UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
LAFAYETTE DIVISION

THE STATE OF LOUISIANA, by and through its Attorney General, LIZ MURRILL, and ROSALIE MARKEZICH, PLAINTIFFS, v. U.S. FOOD AND DRUG ADMINISTRATION, *et al.*, DEFENDANTS.	Civ. No. 6:25-cv-01491 Judge David C. Joseph Magistrate Judge David J. Ayo

BRIEF OF MEDICAL STUDENTS FOR CHOICE AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS' AND PROPOSED INTERVENORS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY RELIEF

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I. INTEREST OF AMICUS CURIAE

Medical Students for Choice ("MSFC") is a non-profit organization with over 10,000 members and nearly 300 chapters in over 26 countries, including approximately 185 chapters across the United States. MSFC seeks to ensure that medical students and trainees have access to comprehensive, evidence-based reproductive healthcare education. MSFC has a strong interest in protecting evidence-based medical education and training. Accordingly, MSFC submits this brief to outline the concerns of the organization's members regarding interference with evidence-based access to mifepristone dispensed by mail across the country.

II. SUMMARY OF ARGUMENT

For over twenty-five years, mifepristone has been used safely and effectively in the United States. Mifepristone was first approved by the Food and Drug Administration ("FDA") in 2000 with a set of initial restrictions. With the benefit of years of scientific evidence, the FDA has updated the mifepristone label and modified certain regulatory restrictions in the mifepristone risk evaluation and mitigation strategy ("REMS") since the drug's initial approval. In 2023, in light of mifepristone's remarkable safety record generally and the robust evidence that mifepristone is safe and effective without in-person dispensing, including evidence developed based on such use during the coronavirus pandemic, the FDA lifted the medically unnecessary requirement that patients travel to a clinic, medical office, or hospital for the sole purpose of picking up mifepristone—a medication that has been safely used by millions of Americans in deeply private moments, including miscarriage.

Now, against the evidence that in-person dispensing of mifepristone is medically unnecessary and burdensome, Plaintiffs (hereinafter "Louisiana") ask this Court to issue a

nationwide injunction reinstating this restriction on access to healthcare. This Court should decline to do so.

First, mifepristone, when used in conjunction with misoprostol, is accepted worldwide as part of a patient-centered and evidence-based protocol, and is safe and effective when dispensed through telehealth or by mail or pharmacy.[1] Mifepristone dispensed by mail or via telehealth offers critical care in rising maternal healthcare deserts across the country, expanding access to reproductive health services for patients who face barriers to attending clinics in-person. States with abortion access rely on telemedicine abortion care and mifepristone dispensed by mail to provide patients with the standard of care and the autonomy over their medical choices that they deserve.

Second, reinstating the in-person dispensing requirement would have a profound impact on medical training and the future of the medical profession nationwide. Future medical professionals rely on learning the best, evidence-based practices to care for patients now and in the future. The limited period medical students and residents spend training sets them up for success, no matter where in the United States they may practice later. MSFC members are also taught to center their burgeoning practices on ethical, patient-centered care.

[1] *See, e.g.*, Laura Schummers, et al., *Abortion Safety and Use with Normally Prescribed Mifepristone in Canada*, 386 NEW ENG. J. MED. 57 (2022), https://pubmed.ncbi.nlm.nih.gov/34879191/; ADVANCING NEW STANDARDS IN REPROD. HEALTH, ANALYSIS OF MEDICATION ABORTION RISK AND THE FDA REPORT "MIFEPRISTONE US POST-MARKETING ADVERSE EVENTS SUMMARY THROUGH 12/31/2024" 1 (2025), https://www.ansirh.org/sites/default/files/2025-05/Issue%20Brief%20MAB%20SAEs-May2025%20Final_0.pdf; WORLD HEALTH ORG., MODEL LIST OF ESSENTIAL MEDICINES: 24TH LIST 55 (2025), https://iris.who.int/server/api/core/bitstreams/17642505-ecd3-4940-a691-4f1dfa0d835a/content; Mitchell D. Creinin & Daniel A. Grossman, *Medication Abortion Up to 70 Days of Gestation*, 136 OBSTET. & GYNECOL. 31, 39 (2020), https://tinyurl.com/ycyvp7ec; Ushma D. Upadhyay, et. al., *Effectiveness and Safety of Telehealth Medication Abortion in the USA*, 30 NATURE MED. 1191, 1191 (2024), https://www.nature.com/articles/s41591-024-02834-w; WORLD HEALTH ORG., ABORTION CARE GUIDELINE, SECOND EDITION: EXECUTIVE SUMMARY 16 (2025), https://iris.who.int/server/api/core/bitstreams/d167e16e-cb54-4d7c-b237-1a3c879638f0/content.

Louisiana's attempt to impose its political preferences on the medical profession and patients nationwide would erect obstacles in the paths of medical students and undermine medical schools' ability to provide future medical professionals with evidence-based, patient-centered education. Reinstating the in-person dispensing requirement risks creating gaps in medical education and diminishing the quality of medical care in this country for generations to come.

III. ARGUMENT

A. Interference With Access To Mifepristone Dispensed by Mail Would Disrupt Evidence-Based Healthcare Nationwide

1. Mifepristone Dispensed by Mail Is Evidence-Based Healthcare

Mifepristone is part of a globally accepted regimen for medication abortion, endorsed by the World Health Organization, and available in nearly 100 countries around the world.[2] Decades of peer-reviewed studies have concluded that mifepristone is safe and effective, and serious adverse events are exceedingly rare.[3] Indeed, mifepristone is safer than penicillin and Viagra.[4]

In 2000, the FDA determined—after a four-year review—that mifepristone was safe and effective for use under specified conditions based on adverse events reporting and ongoing studies of patient outcomes.[5] In 2007, Congress enacted the FDA's REMS regime. *See* 21 U.S.C. § 355-1 (2022). Mifepristone was deemed to have REMS, in accordance with the restrictions on use set out in the 2000 approval. *See* 21 U.S.C. § 331. After years and then decades of reporting and data, the FDA has updated the mifepristone label and modified the REMS.[6] In April 2021, the FDA

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[2] WORLD HEALTH ORG., MODEL LIST OF ESSENTIAL MEDICINES, *supra* note 1. GYNUITY HEALTH PROJECTS, MIFEPRISTONE APPROVED LIST (2024), https://gynuity.org/assets/resources/mife_by_country_and_year_en.pdf.

[3] Jack Resneck, *Reducing Access to Mifepristone Would Harm Patients*, AM. MED. ASSOC. (Mar. 25, 2024), https://www.ama-assn.org/about/leadership/reducing-access-mifepristone-would-harm-patients; *see also, e.g.*, Laura Schummers, et al., *supra* note 1; ADVANCING NEW STANDARDS IN REPROD. HEALTH, *supra* note 1.

[4] Annette Choi & Will Mullery, *How Safe is the Abortion Pill Compared with Other Common Drugs*, CNN (Apr. 21, 2023), https://www.cnn.com/2023/03/15/health/abortion-pill-safety-dg/index.html.

[5] Letter from U.S. Food & Drug Admin. to Population Council (Sept. 28, 2000), https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2000/20687appltr.pdf .

