**STATE OF ARIZONA**

**OFFICE OF THE ATTORNEY GENERAL**

| ATTORNEY GENERAL OPINION<br><br>By<br><br>KRIS MAYES<br>ATTORNEY GENERAL<br><br>June 27, 2024 | No. I24-009<br>(R24-011)<br><br>Re: The meaning of "medical emergency" under A.R.S. § 36-2321(7) |
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To: The Honorable Eva Burch, State Senate, District 9;
The Honorable Christine Marsh, State Senate, District 4;
The Honorable Judy Schwiebert, House of Representatives, District 2; and
The Honorable Stephanie Stahl Hamilton, House of Representatives, District 21.

## Question Presented

For purposes of providing medical care permitted by A.R.S. § 36-2322(A) and (B), when does a "medical emergency" exist, as that term is defined by A.R.S. § 36-2321(7)?

## Summary Answer

To comply with the "medical emergency" exception in A.R.S. § 36-2322(A) and (B), as defined in A.R.S. § 36-2321(7), the treating physician must do two things. First, she must exercise clinical judgment. Courts have recognized that clinical judgment is a well-understood medical concept that involves a physician applying her personal knowledge, training, experience, and discernment to the facts before her in light of the patient's unique circumstances and other medically relevant considerations. Second, the treating physician must determine in good faith that, based on her clinical judgment, either "a condition … so complicates the medical condition

of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death," or "a delay [in providing an abortion] will create serious risk of substantial and irreversible impairment of a major bodily function." A.R.S. § 36-2321(7). In this context, good faith means that the treating physician's assessment must be based on an actual and honest belief, without malice or an intent to deceive, that a medical emergency exists. It does not mean that the treating physician's assessment must be objectively correct if later evaluated by others with the benefit of hindsight.

Once a treating physician forms a good faith clinical judgment that one of the two foregoing circumstances is satisfied, the statute allows her to perform an abortion immediately and does not require her to wait for a patient to deteriorate or inch closer to death. The treating physician's clinical judgment that a "medical emergency" exists cannot be second-guessed after the fact and cannot be prosecuted under A.R.S. § 36-2322—or any other abortion law with the same "medical emergency" exception—unless there is proof that she acted without good faith.

## Background

In March 2022, the Arizona Legislature passed and the Governor signed S.B. 1164, which added A.R.S. §§ 36-2321 through 36-2326 to the statutory scheme regulating abortion. *See* 2022 Ariz. Legis. Serv. Ch. 105 (S.B.1164), § 1. Relevant here is A.R.S. § 36-2322, which states in part:

> A. Except in a medical emergency, a physician may not perform, induce or attempt to perform or induce an abortion unless the physician or the referring physician has first made a determination of the probable gestational age of the unborn human being.... The determination of probable gestational age shall be made according to standard medical practices and techniques used in the medical community.
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> B. Except in a medical emergency, a physician may not intentionally or knowingly perform, induce or attempt to perform or induce an abortion if the probable gestational age of the unborn human being has been determined to be greater than fifteen weeks.

A.R.S. § 36-2322(A)-(B). In short, subsection (A) prohibits physicians from performing an abortion without determining the gestational age of the fetus, and subsection (B) prohibits abortions after 15 weeks gestational age. But neither prohibition applies when there is a "medical emergency." A "medical emergency" is defined as:

> a condition that, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.

A.R.S. § 36-2321(7). This definition in S.B. 1164 is identical to earlier "medical emergency" definitions that the Legislature adopted in relation to other abortion laws. *See* A.R.S. § 36-2151(9); *see also* A.R.S. § 36-2301.01(C)(2).

In June 2022, the U.S. Supreme Court held that there is no federal constitutional right to obtain an abortion, overruling *Roe v. Wade*, 410 U.S. 113 (1973) and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). *See Dobbs v. Jackson Women's Health Org.*, 597 U.S. 215, 231-32 (2022). The Arizona Supreme Court subsequently concluded that the 15-week law in A.R.S. § 36-2322 was "predicated entirely on the existence of a federal constitutional right to an abortion since disclaimed by *Dobbs*," and therefore held that an older abortion law enjoined since *Roe*—A.R.S. § 13-3603—was newly enforceable and governed over the 15-week law. *Planned Parenthood Ariz., Inc. v. Hazelrigg*, 545 P.3d 892, 895 ¶ 2 (Ariz. 2024).

