No. 19-417

IN THE

Supreme Court of the United States

EMW WOMEN'S SURGICAL CENTER, P.S.C., ON BEHALF OF ITSELF, ITS STAFF, AND ITS PATIENTS; ERNEST MARSHALL, M.D., ON BEHALF OF HIMSELF AND HIS PATIENTS; ASHLEE BERGIN, M.D., ON BEHALF OF HERSELF AND HER PATIENTS; TANYA FRANKLIN, M.D., ON BEHALF OF HERSELF AND HER PATIENTS,

Petitioners,

v.

ADAM MEIER, IN HIS OFFICIAL CAPACITY AS SECRETARY OF THE KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF FOR AMICI CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, THE NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY, THE AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS, AND THE AMERICAN ACADEMY OF FAMILY PHYSICIANS SUPPORTING PETITIONERS

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INTEREST OF AMICI CURIAE[1]

The American College of Obstetricians and Gynecologists ("ACOG"), the American Medical Association ("AMA"), the North American Society for Pediatric and Adolescent Gynecology ("NASPAG"), the American College of Osteopathic Obstetricians and Gynecologists ("ACOOG"), and the American Academy of Family Physicians ("AAFP") (together, "Amici") submit this brief amici curiae in support of Petitioners.

ACOG is the nation's leading group of physicians providing health care for women. With more than 58,000 members—representing more than 90% of all obstetricians-gynecologists in the United States including in the Commonwealth of Kentucky (hereafter, "Commonwealth" or "Kentucky")—ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care. ACOG is committed to ensuring access to the full spectrum of evidence-based quality reproductive health care, including abortion care, for all women. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care.

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[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than amici curiae, their members, and their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for the parties received notice of amici's intent to file this brief at least ten days before to its due date. The parties have consented to the filing of this brief.

ACOG has previously appeared as amicus curiae in various courts throughout the country. ACOG's briefs and guidelines have been cited by numerous courts, including this Court, seeking authoritative medical data regarding childbirth and abortion.[2]

AMA is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups, seated in the

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[2] *See, e.g.*, *Whole Woman's Health* v. *Hellerstedt*, 136 S. Ct. 2292, 2312, 2315 (2016) (citing ACOG's amicus brief for academic hospital admitting requirements, medical procedure mortality rate data, and treatment procedures after a miscarriage); *Stenberg* v. *Carhart*, 530 U.S. 914, 932-936 (2000) (quoting ACOG's amicus brief extensively and referring to ACOG as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Hodgson* v. *Minnesota*, 497 U.S. 417, 454 n.38 (1990) (citing ACOG's amicus brief in assessing disputed parental notification requirement); *Simopoulos* v. *Virginia*, 462 U.S. 506, 517 (1983) (citing ACOG publication in discussing "accepted medical standards" for the provision of obstetric-gynecologic services, including abortions); *see also Gonzales* v. *Carhart*, 550 U.S. 124, 170-171, 175-178, 180 (2007) (Ginsburg, J., dissenting) (referring to ACOG as "experts" and repeatedly citing ACOG's amicus brief and congressional submissions regarding abortion procedure); *EMW Women's Surgical Ctr., P.S.C.* v. *Beshear*, 920 F.3d 421, 454 (6th Cir. 2019) (Donald, J., dissenting) (citing ACOG's amicus brief and ACOG ethics pronouncements); *Stuart* v. *Camnitz*, 774 F.3d 238, 251-252, 255 (4th Cir. 2014) (citing ACOG's and AMA's amici brief for medical standards of informed consent in striking North Carolina's mandatory ultrasound display law); *Greenville Women's Clinic* v. *Bryant*, 222 F.3d 157, 168 (4th Cir. 2000) (extensively discussing ACOG's guidelines and describing those guidelines as "commonly used and relied upon by obstetricians and gynecologists nationwide to determine the standard and the appropriate level of care for their patients"); *Women's Med. Prof'l Corp.* v. *Voinovich*, 130 F.3d 187, 198 n.7 (6th Cir. 1997) (discussion of suction curettage terminology).

AMA's House of Delegates, substantially all U.S. physicians, residents, and medical students are represented in the AMA's policy-making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health. AMA members practice in all fields of medical specialization and in every state, including Kentucky.

