No. 19-1392

In the Supreme Court of the United States

THOMAS E. DOBBS, M.D., M.P.H., IN HIS OFFICIAL CAPACITY AS STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, ET AL.,
Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, ET AL.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF *AMICI CURIAE* ROBIN PIERUCCI, M.D. AND LIFE LEGAL DEFENSE FOUNDATION IN SUPPORT OF PETITIONERS

CATHERINE W. SHORT
Counsel of Record
ALEXANDRA SNYDER
ALLISON K. ARANDA
SADIE DANIELS
Life Legal Defense Foundation
PO Box 2105
Napa, CA 94558
(707) 224-6675
kshort@lldf.org
Counsel for Amici Curiae

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INTEREST OF AMICI[1]

Amica Robin Pierucci, M.D., has been a practicing neonatologist for over twenty years. She also has a master's degree in bioethics and completed the National Catholic Bioethics Center ethics certificate course. In addition to her full-time clinical duties within the neonatal intensive care unit of a large regional medical center, Dr. Pierucci remains active in perinatal palliative care, and ongoing performance improvement projects. She has multiple publications in peer and non-peer reviewed journals and has spoken around the country on multiple perinatal and ethical topics. As an expert in caring for extremely young premature babies, Dr. Pierucci understands that medical science provides only limited ability to determine neonatal survival and that such a determination is best made by trained and experienced neonatologists, not abortion providers.

Dr. Pierucci contests the disconnect between two standards of care that are allowed under current law: the same patient that neonatologists such as herself are ethically, medically, and legally responsible to treat, obstetricians can legally abort. While the law currently allows two standards of care, the science informs us that a unique human

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[1] This brief was wholly authored by counsel for amici Robin Pierucci, M.D. and Life Legal Defense Foundation. No party or counsel for any party made any financial contribution toward the preparation or submission of the brief. Counsel of record for the parties received timely notice of the intent to file this brief and emailed written consent to its filing.

with DNA that is different from both genetic parents is alive from conception. Though human beings look different at different stages of development (e.g., embryo, fetus, neonate, toddler, adolescent, adult, elderly), we are always human beings. Because we are always human beings, doctors always have the obligation to provide the best care possible, and the state will always have an equal obligation to safeguard all its members.

Amicus Life Legal Defense Foundation is a California non-profit 501(c)(3) public interest legal and educational organization that works to assist and support those who advocate in defense of life. Its mission is to give innocent and helpless human beings of any age, particularly unborn children, a trained and committed defense against the threat of death, and to support their advocates in the nation's courtrooms. Life Legal Defense Foundation believes life begins at the moment of conception and does not end until natural death. We litigate cases to protect human life, from preborn babies targeted by a billion-dollar abortion industry to the elderly, disabled, and medically vulnerable denied life-sustaining care.

Life Legal Defense Foundation sees in the present case an opportunity for this Court to right a 47-year-old wrong: the stripping from states of their authority to protect the lives of innocent human beings within their borders.

SUMMARY OF THE ARGUMENT

The Fifth Circuit held that the State of Mississippi's Gestational Age Act was an

unconstitutional ban on pre-viability abortions, based on Supreme Court precedent in *Planned Parenthood v. Casey,* 505 U.S. 833 (1992). Cert. Pet. App. 13a. The lower court noted that, although viability "may differ with each pregnancy" and is dependent on a variety of factors, nonetheless "viability is the critical point." *Id*. at 12a and n. 34 (quoting *Colautti v. Franklin*, 439 U.S. 379, 388-89 (1979)). Because of this Court's precedents, the Fifth Circuit was forced to adhere to a legal framework this Court has never explained.

This Court first bestowed constitutional significance on the concept of viability in its abortion jurisprudence in 1973, at which time it stated, "Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." *Roe v. Wade*, 410 U.S. 113, 160 (1973). Within two decades, that already generous window has shifted by several weeks.[2]

More importantly, as this brief will demonstrate, viability outside the womb depends on a variety of external and subjective factors, including individual physicians' competence, continuing education in neonatal medicine, personal and institutional philosophies of the

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[2] *See, e.g., Isaacson v. Horne*, 716 F.3d 1213, 1233 (9th Cir. 2013) (Kleinfeld, J., concurring) ("Viability is the 'critical fact' that controls constitutionality. That is an odd rule, because viability changes as medicine changes. As *Planned Parenthood v. Casey* noted, between *Roe v. Wade* in 1973 and the time Casey was decided in 1992, viability dropped from 28 weeks to 23 or 24 weeks, because medical science became more effective at preserving the lives of premature babies.")

provision of life-sustaining medical interventions, and physician attitudes toward disabilities and societal challenges.

