions Law ¶¶ 202, 206.) The State disagrees. (*See* Def. State of Idaho's Proposed Findings Fact & Conclusions Law ¶¶ 124–58.) Whether Plaintiffs' interpretation is right is a definite and concrete issue for the Court to decide, not some abstract dispute. Deciding it doesn't require applying the law to hypothetical facts. And, as just noted, Dr. Corrigan needs to know the answer.

20. Claim III is ripe too. Through Claim III, Plaintiffs seek a declaratory judgment that pregnant women have a constitutional right of access to abortion care when a physician determines that abortion is within the medical standard of care to treat their high-risk or complicated pregnancies. (Pls.' Proposed Findings Fact & Conclusions Law ¶ 137.) In particular, they say this constitutional right applies when an abortion would alleviate (i) "a pre-existing or underlying physical or mental health condition that cannot effectively be treated during pregnancy, is exacerbated by pregnancy, requires recurrent invasive intervention, or otherwise makes continuing the pregnancy unsafe for the pregnant patient"; (ii) "a physical or mental health condition caused by pregnancy or a complication of pregnancy that poses a risk of infection, bleeding, or organ damage, or otherwise makes continuing the pregnancy unsafe for the pregnant patient"; or (iii) "a lethal fetal diagnosis,

regardless of whether the fetal diagnosis increases the pregnant patient's health risks of continuing the pregnancy and giving birth." (*Id.*) The State denies the existence of any such constitutional right. (*See* Def. State of Idaho's Proposed Findings Fact & Conclusions Law ¶¶ 159–232.) Whether this constitutional right exists is a definite and concrete issue for the Court to decide, not some abstract dispute. Deciding it doesn't require applying the law to hypothetical facts. And, again, Dr. Corrigan needs to know the answer.

Sovereign Immunity

21. The State contends that Claim I should be dismissed based on the doctrine of sovereign immunity,[2] (Def. State of Idaho's Proposed Findings Fact & Conclusions Law ¶¶ 117–23), which generally bars suits against the State to which it hasn't consented (statutorily or otherwise), *e.g.*, *Von Lossberg v. State*, 170 Idaho 15, 20, 506 P.3d 251, 256 (2022). In two ways, however, the State consented to be sued on Claim I, waiving any sovereign-immunity defense it otherwise had.

22. First, in a motion filed on October 31, 2023, near the outset of this litigation, the State sought the dismissal of the other defendants (Governor Little, Attorney General Labrador, and the Idaho State Board of Medicine)—but not its dismissal—on standing grounds, saying that "while the State of Idaho is a proper defendant in this action, the same cannot be said for the other defendants." (Mem.

[2] The doctrine of sovereign immunity doesn't provide a defense to constitutional claims, *see Tucker*, 162 Idaho at 18, 394 P.3d at 61, so the State doesn't invoke it as a defense to Claim III.

Supp. Defs.' Mot. Dismiss 19–20.) The State's representation that it is a proper defendant to this action is a clear expression of its consent to be sued on Claim I.

23. Second, the State failed to pursue a sovereign-immunity defense not only in making the just-mentioned motion to dismiss but also in moving for summary judgment the better part of a year later, on August 19, 2024. Indeed, the only time the State mentioned sovereign immunity before raising it as a defense in the trial brief it filed on November 6, 2024, (Def. State of Idaho's Trial Br. 18–19), just six days before the trial began, was in the answer it filed ten months earlier, on January 12, 2024, (Def. State of Idaho's Answer 55). The State may not begin defending itself on sovereign-immunity grounds at trial, after other lines of defense fail to end the litigation short of trial.

24. That approach to litigation is a waiver of a state's Eleventh Amendment immunity from suit in the federal courts. *See, e.g.*, *Hill v. Blind Indus. & Servs. of Maryland*, 179 F.3d 754, 756 (9th Cir. 1999) (holding that a state agency waived its Eleventh Amendment immunity "by participating in extensive pre-trial activities and waiting until the first day of trial before objecting to the federal court's jurisdiction on Eleventh Amendment grounds"). The result should be no different in state court. Indeed, "the Eleventh Amendment confirm[s], rather than establish[es], sovereign immunity as a constitutional principle." *Alden v. Maine*, 527 U.S. 706, 728 (1999) (noting that "the scope of the States' immunity from suit is demarcated not by the text of the [Eleventh] Amendment alone but by fundamental postulates implicit in the constitutional design."). The principle doesn't extend so

far as to permit treating sovereign immunity as a defense of last resort. It is, after all, an immunity "from suit," *e.g.*, *id.*; *Bliss v. Minidoka Irrigation Dist.*, 167 Idaho 141, 152, 468 P.3d 271, 282 (2020), not from an adverse judgment. A state waives its right to immunity "from suit" by participating extensively in a suit before invoking sovereign immunity as an escape hatch, as the State did here.

Claim I, for a declaratory judgment

25. Claim I, again, isn't a constitutional challenge to Idaho's Abortion Laws but, instead, a claim under Idaho's Uniform Declaratory Judgment Act ("IDJA"), I.C. §§ 10-1201 to -1217, for a declaratory judgment concerning the medical circumstances in which Idaho's Abortion Laws allow abortion. It seeks essentially the same relief as Claim III. (*Compare* Pls.' Proposed Findings Fact & Conclusions Law ¶ 137, *with id.* ¶¶ 202, 206.) A victory for Plaintiffs on Claim I would, then, at least partly obviate the need to consider Claim III, a constitutional challenge to Idaho's Abortion Laws. Consequently, the doctrine of constitutional avoidance requires the Court to decide Claim I first. *See, e.g.*, *Miller v. Idaho State Patrol*, 150 Idaho 856, 864, 252 P.3d 1274, 1282 (2011). Another reason to decide Claim I first is that, as a practical matter, the Court can't determine whether, as Plaintiffs say, Idaho's Abortion Laws unconstitutionally restrict abortion without first ascertaining the medical circumstances in which they allow abortion.

26. Because Claim I must be decided before Claim III, Idaho's Abortion Laws effectively must be presumed constitutional in deciding Claim I. That presumption makes both laws enforceable, so the General Abortion Ban has

primacy over the Fetal Heartbeat Law. (*See* Conclusion of Law 4.) The outcome of Claim I is, as a result, determined by the General Abortion Ban alone.[3]

27. IDJA empowers courts to "declare rights, status, and other legal relations, whether or not further relief is or could be claimed." I.C. § 10-1201. Given its remedial purpose—"to settle and to afford relief from uncertainty and insecurity with respect to rights, status and other legal relations"—it "is to be liberally construed and administered." I.C. § 10-1212; *see also Lingnaw v. Lumpkin*, 167 Idaho 600, 605, 474 P.3d 274, 279 (2020).

28. Still, "a declaratory judgment can only be rendered in a case where an actual or justiciable controversy exists." *Harris v. Cassia County,* 106 Idaho 513, 516, 681 P.2d 988, 991 (1984). "This concept precludes courts from deciding cases which are purely hypothetical or advisory." *State v. Rhoades,* 119 Idaho 594, 597, 809 P.2d 455, 458 (1991). To that end, an IDJA plaintiff who seeks to settle an uncertainty concerning the meaning of a statute must be "[a] person . . . whose rights, status or other legal relations are affected by [the] statute." I.C. § 10-1202. Such a person "may have determined any question of construction or validity arising under the . . . statute . . . and obtain a declaration of rights, status or other legal relations thereunder." *Id.*

[3] If, in deciding Claim III, the Court concludes that one or both of Idaho's Abortion Laws are unconstitutional in some respect, the Court will revisit whether the General Abortion Ban retains its primacy over the Fetal Heartbeat Law.

29. Claim I is a proper IDJA claim brought by at least one proper IDJA plaintiff, not an impermissible request for an advisory opinion on how Idaho's Abortion Laws apply to hypothetical situations. It seeks to settle uncertainty about the medical circumstances in which abortion is legal. Among Plaintiffs, at least Dr. Corrigan is a person whose rights, status, or other legal relations are affected by Idaho's Abortion Laws; she performs abortions, giving her an interest in alleviating the confusion she experiences (and other physicians experience) in trying to discern the medical circumstances in which abortion is legal. (Tr. 241:2–6, 246:18–22 (Corrigan), 610:10–611:2 (Raja), 701:12–703:5 (Harmon).)

30. The aim of interpreting statutes—to "determine and give effect to the legislative intent"—is advanced by giving the statutory language its "plain, usual, and ordinary meaning." *Kaseburg v. State Bd. of Land Comm'rs*, 154 Idaho 570, 577, 300 P.3d 1058, 1065 (2013) (first quoting *Idaho Cardiology Assocs., P.A. v. Idaho Physicians Network, Inc.*, 141 Idaho 223, 227, 108 P.3d 370, 374 (2005); and then quoting *Two Jinn, Inc. v. Idaho Dep't of Ins.*, 154 Idaho 1, 3, 293 P.3d 150, 152 (2013)). Statutes must be considered "as a whole," *e.g.*, *State v. Casper*, 169 Idaho 793, 797, 503 P.3d 1009, 1013 (2022), not as assemblages of "isolated provisions," *e.g.*, *State v. Burke*, 166 Idaho 621, 623, 462 P.3d 599, 601 (2020). If a statute is unambiguous, statutory interpretation "begins and ends with [its] plain language." *IDHW v. John Doe (2022-32)*, 171 Idaho 677, 680–81, 525 P.3d 715, 718–19 (2023). In that case, the court "follows the law as written." *Id.* (quoting *Breckenridge Prop. Fund 2016, LLC v. Wally Enters., Inc.*, 170 Idaho 649, 657, 516 P.3d 73, 81 (2022)).

If, however, a statute is ambiguous, the court considers the "language used, the reasonableness of proposed interpretations, and the policy behind the statute" to determine legislative intent. *Kaseburg*, 154 Idaho at 577, 300 P.3d at 1065 (quoting *Ward v. Portneuf Med. Ctr., Inc.*, 150 Idaho 501, 504, 248 P.3d 1236, 1239 (2011)). A statute is ambiguous if its "meaning is so doubtful or obscure that reasonable minds might be uncertain or disagree as to its meaning." *Hamberlin v. Bradford*, 165 Idaho 947, 951, 454 P.3d 589, 593 (2019).

