IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
WESTERN DIVISION

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, et al.,	)	
Plaintiffs,	)	No. 16 CV 50310
v.	)	Judge Frederick J. Kapala
BRUCE RAUNER and BRYAN A. SCHNEIDER,	)	Magistrate Judge Iain D. Johnston
Defendants.	)	

BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, ILLINOIS ACADEMY OF FAMILY PHYSICIANS, *ET AL.*, IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Amici Curiae[1] include leading organizations of medical professionals that promote evidence-based, quality health care; medical ethicists; and physicians who have treated patients harmed when their health care providers denied them standard of care information on religious grounds. *Amici* submit this brief to describe the medical, ethical and legal foundations for the patient protections enacted in the 2017 amendments to the Illinois Health Care Right of Conscience Act ("HCRCA"), 745 ILCS 70/1, *et seq.* ("2017 Amendments").[2]

Under Illinois statutory and common law, health care providers must give patients all relevant information about their medical circumstances and treatment options – including the risks, benefits, and alternatives associated with such options. Health care professionals who fail to provide information within the current standards of medical practice may be subject to malpractice suits and professional discipline. In 1977, Illinois adopted the HCRCA, which gave

[1] *See* Exhibit 1 for a complete list and descriptions of *amici curiae*.

[2] Senate Bill 1564, Pub. Act 990-0690 (eff. Jan. 1, 2017) (amending 745 ILCS 70/1, *et seq*.).

one category of health care providers – those with religious objections to certain health care services – an exemption from such liability and discipline. The HCRCA allowed individuals and institutions that hold themselves out as health care providers to refuse to provide their patients with treatment, and even information, on religious grounds.

During the 99th General Assembly, the legislature heard from patients and providers about the harm this exemption was causing patients. In response, it passed the 2017 Amendments – recalibrating the HCRCA to ensure that, when health care providers rely on the protections of the HCRCA to deny patients standard of care treatment on religious grounds, their patients will nevertheless learn about their condition, prognosis, and legal treatment options, and will have the information they need to access care.

Plaintiffs ask this Court to enjoin the 2017 Amendments to permit them and others to continue to deny patients standard of care medical information. *Amici* file this brief to assist the Court in understanding the medical, ethical, and legal principles undermined when health care providers withhold essential information from patients who come to them for guidance and care.

ARGUMENT

I. The 2017 Amendments Incorporated Into Illinois Law Critical Patient Protections which Align with the Requirements of Medical Practice.

A. All Health Care Providers Have Ethical and Legal Duties to Provide Patients Information Relevant to their Medical Circumstances and Treatment Options.

The expectation of trust that lies at the center of the relationship between health care providers and patients gives rise to a range of duties, including the requirement, embodied in the doctrine of "informed consent," that providers give their patients all relevant information about their medical circumstances and treatment options. This doctrine promotes "two values: personal well-being and self-determination. To ensure that these values are respected and enhanced, . . .

patients who have the capacity to make decisions about their care must be permitted to do so voluntarily and must have all relevant information regarding their condition and alternative treatments, including possible benefits, risks, costs, [and] other consequences. . . .”[3]

These principles are reflected in standards set by the leading medical professional organizations, including the American Medical Association (“AMA”), American College of Obstetricians and Gynecologists (“ACOG”), American Nurses Association (“ANA”), American Academy of Physician Assistants (“AAPA”), American College of Nurse-Midwives (“ACNM”), and American Academy of Pediatrics (“AAP”). [4] These organizations all affirm that the standard of care requires medical professionals to give patients full, accurate, and relevant medical information to facilitate informed decision making. Such information must include treatment

[3] U.S. President’s Commission for the Study of Ethical Problems in Medical and Biomedical Behavioral Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*, 2 (1982) (“President’s Commission Report”), *available at* https://repository.library.georgetown.edu/bitstream/handle/10822/559354/making_health_care_decisions.pdf?sequence=1&isAllowed=y (last visited Mar. 23, 2017).

[4] *See* American Medical Association, *Code of Medical Ethics* (“AMA Code of Ethics”), 2.1.1 Informed Consent (2016), *available at* https://www.ama-assn.org/about-us/code-medical-ethics (last visited Mar. 23, 2017); American College of Obstetricians and Gynecologists, *Code of Professional Ethics*, 2 (2011), *available at* https://www.acog.org/-/media/Departments/National-Officer-Nominations-Process/ACOGcode.pdf?dmc=1&ts=20161118T1256054925 (last visited Mar. 23, 2017); American Nurses Association, *Code of Ethics for Nurses* (2015), 1.4, 2.1, *available at* http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html (last visited Mar. 23, 2017); American Academy of Physician Assistants, *Guidelines for Ethical Conduct for the Physician Assistant Profession* (“AAPA Guidelines”) (2013), 6-7, *available at* https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf (last visited Mar. 23, 2017); American College of Nurse-Midwives, *Code of Ethics* (2013), (“ACNM Code of Ethics”), *available at* http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000048/Code-of-Ethics.pdf (last visited Mar. 23, 2017); American Academy of Pediatrics, Committee on Bioethics, *Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience*, 124 Pediatrics 1689 (2009) (“AAP Statement”), *available at* http://pediatrics.aappublications.org/content/124/6/1689 (last visited Mar. 23, 2017).