[6] *See* U.S. FOOD & DRUG ADMIN., *Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Jan. 17, 2025), https://shorturl.at/YCNy2.

announced that it would exercise enforcement discretion relating to the in-person dispensing requirement to permit mailing of mifepristone during the COVID-19 Public Health Emergency, and later that year announced its intention to permanently lift the requirement based on decades of evidence supporting increased access to mifepristone and evidence from the pandemic demonstrating the safety of remote dispensing (the "2023 REMS Update").[7]

The 2023 REMS Update removed the in-person dispensing requirement and allowed pharmacies to dispense mifepristone.[8] Despite its proven safety and efficacy, mifepristone is still one of the most heavily regulated medications on the U.S. market today. The FDA has imposed REMS for only 72 of the more than 20,400 FDA approved prescription drugs on the market.[9] Medications with REMS restrictions include such medications as fentanyl and other opioids, antipsychotics, and cancer drugs with potentially severe side effects.[10] Today, to prescribe mifepristone, a healthcare provider must be specially certified, sign a Prescriber Agreement Form affirming that they have the ability to assess the duration of a pregnancy, diagnose ectopic pregnancies, and provide surgical intervention if needed, and review a Patient Agreement Form with the patient outlining the risks involved that both the prescriber and patient must sign.[11] Similarly, pharmacies must be specially certified and complete a Pharmacy Agreement Form

[7] U.S. FOOD & DRUG ADMIN., RISK EVALUATION AND MITIGATION STRATEGY (REMS) SINGLE SHARED SYSTEM FOR MIFEPRISTONE 200 MG (2025), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifepristone_2025_09_30_REMS_Full.pdf. The FDA first halted enforcement of the in-person dispensing requirement in July 2020 as a result of a court order. U.S. FOOD & DRUG ADMIN., *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Feb. 2, 2026), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/questions-and-answers-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation.

[8] U.S. FOOD & DRUG ADMIN., (2025 REMS), *supra* note 7.

[9] U.S. FOOD & DRUG ADMIN., *Approved Risk Evaluation and Mitigation Strategies (REMS)*, https://www.accessdata.fda.gov/scripts/cder/rems/index.cfm (last visited Feb. 19. 2026); U.S. FOOD & DRUG ADMIN., FDA AT A GLANCE (2026), https://www.fda.gov/media/154548/download.

[10] U.S. FOOD & DRUG ADMIN., *Approved Risk Evaluation and Mitigation Strategies*, *supra* note 9; Julia Kaye, et al., *The Mifepristone REMS: A Needless and Unlawful Barrier to Care*, 104 CONTRACEPTION P12 (July 2021), https://shorturl.at/swTY2; MEDXDRG, *What Drugs Require REMS? A Guide to FDA Safety Programs*, https://medxdrg.com/what-drugs-require-rems-a-guide-to-fda-safety-programs (last visited Feb. 19, 2026).

[11] U.S. FOOD & DRUG ADMIN., (2025 REMS), *supra* note 7, at 1–2, 6–12.

requiring that the pharmacy maintain detailed records, train staff on all relevant procedures, track and verify shipments, comply with audits, and many other requirements.[12]

After nearly a quarter-century of mifepristone's safe and effective use in the United States, medication abortions now account for more than half of all abortions in the country.[13] In the United States, the medically accepted standard of care for the medical termination of an early pregnancy includes two medications.[14] First, the patient takes mifepristone, which interrupts early pregnancy by blocking the effects of the hormone progesterone. Second, the patient takes misoprostol, which causes the uterus to contract to expel the pregnancy. Mifepristone is used together with misoprostol in both medical abortions and miscarriage management.[15]

Lily Leibner, an MSFC student and second-year medical student in New York, explains the benefits of mifepristone in protecting future fertility during a miscarriage:[16]

> Prior to medical school, I worked at a reproductive endocrinology and infertility clinic. Mifepristone serves many purposes and is even commonly used in the fertility space in patients actively trying to conceive. When patients undergo any type of pregnancy loss – in the infertility field, these are typically wanted pregnancies that result in loss for various reasons – mifepristone is often used to help expel

[12] *Id.* at 2–3, 13–17.

[13] Rachel K. Jones & Amy Friedrich-Karnik, *Medication Abortion Accounted for 63% of All US Abortions in 2023—An Increase from 53% in 2020*, GUTTMACHER INST. (Mar. 2024), https://www.guttmacher.org/2024/03/medication-abortion-accounted-63-all-us-abortions-2023-increase-53-2020.

[14] U.S. FOOD & DRUG ADMIN., (2025 REMS), *supra* note 7; Mitchell D. Creinin & Daniel A. Grossman, *supra* note 1.

[15] Mitchell D. Creinin & Daniel A. Grossman, *supra* note 1; Honor MacNaughton, et al., *Mifepristone and Misoprostol for Early Pregnancy Loss and Medication Abortion*, 103 AM. FAM. PHYSICIAN 473, 475 (Apr. 15, 2021), https://www.aafp.org/pubs/afp/issues/2021/0415/p473.pdf; Courtney A. Schreiber, et. al, *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss*, 378 N. ENGL. J. MED. 2161 (Jun. 7, 2018), https://pubmed.ncbi.nlm.nih.gov/29874535/. A regimen including both mifepristone and misoprostol leads to more successful and quicker abortions and a decreased need for surgical intervention for miscarriage. WORLD HEALTH ORG., MEDICAL MANAGEMENT OF ABORTION 20 (2018), https://shorturl.at/ao9u4; Sarah Prager, et al., *ACOG Practice Bulletin No. 200: Early Pregnancy Loss*, 132 OBSTET. & GYNEC. 197 (Nov. 2018), https://pubmed.ncbi.nlm.nih.gov/30157093/. A misoprostol-only regimen can be more "physically challenging" for patients and result in increased side effects. Dana M. Johnson, et al., *Experiences with Misoprostol-Only Used for Self-Managed Abortion and Acquired from an Online or Retail Pharmacy in the United States*, 131 CONTRACEPTION 110345 (Mar. 2024), https://pubmed.ncbi.nlm.nih.gov/38049047/.

[16] The statements provided herein express the views of each speaker as a member of MSFC and should not be attributed to any other institutions with which such speakers may be affiliated. Some names have been anonymized for privacy. All statements have been provided to MSFC by verified MSFC members.

> the pregnancy that has already been deemed inviable (often due to cessation of fetal heart rate for an unknown reason). Studies have shown that medical management of pregnancy loss with mifepristone (in combination with misoprostol) is the most effective medical management approach to help patients quickly move forward and try to conceive again (naturally or via assisted reproductive technology).

Multiple studies confirm that mifepristone provided through telemedicine and delivered by mail is just as safe and effective as mifepristone dispensed in a clinical setting.[17] One study reviewed the medical records of over 6,000 patients who either spoke with a provider over video or a secure chat platform for an initial consultation for medical abortion.[18] If the provider found the patient eligible using a standardized protocol that relied primarily on patient medical history and responses to provider questions, the provider prescribed mifepristone and misoprostol to be delivered by mail-order pharmacy.[19] The study found that 98% of abortions were successfully completed and only 0.25% resulted in a serious adverse event; these rates are comparable to in-person medication abortion care.[20]

In addition, one study of 510 patients from five states who received mifepristone by mail found no adverse effects related to mail-order pharmacy dispensing, and over 90% of patients reported satisfaction with their treatment.[21] Another study of 2,600 health records from medication abortions provided by mail or in clinics showed that dispensing by mail did not meaningfully prolong the mean time from initial patient outreach to mifepristone ingestion.[22]

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[17] *See, e.g.*, ARA Aiken, et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion (Termination of Pregnancy) Provided via Telemedicine: a National Cohort Study*, 128 BJOG 1464 (Mar. 24, 2021), https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.16668.

[18] Upadhyay, et al., *supra* note 1, at 1191.

[19] *Id.* at 1192.

