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In the Supreme Court of the United States

DANCO LABORATORIES, LLC,
Applicant,
v.
STATE OF LOUISIANA, et al.,
Respondents.

GENBIOPRO, INC.,
Applicant,
v.
STATE OF LOUISIANA, et al.,
Respondents.

BRIEF OF *AMICUS CURIAE* PHYSICIANS FOR REPRODUCTIVE HEALTH IN SUPPORT OF APPLICATIONS BY DANCO AND GENBIOPRO TO STAY OR VACATE THE JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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INTEREST OF AMICUS CURIAE[1]

Physicians for Reproductive Health ("PRH") is a physician-led nonprofit that seeks to assure meaningful access to comprehensive reproductive health services, including contraception and abortion. Since its founding in 1992, PRH has organized and amplified the voices of medical providers to advance reproductive health, rights, and justice. PRH's network of over 550 physicians work in forty-six states, Puerto Rico, and the District of Columbia. PRH has unique insight into the challenges physicians and patients face when confronted by laws and policies that prevent pregnant people from accessing necessary medical care and harm their ability to live freely, with dignity, safety, and security. To that end, in public discussions of reproductive health, PRH shares the physician's distinctive voice, expertise, and experience by gathering and publishing physician stories.

Requiring in-person mifepristone dispensation directly impacts PRH physicians' ability to provide patients with a safe and effective medication that is part of the most commonly recommended medication regimen to end a pregnancy. PRH and its network can attest that mifepristone is an incredibly safe and effective drug, whether dispensed in-person or via mail or at a local pharmacy following a telehealth visit. Indeed, PRH physicians are uniquely equipped to share the harm that they have incurred and will incur from reproductive health restrictions.

[1] No counsel for any party has authored this brief in whole or in part, and no person has made any monetary contribution intended to fund the preparation or submission of this brief.

SUMMARY OF ARGUMENT

Jane Doe is a 14-year old who found out she was pregnant shortly after she was raped. With the support of her mother and her doctors, she decided that her safest option, and the option least likely to retraumatize her, was terminating the pregnancy using a medication regimen of mifepristone and misoprostol.[2] However, Jane could not obtain the necessary medication at a local clinic because she lives on an island where, although abortion is legal, there are zero in-person abortion providers. The closest provider is located in Honolulu, Hawai'i, which is a flight away. Jane and her family did not have the means to pay for flights and hotels, which would have been prohibitively expensive. They also wanted to avoid further disruption to Jane's life and routine, and flying to Honolulu to end her pregnancy would have required missing school. Moreover, planning a trip to Honolulu would have delayed treatment, potentially narrowing the medical options Jane had for ending her pregnancy and subjecting her to a more invasive procedure.

Thankfully, Jane had another option: she met with a telehealth provider who was able to mail the mifepristone and misoprostol prescriptions, and she safely and legally ended her pregnancy at home. The Food & Drug Administration's ("FDA") 2023 modification to the Risk Evaluation and Mitigation Strategy ("2023 REMS") allows mifepristone to be dispensed by mail or at a pharmacy, and it is under this

[2] *See* Kristen Chalmers et al., *Abortion Experiences of Individuals with a History of Trauma(s): A Qualitative Study*, 149 Contraception 1, 5 (2025) (stating that "the invasive nature of transvaginal ultrasounds and procedures" can be "uncomfortable for some participants who related this exam to prior sexual abuse," and the ability to choose medication abortion to "do it privately and on [the patient]'s own time . . . in [the patient's] house" can help sexual assault survivors).

framework that Jane was able to receive care, despite her remote location. Indeed, after receiving care through telemedicine, Jane was able to safely and legally complete her medication abortion in the comfort of her own home surrounded by loved ones, helping her move forward from this traumatic experience in her young life.

The Fifth Circuit's May 1, 2026 order, which granted Plaintiffs-Appellees' appeal to stay the 2023 REMS, would prevent patients like Jane from receiving safe and effective abortion care or miscarriage management in this way—via mail or at a pharmacy following a telehealth visit. The result would be devastating to patients facing geographical barriers, financial constraints, threats of intimate partner violence, and/or transportation limitations—as well as a host of other personal circumstances—that may make it extremely difficult to travel to obtain care in-person. The Fifth Circuit's decision unnecessarily limits the options for managing pregnancy loss and accessing abortion care, restricts patient autonomy, and constrains doctors' ability to dispense a safe and effective medication for no medically justified reason.

This brief addresses the use of mifepristone from the perspective of physicians who provide reproductive health care, including abortion and miscarriage care, to patients across the United States. It combines conventional legal argumentation with first-person narratives from the physicians themselves.[3] The physicians'

[3] This *amicus* brief includes narratives from PRH providers from around the country, many of whom specialize in family medicine, complex family planning, maternal fetal medicine, and obstetrics and gynecology ("OBGYN"). These narratives were compiled from interviews conducted by the undersigned counsel, and each physician personally reviewed and approved their statements herein. The medical opinions expressed are their own and not necessarily shared by the institutions with which they are affiliated.

perspectives illustrate why leaving all medically sound options on the table, including dispensing mifepristone via mail or at local pharmacies, is critical.