options to which the provider objects on conscience grounds, if those options are relevant to the patient's medical decision making.[5]

Illinois common law incorporates these foundational principles. It recognizes that physicians are "learned, skilled and experienced in subjects of vital importance to the patient but about which the patient knows little or nothing." *Goldberg ex rel. Goldberg v. Ruskin*, 128 Ill. App. 3d 1029, 1040 (1st Dist. 1984), *aff'd on other grounds sub nom. Goldberg v. Ruskin*, 113 Ill. 2d 482 (1986) (internal quotations omitted). Physicians thus take on an affirmative duty to "advise the patient in accordance with proper medical practice," *id*. at 1039-40, with "the same degree of knowledge, skill and ability as an ordinarily careful professional would exercise under similar circumstances." *Jones v. Chi. HMO Ltd. of Ill.*, 191 Ill. 2d 278, 295 (2000). They have a legal duty to give patients the information they need to make informed decisions about which, if any, treatment to accept – including information about the foreseeable risks and benefits of a recommended intervention, as well as any reasonable alternatives. *See Guebard v. Jabaay*, 117 Ill. App. 3d 1, 6 (2d Dist. 1983); *see also In re Estate of Longeway*, 133 Ill. 2d 33, 44 (1989).

The obligation to practice medicine in accordance with professional ethical standards is also reflected in Illinois statutory law. Both the Medical and Nurse Practice Acts expressly obligate providers to comport with the current standards of ethical medical practice. *See* 225 ILCS 60/22, *et seq.*; 225 ILCS 65/70-5, *et seq*. The Medical Patient Rights Act, 410 ILCS 50/0.01, *et seq.*, also codifies the rights of patients to obtain care that is consistent with current

[5] *See* AMA Code of Ethics, 1.1.7 Physician Exercise of Conscience; ACOG, *Committee Opinion 385: The Limits of Conscientious Refusal in Reproductive Medicine* (2016) ("ACOG Committee Opinion 385"), *available at* https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co385.pdf?dmc=1&ts=20141016T2204511145 (last visited Mar. 23, 2017).

standards of medical practice – including the right "[t]o receive information concerning his or her condition and proposed treatment." 410 ILCS 50/3(a).

Before it was amended, the HCRCA excused both individual and institutional providers with religious objections from their obligations to provide patients with information to which they objected. 745 ILCS 70/6 (permitting physicians with religious objections to refuse to "assist, counsel, suggest, recommend, refer, or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience."); *see also* 745 ILCS 70/4, 9. These accommodations applied to a wide range of health care services,[6] shielding one category of health care professionals and facilities – those with religious objections – from liability and professional discipline for harming patients.

The amended HCRCA still provides extensive accommodations, but it now ensures that patients will receive the information they need to make informed medical decisions and to access care. Under the amended law, objecting health care providers may assert a defense under the HCRCA, but *only* when they follow protocols to ensure that patients are informed of their "condition, prognosis, legal treatment options, and risks and benefits of the treatment options in a timely manner, consistent with current standards of medical practice or care." 2017 Amendments at § 6.1(1). If a patient requests a service that no one in the facility will provide, the patient must either be referred or transferred elsewhere, or given written information about other providers who the objecting provider reasonably believes may offer the service – someone else who can counsel the patient and facilitate access to care. *Id*. at § 6.1(2), (3).

[6] "Health care" includes: "any phase of patient care, including but not limited to, testing; diagnosis; prognosis; ancillary research; instructions; family planning; counseling, referrals, or any other advice in connection with the use or procurement of contraceptives and sterilization or abortion procedures; medication; or surgery or other care or treatment rendered by [a broad list of health care professionals in Illinois] intended for the physical, emotional, and mental well-being of persons." 745 ILCS 70/3.