NASPAG provides multidisciplinary leadership in education, research, and gynecologic care to improve the reproductive health of youth. NASPAG pursues scientific and educational goals, including to serve and be recognized as the lead provider in pediatric and adolescent gynecological education, research, and clinical care. NASPAG conducts and encourages multidisciplinary and inter-professional programs of medical education and research in the field and advocates for the reproductive well-being of children and adolescents and the provision of unrestricted, unbiased, and evidence-based medical practice.

ACOOG is a nonprofit, nonpartisan organization committed to excellence in women's health representing over 2,500 providers. ACOOG educates and supports osteopathic physicians to improve the quality of life for women by promoting programs that are innovative, visionary, inclusive, and socially relevant. ACOOG is likewise committed to the physical, emotional, and spiritual health of women.

AAFP is the national medical specialty society representing family physicians. Founded in 1947 as a not-for-profit corporation, its 134,600 members are physicians and medical students from all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands, and the Uniformed Services of the United States. AAFP seeks to improve the health of patients,

families, and communities by advocating for the health of the public and serving the needs of members with professionalism and creativity.

INTRODUCTION AND SUMMARY OF ARGUMENT

Kentucky's Ultrasound Informed Consent Act, referred to as House Bill 2 ("H.B. 2" or "the Act"), distorts the informed consent process and should be invalidated. The Act forces a clinician during the course of a ultrasound prior to an abortion to place the ultrasound image in the pregnant woman's view, to orally describe the image in state-specified detail, and to auscultate with it calls a "fetal heartbeat" if available, which is actually the electrical pulsing of fetal tissues that may develop into a heartbeat—even if the patient asks the clinician not to display the image or describe the fetus or if she requests to turn off the volume of the ultrasound, and, moreover, even if the clinician believes that forcing this experience on the patient would harm her. H.B. 2 contains but one limited exception for medical emergencies. The Sixth Circuit's decision upholding this law is squarely at odds with the Fourth Circuit's decision rightly striking down a virtually identical law.[3] Insightfully, the Fourth Circuit's decision that such laws are harmful to patients and impermissibly interfere with the practice of medicine relied extensively on the input of the medical community for standards of medical ethics and practice.[4]

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[3] *Compare EMW Women's Surgical Ctr., P.S.C.* v. *Beshear*, 920 F.3d 421 (6th Cir. 2019), *with Stuart* v. *Camnitz*, 774 F.3d 238 (4th Cir. 2014).

[4] *Stuart*, 774 F.3d at 251-252.

As medical professionals, including those who specialize in the health care of women, and in light of the Act's intrusion on clinicians' First Amendment rights with respect to how they communicate with their patients, Amici are uniquely positioned to evaluate both the medical necessity of the law and its impact on patients.

First, H.B. 2 is squarely in conflict with informed consent principles, which forbid clinicians from acting over the objections of competent patients. Moreover, the Act does not actually promote informed consent because patients can simply close their eyes to avoid seeing the ultrasound images and cover their ears to avoid listening to the clinician deliver the state-imposed script and the required fetal cardiac tissue auscultation.

Second, in mandating that a clinician transmit a message over a patient's objection, the Act affirmatively undermines informed consent. Patients who are forced to hear unwanted information may feel coerced or otherwise pressured in a way that erodes their ability to give informed consent. It is contrary to sound medical practice to force clinicians to convey information that will harm their patients. Further, apart from a limited exception for medical necessity, the Act contains no waiver clause—an important, medically-recognized exception to the doctrine of informed consent.

Third, H.B. 2 unduly interferes with the patient-clinician relationship, which is built on trust, honesty, and confidentiality. Clinicians—not the Commonwealth—are in the best position to work collaboratively with patients to determine what medical information a patient should receive based on a patient's particular circumstances. Further, forcing clinicians to disregard

their professional judgment by subjecting patients to information that the patient does not wish to receive undermines trust and places the clinician and her patient in an unnecessarily, and potentially harmful, adversarial relationship.

The Court should grant the petition for certiorari and reverse the decision of the Court of Appeals for the Sixth Circuit.[5]

ARGUMENT

I. KENTUCKY'S ULTRASOUND INFORMED CONSENT ACT (H.B. 2) IS INCOMPATIBLE WITH THE DOCTRINE OF INFORMED CONSENT

The mandated speech, display, and auscultation requirements in H.B. 2 are contrary to the concept of informed consent, an ethical doctrine integral to contemporary medical ethics and practice.[6]

In dismissing the judgment of the medical community, the Sixth Circuit grossly mischaracterizes the D.C. Circuit's decision in *Canterbury* v. *Spence*[7] in its conclusion that "[t]he validity of this regulation does not turn on what any private party claims is the norm

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[5] Citations to documents filed in the district court's proceeding, W.D. Ky., No. 17-cv-00016, are referenced herein with record entry and page identification number "RE_, PageID##__."