Amici join Petitioner Dobbs in urging this Court to revisit the doctrine of viability and clarify that the State's interest in preserving the life of human beings in the womb is not contingent on the entirely unrelated question of the possible medical outcomes if the mother went into labor and delivered the child prematurely.

This Court should grant the Petition and reverse the judgment of the Fifth Circuit.

ARGUMENT

I. THE VIABILITY BENCHMARK WITH *ROE* CONFLICTS WITH THIS COURT'S DETERMINATION THAT THERE IS AN UNQUALIFIED COMPELLING STATE INTEREST IN PRESERVING HUMAN LIFE.

In *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990), this Court found that the state not only has an interest in protecting an individual's right to life, but also has "an interest in life" itself. *Id.* at 281. This holding was consistent with the Court's finding in *Roe v. Wade* that the state has an "important and legitimate interest in protecting the potentiality of human life." *Roe*, 410 U.S. at 162. In both cases, the state's interest in life and in protecting human life were weighed against an

individual's constitutional rights (right to due process and right to privacy, respectively).

In *Roe,* this Court determined that the state's interest in the protection of human life became compelling at viability, relying on the fetus' "capability of meaningful life outside the mother's womb." *Id.* at 163. By contrast, in *Cruzan* this Court rejected the idea of "meaningful life," holding that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan*, 497 U.S. at 282; *Washington v. Glucksberg*, 521 U.S. 702, 729 (1997) (quoting *Cruzan* and holding that the state "has an *unqualified* interest in the preservation of human life") (emphasis added). *See also Britell v. United States*, 372 F.3d 1370, 1383 (Fed. Cir. 2004) ("It is not the role of the courts to draw lines as to which fetal abnormalities or birth defects are so severe as to negate the state's otherwise legitimate interest in the fetus' potential life."); *State v. Final Exit Network, Inc.*, 889 N.W.2d 296, 305-06 (Minn. Ct. App. 2016) ("The state has a compelling interest in the preservation of D.D.'s life, and the prevention of her suicide, regardless of her incurable [non-viable] condition.")

Limiting a state's ability to protect human lives directly to only those lives deemed "meaningful" because the arbitrary benchmark of viability has been reached is in direct conflict with this Court's 1990 holding in *Cruzan,* that a state

need not qualify its interest in the preservation of human life before acting.

This Court should grant the petition to resolve the conflict between its abortion jurisprudence and its decisions in *Cruzan* and *Glucksberg* allowing states to protect human life regardless of the "meaningfulness" of that life as measured by the uncertain yardstick of viability.

II. THERE IS NO "POINT" IN PREGNANCY AT WHICH VIABILITY "OCCURS."

In *Roe*, this Court established viability as the "point" at which the state's interest in protecting human life becomes compelling, allowing the state to prohibit abortion. The Court defined viable as "potentially able to live outside the mother's womb, albeit with artificial aid." *Roe*, 410 U.S. at 160. One commentator noted that, with this holding, this Court "seems to mistake a definition for a syllogism."[3] Indeed, this Court has *never* attempted to elaborate on why a child's ability or inability to survive outside the womb in the case of a premature delivery has any bearing on the state's interest in protecting the child from being killed inside the womb.

In *Roe*, the Court could not locate the so-called "point" of viability more precisely than to say that it is "usually placed about seven months (28

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[3] John Hart Ely, *The Wages of Crying Wolf: A Comment on* Roe v. Wade, 82 YALE L. J. 920, 924 (1973).

weeks) but may occur earlier, even at 24 weeks." *Id*. Thus, even as first enunciated by this Court, the "point" when viability "occurred" ranged across 10% of a full-term 40-week pregnancy.[4]

A few years later, this Court acknowledged that multiple factors go into the assessment of viability including "fetal weight, based on an inexact estimate of the size and condition of the uterus; the woman's general health and nutrition; *the quality of the available medical facilities*; and other factors." *Colautti*, 439 U.S. at 395-96 (emphasis added). In other words, there is no "point" of viability in pregnancy generally, or even in any particular pregnancy.

