[SCHEDULED ORAL ARGUMENT SEPTEMBER 26, 2018]

No. 18-5093

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

ALEX M. AZAR II, Secretary of Health and Human Services, *et al.*,

Defendants-Appellants,

v.

ROCHELLE GARZA, as guardian *ad litem* to unaccompanied minor JANE DOE, on behalf of herself and others similarly situated, *et al.*,

Plaintiffs-Appellees,

BRIEF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN ACADEMY OF PEDIATRICS, THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA, THE AMERICAN COLLEGE OF PHYSICIANS, AND THE SOCIETY FOR ADOLESCENT HEALTH AND MEDICINE AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES

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Dated: August 6, 2018

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Federal Rules of Appellate Procedure and D.C. Circuit Rule 26.1, *amici* the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Pediatrics, the Medical Society of the District of Columbia, the American College of Physicians, and the Society for Adolescent Health and Medicine state that they are non-profit organizations, with no parent corporations or publicly traded stock, and no publicly held company has 10% or greater ownership in *amici*.

CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

Pursuant to D.C. Cir. Rule 28(a)(1)(A), the undersigned certifies as follows:

(A) **Parties and *Amici*.** To *amici*'s knowledge, all parties, intervenors, and *amici* appearing in this Court are listed in the Brief for Appellees in this case, No. 18-5093, other than the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Pediatrics, the Medical Society of the District of Columbia, the American College of Physicians, and the Society for Adolescent Health and Medicine, filing this brief as *amici* in support of Appellees.

(B) **Ruling Under Review.** To *amici*'s knowledge, references to the ruling at issue appear in the Brief for Appellees in this case, No. 18-5093.

(C) **Related Cases.** To *amici*'s knowledge, references to any related cases appear in the Brief for Appellees in this case, No. 18-5093.

STATEMENT REGARDING CONSENT TO FILE AND AUTHORSHIP

All parties have consented to the filing of this brief.

No counsel for a party authored this brief in whole or in part, and no counsel for a party, nor any person other than the *amici curiae*, its members, or its counsel, contributed money that was intended to fund the preparation or submission of this brief. *See* Fed. R. App. P. 29(a)(4)(E).

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I. Interests of *Amici Curiae*

The following medical organizations respectfully submit this brief as *Amici Curiae* in support of Appellees:

- **The American College of Obstetricians and Gynecologists** ("ACOG"). With more than 58,000 members representing more than 90% of all board-certified obstetricians and gynecologists in the nation, ACOG is the premier professional membership organization of obstetricians and gynecologists and others dedicated to the improvement of women's health.

- **The American Medical Association** ("AMA") is the largest professional association of physicians, residents, and medical students in the U.S. Through medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy making process. AMA's objectives are to promote the science and art of medicine and the betterment of public health.

- **The American Academy of Pediatrics** ("AAP") is a national, not-for-profit organization dedicated to furthering the interests of child and adolescent health. AAP's membership includes more than 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. AAP has become a powerful voice for child and adolescent health through education, research, advocacy, and the provision of expert advice.

- **The Medical Society of the District of Columbia** ("MSDC") is the largest medical organization representing metropolitan Washington physicians in the District. The AMA and MSDC join this brief on their own behalves and as representatives of the **Litigation Center of the American Medical Association and the State Medical Societies**. The Litigation Center is a coalition among the AMA and the medical societies of each state, whose purpose is to represent the viewpoint of organized medicine in the courts.

- **The American College of Physicians** ("ACP") is the largest medical

specialty organization in the U.S. ACP membership includes 154,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults.

- **The Society for Adolescent Health and Medicine** ("SAHM") was founded in 1968 and is a multidisciplinary organization committed to improving the physical and psychosocial health and well-being of all adolescents through advocacy, clinic care, health promotion, health service delivery, professional development, and research.