[6] ACOG Comm. on Ethics, Opinion No. 439 (Aug. 2009, reaffirmed 2015), http://bit.ly/ACOGOp439; Evidentiary Hr'g Tr. 99:1-10, RE 55, PageID #757 (testimony of Dr. Joffe that H.B. 2 is "entirely inconsistent" with informed consent as defined in ACOG Ethics Committee opinion).

[7] 464 F.2d 772 (D.C. Cir. 1972).

for the practice of medicine."[8] *Canterbury* obliges clinicians to disclose certain risks inherent to medical procedures to empower their patients to make informed decisions about their own medical treatment. It does not grant legislatures, or courts, the limitless right to substitute their judgment for that of the medical community.

Informed consent is rooted in the concept of self-determination and the fundamental understanding that patients have the right to make their own decisions regarding their own bodies.[9] There are two elements of informed consent: comprehension and free consent. Comprehension implies that the patient has "been given adequate information about her diagnosis, prognosis, and alternative treatment choices, including the option of no treatment."[10] Free consent, meanwhile, mandates that the patient have "the ability to choose among options" and is "incompatible with being coerced or unwillingly pressured by forces beyond oneself."[11] Further, "[b]oth of these elements together constitute an important part of a patient's 'self-determination' (the taking hold of her own life and action, determining the meaning and the possibility of what she undergoes as well as what she does)."[12] In seeking informed consent, clinicians should "[a]ssess the patient's ability to understand relevant medical information and the implications

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[8] *EMW Women's Surgical Ctr., P.S.C.* v. *Beshear*, 920 F.3d 421, 439 (6th Cir. 2019) (citing *Canterbury*, 464 F.2d at 784, 787).

[9] ACOG Comm. on Ethics, Opinion No. 439.

[10] *Id.*

[11] *Id.*

[12] *Id.*

of treatment alternatives and to make an independent, voluntary decision [while presenting] relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information."[13]

H.B. 2 fails to further either of the two fundamental elements of informed consent. The Act mandates several speech, display, and auscultation requirements, which take place while a patient is disrobed, lying down on her back, and has an ultrasound probe on her abdomen or—as is necessary with early first trimester abortions—inside her vagina. [14]

H.B. 2 requires a provider to perform an ultrasound, "[d]isplay the ultrasound images so that the pregnant woman may view the images," and give "a simultaneous explanation of what the ultrasound is depicting, [including] the presence and location" of the fetus within the uterus and "the dimensions of the embryo or fetus and the presence of external members and internal organs, if present and viewable."[15] The provider must also "a[u]scultate [sic] the fetal heart-

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[13] American Medical Ass'n ("AMA") Code of Medical Ethics, Opinion 2.1.1(a)-(b) Informed Consent (2016), http://bit.ly/AMAOpinons; Evidentiary Hr'g Tr. 90:13-91:6, RE 55, PageID ##748-749 (testimony of Dr. Joffe that forcing patient to view ultrasound and listen to explanation and sounds available is the "definition of insensitivity," the *opposite* of a physician's obligation to treat patients "sensitively," as the AMA Code of Medical Ethics dictates).

[14] Evidentiary Hr'g Tr. 38:9-41:3, RE 55, PageID ##696-699 (testimony of Dr. Joffe describing the ultrasound process and explaining how H.B. 2's requirements take place contemporaneously).

[15] Ky. Rev. Stat. § 311.727(2)(a)-(c), (e).

beat … so that the pregnant woman may hear the heartbeat if the heartbeat is audible."[16] As the district court noted, a clinician must complete the speech, display, and auscultation requirements, even if the patient objects, and even if the clinician earnestly believes it is against the patient's best interest—or face civil penalties or a suspension or loss of his or her medical license.[17]

Under pre-H.B. 2 practice, which is not challenged here, providers performed a ultrasound prior to an abortion and offered patients the opportunity to view the images and hear a description of the results, which, if the patient desired, could include listening to the ultrasound.[18] H.B. 2 eliminates any consideration of patient desire by creating a mandatory regime that erodes, rather than furthers, a patient's autonomous decision-making.

