No. 14-1150

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

GRETCHEN S. STUART, MD, on behalf of herself and her patients seeking abortions; JAMES R. DINGFELDER, MD, on behalf of himself and his patients seeking abortions; DAVID A. GRIMES, MD, on behalf of himself and his patients seeking abortions; AMY BRYANT, MD, on behalf of herself and her patients seeking abortions; SERINA FLOYD, MD, on behalf of herself and her patients seeking abortions; DECKER & WATSON, INC., d/b/a Piedmont Carolina Medical Clinic; PLANNED PARENTHOOD OF CENTRAL NORTH CAROLINA; A WOMEN'S CHOICE OF RALEIGH, INC.; PLANNED PARENTHOOD HEALTH SYSTEMS, INC.; TAKEY CRIST, on behalf of himself and his patients seeking abortions; TAKEY CRIST, M.D., P.A., d/b/a Crist Clinic for Women,

Plaintiffs-Appellees,

v.

PAUL S. CAMNITZ, MD, in his official capacity as President of North Carolina Medical Board and his employees, agents and successors; ROY COOPER, in his official capacity as Attorney General of North Carolina and his employees, agents and successors; ALDONA ZOFIA WOS, in her official capacity as secretary of the North Carolina Department of Health and Human Services and her employees, agents and successors; JIM WOODALL, in his official capacity as District Attorney for Prosecutorial District 15B and his employees, agents and successors; LEON STANBACK, in his official capacity as District Attorney for Prosecutorial District 14 and his employees, agents and successors; DOUGLAS HENDERSON, in his official capacity as District Attorney for Prosecutorial District 18 and his employees, agents and successors; BILLY WEST, in his official capacity as District Attorney for Prosecutorial District 12 and his employees, agents and successors; C. COLON WILLOUGHBY, JR., in his official capacity as District Attorney for Prosecutorial District 10 and his employees, agents and successors; BENJAMIN R. DAVID, in his official capacity as District Attorney for Prosecutorial District 5 and his employees, agents and successors; ERNIE LEE, in his official capacity as District Attorney for Prosecutorial District 4 and his employees, agents and successors; JIM O'NEILL, in his official capacity as District Attorney for Prosecutorial District 21 and his employees, agents and successors,

Defendants-Appellants.

On Appeal from the United States District Court for the
Middle District of North Carolina at Greensboro
Case No. 1:11-cv-00804-CCE-LPA

BRIEF FOR *AMICI CURIAE* AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS-APPELLEES AND IN SUPPORT OF AFFIRMANCE

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CERTIFICATE OF INTERESTED PERSONS

Amici curiae, the American College of Obstetricians and Gynecologists and the American Medical Association, are non-profit organizations, with no parent corporations or publicly traded stock.

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STATEMENT OF INTEREST OF *AMICI CURIAE*

The American College of Obstetricians and Gynecologists (the "College" or "ACOG") and the American Medical Association ("AMA") submit this brief *amici curiae* in support of Appellees.[1]

ACOG is a non-profit educational and professional organization founded in 1951. The College's objectives are to foster improvements in all aspects of healthcare 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, the College and the Congress are the leading professional associations of physicians who specialize in the healthcare of women.

The membership of the North Carolina Section of the Congress includes 1,058 obstetrician-gynecologists who provide medical care to the women of North

[1] Pursuant to Federal Rule of Appellate Procedure 29, the parties have consented to the filing of this *amicus* brief. Also pursuant to Rule 29, undersigned counsel for *amici curiae* certify that: (1) no counsel for a party authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity—other than *amici curiae*, its members, and its counsel—contributed money intended to fund the preparation or submission of this brief.

Carolina. The College and the Congress recognize that abortion is an essential health care service and oppose laws regulating medical care that are unsupported by scientific evidence and that are not necessary to achieve an important public health objective.