It gets worse. *Colautti* assigned the role of assessing the viability of the fetus to the "responsible attending physician," i.e., the abortion provider. However, to the extent any given abortion provider has relevant[5] specialized training, such training would be in obstetrics, not neonatology.

Abortion providers are unlikely to stay current on medical advancements for infant survival. The largest abortion provider networks, Planned Parenthood Federation of America and the National Abortion Federation, offer continuing

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[4] Pregnancy is commonly dated from the onset of the mother's last menstrual period (LMP), approximately two weeks before conception. All gestational ages described in this brief are dated from LMP.

[5] Relevant as opposed to specialized training in, e.g., radiology or ophthalmology. Cf. *June Medical Servs. L. L. C. et al. v. Russo*. 2020 LEXIS 3516 at *116 (2020) (abortion provider "hired a radiologist and ophthalmologist to do abortions").

medical education on clinical abortion procedure but not on infant viability.[6] The American College of Obstetrics and Gynecology follows the same pattern, focusing its continuing education offerings related to abortion on maternal care, not infant viability.[7] *Neonatologists, not obstetricians, are the experts in viability*.

Unsurprisingly, the presence or absence of specialized training makes a noticeable difference in how physicians practice as well. A 2015 study by the Indiana University School of Medicine found that obstetricians and neonatologists approach patient consultations in drastically different ways. Obstetricians tend to discuss topics like maternal health risks, while neonatologists focus on post-birth complications and treatment options for the

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[6] Among abortion providers, infant survival is a "complication" to be carefully avoided. *See, e.g.*, Liz Jeffries & Rick Edmonds, *Abortion: The Dreaded Complication*, THE PHILADELPHIA INQUIRER, Aug. 2, 1981, available at https://digitalcollections.library.cmu.edu/awweb/awarchive?type=file&item=693589.

[7] Lists of continuing education topics are available online. Planned Parenthood, https://www.plannedparenthood.org/search/?q=cme. (last visited July 16, 2020); National Abortion Federation, Continuing Medical Education, https://prochoice.org/health-care-professionals/continuing-medical-education. (last visited July 16, 2020); American College of Obstetrics and Gynecology, Education and Professional Development Opportunities, https://www.acog.org/education-and-events. (last visited July 16, 2020).

baby.[8] Moreover, better survival rates for premature babies are found when there is a health care team, treating and interacting with both mother and child, rather than a single physician.

Injecting further subjectivity into the viability calculus is the fact that a physician's personal philosophy and attitude regarding the provision of life-sustaining medical interventions impacts the actual survival rate of an infant. Study after study throughout the world has shown that offering immediate life-sustaining treatment to preemies is the largest modifiable factor affecting infant survival.[9]

Compare, for example, the difference in survival rates between two American neonatal

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[8] B. Tucker Edmonds, F. McKenzie, et al., *Comparing Obstetricians' and Neonatologists' Approaches to Periviable Counseling,* 35 J. Perinatology 344 (May 2015).

[9] See, e.g., C. H. Backes et al., *Outcomes Following a Comprehensive Versus a Selective Approach for Infants Born at 22 Weeks of Gestation*, 39 J. Perinatology 39, 45 (2019) (hospital that routinely provided prenatal corticosteroid administration, neonatal resuscitation, and intensive care had substantially higher survival rates [53 percent] than the hospital that only selectively provided such care [8 percent]); J. Lorenz, *Management decisions in extremely premature infants*, 8 Seminars in Neonatology 475 (December 2003), available at https://www.sciencedirect.com/science/article/abs/pii/S1084275603001180 ("There is significant variability between developed nations in the survival of extremely premature infants among cohorts born within perinatal tertiary care centres. This is, at least to some degree, the result of differences in the aggressiveness of obstetrical and neonatal management at these gestational ages.")

