United States Court of Appeals

for the

Fifth Circuit

Case No. 26-30203

STATE OF LOUISIANA, by & through its Attorney General, LIZ MURRILL; ROSALIE MARKEZICH,

Plaintiffs-Appellants/Cross-Appellees,

v.

FOOD & DRUG ADMINISTRATION; KYLE DIAMANTAS, Acting Commissioner, U.S. Food and Drug Administration; MICHAEL DAVIS, in his official capacity as Acting Director, Center for Drug Evaluation & Research, U S Food & Drug Administration; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., Secretary, U.S. Department of Health and Human Services,

Defendants-Appellees.

GENBIOPRO, Incorporated

Intervenor-Appellee/Cross-Appellant,

v.

DANCO LABORATORIES, L.L.C.,

Intervenor-Appellee/Cross-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF LOUISIANA, LAFAYETTE IN NO. 6:25-CV-1491, HONORABLE DAVID CLEVELAND JOSEPH, U.S. DISTRICT JUDGE

BRIEF FOR *AMICUS CURIAE* MEDICAL STUDENTS FOR CHOICE IN SUPPORT OF INTERVENORS-APPELLEES

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SUPPLEMENTAL CERTIFICATE OF INTERESTED PERSONS

No. 26-30203, *Louisiana, et al. v. Food and Drug Administration, et al.*

Pursuant to Fifth Circuit Rule 29.2, the undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Amicus Curiae
Medical Students for Choice

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INTEREST OF AMICUS CURIAE[1]

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. Given MSFC's strong interest in protecting evidence-based medical education and training, MSFC submits this brief pursuant to the parties' consent to outline its members' concerns regarding interference with evidence-based access to mifepristone dispensed by mail and retail pharmacies across the country.

SUMMARY OF ARGUMENT

For over 25 years, mifepristone has been used safely and effectively in the United States. Since FDA approval in 2000, the FDA has reviewed restrictions on mifepristone and removed some found to be medically unnecessary, unduly burdensome on patients, and taxing on the healthcare system. The FDA's removal of the in-person dispensing requirement—allowing mifepristone to be dispensed at pharmacies and by mail—was based on robust medical evidence and real-world

[1] No counsel for any party authored this brief in whole or in part and no entity or person, other than *amicus curiae*, its members, or its counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

experiences demonstrating that mifepristone is safe and effective, regardless of where it is dispensed. The Supreme Court's stay has maintained mifepristone's availability by mail and at pharmacies while this appeal proceeds. Against medical evidence, Plaintiffs-Appellants (hereafter "Louisiana") ask this Court to reinstate the barrier nationwide. This Court should affirm the district court's denial of Louisiana's request for a stay pursuant to 5 U.S.C. § 705.

First, decades of medical research and evidence, as well as lived experience including during the coronavirus pandemic, demonstrate that mifepristone can be safely prescribed through telemedicine and dispensed by mail and at pharmacies.[2]

Second, reinstating the in-person dispensing requirement disrupts evidence-based and patient-centered training for medical students and residents nationwide. Future obstetricians and gynecologists seek training in medication abortions and miscarriage management to ensure they can provide needed healthcare, and all future physicians increasingly receive telemedicine training as a core competency.

Third, dispensing mifepristone at pharmacies and by mail offers critical care, including miscarriage management, in areas where patients cannot access

[2] *See, e.g.*, Ushma Upadhyay et. al., *Effectiveness and Safety of Telehealth Medication Abortion in the USA*, 30 NATURE MED. 1191, 1192–93 (2024), https://bit.ly/4wSpaDv; Abigail 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, 1469 (2021), https://https://bit.ly/4pvBXJP; Daniel Grossman et al., *Mail-Order Pharmacy Dispensing of Mifepristone for Medication Abortion After In-Person Screening*, 184 JAMA INTERNAL MED. 873, 879 (2024), https://bit.ly/4fKJMYC.

reproductive healthcare—now accounting for one in four U.S. counties ("reproductive care deserts").[3] In states that allow abortion, telemedicine provides patients with safe, accessible, and private abortion care. Imposing a medically unnecessary barrier to care and a further burden on the healthcare system is harmful to patients and the medical profession and risks a further loss of medical talent from the United States.