The College has previously been granted leave to appear as *amicus curiae* in various courts throughout the country including the U.S. Supreme Court. In addition, the College's work has been cited frequently by the Supreme Court and other federal courts 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 AMA's House of

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[2] *See, e.g.*, *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); *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").

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 North Carolina.

SUMMARY OF ARGUMENT

The district court correctly held that the "Display of Real-Time View" Requirement (the "Requirement") of North Carolina's Woman's Right to Know Act (the "Act") serves no medical purpose and should be invalidated. The Requirement forces a physician to perform an ultrasound on a pregnant woman at least four hours (and not more than 72 hours) prior to an abortion procedure, to place the image in the woman's view, and to provide a detailed description of the image—even if the woman asks the physician not to display and describe the image, and even if the physician believes that forcing this experience on the patient would harm her. The district court correctly recognized that the Requirement is antithetical to principles of informed consent and unduly interferes with the patient-physician relationship. As physicians, including physicians who specialize in the health care of women, *amici* are uniquely positioned to evaluate both the medical necessity of the law and its impact on patients.

First, the Requirement is squarely in conflict with informed consent principles, which forbid physicians from acting over the objections of competent patients. As Appellants concede, the Requirement 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 physician deliver the state-imposed script. Thus, the Requirement serves no valid medical purpose, yet it undermines patient autonomy and a physician's professional judgment on how best to treat a patient.

Second, the Requirement offends the principles of informed consent because it does not allow exceptions for either therapeutic privilege or waiver, both well-established principles in informed consent doctrine. It is contrary to good medical practice to force physicians to convey information that will harm their patients. But that is precisely what the law requires in certain circumstances. Furthermore, a patient should have the freedom to determine the information she does—and does not—wish to hear, particularly where the information provides no medical benefit.

Finally, the Requirement unduly interferes with the patient-physician relationship, which is built on trust, honesty, and confidentiality. Physicians—not the government—are in the best position to determine what medical information a patient should receive based on her particular circumstances.

For these reasons, the district court's decision should be affirmed.

ARGUMENT

I. THE "DISPLAY OF REAL-TIME VIEW" REQUIREMENT OF NORTH CAROLINA'S RIGHT TO KNOW ACT IS ANTITHETICAL TO THE DOCTRINE OF INFORMED CONSENT

The "Display of Real-Time View" Requirement is contrary to the long-standing principle of informed consent, an ethical concept that is integral to contemporary medical ethics and practice.[3] Informed consent is rooted in the concepts of self-determination and autonomy, and is based on the principle, fundamental in medicine and jurisprudence, that patients have the right to make decisions regarding their own bodies.[4] Informed consent ensures that each patient is provided the information she needs to meaningfully consent to medical procedures.[5] Informed consent includes freedom from external coercion,

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[3] ACOG Comm. on Ethics, *Comm. Op. No. 439* (2009, reaffirmed 2012).

[4] *See* Laurie, *Recognizing the Right Not to Know: Conceptual, Professional, and Legal Implications*, 42 J. L. Med. Ethics 1, 54 (2014) ("[C]onsent and refusal serve as a means to control what happens to our bodies and, by extension, our tissues and data as intimate adjuncts to ourselves and our sense of personal identity."); *see also* Minkoff & Marshall, *Government-Scripted Consent: When Medical Ethics and Law Collide*, Hastings Center Report 39, No. 5 (2009), at 21 (Informed consent "is grounded in the principle of respect for persons, which affirms an individual's consequent right to autonomous decision-making.").