31. Again, the General Abortion Ban allows abortions performed by a physician who "determined, in his good faith medical judgment and based on the facts known to [him] at the time, that the abortion was necessary to prevent the death of the pregnant woman," so long as it wasn't performed to avert a risk of self-harm by the pregnant woman and the manner of performing it "provided the best opportunity for the unborn child to survive, unless . . . termination of the pregnancy in that manner would have posed a greater risk of the death of the pregnant woman." I.C. § 18-622(2)(a)(i)–(ii). Plaintiffs propose interpreting this "prevent the death" exception to allow physicians to perform abortion when they determine in good faith that, for reasons other than averting a risk of self-harm, it is within the medical standard of care for a high-risk or complicated pregnancy.[4] (Pls.' Proposed

[4] Plaintiffs may want a declaratory judgment that specifies at least some of the medical circumstances in which the standard of care calls for abortion care. (*See* Pls.' Proposed Findings Fact & Conclusions Law ¶¶ 24–27, 202, 203.) Such a granular approach to formulating a declaratory judgment, however, is neither necessary nor appropriate. Among other concerns with a granular approach is that the standard of care isn't static; it changes as medical science develops.

Findings Fact & Conclusions Law ¶¶ 202, 206.) Plaintiffs' proposed interpretation isn't, however, a reasonable interpretation of the statutory language. The standard the legislature chose for determining an abortion's lawfulness unambiguously isn't whether the medical standard of care calls for performing it. Further, the legislature's "prevent the death" phrasing evinces no concern for maternal-health complications not dire enough to pose a death risk, yet Plaintiffs' proposed interpretation seemingly would allow physicians to perform abortion in response to maternal-health complications not so dire, contrary to the legislature's intent.

32. Plaintiffs call the "prevent the death" exception "ambiguous." (Pls.' Proposed Findings Fact & Conclusions Law 1.) They are right, as the Court determined in Finding of Fact 22, that the medical community finds it confusing (and understandably so). Nevertheless, the Court isn't convinced that the "prevent the death" exception is, as a legal matter, ambiguous. It is ostensibly ambiguous because it doesn't specify (i) how certain a physician must be that a pregnant woman will die without an abortion, or (ii) how imminent her death must be. But it allows physicians to make a subjective determination, according to their "good faith medical judgment," concerning whether an abortion is necessary to prevent a pregnant woman's death, without imposing certainty or imminence requirements. I.C. § 18-622(2)(a)(i). By committing that determination to the good faith medical judgment of the performing physician, the "prevent the death" exception resolves the ostensible ambiguity. This conclusion is explained more fully below.

33. In interpreting the "prevent the death" exception, the Court doesn't write on a blank slate because the Idaho Supreme Court interpreted it in *Planned Parenthood*, *see* 171 Idaho at 445–46, 522 P.3d at 1203–04, though less extensively than this case calls on this Court to interpret it. This Court's interpretation must be consistent with *Planned Parenthood*.

34. *Planned Parenthood*'s existence, though, doesn't obviate the need for the requested declaratory judgment. *Planned Parenthood* is a precedential opinion concerning the "prevent the death" exception's meaning. It isn't, however, equivalent to a declaratory judgment—particularly not one that further clarifies the exception at the margins.

35. *Planned Parenthood* holds that the "prevent the death" exception's "good faith medical judgment" language "clearly" establishes "a subjective standard"—one that "leaves wide room for the physician's good faith medical judgment" rather than imposes a standard of "objective certainty"—concerning whether an abortion is necessary to prevent a pregnant woman's death. *Id.* at 445, 522 P.3d at 1203 (emphasis and internal quotation marks omitted). In other words, the "good faith medical judgment" language allows room "for the 'clinical judgment that physicians are routinely called upon to make for proper treatment of their patients'"—"room that operates for the benefit, not the disadvantage, of the pregnant woman." *Id.* at 445–46, 522 P.3d at 1203–04 (quoting *Spears v. State*, 278 So. 2d 443, 445 (Miss. 1973)). In setting a subjective standard rather than an objective one, the "prevent the death" exception is unambiguous—even if it is

ambiguous, as Plaintiffs suggest, because it doesn't specify how certain a physician must be that a pregnant woman will die without an abortion or how imminent her death must be.

36. The Idaho Supreme Court addressed the ostensible ambiguity in *Planned Parenthood*, holding that the "prevent the death" exception requires neither "a particular level of immediacy" of the death to be prevented by an abortion nor a "certain percent chance" that, without an abortion, the death will occur. *Id.* It also held that imminence or certainty requirements would be at odds with the "subjective nature" of the legal standard for determining an abortion's lawfulness because they would "add an objective component." *Id.* at 446, 522 P.3d at 1204. The Idaho Supreme Court seems, then, to have considered the "prevent the death" exception clear—in other words, unambiguous—in not requiring that the death to be prevented by an abortion must be either imminent or assured.

37. Even if the "prevent the death" exception were ambiguous on this point, the ambiguity must be resolved by construing the exception broadly, such that the death to be prevented by an abortion need be neither imminent nor assured. A broad construction is appropriate for three reasons.

38. First, the just-described holdings of the Idaho Supreme Court—that the exception requires neither "a particular level of immediacy" nor a "certain percent chance" of the death to be prevented by an abortion—suggest a broad construction rather than a narrow one.

39. Second, a narrow construction wouldn't serve the legislative policy of Idaho's Abortion Laws, which are rooted in respect for human life. The legislature sought to protect fetal life because, in its view, "[t]he life of each human being begins at fertilization." I.C. § 18-8802(1). A narrow construction, though, would risk the extant, fully formed human lives of pregnant women. The legislature presumably didn't intend to gamble with the lives of pregnant women by conditioning access to abortion care on a high likelihood a pregnant woman will die without it or on her arrival at death's door before it can be provided. Indeed, even a modest likelihood that a pregnant woman will die without abortion care is a huge risk to take with her life, which the legislature surely didn't intend to deem less worthy of protection than the fetal life growing in her uterus. So, any ambiguity in the "prevent the death" exception's statutory language should be resolved in favor of a broad construction, which would better promote the statutory policy of respect for human life. *See Kaseburg*, 154 Idaho at 577, 300 P.3d at 1065 (favoring an interpretation of an ambiguous statute that furthers the statutory policy).

40. Third, if the ostensible ambiguity can't be resolved, as the Court suggests, "by looking at the text, context, history or policy of the statute," the rule of lenity would kick in, compelling a construction of a "grievously ambiguous" criminal statute that favors the accused rather than the government. *State v. Pizzuto*, 171 Idaho 100, 112–13, 518 P.3d 796, 808–09 (2022) (brackets omitted) (quoting *State v. Bradshaw*, 155 Idaho 437, 440, 313 P.3d 765, 768 (Ct. App. 2013)). A broad construction of the exception favors an accused physician.

41. Consistent with all these conclusions, the Court interprets the "prevent the death" exception—whether it is unambiguous (as the Court concludes) or ambiguous (as Plaintiffs suggest)—as follows: (i) whether an abortion is necessary to prevent the patient's death is determined subjectively, according to the performing physician's good faith medical judgment based on the facts known to the physician at the time of the abortion; and (ii) because the "prevent the death" exception doesn't require a "certain percent chance" that the patient will die without an abortion or "a particular level of immediacy" of the patient's death, and because the underlying legislative policy is better furthered by a broad (rather than narrow) construction of the exception, the exception is satisfied by the presence of a non-negligible risk, in the good faith medical judgment of the performing physician, that—because of an existing medical condition or pregnancy complication that would be alleviated by an abortion—the patient will die sooner if an abortion isn't performed than she will die if an abortion is performed.[5]

42. In sum, on Claim I, Plaintiffs are entitled to a declaratory judgment that Idaho's Abortion Laws don't make it a crime to perform an "abortion" as

[5] Since *Planned Parenthood*'s issuance on January 5, 2023, three annual legislative sessions have come and gone. During the 2023 legislative session, the legislature amended the General Abortion Ban in apparent reaction to some aspects of *Planned Parenthood*. *See* 2023 Idaho Sess. Laws ch. 298. The legislature is presumed to know about *Planned Parenthood*'s interpretation of the "prevent the death" exception, including that the patient's death need be neither imminent nor assured for the exception to apply. Had the legislature intended the exception to apply only if the patient assuredly will die imminently without an abortion, presumably it would've amended the General Abortion Ban accordingly.

defined in I.C. § 18-604(1)[6] 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 risk increasing the risk of her death, best facilitates the unborn child's survival outside the uterus, if feasible.

Claim III, for violation of article I, § 1

43. Again, Claim III seeks a declaratory judgment that article I, § 1 of the Idaho Constitution grants pregnant women a constitutional right of access to abortion care if a physician determines that abortion is within the medical standard of care to treat their high-risk or complicated pregnancies. (Pls.' Proposed Findings Fact & Conclusions Law ¶ 137.) In particular, Plaintiffs say this constitutional right applies when an abortion would alleviate (i) "a pre-existing or underlying physical or mental health condition that cannot effectively be treated during pregnancy, is exacerbated by pregnancy, requires recurrent invasive intervention, or otherwise makes continuing the pregnancy unsafe for the pregnant patient"; (ii) "a physical or mental health condition caused by pregnancy or a complication of

[6] According to *Planned Parenthood*, "non-viable pregnancies (i.e., where the unborn child is no longer developing) are plainly not within the definition of 'abortion.'" 171 Idaho at 445, 522 P.3d at 1203.

pregnancy that poses a risk of infection, bleeding, or organ damage, or otherwise makes continuing the pregnancy unsafe for the pregnant patient"; or (iii) "a lethal fetal diagnosis, regardless of whether the fetal diagnosis increases the pregnant patient's health risks of continuing the pregnancy and giving birth." (*Id.*) They also say it applies when an abortion is necessary to preserve the ability to procreate. (*Id.* ¶¶ 152–53.)

44. The declaratory relief awarded to Plaintiffs on Claim I (*see* Conclusion of Law 42) is narrower than that sought through Claim III, so Claim III must be decided on the merits, despite the doctrine of constitutional avoidance mentioned in Conclusion of Law 25. Claim III is rendered partly moot, though, by the declaratory relief granted on Claim I; Plaintiffs don't need—and the Court won't entertain granting—a declaration that it would be unconstitutional to prohibit abortion in circumstances in which abortion isn't prohibited in the first place.

45. A party challenging a statute's constitutionality "must overcome a strong presumption of validity" to carry the burden of proving it unconstitutional. *Olsen v. J.A. Freeman Co.*, 117 Idaho 706, 709, 791 P.2d 1285, 1288 (1990).