By multiple objective measures, mifepristone—whether dispensed in-person, via mail, or at a local pharmacy—is very safe and effective. Consistent with the overwhelming medical consensus and literature, every doctor interviewed for this *amicus* brief prescribes mifepristone regularly and agrees that it is a safe and effective method for terminating pregnancy or managing pregnancy loss. None had medical concerns about dispensing mifepristone remotely; in fact, numerous providers shared patient stories, like Jane's, about why remote access is essential.

Upholding the Fifth Circuit's order, which upended federal policy and the status quo of more than five years with a nationwide mandate that mifepristone be dispensed only in-person at a health center, would severely limit access to mifepristone and block patients from receiving medically-appropriate and legal care. Indeed, requiring in-person dispensing of mifepristone will exacerbate existing inequities in abortion care and miscarriage management access, particularly for patients who already face structural barriers to care—including patients of color, low-income patients, and patients living in rural areas. The inability to remotely access medication for abortion care and miscarriage management will constrain patients' autonomy in deciding where, when, and how to manage their pregnancies and pregnancy losses, and will further erode physicians' ability to provide preferred care to their patients, undermining physicians' ability to exercise their judgment and core

principles of medical ethics. For all these reasons, this Court should block the Fifth Circuit's extraordinary stay.

ARGUMENT

I. Mifepristone Dispensed Remotely After Telehealth Appointments Is Safe And Effective For Medication Abortions And Miscarriage Management

In 2000, the FDA authorized mifepristone to be used with misoprostol to terminate a pregnancy or to manage a miscarriage.[4] In this two-drug regimen, frequently referred to as medication abortion, the patient takes one dose of mifepristone followed by one or more doses of misoprostol.[5] Patients taking these medications will experience bleeding and cramping when passing a pregnancy, but they face extremely low rates of complications.[6] Though a medication abortion also can be safely and effectively completed using misoprostol alone, studies have shown that using mifepristone with misoprostol can reduce side effects.[7]

When the FDA initially approved mifepristone in 2000, it required that mifepristone be dispensed only in-person at health care facilities.[8] But in July 2020, the FDA's in-person dispensing requirement was enjoined by court order due to the

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[4] *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation*, FDA (Apr. 8, 2026), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (hereinafter "FDA Mifepristone Q&A").

[5] *Id.*; Dr. Kristyn Brandi, *What to Know About Abortion and Miscarriages With or Without Mifepristone*, Am. Coll. Of Obstetricians and Gynecologists ("ACOG") (last reviewed Apr. 24, 2026), https://www.acog.org/womens-health/experts-and-stories/the-latest/what-to-know-about-abortion-and-miscarriages-with-or-without-mifepristone.

[6] ACOG Practice Bulletin No. 225, *Medication Abortion Up to 70 Days of Gestation* (Oct. 2020, *reaff'd* 2023), https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-of-gestation.

[7] ACOG Practice Bulletin No. 200, Early Pregnancy Loss (Nov. 2018, *reaff'd* 2025); Elizabeth G. Raymond et al., *Medication Abortion with Misoprostol-Only: A Sample Protocol*, 121 Contraception 1, 5 (2023).

[8] *See* FDA Mifepristone Q&A, *supra* note 4.

COVID-19 pandemic.[9] In April 2021, relying on significant research indicating that mifepristone is safely dispensed outside of healthcare facilities, the FDA announced that it would lift the in-person dispensation requirement during the COVID-19 public health emergency. The FDA announced in December 2021 that it would make that change permanent, and the updated REMS took effect in January 2023.[10]

Over the twenty-six years that mifepristone has been authorized for use by the FDA, it has been used by more than 7.5 million people for abortion and miscarriage care in the United States.[11] Medication abortions have become the most common method of abortion in the United States, accounting for 63% of all abortions performed in formal healthcare systems in 2023.[12]

A. "[Mifepristone] is completely safe."

Physicians overwhelmingly agree that mifepristone is a safe and effective option for abortion care and miscarriage management. All physicians interviewed for

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9 *FDA v. Am. Coll. Of Obstetricians & Gynecologists*, 141 S. Ct. 578, 580–81 (2021).

10 FDA Mifepristone Q&A, *supra* note 4. The FDA's decision was based on "a comprehensive review of the published literature, other relevant safety and adverse event data, and information provided by advocacy groups, individuals, and the applicants," and the resulting conclusion that there "did not appear to be a difference in adverse events between periods when in-person dispensing was and was not enforced." *Id.* The FDA then "approved a REMS modification that removes the in-person dispensing requirement and adds pharmacy certification." *Id.*

11 Press Release, Planned Parenthood, *25 Years After Its FDA Approval, Mifepristone is Still Safe and Effective* (Sept. 25, 2025), https://www.plannedparenthood.org/about-us/newsroom/press-releases/25-years-after-its-fda-approval-mifepristone-is-still-safe-and-effective.