[5] ACOG Comm. on Ethics, *Comm. Op. No. 439*; *see also* AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent* ("Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients.").

manipulation, or infringement of bodily integrity.[6] It is freedom from being acted on by others when they have not taken account of and respected the individual's own preference and choice.[7]

The Act at issue sets forth requirements that a physician *must* satisfy before performing an abortion, even though the information the physician is required to provide is unnecessary for the patient to give informed consent. At least four hours (and not more than 72 hours) before the abortion procedure, the provider must perform an ultrasound, display the ultrasound images "so that the pregnant woman may view them," and give "a simultaneous explanation of what the display is depicting, which shall include the presence, location, and dimensions of the unborn child within the uterus … [and] the dimensions of the embryo or fetus and the presence of external members and internal organs, if present and viewable."[8] Other than in the case of a medical emergency, there are no exceptions to the Requirement.[9]

To avoid a loss of license and/or potential civil penalties, a physician must deliver this information even over the patient's objection and even when the physician believes in his or her medical judgment that it is against the best interests

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6 *See* Minkoff & Marshall, *supra* n.4, at 21 ("Informed consent requires voluntariness – freedom from coercion, undue influence, or bias[.]).

7 ACOG Comm. on Ethics, *Comm. Op. No. 439.*

8 N.C. Gen. Stat. §§ 90-21.85(a)(2), (3) & (4).

9 *See* Section II., *infra*.

of the patient to receive the information. In addition, this information must be delivered when a patient is at her most vulnerable: in the midst of a medical procedure while the patient lies captive on an examination table, with a probe on her abdomen or inserted into her vagina.

Informed consent has two essential elements: (1) comprehension and (2) free consent.[10] Both of these elements together constitute an important part of a patient's "self-determination."[11] "Comprehension" requires that the physician give the patient adequate information about her diagnosis, prognosis, and alternative treatment choices, including the option of no treatment.[12] As set forth *infra* at Section I. A., no procedure in medicine requires that the physician show a patient images from her own body in order for her to comprehend her diagnosis and treatment options. "Free consent" requires that the patient have the ability to choose among options; it is incompatible with being coerced or unwillingly pressured by forces beyond oneself.[13] Indeed, "[t]rue consent to what happens to

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[10] ACOG Comm. on Ethics, *Comm. Op. No. 439.*

[11] *Id.*; AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent*; *see also Whitlock v. Duke Univ.*, 637 F. Supp. 1463, 1467 (M.D.N.C. 1986) (In order for informed consent to be valid, it must be "competent, voluntary, and understanding." (internal citations omitted)).

[12] ACOG Comm. on Ethics, *Comm. Op. No. 439*; *see also* Minkoff & Marshall, *supra* n.4, at 22.

[13] ACOG Comm. on Ethics, *Comm. Op. No. 439*; AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent*.

one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each."[14]

As an ethical doctrine, informed consent is a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care.[15] A core principle of informed consent is that it is the patient that decides how much, or how little, information he or she wants to receive. It has long been recognized that patients can still provide informed consent while declining to receive certain information, so long as their declination is a result of free choice. Thus, patients can "*autonomously* opt to be provided with less than maximal information without violating the spirit of informed consent."[16] If a patient chooses not to consider certain information, that is a decision a physician should respect.[17]

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[14] *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

[15] ACOG Comm. on Ethics, *Comm. Op. No. 439*; AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent.*

[16] Woodcock, *Abortion Counseling and the Informed Consent Dilemma*, 25 Bioethics 495, 499 (2011); *see also* Minkoff & Marshall, *supra* n.4, at 21 ("The selection of data to be shared, the values that frame the facts, and the emotional perspective by which they are proffered all contribute to a context that either animates or degrades a person's autonomy.").

[17] *See Stuart v. Loomis*, --- F. Supp. 2d ----, Civ. No. 11-804, 2014 WL 186310, at *4 (M.D.N.C. Jan. 17, 2014) ("A patient's refusal of information is itself an exercise of choice, and its acceptance can be part of respect for the patient's autonomy and implicit in the ethical concept of informed consent is the goal of maximizing a patient's freedoms.").