46. The "fundamental object in construing constitutional provisions is to ascertain the intent of the drafters by reading the words as written, employing their natural and ordinary meaning, and construing them to fulfill the intent of the drafters." *Sweeney v. Otter*, 119 Idaho 135, 139, 804 P.2d 308, 312 (1990). "In interpreting the Idaho Constitution, the rules of statutory construction apply." *Reclaim Idaho v. Denney*, 169 Idaho 406, 427, 497 P.3d 160, 181 (2021).

47. As Plaintiffs say, article I, § 1 of the Idaho Constitution grants the citizenry "certain inalienable rights," including "enjoying and defending life" and "pursuing happiness and securing safety." Idaho Const. art. I, § 1. The Idaho Supreme Court has held that article I, § 1 doesn't make abortion a fundamental right. *Planned Parenthood*, 171 Idaho at 418–37, 522 P.3d at 1176–95. This Court is bound by that holding.

48. Realizing as much, Plaintiffs don't contend article I, § 1 makes abortion a fundamental right per se. They contend, instead, that the rights explicitly recognized by article I, § 1—which are fundamental rights because all individual rights explicitly recognized by the Idaho Constitution are fundamental rights—encompass the right to seek medical care for health- and life-threatening conditions, including abortion care when medically indicated. This is, in substance, a contention that implicit in the rights explicitly recognized by article I, § 1 is a right—also a fundamental one; individual rights implicitly recognized by the Idaho Constitution are fundamental rights too—to seek medical care for health- and life-threatening conditions, including abortion care when medically indicated.

49. According to *Planned Parenthood*, "for [a court] to read a fundamental right into the Idaho Constitution, [the court] must examine whether the alleged right is so 'deeply rooted' in the traditions and history of Idaho at the time of statehood that [the court] can fairly conclude that the framers and adopters of the Inalienable Rights Clause [article I, § 1] intended to implicitly protect that right." 171 Idaho at 390, 522 P.3d at 1148. Presumably believing they can rest their case

on rights explicitly recognized by article 1, § 1—without showing that part and parcel of those explicit rights is a deeply rooted right to seek medical care for health- and life-threatening conditions, including abortion care when medically indicated—Plaintiffs don't apply this legal test in their 167-page post-trial submission. The phrase "deeply rooted," for example, appears nowhere in that submission. The Court should not try to construct for Plaintiffs an argument by which the applicable legal test, which they fail to apply, is satisfied. Claim III fails for this reason. Indeed, because Plaintiffs haven't proved a deeply rooted right to seek medical care for health- and life-threatening conditions, including abortion care when medically indicated, the Court has no occasion to review the propriety of Idaho's Abortion Laws' infringement of that unproven right according to a "strict scrutiny" or "rational basis" test.

50. Claim III also fails because, even assuming the existence of an implicit constitutional right to seek medical care for health- and life-threatening conditions, the Court can't conclude, for reasons explained below, that this implicit right is broad enough to encompass a right to abortion care to alleviate medical conditions that aren't life-threatening (including, inter alia, any conditions that put a pregnant woman's future fertility at risk without threatening her life).

51. *Planned Parenthood* makes clear that article I, § 1 must be understood in light of the abortion restrictions in force when the Idaho Constitution was adopted because it "was framed, in part, by those same individuals" involved in enacting the abortion restrictions. 171 Idaho at 421, 522 P.3d at 1179 (emphasis

omitted). When the Idaho Constitution was adopted, performing or obtaining an abortion was, under Idaho law, a crime punishable by prison time unless the abortion was "necessary to preserve [the pregnant woman's] life." *Id.* at 392, 522 P.3d at 1150 (emphasis omitted) (quoting Idaho Rev. Stat. §§ 6794, 6795 (1887)). Plaintiffs say this restriction, despite its plain language, was always understood to allow any "therapeutic" abortion, meaning an abortion that protects a pregnant woman's health whether or not considered necessary to preserve her life. The Court isn't convinced that this proposition is true or, in any event, reconcilable with *Planned Parenthood*, which rejected a dissenting justice's view that article I, § 1 recognizes "an implicit fundamental right to abortion to prevent the death of the mother and to protect her health from injury, harm, or destruction," observing that "an exception to the criminalization of abortion does not necessarily mean that the framers of our Constitution intended to enshrine the excepted conduct as a fundamental right." 171 Idaho at 435–36, 522 P.3d at 1193–94.

52. According to *Planned Parenthood*, courts must "interpret the Idaho Constitution based on its meaning at the time it was adopted by those who framed and adopted it," so they "cannot ignore the historic laws criminalizing abortion in Idaho . . . at the time the Inalienable Rights Clause [article I, §1] was framed and adopted." *Id.* at 428, 522 P.3d at 1186. Hence, *Planned Parenthood* compels the conclusion that even if article I, § 1 implicitly recognizes a right to seek medical care for health- and life-threatening conditions, that right is circumscribed to exclude the

right of pregnant women to seek abortion care to alleviate medical conditions that aren't life-threatening.

53. What's left of Claim III is Plaintiffs' assertion that Idaho's Abortion Laws violate article I, § 1 by prohibiting physicians from deeming an abortion "necessary to prevent the death of the pregnant woman," thus authorizing the abortion under the General Abortion Ban, when the reason for deeming the abortion necessary is "the physician believes that the woman may or will take action to harm herself" without an abortion. I.C. § 18-622(2)(a). Accepting this assertion would require the Court to reach two conclusions. First, the Court would have to conclude that article I, § 1 implicitly recognizes a general right to seek life-saving abortion care, despite *Planned Parenthood*'s caution that the existence of the territorial-era "exception to the criminalization of abortion [for abortions necessary to preserve the pregnant woman's life] does not necessarily mean that the framers of our Constitution intended to enshrine the excepted conduct as a fundamental right." 171 Idaho at 435–36, 522 P.3d at 1193–94. Second, the Court would have to conclude that the implicit general right to seek life-saving abortion care applies even when the risk of a pregnant woman's death is strictly a suicide risk, despite the absence of evidence that the territorial-era exception was understood to apply in that situation and despite that its language hardly suggests it applies in that situation. Perhaps the first conclusion could be justified despite the cautionary language in *Planned Parenthood*. Regardless, on this record, the second conclusion isn't justified.

54. For these reasons, Claim III fails.

Accordingly,

IT IS ORDERED that, on Claim I, Plaintiffs are entitled to a declaratory judgment that Idaho's Abortion Laws do not make it a crime to perform an "abortion" as defined in I.C. § 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 risk increasing the risk of her death, best facilitates the unborn child's survival outside the uterus, if feasible.

IT IS FURTHER ORDERED that judgment will be entered in favor of the State on Claim III.

Jason D. Scott 4/11/2025 1:55:23 PM

Jason D. Scott
DISTRICT JUDGE

CERTIFICATE OF SERVICE

I certify that on 4/11/2025, I served a copy of this document as follows:

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By: Sabrina Stokes
Deputy Court Clerk

CLERK OF THE DISTRICT COURT FOURTH JUDICIAL DISTRICT ADA COUNTY, IDAHO

Appendix D

fluctuation of opinion, and contrary rather to my first impression, I have been led by the above reasoning to the conclusion that there is not in the section any sufficiently certain indication of intention to alter the previous law, and that the notice in this case which truly states the exact amount of rent and costs ascertained by the decree is right, though it omits to notice the intervening payment of a year's rent made by the tenant. The demurrer must be overruled, with costs.

Solicitor for the plaintiffs: *John Malone.*

Solicitors for the defendants: *Longfield, Kelly, & Armstrong.*

MABEL WALKER *v.* GREAT NORTHERN RAILWAY COMPANY OF IRELAND (1).

(1890—E. No. 201.)

Negligence by Railway Company—Personal injuries—Infant en ventre sa mere *—Right of action.*

In an action against a Railway Company for damages caused to the plaintiff by the negligence of the defendants, the statement of claim alleged that at the date of the injuries complained of the plaintiff's mother A. W. was quick with child, namely, with the plaintiff, to whom she afterwards gave birth; that the said A. W., being so quick with child, was received by the defendants as a passenger, to be safely and securely carried for reward to the defendants. Averment that the defendants so negligently and unskilfully conducted themselves in carrying the said A. W., and the plaintiff, being then *en ventre sa mere*, that the plaintiff was thereby wounded, permanently injured, and crippled:—

Held, on demurrer, that the statement of claim disclosed no cause of action.

ACTION for personal injuries. Demurrer to the plaintiff's statement of claim, which was as follows:—

1. At the time of the happening of the injuries hereinafter complained of the defendants were and still are a railway company,

(1) Before O'BRIEN, C.J., HARRISON, O'BRIEN, and JOHNSON, JJ.

Q. B. Div. 1890.

WALKER v. GT. NORTHN. RAILWAY CO.

having a railway from Armagh to Warrenpoint, in the county of Down, used by them for the carrying of passengers for hire from Armagh aforesaid to Warrenpoint aforesaid.

2. The mother of the plaintiff is Mrs. Annie Walker, of the city of Armagh, and on the date hereinafter mentioned was quick with child, namely, with the plaintiff, to whom she subsequently gave birth.

3. On the 12th day of June, 1889, the said Annie Walker, so quick with child as aforesaid, became and was received by the defendants as a passenger upon their said railway, to be by them carried on their said railway a journey from Armagh aforesaid to Warrenpoint aforesaid, for reward to the defendants, yet the defendants so negligently and unskilfully conducted themselves in carrying the said Annie Walker, and the plaintiff, then being *en ventre sa mere*, as aforesaid, and in managing the said railway and the carriage in which the said Annie Walker was a passenger upon the said railway on the journey aforesaid, that the plaintiff was thereby wounded and permanently injured and crippled and deformed. The plaintiff claimed £1000 damages.

R. E. Meredith (with him *The Right Hon. S. Walker*, *Q.C.*, and *James Orr*, *Q.C.*), for the defendants, in support of the demurrer :—

The infant plaintiff was not at the time of the alleged accident a person *in rerum naturâ*, therefore cannot sustain the present action. Where a person dies leaving his wife *enceinte*, the common law, not considering the infant *en ventre sa mere* to be in existence, casts the freehold on the person who is then heir: Cruise's Digest, vol. 3, Title 29, Descent, chap. 3, s. 11. See also *Richards* v. *Richards* (1); Russell on Crimes, p. 645.

Liability of railway companies for injuries to passengers is founded on a contract to carry, express or implied, or a duty to persons who are lawfully on the railway by the company's licence or invitation. In this case their contract was only with the plaintiff's mother to carry her safely. They never contracted to carry the present plaintiff, and they never received or invited her to be upon their railway for carriage, and therefore no liability arose.

(1) Johns. 754, at pp. 762, 763.