ARGUMENT

I. Mifepristone Dispensed by Mail and by Pharmacy Is Evidence-Based Healthcare

Mifepristone is part of a globally accepted regimen for medication abortion and miscarriage management, listed by the World Health Organization as an essential medicine and available in nearly 100 countries.[4] Decades of peer-reviewed studies have concluded that mifepristone is safe and effective, and serious adverse events are exceedingly rare, including when prescribed via telehealth and dispensed by mail or pharmacy.[5]

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[3] *See* 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 (2025), at 10, https://bit.ly/48GKsdO.

[4] WORLD HEALTH ORG., MODEL LIST OF ESSENTIAL MEDICINES: 24TH LIST (2025), at 55, https://bit.ly/3OFXDFa; GYNUITY HEALTH PROJECTS, MIFEPRISTONE APPROVED LIST (2024), https://bit.ly/4cPOz9V.

[5] *See, e.g.*, Rajita Patil et al., *Comparing Efficacy of Medication Abortion by Health Care Modality at a California Health System*, 147 OBSTETRICS & GYNECOLOGY 716, 716 (2026), https://bit.ly/3RPms2L; Finley Baba et al., *Satisfaction with and Feasibility of No-Test Telehealth Medication Abortion vs In-Person Care with Ultrasound in the United States*, CONTRACEPTION 1, 3 (2026), https://bit.ly/4gMKOo0; Laura Schummers et al., *Abortion Safety and Use with Normally*

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.[6] In 2007, Congress enacted the FDA's Risk Evaluation and Mitigation Strategies ("REMS") regime. 21 U.S.C. § 355-1 (2022). Under the REMS regime, the FDA must periodically evaluate REMS and seek input from the medical profession to ensure they are "not unduly burdensome on patient access" and to "minimize the burden on the health care delivery system." *Id.* § 355-1(f)(5)(A)-(B).

With decades of reporting and data, the FDA updated mifepristone's label and modified the REMS to remove certain medically unnecessary restrictions on access to the drug and associated burdens on the healthcare system.[7] The updates included

Prescribed Mifepristone in Canada, 386 NEW ENG. J. MED. 57 (2022), https://bit.ly/3ThDp6o; Upadhyay et al., *Effectiveness and Safety of Telehealth Medication Abortion*, *supra* note 2, at 1192–93; Aiken et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion*, *supra* note 2, at 1469; Grossman et al., *Mail-Order Pharmacy Dispensing of Mifepristone*, *supra* note 2, at 879; Jack Resneck, *Reducing Access to Mifepristone Would Harm Patients*, AM. MED. ASSOC. (Mar. 25, 2024), https://bit.ly/4d7mCt1; Lauren Porsch et al., *Advanced Practice Clinicians and Medication Abortion Safety: A 10-Year Retrospective Review*, 101 CONTRACEPTION 357 (2020), https://bit.ly/4vEkdgB; Erica Chong et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience During the COVID-19 Pandemic*, 104 CONTRACEPTION 43, 43 (2021), https://bit.ly/45grTuC; Lauren Ralph et al., *Comparison of No-Test Telehealth and In-Person Medication Abortion*, 332 JAMA 898, 898 (2024), https://bit.ly/3Rv98QV; Emily Godfrey et al., *Patient Perspectives Regarding Clinician Communication During Telemedicine Compared With In-Clinic Abortion*, 141 OBSTETRICS & GYNECOLOGY 1139, 1140 (2023), https://bit.ly/4brha4n.

[6] U.S. Food & Drug Admin., Letter to Population Council (Sept. 28, 2000), at 1, https://bit.ly/4enXzEk.