A. The Requirement Is Not Necessary For Informed Consent

The Requirement is unnecessary because other statutory provisions, along with generally applicable informed consent law and established medical practices in North Carolina, ensure that women are more than adequately informed and made aware of the availability of information about fetal development. The general North Carolina statute governing informed consent to health care treatment addresses what is required for informed consent.[18] Specifically, section 90-21.13(a)(2) provides that informed consent exists where:

> A reasonable person, from the information provided by the health care provider under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other health care providers engaged in the same field of practice in the same or similar communities.[19]

Thus, under North Carolina law and general principles of medical ethics, physicians are already required to provide—and do provide—patients with the information necessary to understand the procedure and the risks and hazards inherent in it.[20]

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[18] N.C. Gen. Stat. § 90-21.13.

[19] *Id*. § 90-21.13(a)(2).

[20] It is undisputed that, regardless of the Act, physicians in North Carolina (1) offer ultrasound images to all patients, except for those at risk of significant psychological harm; (2) show and describe those images to any patient who wishes to receive such information; and (3) do not force the images or descriptions on a

The Requirement cannot be aimed at providing informed consent because while physicians are required to deliver a particular message, patients are not required to receive that message. The Act provides that "[n]othing in this section shall be construed to prevent a pregnant woman from averting her eyes from the displayed images or from refusing to hear the simultaneous explanation and medical description."[21] Thus, a woman who does not watch or listen to the real-time display and description can still give valid informed consent to an abortion under the Act.

Appellants contend that the Requirement aids the State's interest in voluntary and informed consent. But a law that requires a physician to speak and display images *even when the patient is not looking or listening* cannot possibly inform a patient of anything. On the contrary, the Requirement merely advances the State's view of abortion under the guise of informed consent. Indeed, Appellants admit that the Requirement serves no medical purpose when the patient can simply avoid the information altogether.[22] During his deposition, Appellants' expert stated that a woman can refrain from hearing the information and viewing the images if she so chooses:

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patient who does not wish to receive such information. *See Loomis*, 2014 WL 186310, at *5.

[21] N.C. Gen. Stat. § 90-21.85(b).

[22] *See* Bowes Dep. 132:16-133:1 ("Q: So [the Requirement] doesn't help women, then, understand the nature of the fetus? A: That's right."), 140:5-13.

> A: Well, it says that, you know, she can not look at the screen, she can ask that somebody put earmuffs on her or something like that. I mean she's not required to hear the—he is required to provide it. She's not required to hear it or see it.
>
> …
>
> Q: And in order not to view the ultrasound monitor, if it's placed in front of her, what do you imagine the patient having to do?
>
> A: Close her eyes.[23]

For those patients who choose not to see and hear the ultrasound information, the Requirement does not make consent to the abortion any more "informed."[24] In such circumstances the Requirement becomes an absurd exercise that, as the district court held, is performative rather than informative.[25]

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[23] *Id.* at 87:1-5, 14-17.

[24] Appellants' expert conceded that delivery of the state's message to a woman who has covered her eyes and blocked her ears does not improve the quality of informed consent. *See id.* at 140:5-13 (Q: "If the patient doesn't want to see the ultrasound, turns her head, closes her eyes, how does that improve the quality of informed consent? A: It doesn't. Q: And if a patient doesn't want to hear the description of the images on the ultrasound and therefore has to put her fingers in her ears, how does [that] improve the quality of informed consent? A: It doesn't."); *see also Loomis*, 2014 WL 186310, at *3 ("When a [physician] displays and describes ultrasound images to patients who take steps to avoid seeing the images or hearing the description, the quality of informed consent is not improved and no medical purpose is served.").

[25] *See Loomis*, 2014 WL 186310, at *12 ("To the extent the Act requires providers to speak the state's message to women who cover their ears and eyes to avoid the state's message, it is performative rather than informative, and it does not serve any legitimate purpose.").