No analogy can be drawn from cases of unborn infants suing under Lord Campbell's Act for injuries to the parent, as in *The George and Richard* (1), because the law under that Act is governed by the principles which apply to cases of an infant's property or rights as the child of its parents.

No authority can be shown for this action, which is altogether unprecedented.

John Stanley and *Gerrard, Q.C.* (with them *O'Shaughnessy, Q.C.*), for the plaintiff:—

Life begins, in contemplation of law, as soon as an infant is able to stir in its mother's womb: Black. Com. vol. 1, p. 116; 3 Inst. p. 50. A child *en ventre sa mere* is a person *in rerum naturâ*, and by the rules of the common and civil law is to all intents and purposes a child: *Wallis* v. *Hodson* (2); *Burdet* v. *Hopegood* (3); *Blasson* v. *Blasson* (4). The Court will grant an injunction in his favour to stay waste: *Lutterel's Case*, cited in *Hale* v. *Hale* (5) and *Musgrave* v. *Parry* (6). If a child *en ventre sa mere* receives before birth from a person a mortal wound the act amounts to murder: *Rex* v. *Joseph Senior* (7); *The Queen* v. *West* (8). See also Russell on Crimes, vol. 1, p. 646; 3 Inst. p. 50. For the assertion of rights, or the protection of the property, of an infant *en ventre sa mere*, the law considers a child to have commenced its existence as soon as it is conceived in the womb: *Thelluson* v. *Woodford* (9); and see also Daniell Ch. Pr. p. 105; and such a child is now considered for all purposes as if actually born. The right of an infant *en ventre sa mere* to recover damages by virtue of the provisions of Lord Campbell's Act has been established: *The George and Richard* (1). A passenger's right to be safely carried does not depend upon his having made a contract but upon the fact that he is a passenger, and that that fact casts on the company a duty to carry safely. The plaintiff was in the train lawfully, without fraud, and with the company's consent, and whilst so upon the

(1) L. R. 3 Ad. & Eccl. 466.
(2) 2 Atk. 116.
(3) 1 P. W. 486.
(4) 2 De G. J. & S. 669.
(5) Finch's Prec. in Ch. 50.
(6) 2 Vern. 710.
(7) 1 Mood. C. C. 346.
(8) 2 Car. & Kir. 784.
(9) 4 Ves. 227.

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railway was injured by the admitted negligence of the defendants, and is entitled to compensation: *Dalyell* v. *Tyrer* (1); *Marshall* v. *York, Newcastle, and Berwick Railway Co.* (2); *Austin* v. *Great Western Railway Co.* (3); *Stockdale* v. *Lancashire and Yorkshire Railway Co.* (4); *Martin* v. *Great Indian Peninsular Railway Co.* (5); *Foulkes* v. *Metropolitan District Railway Co.* (6); Bevan on Negligence, p. 641.

The Right Hon. S. Walker, Q. C., in reply.

Cur. adv. vult.

1891. Jan. 26.

O'BRIEN, C.J.:—

This case comes before us on demurrer to the statement of claim, which states—[His Lordship read the statement of claim]. Now, this is the statement of claim, which has been challenged by demurrer as disclosing no cause of action.

Counsel for the company say no such action lies; that at the time the injuries were inflicted the child was not a person *in rerum naturâ*; that it had no personality; that it was simply part of the mother, and that therefore no action can be maintained. In support of their contention they principally rely upon an undoubted proposition of criminal law, that under no circumstances is it held, at the present day, to be murder to destroy a child whilst in the womb. They quote from Russell on Crimes, page 645, where it is stated, on the authority of Lord Hale, "that an infant in its mother's womb, *not being in rerum naturâ*, is not considered as a person who can be killed within the description of murder, and that therefore, if a woman being quick or great with child take any potion, or cause an abortion, or if another give her any such potion, or if a person strike her whereby the child within is killed, it is not murder or manslaughter." And they also rely upon what seems clearly established in the case of descent at common law, that a child *en ventre sa mere* is considered not in existence; and, referring to *Richards* v. *Richards* (7), they show "that the qualified

(1) 28 L. J. Q. B. 52.
(2) 11 C. B. 655.
(3) L. R. 2 Q. B. 442.
(4) 11 W. R. 650.
(5) L. R. 3 Ex. 9. [157.
(6) 4 C. P. Div. 267; 5 C. P. Div.
(7) Johns. 754.

heir was entitled to the rents and profits until the posthumous heir was born."

To this contention on behalf of the defendants, counsel for the plaintiff reply that, as to the child *en ventre sa mere* not taking by descent at common law, this is an exception to the general rule, and that it arose from the rigour of the common law with regard to real estates requiring a tenant to the *præcipe*, as pointed out by Sir Richard Arden, Master of the Rolls, in *Thelluson* v. *Woodford* (1); and they rely upon the language of Mr. Justice Buller in the same case, who, when replying to the allegation that a child *en ventre sa mere* was a nonentity, sarcastically observed (p. 321): "Let us see what this nonentity can do. He may be vouched in a recovery, though it is for the purpose of making him answer over in value. He may be even executor. He may take under the Statute of Distributions. He may take by devise. He may be entitled under a charge for raising portions. He may have an injunction, and he may have a guardian. Some other cases put this beyond all doubt. In *Wallis* v. *Hodson* (2) Lord Hardwicke says, 'The principal reason I go upon in the question is, that the plaintiff was *en ventre sa mere* at the time of her brother's death, and consequently a person *in rerum naturâ*, so that, by the rules of the common and civil law, she was to *all intents and purposes a child as much as if born in the father's lifetime.*' In the same case Lord Hardwicke takes notice that the civil law confines the rules to cases where it is for the benefit of the child to be considered as born; but notwithstanding, he states *the rule to be that such child is to be considered living to all intents and purposes.*" And the plaintiff's counsel also rely upon a passage lower down (at the close of page 322) in Mr. Justice Buller's judgment, where he states—"In *Doe* v. *Clarke* (3) the words 'that whenever such consideration would be for his benefit, a child *en ventre sa mere* shall be considered actually born' were used by me because I found them in the book from whence the passage was taken. Why should not children *en ventre sa mere* be considered *generally* as in existence? *They are entitled to all the privileges of other persons.*"

But counsel for the plaintiff join issue also as to the effect of

(1) 4 Ves. 335. (2) 2 Atk. 117. (3) 2 H. Bl. 399.

Q. B. Div. 1891.

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the criminal law, and relying upon Coke (3 Inst., p. 50), they show that if a criminal act is done to the child when in the womb, and the child is born alive, and dies from the effect of that act, it is murder or manslaughter, according to the circumstances, and they rely especially upon the case of *Rex* v. *Senior* (1)—a case considered by all the English Judges, except two, and in which it was unanimously decided that a doctor who, through culpable ignorance and want of skill, inflicted a wound on a child in the act of being born, and before it was born, and of which it died after it was born, was properly found guilty of manslaughter. The rules of the civil law are also appealed to—"*Qui in utero est perinde ac si in rebus humanis esset custoditur, quoties de commodis ipsius partûs quæritur, quanquam alii, antequam nascatur, nequaquam prosit.*" And another expression of the same rule of the civil law is also referred to—"*Qui in utero sunt in toto pæne jure civili intelliguntur in rerum naturâ esse.*" And again—"*Nascituri fictione tamen juris pro jam natis habentur quoties de ipsorum commodo agitur*": see *Blasson* v. *Blasson* (2), where these rules are collected. And finally, counsel for the plaintiff refer to the decision of Sir Robert Phillimore in the case of *The George and Richard* (3), where that learned Judge held that a child *en ventre sa mere* was a child within the meaning of Lord Campbell's Act, so as to be capable, when born, of maintaining an action in respect of the pecuniary loss sustained by the death of its father, owing to the wrongful act of others done whilst it was in the womb.

Now these are substantially the authorities referred to on behalf of the plaintiff; and having regard to these authorities, I wish it to be clearly understood that in deciding this case I do not intend to go this length, viz. that if a person knowing that a woman is *enceinte* wilfully inflicts injuries on her with a view to injuring the child, and the child is born a cripple, or after its birth becomes a cripple, owing to the injuries so wilfully inflicted, an action does not lie at the suit of the child so crippled. I am far from saying that such action would lie under such circumstances at the suit of the child when born; but before I would hold an action under such circumstances did not lie, I would desire to hear further

(1) 1 Moody, C. C. 346. (2) 2 De G. J. & S. 670. (3) L. R. 3 Ad. & Eccl. 466.

discussion as to the limitations of the rule that a child *in utero* is considered as actually born when it is necessary for the benefit of such unborn child so to consider it.

I would like to have it further discussed whether that rule is limited to taking benefits by succession and bequest, or whether it would apply to a case where the child has been so wilfully injured in the womb that it is born a cripple, or becomes one after its birth, and is thereby permanently deprived of the ability to earn a livelihood. In the case I put it would be manifestly for the benefit of the child that it should be considered as born at the time the injuries were inflicted, and that an action could be maintained.

I would also wish to hear further discussion as to the generality of the language of Lord Hardwicke in the case in 2nd Atkins. No doubt that was a case of succession to personal property and as to whether a child *en ventre sa mere* could take under the Statute of Distributions, but the language of that great Judge is very general, as was observed by Mr. Justice Buller in *Thelluson* v. *Woodford* (1).

I would like further assistance from the bar as to what limitation is to be put upon the language of Mr. Justice Buller who said in *Thelluson* v. *Woodford* (1), "why should not children *en ventre sa mere* be considered as *generally* in existence; *they are entitled to all the privileges of other persons*"; and I would be the more anxious for assistance as to this passage in Mr. Justice Buller's judgment, having regard to the fact that in the same judgment he shows he considers his language in *Doe* v. *Clarke* (2) too restricted, and that he agrees with the very explicit statement of Chief Justice Eyre in the same case of *Doe* v. *Clarke* (2), who in giving judgment said:—"But independent of this intention I hold that an infant *en ventre sa mere* who by the course and order of nature is then living comes clearly within the description of children living at the time of his decease"—an opinion which seems to have been adopted by the Master of the Rolls in *Thelluson* v. *Woodford* (1), and is also referred to with apparent approval by the Lord Chief Baron M'Donald in expressing the unanimous opinion of the Judges in answer to the questions put to them in

(1) 4 Ves. 334. (2) 2 H. Bl. 399.