[7] U.S. Food & Drug Admin., *Information About Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Jan. 17, 2025), https://bit.ly/4d6qBWN.

removing the in-person dispensing requirement based on robust medical evidence, including evidence from the coronavirus pandemic showing the safety of dispensing mifepristone by mail and by retail pharmacies.[8]

Multiple studies confirm that mifepristone provided through telemedicine and delivered by mail or by pharmacy is just as safe and effective as mifepristone dispensed in a clinical setting.[9] One study reviewed the medical records of over 6,000 patients who spoke with a provider over video or a secure chat platform for an initial consultation for medication abortion.[10] 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.[11] The study found that 99.7% of abortions using telemedicine were not followed by a serious adverse

[8] *See* U.S. Food & Drug Admin., *Risk Evaluation and Mitigation Strategy (REMS) Single Shared System for Mifepristone 200 MG* (Sept. 2025), https://bit.ly/4cQT7gj; U.S. Food & Drug Admin., *Questions and Answers on Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation* (Apr. 8, 2026), https://bit.ly/48JhQAx.

[9] *See, e.g.*, Aiken et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion*, *supra* note 2, at 1469; Grossman et al., *Mail-Order Pharmacy Dispensing of Mifepristone*, *supra* note 2, at 879; Godfrey et al. *Patient Perspectives Regarding Clinician Communication During Telemedicine Compared With In-Clinic Abortion*, *supra* note 5, at 1140; Ralph et al., *Comparison of No-Test Telehealth and In-Person Medication Abortion*, *supra* note 5, at 898; Chong et al., *Expansion of a Direct-to-Patient Telemedicine Abortion Service in the United States and Experience During the COVID-19 Pandemic*, *supra* note 5, at 43.

[10] Upadhyay et al., *Effectiveness and Safety of Telehealth Medication Abortion*, *supra* note 2, at 1192.

[11] *Id.*

event, which matched published estimates of in-person dispensing.[12]

In addition, a study of 510 patients from five states who received mifepristone by mail-order pharmacy dispensing found no related adverse effects, and 96.6% of patients reported satisfaction with mail-order dispensing.[13] Another study extracting data from published studies between 2011 and 2022 found that patients across the country report that telemedicine provides relief from barriers to accessing abortion services, including distance to a clinic, fear of protestors, and privacy concerns.[14]

As MSFC member and fourth-year medical student in New Mexico, Tim H., explains:[15]

> Holding a telehealth versus in-person consultation does not make a difference in providing medication 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.

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[12] *Id.* at 1193, 1197.

[13] Grossman et al., *Mail-Order Pharmacy Dispensing of Mifepristone*, *supra* note 2, at 878.

[14] 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, 754 (2023), https://bit.ly/3Rjqssd.

[15] 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.

Reinstating the in-person dispensing requirement would limit access to healthcare, and at times, to life-saving treatment. Vinootna Kantety, MSFC member and second-year medical student, confirms this reality:

> 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 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.

Likewise, Lily Leibner, an MSFC member and second-year medical student in New York, explains that mifepristone protects future fertility during miscarriage:

> 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 the pregnancy that has already been deemed inviable. 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, minimizing harm to the patient.

Around the world, mifepristone is safely prescribed and dispensed by mail and by pharmacies. The World Health Organization recommends mailing mifepristone to give patients "an alternative to in-person interactions," explaining that it is "effective, efficient, accessible, acceptable/patient centered, equitable and

safe."[16] 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."[17] Several other countries also allow abortion services to be provided through telemedicine.[18] Imposing a nationwide restriction sets the United States behind its international peers and internationally recognized standards of medical care.

II. Interference With Evidence-Based Care Harms Medical Students and Residents Nationwide

Medical schools in the United States must teach students to use the scientific method combined with clinical experience to arrive at the best medical decisions for their patients.[19] Medical students must be taught to care for patients based on principles derived from published evidence, national and international guidelines, and clinical experience, all with the goal of improving outcomes based on the highest quality evidence available.[20] Studies have demonstrated the benefits of an evidence-

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[16] WORLD HEALTH ORG., ABORTION CARE GUIDELINE, SECOND EDITION: EXECUTIVE SUMMARY (2025), at 1–2, 16, https://bit.ly/48HQOcP.