No other area of medicine requires a patient to view images of her own body in order to understand her medical condition or help her give informed consent. To the contrary, in all other medical contexts it is a patient's choice whether to receive such information.[26] For example, performing an angiogram before the placement of a stent is a medically appropriate preoperative procedure, but there is no requirement that the patient view the screen before consenting to the operative procedure.[27] Some patients choose to view medical images, and others prefer not to. So too in the abortion context: "There are no circumstances in which a patient's viewing of the fetus is medically necessary."[28] Moreover, apart from being unnecessary, to force a patient to view such images over her objection would unquestionably violate the patient's autonomy and contravene the physician's medical ethics.[29]

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[26] *See* Minkoff & Ecker, *When Legislators Play Doctor: The Ethics of Mandatory Preabortion Ultrasound Examinations*, 120 Obstetrics & Gynecology 647, 649 (2012); *see also* Woodcock, *supra* n.16, at 500 ("Details are routinely omitted in other contexts, unless patients ask for them, because of the diminishing returns that apply to the time spent explaining them and the odds that they will affect patient decisions, e.g., the intricate surgical details of an appendectomy.").

[27] Minkoff & Ecker, *supra* n.26, at 647.

[28] *Id.* at 647.

[29] *Id.* at 648 ("[U]nwanted and coercive information are an affront to autonomy, and instead of enabling decisions can be confounding and potentially paralyzing in their effect.").

B. The Requirement Undermines Informed Consent

Far from furthering informed consent, the Requirement in fact undermines a patient's ability to provide informed consent. The goal of informed consent is to protect the autonomy of the patient and to facilitate her ability to make a meaningful choice. To further that goal, informed consent must be more than a simple recitation of information. It should be a discussion and a dialogue in which the physician can account for the unique needs of an individual patient faced with a given choice.[30] Therefore, it is problematic to dictate a particular script that does not allow the physician to exercise discretion with each patient.

A patient's decision about medical care must be voluntary— not dictated by government—and no aspect of the process should be done without a patient's consent.[31] Forcing upon a patient information she has declined to receive violates her autonomy and creates unwarranted obstacles to her ability to receive care.[32]

In addition, the Requirement misuses the practice of informed consent by preventing a physician from exercising his or her best medical judgment based on conversations with the patient. "[W]ithin the broad requirement for informed

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[30] ACOG Comm. on Ethics, *Comm. Op. No. 439*; AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent*.

[31] ACOG Comm. on Ethics, *Comm. Op. No. 439* (doctrine of informed consent requires that the physician respect the patient's "capacity to set one's own agenda."); AMA Code of Medical Ethics, *Opinion 8.08 - Informed Consent* ("The patient should make his or her own determination about treatment.").

[32] Minkoff & Ecker, *supra* n.26, at 648.

consent, the individual practitioner traditionally has been permitted, and indeed expected, to exercise independent judgment in determining what the potential treatments, risks, benefits, and alternatives are in any particular case, and, thus, what information should be communicated to the patient."[33]

As Appellants' own expert acknowledged, the Requirement is actually in tension with informed consent standards, which generally grant physicians discretion to choose how they obtain consent, and prohibit them from acting over the objections of competent patients.[34] Instead, the Requirement interferes with the exercise of professional judgment and forces physicians to act contrary to their patients' wishes. It therefore "create[s] a conflict between the obstetrician's obligation to the patient and the obligation to the law," and "drive[s] a wedge between the physician and the patient."[35]

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[33] Kapp, *Abortion and Informed Consent Requirements*, 144 Am. J. Obstet. & Gynecol. 1, 3 (1982); *see* Woodcock, *supra* n.16, at 502 ("[B[eyond the basic requirements (and constraints) that are minimally necessary for a medically responsible discharge of informed consent, there is no way for fixed policy standards to substitute for the practical skills that allow healthcare workers to ascertain what further information will enable patients to reach fully autonomous decisions.").

[34] *See* Bowes Dep. 62, 73.

[35] Minkoff & Ecker, *supra* n.26, at 649.