Plaintiffs incorrectly assert that the amended HCRCA imposes a new set of obligations applicable only to religious objectors. *See* Plaintiffs' Memorandum in Support of Plaintiffs' Motion for Preliminary Injunction ("Pls.' Br."), Doc. No. 36 at 1. In fact, under Illinois law, *all* health care providers who fail to comply with their ethical and legal duties to give patients standard of care information risk facing a malpractice action or disciplinary proceeding for the resulting harm. The 2017 Amendments do not create new duties for religious objectors; they simply make clear that even when such providers take advantage of Illinois' broad religious accommodations, they must still ensure that their patients remain the center of the professional relationship and are not denied relevant information about their health. Plaintiffs also incorrectly contend that the 2017 Amendments were not necessary, because the State had the ability to hold doctors accountable when patients were harmed but failed to "employ these options." Pls.' Br. at 21. Plaintiffs ignore that the HCRCA provided religious objectors a nearly limitless defense to liability and discipline before it was amended. Patients were thus left without recourse under Illinois law when their providers withheld standard of care information on religious grounds.

B. The 2017 Amendments Were Necessary to Protect Patients from Harm.

The Illinois General Assembly heard from providers and patients about their experiences with health care limited by religious doctrine.[7] It heard the harrowing story of Mindy Swank – a young woman who attempted to access care after her water broke prematurely. Although Ms. Swank learned that the fetus she was carrying suffered from severe anomalies, and that her preterm membrane rupture could lead to an infection that would threaten her health and fertility

[7] *See, e.g.*, Illinois 99th Gen. Assemb., *Senate Floor Debate* 180-205 (Apr. 22, 2016) ("SB 1564 Sen. Deb. Tr."), *available at* http://www.ilga.gov/senate/transcripts/strans99/09900031.pdf (last accessed Mar. 23, 2017); Illinois 99th Gen. Assemb., *House of Representatives Human Services Comm. Hearing on Senate Bill 1564* (May 13, 2015), Doc. No. 1-2 ("SB 1564 H.R. Comm. Tr.").

if she did not end her pregnancy, she struggled to obtain the information and services necessary to end her doomed pregnancy because of the religious restrictions imposed in some of the facilities where she tried to access care. *Id.*[8] She urged the Illinois legislature to change the law to "ensure that other couples will get the information that they need to make informed healthcare decisions and to access the care that they need." SB 1564 H.R. Comm. Tr. at 4.[9]

The legislature also heard from Dr. Maura Quinlan, a board-certified obstetrician-gynecologist ("Ob/Gyn") and Chair of the Illinois Section of ACOG. *See* SB 1564 H.R. Comm. Tr. at 4-5. Dr. Quinlan highlighted her own experience seeing patients after another provider had withheld information about treatment options because of religious health care restrictions. Based on what she observed, and on "doctors' basic ethical obligations," she testified that the HCRCA needed to be amended to ensure that "[p]atients seeking health care [do] not have to wonder if they're receiving information about all of their treatment options." *Id.*

The physician members of *amici* ACOG and the Illinois Academy of Family Physicians ("IAFP"), as well as individual *amici* and their colleagues, regularly treated patients who suffered harm when their health care providers denied them standard treatment and information. For example, in the spring of 2014, a patient who was 14 weeks pregnant actively bled and contracted for days in a Catholic hospital that limited her care based religious restrictions.[10]

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[8] *See also* American Civil Liberties Union, *Health Care Denied: Patients and Physicians Speak Out About Catholic Hospitals and the Threat to Women's Health and Lives* (2016) at 8-9, *available at* https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf (last visited Mar. 23, 2017).

[9] *See also* SB 1564 Sen. Deb. Tr. at 180 (Statement of Sponsor, Senator Daniel Biss) ("The purpose of this bill is to make sure that information about what different treatment options are . . . is provided on the front end to all patients so as to avoid" experiences like Ms. Swank's).

[10] The hospital adhered to the Ethical and Religious Directives for Catholic Health Care Services, imposed on all Catholic health care facilities by the United States Conference of Catholic Bishops. U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (5th ed. 2009) ("ERDs"), *available at* http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf (last

When the patient was transferred to the University of Chicago Medical Center, Dr. Sabrina Holmquist found the patient's uterus filled with so much blood it was the size of a 20-week uterus. Doctors at the Catholic hospital had told the patient they could keep her baby alive by giving her repeated blood transfusions. They did not tell her that it would be impossible to keep a 14-week fetus alive for the months necessary for it to be able to survive outside the womb. They did not tell her that standard of care treatment options in this situation included quickly ending the pregnancy to stop the serious risk to the woman. By the time the patient was transferred for an emergency abortion, she was unstable and at risk for dying in transit.