[17] Int'l Fed'n of Gynecology & Obstetrics, *FIGO Endorses the Permanent Adoption of Telemedicine Abortion Services* (Mar. 18, 2021), https://bit.ly/3OJrv3v.

[18] CTR. FOR REPROD. RTS., EUROPE ABORTION LAWS 2025: POLICIES, PROGRESS AND CHALLENGES (2025), at 26, https://bit.ly/4w9K5Cp.

[19] *See* Steven Tenny & Matthew Varacallo, *Evidence-Based Medicine*, STATPEARLS (Sept. 10, 2024), https://bit.ly/4pvvtut ("Evidence-based medicine (EBM) uses the scientific method to organize and apply current data to improve healthcare decisions.").

[20] *Id.*

based medical education on patient care and outcomes,[21] including improved patient satisfaction and reduced healthcare costs.[22]

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 wisely in solving problems of health and disease."[23]

MSFC member and physician-scientist trainee, Jordan Phillips, 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.

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[21] *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 (2021), https://bit.ly/4vJ7SI3; Josephine Dorsch et al., *Impact of an Evidence-Based Medicine Curriculum on Medical Students' Attitudes and Skills*, 92 J. MED. LIBR. ASS'N 397, 401 (2004), https://bit.ly/4weTc4l; David Sackett & William Rosenberg, *On the Need for Evidence-Based Medicine*, 17 J. PUB. HEALTH MED. 330, 332 (1995), https://bit.ly/4b16bym.

[22] *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, 7 (2023), https://bit.ly/3T8mdjP.

[23] LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL (2025), at 4, 10, https://bit.ly/4cSsurb.

Meredith R., MSFC member and second-year medical student, similarly describes how her medical 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 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.

Evidence-based training in medication abortion and miscarriage management is essential for future OB-GYNs and general practitioners, including through standard healthcare practices including telemedicine and mail dispensing.

To become a licensed OB-GYN, the Accreditation Council for Graduate Medical Education ("ACGME") requires access to abortion training during residency.[24] For example, the ACGME requires that residents receive training in: (i) "educating patients on the surgical and medical therapeutic methods related to the provision of abortions"; (ii) "the management of complications of abortions"; and (iii) "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

[24] ACCREDITATION COUNCIL FOR GRADUATE MED. EDUC., ACGME PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION IN OBSTETRICS AND GYNECOLOGY § 4.11.i.4 (2025), https://bit.ly/48CuNMG.

management, and post-pregnancy loss care."[25] Standard abortion care now includes telemedicine, as recognized by the American College of Obstetricians and Gynecologists and other organizations.[26]

This is consistent with general trends in medical training, in which telemedicine is emerging as an increasingly critical skill across fields. The Association of American Medical Colleges published a report on competencies in telemedicine to include in medical school curricula and continuing medical education, noting telemedicine has "become an increasingly important and commonly used tool for delivering care to patients."[27] The core competencies include communicating with patients effectively via telemedicine, obtaining clinical information to ensure high-quality care, and delivering telemedicine in a way that "addresses and mitigates cultural biases."[28] Studies increasingly advocate for telemedicine curricula to be integrated into medical schools and have shown that

[25] *Id.* at §§ 4.11.i.2–4, 4.11.j.

[26] Mitchell Creinin & Daniel Grossman, *Medication Abortion Up to 70 Days of Gestation*, 136 OBSTET. & GYNECOL. 31, 35 (2020), https://bit.ly/4w1KBS1; *see also* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, UPDATED MIFEPRISTONE REMS REQUIREMENTS (Oct. 2025), https://bit.ly/4f1ERmb; Rajita Patil et al., *Society of Family Planning Committee Statement: Telemedicine in Family Planning Care Part 1*, CONTRACEPTION 2 (2025), https://bit.ly/4fqH0GN; NAT'L ABORTION FED'N, 2024 CLINICAL POLICY GUIDELINES FOR ABORTION CARE (2024) at 1, 17, https://bit.ly/4fgcrVj.