II. THE REQUIREMENT FURTHER OFFENDS THE PURPOSE AND ETHICAL PRINCIPLES OF INFORMED CONSENT BECAUSE IT DOES NOT PERMIT EXCEPTIONS FOR EITHER THERAPEUTIC PRIVILEGE OR WAIVER

The Act allows for neither the therapeutic privilege nor waiver exceptions, which are essential to the doctrine of informed consent. Exceptions to the doctrine exist because informed consent is not a one-size-fits-all concept. The ability to understand and cope with medical information relayed during the informed consent process varies among patients.

The Act nevertheless allows for only one exception to address a patient's unique circumstances: medical emergency. Therefore, regardless of whether the physician believes a patient will be seriously harmed by the ultrasound information (therapeutic privilege), or the patient herself wishes to opt out of the Requirement (waiver), the physician must still perform the ultrasound at least four (and not more than 72) hours prior to the procedure, display the ultrasound, and describe it to the patient, unless the patient fits the narrow statutory definition of a "medical emergency."

A. The Absence Of A Therapeutic Privilege Exception Is Contrary To The Doctrine Of Informed Consent And Good Medical Practice

Therapeutic privilege is the limited privilege of a physician to withhold information from a patient when, in the physician's best medical judgment, the information about the patient's medical condition and options will seriously harm

the patient.[36] A physician does not enjoy a limitless prerogative to withhold information whenever there may be harm to a patient; rather, the privilege should be exercised judiciously, so as not to override patient autonomy and the physician's obligation to seek informed consent.[37]

Indeed, while physicians must provide sufficient information about the treatment or procedure and its risks, they should be able to exercise the therapeutic privilege to withhold discrete pieces of information that in their medical judgment would be particularly harmful to a patient. For example, a physician may decline to show a cancer patient a positron emission tomography ("PET") scan showing the advanced developmental stage of the cancer because, in the physician's best medical judgment, the image would cause the patient unnecessary distress and anxiety.

Similarly, there are patients seeking abortions who would be *seriously* harmed by seeing an ultrasound image and hearing a description of it. For instance, some women make the difficult decision to have an abortion after learning that they are carrying a fetus with severe abnormalities or that are not otherwise viable. For such women, listening to a physician explain the details of the fetus' deformities would be extremely upsetting. Others become pregnant as the result of a rape. To subject those women to a forced narrative script describing

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[36] ACOG Comm. on Ethics, *Comm. Op. No. 439*; AMA Code of Medical Ethics, *Opinion 8.082 - Withholding Information from Patients*.

[37] *Id.*

the ultrasound for no medical reason after having already been physically assaulted and traumatized would be cruel and unnecessary. In these cases, the physician—not the State of North Carolina—is best positioned to determine that the patient would be seriously harmed, based on the totality of her particular circumstances.

Enabling a physician to prevent serious harm to a patient through the therapeutic privilege is necessary, even in light of the Act's emergency exception. The Act defines "medical emergency" as:

> A condition which, in reasonable medical judgment, so complicates the medical condition of the 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 physical impairment of a major bodily function, *not including any psychological or emotional conditions*.[38]

That narrow exception, however, is insufficient to allow the physician to fulfill his or her ethical obligations of "beneficence" and "nonmaleficence"—to ensure a patient's welfare by avoiding harm to the patient—which includes not just avoiding life-threatening physical harm but also preventing psychological or emotional harm.[39] Indeed, the Supreme Court has recognized that a physician should consider multiple factors to determine what is best for his or her patient, not

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[38] N.C. Gen. Stat. § 90-21.81(5) (emphasis added).