12 Rachel K. Jones et al., *Medication Abortion Now Accounts for More Than Half of All US Abortions*, Guttmacher Institute (Dec. 2022), https://www.guttmacher.org/article/2022/02/medication-abortion-now-accounts-more-half-all-us-abortions; Rachel K. Jones & Amy Friedrich-Karnick, *Medication Abortion Accounted for 63% of All US Abortions—An Increase from 53% in 2020*, Guttmacher Institute (Mar. 2024), https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020#:~:text=While%20there%20are%20no%20comprehensive,medication%20abortion%20are%20at%20risk.

this *amicus* brief report that it is exceptionally rare for a patient to experience a mifepristone-related complication, if ever. For example, Dr. Aishat Olatunde, a board certified OBGYN and complex family planning specialist practicing in the Mid-Atlantic, estimates that she has prescribed mifepristone "thousands of times" since completing her medical training seven years ago, and "prescribe[s] mifepristone probably every day that [she is] in the office." She calls mifepristone "a very safe medication," and she rarely, if ever, sees complications from it.

Similarly, Dr. Avanthi Jayaweera, a family medicine physician practicing in the Mid-Atlantic, has prescribed mifepristone for thousands of patients, none of whom experienced serious adverse events as a result. Dr. Jayaweera stated she has "no concerns about using mifepristone" because it "is super safe, and I have felt very comfortable prescribing it." While Dr. Jayaweera's clinics do not dispense mifepristone remotely, in her opinion, there is "no clinical justification" for imposing restrictions on the dispensing of mifepristone.

Dr. Olivia Manayan, an OBGYN and complex family planning fellow who practices in Honolulu, reports the same. She says mifepristone is "incredibly safe." Further, Dr. Emma Trawick, a maternal fetal medicine fellow in the Southeast who has prescribed mifepristone hundreds of times for medication abortion and pregnancy loss believes that mifepristone is "a very, very, very safe drug" that is "a key piece of fetal loss management." Dr. Bhaskari Burra, a maternal fetal medicine physician in the Southeast, echoes this sentiment, stating that mifepristone is "bottom line, a very safe medication."

The experiences of PRH physicians are supported by overwhelming scientific and medical evidence. Medical and scientific research studies from the last three decades demonstrate the safety and efficacy of mifepristone (and misoprostol), both for medication abortion and miscarriage management.[13] Moreover, the risks associated with mifepristone are "exceedingly rare, generally far below 0.1% for any individual adverse event."[14] None of those risks are unique to mifepristone use. Rather, they arise whenever the uterus is emptied, whether through medical abortion, procedural abortion, miscarriage, or childbirth.[15] Research has not demonstrated a causal link between mifepristone and serious adverse effects.[16]

Hundreds of peer-reviewed studies on mifepristone are consistent with PRH providers' clinical experience: mifepristone is safe, and its availability makes both medication abortion and pregnancy loss safer.[17] And evidence available during the

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[13] "To date, mifepristone has been discussed in more than 901 medical reviews and used in at least 670 published clinical trials—of which 462 were randomized controlled studies, the gold standard in research design." Amicus Brief of ACOG, et al., as Amici Curiae Supporting Defendants at 5, *State of Louisiana v. United States Food & Drug Admin.*, No. 6:25-CV-1491 (W.D.L.A. 2026) Dkt.170-2, https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/amicus-briefs/2026/20260223_louisiana-usfda.pdf?rev=8a3aa82f29e3430f847dea56d7f65b0d; *see also* Ushma Upadhyay et al., *Reproductive Health Researchers' Comment*, ANSIRH, at 1–2 (2025) ("Decades of conclusive scientific evidence amassed through more than one hundred rigorous studies based on hundreds of thousands of patient outcomes have overwhelmingly established the safety and effectiveness of mifepristone for medication abortion and management of early pregnancy loss.") (collecting studies).

[14] U.S. Food & Drug Admin., Ctr. for Drug Evaluation & Research, Application No. 020687Orig1s020, Medical Review(s), at 47 (Mar. 29, 2016).

[15] Mifepristone Labeling and Medication Guide, at 16 (Jan. 2023), https://www.accessdata.fda.gov/drugsatfda_docs/label/2023/020687Orig1s025Lbl.pdf.

[16] *Id.* at 1–2, 5; U.S. Food & Drug Admin., NDA 020687 & ANDA091178, *Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2024* (2025), https://www.fda.gov/media/185245/download (discussing extremely low 0.00048% fatality rate among people who took mifepristone, including deaths unrelated to abortion or pregnancy).

[17] *See, e.g.*, ANSIRH, Analysis of Medication Abortion Risk and the FDA Report "Mifepristone US Post-Marketing Adverse Events Summary Through 12/31/2022," at 2–3 (2024), https://www.ansirh.org/sites/default/files/2024-05/Analysis%20of%20MA%20Risk%20and%20FDA%20Report%20Issue%20Brief%20FINAL.pdf.

2023 REMS decision-making process supported that conclusion.[18] Mifepristone's safety does not change when dispensed remotely. Indeed, researchers have confirmed that mifepristone is equally safe and effective when administered at home, rather than in a clinic.[19]

B. Telehealth allows physicians to examine patients effectively, and physicians use their medical and professional judgment when recommending in-person care.