Several weeks later, however, the Legislature repealed A.R.S. § 13-3603. 2024 Ariz. Legis. Serv. Ch. 181 (H.B. 2677). As a result, the 15-week law in A.R.S. § 36-2322 is the governing law in Arizona regarding the temporal limitations on obtaining an abortion and the exception to those limitations.

Your request of June 11, 2024, indicates that confusion regarding the scope and application of the "medical emergency" exception is creating significant problems within the medical

community. Specifically, you stated that "there is an urgent need to inform practitioners as to what is legally appropriate under current state law" because Arizonans are facing threats to "their future reproductive health" and "potentially life-threatening situation[s]" as a result of "confusion by doctors as to what constitutes a medical emergency."

In light of that confusion and the significant stakes for Arizona families and healthcare providers, we issue this Opinion in response.[1]

## Analysis

### I. Whether a medical emergency exists under A.R.S. § 36-2321(7) is based on the treating physician's personal "good faith clinical judgment."

Whether an abortion is permitted under the "medical emergency" exception to A.R.S. § 36-2322(A) and (B) is dependent on the treating physician's personal "good faith clinical judgment" that the facts at hand satisfy the statute. That "good faith clinical judgment" test requires only two things: first, the physician must use clinical judgment, and second, the physician must act in good faith in forming a clinical judgment that a "medical emergency" exists. As long as those requirements are met, and absent proof of bad faith, nothing in the statute allows the physician's judgment to be second-guessed after the fact, even if other physicians might have come to a different conclusion.

#### A. The "medical emergency" exception is disjunctive.

We begin, as we must, with the plain text of the medical emergency exception. *See In re Riggins*, 544 P.3d 64, 67 ¶ 12 (Ariz. 2024). Two aspects of the definition's structure are especially

[1] The discussion that follows is equally applicable to the identical definition of "medical emergency" in A.R.S. § 36-2151(9) and § 36-2301.01(C)(2), and the many other abortion laws that include the same "medical emergency" exception. *See, e.g.*, A.R.S. §§ 13-3603.02, 36-449.03, 36-2152, 36-2153, 36-2156, 36-2157, 36-2158, 36-2159, 36-2161, 36-2163, 36-2162.01, 36-2301, 36-2301.01.

instructive as a threshold matter. *See* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 167 (2012) (stating that statutes should be read "to consider the entire text, in view of its structure and of the physical and logical relation of its many parts").

First, the definition is disjunctive. It is comprised of two main clauses separated by "or": the "so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death" clause, and the "delay will create serious risk of substantial and irreversible impairment of a major bodily function" clause. *See* A.R.S. § 36-2321(7). It is well settled that "[t]he word 'or' generally means '[a] disjunctive particle used to express an alternative or to give a choice of one among two or more things.'" *See State v. Bowsher*, 225 Ariz. 586, 587 ¶ 7 (2010) (citation omitted); *see also* Scalia & Garner at 116-17 (Conjunctive/Disjunctive Canon). This means that if either part of the definition in § 36-2321(7) is satisfied, then a "medical emergency" exists and the prohibitions and requirements in A.R.S. § 36-2322(A) and (B) do not apply.

Second, the phrase "on the basis of the physician's good faith clinical judgment" prefaces the whole definition and modifies both parts. A.R.S. § 36-2321(7). When the same modifier applies to "two disjunctive terms … each possibility must make sense standing alone." *Premier Physicians Grp., PLLC v. Navarro*, 240 Ariz. 193, 197 ¶ 18 (2016). Thus, whether a "medical emergency" exists under either clause hinges entirely on the treating physician's "good faith clinical judgment" that one exists. A.R.S. § 36-2321(7); *cf. Premier Physicians*, 240 Ariz. at 197 ¶ 18 ("Because 'before' and 'within thirty days after' each modify the same phrase, … that phrase is most reasonably understood as bearing the same meaning under either modifier…."). For that reason, we start with the meaning of "good faith clinical judgment."