[27] ASS'N OF AM. MED. COLLS., TELEHEALTH COMPETENCIES ACROSS THE LEARNING CONTINUUM (2021), at 2, https://bit.ly/3QGmzNp.

[28] *Id.* at 3–6.

telemedicine programs are effective.[29] As one study of telemedicine training for medical students demonstrated, discussing miscarriage diagnosis and treatment in a virtual, objective, structured clinical exam setting met assessment goals.[30]

Tori Misiaszek, an MSFC member and second-year medical student in Montana, explains the centrality of telemedicine 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.

Similarly, MSFC member and medical student Samantha Keller shares her concerns regarding the reimposition of the in-person requirement's effect on the quality of medical training:

> 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

[29] *See, e.g.*, Susan Frankl et al., *Preparing Future Doctors for Telemedicine: An Asynchronous Curriculum for Medical Students Implemented During the COVID-19 Pandemic*, 96 ACAD. MED. 1696 (2021), https://bit.ly/4gKtPmh; Lana Shawwa, *The Use of Telemedicine in Medical Education and Patient Care*, 15 CUREUS 4 (2023), https://bit.ly/4gRfeFF.

[30] 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 (2023), https://bit.ly/4fy8Alz.

> medical students and residents are able to learn about evidence-based reproductive healthcare and how to provide it equitably.

Alicia G., an MSFC member and second-year medical student, describes how reinstating the in-person dispensing requirement would affect training and 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. 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 and residents across the country ill-equipped to provide accepted standards of reproductive healthcare.

Reinstating the in-person dispensing requirement undermines another central tenet of medical school curricula: to teach medical students to follow principles of medical ethics in caring for patients.[31] Although the precise content of ethical curricula varies among medical schools,[32] the four commonly accepted principles of medical ethics are respect for autonomy (respecting and supporting autonomous

[31] *See* LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE, *supra* note 23, at 10 (requiring accredited medical schools to "assure that students receive instruction in appropriate medical ethics, human values, and communication skills before engaging in patient care activities").

[32] *See* Lisa Lehmann et al., *A Survey of Medical Ethics Education at U.S. and Canadian Medical Schools*, 79 ACAD. MED. 682 (2004), https://bit.ly/4vJ8NIv.

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).[33]

Tim H. describes how an in-person dispensing requirement for mifepristone 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.

Other MSFC members expressed similar concerns. Ms. Phillips noted that "[i]n 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." Ms. Keller added that restricting mail-in mifepristone would "narrow our education around telemedicine workflows, follow-up, and patient-centered

[33] Tom Beauchamp & James Childress, *Principles of Biomedical Ethics* (9th ed. 2026); Thomas McCormick et al., *Principles of Bioethics,* UNIV. OF WASH. MED., https://bit.ly/3QGnVaX (last visited July 16, 2026); *see also* Am. Coll. of Obstetricians & Gynecologists, *Ethical Considerations With Telehealth in Obstetrics and Gynecology*, 146 OBSTET. & GYNECOL. 572, 573–78 (2025), https://bit.ly/4w9fNzo.

counseling, which are increasingly essential skills."

A nationwide restriction that defies decades of medical evidence, research, and proven safety of mail and pharmacy dispensing of mifepristone is harmful to medical students, residents, and future practitioners. Moreover, such a medically unnecessary restriction tarnishes the United States' reputation as an international leader in medical education and irreversibly harms the next generation of medical providers and patients.

III. Dispensing Mifepristone by Mail and by Pharmacy Is Critical Amidst Rising Reproductive 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 services, birth centers, obstetricians, gynecologists, certified nurse midwives, or abortion providers.[34] Reproductive care deserts are exacerbated by hospital closures, with 181 hospitals closing across the country since 2005, a figure attributed to "the shortage of obstetricians and family physicians."[35] Of course, future obstetricians, gynecologists, and family physicians require hospitals and clinics that offer the training that medical residents require and seek, including training in medication

[34] *See* Eli Adashi et al., *Maternity Care Deserts: Key Drivers of the National Maternal Health Crisis*, 38 J. AM. BD. FAM. MED. 165, 165 (2025), https://bit.ly/4pFZs2U; NAT'L WOMEN'S LAW CTR., WHEN WOMEN ARE DESERTED, *supra* note 3, at 5.