facilities that work with extremely pre-term births. At the University of Iowa, physicians default to immediate, active medical treatment for all pre-term infants starting at 22 weeks' gestation.[10] These physicians have long seen over a 60% survival rate for babies in the 22-week category. Physicians at the University directly credit their default-to-treatment strategy for the high survival rate.[11] By contrast, Providence Women and Children's Services of Oregon has a very different rate of survival for 22-week births. The physicians there have a facility-wide policy to not provide care for any 22-week births, regardless of the parents' wishes, and thus they have a 0% survival rate. Moreover, because the success of treatment rate is also dependent on the experience of doctors, Providence has a much lower survival rate for 23-week births, as well – only 21%, compared to the national average of 38%.[12]

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[10] In a 2020 publication, University of Iowa neonatologists reported they provided immediate, active medical intervention for 97% of periviable births in their facility between 2006 and 2015. For the purposes of this study, a periviable birth was defined as a birth that occurred after 21 weeks' gestation, but before 26 weeks' gestation.

[11] Keith Barrington, *Active intervention at 22 weeks' gestation, is it futile?,* Neonatal Research Blog (Oct. 29, 2018), available at https://neonatalresearch.org/2018/10/29/active-intervention-at-22-weeks-gestation-isit-futile/; P. Watkins, J. Dagle, et al., *Outcomes at 18 to 22 Months of Corrected Age for Infants Born at 22 to 25 Weeks of Gestation in a Center Practicing Active Management,* 217 J. Pediatrics 52 (Feb 2020).

[12] Patrick J. Marmion, *Periviability and the 'god committee,'* 106 Acta Paediatrica 857 (Jun 2017).

Clearly, the willingness of a neonatologists to provide active care to a baby after birth is a large factor in the child's chance of survival. The philosophy of defaulting against care lowers the survival rate, even for those children who *do* receive care. Conversely, when a facility defaults to immediate active medical intervention, survival rates of all treated neonates increase.[13]

The decision for or against medical care for premature babies is also shaped by attitudes toward disability. A November 2019 report from the National Council on Disability found:

> [m]any healthcare providers critically undervalue life with a disability. Providers often perceive people with disabilities to have a low quality of life when, in reality, most report a high quality of life and level of happiness, especially when they have access to sufficient healthcare services and supports. This misperception has negatively influenced physicians' medical futility decisions and resulted in the withdrawal of necessary medical care from people with disabilities.[14]

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[13] M. A. Rysavy, A. Das, S. R. Hintz, J. B. Stoll, B. R. Vohr, et al., *Between-hospital variation in treatment and outcomes in extremely preterm infants*, 372 New Engl. J. Med. 1801 (2015).
[14] National Counsel on Disability, *Medical Futility and Disability Bias*, Bioethics and Disability Series at 10 (Nov. 2019).

Such biases play a large role in setting institutional policies concerning whether to default against care in dealing with premature newborns, where there is an incorrect presumption that most if not all survivors will have severe disabilities. [15] In discussing treatment decisions with parents, doctors may use the word *futile* as code to mean that the survival of the baby is not worth the cost of the treatment. [16] Though various studies have shown that, when adjusted for future life expectancy, costs for NICU treatments are one-twentieth to one-tenth the costs of treatments for adult ICU patients,[17] some researchers and doctors are reluctant to allow that the quality of life obtained is worth the treatment costs. In doing so, a circular dynamic is established where anticipated poor prognoses lead to denial of medical care, which in turn leads to poor outcomes and low survival rates, reinforcing the data underlying the original poor prognosis.

The same circularity can manifest itself with regard to social conditions. In 2018, the University of Texas released a report of the disparity between infant mortality rates from zip code to zip code.[18]

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[15] P. Watkins, J. Dagle, et al., *Outcomes at 18 to 22 Months of Corrected Age for Infants Born at 22 to 25 Weeks of Gestation in a Center Practicing Active Management*, 217 J. Pediatrics 52 (Feb 2020). *See also* Patrick J. Marmion, *Decreasing disabilities by letting babies die*, 33 Issues in Law and Medicine 209 (Nov 2018).

[16] Barrington, *supra* n. 11.

[17] Marmion, *supra,* n. 12.

[18] E. Nehme, et al., *Infant mortality in communities across Texas*, The University of Texas (2012).