All physicians interviewed unequivocally said that they would be comfortable dispensing mifepristone via mail or at a local pharmacy following a virtual assessment. PRH physicians report that in-person and telehealth assessments for prescribing mifepristone are substantially similar, and emphasize their ability to date a pregnancy using the patient's last menstrual cycle, recognize the symptoms of ectopic pregnancy, and counsel patients about their available options via telehealth. Dr. Tal Lee, an OBGYN in New York, explains that the standard of care for dating a pregnancy is having a patient report "the first date of their last period." Dr. Olatunde agrees, explaining that providing ultrasounds for patients in-person is not a "medical necessity." Dr. Jayaweera confirms that "if [patients] meet certain clinical criteria, they don't need a physical exam" to date the pregnancy.

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[18] *See, e.g.*, ANSIRH, *U.S. Studies on Medication Abortion Without In-Person Clinician Dispensing of Mifepristone*, at 1 (2021), https://www.ansirh.org/sites/default/files/2024-07/Issue%20Brief%20MAB%20without%20in%20person%20dispensing%207.2.24.pdf; Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 Obstetrics & Gynecology 778, 778–82 (2017), https://pubmed.ncbi.nlm.nih.gov/28885427/.

[19] Kristina Gemzell-Danielsson et al., *Home Use of Mifepristone for Medical Abortion: A Systemic Review*, 51 BMJ Sexual & Reprod. Health 1, 1 (2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12322458/pdf/bmjsrh-51-3.pdf.

All physicians interviewed explained that if concerns arise during a telehealth visit regarding the patient's eligibility for a medication abortion, they recommend that the patient come for an in-person visit. Dr. Manayan explains that "if [patients are] . . . pretty unsure about dating or have irregular periods, I will recommend an ultrasound prior [to confirming their eligibility for mifepristone]." Dr. Lee identified three potential examples where she would request an in-person visit with a patient before prescribing mifepristone: (i) if, based on the first day of their last menstrual period, the patient was too far along in their pregnancy to be eligible for medication abortion; (ii) if the patient was uncertain when their last period was, and had irregular periods, and would thus require an ultrasound to date the pregnancy; or (iii) if the patient was having symptoms of an ectopic pregnancy, such as severe abdominal pain.

An in-person dispensing requirement would mandate that all patients travel to a healthcare center *even when there is no clinical reason to do so*, while the current model enables physicians to tailor care to their patients' individual clinical circumstances and only refer them for in-person care *when that is actually medically appropriate*.

Importantly, PRH physicians emphasize that a key diagnostic for ectopic pregnancy is the patient's description of their symptoms, which can be accomplished both via telehealth and in-person. Their experience confirms that requiring in-person screening would not improve the diagnosis of ectopic pregnancies. In Dr. Olatunde's words, "the guidance on symptoms is more helpful than the ultrasound." Moreover,

Louisiana's position that prescribing mifepristone via telehealth increases risks relating to ectopic pregnancies is not supported by the scientific research or by PRH physicians' experiences.[20] Indeed, "substantial data and current clinical … guidelines support treatment of patients in whom ectopic pregnancy has not been definitively excluded because the condition can be detected and managed afterwards," so prescribing mifepristone and misoprostol together for those patients "is consistent with the standard of care."[21] Furthermore, patients who are too early in their pregnancy to determine the location of their pregnancy are thoroughly counseled on when to seek care for symptoms that may indicate an ectopic pregnancy requiring monitoring.

In the extremely rare event of a ruptured ectopic pregnancy, PRH physicians confirm that recognizing symptoms is a foundational, basic part of their training, and attest that they can easily distinguish between a miscarriage or medication abortion and a rupturing ectopic pregnancy via telehealth assessment. In fact, Dr. Lee says that the "uterine cramping" pain a patient will describe during an abortion or miscarriage is not the same as the pain a patient would describe during a rupturing ectopic pregnancy, which would present as "severe, diffuse abdominal pain." Similarly, Dr. Trawick explained that recognizing the symptoms of rupturing ectopic pregnancies is one of the "first thing[s] you learn in residency," and emphasizes that

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[20] Compl. ¶ 37, *State of Louisiana v. United States Food & Drug Admin.*, No. 6:25-CV-1491 (W.D. La. Oct. 6, 2025), ECF No. 1.

[21] Elizabeth G. Raymond et al., *Commentary: No-Test Medication Abortion: A Sample Protocol For Increasing Access During A Pandemic and Beyond*, 101 Contraception 361, 363 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7161512/pdf/main.pdf.

"the symptoms of a ruptured ectopic pregnancy do not mirror the symptoms of a miscarriage. So if someone called you with symptoms of [ruptured] ectopic pregnancy you would know." Physicians interviewed expressed strong confidence that they would not miss the symptoms of a rupturing ectopic pregnancy if counseling a patient via telehealth, and uniformly said that if a patient called with those symptoms they would immediately help the patient access in-person, emergency care.