[20] *Id.* at 1194.

[21] Daniel Grossman, et al., *Mail-Order Pharmacy Dispensing of Mifepristone for Medication Abortion After In-Person Screening*, 184 JAMA INTERNAL MED. 873 (Aug. 2024), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2818276.

[22] Leah Koenig, et al., *Mailing Abortion Pills Does Not Delay Care: A Cohort Study Comparing Mailed to In-Person Dispensing of Abortion Medications in the United States*, 121 CONTRACEPTION (May 2023), https://pubmed.ncbi.nlm.nih.gov/36736715/.

MSFC member and fourth-year medical student, Tim H., affirms what these studies show:

> Holding a telehealth versus in-person consultation does not make a difference in providing medical abortion care. Handing a patient a pill in person adds nothing of value to the medical management of abortion. This is especially true considering that, even when picking up mifepristone at a clinic, the patient will take it and misoprostol at home and complete the abortion at home either way Requiring in-person dispensing of mifepristone is not medically indicated or evidence-based law.

Telehealth medication abortion is legally permitted in 28 states, districts, and territories in the United States, and permitted through a hybrid model in seven states.[23] By the end of 2024, one in four abortions in the United States were provided through telehealth.[24] Reinstating the in-person dispensing requirement for mifepristone would limit access to healthcare, and at times, life-saving treatment. In addition to its critical use in abortion care, multiple studies demonstrate the benefits of its expanded use through telehealth to improve access and outcomes for patients experiencing miscarriages.[25] Another study suggests that telehealth-prescribed mifepristone may assist in the timely diagnosis and treatment of ectopic pregnancy.[26]

Vinootna Kantety, an MSFC member and second-year medical student, confirms the potentially lifesaving benefits of mifepristone:

> Mifepristone is often used in combination with misoprostol to provide care to patients experiencing unwanted pregnancies. It is also given in miscarriage management to empty the uterus, which ensures that patients will not get subsequent infections, sepsis, or death from fetal remnants. The use of mifepristone in pregnancy or

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[23] *State of Telehealth Medication Abortion (TMAB)*, RHITES, https://www.rhites.org/maps (last visited Feb. 19, 2026).

[24] SOCIETY OF FAMILY PLANNING, #WECOUNT REPORT, APRIL 2022 TO DECEMBER 2024 1 (June 23, 2025), https://societyfp.org/wp-content/uploads/2025/06/WeCount-Report-9-December-2024-data.pdf.

[25] *See, e.g.*, Marta A.W. Rowh, et al., *Closing the Gap: Expanding Access to Mifepristone for Early Pregnancy Loss Through Operational Innovation*, 7 JACEP OPEN 1 (Feb. 2026), https://www.sciencedirect.com/science/article/pii/S2688115225002401; Jessica L. Tarleton, et al., *Society of Family Planning Clinical Recommendation: Medication Management for Early Pregnancy Loss*, 144 CONTRACEPTION (2025), https://www.sciencedirect.com/science/article/abs/pii/S0010782424005195.

[26] M.A. Biggs, et al., *Experiences of Ectopic Pregnancy Among People Seeking Telehealth Abortion Care*, 134 CONTRACEPTION (2024), https://www.sciencedirect.com/science/article/abs/pii/S0010782424000581.

> miscarriage management is lifesaving – it prevents unsafe attempts by patients to terminate pregnancies, allows pregnant patients to have autonomy in their lives, and is exponentially safer than carrying a fetus to term and delivering a newborn.

The research supports this testimony: abortions are much safer than continuing pregnancy and childbirth.[27] Around the world, mifepristone is safely prescribed and dispensed outside clinical settings. The World Health Organization recommends mailing of mifepristone to give patients "the option of telemedicine as an alternative to in-person interactions."[28] The World Health Organization confirms that this allows for care that is "effective, efficient, accessible, acceptable/patient centered, equitable and safe" since "complications are rare with both medical and surgical abortion."[29] The International Federation of Gynecology and Obstetrics similarly advocates for telemedicine as a "safe and private method to have an abortion in early pregnancy," stating that an "in-person meeting is not essential to the provision of safe and effective abortion services."[30] Several other countries also allow abortion services to be provided through telehealth and/or outside clinical settings including the United Kingdom, France, Ireland, New Zealand, Finland, and Lithuania.[31] In requesting a nationwide injunction to reimpose the in-person

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[27] *See* Farah H. Morgan & Marc J. Laufgraben, *Mifepristone for Management of Cushing's Syndrome*, 33 PHARMACOTHERAPY 319 (Mar. 2013), https://pubmed.ncbi.nlm.nih.gov/23436494/; *see also* Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215 (Feb. 2012), https://journals.lww.com/greenjournal/abstract/2012/02000/the_comparative_safety_of_legal_induced_abortion.3.aspx.

[28] WORLD HEALTH ORG., *Abortion Care Guideline*, *supra* note 1, at 16.

[29] The FDA indicates that mifepristone may be used to terminate pregnancy through ten weeks gestation. U.S. FOOD & DRUG ADMIN., *Information about Mifepristone*, *supra* note 6; WORLD HEALTH ORG., *Abortion Care Guideline*, *supra* note 1, at 1–2, 16.

[30] INT'L FED'N OF GYNECOLOGY & OBSTETRICS, FIGO ENDORSES THE PERMANENT ADOPTION OF TELEMEDICINE ABORTION SERVICES (2021), https://www.figo.org/sites/default/files/2021-03/FIGO%20Statement%20%E2%80%93%20FIGO%20endorses%20the%20permanent%20adoption%20of%20telemedicine%20abortion%20services_v6_0.pdf.

[31] CTR. FOR REPROD. RTS., LEGAL AND POLICY BARRIERS TO SELF-MANAGED ABORTION: A COMPARATIVE ANALYSIS OF 39 JURISDICTIONS 18, 21 (2024), https://reproductiverights.org/wp-content/uploads/2024/09/Self-Managed-Abortion-Report-2024.pdf; CTR. FOR REPROD. RTS., EUROPE ABORTION LAWS 2025: POLICIES, PROGRESS AND CHALLENGES 26 (2025), https://reproductiverights.org/wp-content/uploads/2025/10/Europe-Abortion-Laws-2025-1.pdf.

dispensing requirement, Louisiana asks this Court to set the United States behind its international peers and internationally recognized standards of medical care.

2. Mifepristone Dispensed by Mail Is Critical Healthcare Amidst Rising Maternal Care Deserts

Many states rely on mifepristone dispensed by mail to provide evidence-based and patient-centered care. In states that permit medication abortions or miscarriage management, many patients seek care through telehealth for a variety of reasons including privacy, convenience, and accessibility, and even at times lifesaving care.[32]

a) Restrictive Abortion Laws Lead to Medical "Brain Drains" and Exacerbate Maternal Care Deserts

The United States is facing a healthcare access epidemic. The unavailability of licensed maternal healthcare providers has resulted in "maternal care deserts," namely, counties where there are no hospitals offering obstetric care, birth centers, obstetricians, or licensed midwives.[33] Over 70% of all birthing centers are located within just 10 states.[34] Meanwhile, over half of all U.S. counties do not have a hospital that provides obstetric care and 35% do not have a single birthing facility or obstetric clinician.[35] An international study found that "[t]he United States continues to have the highest rate of maternal deaths of any high-income nation"—over two to seven times higher than Canada, France, the United Kingdon, Germany, Australia, Sweden, and the

[32] Danielle Costano, *Maternity Deserts in the United States and the Threat to Women's Health*, HUM. RTS. RSCH. CTR. (Mar. 4, 2025), https://www.humanrightsresearch.org/post/maternity-deserts-in-the-united-states-and-the-threat-to-women-s-health; Maeve E. Wallace, et al., *Health Care Use and Health Consequences of Geographic Lack of Access to Abortion and Maternity Care*, 51 BIRTH: ISSUES IN PERINATAL CARE 363, 364 (June 2024), https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12792?msockid=09ac90faa1ff693a020384fba06668d6.