A. The Act Does Not Further Informed Consent Because It Provides No Additional Medically Necessary Information

Informed consent occurs when a patient authorizes a medical procedure in comprehension of its risks, its benefits, and its alternatives.[19] It is axiomatic that for

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[16] *Id.* § 311.727(2)(d).

[17] *EMW Women's Surgical Ctr., P.S.C.* v. *Beshear*, 283 F. Supp. 3d 629, 634 (W.D. Ky. 2017), *rev'd and remanded*, 920 F.3d 421 (6th Cir. 2019).

[18] *See* Evidentiary Hr'g Tr. 35:12-36:12, RE 55, PageID ##693-694 (testimony of Dr. Franklin).

[19] Bester et al., *The Limits of Informed Consent for an Overwhelmed Patient: Clinicians' Role in Protecting Patients and Preventing Overwhelm*, 18 AMA J. Ethics 869 (2016).

a statute to genuinely further informed consent, it must actually provide this information to a patient. H.B. 2 fails to further informed consent because it furnishes no information to further a patient's comprehension beyond what was already available under existing law in Kentucky. Before H.B. 2, patients seeking an abortion already had access to all the information the Act now mandates—the difference is that instead of merely being available, the information is now forced upon them regardless of their wishes.[20]

Kentucky abortion providers *already* performed an ultrasound.[21] They *already* offered patients the opportunity to hear and see the results.[22] In furnishing patients with available information and allowing them to accept it (or not), Kentucky abortion providers already followed general principles of medical ethics and practice. Conversely, H.B. 2 mutates the symbiotic interaction between clinician and patient that is critical to the informed consent dialogue and turns it into a one-way performance: the clinician must convey the mandatory speech, display, and auscultation requirements, even if her patient does not want to receive them and even if the clinician believes them to be contrary to her patient's best interest.

Further, in *no other area of medicine* is it required for a patient to view images of the inside of her own body to understand her medical condition competently

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[20] *See* Evidentiary Hr'g Tr. 35:12-36:12, RE 55, PageID ##693–694 (testimony of Dr. Franklin).

[21] *Id.*

[22] *Id.*

enough to give her informed consent.[23] Accordingly, H.B. 2's requirements have no bearing on the patient's ability to give informed consent to an abortion procedure.

B. The Act's Own Language Demonstrates It Cannot Further Informed Consent Because It Only Requires A Clinician To Convey Its Message—Not That The Patient Receive It

The Act cannot be aimed at providing informed consent because although it sets forth information a patient purportedly needs before she can consent, nothing in the Act actually requires her to receive the information. H.B. 2 provides:

> [N]othing in this section shall be construed to prevent the pregnant woman from averting her eyes from the ultrasound images or requesting the volume of the heartbeat be reduced or turned off if the heartbeat is audible. Neither the physician, the qualified technician, nor the pregnant woman shall be subject to any penalty if the pregnant woman refuses to look at the

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[23] *See* Evidentiary Hr'g Tr. 88:17-21, RE 55, PageID #746 (testimony of Dr. Joffe: "I would add one thing to that, which is that the showing of images—I can't think of any other context in medicine—in any area of medicine, including my own area of cancer medicine, but in any other that I'm familiar with, in which the showing of images is viewed as a necessary part of informed consent."); *see also id.* at 151:23-152:13, PageID ##809-810 (testimony of Dr. Nichols that there are no medical procedures in gynecology and obstetrics where showing and describing a patient's ultrasound is necessary to obtain informed consent; the process of obtaining informed consent for abortion is no different from other medical procedures performed by OB/GYN).

> displayed ultrasound images or to listen to the heartbeat if the heartbeat is audible."[24]

According to the Act's own language, a woman who completely avoids the Act's mandatory speech, display, and auscultation requirements can still give valid consent to an abortion procedure. A law that allows a patient to completely avert her eyes and cover her ears, acquiring no new information whatsoever, cannot inform a patient of anything.[25]

The fact that a woman can close her eyes and cover her ears, yet still consent to an abortion procedure belies the Commonwealth's claim that the Act conveys any medical information at all, let alone that which is necessary to consent to a procedure. It is proof that the Commonwealth's ultimate goal is to force private practitioners to convey the state's particular message, not for patients to receive medically necessary information to consent to an abortion procedure.

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[24] Ky. Rev. Stat. § 311.727(3). The Commonwealth appears to concede that despite the absence of specific language, H.B. 2's language allowing the patient to "avert her eyes" would permit a patient to also cover her ears to avoid hearing the ultrasound explanation and fetal pulsing, if applicable. *See* Resp. C.A. Br. 63.