A similar situation arose in the spring of 2015 when Doctor AuTumn Davidson was called to the University of Illinois Hospital in the middle of the night to perform an emergency abortion. A patient who was about 19 weeks pregnant was bleeding heavily as a result of a pregnancy complication called sub-chorionic hemorrhage. This patient had sought care at two religiously affiliated hospitals, both of which sent her away without telling her that standard of care treatment options in this situation included ending the pregnancy, as the odds of continuing the pregnancy long enough to deliver a viable baby were very low and the continued bleeding created a serious risk to her health. She was bleeding so heavily that one of the religious hospitals gave her a blood transfusion, yet its providers still withheld that she had the option of obtaining standard of care medical treatment elsewhere. At the second hospital, someone whispered that they were not "supposed to" talk to patients about abortion, but that if she wanted an abortion, she could go elsewhere. By the time she was admitted at the University of Illinois,

visited Mar. 23, 2017). The ERDs prohibit a wide range health care services. *See, e.g., id*. at Directives 24, 41, 45, 52, 53, and 60. Some providers interpret them to require withholding from patients not just care, but also information about the prohibited services. *See, e.g., id*. at Directives 27 and 28 (limiting information to that which is "morally legitimate").

this patient's life and health were in jeopardy because she had not been timely informed about her medical circumstances and options by the first two providers. *See* Health Care Denied at 5.

Prior to the 2017 Amendments, the only patient protection in the HCRCA was the requirement that health care providers treat patients in emergency situations. 745 ILCS 70/6, 9. This exception had been narrowly interpreted to cover only those situations involving "'an element of urgency and the need for immediate action,' such as 'a ruptured appendix or surgical shock.'" *Morr-Fitz, Inc. v. Quinn*, 2012 IL App (4th) 110398, ¶ 76 (quoting *Gaffney v. Bd. of Trs. of Orland Fire Prot. Dist.*, 2012 IL 110012, ¶ 62). However, many patients face medical circumstances that do not fall within these parameters but that nevertheless require immediate disclosure of standard of care treatment options for the very purpose of preventing an emergency from arising. Patients who are not given timely information because of their health care provider's religious objections face the risk of a worsening condition that might be avoided with prompt disclosure and access to care. Had Dr. Davidson's and Dr. Holmquist's patients been fully informed of their circumstances and options when they first sought care for their pregnancy complications, they might have avoided a life threatening emergency.[11]

Patients seeking health care other than abortion were also harmed by the broad religious exemption in the HCRCA before it was amended. A reproductive endocrinologist (specializing in infertility treatment) who is a member of the Illinois Section of ACOG saw multiple patients previously treated by providers who practice religiously based fertility care that opposes the use of *in vitro* fertilization ("IVF"). These patients were subjected to medical procedures which had

[11] In entering a preliminary injunction for plaintiffs in *Pregnancy Care Center of Rockford v. Bruce Rauner, et. al.*, the court misperceived the narrow scope of the HCRCA's emergency exception, and the wide range of circumstances in which patients require timely and complete information about their treatment options to avoid an emergency. No. 2016-MR-741, Memorandum Opinion and Order, 12 (Ill. 17th Judicial Dist. Winnebago Cty. Dec. 20, 2016).

little to no chance of resulting in pregnancy, when IVF would have had a high likelihood of success. In each case, the patients were given treatments that would not be considered standard of care for someone their age and in their circumstances, and were never told about available standard of care treatment options that would have a much greater chance of success. In one case, by the time the patient learned the information she had been denied by the religious practice, she had virtually no chance of conceiving with her own eggs.

Angela Valavanis, a 39 year old mother of three, was denied information about religious restrictions that prevented her from having her tubes tied ("tubal ligation") at the time of a cesarean section ("c-section"), when it is safest to do so. Ms. Valavanis had given her obstetrician gynecologist ("Ob/Gyn") a written birth plan, which stated that she wanted a tubal ligation if she had to have a c-section. No one told her that, because her Ob/Gyn delivered in a Catholic hospital, she would not be able to have the tubal ligation she had requested until she had been in labor for three days and was being wheeled in for a c-section – too late to arrange to deliver elsewhere. *See* Health Care Denied at 23-24.[12]

Given the range of factors to be considered in making decisions about reproductive health, it is critical that patients receive timely and comprehensive counselling so they can make informed decisions about care. For this reason, AGOG's Ethics Committee instructs physicians to "impart accurate and unbiased information," including all "scientifically accurate and professionally accepted characterizations of reproductive health services," tailored to the

[12] The 2017 Amendments were also necessary to protect patients in areas other than reproductive health care. For example, patients treated at the end of life by providers with moral objections to withdrawing life sustaining treatment could be turned away without the information needed to make informed decisions about their options. *See, e.g.*, ERDs, Directive 55 (limiting medical information relating to end-of-life care to "morally legitimate choices").

patient's needs. ACOG Committee Opinion 385 at 3-5.[13] Withholding such information can lead to delay that increases risk,[14] decreases the effectiveness of a particular treatment, or, in the case of time-sensitive treatments such as emergency contraception and abortion, deprives a patient of the treatment altogether.[15]

II. Contrary to Plaintiffs' Contention, Pregnancy Termination is a Medically Relevant and Necessary Treatment Option for Many Patients.