[33] *See* Eli Y. Adashi, et al., *Maternity Care Deserts: Key Drivers of the National Maternal Health Crisis*, 38 J. AM. BD. FAM. MED. 165, 165 (2025), https://pubmed.ncbi.nlm.nih.gov/40268316/.

[34] *See* Ashley Stoneburner, et al., *Nowhere to Go: Maternity Care Deserts Across the US*, MARCH OF DIMES (2024), https://www.marchofdimes.orghttps://www.marchofdimes.org/sites/default/files/2024-09/2024_MoD_MCD_Report.pdf.

[35] *Id*.

Netherlands—and over 80% of these deaths "are likely preventable."[36] Moreover, abortion care deserts exist in just under half of all U.S. counties.[37] In total, nearly one quarter of all counties in the United States are considered abortion *and* pregnancy care deserts.[38]

Restrictive abortion laws have exacerbated maternal care deserts, including by impacting the choices of where medical students are able and willing to complete their education and training, and later work and reside. To become a licensed OB-GYN, the Accreditation Council for Graduate Medical Education ("ACGME") requires access to abortion training during residency.[39] As a few examples, the ACGME requires that: (i) "Residents must be involved in educating patients on the surgical and medical therapeutic methods related to the provision of abortions"; (ii) "Residents must participate in the management of complications of abortions"; (iii) "Programs must provide clinical experience or access to clinical experience in the provision of abortions as part of the planned curriculum"; and (iv) "Residents must have didactic activities and clinical experience in the comprehensive management of spontaneous abortion and pregnancy loss, including patient education, expectant management, medication management, uterine evacuation, complication management, and post-pregnancy loss care."[40]

Residents are permitted to opt-out of training on *induced* abortions for religious or moral reasons, but not spontaneous abortions (miscarriage).[41] In practice, clinical training on induced

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[36] Munira Gunja, et al., *Insight into the U.S. Maternal Mortality Crisis: An International Comparison* (June 4, 2024), COMMONWEALTH FUND, https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison.

[37] NAT'L WOMEN'S LAW CTR., WHEN WOMEN ARE DESERTED: THE PREVALENCE AND INTERSECTION OF ABORTION CARE DESERTS, PREGNANCY CARE DESERTS, BROADBAND INTERNET DESERTS, AND FOOD DESERTS IN THE UNITED STATES 5 (2025), https://nwlc.org/wp-content/uploads/2025/04/Updated-Deserts-Report-1.pdf.

[38] *Id.* at 3.

[39] ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., ACGME PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION IN OBSTETRICS AND GYNECOLOGY 27 (2025), https://www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/220_obstetricsgynecology_2025_reformatted.pdf.

[40] *Id.* at §§ 4.11.i.2–4, 4.11.j.

[41] *Id.* at § 4.11.i.4.a.

abortions "is directly relevant to preserving the life and health of pregnant patients in some instances and equips residents with the skills and knowledge necessary for providing care in other reproductive health care contexts, including but not limited to, the ability to safely evacuate the uterus in the first and second trimesters in various clinical scenarios, such as spontaneous abortion (miscarriage) and its complications."[42] For that reason, the ACGME requires that residents in states where induced abortion training is unlawful be provided this training at a sponsoring institution in another state.[43]

Given the importance of abortion training to future OB-GYNs, states with restrictive abortion laws are experiencing a "medical brain drain," in which many future physicians are choosing to study, and then practice, out-of-state.[44] Even existing maternal healthcare providers are moving out of states with restrictive abortion laws in part due to fears of legal consequences for providing at times life-saving care, which has detrimental effects on maternal healthcare including for women who want to continue their pregnancies.[45] Indeed, according to a survey of more than 2,000 current and future physicians, over 82% of respondents reported that they preferred to apply to work or train in states with abortion access, and over 76% reported that they would not apply to work or train in states where there are legal consequences for providing abortion care.[46]

As MSFC member and third-year medical student in Ohio, Soumya Jaiswal, shared:

> As a medical student in the process of applying to residency programs, it is abundantly clear that state legislation is the single

[42] *Id.* at § 4.11.i.4.b., cmt.
[43] *Id.* at § 4.11.i.4.b.
[44] Sarah McNeilly & Vivian Kim, *Standardize Abortion Education Across U.S. Medical Schools*, MEDPAGE TODAY (Jul. 1, 2022), https://www.medpagetoday.com/opinion/second-opinions/99550?trw=no.
[45] Alice M. Ollstein & Megan Messerly, *"It's a Crisis": Maternal Health Care Disappears for Millions*, POLITICO (Aug. 1, 2023), https://www.politico.com/news/2023/08/01/maternal-health-care-crisis-00109106.
[46] Simone A. Bernstein, et al., *Practice Location Preferences in Response to State Abortion Restrictions Among Physicians and Trainees on Social Media*, 38 J. GEN. INTERNAL MED. 2419, 2419 (Feb. 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10406982/pdf/11606_2023_Article_8096.pdf.

> most important factor amongst my peers in considering which OBGYN programs to apply. A successful applicant has little to no incentive to stay in states where we will be receiving incomplete training, not driven by science or truth, when we can go elsewhere to train and practice without fear of prosecution. As anti-abortion legislation has infected numerous states these past few years, we have already begun seeing provider deserts in these states, leaving all those requiring complex OBGYN care in the lurch, including patients with high-risk pregnancies.

Similarly, MSFC member and second-year medical student, Meredith R., explains:

> My OB-GYN-inclined friends want to attend residency in states with protective abortion laws. The guidance we have received in school is that we should train in states with permissive abortion laws, as it is not as easy to receive the proper training in restrictive states. I have a friend from Texas who wants to become a provider in Texas, but is currently training in New York to receive the proper evidence-based education in maternal health practices. Students who attend residency in restrictive states sometimes have to spend months in another state to receive full training.

Samantha Keller, MSFC member and medical student, describes how central access to telemedicine abortion care is to her decision on where to train and practice medicine:

> Access to mail-order mifepristone directly affects me, including my decisions about where I train and ultimately practice. I have seen through my clinical training and work how critical telehealth and mail-based medication abortion are for patients who face significant barriers to in-person care. Limiting access to mail-order mifepristone would not only restrict patient care but would also constrain medical education and leave trainees unprepared to care for patients in underserved, rural, or resource-limited settings. For me, access to comprehensive abortion training is inseparable from practicing ethical, patient-centered medicine. The ability to learn and provide both in-person and virtual abortion care is a determining factor in where I choose to train and build my career.

Ms. Kantety shared a similar sentiment:

> States that do not allow me to use my medical training unbiasedly are states that I am not inclined to live in or practice in as a physician. I do not want to go through this much schooling to then have my hands tied by legislators who do not understand anything about the human body. It would not be right to force a less effective, alternative solution onto a patient because a court or legislature has

> deviated from science-backed principles. That is not evidence-based practice and opens opportunity to inflict harm upon patients, which I refuse to do. I would rather live in a different state where I can practice to the best scope of my training and knowledge. These stringent laws exacerbate barriers to care in restrictive states.