II. Introduction

Amici are the leading medical organizations representing physicians in the United States.[1] They include the AMA, the largest professional association of physicians, residents, and medical students, in the country; ACOG, the nation's leading organization of physicians who provide health services unique to women; the AAP, representing more than 60,000 pediatricians and pediatric subspecialists; the ACP, the largest medical specialty organization in the United States with 154,000 members in more than 145 countries; the MSDC, the largest medical

[1] Courts, including the U.S. Supreme Court, frequently rely on submissions by *amici* as authoritative sources of medical information, including on issues concerning abortion care and adolescent health care. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing *amici* brief submitted by ACOG, AMA, AAP, and other medical associations in assessing disputed admitting privileges and surgical center requirements); *Hodgson v. Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG, AAP, SAHM, and other medical organizations' brief in assessing disputed parental notification requirement); *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 916–17 (9th Cir. 2014) (citing brief submitted by ACOG and AMA as further support for a particular medical regimen), *cert. denied*, 135 S. Ct. 870 (2014).

organization representing metropolitan Washington physicians in the District; and SAHM, a multidisciplinary organization that advocates for adolescent well-being. *Amici* are dedicated to health care, to research, and to evidence-based health policy. *Amici* are committed to improving the health of women, children, and adolescents, and to preserving access to health care at all ages.

All women—including the exceedingly vulnerable minor women in the custody of federal immigration authorities—should have timely access to complete reproductive health care, including abortion care. ***All*** women should be able to consult medical providers in confidence and without political interference regardless of age, income, or immigration status.

ORR's policy is at fundamental odds with these principles. ORR's policy is medically and scientifically unsound. It prevents minor women from accessing the prompt, confidential, and complete care they need. It compounds the significant challenges faced by an already-vulnerable population of young women. Abortion is one of the safest medical procedures performed in the United States, and far safer than carrying pregnancy to term or childbirth, especially for minors. By obstructing access to critical reproductive care, including abortion, ORR endangers the health and well-being of minor women in federal custody.

For these and the reasons outlined below, *amici* oppose ORR's policy and support Jane Doe. *Amici* respectfully submit this brief to share with the Court their

collective understanding about the negative impact that ORR policy has on unaccompanied minors' health. Neither Ms. Doe nor any other similarly situated young woman should be forced to carry her pregnancy to term or be deprived of timely access to medically sound, confidential health care.

III. Argument

ORR's medically unsupportable policy threatens the lives and well-being of minor women. Young women crossing the United States border face numerous dangers, including a high risk of sexual assault.[2] Many are fleeing violence in their home countries.[3] Once in the custody of immigration authorities, minors face poor access to medical care and remain highly vulnerable to sexual assault.[4] Many learn that they are pregnant. The policy ORR adopted last year compounds the dangers

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[2] UNHCR, *Women on the Run*, Oct. 2015, *available at* http://www.unhcr.org/en-us/publications/operations/5630f24c6/women-run.html.

[3] UNHCR, *Children on the Run: Unaccompanied Children Leaving Central America and Mexico and the Need for International Protection*, Mar. 2014, *available at* http://www.unhcr.org/en-us/about-us/background/56fc266f4/children-on-the-run-full-report.html.

[4] ACOG Committee Opinion No. 627, *Health Care for Unauthorized Immigrants*, Mar. 2015; Chantal Da Silva, *Arizona Migrant Children's Detention Center Worker Arrested For Alleged Sexual Abuse of 14-Year-Old Girl*, Newsweek, Aug. 2, 2018, *available at* https://www.newsweek.com/arizona-migrant-childrens-detention-center-worker-arrested-alleged-sexual-1053614; Tessa Stuart, *The Trump Administration Was Ordered to Stop Drugging Kids in Custody*, Rolling Stone, Aug. 1, 2018, *available at* https://www.rollingstone.com/politics/politics-news/trump-administration-drugging-kids-704431/.

that pregnant minors face.[5] By mandating that young women inform their parent or sponsor of their decision to seek abortion care and/or that they submit to medically inaccurate counseling, the policy adds extreme and unfounded barriers that prevent women from obtaining the reproductive health care they need, while depriving them of the confidentiality that is at the very heart of the patient-physician relationship. The policy should remain enjoined.

A. Abortion is an Extremely Safe Medical Procedure.

Legal abortion is extremely safe. The risk of death resulting from an abortion has been exceptionally low—no more than a fraction of a percent—for decades.[6] Even minor complications from the procedure are very rare,[7] making abortion as safe or safer than many routine outpatient procedures, such as

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[5] Letter from ACOG, AAP, and Society for Adolescent Health and Medicine to Scott Lloyd, Oct. 20, 2017, *available at* https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/2017%20sign%20on/ACOG-AAP-SAHM-Letter-to-Director-Lloyd.pdf.