Plaintiffs ask this Court to enjoin the 2017 Amendments in part to permit them and others who hold themselves out as health care providers to refuse to discuss abortion with patients even when it is a standard of care treatment option. They contend that there is no "benefit" to abortion and that it is never a treatment option. Compl. at ¶¶ 88, 150; Pls.' Br. at 3-4. This position is inconsistent with medical science and the critical needs of some patients.

For women facing unintended pregnancy, abortion is a constitutionally protected treatment option. In addition, abortion procedures save lives and preserve health in a wide range of other circumstances, from complications that arise in the course of a pregnancy, to preexisting medical conditions that are exacerbated by pregnancy. As illustrated in the cases above,

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[13] Contrary to Plaintiffs' contention, *see* Complaint, Doc. No. 1 ("Compl.") at ¶¶ 89-90; Pls.' Br at 4, neither the amended HCRCA nor the doctrine of informed consent forces health care providers to talk about abortion – or any other health care services – with patients who do not want or need such information. Rather, the dialogue must be tailored to information relevant to the needs and wishes of a given patient. *See* Presidents Commission Report at 71; 745 ILCS 70/6.1(1) (requiring information consistent with the standard of care).

[14] *See Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 990 (W.D. Wis.), *aff'd sub nom. Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015), *cert. denied*, 136 S. Ct. 2545 (2016) (delays "obviously . . . mean that women are receiving abortions later in gestation, which in turn increases health risk.").

[15] Mark R Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis* 105 (2011). For example, if a rape victim seeks care at an emergency room, she may not know that emergency contraception ("EC") could substantially reduce her risk of becoming pregnant. *Id.* at 104. The longer she waits to use the EC, the less effective it becomes, and in a short time, the patient might miss the "opportunity to decide whether or not to take EC." *Id.*; s*ee also* ACOG Comm. Op. 385 at 1-2

complications include conditions that can cause bleeding, and incomplete miscarriages that can cause deadly infections if the uterus is not evacuated.[16] Medical conditions for which patients should be advised to consider early termination to avoid risk to their health or life include severe cardiac conditions, such as aortic stenosis[17] pulmonary hypertension,[18] and blood disorders, such as leukemia.[19]

A woman carrying a fetus with a severe anomaly may also decide that the risk of carrying the pregnancy to term does not outweigh the benefit.[20] Such decisions arise in a range of medical circumstances in which the fetus might not survive or thrive after delivery. Of course, a woman might decide to continue a pregnancy despite the presence of severe, even fatal fetal anomalies and the risk to her health of doing so. Pregnant women often choose to "assume quite significant

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[16] *See, e.g.*, Anthony Sciscione and Gwendolyn Grant, *Patient counseling following periviable premature rupture of the membranes*, Contemporary OB/GYN (2014), *available at* http://contemporaryobgyn.modernmedicine.com/contemporary-obgyn/news/patient-counseling-following-periviable-premature-rupture-membranes-3?page=full (last visited Mar. 23, 2017) (In the setting of periviable premature rupture of the membranes pregnancy termination "should be discussed as an option given the neonatal prognosis and maternal risks.").

[17] *See, e.g.*, Lorna Swan, *Congenital heart disease in pregnancy,* 28 Best Practice and Research Clinical Obstetrics and Gynaecology, 495, 501 (2014) ("If a woman with significant aortic stenosis . . . become[s] pregnant, then an attempt to stratify the risks associated with continuing with the pregnancy should be made. Women with high-risk features may wish to consider termination of pregnancy.").

[18] *See, e.g.*, Petronella G. Pieper, *et al.*, *Pregnancy and pulmonary hypertension*, 28 Best Practice and Research Clinical Obstetrics and Gynaecology 579, 588 (2014) ("Pulmonary hypertension during pregnancy is associated with considerable risks of maternal mortality and morbidity. . . When women with pulmonary hypertension become pregnant, termination of pregnancy is recommended.").

[19] *See, e.g.*, Irit Avivi and Benjamin Brenner, *Management of acute myeloid leukemia during pregnancy*, 10 Future Oncology 1407 (2014) ("[T]he recommended approach in case[s] of leukemia occurring very early during gestation is pregnancy termination and prompt employment of full conventional therapy.").