Sarah Boliek, an MSFC member and second-year medical school student, described how restrictive laws harm medical access even beyond abortion and maternal care:

> Many have testified that state-wide restrictions on surgical and medical abortion will lead to shortages of prenatal care providers, but I do not think this shortage will be limited to just OB-GYN specialists. I am planning on going into primary care and I will be avoiding any states with abortion bans. As a primary care doctor, I will be trained in providing medication abortions using mifepristone and I do not want to live in a state where laws restrict any form of safe and necessary care for my patients.

Telehealth is critical in the current U.S. maternal healthcare crisis. "In maternity care, telehealth has enabled virtual consultations with specialists, remote ultrasound monitoring by maternal-fetal medicine experts, postpartum blood pressure monitoring using Wi-Fi connected devices, and fertility tracking through patient-generated data."[47] Following the coronavirus pandemic, U.S. OB-GYNs who reported using telehealth for physician-to-patient interactions increased from roughly 12% to over 84%.[48] Studies that followed showed no statistically significant adverse impacts on patient care or outcomes, and therefore, supported the continued use of telehealth in maternal care.[49] A comprehensive review of over 90 studies on telehealth used for antenatal care—which aims to detect and manage pregnancy complications—reported on the

[47] *See* Ashley Stoneburner, et al., *supra* note 34, at 42.

[48] AMERICAN COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *Ethical Considerations With Telehealth in Obstetrics and Gynecology*, 146 OBSTET. & GYNECOL. 572, 573 (Oct. 2025), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-statement/articles/2025/10/ethical-considerations-with-telehealth-in-obstetrics-and-gynecology.pdf?rev=ca7803b444304550b29eb4adf5bdf2e9&hash=281232497300417A9E5D7395ECA3CD64 .

[49] *See, e.g.*, Alison Shmerling, et al., *Prenatal Care via Telehealth*, 49 PRIMARY CARE 609 (2022), https://www.primarycare.theclinics.com/article/S0095-4543(22)00042-2/pdf/; Beatriz Tenorio & Julie R. Whittington, *Increasing Access: Telehealth and Rural Obstetric Care*, 50 OBSTET. & GYNECOL. CLINICS OF N. AM. 579 (Sept. 2023), https://pubmed.ncbi.nlm.nih.gov/37500218/.

clinical safety of telehealth for both real-time visits and remote monitoring including blood pressure, fetal heart rate, at-home cardiotocograph, and even teleultrasound monitoring.[50] In addition, in states with protective reproductive healthcare laws, mifepristone provided by mail or by telehealth offers a safe and effective avenue to receive critical healthcare, particularly in many parts of the country where maternal healthcare is a far distance away.[51]

Louisiana should not be permitted to exacerbate the maternal healthcare crisis by imposing further restrictive abortion laws across the country.

b) States that Protect Abortion Care Need Access To Mifepristone Dispensed by Mail

Reimposing the in-person dispensing requirement would unnecessarily halt the effective and evidence-based practice of telemedicine abortion care across the country and restrict the autonomy of certain states to choose to allow telehealth abortion care in varying circumstances following *Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 338 (2022) (Kavanaugh, J., concurring) ("Today's decision . . . does not prevent the numerous States that readily allow abortion from continuing to readily allow abortion.").

States that allow medication abortion and miscarriage management rely on telemedicine and mifepristone dispensed by mail to provide patient-centered and evidence-based care. A 2023 study found that "patients in the United States face[] exceptional barriers to reach abortion providers."[52] These barriers disproportionately affect access for people of color, young people, and low-income patients.[53] The study concluded that telehealth was effective in "reducing abortion-related travel barriers in states where abortion remains legal, especially among patient

[50] Jessica Atkinson, et al., *Telehealth in Antenatal Care: Recent Insights and Advances*, 21 BMC MED. 332 (Aug. 2023), https://link.springer.com/article/10.1186/s12916-023-03042-y/.

[51] *See supra*, at 3–9.

[52] Leah R. Koenig, et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States, Spacial Analysis*, 9 JMIR PUB. HEALTH & SURVEILLANCE 45671 (2023), https://publichealth.jmir.org/2023/1/e45671/.

[53] *Id*.

populations who already face structural barriers to abortion care."[54] For example, 56.9% of patients living in rural and suburban areas stated that telehealth made it possible to obtain timely abortions.[55] The increased availability of care is critical across the United States.

New Mexico is an instructive example. The state's abortion laws allow for medication abortions both in person at a clinic and at home via telehealth.[56] Access to in-person abortions under the law does not mean that telehealth abortions and mifepristone via mail are not critical. There are only 12 abortion clinics in New Mexico, and half of these are located in Albuquerque alone.[57] Moreover, one-third of counties in New Mexico are maternity care deserts; there are ***no*** hospitals or birth centers offering obstetric care or obstetric providers in those counties.[58]

New Mexico medical student and MSFC member, Tim H., shared how patients in the state and in other localities benefit from telemedicine abortion care:

> Many patients cannot get to the clinics due to lack of resources or transportation. In addition, there are many patients with extreme anxiety. Getting an abortion is very sensitive, and many patients prefer to discuss their options at home. This empowers patients and allows them to make decisions in a safe space.

This is supported by research. The Society of Family Planning found that 13% of abortions in the state from January to June 2025 were provided via telehealth.[59] In addition, overall, "telehealth abortion care is highly acceptable [to patients] and benefits include privacy and expediency."[60] Patients report high satisfaction with telehealth abortion services and

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[54] *Id.*

[55] *Id.*

[56] *Information About Abortion*, NM HEALTH, https://www.nmhealth.org/about/phd/phdo/arh/info/ (last visited Feb. 15, 2026).

[57] *New Mexico Abortion Clinic Guide*, PLAN C PILLS, https://abortion-clinic.plancpills.org/new-mexico#abortion-clinics (last visited Feb. 19, 2026).

[58] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN NEW MEXICO 1 (2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-NewMexico.pdf.

[59] SOCIETY OF FAMILY PLANNING, #WECOUNT REPORT, APRIL 2022 TO JUNE 2025 8 (2025), https://societyfp.org/wp-content/uploads/2025/12/WeCount-Report-10-June-2025-data.pdf.

[60] Leah R. Koenig, et al., *Patient Acceptability of Telehealth Medication Abortion Care in the United States, 2021–2022*, 114 AM. J. PUB. HEALTH 241 (2024), https://pubmed.ncbi.nlm.nih.gov/38237103/.

comfortability with virtual visits.[61] Patients across the country also report that telehealth provides relief from barriers related to accessing in-person abortion services, including distance to a clinic, fear of protestors, and privacy concerns.[62]

Colorado is similar. In 2024, voters approved a ballot initiative to amend the state constitution. The constitution states that "[t]he right to abortion is hereby recognized. Government shall not deny, impede, or discriminate against the exercise of that right." Co. Const. Art. II, u00a7 32.[63] However, 37.5% of counties in the state are maternity care deserts, higher than the United States average.[64] Between January to June 2025, 31% of all abortions in Colorado were provided via telehealth.[65]

Other states that allow telehealth abortion care and mifepristone dispensed by mail rely on mifepristone these methods to provide safe and accessible treatment. For example, in Virginia, where abortion is legal under certain circumstances, there are just twenty abortion clinics operating in the state and nearly 31% of counties are maternity care deserts.[66] This lack of access makes telehealth and mail-order abortion medication critical. Between January to June 2025, 27% of abortions in the state were provided via telehealth.[67] In addition, notwithstanding that abortion care is legally permissible in limited circumstances in Pennsylvania, abortion care was available in less than 21% of counties in the state in 2023.[68] There are currently twenty abortion clinics

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[61] Camille Brown, et al., *The Provision of Abortion Care via Telehealth in the United States: A Rapid Review*, 68 J. MIDWIFERY WOMEN'S HEALTH 744, 746 (2023), https://onlinelibrary.wiley.com/doi/epdf/10.1111/jmwh.13586.