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Thelluson v. *Woodford* (1): see Cruise's Dig., vol. 6, p. 452. Lord Chief Baron M'Donald said—"Lord Chief Justice Eyre holds that, independent of intention, an infant *en ventre sa mere*, by the course and order of nature, is then living, and comes clearly within the description of children living at the parent's decease; and he professes not to accede to the distinction between the cases in which a provision has been made for children generally, and where the testator has been supposed to mark a personal affection for children who happened to be actually born at the time of his death."

I would, also, before going the length I have mentioned, wish to have further argument as to what was the principle of the decision in the case of *Rex* v. *Senior* (2).

There, beyond all question, the injury of which the child died after its birth was inflicted before it was born, and at a time when it would *not* have been manslaughter in the doctor if the child had not been subsequently born alive.

The indictment in *Senior's Case* (2) expressly charges manslaughter by wounding the child on the head. In discussing *Rex* v. *Senior* (2) I would expect something more than the allegation that that was a case under the criminal law. It is somewhat vaguely said the criminal law punishes wrongs for the benefit of the community at large—for the protection of the public. This is certainly so; but while the criminal law attaches penalties to the commission of certain acts, in order to deter persons from their commission and to protect the public, it is very circumspect and very tender as to its own action in interfering with human life or liberty, and is very precise in its definition of wrongs and requirements as regards proof against individuals before attaching criminal responsibility; and I was under the impression that injuries which result in manslaughter in the case of the death of an individual would afford a cause of action to that individual in case the injuries did not reach to the extreme result of death.

It is stated in the fourth volume of Blackstone's Commentaries, 15th edition, by Christian (the best edition of those Commentaries).

(1) 11 Ves. 140.

(2) 1 Moody, C. C. 346.

at page 6, that—"In all cases the crime includes an injury; every public offence is also a private wrong, and somewhat more; it affects the individual, and it also affects the public." And later on, at page 7, the same distinguished author observed —"Upon the whole, we may observe, in taking cognizance of all wrongs or unlawful acts, the law has a double view, viz. not only to redress the party injured, by either restoring him to his right, if possible, or by giving him an equivalent, . . . but also to secure to the public the benefit of society by preventing or punishing every breach and violation of those laws which the sovereign power has thought proper to establish for the government and tranquillity of the whole."

Referring to the commission of crimes amounting to felony, it is stated in the last (the 10th) edition of Stephen's Commentaries, that "there still exists the remedy for the private wrong: even in cases of felony it is only *suspended* during the prosecution of the crime." And the cases of *Stone* v. *Marsh* (1), *Wellock* v. *Constantine* (2), and *Wells* v. *Abrahams* (3), are referred to; but it is doubtful, having regard to *Wells* v. *Abrahams* (3), especially to the judgment of Lord Blackburn in that case, whether the civil remedy is even suspended. No doubt Lord Coke says in *The Earl of Bedford's Case* (4), "*filius in utero matris est pars viscerum matris*"; adding, nevertheless, "yet the law in many cases hath consideration of him in respect of the apparent expectation of his birth." But if the crime against the public includes a *tort* to the individual, and if the law, notwithstanding difficulties of proof, as was decided in *Rex* v. *Senior* (5), on the authority of Lord Coke—for 3 Inst. p. 50 was the only authority referred to—takes notice of an act done before birth, in order to attach criminal responsibility for a consequence ensuing after birth, why should it not take notice of an act done before birth, such as an assault, as was proved in *Senior's Case* (5) to attach civil responsibility for a consequence—say the state of being crippled—ensuing after birth?

In discussing the rule that a child *en ventre sa mere* is considered as born when it is for its benefit so to consider it, I would certainly

(1) 6 B. & C. 551.
(2) 2 H. & C. 146.
(3) L. R. 7 Q. B. 554.
(4) 7 Rep. 8*b*.
(5) 1 Moody, C. C. 346.

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bear in mind, in considering how far that rule was to be applied, the language of Sir Robert Phillimore in the case of *The George and Richard* (1). In giving judgment he said:—"It has been argued that the peculiar language of Lord Campbell's Act requires the actual existence of the claimant as *a condition precedent to a right of action*. I am not of this opinion." He determined that the proctor for the unborn child had a right to claim in the suit, though, as he said, until the child was born a reference on the subject could not be made.

Now, having regard to the manner in which this case has been argued, I have said so much to guard myself personally, and, so far as I am concerned, to keep the case I mentioned an open question, should it ever arise.

I decide the present case upon a single ground, namely, that there are no facts set out in the statement of claim which fix the defendants with liability for breach of duty as carriers of passengers. This is not a case of trespass. It is now settled law that railway companies do not warrant the absolute safety of passengers: all they undertake with regard to passengers is a duty to carry with due and reasonable care, and their liability is for negligence arising from a breach of that duty. See *Macawley* v. *Furness Railway Co.* (2); *Hall* v. *North Eastern Railway Co.* (3); also Macnamara on Carriers, pp. 485 and 492, where the cases are collected.

As is correctly stated in Saunders on Negligence, p. 1, there is no absolute or intrinsic negligence: it is always relative to some circumstances of time, place, or person. In the case of *Whelan* v. *Cork Steamship Co.* (4)—an action in which I was engaged when at the Bar—the Lord Chief Baron refers to what Mr. Justice Willes said in *Grill* v. *The Iron Screw Collier Co.* (5):—"Confusion," said that learned Judge, "has arisen from regarding negligence as a positive instead of a negative word. It is really the absence of such care as it was the duty of the defendants to use."

All the Judges who heard the case of *Whelan* v. *Cork Steam-*

(1) L. R. 3 Ad. & Eccl. 480.
(2) L. R. 8 Q. B. 57.
(3) L. R. 10 Q. B. 437.
(4) Ir. R. 8 C. L. 393.
(5) L. R. 1 C. P. 612.

ship Co. (1) agreed in this view of the law, though they differed in opinion as to the course pursued at the trial. The case was afterwards argued in the Common Pleas on demurrer, because the action was brought to trial whilst a demurrer was pending, and the demurrer was allowed on the ground that the facts stated did not disclose any duty for which an action could be maintained. It is, however, an elementary rule of law, that if the action is one that can be maintained only in respect of a breach of duty, and the particular duty cannot be inferred from the facts stated, objection may be taken by demurrer.

Now, applying that rule to the present case, let us see what the statement of claim alleges, or rather does not allege. It does not allege that the mother made any contract in reference to the child—the contract was with the mother in respect of herself alone. It does not allege that any consideration was received by the company in respect of the child. It does not allege that the company, through its servants or otherwise, knew anything about the child or the condition of the mother.

It is quite plain, for aught that appears in this statement of claim, that however the child in the womb may be regarded, whether as part of the mother or having a distinct personality—whether an entity or a non-entity—it was, so far as any actual relation the company had with it, a non-entity; and, therefore, in my opinion, the existence of the duty, for the breach of which the defendants would be liable as carriers of passengers, cannot be inferred. To infer the existence of such a duty from the mere possibility that the mother was with child when she was received as a passenger by the defendants would be to act without the sanction of any judicial decision or, in my opinion, of any legal principle. The demurrer must therefore be allowed.

HARRISON, J.:—

I concur in the judgment that this demurrer should be allowed, and I am of opinion that no cause of action is disclosed in the statement of claim. The defendants are therein stated to have so negligently and unskilfully conducted themselves in carrying the

(1) Ir. R. 8 C. L. 393.

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plaintiff's mother, and the plaintiff, then being *en ventre sa mere*, and in managing their railway, in which plaintiff's mother was a passenger on a certain journey, that plaintiff was permanently injured. The contract of carriage is, however, alleged to have been with the plaintiff's mother. No contract is alleged to have been made with or on behalf of the plaintiff, and no facts are averred that show any duty on the part of the defendants towards the plaintiff for breach of which an action could lie. When the accident occurred on the 12th June the plaintiff was still unborn, and had no existence apart from her mother, who was the only person whom the defendants contracted to carry on their line, and no cause of action as against the defendants could, in my opinion, then exist on the part of the plaintiff, or arise after the plaintiff was born, from the mere fact that her mother had been received by the defendants as a passenger, being at the time *enceinte* of the plaintiff, and that while she was a passenger an accident occurred through the defendants' negligence, which after the plaintiff's birth, it appeared, had injured her. If it were, however, assumed that such a cause of action could exist or arise after the plaintiff's birth, the plaintiff is not averred or shown to have been on the defendants' railway "with the defendants' authority" when the accident occurred. This was proved in the case of *Austin* v. *Great Western Railway Co.* (1), cited in the argument, where a child, a little over three years of age, and carried openly in its mother's arms into a train, but for whom she took no ticket, was held entitled to sue the railway company (as a passenger) for injuries sustained on the journey. "It was laid down," said Blackburn, J., in giving judgment (2), "in the case of *Marshall* v. *York, Newcastle, and Berwick Railway Co.* (3), that the right which a passenger has to be carried safely does not depend on his having made a contract, but that the fact of his being a passenger cast a duty on the company to carry him safely. If there had been fraud on the part of the plaintiff, or if the plaintiff had been taken into the train without the defendants' authority, no such duty would arise."

In the present case it is not even averred that the defendants

(1) L. R. 2 Q. B. 442. (2) At p. 445. (3) 11 C. B. 655.

knew of the pregnancy of the plaintiff's mother when they received her as a passenger; it is merely averred that in fact she was then quick with child, viz. with the plaintiff, to whom she subsequently gave birth.

The defendants are, in my opinion, entitled to judgment.

O'BRIEN, J.:—

A woman who is with child is in a railway accident, and the infant when born is found to be deformed. Can the infant maintain an action against the company for negligence? It is admitted that such a thing was never heard of before. And yet the circumstances which would give rise to such a claim must at one time or another have existed. But as there was a germ of life *in esse* at the time of the occurrence, so it is thought there are to be found, in the principles and propositions of the law, the germs of the legal creation which for the first time professional ingenuity has produced. The pity of it is as novel as the case—that an innocent infant comes into the world with the cruel seal upon it of another's fault, and has to bear a burthen of infirmity and ignominy throughout the whole passage of life. It is no wonder, therefore, that sympathy for helpless and undeserved misfortune has led to what is literally a kind of creative boldness in litigation. I would not myself see any injustice in the abstract in such an action being held to lie, or in the risks of a carrier being extended to the necessary incidents of nature. And possibly the consideration from the mother could be construed to include the child also, with but a slight further stretch in the analogy of the case of a servant and others that have been cited. But there are instances in the law where rules of right are founded upon the inherent and inevitable difficulty or impossibility of proof. And it is easy to see on what a boundless sea of speculation in evidence this new idea would launch us. What a field would be opened to extravagance of testimony, already great enough—if Science could carry her lamp, not over certain in its light where people have their eyes, into the unseen laboratory of nature—could profess to reveal the causes and things that are hidden there—could trace a hare-lip to nervous shock, or a bunch of grapes on the face to the fright—could, in fact, make *lusus naturæ* the same thing as *lusus scientiæ*.