[20] ACOG FAQ No. 43: Induced Abortion (2015), *available at* http://www.acog.org/Patients/FAQs/Induced-Abortion (last visited Mar. 23, 2017) ("The risk of dying from giving birth is 14 times greater than the risk of dying from an early abortion.").

risks for her fetus."[21] However, law and medical ethics require that risks be taken on voluntarily. "The informed consent process should, therefore, contain reasonable safeguards against limits to voluntariness, ranging from undue influence to coercion." *Id.*

Plaintiff clinics represent themselves as medical providers, *see, e.g.*, Pls.' Br. at 3, that offer comprehensive counseling to pregnant women about all of their options and specifically about abortion.[22] They encourage women to come to them for these services, but in this litigation, they admit that they do not talk to their patients about abortion as a "legal treatment option." Compl. at ¶¶ 150-151; Pls.' Br. at 3-4. If the Plaintiffs do, in fact, deny accurate, unbiased information about pregnancy termination to those patients for whom it is relevant or necessary, they are not only violating their ethical obligations to patients as health care providers, but they may be putting those patients at increased risk of harm.

In *Nat'l Inst. of Family & Life Advocates v. Harris*, the court discussed "crisis pregnancy centers" like plaintiff clinics, noting that they often "pose as full-service women's health clinics, but aim to discourage and prevent women from seeking abortions" in order to fulfill their goal of "interfer[ing] with women's ability to be fully informed and exercise their reproductive rights." 839 F.3d 823, 829 (9th Cir. 2016), *citing* California Assemb. Comm. on Health, *Analysis of Assemb. Bill No. 775*, 3 (such clinics often employ "intentionally deceptive advertising and counseling practices [that] often confuse, misinform, and even intimidate women from making

[21] ACOG and AAP Committee Opinion, *Maternal-Fetal Intervention and Fetal Care Centers* (2014), *available at* http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Maternal-Fetal-Intervention-and-Fetal-Care-Centers (last visited Mar. 23, 2017).

[22] *See, e.g.* Mosaic Pregnancy and Health Center, *available at* http://revealmosaic.com/ (last visited Mar. 23, 2017) (offering patients "medically accurate abortion information"); Mosaic Pregnancy and Health Center, *Abortion*, http://revealmosaic.com/abortioninformation/ (last visited Mar. 23, 2017) (stating staff are "trained to discuss all options"); Informed Choices, *What You Can Expect*, http://www.informedchoices.org/what-you-can-expect.php (last visited Mar. 23, 2017) (offering to help patients think through "all of [their] pregnancy options.").

fully-informed, time-sensitive decisions about critical health care."); s*ee also* SB 1564 Sen. Deb. Tr. at 188 (Statement of Senator Dale Righter) ("Crisis pregnancy centers exist for the purpose of providing care, but also, quite frankly, avoiding abortion.")

The patient protections contained in the 2017 Amendments were enacted to eliminate the risk posed by individuals and entities that hold themselves out as health care providers while withholding medically relevant information from their patients. It was drafted to ensure that health care providers objecting to offering certain services nevertheless ensure that their patients get the information they need to make a fully informed medical decision and, ultimately, access care. *See* SB 1564 Sen. Deb. Tr. at 181 (Statement of Senator Daniel Biss) (explaining that the 2017 Amendments were needed to "ensure[] that patients will be given timely, medically accurate information about the range of legal treatment options available.").

III. Websites, Phonebooks, and Bars Cannot Replace the Patient Protections of the 2017 Amendments.

Plaintiffs' claim that the required protocols in the amended HCRCA are unnecessary, as patients can access relevant medical information from websites and telephone books in bars. *See* Compl. at ¶ 54. To the contrary, patients seek care from health care providers when resources like the internet are insufficient. *See* Wicclair, *supra*, at 103 ("Despite the Internet and various other resources available to the general public, patients often are dependent on health care professionals for reliable information about a good or service that will meet their health needs and interests."). Plaintiffs' contention is thus dangerously inconsistent with their obligations to patients. *Id*. Patients do not suspect that their health care providers will withhold information about standard treatments, and in the face of provider silence many patients will not know that a treatment option exists or to look on the internet for it. *See* AAP Statement at 1691. The requirement of Section 6.1(1) of the 2017 Amendments – providing that all patients be informed

of their "condition, prognosis, legal treatment options, and risks and benefits of the treatment options in a timely manner, consistent with current standards of medical practice or care," Pub. Act 0990-0690 at § 6.1(1) – simply cannot be replaced by a website or phonebook.