[62] *Id.* at 747, 754.

[63] *See* CTR. FOR REPROD. RTS., *Colorado*, https://reproductiverights.org/maps/abortion-laws-by-state/colorado/#f7a39bda-f9c3-444d-bf70-96ffd169fe11 (last visited Feb. 18, 2026).

[64] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE DESERTS IN COLORADO 1 (2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Colorado.pdf.

[65] SOCIETY OF FAMILY PLANNING, *supra* note 59, at 8.

[66] *Virginia Abortion Clinic Guide*, PLAN C PILLS, https://abortion-clinic.plancpills.org/virginia (last visited Feb. 18, 2026); MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN VIRGINIA (2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Virginia.pdf.

[67] SOCIETY OF FAMILY PLANNING, *supra* note 59, at 8.

[68] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN PENNSYLVANIA (2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Pennsylvania.pdf; PA. DEP'T

state-wide.[69] Between January to June 2025, 25% of abortions in the state were provided via telehealth and dispensing by mail.[70] Without that access, thousands of patients would be left without this evidence-based and safe care option.

Bianca Stern, an MSFC member and second-year medical student at UC Irvine School of Medicine in California, describes her experience with how mifepristone by mail expands access for patients:

> Eliminating mail access would disproportionately burden patients who live far from clinics, lack reliable transportation, cannot take time off work, are experiencing intimate partner violence, or require urgent early care. These barriers fall most heavily on rural, low-income, and marginalized communities, exacerbating existing health inequities without improving patient safety. Preserving this access pathway is essential to ensuring that evidence-based care remains available to all patients.

Even in urban areas like New York City, MSFC member and medical student Ms. Keller describes the importance of accessing medical abortion care through mail and telehealth:

> As a medical student who has worked in OB-GYN settings and volunteers as an abortion doula, I have seen how access barriers shape whether patients can receive timely care. Mail-based options matter for patients who cannot easily take time off work, travel long distances, arrange childcare, or safely disclose an appointment.

The research is clear. With telehealth, patients living in rural areas or without reliable transportation have expanded access to the safe, effective, and evidence-based abortion care that they desire. Banning telemedicine abortion care restricts patients' access to preferred care and prevents providers from adhering to medical ethics requiring patient-centered care.

OF HEALTH, 2023 ABORTION STATISTICS 7 (2024), https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/healthstatistics/vitalstatistics/documents/2023%20pennsylvania_annual_abortion_report_final_pdf.pdf.

[69] *Pennsylvania Abortion Clinic Guide*, PLAN C PILLS, https://abortion-clinic.plancpills.org/pennsylvania#abortion-clinics (last visit Feb. 17, 2026).Pennsylvania Abortion Clinic Guide, Plan C Pills, https://abortion-clinic.plancpills.org/pennsylvania#abortion-clinics (last visit Feb. 17, 2026).

[70] SOCIETY OF FAMILY PLANNING, *supra* note 59, at 8.

B. Interference With Evidence-Based Healthcare Would Negatively Impact Medical Training Nationwide

Enjoining the FDA's evidence-based decision to allow remote dispensing of mifepristone would undermine the evidence-based training that medical schools are entrusted and required to teach. This would in turn hinder the next generation of medical professionals from practicing in alignment with the medical standards of their specialties and prevent them from providing world-class care for their patients.

1. Medical Schools Must Teach Evidence-Based Medicine

Medical schools in the United States must be able to teach students to use the scientific method combined with clinical experience to arrive at the best medical decisions for their patients.[71] Armed with a strong scientific foundation, medical students must be taught to care for patients based on principles derived from published evidence, national and international guidelines, medical society consensus, and clinical experience, all with the goal of improving medical outcomes based on the highest quality evidence available.[72] Studies have demonstrated the benefits of an evidence-based medical education on patient care and outcomes.[73] In turn, this education can prepare students to become evidence-based practitioners of medicine, leading to improved patient satisfaction and outcomes and reduced healthcare costs.[74]

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[71] *See* Steven Tenny & Matthew A. Varacallo, *Evidence-Based Medicine*, STATPEARLS (Sept. 10, 2024), https://www.ncbi.nlm.nih.gov/books/NBK470182/ ("Evidence-based medicine (EBM) uses the scientific method to organize and apply current data to improve healthcare decisions.").

[72] *Id.*

[73] *See* Laura Menard, et al., *Integrating Evidence-Based Medicine Skills into a Medical School Curriculum: A Quantitative Outcomes Assessment*, 26 BMJ EVID. BASED MED. 249 (Oct. 2021), https://pubmed.ncbi.nlm.nih.gov/33093190/; Josephine L. Dorsch, et al., *Impact of an Evidence-Based Medicine Curriculum on Medical Students' Attitudes and Skills*, 92 J. MED. LIBR. ASS'N 397 (Oct. 2004), https://pubmed.ncbi.nlm.nih.gov/15494754/.

[74] *See* Linda Connor, et al., *Evidence-based Practice Improves Patient Outcomes and Healthcare System Return on Investment: Findings from a Scoping Review*, 20 WORLDVIEWS ON EVID.-BASED NURSING 6 (2023), https://pubmed.ncbi.nlm.nih.gov/36751881/.

Evidence-based training by medical schools is mandatory. The Liaison Committee on Medical Education requires accredited medical schools to select curricular content that teaches students how scientific research "is conducted, evaluated, explained to patients, and applied to patient care," and "provides opportunities for medical students to acquire skills of critical judgment based on evidence and experience, and develops medical students' ability to use those principles and skills effectively in solving problems of health and disease."[75]

Jordan P., MSFC member and physician-scientist trainee, explains her experience in receiving evidence-based training:

> Throughout medical school, I have been trained to understand and apply evidence-based standards of care when treating patients. Our practice of medicine is grounded in decades of rigorous research, guidelines developed by experts in our field and the collective experience of physicians treating patients every day.

Meredith R. describes how her school teaches evidence-based medicine:

> In lectures, it is very much emphasized to follow the evidence-based standards of care. Our professors encourage us to review official guidelines if we are ever unsure of how to proceed with treatment. In my clinical rotation, I have even seen residents look up official guidelines, such as from the ACOG [the American College of Obstetricians and Gynecologists], to ensure their treatment is grounded in evidence. While individual patient factors are always considered, it is very important to strictly adhere to accepted standards of care.

As Ms. R. indicates, ACOG is one of the leading authorities in OB-GYN care in the United States, looked to by medical students, residents, and professionals to follow evidence-based care

[75] LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL 10 (2025), https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Flcme.org%2Fwp-content%2Fuploads%2F2025%2F05%2F2025-26-Functions-and-Structure_2025-05-21.docx&wdOrigin=BROWSELINK.

practices. ACOG recommends medication abortion provided by telemedicine, indicating it can be "provided safely and effectively . . . with a high level of patient satisfaction."[76]

Moreover, medical students are taught to learn the FDA's guidance for medications as part of their curriculum.