### B. With the statutory language "good faith clinical judgment," the Legislature clearly chose a subjective standard focused on the treating physician's mindset.

Unlike other statutes that refer generically to "good faith," the medical emergency definition refers more specifically to "good faith *clinical judgment*." A.R.S. § 36-2321(7) (emphasis added). The "good faith clinical judgment" requirement is also different because "good faith" is not a noun and end in itself; it is a phrasal adjective that describes "clinical judgment." *See* Scalia & Garner at 140 ("Words are to be given the meaning that proper grammar and usage would assign them."). Accordingly, "good faith" in this context must be construed in conjunction with the bottom-line requirement that it modifies. And therefore, we first discuss the meaning of "clinical judgment" and then the nature of the "good faith clinical judgment" inquiry as a whole.

#### 1. "Clinical Judgment"

Courts "understand the term 'clinical judgment' to be a shorthand for a physician's judgment of his patient's condition made in the light of his professional training and experience and based on both his physical observation of the patient and the patient's own description of her symptoms." *A Woman's Choice-East Side Women's Clinic v. Newman*, 671 N.E.2d 104, 109 n.7 (Ind. 1996). In various contexts, "clinical judgment" has been similarly described as "a special type of judgment rooted in a high level of clinical expertise and experience," *United States v. Williams*, 1 F. Supp. 3d 1124, 1139 (D. Haw. 2014) (citation omitted), which "emerges directly from extensive data," the provider's "explicit training," and "familiarity with the [patient] and the [patient's] environments," *Inland Counties Reg'l Ctr., Inc. v. Superior Court*, 10 Cal. App. 5th 820, 828 (Cal. App. 2017) (citation omitted).

Although clinical judgment is based on objective information, it is distinct from the data and training that inform its exercise. *Cf. Aguchak v. United States*, No. 3:15-cv-0105-HRH, 2017 WL 5244174, at *4 (D. Alaska Oct. 27, 2017) (quoting from an American Heart Association guide

that certain diagnostic criteria "must not" and "should not replace clinical judgment"); 21 C.F.R. § 882.5855(b)(iv) (requiring neurological therapeutic devices to include "[a] warning regarding use of the data with respect to not replacing clinical judgment"). Indeed, clinical judgment is necessarily fact-specific and unique to each physician because it requires "the physician's medical knowledge [to be applied] to an individual patient's circumstances." *Grier v. Goetz*, 424 F. Supp. 2d 1052, 1062 (M.D. Tenn. 2006); *cf. Hall v. Florida*, 572 U.S. 701, 722-23 (2014) (distinguishing between the "clinical judgment" necessary for "the diagnosis of intellectual disability" and "an actuarial determination" (citation omitted)).

Clinical judgment "is of significant importance" in medical matters of "relative subjectivity," *United States v. Jimenez-Bencevi*, 934 F. Supp. 2d 360, 371 (D.P.R. 2013) (adaptive behavior analysis), and matters that require "a timely assessment" and "involve[] an ambiguous set of circumstances," *Coleman v. Brown*, No. 2:90-cv-0520, 2013 WL 3773963, at *1 (E.D. Cal. July 12, 2013) (identifying suicide risk). But whatever the situation or area of medicine, the "'good-faith clinical judgment' standard is a familiar one to physicians," and they "routinely make medical emergency determinations … in [the exercise of] their 'good-faith clinical judgment.'" *Womancare of Orlando, Inc. v. Agwunobi*, 448 F. Supp. 2d 1293, 1307 (N.D. Fla. 2005). In sum, the caselaw makes clear that "clinical judgment" has "a common meaning ascribed by the populace" to which A.R.S. § 36-2123(7) applies—physicians. *Heath v. Kiger*, 217 Ariz. 492, 494 ¶ 8 (2008).