[6] Karen Pazol et al., Ctrs. Disease Cont. & Prev., *Abortion Surveillance—United States, 2012*, 1, 11, 40 tbl.23 (2015) (finding that between 1978 and 2007, the national mortality rate ranged from 0.52 per 100,000 (or .00052 percent) to .78 per 100,000 (or .00078 percent)).

[7] Kari White et al., *Complications from First-Trimester Aspiration Abortion: A Systematic Review of the Literature*, 92 Contraception 422, 434, 435 tbl.7 (2015); *see also* Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454, 458 & tbl.2 (2013) (finding that the risk of major complications from first-trimester aspiration abortions is just .05 percent).

colonoscopies.[8] *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016) (citing brief submitted by major medical organizations, including ACOG, AMA, and AAP). Abortion is safe for minors, too. No negative medical or psychological after-effects are associated with abortion among minor women.[9]

The safety of legal abortion stands in sharp contrast to the risks of childbirth, particularly among minors.[10] Women are thirty times more likely to die in childbirth than as a result of legal abortions by all methods, and seventy times more likely to die from childbirth than from surgical abortion in the United

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[8] White et al., *supra* note 7, at 436 (the "percentage of complications [from first-trimester aspiration abortion] is comparable to other common office-based procedures, like vasectomy, and lower than that reported for [routine procedures], such as colonoscopy").

[9] AAP Committee on Adolescence, *The Adolescent's Right to Confidential Care When Considering Abortion*, 139 Pediatrics 1, 4 (Feb. 2017), *available at* http://pediatrics.aappublications.org/content/139/2/e20163861 (teenagers who obtained an abortion were no more likely to have psychological problems than teenaged women who carried to term); Alan Guttmacher Inst., *Fact Sheet: Induced Abortion in the United States* (2018), *available at* https://www.guttmacher.org/fact-sheet/induced-abortion-united-states (first-trimester abortions generally "pose virtually no long-term risk of problems such as infertility"); Nancy E. Adler et al., *Abortion Among Adolescents*, 58 Am. Psychol. 211, 212 (Mar. 2003) (finding no convincing evidence of significant negative psychological sequelae from induced abortion for adolescents).

[10] Sam Rowlands, *Review: Misinformation on Abortion*, 16 Eur. J. Contraception & Reprod. Health Care 233, 234 (2011); Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 216 (2012).

States.[11] The mortality and complication rates for adolescents who give birth are even higher—***twice*** that of adult women.[12]

B. Mandatory Parent and/or Sponsor Notification and Forced Counseling are Medically Unnecessary and Endanger Minors.

1. Mandatory Notification Serves No Medical Purpose.

Minors are capable of determining whether to end a pregnancy and the low risk of abortion means that it is safe for them to do so. Minors can provide their medical history to physicians to receive the appropriate care[13] and can understand and choose among their treatment options.[14] No evidence supports the notion that an individual first becomes a competent decision-maker at 18 years old.[15] It is wholly illogical and unsupported by medical evidence for ORR to presume minors are competent to decide to carry a pregnancy to term and give birth, but not competent to decide to terminate a pregnancy.

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[11] Rowlands, *supra* note 10, at 234–35, 235 tbl.1.

[12] Jonathan D. Klein et al., *Adolescent Pregnancy: Current Trends and Issues*, 116 Pediatrics 281, 283 (2005); *see also* ACOG Committee Opinion No. 627, *supra* note 4 (childbirth-related hospitalization and birth complications are more common among undocumented women).

[13] *Reproductive Health Servs. v. Strange*, No. 2:14-cv-1014-SRW (M.D. Ala. 2014) (Hillard Expert Rep. 6–7); Bruce Ambuel & Julian Rappaport, *Developmental Trends in Adolescents' Psychological and Legal Competence to Consent to Abortion*, 16 Law. Hum. Behav. 129 (1992).

[14] Adler et al., *supra* note 9, at 213.