Ms. Stern describes what she has learned about the FDA's current evaluation of mifepristone:

> [F]rom the beginning of my training I have been taught that my ethical and professional obligation is to practice evidence-based medicine and follow established standards of care. We are trained to rely on the scientific expertise of the U.S. Food and Drug Administration, which is tasked by Congress with rigorously evaluating drug safety and efficacy. Medication abortion with mifepristone, including through telehealth with mail dispensing, is taught to us as a safe, effective, and well-supported standard of care. The FDA's decision to remove the in-person dispensing requirement reflects the same evidence-based principles that guide my own medical education.

Reinstating this medically unnecessary and outdated restriction on mifepristone would leave medical schools with the impossible task of teaching students to provide evidence-based care, but to potentially disregard the scientific evidence they are taught to rely on. *See Weinberger v. Bentex Pharms., Inc.*, 412 U.S. 645, 653–54 (1973) (evaluating "reports as to the reputation of drugs among experts in the field is not a matter well left to a court without chemical or medical background").

2. Medical Training Must Include Telehealth Reproductive Care

Telemedicine is emerging as a critical skill in medical training. The Association of American Medical Colleges published a report on competencies in telehealth to include in medical

[76] Mitchell D. Creinin & Daniel A. Grossman, *supra* note 1; *see also* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, UPDATED MIFEPRISTONE REMS REQUIREMENTS (2023), https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2023/01/updated-mifepristone-rems-requirements.

school curricula and continuing medical education, noting that telehealth has "become an increasingly important and commonly used tool for delivering care to patients," and therefore providing telehealth training is essential.[77] The suggested competencies include communicating with patients effectively via telehealth, obtaining clinical information to ensure high-quality care, and delivering telehealth in a way that "addresses and mitigates cultural biases."[78] Studies increasingly advocate for telemedicine curricula to be integrated into medical schools and have shown that telemedicine programs are effective.[79] Indeed, one study of telehealth training for medical students demonstrated that discussing miscarriage diagnosis and treatment virtually with patients met assessment goals in an objective structured clinical exam setting.[80]

Tori Misiaszek, an MSFC member and second-year medical student at Rocky Vista University in Montana, explains the centrality of telehealth to her training:

> Telehealth is now integrated into medical education as a standard component of patient care delivery. We are taught how to conduct remote histories, assess patient safety, prescribe medications when appropriate, and provide follow-up care virtually. Telemedicine has become particularly important in reaching patients in rural areas and those facing transportation or geographic barriers.

Ms. Keller echoes Ms. Misiaszek's experience:

> As a medical student, it has become clear to me that telehealth is not only comparable to in-person care but, in some situations, even more essential. Our medical school emphasizes this modality heavily, to the extent that one of our limited annual Objective Structured

[77] ASS'N OF AM. MED. COLLS., TELEHEALTH COMPETENCIES ACROSS THE LEARNING CONTINUUM 2 (2021), https://store.aamc.org/downloadable/download/sample/sample_id/412/.

[78] *Id.* at 3–6.

[79] *See, e.g.*, Susan E. Frankl, et al., *Preparing Future Doctors for Telemedicine: An Asynchronous Curriculum for Medical Students Implemented During the COVID-19 Pandemic*, 96 ACAD. MED. 1696 (Dec. 2021), https://www.sap2.org.ar/i2/archivos/2593.pdf; Lana Shawwa, *The Use of Telemedicine in Medical Education and Patient Care*, 15 CUREUS 37766 (Apr. 18, 2023), https://www.cureus.com/articles/148497-the-use-of-telemedicine-in-medical-education-and-patient-care#!/.

[80] Lona Prasad, et al., *An Objective Structured Clinical Exam on Breaking Bad News for Clerkship Students: In-Person Versus Remote Standardized Patient Approach*, 19 MEDEDPORTAL 11323 (Jul. 2023), https://www.mededportal.org/doi/epdf/10.15766/mep_2374-8265.11323.

> Clinical Examinations (OSCEs) was dedicated entirely to telehealth delivery and best practices.

Ms. R. explains her experience learning about telehealth in medical school in a state with protective abortion laws:

> In one of my trainings, I conducted a mock telehealth appointment, where I learned the patient care I can successfully provide through telehealth. As I go through clinical rotations, I shadow doctors conducting telehealth appointments frequently, and I can ask questions and discuss treatment. We are even trained on how to perform a physical exam by telehealth to the extent possible. For example, for a neurologic exam assessing gait, we can ask patients to stand up and walk around the room and evaluate through sight. I have been surprised by how much providers are able to do virtually.

As telemedicine grows in importance in the medical profession, medical schools must be able to teach future providers how to effectively administer telehealth across disciplines.[81] If mifepristone is no longer allowed to be provided by telemedicine, schools will not be able to teach the effective prescription of mifepristone by telehealth.

Ms. Keller shares her concerns with the quality of medical training if the in-person requirement were reimposed:

> From a training standpoint, limiting mail distribution would push care back toward in-person-only models even when not medically necessary, which would reduce exposure to real-world practice patterns and weaken preparation for caring for patients in rural settings, "maternity care deserts," or states where access already hinges on logistics. In short, it would not just change how care is delivered. It would reduce the breadth of what medical students and residents are able to learn about evidence-based reproductive healthcare and how to provide it equitably.

[81] *Telehealth Trends*, HEALTH & HUM. SERVS., https://telehealth.hhs.gov/research-trends (last visited Feb. 18, 2026) (95 percent of Health Resources and Services Administration-funded "health centers used telehealth to provide primary care in 2024" and citing 63-fold increase in Medicare beneficiary telehealth visits in 2020); Erin M. Spaulding, et al., *Prevalence and Disparities in Telehealth Use Among US Adults Following the COVID-19 Pandemic: National Cross-Sectional Survey*, 26 J. MED. INTERNET RSCH. 52124 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11127137/ (telehealth attendance high more than a year after telemedicine expansion during the pandemic).

Alicia G., an MSFC member and second-year medical student, describes how a ban on mifepristone dispensed by mail would affect training and patient care for future generations:

> A ban on mail-in mifepristone would limit my education about managing care for patients who rely on telemedicine, who live in areas where access to reproductive care is sparse, or who are otherwise unable to obtain reliable transportation to reach a clinic or hospital. Furthermore, there would be fewer healthcare providers who have the qualifications to prescribe mail-in mifepristone, and who can pass the training down to future providers. This would ultimately decrease the scope of practice of reproductive care, and leave patients with less options, less autonomy over their privacy and health.

Such a restriction leaves a generation of medical students across the country ill-equipped to provide accepted standards of abortion care in the country or otherwise forced to seek continuing medical education later in their careers that might not provide the same level of detail or adequate training.

3. Medical Training Must Include Ethical Patient Care

Reinstating an in-person dispensing requirement would undermine another central tenet of medical school curricula: to teach medical students to follow principles of medical ethics in caring for patients.[82] Although the precise content of ethical curricula varies among medical schools,[83] the four commonly accepted principles of medical ethics are respect for autonomy (respecting and supporting autonomous decisions); nonmaleficence (avoiding causation of harm); beneficence (relieving, lessening, or preventing harm, providing benefits, and balancing benefits against risks and costs); and justice (fairly distributing benefits, risks, and costs).[84]

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[82] *See* LIAISON COMM. ON MED. EDUC., *supra* note 75, at 11 (requiring accredited medical schools to "ensure that the medical curriculum includes instruction for medical students in medical ethics and human values both prior to and during their participation in patient care activities and require medical students to behave ethically in caring for patients and in relating to patients' families and others involved in patient care").

[83] *See* Lisa S. Lehmann et al., *A Survey of Medical Ethics Education at U.S. and Canadian Medical Schools*, 79 ACAD. MED. 682 (2004), https://pubmed.ncbi.nlm.nih.gov/15234922/.