The Arizona Legislature has used "clinical judgment" several times in various contexts without ever defining it, including in S.B. 1164. *See, e.g.*, A.R.S. §§ 32-1263(D)(16), 32-1263.02(Q)(1) (dentistry), 36-509(A)(8) (mental health services), 36-3605(1) (stating that a "health care provider shall use … clinical judgment in considering whether the nature of the

services necessitates physical interventions and close observation" or telehealth).[2] These repeated uses of a key term without any accompanying definition indicate that, just like many courts and any healthcare provider, the Legislature has consistently understood "clinical judgment" to be a straightforward and unambiguous medical concept that requires no statutory elaboration. *Cf. In re Drummond*, 543 P.3d 1022, 1025 ¶¶ 5, 7 (Ariz. 2024) ("We 'determine the plain meaning of the words the legislature chose to use, viewed in their broader statutory context.' … Absent a statutory definition, courts generally give words their ordinary meaning…." (citation omitted)).

Furthermore, the Legislature explicitly advised that S.B. 1164 did not "alter generally accepted medical standards." S.B.1164, § 2(1). That express preservation of generally accepted medical standards in S.B. 1164 confirms that the 15-week law in A.R.S. § 36-2322 did not change the standard of care or otherwise change how providers have long been—and should continue—applying their clinical judgment to assess the existence of a "medical emergency."

**2. "Good Faith"**

As a general matter, "good faith" requirements "appear[] frequently in various statutory contexts" and court rules, but that language's meaning and whether it calls for "a subjective measuring approach or … an objective standard" can vary. *In re Est. of Gordon*, 207 Ariz. 401, 405 ¶ 20 (App. 2004). Some statutes call for an objective approach to good faith, which requires a comparison to "what a [similarly situated person] would do in similar circumstances." *Villa De*

[2] So too with the use of that term by administrative agencies, which directly regulate the individuals who exercise clinical judgment. *See* A.C.C. R9-31-701 (defining "medical review" to include clinical judgment); R9-10-1309(1)(b)(ii) (referring to "clinical judgment, as documented in the patient's medical record"); R4-23-651 (defining "formulary" as "a continually revised compilation of pharmaceuticals … that reflects the current clinical judgment of the medical staff"); R4-23-1104(B)(7)(d) (prohibiting a pharmacist from delegating to a pharmacy technician "any task that requires the exercise of clinical judgment"); R4-19-101 (defining "nursing diagnosis" as "a clinical judgment, based on analysis of comprehensive assessment data, about a client's response to actual and potential health problems or life processes").

*Jardines Ass'n v. Flagstar Bank, FSB*, 227 Ariz. 91, 96 ¶ 14 (App. 2011) (citation omitted). By contrast, a subjective standard focuses only on a person's internal understanding and simply requires a person to act with "an honest belief without malice or a design to defraud or to seek an unconscionable advantage," without requiring that conduct to be reasonable as compared to others. *Shepherd v. Costco Wholesale Corp.*, 250 Ariz. 511, 515-16 ¶¶ 20, 23-25 (2021). And other statutes are hybrids, containing both subjective components that "inquir[e] into the actual state of mind of the party" and objective components that "require[] an objective measurement of the [reasonableness] of the party's action in light of" the applicable standard. *San Tan Irr. Dist. v. Wells Fargo Ban*k, 197 Ariz. 193, 197 ¶ 13 (App. 2000).

Relevant here, then, is whether compliance with A.R.S. § 36-2321(7) turns on the treating physician's state of mind the moment she forms a clinical judgment that a medical emergency exists. Or, whether the treating physician's honest judgment is irrelevant because the statute instead requires an after-the-fact comparison of the treating physician's assessment to what a hypothetical reasonable physician would have concluded. Although there might be ambiguity in other statutory contexts about whether an objective or subjective approach is the correct standard, there is no such ambiguity here as to "good faith clinical judgment." "By its very nature, a physician's clinical judgment is not objective. It is a subjective application of the physician's medical knowledge … to an individual patient's circumstances." *Grier*, 424 F. Supp. 2d at 1062. That medical reality is instructive because courts "do not view statutory words in isolation, but rather draw their meaning from the context in which they are used." *In re Drummond*, 543 P.3d at 1026 ¶ 9 (citation omitted).