[15] AAP Committee on Adolescence, *supra* note 9, at 3.

Minors can also manage the limited care required after an abortion is completed. Abortion is one of the safest medical procedures in the United States. Abortion patients "may return to their normal daily activities when they feel ready . . . generally within hours or 1-2 days following a first trimester abortion."[16] Adolescents are able to follow the simple aftercare instructions given to patients and to recognize their symptoms in the rare case of potential complications.[17]

2. Mandatory Notification Puts Minors at Risk of Immediate Danger and Adverse Health Effects.

Notifying a parent or sponsor of a pregnancy against an adolescent's considered judgment risks severe parental anger and rejection.[18] A third of minors who do not inform parents of an abortion decision have experienced family violence in the past and fear more violence if they share their decision.[19] The potential for violence, abuse, coercion, conflict, and rejection is particularly significant in non-supportive or dysfunctional families.[20] Minors in ORR custody

[16] Kathleen M. McIntosh, RN, et al., *Routine Aftercare and Contraception*, in *A Clinician's Guide to Medical and Surgical Abortion* 188 (Maureen Paul, MD, ed., 1999).

[17] *Id.*

[18] AAP Committee on Adolescence, *supra* note 9, at 4–5.

[19] *Id.*; *see also* J. Shoshanna Ehrlich, *Grounded in the Reality of Their Lives: Listening to Teens Who Make the Abortion Decision without Involving Their Parents*, 18 Berkeley J. of Gender, Law & Just. 61, 166 (2003).

[20] AAP Committee on Adolescence, *supra* note 9, at 4.

are no less, and perhaps more, vulnerable to these types of danger and abuse on reunification with a parent or placement with a sponsor.

Even for minors who are not at direct risk of violence, a lack of confidentiality is dangerous. Mandatory notification can be a "critical barrier" to adolescents receiving appropriate health care.[21] In fact, confidentiality concerns are *the* leading reason adolescents forgo necessary medical care of all kinds,[22] and an especially strong barrier when it comes to reproductive health care services for adolescents.[23] Forgoing care due to confidentiality concerns is not a neutral choice. Adolescents and teenagers who are deterred by a lack of confidentiality not only forgo care, but face a substantially higher prevalence of risk factors related to sexual and reproductive health, substance use, and mental health, such as depressive symptoms, suicidal ideation, and suicide attempts.[24]

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[21] ACOG Committee Opinion No. 599, *Adolescent Confidentiality and Electronic Health Records*, May 2014.

[22] *See* Jocelyn A. Lehrer et al., *Forgone Health Care Among U.S. Adolescents: Associations between Risk Characteristics and Confidentiality Concern*, 40 J. Adolescent Health 218, 218–19 (2007).

[23] *See* ACOG Committee Opinion No. 598, *The Initial Reproductive Health Visit*, May 2014; M. Diane McKee et al., *Predictors of Timely Initiation of Gynecologic Care among Urban Adolescent Girls*, 39 J. Adolescent Health 183, 183–84 (2006); Liza Fuentes et al., *Adolescents' and Young Adults' Reports of Barriers to Confidential Health Care and Receipt of Contraceptive Services*, 62 J. Adolescent Health 36, 43 (2018).

[24] *See* Lehrer et al., *supra* note 22, at 218–19.

While *amici* support efforts to reasonably encourage minors to involve their parents in their decision to seek reproductive health care, mandatory notification as required by ORR policy is dangerous for minors, in the short and long term. It does not promote family communication, or the physical or emotional health of young women.[25] Notification should be voluntary, not mandatory, and should not intrude on a minor's ability to seek timely reproductive health care or to confidentially consult with a medical provider.

Confidentiality protections are paramount for adolescents and young adults seeking sensitive health care services.[26] When confidentiality is assured, adolescents and young adults are more willing to seek and obtain care, to disclose sensitive information, and to seek health care in the future.[27]

3. Forced Crisis Pregnancy Center Counseling Poses Risks to Minors.

No medical evidence supports the pseudo-counseling forced on minors at

[25] AAP Committee on Adolescence, *supra* note 9, at 3; Adler et al., *supra* note 9, at 214.