[84] Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* (8th ed. 2019); Thomas R. McCormick, et al., *Principles of Bioethics,* UNIV. OF WASH. MED., https://depts.washington.edu/bhdept/ethics-

Tim H. describes precisely how an in-person dispensing requirement inhibits his ability to adhere to medical ethics:

> Adding restrictive abortion laws infringes on basic medical ethics. Autonomy, because I could not offer my patients the full range of care available to them to allow them to make the decision they want. Nonmaleficence, because I can cause harm by not prescribing mifepristone through telehealth or mail. Many people cannot access clinics and therefore I would not be able to prescribe mifepristone to patients who want it. Beneficence, because I won't be able to fully assess the benefits against the risks without accessing the full spectrum of care. Justice, because I cannot provide equal resources to all people if I cannot prescribe by telehealth or mail.

Ms. P. worries that a ban on mifepristone dispensed by mail would impact her ability to honor her patients' autonomy and learn best practices in patient-centered care:

> A ban on mail-in mifepristone would impact how I learn to advocate for my patients and discuss [or] provide options for abortion care. In medical school, we learned the importance of presenting our patients with all evidence-based options to their care and to respect and support each patient's autonomy in making informed decisions about their health. Banning mail-in mifepristone . . . will completely transform the ways in which we are able to discuss, approach and help patients seeking this form of healthcare.

Ms. Keller describes similar concerns:

> If [mail-in mifepristone] were restricted, trainees would have fewer opportunities to learn how to counsel patients on the full range of safe, guideline-consistent medication abortion care, including how to choose an appropriate modality based on a patient's clinical situation and constraints. It would also narrow our education around telehealth workflows, follow-up, and patient-centered counseling, which are increasingly essential skills.

Banning mifepristone provided through telemedicine or by mail nationwide would leave medical students in the United States with nowhere to go to receive the education they need to become successful, patient-centered practitioners. Such a restriction would tarnish the United

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medicine/bioethics-topics/articles/principles-bioethics (last visited Feb. 18, 2025); *see also* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *Ethical Considerations*, *supra* note 48.

States' reputation as an international leader in medical education and would irreversibly harm the next generation of medical providers and the patients who receive their care.

IV. CONCLUSION

For the foregoing reasons, the Court should deny Plaintiffs' motion.

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ATTORNEY WORK PRODUCT

CERTIFICATE OF SERVICE

I hereby certify that on February 20, 2026, I presented the foregoing to the Clerk of Court by filing and uploading to the CM/ECF system, which will send notification of such filing to all parties.

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
LAFAYETTE DIVISION

THE STATE OF LOUISIANA, by and through its Attorney General, LIZ MURRILL, and ROSALIE MARKEZICH, PLAINTIFFS, v. U.S. FOOD AND DRUG ADMINISTRATION, *et al.*, DEFENDANTS.	Civ. No. 6:25-cv-01491 Judge David C. Joseph Magistrate Judge David J. Ayo

MOTION FOR LEAVE TO FILE BRIEF OF MEDICAL STUDENTS FOR CHOICE AS *AMICUS CURIAE* IN SUPPORT OF DEFENDANTS' AND PROPOSED INTERVENORS' OPPOSITION TO PLAINITFFS' MOTION FOR PRELIMINARY RELIEF

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Medical Students for Choice ("MSFC"), by and through the undersigned counsel, respectfully requests permission to file an Amicus Curiae Brief in support of Defendants' and Proposed Intervenors' Opposition to Plaintiffs' Motion for Preliminary Relief. ECF No. 51. The parties have consented to the filing of *Amicus* briefs. ECF No. 39. Proposed *Amicus*'s brief is attached as Exhibit A.

MSFC is a non-profit organization with over 10,000 members and nearly 300 chapters in over 26 countries, including approximately 185 chapters across the United States. MSFC seeks to ensure that medical students and trainees have access to comprehensive, evidence-based reproductive healthcare education. MSFC has a strong interest in protecting evidence-based medical education and training. Accordingly, MSFC moves for leave to submit the attached brief to outline the concerns of the organization's members concerning judicial interference with evidence-based access to mifepristone dispensed by mail across the country.

The Fifth Circuit has held that courts "would be 'well advised to grant motions for leave to file amicus briefs unless it is obvious that the proposed briefs do not meet Rule 29's criteria as broadly interpreted.'" *Lefebure v. D'Aquilla*, 15 F.4th 670, 676 (5th Cir. 2021) (quoting *Neonatology Assocs., P.A. v. C.I.R.*, 293 F.3d 128, 133 (3d Cir. 2002)) (discussing Fed. R. App. P. 29). In analyzing whether Rule 29's criteria has been met, this Court has considered factors such as "whether the proposed *amicus* has a unique interest in the case, and whether the proposed *amicus* brief is 'timely and useful or otherwise necessary to the administration of justice.'" *Boudreaux v. Sch. Bd. of St. Mary Par.*, 2023 WL 4771231, at *3 (W.D. La. July 24, 2023) (quoting *U.S. ex rel. Gudur v. Deloitte Consulting LLP*, 512 F. Supp. 2d 920, 927 (S.D. Tex. 2007), *aff'd sub nom. U.S. ex rel. Gudur v. Deloitte & Touche*, 2008 WL 3244000 (5th Cir. Aug. 7, 2008)).

MSFC has a unique interest in this case. MSFC seeks argue that Plaintiffs' request for a nationwide injunction against the 2023 update to the Food and Drug Administration's Risk Evaluation and Mitigation Strategy for mifepristone, which allows dispensing via mail and pharmacy (the "2023 REMS Update"), will harm medication education and training across the country. In particular, the relief sought from this Court would reduce the quality of medical education and residency programs, as well as restrict future doctors' ability to provide the best reproductive healthcare, including safe abortions for patients across the country. MSFC's mission to ensure comprehensive, evidence-based reproductive healthcare education is therefore implicated by this case.

MSFC's proposed *Amicus* brief is also timely and useful to the Court. It is timely because it follows the briefing schedule set forth by this Court and agreed to by the parties. ECF No. 39. Furthermore, it is useful because MSFC's unique perspective as a non-profit organization with over 10,000 medical student and resident members will aid the Court in evaluating the impact of its decision on medical education and the medical profession nationwide.

For the foregoing reasons, MSFC respectfully requests that the Court grant the motion for leave to file the attached brief.

Respectfully submitted,

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THE STATE OF LOUISIANA, by and through its Attorney General, LIZ MURRILL, and ROSALIE MARKEZICH, PLAINTIFFS, v. U.S. FOOD AND DRUG ADMINISTRATION, *et al.*, DEFENDANTS.	Civ. No. 6:25-cv-01491 Judge David C. Joseph Magistrate Judge David J. Ayo

[PROPOSED] ORDER ON *AMICUS CURIAE* MEDICAL STUDENTS FOR CHOICE'S MOTION FOR LEAVE TO FILE BRIEF IN SUPPORT OF DEFENDANTS' AND PROPOSED INTERVENORS' OPPOSITION TO PLAINITFFS' MOTION FOR PRELIMINARY RELIEF

Considering the motion of Medical Students for Choice, and considering this Court's Order Regarding Joint Motion and Notice of Stipulation Regarding Amicus Curiae Briefs, Answer Deadline, and Briefing Schedule, it is therefore ordered that the motion is GRANTED.

The proposed *amicus curiae* brief shall be filed into the record.

SO ORDERED on this the ___ day of _____, 2026.

_____

The Honorable David C. Joseph
United States District Court