Though Texas had an infant mortality rate lower than the national average, troubling findings were uncovered when some zip codes were shown to have disparities as high as 12 times the rates of neighboring zip codes.[19] While all races had areas of high infant mortality, Black mothers had the highest rates of infant mortality overall.[20]

Even when a mother lives in a locale flooded with medical resources, a child's chance of survival can decrease if none of the local hospitals have enough experience in saving the lives of extremely premature babies. While generally speaking, the availability of a NICU in a geographical area increases chances of survival, when NICUs become more commonplace, each unit may see fewer individual cases of periviable births each year and, thus, have less experience in successfully treating these babies.[21] This can then perpetuate the myth that active treatment is "futile," which may indurate a physician's incorrect assumption that a child of a certain age or weight is simply non-viable.

In sum, this Court's assumption in *Roe*, *Colautti*, and *Casey* that there is a "point" in pregnancy when viability "occurs" is mistaken. Viability is a prediction, not a point. Even if there were such a point, it would be impossible for most doctors, especially abortion providers who rarely

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[19] *Id.* at 7.

[20] *Id.* at 12.

[21] R. Patel, M. Rysavy, et al., *Survival of Infants Born at Periviable Gestational Ages*, 44 Clinics in Perinatology 287 (June 2017).

provide care for even uncomplicated pregnancies, to determine where it is. Viability depends on myriad factors that vary and fluctuate both before *and after* birth, from the physical to the philosophical, from the personal to the institutional to the systemic.

III. ATTACHING CONSTITUTIONAL SIGNIFICANCE TO VIABILITY IS ILLOGICAL.

Why is any of this relevant to the case at issue? Mississippi's Gestational Age Act bans almost all abortions after 15 weeks' gestation. Petitioners have never suggested that an unborn child at 15 weeks' gestation is capable of sustained survival outside the womb under any circumstances, so why does uncertainty about the "point" of viability matter?

It matters because this Court has built a constitutional framework on an illogical and imaginary premise, undeserving of the benefit of *stare decisis*.

As noted above, this Court's explanation in *Roe* of the significance of the non-existent "point" of viability consisted simply of restating the definition of viability. *Colautti*, in turn, took the significance of viability as a given, with no further attempt at explaining the logic behind it. Rather, *Colautti* emphasized that, because the point of viability (i.e., "a reasonable probability of the fetus' sustained survival outside the womb") is specific to each pregnancy and can be determined only by the attending physician, "neither the legislature nor

the courts may proclaim one of the elements entering into the ascertainment of viability -- be it *weeks of gestation* or fetal weight or any other single factor -- as the determinant of when the State has a compelling interest in the life or health of the fetus." *Colautti,* 439 U.S. at 388-389 (emphasis added). This Court has never revoked or modified *Colautti*'s holding that an abortion ban based on gestational age is impermissible, and that determination of viability must be left to the judgment of the "responsible attending" abortion provider.

As the years rolled by, dissenting justices continued to point out the illogic of attaching constitutional significance to viability, e.g.,

> The governmental interest at issue is in protecting those who will be citizens if their lives are not ended in the womb. The substantiality of this interest is in no way dependent on the probability that the fetus may be capable of surviving outside the womb at any given point in its development, as the possibility of fetal survival is contingent on the state of medical practice and technology, factors that are in essence morally and constitutionally irrelevant. The State's interest is in the fetus as an entity in itself, and the character of this entity does not change at the point of viability under conventional medical wisdom. Accordingly, the State's interest, if compelling after viability, is equally compelling before viability.

Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 795 (1986) (White, J., dissenting). *See also*, *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 461 (1983) (O'Connor, J., dissenting) ("The choice of viability as the point at which the state interest in *potential* life becomes compelling is no less arbitrary than choosing any point before viability or any point afterward.")

However, the plurality in *Casey*, relying on *stare decisis*, reaffirmed the Court's commitment to the constitutional significance of viability, even while acknowledging that its original judgment might have been unsound:

> [V]iability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions. The soundness *or unsoundness* of that constitutional judgment in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity can somehow be enhanced in the future.