Reflecting that principle, there appears to be no real dispute in the caselaw that the phrase "good faith clinical judgment" requires an analysis of whether the treating physician acted

honestly—it does not require a comparison to what other physicians would have done. For example, the Ninth Circuit has found language identical to A.R.S. § 36-2321(7) "plainly included a subjective standard—an allowance that a physician may act by his own medical judgment so long as he acts in good faith—rather than [an] objective, 'prudent physician' standard." *Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908, 933 (9th Cir. 2004).[3]

Other courts have similarly taken it as a given that this sort of "reference to the physician's best clinical judgment certainly places in the physician's hands the medical judgment that would satisfy the requirements of the statute." *Fargo Women's Health Org. v. Schafer*, 18 F.3d 526, 535 (8th Cir. 1994). The Idaho Supreme Court recently recognized the same, explaining that the statutory language "in his good faith medical judgment and based on the facts known to the physician at the time" left "wide room" for the physician's discretion and was "clearly a subjective standard, focusing on the particular physician's judgment" not "objective certainty." *Planned Parenthood Great Nw. v. State*, 522 P.3d 1132, 1203 (Idaho 2023) (citation omitted); *see also Kurzner v. Sanders*, 627 N.E. 2d 564, 567-68 (Ct. App. Ohio 1993) (stating that "the word 'judgment' connotes subjectivity" and distinguishing between doctor's "best clinical judgment" and "whether he objectively exercised due care").

Unlike the language the Arizona Legislature chose in A.R.S. § 36-2321(7), some states have included references to reasonableness in their medical emergency definitions. That sort of language, such as "in good faith and in the exercise of reasonable medical judgment," clearly indicates "that the physician cannot rely solely on his or her own best clinical judgment … instead,

[3] The court was referring to the identical Pennsylvania "medical emergency" exception at issue in *Casey*, 505 U.S. at 879 (quoting 18 Pa. Cons. Stat. § 3203 (1990)), and an Arizona statute that was at issue in *Planned Parenthood of Southern Arizona v. Lawall*, 180 F.3d 1022, 1032 (9th Cir. 1999) (quoting what was then A.R.S. § 36-2152(F), now (H)(2)).

that determination must be objectively reasonable as well." *Women's Med. Pro. Corp. v. Voinovich*, 911 F. Supp. 1051, 1077, 1082-83, 1085 (S.D. Ohio 1995); *see also In re State*, 682 S.W.3d 890, 894 (Tex. 2023) ("By requiring the doctor to exercise 'reasonable medical judgment,' the Legislature determined that the medical judgment involved must meet an objective standard."); *cf. also San Tan Irr. Dist.*, 197 Ariz. at 197 ¶ 13 (holding that the phrase "the observance of reasonable commercial standards of fair dealing" in statute "require[d] an objective measurement of the fairness of the party's action").

Consistent with the apparent consensus among these courts, the Legislature plainly understands the difference between subjective good faith and objective reasonable care, and it knows how to require the latter when that is what it intends. *See, e.g.*, A.R.S. §§ 36-2266(C), 36-2228(C) (requiring "reasonable care and … good faith" in order for immunity to apply); A.R.S. § 32-1979(D) (same); A.R.S. § 32-1979.01(D) ("acting reasonably and in good faith"); A.R.S. § 36-420(C) (requiring care to be "in good faith and consistent with cardiopulmonary resuscitation or first aid certification standards" for "liability exclusion" to apply). The same is true in the abortion context in particular, where the Legislature knows how to require an objective determination based on specific procedures. *See, e.g.*, A.R.S. § 36-449.03(D)(5) (stating that "the physician is responsible for estimating the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care … and shall write the estimate in the patient's medical history").[4]

[4] Federal regulations also reflect the understanding that "clinical judgment" is different from objective medical knowledge and standards of care. *See, e.g.*, 42 C.F.R. § 414.90(b)(iii) (Medicare regulation stating that a "program requires a physician to demonstrate, through a formalized secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality"); 20 C.F.R. § 656.5(a)(3)(ii) (stating that a nurse is "a person who applies the art and science of nursing" which includes "making clinical judgments involving the observation, care and counsel of [patients]").