Further, physicians' medical advice on medication abortion and miscarriage management does not differ between telehealth and in-person appointments, and patients receive the same information about the potential risks and side effects of mifepristone regardless of whether the appointment is in-person.[22] Indeed, Dr. Olatunde emphasizes "the words I say are exactly the same" for in-the person and telehealth abortion counseling appointments. Moreover, while physician counseling on these risks remains the same in-person and remotely, physicians also stress the importance of individualized patient care. For example, when providing counselling remotely to patients across Hawai'i's islands, Dr. Manayan "accommodate[s] for if [patients] are in a place where it is not so easy to reach us if there was a complication, like on a neighbor island, so they know the closest place to get emergency care."

PRH physicians' experiences indicate that complications requiring emergency care are even more rare than statistics might indicate, and that patients who do seek follow-up or emergency room care typically do so for routine, non-emergent side-

[22] *See, e.g.*, *Grossman & Grindlay*, *supra* n.18 (finding that among people who received medication abortion care via telehealth, only 0.18% experienced any adverse effects, compared with 0.32% of those who received in-person care).

effects of medication abortion, for which no treatment or intervention is actually needed. Dr. Lee staffs her clinic's OBGYN emergency line and says "it's very rare" to receive calls from people who have taken mifepristone, and that, if they do call, "[u]sually [it is] because they're having expected bleeding and some people find that to be concerning. That's completely reasonable; people have different amounts of bleeding that they're comfortable with. Usually they're looking for reassurance . . . to have someone say, this is normal, you'll be okay." She has seen "no bad outcomes for medication abortions" after prescribing misoprostol and mifepristone hundreds of times. Similarly, Dr. Olatunde explains, "it's pretty uncommon" for patients to require emergency care, and "rare" for patients to "present[] with complications from their abortion or miscarriage management."

Finally, as with an in-person visit, physicians offering telehealth are always on alert for patients who are at risk of intimate partner violence, abuse, or coercion and have mechanisms in place to help identify these situations. Indeed, Dr. Manayan and others report that telehealth appointments can be the safest option or the only option that victims of intimate partner violence may have to access care. Dr. Manayan has seen telehealth patients attend the appointment from work and explain that "their partners are tracking their location" and "as long as they are at work their partner won't know that they are getting that care." Moreover, a systematic review of reproductive coercion research studies found that cases in which a partner seeks to force pregnancy are more common than cases in which a partner seeks to force

terminating a pregnancy.[23] For this reason, the option to terminate a pregnancy can be a lifeline for pregnant patients in abusive relationships. Indeed, Dr. Manayan describes a patient who "did not want to be tied" to an abusive partner and "feared that having a child with him would not allow for complete separation." For that patient, receiving abortion care remotely saved her from being "forced . . . to carry a pregnancy that would negatively impact her life."[24]

PRH physicians confirm that it is safe to dispense mifepristone via mail or at a local pharmacy following a telehealth visit because physicians are perfectly capable of assessing whether the patient is a candidate for medication abortion or not during a virtual appointment, and attest that in some cases, a virtual appointment might offer vulnerable patients safety advantages.

II. PRH Physicians' Experiences Demonstrate That Removing Access To Mifepristone Via Mail Or At A Local Pharmacy Will Threaten Patients' Health And Autonomy

Removing remote access to mifepristone threatens patient health and autonomy. The physicians interviewed for this brief confirm that limiting their ability to dispense mifepristone remotely can cause medical harm when the patient is seeking a medication abortion in a life-threatening situation, especially if they are unable to access in-person abortion care due to geographic barriers or personal

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[23] *See* Karen Trister Grace & Jocelyn C. Anderson, *Reproductive Coercion: A Systematic Review*, 19 *Trauma, Violence & Abuse* 371 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC5577387/pdf/nihms895763.pdf (breaking down rates of abortion coercion vs. pregnancy coercion, birth control sabotage, and other forms of reproductive coercion designed to force pregnancy on a survivor).

[24] Sarah Varney & Rachel Wellford, *Transcript: Abortion Restrictions May Be Fueling A Rise in Domestic Violence, Experts Warn*, PBS News Hour (Oct. 16, 2025), https://www.pbs.org/newshour/show/abortion-restrictions-may-be-fueling-a-rise-in-domestic-violence-experts-warn.

circumstances. Similarly, physicians worry about the ethical harm caused by limiting patient choice. Although physicians are ethically obligated to respect patient autonomy by "acknowledg[ing] an individual's right to hold views, to make choices, and to take actions based on her own personal values and beliefs,"[25] the Fifth Circuit's order harms their ability to do so by removing a safe and effective option from their medical toolkit.

Dr. Benjamin Brown, an OBGYN and complex family planning specialist who also specializes in and conducts research on clinical medical ethics, explains that patient autonomy is "central" to the medical practice. "It's ***the*** thing that determines the plan of care" when there are multiple medically appropriate options, and "[p]recluding someone from accessing a mode of care if that restriction is not medically grounded" raises ethical concerns for providers. Dr. Brown explains that while he is "the expert in the biomedical piece—how to interpret lab results, how to do a procedure," he is "not the expert in the needs of the person in front of [him] and their values. There's only one expert in that, and that's them." He emphasizes that when physicians "want to help the patient have the best healthcare outcome, the best treatment for them, that means making sure the plan of care is grounded in their values, needs, [and] preferences" and that "shared decision-making" between physician and patient "is the standard of care."