Casey, 505 U.S. at 860 (emphasis added). In affirming "*Roe*'s central holding," the *Casey* plurality also restated *Roe*'s utterly false premise

that viability "occurs" at a "point" or "moment" in pregnancy.

The *Casey* plurality made a self-conscious attempt to explain the reasoning behind the viability standard:

> The second reason is that the concept of viability, as we noted in *Roe*, is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman.[22]

Casey, 505 U.S. at 870. However, as Justice Scalia pointed out,

> [t]he arbitrariness of the viability line is confirmed by the Court's inability to offer any justification for it beyond the conclusory

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[22] This Court also half-heartedly offered a third justification for drawing a line a viability: "The viability line also has, as a practical matter, an element of fairness. In some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child." *Casey*, 505 U.S. at 870. However, given government data showing that over 90% of abortions are performed in the first trimester and over 98% by 20 weeks of pregnancy (CDC, *Abortion Surveillance – Findings and Reports* (2016), available at https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm), laches could be said, as a matter of fairness, to come into play well before viability.

> assertion that it is only at that point that the unborn child's life "can in reason and all fairness" be thought to override the interests of the mother. . . . Precisely why is it that, at the magical second when machines currently in use (though not necessarily available to the particular woman) are able to keep an unborn child alive apart from its mother, the creature is suddenly able (under our Constitution) to be protected by law, whereas before that magical second it was not? That makes no more sense than according infants legal protection only after the point when they can feed themselves.

Id. at 989, fn. 5 (Scalia, J., concurring and dissenting).[23]

With a touch of unconscious irony, the *Casey* plurality distinguished the freedom of legislatures to "draw lines which appear arbitrary without the necessity of offering a justification" from its own duty to justify its line-drawing. *Id.* at 870. But no legal scholar has found this Court's justification persuasive, much less compelling.[24] This Court's

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[23] A closer analogy than Justice Scalia's might be found in the concept of "pool safe," defined as the stage of development at which a child has a reasonable chance of survival if he or she accidentally falls into a swimming pool. Analogizing to viability, the state may act to protect the life of a pool-safe child, but may not act to protect a child who is not pool safe from being held face down in a bucket of water until dead.

[24] See, e.g., Paul Benjamin Linton and Maura K. Quinlan, *Does Stare Decisis Preclude Reconsideration of Roe v. Wade? A Critique of Planned Parenthood v. Casey*, 70 Case W. Res. L.

fictitious "point of viability" line has less justification than Mississippi's line of 15 weeks, based as the latter is on the science of fetal development, preservation of maternal health, and protection of medical ethics. *Compare* Pet. Cert. at 15-20 (examining viability standard) *with id.* at 20-26 (justification for 15-week abortion limit).

The *Casey* plurality also noted that "there is no line other than viability which is more workable." *Casey*, 505 U.S. at 370. But, as demonstrated above, viability is not a line, or a point, or a moment, and for that reason, it is less "workable," and certainly gives less notice, than a limit on abortion stated in weeks of gestational age justified by factors such as anatomical development, the capability of feeling pain, or the presence of a heartbeat. Viability as determined by the abortion provider is "workable" only in the sense that it is unenforceable, and thus does not give rise to difficult cases. It "works" for the abortion industry, but not for the state trying to protect unborn children.

CONCLUSION

Mississippi's 15-week abortion restriction is well-supported by the state's compelling interest in the preservation of human life. Additionally, the

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Rev. 283 (2019), available at https://scholarlycommons.law.case.edu/caselrev/vol70/iss2/9 for a detailed critique of the viability standard.

viability threshold for a compelling state interest in preserving human life, created by this Court in 1973, should be abandoned in favor of the medically updated and philosophically consistent standard of an "unqualified" interest in protecting life that this Court upheld in the 1990 case of *Cruzan*. This Court should grant the petition for certiorari and reverse the judgment of the Fifth Circuit.

Respectfully submitted,

CATHERINE W. SHORT
Counsel of Record
ALEXANDRA SNYDER
ALLISON K. ARANDA
SADIE DANIELS
Life Legal Defense Foundation
PO Box 2105
Napa, CA 94558
Tel.: (707) 224-6675
Fax: (707-224-6676
kshort@lldf.org

Counsel for Amici Curiae

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