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There may be a question of evidence, Mr. Gerrard modestly put it; but the law may see such danger in that evidence, may have such a suspicion of human ignorance and presumption, that it will not allow any question of evidence to be entered into at all. However, we have to see whether the right claimed exists in the English legal system, or flows out of any admitted principles in that system. The law is in some respects a stream that gathers accretions with time from new relations and conditions. But it is also a landmark that forbids advance on defined rights and engagements; and if these are to be altered, if new rights and engagements are to be created, that is the province of legislation and not of decision.

Now, let us see whether the law has decided the point at which this action can be maintained, or contains any principle out of which the right can be developed by any authority short of the Legislature. The criminal law has been referred to for the purpose of showing that an unborn infant is a person in law, because murder may be committed if the infant be afterwards born and die from the effect of violence. But the criminal law is conversant with wrongs and not with rights. It regards not the person but society. It results not in a benefit to the party injured, but in a satisfaction to the community. Crimes are invasions of natural rights and relations, among which life and personal safety are the highest. In the instance put the violence is a continuing act, which takes away the life after birth, and therefore the legal consequence of murder is unavoidable. It would come nearer to the exigency of the case for the plaintiff, as was put in the argument, if it could be shown that a prosecution for an assault or an action for an assault had ever been maintained in the case of an unborn infant. As to the cases cited in reference to property, even those put by Mr. Justice Buller, as to what this kind of entity, a child in the womb, could do—that he could take a gift by will—could be named executor—could be vouched in a recovery—could have waste restrained; these and others are all cases of relations cast upon the infant by law or by the act of others, and which relations must be fulfilled in some way. The rule of the civil law that made the infant a distinct person, when it was for his benefit, is supposed to include, in the extent of the principle, compensation for

negligence. That rule has been adopted with English law in reference to property, of which we have the latest and perhaps the most extreme instance in a case to which the Chief Justice has referred us—the case of *Blasson* v. *Blasson* (1)—where it was held that a gift to children born and living vested in those who were unborn, and were not living, except in the sense that they were not dead; while in the same case it was necessary to hold that the period of division—twenty-one years of age—though applied to all the children alike, must still exclude the unborn children who were included in the gift. The rule quoted from the Digest says:—"*Qui in utero sunt in toto pœne jure civili intelliguntur in rerum naturâ esse.*" Yet the examples given in the Digest, in which unborn children were severed from the mother by fiction, except as to inheritance, relate wholly to personal status, and to the right of return, captivity in war, and patronage—relations and institutions unknown except to the civil law. That law did not include personal compensation for negligence—railway shock was not as yet. But the question remains, What has the carrier to say to this invisible person of the civil law? Railway liability is a branch of the general law of carriers. The stage-coach was the predecessor of the railway. The contract of carriage is founded on consideration. To the company as to the stage-coach manager a person is someone who can pay the fare. The carrier saw the person he was going to carry. His duty was to that person. The carrier would be surprised to hear, while he was paid for one, that he was carrying two, or even three, for it might be a case of twins, as Mr. Walker suggested. He carries for hire. That is the fundamental account of his position and liability. The case put, of a child born and hurt during the journey, whether the liability could be enlarged to comprehend a case of that kind, in which there was no contract and no consideration, may involve much difficulty. There one element would be wanting—the consideration. Here the two are wanting—the right and the consideration. There is no person and no duty. In law, in reason, in the common language of mankind, in the dispensations of nature, in the bond of physical union, and the instinct of duty and solicitude, on which the

(1) 2 De G. J. & S. 665.

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continuance of the world depends, a woman is the common carrier of her unborn child, and not a railway company.

JOHNSON, J.:—

The only question for decision is whether the present action can be maintained in the present state of the law and the authorities. By receiving Mrs. Walker as a passenger on their railway it was the duty of the defendants to carry her safely with all reasonable care. Their negligence in the discharge of that duty entitled her to recover from them legal damages. Counsel, in answer to me during the argument, stated that she had brought her action and had been settled with. At the same time, and by the same act of negligence, the child with which she was *enceinte* was injured while unborn, was subsequently born injured, and is the plaintiff in this action. It is contended for the plaintiff that besides or independently of the defendants' duty to Mrs. Walker, arising out of their relation of carrier and passenger, another or further duty was cast by the law on the defendants to carry safely her unborn child, inasmuch as if the child had been then born (instead of being unborn), that would have been their duty flowing from their reception of the child as a passenger; and that in contemplation of law, although she was unborn, she had while unborn (if eventually born alive) the rights and privileges of a child born and *in esse* (except in respect of real estate by descent), and therefore the right to maintain this action. As 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. Her age and her existence are reckoned from her birth, and no precedent has been found for this action. Lord Coke says:—"Although *filius in utero matris est pars viscerum matris;* yet the law in many cases hath consideration of him in respect of the apparent expectation of his birth": *Earl of Bedford's Case* (1). This imputed existence *in esse* to an unborn child is a fiction of the civil law, which regards an unborn child as born for some (not for all) purposes connected with the acquisition and preservation of real or personal property; *quoties de commodis ipsius partûs quæritur* (Dig. lib. 1., Tit. 5., cited by Lord Westbury, C., in *Blasson* v.

(1) 7 Rep. 8*b*.

Blasson (1)); but as Wood, V.-C. (dealing with the interest and possession of the heir-apparent, divested by the birth of a posthumous heir) points out in *Richards* v. *Richards* (2), "this clearly cannot be so for all purposes, otherwise no question as to intermediate rents (that is the rents while the posthumous heir was unborn) could ever have arisen." Lord Hardwicke, in *Burnet* v. *Mann* (3), says "the general rule is that they (unborn children) are considered *in esse* for their benefit, not for their prejudice"; and according to *Blasson* v. *Blasson* (1) they are not regarded as born unless it is necessary for the benefit of the unborn child itself *ipsius partûs*. Thus it would appear that according to this fiction an unborn child may in the civil law at the same moment be regarded as *in esse* and not *in esse;* for its own benefit *in esse*, to its prejudice, not *in esse;* and unless for the benefit of itself not *in esse*. As the civil law prevailed in the Ecclesiastical and Admiralty Courts, and also entered largely into the jurisprudence administered in the Court of Chancery, most of the authority by which an unborn child is for its own benefit regarded as born is to be found in the decisions of those Courts.

In the Ecclesiastical Court an unborn child may be appointed executor (Bac. Abr. Executors [A]. s. 7); thus until 1830, when the right was curtailed (1 Geo. 4, 1 Wm. 4, c. 40) he might be beneficially entitled to the undisposed of residue, may be a legatee (*Jaggard* v. *Jaggard* (4)), devisee, or devisee for life with executory limitations over (*Long* v. *Blackall* (5)), is a *child* as a general rule of construction of wills (Cases Collected, 2 Jarm., 4th ed., pp. 185, 186; Theob., 3rd ed., p. 231), powers (Sugden, 8th ed., p. 673), marriage articles (*Millar* v. *Turner* (6)), and statutes: and thus is within the Statute of Distributions (22 & 23 Car. 2, c. 10 (Eng.); 7 Wm. 3, c. 6 (Ir.)), which Lord Hardwicke, C., lays it down as "settled, is to be construed by the rules of the civil law" (*Wallis* v. *Hodson* (7)); and also within Lord Campbell's Act, 9 & 10 Vict. c. 93 (*The George and Richard* (8)); is expressly mentioned in the 14 & 15 Car. 2, c. 19 (Ir.), s. 6, by which a father was

(1) 2 De G. J. & S. 665, at p. 670.
(2) Johns. 754, at p. 764.
(3) 1 Vez. 156.
(4) Finch's Prec. Ch. 175.
(5) 7 T. R. 100.
(6) 1 Vez. 85.
(7) 2 Atk. 115.
(8) L. R. 3 Ad. & Ec. 466.

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empowered by deed or will to appoint a guardian for his child; and also in the 10 & 11 Wm. 3, c. 16 (Eng.) (and 8 Anne, c. 4 (Ir.), repealed by 42 & 43 Vict. c. 24), enabling posthumous children to take in remainder where there are no trustees to preserve contingent remainders. In the exercise of its protective jurisdiction also the Court of Chancery may be called on to stay waste on his behalf: *Robinson* v. *Litton* (1), and is said to have done so in *Lutterel's Case*, cited in *Hale* v. *Hale* (2), though there is no report of *Lutterel's Case* to show how the application was made, who were the parties, what was the nature of the estate, or whether there was a legal estate vested in trustees. In short, as Lord Westbury said in *Blasson* v. *Blasson* (3), where, however, the doctrine was not applied, because it was not for the benefit of the unborn child itself—"the fiction or indulgence of the law which treats the unborn child as actually born applies only for the purpose of enabling the unborn child to take a benefit which if born it would be entitled to." In the Common Law Courts, however, independently of the Criminal Law, this doctrine of the Civil Law (which probably had its origin in the parental obligation to provide for children) prevailed only to a limited extent, after a considerable struggle, and with reference to property. An unborn child might be contingently vouched to warranty, but not alone: it was (Co. Litt. 390*b*; and *Alice Weston's Case* (in Dower) (4)) "if God gave him birth, and if not such a one heire to the warrantie, but he cannot be vouched alone without the heir at Common Law, for process shall be presently awarded against him." His rights might have been concluded before his birth. In the old Writ of Mesne a judgment then known as Forejudger (5) was given, where the mesne lord, who was bound to acquit the tenure of services demanded by the lord above of whom the tenement was held, failed to do so. Under those circumstances the tenant in a writ of mesne, to which the mesne lord did not appear, was entitled to judgment (called Forejudger), the effect of which was that the mesne lord lost his seignory, and the tenant held thenceforth direct from the lord above, as the mesne lord

(1) 3 Atk. 209, at p. 211.
(2) Finch's Prec. Ch. 50.
(3) 2 De G. J. & S. 665, at p. 670.
(4) Year Book, XI. Edw. 3 (ed. 1883), pp. 138, 139.
(5) Termes de la Ley.

held before. Lord Coke, dealing with this subject in Co. Litt. 100*b*, says:—"But if the daughter, the sonne being *en ventre sa mere*, be forejudged it shall bind the sonne that is born afterwards, because he had no right" (right of entry presumably) "at the time of the forejudgment."