Notably, the Legislature did not include any similar language in the "medical emergency" definition in A.R.S. § 36-2321(7). Rather, the medical emergency exception hinges on language that unquestionably calls for an analysis of the treating physician's honest clinical judgment alone. The statute does not mention "reasonableness" or otherwise call for an objective comparison of the treating physician's determination to what other physicians would have done. Accordingly, to "give effect to every [word]" in A.R.S. § 36-2321(7), and "so that no provision [in that statute or other statutes with different language] is rendered meaningless, insignificant, or void," *Mejak v. Granville*, 212 Ariz. 555, 557 ¶ 9 (2006), the phrase "good faith clinical judgment" must be understood to establish a subjective standard for determining whether a medical emergency exists.

That A.R.S. § 36-2321(7) establishes a subjective standard just means that the treating physician must exercise clinical judgment and make "a good faith judgment call" about whether a medical emergency exists, but the statute does not require (or allow) a post-hoc inquiry into whether that judgment call was "objectively 'correct.'" *Planned Parenthood Great Nw.*, 522 P.3d at 1205; *see also Voinovich*, 911 F. Supp. at 1082-83 (discussing subjective and objective aspects of statute and explaining that an additional reasonableness requirement means a doctor's "belief must be objectively reasonable to other physicians").

Relatedly, the "medical emergency exception does not require certainty …. It calls only for a physician's 'good faith clinical judgment.'" *Tucson Women's Ctr. v. Ariz. Med. Bd.*, 666 F. Supp. 2d 1091, 1102 (D. Ariz. 2009) (quoting what was then A.R.S. § 36-2151(5) and rejecting arguments that the statute requires doctors to "'be certain[]' that the risk posed by delaying … abortions would cause" the results in the statute); *see also Planned Parenthood Great Nw.*, 522 P.3d at 1204 (stating that "'a medical consensus' on what is 'necessary' to prevent the death of the woman when it comes to abortion is not required"). And to act in good faith, a physician must

simply "act[] under an honest belief, without malice or a design to defraud." *Shepherd*, 250 Ariz. at 516 ¶ 25; *see also Acting in Good Faith, Black's Law Dictionary* (11th ed. 2019) (defining "acting in good faith" as "[b]ehaving honestly and frankly, without any intent to defraud or to seek an unconscionable advantage").

In other words, the statute does not require the treating physician to be certain about the consequences of failing to provide an abortion and precisely when those consequences will occur, only to arrive at her clinical judgment in "good faith." If the treating physician forms an honest clinical conclusion that something "so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death," or that a "delay will create serious risk of substantial and irreversible impairment of a major bodily function," then a medical emergency exists. It does not matter for purposes of Title 36 whether a prosecutor (or other doctors) might later believe that the physician objectively erred in her conclusion. Because the Legislature chose to focus on the treating physician's mental state at the moment of her medical emergency determination, no prosecutor can second-guess a treating physician's clinical judgment that an abortion was warranted, absent proof of bad faith.

## II. A physician's exercise of "good faith clinical judgment" is highly fact-specific.

Pregnancy is complex and there are myriad combinations of unique circumstances and risk factors that can lead to any number of complications. It would be impossible and inappropriate to speculate in a factual vacuum about how the statute should apply to particular circumstances. *Cf. Stafford v. Burns*, 241 Ariz. 474, 480-81 ¶ 12 (App. 2017) ("The gamut of services that may be necessary to [stabilize a patient] cannot readily be distilled into a universally applicable and finite list…. The evaluation and treatment of a medical condition is necessarily a fluid process, whereby a patient's status as serious or stable may change from moment to moment. This is particularly

true where the condition qualifies as an emergency … manifesting through acute symptoms, severe pain, and the risk of serious dysfunction or bodily impairment.").

Nonetheless, the statutory text and relevant caselaw offer some general guideposts for treating physicians exercising their "good faith clinical judgment" under A.R.S. § 36-2321(7).

**A. "Necessitate the immediate abortion of her pregnancy to avert her death."**

Under the first part of the statutory definition, a "medical emergency" exists when "a condition … so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death." A.R.S. § 36-2321(7).