The alternatives proposed by the Plaintiffs are also grossly insufficient to replace the patient protections in Sections 6.1(2) and (3) of the amended HCRCA. These provisions state that, if no one in the objecting facility will provide the service requested by the plaintiff, the patient should either be referred or transferred, or given written information about other providers who the objecting provider reasonably believes may offer the service being denied. *Id.* at § 6.1(2), (3). Patients who seek health care from a provider with a religious objection to providing certain services are unlikely to know their medical options or "how to identify a willing health care professional" from which they may be able to obtain those services. AAP Statement at 1692. For this reason, professional medical organizations recognize that health care providers have a role to play in facilitating patient access to care; indeed, many medical ethical guidelines go further than the amended HCRCA, requiring health care providers with conscience objections to make direct referrals to medical professionals who offer the needed services.[23] The protocols set out in the 2017 Amendments simply ensure that patients who seek care from providers with religious objections will not be left in the dark about their options. Instead, they will get information about another provider who can counsel them and facilitate access to care. These limited protections ensure that all patients are equipped to make informed medical decisions and are not harmed as a result of their health care providers' religious objections. Such critical protections cannot be replaced by a website or a phonebook in a bar.

[23] *See e.g.* ACOG Committee Opinion 385 at 1 (describing provider duty to refer patients in a timely manner to other providers if they have a conscience objection to the care the patient requests); AAPA Guidelines at 4-5 (same); AAP Statement at 1692 (same).

CONCLUSION

Amici curiae respectfully urge this Court to consider the full medical and ethical context for the protections enacted in the 2017 Amendments and, accordingly, deny Plaintiffs' Motion for Preliminary Injunction.

Dated: March 24, 2017

Respectfully Submitted,

/s/ Lorie A. Chaiten
One of the attorneys for *Amici Curiae*

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CERTIFICATE OF SERVICE

I, Lorie Chaiten, an attorney, hereby certify that I caused true and correct copies of the foregoing BRIEF OF *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, ILLINOIS ACADEMY OF FAMILY PHYSICIANS, *ET AL.*, IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION to be served upon all counsel of record via the ECF system of the U.S. District Court, Northern District of Illinois, Western Division, on this 24th day of March, 2017.

/s/ Lorie A. Chaiten

EXHIBIT 1

AMICI CURIAE

The American College of Obstetricians and Gynecologists ("ACOG" or the "College") is a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of the health care of women; to establish and maintain the highest possible standards for education; to publish evidence based practice guidelines; to promote high ethical standards; and to encourage contributions to medical and scientific literature. The College's companion organization, the American Congress of Obstetricians and Gynecologists (the "Congress"), is a professional organization dedicated to the advancement of women's health and the professional interests of its members. Sharing more than 57,000 members, including 2373 obstetrician-gynecologists in Illinois, the College and the Congress are the leading professional associations of physicians who specialize in the health care of women.

The Illinois Academy of Family Physicians ("IAFP") is a professional medical society dedicated to maintaining high standards of family medicine representing more than 4,600 family physicians, residents and medical students in Illinois. IAFP provides continuing medical education programming, advocacy through all levels of government, and opportunities for member engagement and interaction. The IAFP is a constituent chapter of the American Academy of Family Physicians, which represents more than 124,000 members nationwide and promotes and maintains high standards for medical practice among physicians who practice family medicine.

Julie Chor, MD, MPH, is an Assistant Professor of Obstetrics and Gynecology and Assistant Director of the MacLean Center for Clinical Medical Ethics at the University of

Chicago. Dr. Chor is Board Certified in Obstetrics and Gynecology. She serves on the Advisory Committee of the Illinois Section of the American Congress of Obstetricians and Gynecologists. Dr. Chor received her medical degree from the University of Chicago and subsequently completed her residency training in Obstetrics and Gynecology, a Fellowship in Family Planning, and a Master's Degree in Public Health at the University of Illinois at Chicago. After spending two years as the Assistant Director of Family Planning at the John H. Stroger, Jr. Hospital of Cook County, Dr. Chor returned to the University of Chicago where she completed fellowship training in Clinical Medical Ethics at the MacLean Center. Dr. Chor is a clinician-researcher, whose clinical work focuses on Family Planning, Obstetric care, and Adolescent Gynecology.

AuTumn Davidson, MD, MS, is an Obstetrics and Gynecology at Kaiser Permanente in Portland, Oregon. She is Board Certified in Obstetrics and Gynecology. She is an active member of the American Congress of Obstetricians and Gynecologists. Following her residency in Obstetrics and Gynecology at the University of Massachusetts, Dr. Davidson completed a Fellowship in Family Planning at the University of Chicago. She was on faculty at the University of Illinois at Chicago, where she served as the Director of the Kenneth J. Ryan Residency Training Program and the Director of the Center for Reproductive Health from 2014 through March, 2017. She currently provides abortion care at Kaiser. In addition to general Obstetrics and Gynecology, Dr. Davidson's clinical interests include family planning and contraceptive provision for medically complicated women.