[35] Adashi et al., *Maternity Care Deserts*, *supra* note 34, at 166.

abortion, miscarriage management, and telemedicine. This cycle of provider and hospital shortages reinforces and exacerbates the crisis of reproductive care deserts in the United States.

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.[36] Abortion care deserts exist in nearly half of all U.S. counties.[37] In total, nearly one quarter of all counties are considered abortion *and* pregnancy care deserts.[38] As an international study found, "[t]he United States continues to have the highest rate of maternal deaths of any high-income nation"—two to seven times higher than Canada, France, the United Kingdon, Germany, Australia, Sweden, and the Netherlands—and over 80% of these deaths "are likely preventable."[39]

Telemedicine is critical in the current U.S. reproductive healthcare crisis. Following the coronavirus pandemic, the number of U.S. OB-GYNs who reported using telemedicine for physician-to-patient interactions increased from roughly 12% of OB-GYNs to over 84%.[40] Studies that followed showed no statistically

[36] *See* Ashley Stoneburner et al., *Nowhere to Go: Maternity Care Deserts Across the US*, MARCH OF DIMES (2024), at 3, 5, https://bit.ly/3RnhZUW.

[37] NAT'L WOMEN'S LAW CTR., WHEN WOMEN ARE DESERTED, *supra* note 3, at 5.

[38] *Id.* at 3.

[39] Munira Gunja et al., *Insight into the U.S. Maternal Mortality Crisis: An International Comparison*, COMMONWEALTH FUND (June 4, 2024), https://bit.ly/4tfHy74.

[40] Am. Coll. of Obstetricians & Gynecologists, *Ethical Considerations*, *supra* note 33, at 573.

significant adverse impacts on patient care or outcomes, and therefore supported the continued use of telemedicine in reproductive care.[41] "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."[42] A comprehensive review of over ninety studies on telemedicine used for antenatal care—which aims to detect and manage pregnancy complications—reported positively on the clinical safety and patient satisfaction of telemedicine for both real-time visits and remote monitoring including blood pressure, fetal heart rate, at-home cardiotocograph, and even teleultrasound monitoring.[43]

In many states that permit medication abortions, patients can obtain mifepristone at local pharmacies, by mail, or through telemedicine for accessibility, privacy, and at times, lifesaving treatment.[44] Telemedicine medication abortion is

[41] *See, e.g.*, Alison Shmerling et al., *Prenatal Care via Telehealth*, 49 PRIMARY CARE 609, 615 (2022), https://bit.ly/4fM7tQd.

[42] *See* Stoneburner et al., *Nowhere to Go: Maternity Care Deserts Across the US*, *supra* note 36, at 42.

[43] Jessica Atkinson et al., *Telehealth in Antenatal Care: Recent Insights and Advances*, 21 BMC MED. 332, at 2, 13–14 (2023), https://bit.ly/4fqLtcx.

[44] *See* Christopher Scannel et al., *Changes in Mifepristone Use at Pharmacies After Removal of the FDA In-Person Dispensing Requirement*, JAMA (2026), https://bit.ly/4fuJ0xI; Leah Koenig et al., *The Role of Telehealth in Promoting Equitable Abortion Access in the United States, Spatial Analysis*, 9 JMIR PUB. HEALTH & SURVEILLANCE 1, 1 (2023), https://bit.ly/3TxQHM9; Courtney Schreiber et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss*, 378 NEW ENGL. J. MED. 2161, 2169 (2018), https://bit.ly/4fxp0uh; Marta Rowh et al., *Closing the*

legally permitted in twenty-nine states, districts, and territories, and another six states through a hybrid model.[45] By the end of 2024, one in four abortions in the United States was provided through telemedicine.[46] And by the end of 2025, approximately 29% of abortions were provided through telemedicine.[47] Enjoining this care nationwide runs counter to the Supreme Court's instruction in *Dobbs v. Jackson Women's Health Organization* to return abortion regulation to state legislatures. 597 U.S. 215, 302 (2022) ("We . . . return that authority [to regulate or prohibit abortion] to the people and their elected representatives."); *id.* at 339 (Kavanaugh, J., concurring) ("Today's decision . . . does not prevent the numerous States that readily allow abortion from continuing to readily allow abortion.").