[39] ACOG Code of Professional Ethics, Ethical Foundations (July 2011). The principle of "beneficence" requires that in deciding whether a particular medical intervention is medically appropriate, only actions which will result in good for the patient are desirable. The principle of "nonmaleficence" requires that a doctor should never inflict harm on a patient.

solely the patient's *physical* well-being.[40] Thus, it would be contrary to accepted medical practice to subject a patient to a procedure if the physician believed it would seriously harm the patient emotionally or psychologically. Forcing an image and oral description of an ultrasound on a patient who does not wish to see or hear it would be particularly harmful to certain patients' emotional well-being, and physicians must be permitted to prevent harm to patients in those circumstances.[41]

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[42] the Supreme Court recognized the importance of the therapeutic privilege. Unlike the Act at issue here, the abortion statute upheld in *Casey* included an exception to the required informed consent provisions "if [the physician] can demonstrate by a preponderance of the evidence, that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physical or mental health of the patient."[43] Relying on this exception, the Court in *Casey* held

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40 "[M]edical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman." *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

41 *See, e.g.*, Woodcock, *supra* n.16, at 498.

42 505 U.S. 833 (1992).

43 *Id.* at 883-884.

that "the statute does not prevent the physician from exercising his or her medical judgment."[44] Unlike the law upheld in *Casey*, the Requirement does not permit a physician to exercise the therapeutic privilege under any circumstances.[45]

B. The Absence Of A Waiver Exception Is Contrary To The Doctrine Of Informed Consent And Good Medical Practice

In addition to barring physicians from exercising their medical judgment to protect a patient from serious harm, the Act also harms women seeking an abortion by not allowing them to waive the Requirement on their own accord. Through waiver, a patient exercises autonomy over her own self by choosing not to receive certain information that would otherwise be a part of informed consent.[46] A patient should be permitted to recognize her own inability to handle information that she believes will be harmful to her or that she simply does not wish to hear, and her

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[44] *Id.* at 884; *see also Salgo v. Leland Stanford Jr. Univ. Board of Trustees*, 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957) ("[T]he physician must place the welfare of his patient above all else … to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent."); *Butler v. Berkeley*, 213 S.E.2d 571, 581-582 (1975) ("The doctor's primary duty is to do what is best for the patient. Any conflict between this duty and that of a frightening disclosure ordinarily should be resolved in favor of the primary duty.").

[45] *See Loomis*, 2014 WL 186310, at *4, 13.

[46] ACOG Comm. on Ethics, *Comm. Op. No. 439*; AMA Code of Medical Ethics, *Opinion 8.082 - Withholding Information from Patients* ("Moreover, physicians should honor patient requests not to be informed of certain medical information or to convey the information to a designated proxy, provided these requests appear to genuinely represent the patient's own wishes.").

physician should be permitted to honor that choice. Doing so does not prevent the patient from providing informed consent, even if the information would typically be provided to the patient before she consents to the procedure, but rather ensures that her consent to the procedure is completely voluntary.

Although the Act allows a patient to "avert[] her eyes from the displayed images or [] refus[e] to hear the simultaneous explanation and medical description," it does not permit a true waiver.[47] Apart from adding to any emotional trauma she may already be experiencing in the moment, a blindfold and earmuffs will not guarantee that the patient does not hear or see the information that she wishes to avoid.

A patient who waives the Requirement would not be missing any pertinent information, as is typically the case with waiver in other circumstances. Here, allowing waiver of the Requirement is not problematic because, as Appellants concede, the Requirement concerns information *beyond what is necessary* for the patient to give informed consent.[48] The Act does not allow for waiver of the Requirement, and therefore, it offends the doctrine of informed consent and good medical practice.

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47 N.C. Gen. Stat. § 90-21.85(b).

48 *See* Section I.A., *supra*.

III. FORCING PHYSICIANS TO COMPLY WITH THE REQUIREMENT UNDULY INTERFERES WITH THE PATIENT-PHYSICIAN RELATIONSHIP

A. Physicians Have An Ethical Obligation To Exercise Their Medical Discretion And Practice Medicine Based On The Specific Needs Of The Patient

The Act is antithetical to the basic precept that the patient-physician relationship is the central focus of all ethical concerns, and the welfare of the patient must therefore form the basis of all medical judgments.[49] A physician's primary task is to serve as a patient's advocate. As an advocate, physicians must exercise all reasonable means to ensure that the most appropriate care is provided to the patient. Serving the best interests of the patient also means respecting the right of individual patients to make *their own choices* about their health care.[50]

For these reasons, it is essential that the patient-physician relationship be protected from unnecessary government intrusion.[51] Laws that require physicians to give, or withhold, specific information when counseling patients, or that

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[49] ACOG Code of Professional Ethics, at 2; AMA Code of Medical Ethics, *Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship*.