[25] The Commonwealth's expert, Dr. Seeds, conceded in his affidavit in the district court that the Act freely allows a patient to avert her eyes and ears from its message. "She is fully allowed to look away and avoid this viewing at her discretion. Further, she is fully allowed to request that the sounds of the fetal heart beat be suppressed to avoid hearing them." Seeds Decl. ¶ 5.2, RE 32-1, PageID #341.

II. THE ACT AFFIRMATIVELY UNDERMINES INFORMED CONSENT

A. By Mandating That Patients Receive Information Unnecessary To Understanding Abortion Or Its Effect On The Fetus, The Act Actually Hinders The Patient's Comprehension

The Act belies the ethical principles of sensitivity and autonomy, which are core to the informed consent requirement.[26] By requiring clinicians not only to administer an ultrasound, but to describe it in detail—without any regard to whether the patient is interested in such detail—the Act's mandatory speech, display, and auscultation requirements violate the autonomy of patients and clinicians alike. The fact that this process takes place when the patient is at her most vulnerable state—increasing the likelihood that the patient may feel coerced or pressured—further hampers the Act's compatibility with well-settled medical ethics.[27] Informed consent and coerced consent are mutually incompatible concepts.

Furthermore, informed consent requires that a clinician assess the patient's ability to "make an independent, voluntary decision [while presenting] relevant

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[26] *See* AMA Code of Medical Ethics, Opinion 2.1.1(a), (b) – Informed Consent; Kreutzfeld, *Avert Your Eyes: The Ethical and Constitutional Injustice of Pre-Abortion Mandatory Ultrasound Laws*, 21 J. Gender, Race & Justice 202, 219 (2017) ("Valuing patient autonomy over the doctor's own opinion is now considered standard practice in ethical medicine.").

[27] *See* Evidentiary Hr'g Tr., 90:13-91:6, RE 55, PageID ##748-749 (testimony of Dr. Joffe that forcing patient to view ultrasound and listen to explanation and fetal cardiac activity is the "definition of insensitivity," *i.e.*, the opposite of a physician's obligation to treat patients sensitively" as defined in the AMA Code of Ethics).

information accurately and sensitively, in keeping with the patient's preferences for receiving medical information."[28] Forcing a patient to receive a message that is not medically necessary, even over her protest, turns this guidance on its head, and is the antithesis of proper informed consent. The Act's requirements must be followed in all circumstances, whether the patient wants the information or not, and whether the clinician considers such information necessary to ensure the patient is informed. Thus, the Act requires clinicians, including Amici, to convey its mandatory message even when that message is contrary to their medical opinion. This intrusion on the patient-clinician relationship can cause significant mental and emotional trauma on a woman who wants to undergo an abortion procedure and who neither wants nor needs the information. [29] The Act's one-size-fits-all, mandatory nature is therefore distinguishable from other informed consent statutes that have been upheld by this Court.[30] While the Pennsyl-

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[28] AMA Code of Medical Ethics, Opinion 2.1.1(a), (b) - Informed Consent.

[29] *See, e.g.*, Evidentiary Hr'g Tr. 47:25-48:5, RE 55, Page ID ##705-706; *see also* Kreutzfeld, 21 J. Gender, Race & Justice at 204 ("[W]omen generally do not wish to consent to a pre-abortion ultrasound and can experience a great deal of trauma as a result."); Russo, *Mandated Ultrasound Prior to Abortion*, 16 Am. Med. Ass'n J. Ethics 240, 242 (2014) (recognizing the risk of psychological damage to the patient upon undergoing an unwanted mandatory ultrasound prior to abortion).

[30] *See Planned Parenthood of Se. Pa.* v. *Casey*, 505 U.S. 833, 883-884 (1992) (O'Connor, Kennedy, Souter, JJ. Opinion) (upholding an informed consent statute in part because it did not require a physician to comply with the informed consent provisions if he or she could demonstrate that furnishing the information would have an adverse impact on the patient's mental health).

vania statute upheld in *Casey* did "not prevent the physician from exercising his or her medical judgment," the Act here unquestionably does.[31]

By requiring a uniform approach to an inherently personal and patient-specific medical procedure, the Act impermissibly interferes with the clinician's ability to practice medicine in accordance with each individual patient's particular preferences and needs.[32] Put simply, the Act is a paradigmatic example of legislative medicine that substitutes a specific viewpoint for universal principles of medical practice. As the Court noted just last term, the state "cannot co-opt [medical] facilities to deliver its message for it. The First Amendment does not permit the State to sacrifice speech for efficiency."[33] The state "cannot commandeer the doctor-patient relationship to compel a physician to express its preference to the patient."[34]

As the Fourth Circuit recognized in *Stuart*, where it invalidated a virtually identical mandatory ultrasound speech-and-display law, "[t]ransforming the physician into the mouthpiece of the state undermines the trust that is necessary for facilitating health doctor-

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[31] *Id.* at 884.