In states that allow it, dispensing mifepristone through local or mail pharmacies offers a safe and effective avenue to receive critical healthcare, particularly in many parts of these states where reproductive healthcare is a far distance away.[48] A 2023 study found that telemedicine was effective in "reducing

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Gap: Expanding Access to Mifepristone for Early Pregnancy Loss Through Operational Innovation, 7 JACEP OPEN 1, 4–5 (2026), https://bit.ly/4whq3pu.

[45] *See State of Telehealth Medication Abortion (TMAB)*, RHITES, https://www.rhites.org/maps (last visited July 16, 2026).

[46] Society of Family Planning, *#WeCount Report, April 2022 to December 2024* (June 23, 2025), at 1, https://bit.ly/4f1JjkM.

[47] Society of Family Planning, *#WeCount Report, April 2022 to December 2025* (June 10, 2026), at 1, http://bit.ly/44dw2PE.

[48] *See, e.g.*, Aiken et al., *Effectiveness, Safety and Acceptability of No-Test Medical Abortion*, *supra* note 2, at 1470; Grossman et al., *Mail-Order Pharmacy Dispensing*, *supra* note 2, at 879–80.

abortion-related travel barriers in states where abortion remains legal, especially among patient populations who already face structural barriers to abortion care."[49] For example, 56.9% of patients in rural and suburban areas stated that telemedicine made it possible to obtain timely abortion.[50] Studies also show the benefits of mifepristone's expanded use through telemedicine for miscarriage management,[51] and to timely diagnose and treat ectopic pregnancy.[52]

New Mexico is instructive. The state's abortion laws allow for medication abortions both in person at a clinic and at home through telemedicine.[53] However, of the fourteen abortion clinics in New Mexico, seven are in Albuquerque.[54] One-third of counties also have no hospitals, birth centers, or OB-GYNs offering obstetric care.[55]

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

[49] Koenig et al., *The Role of Telehealth*, *supra* note 44, at 1.

[50] *Id*. at 6.

[51] *See, e.g.*, Rowh et al., *Closing the Gap*, *supra* note 44, at 5–6; Schreiber, et al., *Mifepristone Pretreatment*, *supra* note 44, at 2169.

[52] Antonia Biggs, et al., *Experiences of Ectopic Pregnancy Among People Seeking Telehealth Abortion Care*, 134 CONTRACEPTION 110405 (2024), https://bit.ly/4pxTH73.

[53] NM Health, *Information About Abortion*, https://bit.ly/49qIsqc (last visited July 16, 2026).

[54] PLAN C PILLS, *New Mexico Abortion Clinic Guide*, https://bit.ly/4f7DMJs (last visited July 16, 2026).

[55] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN NEW MEXICO (2023), at 1, https://bit.ly/4njIqX1.

> 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.

In Colorado, where voters amended the state constitution in 2024 to recognize the right to abortion, eight of the twenty abortion clinics are in Boulder or Denver (with three others in nearby suburbs),[56] 31% of abortions are provided through telemedicine,[57] and 37.5% of counties are also maternal care deserts.[58] In Virginia, six of the twenty-two abortion clinics are in Richmond and another five are clustered in the southeast corner of the state,[59] 28% of abortions are provided through telemedicine,[60] and nearly 31% of counties are also maternal care deserts.[61] In Pennsylvania, nine of the twenty abortion clinics are in Philadelphia or Pittsburgh,[62] 24% of abortions are provided through telemedicine,[63] and 12% of women have no

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[56] PLAN C PILLS, *Colorado Abortion Clinic Guide*, https://bit.ly/4wbFn7e (last visited July 16, 2026).