[26] Soc. Adolescent Health & Med. et al., *Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process*, 58 J. Adolescent Health 374, 375 (2016) (ACOG, SAHM, AAP, and others have issued formal policy statements recognizing the importance of confidentiality).

[27] Carol A. Ford et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care: A Randomized Controlled Trial*, 278 JAMA 1029, 1029 (1997).

crisis pregnancy centers. ORR's policy advances a political agenda at the expense of minors' health and safety.[28]

The sort of "counseling" provided at crisis pregnancy centers is not just medically unnecessary, but misleading and harmful.[29] While these so-called crisis centers purport to offer pregnancy care, their true and sole purpose is in fact to dissuade women from exercising their choice to obtain an abortion through tactics that are manipulative, misleading, and at odds with medical practice. Crisis pregnancy centers traffic in false and medically inaccurate information about abortion,[30] including falsely informing women that abortion significantly increases their risk for breast cancer or can make it difficult to become pregnant in the future.[31] Lies like these do not and cannot assist an adolescent in making a medically informed choice about whether to obtain an abortion.

As with mandatory parental notification, forcing minors to obtain crisis pregnancy center counseling may delay or deter them from seeking needed reproductive health services at all. Those who do comply face the added mental

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[28] *See* ACOG Committee Opinion No. 613, *Increasing Access to Abortion*, Nov. 2014.

[29] *See id.*

[30] *See id.* (citing Joanne D. Rosen, *The Public Health Risks of Crisis Pregnancy Centers*, 44 Perspect. on Sexual and Reprod. Health 201 (2012)).

[31] Rosen, *supra* note 30.

and physical health risks caused by forced disclosure of intimate information, paired with coercion and misleading information. The resulting delays are dangerous even if the adolescent ultimately carries the fetus to term.

C. ORR's Policy of Delaying Access to Abortion Causes Harm.

ORR's policy of mandatory notification and forced counseling delays unaccompanied minors' access to abortion care, which directly jeopardizes their health. The options available to a pregnant woman decrease and the health risks associated with pregnancy increase with the length of pregnancy. Desired abortions should therefore be performed safely and as early as possible.[32]

1. Delaying Access to Abortion Care Increases Health Risks.

Women who seek an abortion but are delayed in doing so are unlikely to seek any reproductive or prenatal care, which endangers their health.[33] Proper medical care allows qualified health professionals to assess and mitigate risks associated with the state of pregnancy. The additional time that abortion is delayed is therefore time during which women may suffer significant health problems that could have been avoided had they received access to timely abortion care.

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[32] ACOG, *College Statement of Policy: Abortion Policy*, Nov. 2014, *available at* https://www.acog.org/-/media/Statements-of-Policy/Public/sop069.pdf?dmc=1&ts=20180805T0140363485.

[33] *See* ACOG Committee Opinion No. 613, *supra* note 28; Susan Hatters Friedman et al., *Characteristics of Women Who Do Not Seek Prenatal Care and Implications for Prevention*, 38 J. Obstetric, Gynecologic & Neonatal Nursing 174, 179 (2009).

Delay may also altogether foreclose the option of a medical abortion—a common method that uses medication only and is increasingly preferred, especially among survivors of rape.[34] Medical abortion is generally not performed in the United States after ten weeks of gestation and, as a result, women who are delayed in obtaining an abortion may be deprived of the option of having a medical abortion,[35] including women for whom it may have been the more medically appropriate procedure.[36]

In addition, complications from abortion procedures, as rare as they are, increase with gestational age.[37] For example, the risk of major complications for

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[34] *See* Nathalie Kapp et al., *Efficacy of Medical Abortion Prior to 6 Gestational Weeks: A Systematic Review*, 97 Contraception 90, 90 (2017); Tara C. Jatlouti et al., Ctrs. Disease Cont. & Prev., *Abortion Surveillance – United States, 2013*, at 8("[F]rom 2004 to 2013, use of early medical abortion increased 110%."), *available at* https://www.cdc.gov/mmwr/volumes/65/ss/ss6512a1.htm.

[35] *See* ACOG Practice Bulletin No. 143, *Medical Management of First-Trimester Abortion*, 6 (Mar. 2014); Jillian T. Henderson et al., *Safety of Mifepristone Abortions in Clinical Use*, 72 Contraception 175, 178 (2005) ("Mortality risk increase[es] by 38% per additional week of gestation.").