[32] *See* Minkoff & Ecker, *When Legislators Play Doctor: The Ethics of Mandatory Preabortion Ultrasound Examinations*, 120 Obstet. & Gynecol. 647, 648 (2012) ("[U]nwanted and coercive information are an affront to autonomy, and instead of enabling decisions can be cofounding and potentially paralyzing in their effect.").

[33] *National Inst. of Family & Life Advocates* v. *Becerra*, 138 S. Ct. 2361, 2376 (2018).

[34] *See Stuart*, 774 F.3d at 253.

patient relationships, and through them, successful treatment outcomes."[35]

> The patient seeks in a physician a medical professional with the capacity for independent medical judgment that professional status implies. The rupture of trust comes with replacing what the doctor's medical judgment would counsel in a communication with what the state wishes told. It subverts the patient's expectations when the physician is compelled to deliver a state message bearing little connection to the search for professional services that led the patient to the doctor's door. [36]

The Court of Appeals noted that clinicians are free to disassociate themselves from the Act's requirements and can tell their patients that such disclosures are required by the Commonwealth.[37] But for purposes of informed consent, the source of the information affects the tendency of its content to influence a patient's decision-making about a medical procedure. If anything, by distancing herself from the information, a clinician is likely to reduce a patient's confidence and trust in the

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[35] *Id.*

[36] *Id.* at 253-254; *see also* Kreutzfeld, 21 J. Gender, Race & Justice at 208 n.52 ("[I]t should be the choice of the doctor and the patient—not the law—whether to have this test. These laws don't have any effect other than interjecting government between the doctor and patient.") (citing Zerwick, *What Do You See When You Look at This Sonogram Image?*, Glamour (Nov. 13, 2014), www.glamour.com/story/how-women-seeking-abortions-feel-about-viewing-a-sonogram).

[37] *See EMW Women's Surgical Ctr.*, 920 F.3d at 439-440.

clinician, further "subvert[ing] the patient's expectations" for her relationship with her clinician.[38]

As the Fourth Circuit did in *Stuart*, Amici have stressed that mandatory ultrasound speech-and-display laws interfere with clinicians' relationships with their patients, and require "physicians to violate the ethical principle of respect for patient autonomy, which entails that patients be able to choose which treatments they receive and that they be able to make treatment decisions without coercion."[39] By intruding on the patient-clinician relationship in a way that substitutes the state's preference against abortion for the clinician's ability to provide information the patient wants or needs to understand the nature and consequences of the procedure at issue, the Act frustrates the very principles of informed consent it was designed to promote.

B. The Act Violates Informed Consent Because It Does Not Allow For Waiver

The Act's mandate also leaves no room for waiver—an important, medically-recognized exception to the doctrine of informed consent—thereby undermining both the comprehension and free consent elements of the doctrine. Waiver is a quintessential element of informed consent because it allows a patient to exercise autonomy by choosing *not* to receive certain information.[40] Patients understand and cope with medical

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[38] *Stuart*, 774 F.3d at 253-254.

[39] Russo, 16 Am. Med. Ass'n J. Ethics at 242.

[40] *See* ACOG Comm. on Ethics, Opinion No. 439, at 7; AMA Code of Medical Ethics, Opinion 2.1.3(b) – Withholding Information from Patients ("Physicians should … honor a patient's request not to receive certain medical information[.]").

information in different ways; proper medical practice therefore necessitates an individualized approach. By prohibiting patients from refusing the receipt of such information, and by prohibiting clinicians from honoring that choice, the Act constricts this autonomy in direct contravention of informed consent.