[57] Society of Family Planning, *#WeCount Report, April 2022 to December 2025*, *supra* note 47, at 10.

[58] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN COLORADO (2023), at 1, https://bit.ly/4cTQIkQ.

[59] PLAN C PILLS, *Virginia Abortion Clinic Guide*, https://bit.ly/4cT3SPb (last visited July 16, 2026).

[60] Society of Family Planning, *#WeCount Report, April 2022 to December 2025*, *supra* note 47, at 10.

[61] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN VIRGINIA (2023), at 1, https://bit.ly/4wdiAYC.

[62] PLAN C PILLS, *Pennsylvania Abortion Clinic Guide*, https://bit.ly/4d0ehHr (last visited July 16, 2026).

[63] Society of Family Planning, *#WeCount Report, April 2022 to December 2025*, *supra* note 47, at

nearby birthing hospital.[64]

Without telemedicine, thousands of patients in these states and others would be left without access to the most common, evidence-based protocols for medication abortion.[65] Moreover, requiring patients to visit clinics and hospitals to receive medication abortion and miscarriage management places further burdens on those facilities.[66]

Bianca Stern, an MSFC member and second-year medical student in California, explains how mail and pharmacy dispensing is critical to access:

> 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 an urban area like New York City, Ms. Keller describes the importance of access to medication abortion through mail:

> As a medical student who has worked in OB-GYN settings and volunteers as an abortion doula, I have seen how access

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[64] MARCH OF DIMES, WHERE YOU LIVE MATTERS: MATERNITY CARE IN PENNSYLVANIA (2023), at 1, https://bit.ly/4dc787f.

[65] *See* Society of Family Planning, *#WeCount Report, April 2022 to December 2025*, *supra* note 47, at 10.

[66] *See* Alexandra Thompson et al., *The Disproportionate Burdens of the Mifepristone REMS*, 104 CONTRACEPTION 16, 17 (2021), https://bit.ly/3RNzL3K.

> 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.

With telemedicine and mail dispensing, patients in rural areas or without reliable transportation have dependable access to safe, effective, and evidence-based reproductive healthcare.

Sarah Boliek, an MSFC member and second-year medical school student, described how restrictive laws impose burdens on the healthcare system generally:

> 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.

The reinstatement of a medically unnecessary restriction on healthcare nationwide risks a loss of medical talent in the United States, as medical students and residents consider where to study, train, and later reside and work. As already demonstrated within the United States, 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.[67] According to a survey of more than 2,000

[67] Sarah McNeilly & Vivian Kim, *Standardize Abortion Education Across U.S. Medical Schools*, MEDPAGE TODAY (July 1, 2022), https://bit.ly/4w5FTE1.

current and future physicians, over 82% of respondents reported that they preferred to apply to work or train in states with abortion access.[68]

As Rose Al Abosy, M.D., explains:

> Now that the situation around abortion training and access in this country is growing increasingly dire, when I think about my future practice as an OB-GYN, I think about what it would be like to practice in a different country. If abortion options become very limited in the United States and I am not permitted to practice medicine here in the way that I was trained, I would consider my options for practicing elsewhere.

The reinstatement of the in-person dispensing requirement for mifepristone nationwide harms evidence-based and patient-centered medical education and training, places greater strain on an overburdened healthcare system already facing a lack of licensed reproductive care providers, and risks a further exodus of medical talent from the United States as such restrictions are compounded.

CONCLUSION

For the foregoing reasons, this Court should affirm the denial of Louisiana's stay request under 5 U.S.C. § 705.

[68] Simone 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 (2023), https://bit.ly/3RRNIO9.

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CERTIFICATE OF SERVICE

I hereby certify that on this July 22, 2026 a true and correct copy of the foregoing Brief was served via the Court's CM/ECF system.

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No. 26-30203 State of Louisiana v. FDA
USDC No. 6:25-CV-1491

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