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[25] ACOG Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology*, 110 Obstetrics & Gynecology 1479, 1481 (Dec. 2007, *reaff'd* 2016), https://journals.lww.com/greenjournal/citation/2007/12000/acog_committee_opinion_no__390__ethical_decision.53.aspx.

Other PRH physicians agree. Dr. Olatunde explains that "it should be patients deciding how they want their care to be provided. It's our job to facilitate and to guide and to provide recommendations based on their personal and individualized scenario and medical situations and outline the options. . . we are the *facilitators* of their care. *Not the deciders, the facilitators*." Dr. Trawick emphasizes that within the realm of medically supported options, patient choice is essential; it is "really important for patients to have all options available to them," including the option to obtain medication via mail or at a local pharmacy. Dr. Lee notes that patients often choose medication abortion so "[t]hey can choose where and when they pass the pregnancy, so they can be maybe in their pajamas surrounded by loved ones if they want. There is no reason to [only] give in the clinic. It's all about what's best for the patient." Dr. Rachel Jensen, a board-certified OB/GYN and specialist in complex family planning practicing in the D.C. area, emphasizes that "[t]elehealth is an incredible way to increase patient-centeredness, and to have more of these conversations in a setting where patients are more comfortable."

As the below accounts demonstrate, requiring mifepristone to be dispensed in-person not only presents risks to a patient's health or life, but also erodes the core medical principle of patient autonomy at the forefront of patient-centered care.

A. "She could have avoided a trip that put her life at risk."

Many patients seeking abortion care suffer from medical conditions that make traveling to a clinic dangerous, and the ability to receive mifepristone via mail or at

a local pharmacy can therefore be life-saving.[26] For example, Dr. Jayaweera described a patient in the early stages of her second pregnancy who was suffering from hyperemesis gravidarum ("HG"), typically a self-limiting[27] condition of nausea and vomiting of early pregnancy that is often "associated with short-term and long-term adverse outcomes for the mother and her offspring."[28] Dr. Jayaweera's patient had an unusually severe and prolonged presentation that became debilitating and life-threatening. She required multiple hospitalizations, frequent IV fluids, and extensive monitoring given severe electrolyte imbalance, dehydration, and profound weight loss, and was rendered "unable to eat, unable to function," and unable to care for her toddler. Dr. Jayaweera became especially worried when the patient lost nine pounds, a symptom Dr. Jayaweera describes as "very concerning for someone who is pregnant." According to Dr. Jayaweera, the HG put both the pregnancy and the patient's life at risk, and the patient risked serious heart complications from abnormalities in electrolyte levels, as well as severe dehydration and malnourishment. While the patient had desperately wanted a second child and had suffered through two early miscarriages, she ultimately made the difficult decision to

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[26] *See, e.g.*, Ushma D. Upadhyay et al., *Distance Traveled for an Abortion and Source of Care After Abortion*, 130 Obstetrics & Gynecology 616, 616–17 (2017), https://journals.lww.com/greenjournal/abstract/2017/09000/distance_traveled_for_an_abortion_and_source_of.17.aspx ("For most patients, greater distance traveled for abortion was associated with increased likelihood of seeking subsequent care at an ED.")

[27] *See* Julia Kathrin Juekstock et al., *Managing Hyperemesis Gravidarum: A Multimodal Challenge*, 8 BMC Med. 1, 1 (2010), https://link.springer.com/article/10.1186/1741-7015-8-46#auth-JK-Jueckstock-Aff1 (as a self-limiting condition, HG symptoms resolve without medical intervention for most patients).

[28] *Id.*

end the pregnancy for the sake of her health and her existing child, with the support of her partner.

There were no abortion providers in the patient's area, however, and Dr. Jayaweera's clinic only dispenses mifepristone in-person. The patient was forced to drive for hours to seek the care that she needed: a medication abortion using mifepristone and misoprostol. Dr. Jayaweera believes that this patient would have been an excellent candidate to receive mifepristone by mail following a telehealth visit because her condition was so severe that it was medically unsafe for her to travel:

> Subjecting someone very ill to that type of travel . . . put her life at risk. I would have not recommended that any patients with these symptoms go on an extended travel like this. But given the state of reproductive healthcare access, she had no other option. Had this patient been able to receive a mifepristone prescription via telehealth, she could have avoided a trip that put her life at risk.

Indeed, the patient was so medically unstable that she received IV fluids directly before the drive. As a result of this harrowing experience, the patient disclosed that while she had previously been firmly "pro-life," her perspective had shifted as a result of the experience. She realized "I couldn't go through with this pregnancy without risking my life or the family's wellbeing." From Dr. Jayaweera's perspective, the lesson here is that "you never think you need an abortion until you need one, and that is why it is so important to allow people to take the lead on their own healthcare."