Notably, the statute does not say "to avert *imminent* death" or "*certain* death." Nor does the ordinary meaning of "avert" entail that the harm to be averted is imminent or inevitable. "Avert" simply means "to see coming and ward off" or "to turn away or aside … in avoidance," and one can "see coming and ward off" a consequence that may occur soon, but not immediately. *See* Avert, Meriam-Webster, https://www.merriam-webster.com/dictionary/avert (listing "avoid" as a synonym). Instead, the temporal aspect of the statutory definition is linked to the medical care to be provided ("the immediate abortion") not to the consequence to be avoided ("death").

As a result, the statute simply cannot be read to mean that death must be imminent before an "immediate abortion" is permitted. Nothing in the statutory language requires the treating physician to delay providing an abortion as necessary medical care until, for instance, the patient is in sepsis, hemorrhaging, or otherwise at death's door. *Cf. Planned Parenthood Great Nw.*, 522 P.3d at 1204 (stating that "there is no 'certain percent chance' requirement that death will occur under the term 'necessary'" and "to impute one would only add an objective component to a wholly subjective" standard). Under the plain statutory text, it is not impending death that "necessitate[s]

the immediate abortion," but rather the existence of a "condition that … so complicates the medical condition of a pregnant woman" that an abortion is necessary to avert eventual death.

In other words, the medical emergency exception is triggered as soon as the treating physician forms an honest clinical judgment that an abortion is the indicated treatment for a patient's condition in order to avert death. So, for instance, if the treating physician examined a patient and determined that the patient's condition would lead to death within 24 hours, the physician need not wait until hour 23 (or 22, 21, or 20, etc.) to perform an abortion—the physician need not wait at all. Once the physician has exercised her clinical judgment and concluded in good faith that the condition requires an abortion to avert death, the patient's condition then "necessitate[s]" that care. A.R.S. § 36-2321(7).

Courts have understood similar statutory text in this way. Interpreting nearly identical "medical emergency" language, the Indiana Supreme Court stated that the "statute permits immediate abortion far short of medical calamities" and applies as soon as the physician "concludes in her best clinical judgment that her patient's condition indicates an abortion is medically necessary." *A Woman's Choice*, 671 N.E. 2d at 110 (interpreting Indiana Code § 16-18-2-223.5). Likewise, the Idaho Supreme Court recently held that the phrase "'necessary to prevent the death of the pregnant woman' ... does not require objective certainty, or a particular level of immediacy, before the abortion can be 'necessary' to save the woman's life." *Planned Parenthood Great Nw.*, 522 P.3d at 1203 (quoting Idaho Code § 18-622(3)(a)(ii)). To the contrary, the court held that the legislature "use[d] broad language to allow for the 'clinical judgment that physicians are routinely called upon to make for proper treatment of their patients.'" *Id.*

Requiring a physician to wait until her patient is at death's door would also run afoul of the principle that "[s]tatutes should be construed sensibly to avoid reaching an absurd conclusion."

*State ex rel. Montgomery v. Harris*, 237 Ariz. 98, 101 ¶ 13 (2014). Once a physician has determined in good faith that an abortion is the indicated care for a patient's condition to avert death, it would serve no purpose to require a physician to wait to provide that necessary care solely to allow the patient to inch closer to death. The medical emergency exception expressly "allows the attending physician the room he needs to make his best medical judgment," and that room "operates for *the benefit*, not the disadvantage, of the pregnant woman." *Planned Parenthood Great Nw.*, 522 P.3d at 1203-04 (quoting *Spears v. State*, 278 So.2d 443, 445 (Miss. 1973)) (emphasis added).

The contrary interpretation would also put physicians between a rock and a hard place. On the one hand, the threat of criminal prosecution and regulatory discipline for providing an abortion too soon. And on the other hand, the possibility of a patient dying or experiencing permanent injuries and the threat of civil liability and regulatory discipline for waiting too long. That tension is untenable for the effective practice of medicine and directly conflicts with the Legislature's stated concern in S.B. 1164 for "protecting the health of women," § 3(A)(6) (citation omitted), and its express direction that the "act does not ... alter generally accepted medical standards," § 2(1).