Sabrina Holmquist, MD, MPH, is an Associate Professor of Obstetrics and Gynecology in the Section of Family Planning at the University of Chicago. She is Board Certified in Obstetrics and Gynecology and holds a Master's Degree in Public Health and Epidemiology

from the University of Illinois at Chicago. Dr. Holmquist completed her residency in Obstetrics and Gynecology at Albert Einstein College of Medicine/Montefiore Medical Center. She completed a Fellowships in Family Planning at the University of Illinois at Chicago/University of Chicago. Dr. Holmquist cares for women with complicated contraceptive and other reproductive health needs. She serves as the medical student Clerkship Director in OB/GYN for the Pritzker School of Medicine, as well as Fellowship Director for the Fellowship in Family Planning at the University of Chicago. Dr. Holmquist has been teaching gynecologic care to medical students, residents and fellows for more for more than 10 years.

Scott Moses, MD, is Board Certified in Obstetrics and Gynecology. He is a faculty member with a primary appointment at the Feinberg School of Medicine of Northwestern University Department of Obstetrics and Gynecology as a Clinical Assistant Professor. He has a secondary appointment as an Assistant Professor of Bioethics and Medical Humanities. He holds a B.S. from Columbia University and a B.A. from the Jewish Theological Seminary. Dr. Moses attended medical school at the University of Illinois and completed residency training at Northwestern University. He completed a Fellowship in Medical Ethics at the University of Chicago and another Fellowship in Medical Humanities at Northwestern University. He is interested in medical education, reproductive ethics, and the nexus between religion, culture, and medicine.

Maura Quinlan, MD, MPH, is a Board Certified Obstetrician Gynecologist and an Assistant Professor of Obstetrics and Gynecology at Northwestern University. Dr. Quinlan is the Chair of the Illinois Section of the American Congress of Obstetricians and Gynecologists. Dr. Quinlan received her medical degree from Loyola University's Stritch School of Medicine. She completed a Master's Degree in Public Health, with an emphasis on maternal and child health

policy, at Yale University. Dr. Quinlan completed her residency in Obstetrics and Gynecology at the University of Chicago where she served as Chief Resident, and later as an Assistant Professor and as the Director of Undergraduate Medical Education for the Department of Obstetrics and Gynecology.

Elizabeth Salisbury-Afshar, MD, MPH, is a Board Certified member of the American Board of Family Medicine, American Board of Addiction Medicine, and American Board of Preventive Medicine. She serves on the Boards of the Illinois Academy of Family Physicians and Health and Medicine Policy Research Group. Dr. Salisbury-Afshar holds a M.D. from Rush University School of Medicine and a M.P.H. from Johns Hopkins School of Public Health. Dr. Salisbury-Afshar's clinical work has focused on working with underserved populations and she continues to volunteer with Heartland Health Outreach, a health center that serves people experiencing homelessness. Dr. Salisbury-Afshar has participated in research studies looking at lack of access to family planning among women who use drugs and/or are in treatment for drug use.

Debra Stulberg, MD, MA, is a certified member of the American Board of Family Medicine. She is a faculty member with a Primary Appointment in the University of Chicago's Department of Family Medicine and Secondary Appointments in the MacLean Center for Clinical Medical Ethics and the Department of Obstetrics and Gynecology. Dr. Stulberg holds a B.A. and M.D. from Harvard University and an M.A. from the Harris School of Public Policy at the University of Chicago. She completed a Fellowship in Medical Ethics and Primary Care Research at the University of Chicago. Her research focuses on, among other things, decreasing risk to vulnerable women associated with lapses in care for ectopic pregnancy, racial and socioeconomic disparities in reproductive health, and the intersection of religion and health care.

Tabatha Wells, MD, is an Assistant Professor of Family Medicine at the University Of Illinois College of Medicine. Dr. Wells attended the Southern Illinois University School of Medicine and serves of the Board of the Illinois Academy of Family Physicians. She provides the full scope family medicine for patients of all ages and has a particular interest in women's health, including prenatal care and obstetrical care and pediatrics.

Santina Wheat, MD, MPH, is an Assistant Professor at Northwestern University Feinberg School of Medicine and a faculty member of the Northwestern McGaw Family Medicine Residency Program. Dr. Wheat is Board Certified by the American Board of Family Physicians. She is the Medical Director at Erie Family Health Center's Humboldt Park Site in Chicago, Illinois, a federally qualified health clinic that serves low-income and under-resourced populations. Dr. Wheat serves on the Board of the Illinois Academy of Family Physicians. She completed her M.D. and M.P.H. at the University of Illinois at Chicago.