In *Richards* v. *Richards* (1) the decision that all rents accrued while the heir-apparent is in possession (whether collected or not before the birth of the posthumous heir) are the property of the heir apparent in possession involves the principle that the posthumous heir had not even a supposed or fictitious existence while *in utero*, and this notwithstanding that the detention of muniments of title may be justified in his behalf: *Earl of Bedford's Case* (2).

In *Long* v. *Reeve* (3) there was a devise to Henry for life, remainder to his first and other sons in tail. Henry died, leaving his wife *enceinte* with a son, afterwards born, and all the Judges held that the contingent remainder to this son failed because he was not *in esse* on the determination of the particular estate by his father's death. This decision was reversed by the House of Lords, but (as Levinz quaintly reports), "all the Judges were much dissatisfied with this judgment of the Lords, nor did they change their opinion thereon"; and in *Doe* v. *Lancashire* (4) Lord Kenyon, C.J., referring to *Long* v. *Reeve*, says:—"Though the House of Lords reversed their judgment against the opinion of all the Judges, they afterwards, by way of saving their own honour, passed the 10 & 11 Wm. 3, c. 16, not declaring what the law was, but enacting that in future" (in marriage and other settlements) "every such child should take in the same manner as if born in the lifetime of his father, though there shall be no estate limited to trustees to preserve contingent remainders." These authorities appear to me to show that the doctrine which regards an unborn child as born for its own benefit (which is the utmost limit of the doctrine), is a fiction adopted from the civil law by the Courts of Equity, for some, but not for all, purposes, and far more seldom recognized in the Courts of Law. The present is and always was a common-law action for personal injuries caused by the negligence or breach of duty of the defendants, and it lies on the

(1) Johns. Rep. 754.
(2) 7 Rep. 8*b*.
(3) 3 Lev. 408.
(4) 5 T. R. 49, at p. 60.

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plaintiff to show what was this duty of the defendants towards the plaintiff, and how it arose. Negligence and duty are respectively relative, not absolute, terms. It is not contended that the duty arose out of contract: the contract was between the defendants and Mrs. Walker, and so far as contract is concerned it was to Mrs. Walker the defendants were liable for breach of it. If it did not spring out of contract it must, I apprehend, have arisen (if at all) from the relative situation and circumstances of the defendants and plaintiff at the time of the occurrence of the act of negligence. But at that time the plaintiff had no actual existence; was not a human being; and was not a passenger—in fact, as Lord Coke says, the plaintiff was then *pars viscerum matris*, and we have not been referred to any authority or principle to show that a legal duty has ever been held to arise towards that which is not *in esse* in fact and has only a fictitious existence in law, so as to render a negligent act a breach of that duty.

Then it is contended that this action lies in analogy to the criminal law, that if a child born alive afterwards dies of injuries received while *in utero*, this is murder in the person who inflicted them (1 Russ., c. 2, 5th ed., p. 646, note (*e*)); but I think that there is no true analogy between crime and tort in this case. Crimes are offences against the public; they are those acts or attempts which tend to the prejudice of the whole community, and as a general rule the criminal intent and the act charged to be criminal must concur to constitute a crime. Tort, on the other hand, is a private wrong sustained by some person or body of persons. The sanction of the one is punishment; the result of the other is compensation. Thus "if a man assaults me, and I lift up my staff to defend myself, and in lifting it up hit another person, an action lies by that person, and yet I did a lawful thing": *Lambert & Olliott* v. *Bessey* (1). It is a tort but not a crime, because it was a necessary act in self-defence; but if one unlawfully and maliciously strikes at one person, and wounds another whom he did not intend to wound, he is guilty of a crime: *Reg.* v. *Latimer* (2), and if death ensues it may even be murder: see Stephen's Dig. C. L. 3rd ed. p. 160, note 4. In early times, the

(1) Sir Thos. Raym., 421, 423. (2) 17 Q. B. Div. 359.

criminal law as to the infant *in utero*, just born alive, was far more stringent and severe, as stated by Bracton, than it is at present. If any person struck a pregnant woman, or administered a potion to her whereby she miscarried, *si puerperium jam formatum vel animatum fuerit et maxime si animatum facit homicidium :* Bract. lib. 3, c. 4, fol. 120, and in Fleta it is stated, *Qui etiam mulierum prægnantem oppresserit vel venenum dederit vel percusserit ut jaceat abortivum vel non concipiat si fœtus erat jam formatus et animatus recti homicida est*: Lib. 1, c. 23, s. 10. This may be accounted for on principles of public policy by the stern severity of the criminal law in the supreme exigencies of public safety, where the offence is prosecuted by the Crown on behalf of the entire community, for the security of society, the preservation of infant life, and the Queen's peace, in order that (as Lord Coke says, 3 Inst. 50), "so horrible a crime should not go unpunished."

This, being a common-law action, could not have been brought in a Court of Equity, and I therefore think there is no conflict between the rules of equity and the rules of common law in reference to it: Jud. Act, sect. 28, sub-sect. 11.

For these reasons, in my opinion, the present action is not maintainable by the present plaintiff, and the demurrer ought to be allowed.

Demurrer allowed.

Solicitor for the plaintiff: *Joshua E. Peel.*
Solicitors for the defendants: *Crawford and Lockhart.*

Appendix E

R. v. BOURNE.

[CENTRAL CRIMINAL COURT (Macnaghten, J.), **July 18, 19, 1938.**]

Criminal Law—Abortion—By surgeon—Danger to life—Pregnancy of young girl due to rape—Offences against the Person Act, 1861 (*c.* 100), *s.* 58.

A young girl, not quite 15 years of age, was pregnant as the result of rape. A surgeon, of the highest skill, openly, in one of the London hospitals, without fee performed the operation of abortion. He was charged under the Offences against the Person Act, 1861, s. 58, with unlawfully procuring the abortion of the girl.

The jury were directed that it was for the prosecution to prove beyond reasonable doubt that the operation was not performed in good faith for the purpose only of preserving the life of the girl. The surgeon had not got to wait until the patient was in peril of immediate death, but it was his duty to perform the operation if, on reasonable grounds and with adequate knowledge, he was of opinion that the probable consequence of the continuance of the pregnancy would be to make the patient a physical and mental wreck.

[EDITORIAL NOTE. As the accused was found not guilty, the statement as to the law in this matter is in the form of the direction to the jury. The judge carefully distinguishes between danger to life and danger to health, and between the act of the professional abortionist and an operation openly performed by a qualified surgeon. The case is one of first impression, and is, therefore, the only statement of the law as to the duties of a surgeon in such cases.

AS TO ABORTION, see HALSBURY, Hailsham Edn., Vol. 9, pp. 458-460, paras. 783-785; and FOR CASES, see DIGEST, Vol. 15, pp. 836-838, Nos. 9190-9205.]

TRIAL OF AN INDICTMENT WITH A JURY. The defendant was charged under the Offences against the Person Act, 1861, s. 58, that he unlawfully procured the abortion of a girl aged about 15 years. The facts are fully stated in the summing up.

The Attorney-General (*Sir Donald Somervell, K.C.*), *L. A. Byrne* and *H. Elam* for the Crown.

Roland Oliver, K.C., and *Gerald Thesiger* for the defendant.

MACNAGHTEN, J.: Members of the jury, now that you have heard all the evidence and the speeches of counsel, it becomes my duty to sum up the case to you and to give you the necessary directions in law, and then it will be for you to consider the facts in relation to the law as laid down by me, and, after consideration, to deliver your verdict. You no doubt are aware that, under our system for the administration of justice, in a trial by jury it is for the judge to give directions to the jury upon matters of law, and it is for the jury to determine the facts. The jury, and the jury alone, are the judges of the facts in the case.

The charge against Mr. Bourne is the very grave charge under the Offences against the Person Act, 1861, s. 58, that he unlawfully procured the abortion of the girl who was the first witness in the case. It is so grave a crime that the punishment may be penal servitude for life. It is one of those crimes, like murder, which is only triable by the judges of the High Court, and, judging by the cases that come before the court,

it is a crime by no means uncommon. This is the second case at these July sessions at this court where a charge of an offence against that section has been preferred, and I mention that case only to show you how different the case now before you is from the type of case which usually comes before a criminal court. In that case, a woman without any medical skill or any medical qualifications did what is alleged against Mr. Bourne here: she unlawfully used an instrument for the purpose of procuring the miscarriage of a pregnant girl. She did it for money. £2 5*s*. was her fee, and she came from a distance to a place in London to do it. £1 had to be paid to make the appointment. She came, she used her instrument, and, within an interval of time measured not by minutes but by seconds, the victim of her malpractice was dead on the floor. She was paid the rest of her fee and she went away. That is the class of case that usually comes before the court. The case here is very different. A man of the highest skill, openly, in one of our great hospitals, performs the operation. Whether it was legal or illegal you will have to determine, but he performs the operation as an act of charity, without fee or reward, and unquestionably believing that he was doing the right thing, and that he ought, in the performance of his duty as a member of a profession devoted to the alleviation of human suffering, to do it. That is the case that you have to try to-day.

It is, I think, true that it is a case of first instance, first impression. So far as I know, the matter has never arisen before a jury for them to determine in circumstances such as these, and there was, it seems, even amongst counsel some doubt as to what was the proper expression of the law in such a case as this. So, yesterday, in response to a request by Mr. Oliver, I indicated to you my view of the law. You will take the law from me. If I err in stating to you what the law is, and if you find the accused guilty, there is a Court of Criminal Appeal which will put the matter right. I have had an opportunity of reading the direction that I gave you yesterday, and I see no reason to alter or to modify it at all. The question that you have got to determine is whether the Crown has proved to your satisfaction beyond reasonable doubt that the act which Mr. Bourne admittedly did was not done in good faith for the purpose only of preserving the life of the girl. If the Crown has failed to satisfy you of that, Mr. Bourne is entitled, by the law of this land, to a verdict of acquittal. On the other hand, if you are satisfied beyond all real doubt that Mr. Bourne did not do it in good faith for the purpose only of preserving the life of the girl, your verdict should be a verdict of guilty.

There has been much discussion before you as to the meaning of the words "preserving the life of the mother." I will deal with that in a moment, but, before doing so, I desire to say that I fully agree with the criticism of Mr. Oliver that the Infant Life (Preservation) Act, 1929, is dealing with the case—indeed, I think I explained it to you yesterday —where the child is killed while it is being delivered from the body of

the mother. It provides that no one is to be found guilty of the offence created by the Act—namely, "child destruction"—unless it is proved that:

> . . . the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.