[36] For example, medical abortion is frequently the most appropriate method for women who have uterine fibroids. *See, e.g.*, Mitchell D. Creinin, *Medically Induced Abortion in a Woman with a Large Myomatous Uterus*, 175 Am. J. Obstetrics & Gynecology 1379, 1379 (1996).

[37] Justin Diedrich & Jody Steinauer, *Complications of Surgical Abortion*, 52 Clinical Obstetrics & Gynecology 205, 205–06 (2009); Deborah Karasek et al., *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law*, 26 Women's Health Issues 60, 65 (2016); Rebecca H. Allen, *Cervical Dilation*

surgical abortions in the first trimester is only 0.16%, but that risk rises for abortions performed in the second trimester (though it remains very low at 0.41%).[38] Accordingly, although abortion remains much safer than carrying to term, even later in the second trimester, it should be performed as early as possible.[39]

2. ORR's Policy of Delaying Access to Abortion May Preclude Access Altogether, Significantly Increasing Risks to Adolescent Health.

For some minors, ORR's policy of delay and obstruction will make an abortion impossible to obtain, even where abortion is in the best interest of the minor's health. As a result, young women who seek an abortion but who remain pregnant, whether to term or simply longer than necessary, are exposed to avoidable pregnancy-related health risks.[40] Denial of abortion also may have

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Before First-Trimester Surgical Abortion (<14 Weeks' Gestation), 93 Contraception 277, 281 (2016); Christine Dehlendorf et al., *Disparities in Abortion Rates: A Public Health Approach*, 103 Am. J. Pub. Health 1772, 1776 (2013).

[38] Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175, 175 (2015); *see also* Allen, *supra* note 37, at 277.

[39] *See* Marian F. MacDorman et al., *Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues*, 128 Obstetrics & Gynecology 1, 1 (2016) (finding maternal mortality rate of 23.8 deaths per 100,000 live births in 2014).

[40] Even if a woman eventually obtains an abortion, delays expose her to preventable health risks. Pregnancy-related risks include hypertension

negative effects on the emotional health of young women.[41] Importantly, these pregnancy-related risks are appreciably higher in adolescents—like the unaccompanied minors in ORR custody—than in adult women.[42]

IV. Conclusion

For the foregoing reasons, this Court should affirm the decision of the District Court.

Dated: August 6, 2018

Respectfully submitted,

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disorders which affect approximately 5–10% of pregnant women and account for "approximately a quarter of maternal deaths and near misses." *See* ACOG, Practice Bulletin No. 190, *Gestational Diabetes Mellitus*, 131 Obstetrics & Gynecology e49, e49 (2018); ACOG Committee Opinion No. 638, *First-Trimester Risk Assessment for Early-Onset Preeclampsia*, Sept. 2015; World Health Org., *WHO Recommendations on Antenatal Care for a Positive Pregnancy Experience*, at 40 (2016).

[41] AAP Committee on Adolescence, *supra* note 9, at 5.

[42] *See, e.g.*, Anne B. Wallis et al., *Secular Trends in the Rates of Preeclampsia, Eclampsia, and Gestational Hypertension, United States, 1987-2004*, 21 Am. J. Hypertension 521, 523–24 (2008).

CERTIFICATE OF COMPLIANCE

In accordance with Fed. R. App. P. 29(a)(5) and 32(a)(7), the undersigned certifies that this brief has been prepared in a proportionally spaced typeface, Times New Roman, in 14-point font. According to the word processing system used to prepare the brief, Microsoft Word 2010, it contains 3628 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

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CERTIFICATE OF SERVICE

I hereby certify that, on August 6, 2018, a true and correct copy of the foregoing Brief of the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Pediatrics, the Medical Society of the District of Columbia, the American College of Physicians, and the Society for Adolescent Health and Medicine as *Amici Curiae* in Support of Plaintiffs-Appellees was filed with the Clerk of the United States Court of Appeals for the D.C. Circuit via the Court's CM/ECF system. Counsel for all parties will be served electronically by the Court's CM/ECF system.

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