Another pregnant patient Dr. Jayaweera treated was suffering from a mental health crisis that was so severe that she became "acutely suicidal." Recognizing that her pregnancy was a reason for her severe depression and suicidal ideation, the

patient decided to get an abortion.[29] Dr. Jayaweera explained that when the patient first decided that she wanted an abortion, she was eligible for a medication abortion using mifepristone and misoprostol, but by the time she had arranged travel and accessed care, her pregnancy had advanced and procedural abortion became the only option.

For this patient, "the abortion was life-saving." And if she had had access to a medication abortion remotely, "she would have been able to get an abortion much earlier in pregnancy, address her severe mental health symptoms and become medically stable a lot sooner." Dr. Jayaweera says that she has "had people tell me, 'I'd rather be dead than move forward with this pregnancy.' Sometimes the way they present is very concerning, and if I'd been able to reach them via telehealth I would have said, 'we need to get you care and we need to get you care now.' This is better than making an [in-person] appointment, which can lead to additional, unnecessary delays, especially if they are traveling far or have other barriers to access care."

Both of Dr. Jayaweera's patients had the time, financial means, and job flexibility to travel to access abortion care. Current and future patients facing life-threatening conditions caused by their pregnancies may not have those privileges. A stay of the 2023 REMS risks forcing critically ill patients to travel to obtain mifepristone or to forego it altogether.

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[29] *Cf.* Kathleen Chin et al., *Suicide and Maternal Mortality*, 24 Springer Nature 239, 239 (2022), https://link.springer.com/article/10.1007/s11920-022-01334-3 ("Suicide is a leading cause of death in the perinatal period (pregnancy and 1 year postpartum).").

B. "They would have to fly to get abortion care."

Medical emergencies are not the only reason patients would benefit from the availability of remote abortion care and miscarriage management, as many patients face other obstacles to accessing care in-person: distance to a clinic, work constraints, disability, intimate partner violence, child care concerns, and a myriad of other barriers. For example, Hawai'i is made up of eight islands, but there are abortion providers on only three of those islands. For this reason, Dr. Manayan reports that telehealth care is essential for Hawai'ian patients because "if an off-island patient was unable to attend their appointment virtually and get their medication mailed to them, they would have to fly to get abortion care." As with Jane Doe, flying is simply not an option for many patients, and particularly for those patients facing historic healthcare inequities, such as the Native Hawai'ian and Pacific Islander populations who are already more likely to not have a primary healthcare provider, or who may simply choose to go without care due to the high costs.[30] Restricting the remote dispensation of mifepristone will only exacerbate these existing inequities by further increasing the cost to obtain care. Therefore, the ability to dispense mifepristone remotely "gives patients the opportunity to have control over their body and their life" without facing additional hurdles.

Patients in states with large rural areas face similar challenges in accessing mifepristone for abortion care and miscarriage management. Dr. Burra works at one

[30] Shannon Schumacher et al., *Health Care Experiences of Native Hawaiian or Pacific Islander Adults*, KFF (Dec. 3, 2024), https://www.kff.org/racial-equity-and-health-policy/health-care-experiences-of-native-hawaiian-or-pacific-islander-adults/.

of the only clinics in the western region of her state that provides specialized care for high-risk pregnancies, and many of her patients live in rural areas that are two to three hours away from her clinic. She has historically prescribed mifepristone to be picked up at a local pharmacy via telehealth for patients experiencing a miscarriage or pregnancy loss. By prescribing mifepristone over telehealth for at-home management, Dr. Burra is "trying to save patients from having to drive several hours" for an unnecessary in-person appointment in the midst of experiencing a miscarriage or pregnancy loss, which can be a traumatic and devastating experience. Dr. Burra reports that patients who live far from the clinic also face logistical barriers to care, such as access to transportation or gas money, child care, and time off work to travel to appointments.[31] The ability to dispense mifepristone remotely via telehealth safely and legally eliminates these burdens.

The patient populations facing these access barriers are typically also the patient populations already facing systemic inequities in healthcare, and thus, a stay of the 2023 REMS would necessarily exacerbate existing racial and economic disparities in maternal health. Indeed, studies show that Black and Indigenous patients already "face greater distances to reach an abortion provider," a disparity that could be lessened by easier access to mifepristone via telehealth and mailed or locally filled prescriptions.[32] Additional medically unnecessary restrictions on

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[31] *See, e.g.*, Maleeha Aziz, *Abortion is Essential: Stories of Liberation*, American Civil Liberties Union, https://www.aclu.org/abortion-stories/maleeha-aziz (last accessed Apr. 24, 2026) (describing financial and emotional cost of traveling to another state in the wake of abortion restrictions and misinformation).