A 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. No person ought to be convicted under sect. 58 of the Act of 1861 unless the jury are satisfied the act was not done in good faith
B for the purpose only of preserving the life of the mother. My view is that it has always been the law that the Crown have got to prove the offence beyond reasonable doubt, and it has always been the law that, on a charge of procuring abortion, the Crown have got to prove that the act was not done in good faith for the purpose of preserving the life
C of the mother. It is said—and, I think, rightly—that this is a case of great importance to the public, and more especially to the medical profession, but you will observe that it has nothing to do with the ordinary cases of procuring abortion to which I have already referred. In those cases, the operation is performed by a person of no skill, with
D no medical qualifications, and there is no pretence that it is done for the preservation of the mother's life. Cases of that sort are in no way affected by the consideration of the question that is put before you. In the ordinary cases, no question of that sort can arise. It is obvious that that defence could not be available to the professional abortionist.
E As I say, you have heard a great deal of discussion as to the difference between danger to life and danger to health. It may be that you are more fortunate than I am, but I confess that I have felt great difficulty in understanding what the discussion really meant. Life depends upon health, and it may be that health is so gravely impaired that death
F results. There was one question that was asked by the Attorney-General in the course of his cross-examination of Mr. Bourne, where the matter was put thus:

> I suggest to you, Mr. Bourne, that there is a perfectly clear line—there may be border-line cases—there is a clear line of distinction between danger to health
G and danger to life?

That is the question that the Attorney-General put, and he assumes that it is so. Is it? Of course there are maladies that are a danger to health without being a danger to life. Rheumatism, I suppose, is not a danger to life, but a danger to health. Cancer is plainly a danger to
H life. But is there a perfectly clear line of distinction between danger to life and danger to health? I should have thought not. I should have thought that impairment of health might reach a stage where it was a danger to life. The answer of Mr. Bourne was:

> I cannot agree without qualifying it. I cannot say just yes or no. I can say there is a large group whose health may be damaged, but whose life almost certainly

will not be sacrificed. There is another group at the other end whose life will be definitely in very great danger.

Then he added:

> There is a large body of material between those two extremes in which it is not really possible to say how far life will be in danger, but we find, of course, that the health is depressed to such an extent that their life is shortened, such as in cardiac cases, so that you may say that their life is in danger, because death might occur within measurable distance of the time of their labour.

He is speaking of a case such as this. If that is a view which commends itself to you, so that you cannot say that there is this division into two separate classes with a dividing line between them, then it may be that you will accept the view that Mr. Oliver put forward when he invited you to give to the words "for the purpose of preserving the life of the mother" a wide and liberal view of their meaning. I would prefer the word "reasonable" to the words "wide and liberal." Take a reasonable view of the words "for the preservation of the life of the mother." I do not think that it is contended that those words mean merely for the preservation of the life of the mother from instant death. There are cases, we were told—and indeed I expect you know cases from your own experience—where it is reasonably certain that a woman will not be able to deliver the child with which she is pregnant. In such a case, where the doctor expects, basing his opinion upon the experience and knowledge of the profession, that the child cannot be delivered without the death of the mother, in those circumstances the doctor is entitled—and, indeed, it is his duty—to perform this operation with a view to saving the life of the mother, and in such a case it is obvious that the sooner the operation is performed the better. The law is not that the doctor has got to wait until the unfortunate woman is in peril of immediate death and then at the last moment snatch her from the jaws of death. He is not only entitled, but it is his duty, to perform the operation with a view to saving her life.

Here let me diverge for one moment to touch upon a matter that has been mentioned to you—namely, the various views which are held by different people with regard to this operation. Apparently there is a great divergence of view even in the medical profession itself. Some there may be, for all I know, who hold the view that the fact that the woman desires the operation to be performed is a sufficient justification for it. That is not the law. The desire of a woman to be relieved of her pregnancy is no justification for performing the operation. On the other hand, no doubt there are people who, from what are said to be religious reasons, object to the operation being performed at all, in any circumstances. That is not the law either. On the contrary, a person who holds such an opinion ought not to be a doctor practising in that branch of medicine, for, if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of some religious opinion, and the woman died, he would be in grave peril of being brought before this court on a charge of man-

slaughter by negligence. He would have no better defence than would a person who, again for some religious reason, refused to call in a doctor to attend his child, where a doctor could have been called in and the life of the child saved. If the father, for a so-called religious reason, refused to call in a doctor, he also would be answerable to the criminal law for the death of his child. I mention those two extreme cases merely to show that the law—whether or not you think it a reasonable law is immaterial—lies at any rate between those two. It does not permit of the termination of pregnancy except for the purpose of preserving the life of the mother. As I have said, I think that those words ought to be construed in a reasonable sense, and, if 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.

These general considerations have got to be applied to the particular facts of this case. The verdict of the jury must depend on the facts of the case proved before them. No doubt—and I think the evidence now makes it clear—it is very undesirable that a young girl should be delivered of a child. Parliament has recently raised the age of marriage for a girl from 12 to 16, presumably on the view that it is very undesirable that a girl under the age of 16 should marry and have a child. The medical evidence given here establishes that view. Apparently the pelvic bones are not set until a girl is 18, and it is an observation that appeals to one's common sense that it must be undesirable that a girl should go through the state of pregnancy, and, finally, of labour, when she is of tender years. Then, too, you must consider the evidence about the effect of rape, especially on a child, as this girl was, under the age of 15. Within the last ten days she has reached the age of 15. 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. You are the judges of the facts, and it is for you to say what weight you give to the testimony of the witnesses, but no doubt you will think it is only common sense that a girl who for 9 months has to carry in her body the reminder of the dreadful scene and then go through the pangs of childbirth must suffer great mental anguish, unless, indeed, she is a girl of a very exceptional character, such as a feeble-minded girl, or one belonging to the class described as "the prostitute class," some girl "marked cross from the womb and perverse." In the case of an ordinary decent girl, brought up in an ordinary decent way, you may well think that Dr. Rees was not over-stating the effect on her mind of giving birth to her child. 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. The case was mentioned of a person suffering from acute appendicitis, and the circumstances that would justify the surgeon in performing the operation for the removal of the appendix. Take the case of a child suffering from symptoms which the doctor diagnoses as appendicitis. The symptoms subside, and the doctor says: "The symptoms have subsided, and the child will probably get quite well, but at the same time I am not sure that they have definitely subsided, and to-morrow the child may be much worse." The doctor says to the parents: "If you will let me operate to-day, I can guarantee the life of your child. The operation can be performed, and can be performed with perfect safety. If, however, the child gets worse, and the appendicitis becomes acute, I may have to operate, and I will have to operate then in such circumstances that I cannot guarantee the life of the child. I will do my best, but the child may die." Supposing that choice is put to a parent: "Will you have the operation to-day or will you wait until to-morrow to see if the operation becomes immediately necessary?" What man or woman can answer the question except by saying: "Do it, and do it now. Do it while it is still safe to do it. Do not wait to see whether she is near death." When the operation is performed, it may be found that the appendix is not inflamed, and that the diagnosis was mistaken, but is the surgeon to blame for performing the operation? He used his best judgment. There you have a case where only the result can prove whether the diagnosis was right or wrong, whether the anticipation was right or wrong. In the case that we are considering—that of the danger to the child—the doctor or the surgeon who has to decide the matter can only base his opinion on knowledge and experience, and, if he in good faith thinks that it is necessary for the purpose of preserving the life of the girl, in the circumstances that I have explained to you, then not only is he entitled to perform the operation but it is also his duty to do so. With regard to any other operation on the human body, obviously no difficulty arises. The surgeon is justified in cutting off an arm or a leg, or taking out an eye, if, in his honest opinion, he thinks it is desirable to do so for the sake of the patient's health. The difficulty that arises in the case of abortion is that by the operation the potential life of the unborn child is destroyed. The law of this land has always held human life to be sacred, and the protection that the law gives to human life it extends also to the unborn child in the womb. The unborn child in the womb must not be destroyed unless the destruction of that child is for the purpose of preserving the yet more precious life of the mother.

I do not think it is necessary for me to recapitulate the evidence that has been given before you with regard to the reasons why Mr. Bourne in this case thought it right to perform the operation. He has given his evidence, and the Attorney-General accepts his evidence as a frank

statement of what actually passed through his mind. In view of the age of the girl and the fact that she had been raped with great violence, he thought that the operation ought to be performed. As I told you yesterday, and as I tell you to-day, the question that you have got to determine is not whether you are satisfied that he did it in good faith for the purpose of preserving the life of the girl. The question is whether the Crown have proved the negative of that. Have the Crown proved that he did not remove the pregnancy of this girl in good faith for the purpose of preserving her life? That is the question you have got to answer when you come to consider the facts. If the Crown have satisfied you beyond reasonable doubt—if there is a doubt, by our law the accused is always entitled to be acquitted—that he did not do this act in good faith for the purpose of preserving the life of the girl, then he is guilty of the offence with which he is charged. If the Crown have failed to satisfy you of that, then by the law of England he is entitled to a verdict of acquittal. The case is a grave case, and no doubt raises matters of grave concern both to the medical profession and to the public. As I said at the beginning of my summing up, it does not touch the case of the professional abortionist. As far as the members of the medical profession themselves are concerned—and they alone could properly perform such an operation—we may hope and expect that none of them would ever lend themselves to the malpractices of professional abortionists. As Mr. Bourne said, in cases of this sort no doctor would venture to act except after consulting some other member of the profession of high standing, so as to confirm his view that the circumstances were such that an operation ought to be performed and that the act was legal.

Solicitors: *The Director of Public Prosecutions* (for the Crown); *Le Brasseur & Oakley* (for the defendant).

[*Reported by* REGINALD TOWNSEND, ESQ., *Barrister-at-Law.*]

Re MAVILLE HOSE, LTD.

[CHANCERY DIVISION (Simonds, J.), **July 12, 1938.**]

Companies—Winding up—Voluntary winding up—Examination of persons—Order to produce books—Procedure to contest validity of order—Discretion of court to order production—Oppressive exercise of discretion—Companies Act, 1929 (*c.* 23), *s.* 214.

A company issued two debentures to an associated company to secure £2,000 and £4,000 respectively. The associated company had guaranteed certain payments which might become due from the first company. Subsequently the first company went into liquidation, and an order was made by the registrar upon the application of the liquidator for the attendance for examination of one of the directors of the associated company. The order, which was made under the Companies Act, 1929, s. 214, went on to order the director at the same time to produce the bank books of the company and all statements of account and all docu-