To be sure, the Act does permit a patient to "avert[] her eyes from the ultrasound images or request[] the volume of the heartbeat be reduced or turned off."[41] But, this provision does not sufficiently restore the patient's autonomy such that she can realistically avoid perceiving the information if she wants to.[42] The Act therefore does not permit a true waiver of the display, speech, and auscultation requirements. Moreover, even assuming the effectiveness of averting one's eyes and/or ears, if "[t]he woman does not receive the information, [] it cannot inform her decision."[43]

The only exception to the Act's mandate that contemplates a patient's unique circumstances is a medical necessity exception. It applies only where medical necessity "compels the performance or inducement of an abortion" or where an "immediate abortion is neces-

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[41] Ky. Rev. Stat. § 311.727(3). This "opt out" is not a waiver because it does not permit her to outright decline the speech, display, and auscultation requirements. Conversely, it is evidence that the ultimate goal of the Act is to force clinicians to convey its message rather than inform a patient of anything. *See supra* Section I.B.

[42] *See* Evidentiary Hr'g Tr. 41:22-42:5, RE 55, PageID ##699-700 ("They can cover their ears, but even still, the sound cannot necessarily be drowned out unless they have their ears covered and they're yelling or … making noises or humming … [T]here's no true way not to hear the heartbeat ….").

[43] *Stuart*, 774 F.3d at 252.

sary."[44] It therefore does not consider the pregnant woman's preferences—*i.e.* her autonomy—in deciding whether to proceed with an abortion. Thus, the clinician must perform an ultrasound, display it, describe it to the patient, and auscultate fetal pulsing, irrespective of whether the patient wishes to opt out of these requirements.

Because the Act does not permit women seeking abortions to waive its requirements on their own accord, it undermines patients' autonomy in contravention of principles of informed consent and sound medical practice.

III. The Act Unduly Interferes With The Practice Of Medicine

A. Ethical Medical Practice Requires Clinicians Exercise Discretion And Tailor The Medical Practice To The Patient's Needs; Stymying That Choice As Is Required By The Act Undermines The Practice Of Medicine

A clinician's chief priority is her patient; she must first and foremost serve as the patient's advocate.[45] Pursuant to this fundamental principle, clinicians tailor medical care to the patient's particular needs. Exercising such medical discretion is informed by years of study and experience.[46] A clinician's ability to maxim-

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[44] Ky. Rev. Stat. § 311.727(5).

[45] *See* AMA Code of Medical Ethics: Principles ("a physician must recognize responsibility to patients first and foremost"); ACOG Code of Professional Ethics, at 2 (Dec. 2018), http://bit.ly/ACOGProfEthics.

[46] *See* AMA Code of Medical Ethics: Principles ("A physician shall continue to study, apply, and advance scientific

ize patient care must be regularly certified by an extensive licensing regime.[47] But the chief consideration of such decisions are the patient's expressed wishes and desires. Therefore, to effectuate this principle, a clinician must respect the patient's right to refuse specific medical intervention or disclosures.[48] Removing a clinician's ability to abide by her patient's wishes, the Act diminishes a clinician's ability to optimally care for her patient.[49]

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knowledge[.]"); ACOG Code of Professional Ethics, at 1 ("[M]aintenance of medical competence through study, application, and enhancement of medical knowledge and skills is an obligation of practicing physicians[.]").

[47] *See* ACOG Code of Professional Ethics, at 4 ("The obstetrician-gynecologist should respect all laws, uphold the dignity and honor of the profession, and accept the profession's self-imposed discipline. The professional competence and conduct of obstetrician-gynecologists are best examined by professional associations, hospital peer-review committees, and state medical and licensing boards. These groups deserve the full participation and cooperation of the obstetrician-gynecologist.").

[48] ACOG Code of Professional Ethics, at 1 ("The welfare of the patient (beneficence) is central to all considerations in the patient-physician relationship. Included in this relationship is the obligation of physicians to respect the rights of patients, colleagues, and other health professionals. The respect for the right of individual patients to make their own choices about their health care (*autonomy*) is fundamental." (emphasis in original)); AMA Code of Medical Ethics, Opinion 1.1.3(d) – Patient Rights; ACOG Code of Professional Ethics, at 1; AMA Code of Medical Ethics, Opinion 2.1.3(b) – Withholding Information from Patients (2016) ("Physicians should … honor a patient's request not to receive certain medical information[.]").

[49] *See, e.g.*, AMA Code of Medical Ethics, Opinion 2.1.3(b) – Withholding Information from Patients (2016) ("Physicians should … honor a patient's request not to receive certain medical information[.]").