[32] Leah R. Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, 9 JMIR Pub. Health & Surveillance 2 (2023), https://publichealth.jmir.org/2023/1/e45671/PDF.

mifepristone access will ultimately worsen maternal health outcomes overall because patients will be "compelled to continue a pregnancy against [their] will, even when serious health threats exist."[33] Tragically, the United States already has the highest maternal mortality rate among developed countries, and Black women in the United States "experienc[e] higher rates of maternal death than any other demographic group."[34] And without accessible options for abortion care, maternal mortality rates in the United States could further increase by 24% across all populations, and by a staggering 39% for Black women specifically.[35]

Further, reducing remote access to abortion medication would increase risks to patient populations who may hesitate to attend an in-person clinic. For example, Dr. Trawick emphasizes that some immigrant patients do not feel comfortable seeking care at a hospital, and that remote access is "routine[ly]" the only way they receive care.[36] For all of these populations, access to abortion care and miscarriage management via mail or at a local pharmacy mitigates inequities, fosters

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[33] Elyssa Spitzer et al., *Abortion Bans Will Result in More Women Dying*, Center for American Progress (Nov. 2, 2022), https://www.americanprogress.org/article/abortion-bans-will-result-in-more-women-dying/.

[34] *Id.*

[35] *Id.*

[36] Physicians in places that have experienced recent immigration crackdowns report that immigrant patients have canceled, missed, or postponed critical appointments because they fear leaving their home and being targeted at medical facilities. *See, e.g.*, Josh Marcus, *Planned Parenthood's No-show Rates in Minnesota Spike as Pregnant Women Avoid ICE, Report Says*, Independent (Feb. 2026), https://www.independent.co.uk/news/world/americas/us-politics/minnesota-ice-planned-parenthood-pregnancy-b2922306.html (no-show rates at a clinic in Minnesota spiked 8% in February 2026); *Bovino Defends Immigration Surge Tactics, Deflects Questions of Abuse*, MPR News (Jan. 2026), https://www.mprnews.org/story/2026/01/20/ice-enforcement-minneapolis-minnesota-latest-updates (patients have missed, canceled, or postponed appointments "due to the fear of being targeted by immigration officials at medical facilities.").

empowerment and respect for patient autonomy, and could improve overall maternal health outcomes.

C. Restrictions on dispensing mifepristone can "compound the grief patients are already experiencing."

Even when patients do not face clear geographical, transportation, time, or health barriers, longstanding medical ethics guidelines require fostering patient autonomy as part of the standard of care.[37] As Dr. Brown emphasizes, those ethical requirements mean that patients should be able to choose the manner in which they experience the end of their pregnancy, whether due to an abortion, miscarriage, or pregnancy loss, to the greatest extent medicine permits. Dr. Olatunde sums up what all of the physicians interviewed repeatedly emphasized: the care they provide is "not one-size-fits-all," and every patient's needs "are specific to them, and it's not going to be the same for every person." According to Dr. Brown, providing physicians with "a broad toolkit" is "the most important way to make sure the [patient] can get the care they need," and taking remote abortion care or miscarriage management "out of my toolkit could prevent me from caring for a patient in the right way for that person."

Restrictions on the dispensation of mifepristone defy these basic principles of patient autonomy. For example, Dr. Trawick recalls the story of a patient who experienced a devastating fetal loss. Dr. Trawick confirmed that at-home management of this pregnancy loss was completely safe for the patient, and that "the patient desperately just wanted it to be managed at home." But there was no

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[37] *See generally* Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* (9th Ed. 2026).

mifepristone available in her area, and her state does not allow physicians to mail mifepristone. As a result, during a very challenging time, one more important choice was taken away from her. Dr. Trawick explained:

> Instead of being able to receive mifepristone in the mail, which would have been perfectly safe and less disruptive to the patient and her family, the patient had to drive about 5 hours to a clinic for a procedural abortion . . . .This situation was not medically complicated, but the legal complexity only makes [physicians'] jobs harder and compounds the grief patients are already experiencing . . . . It just stinks to not be able to meet patients with the options that are medically safe for them because of regulations.

The ever-growing restrictions on reproductive health also undermine physicians' ability to provide care they know is safe, consistent with their ethical obligations. Indeed, physicians nationwide are no longer able to focus on managing safe, effective, patient-centered care. Instead, as Dr. Jensen reflects, reproductive health restrictions "impede[] our ability to use our medical judgment." She says that clinicians working in reproductive health under medically unnecessary restrictions have "the knowledge, the tools and the technology" to provide mifepristone remotely where appropriate without requiring medically unnecessary travel, but may be legally prevented from doing so. Dr. Brown echoes this sentiment, emphasizing that "there's just no way for policy to anticipate all of the contours of what's going on in one individual's life such that it can be written out in the law to anticipate every need for every Jane Doe patient." Dr. Trawick similarly states that the increased restrictions and regulations "[m]ake[] me constantly feel like I'm not able to provide the care for patients that they deserve and need. . . .[It] makes me feel like I'm

participating in these restrictive regulations, saying you can't have this procedure here . . .that makes me feel complicit."

The Fifth Circuit's decision would require in-person dispensing of mifepristone on a nationwide basis by staying the 2023 REMS. But this would only further limit physicians' ability to offer safe and effective treatment and restrict autonomy for patients choosing to end their pregnancy or manage a pregnancy loss.

CONCLUSION

For all of the reasons set forth herein, PRH respectfully asks that this Court stay or vacate the Fifth Circuit's ruling.

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Respectfully submitted,

s/ Janice Mac Avoy

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