### B. "Delay will create serious risk of substantial and irreversible impairment of a major bodily function."

Under the second part of the statutory definition, a "medical emergency" also exists when "a condition … so complicates the medical condition of a pregnant woman … [that] a delay [in providing an abortion] will create serious risk of substantial and irreversible impairment of a major bodily function." A.R.S. § 36-2321(7).

"'Major bodily function' includes functions of the immune system, normal cell growth, and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine and reproductive functions." A.R.S. § 36-2321(6). This list is not exhaustive of all major bodily

functions a physician may consider, however. The statute's use of "includes" indicates that other bodily functions may qualify as "major," which treating physicians should assess based on the facts of each case and consistent with their clinical judgment. *See Vangilder v. Ariz. Dep't of Revenue*, 252 Ariz. 481, 487 ¶ 22 (2022) ("[T]he statutory definition of the term 'including' is 'not limited to,' and it is 'not a term of exclusion.'" (quoting A.R.S. § 1-215(14))).

What constitutes a "substantial[] and irreversibl[e]" impairment, and what degree of risk rises to the level of "serious risk," are likewise questions for the treating physician to determine according to her good faith clinical judgment. The physician's analysis will surely vary depending on the major bodily function at issue and each patient's personal situation and history; nothing in the statute artificially constrains that clinical judgment by imposing a certain percentage threshold at which the events must be likely to occur. *See A Woman's Choice*, 671 N.E.2d at 109 (stating that clinical judgment "allows the attending physician the flexibility to exercise to the fullest extent her professional judgment when diagnosing a patient" and that "all relevant factors pertaining to a woman's health" are "implicit in the term 'clinical judgment'").

* * *

Two final points bear mention. First—and relevant to both prongs of the medical emergency definition—different patients might make different decisions about when to consent to an abortion as the appropriate care, but those patients' personal choices do not undermine the treating physician's good faith conclusion that a medical emergency exists. For instance, suppose a treating physician diagnoses two patients with cancer and concludes in both cases that at least one part of the medical emergency definition is satisfied. One patient with a lower risk tolerance might immediately choose to terminate the pregnancy to begin treating her cancer. But the other patient might choose to wait because of her personal beliefs about abortion. The latter patient's

choice to wait based on her personal risk assessment and beliefs does not evidence a lack of good faith by the physician as to the former patient.

Second, there are certain situations that, as a factual matter, might very well qualify as clinical emergencies—either immediately or at some point in time—but which do not implicate A.R.S. § 36-2322 and do not require physicians to find a statutorily defined "medical emergency" before treating the patient. For example, the definition of "abortion" excludes "the use of any means … to terminate an ectopic pregnancy or to remove a dead fetus." A.R.S. § 36-2151(1); *see id.* § 36-2321(1) (stating that "'abortion' has the same meaning prescribed in § 36-2151"). Thus, if a fetus is no longer living, the procedure to remove it is not an "abortion," and physicians need not determine that there is a "medical emergency" under A.R.S. § 36-2321(7) before providing the appropriate medical care. Likewise, in the case of an ectopic pregnancy where the fertilized ovum has implanted outside of the uterus, a procedure to treat that situation is not an "abortion," and therefore A.R.S. § 36-2322 and § 36-2321(7) do not apply and do not require anything of physicians before they can provide the appropriate medical care. *See also Planned Parenthood Great Nw.*, 522 P.3d at 1203 (recognizing that "the fallopian tube, ovary, or abdominal cavity [where a fertilized egg may have] implanted [all] necessarily cannot support its growth").

**Conclusion**

To comply with the "medical emergency" exception in A.R.S. § 36-2322(A) and (B), as that term is defined in A.R.S. § 36-2321(7), a physician must do two things. She must exercise clinical judgment, and she must have an actual and honest belief—based on her clinical judgment—that either "a condition … so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death," or "a delay [in providing an abortion] will create serious risk of substantial and irreversible impairment of a major

bodily function." The physician's clinical judgment that an abortion was warranted cannot be second-guessed after the fact and cannot be prosecuted unless there is proof that she lacked good faith in making that determination.

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