Amici are not alone in their views with respect to performing any procedure, offering any disclosure, or withholding any disclosure that contravenes a patient's wishes. This principle is universally applicable; it is not cabined to the field of obstetrics and gynecology. Thus, Amici comprise medical groups that do not solely focus on obstetrics and gynecology and similarly oppose laws like H.B 2, which do not take into account a patient's wishes when requiring clinicians to give, or withhold, specific information.

B. Forcing Clinicians to Convey Information that Patients May Not Wish to Receive Irrevocably Harms the Patient

Forcing clinicians to convey a message against their patients' wishes irrevocably harms the patient-clinician relationship in two distinct but interrelated ways: it unnecessarily introduces emotional discord into the relationship, and it pits patient against clinician as adversaries in what is supposed to be a collaborative and trusting relationship.

The Act's interference with the patient-clinician relationship by compelling clinicians to convey information that a patient has decided she does not want to receive is all but guaranteed to cause needless anxiety and discomfort. Such feelings of unease could be greatly compounded based on the patient's circumstances. Specifically, the patient's choice will have been ripped from her while she is already extraordinarily vulnerable—disrobed on an examination table in a medical facility, per the Act's requirements, and almost certainly

with a probe inserted into her vagina.[50] Traumatic feelings and emotional discomfort could be even further compounded if the patient seeks an abortion after she became pregnant as a result of a rape or if she was carrying a fetus diagnosed with a debilitating medical condition.[51]

Having considered the potential emotional trauma caused by the Act, the district court concluded that "[r]equiring physicians to force upon their patients the information mandated by H.B. 2 has more potential to harm the psychological well-being of the patient than to further the legitimate interests of the Commonwealth."[52] The Act is thus antithetical to a clinician's ethical responsibility to prioritize her patient's wellbeing.[53]

Beyond introducing unjustifiable trauma to a patient's care, the Act harms the patient by creating an adversarial relationship between her and her clinician. The patient-clinician relationship is grounded on confi-

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[50] To make matters worse, this runs noticeably counter to the context in which most medically relevant information is conveyed—fully clothed and in the clinician's office.

[51] *See* Evidentiary Hr'g Tr. 165:10-17, RE 55, PageID #823 (testimony of Dr. Nichols: "there's a subset of patients who are particularly bothered by going through a vaginal ultrasound. Those who certainly are, for example, the victim of rape would be … [particularly bothered].").

[52] *EMW Women's Surgical Ctr.*, 283 F. Supp. 3d at 646 (citing *Stuart*, 774 F.3d at 253 ("H.B. 2 also fails to serve the Commonwealth's interests because it appears to inflict psychological harm on abortion patients.")).

[53] ACOG Code of Professional Ethics, at 1; AMA Code of Medical Ethics, Opinion 1.1.1 – Patient-Physician Relationships (2016).

dentiality, trust, and honesty.[54] With these pillars intact, patients can rely on their clinicians for advice about the most intimate and important medical decisions.[55] But requiring a patient undergo an unnecessary and invasive process of hearing and seeing information that she has unequivocally stated she does not wish to consume erodes those tenets by potentially inflicting mental and emotional trauma in her.[56] Moreover, clinicians cannot alleviate this distress by simply informing patients that they disagree with the Act's requirements; testimony from practitioners shows that the relationship would already have been irrevocably damaged.[57]

By pitting clinician against patient and forcing an already vulnerable woman to defend herself from her supposed advocate, the Act affirmatively harms the patient and is thus antithetical to clinicians' ethical obligations to their patients.

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[54] ACOG Code of Professional Ethics, at 2; AMA Code of Medical Ethics, Opinion 1.1.1 – Patient-Physician Relationships (2016).

[55] *See Canterbury*, 464 F.2d at 782 ("The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arm's length transactions. [A patient's] dependence upon the physician for information affecting [her] wellbeing, in terms of contemplated treatment, is well-nigh abject.").

[56] *See* Evidentiary Hr'g Tr. 47:25-48:5, RE 55, PageID ##705-706; Lazzarini, *South Dakota's Abortion Script — Threatening the Physician–Patient Relationship*, 359 N. Engl. J. Med. 2189, 2191 (2008) ("By assuming that women are incapable of making decisions about abortion as competent adults in consultation with their physicians, these statutes tend to reduce women to their reproductive capacity and suggest that they need the paternalistic protection of legislatures and society.").

[57] *See* Evidentiary Hr'g Tr. 49:2-12, RE 55, PageID #707; *id.* 101:15-102:9, PageID ##759-760 (testimony of Dr. Joffe).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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OCTOBER 2019