[50] *See* Minkoff & Ecker, *supra* n.26, at 648 ("[I]t is also important to recognize that patients have the right to request a limit to information being proffered in the process, particularly if they feel it is not germane to a decision they have already made.").

[51] *See id.* at 649 ("Prescriptions for counseling and caring can lead a therapeutic relationship to deteriorate into an adversarial one. Given the precedence that should be afforded to their fiduciary obligation to their patients, physicians' participation in legislated care, care coerced under threat of penalty, and transmittal of unwanted and potentially irrelevant information could be considered and abdication of professional obligations.").

mandate which tests, procedures, treatment alternatives, or medicines physicians can perform, prescribe, or administer are detrimental to the patient-physician relationship and are ill-advised.[52]

Consistent with the requirements of a medical license, physicians must use their judgment and provide individualized care based on each patient's needs.[53] Contrary to good medical practice, however, the Requirement leaves no room for a physician to exercise *any* discretion, even in instances when the physician genuinely believes that providing the required information would harm the patient.

First, the Requirement interferes with the patient-physician relationship by compelling physicians to convey information that is all but guaranteed to induce emotional turmoil in a large number of patients. For any woman who has decided to have an abortion and who has concluded that she does not want to view images of the fetus or hear them described, forcing such experiences upon a patient would cause her needless anxiety and anger. These emotions are heightened in women who become pregnant as a result of a rape or who are carrying a fetus that is not

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[52] ACOG Statement of Policy, at 1; AMA Code of Medical Ethics, *Opinion 8.082 - Withholding Information from Patients* ("[P]hysicians should honor patient requests not to be informed of certain medical information[.]").

[53] *See Roe v. Wade*, 410 U.S. 113, 114 (1973) ("The abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.").

viable.[54] In addition, the Act requires that the information be conveyed when the patient is incredibly vulnerable—while disrobed on an examination table—as opposed to fully dressed and in the physician's office where most informed consent discussions occur.[55] That the Requirement will induce such emotional distress in a vast array of women is at odds with a physician's obligation to adhere to the principle of beneficence, or concern for the welfare of the patient.[56]

Second, the Requirement undermines the patient-physician relationship by forcing physicians to provide information that has no medical benefit. Legal abortion is one of the safest medical procedures.[57] Major complications from abortion are extremely rare.[58] In fact, the risk of death associated with childbirth is fourteen times higher than that with abortion.[59] The Requirement is irrelevant to

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[54] *See* Section II.A., *supra*; *see also Loomis*, 2014 WL 186310, at *13 ("even the state's expert emphasizes that 'there can obviously be no rigid prescription' as to what a patient medically and ethically should be told, and that an individual approach to patients is generally required.").

[55] *See* N.C. Gen. Stat § 90-21.85(a). Indeed, for women in the early stages of pregnancy, as is the case for most abortions, this information must be delivered while there is a probe inserted into the patient's vagina.

[56] ACOG Code of Professional Ethics at 1; AMA Code of Medical Ethics, *Opinion 10.015 - The Patient-Physician Relationship*.

[57] Raymond & Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 Obstetrics & Gynecology 215, 215 (2012).

[58] *Id.*

[59] *Id.*

the patient's understanding of the risks, benefits, and alternatives to the procedure.[60]

Furthermore, many patients who have decided to have an abortion have already had at least one ultrasound performed. Most women undergo an ultrasound as part of their initial obstetric appointment; in addition, for high risk patients or those who are carrying a fetus with abnormalities, an ultrasound is invariably performed to better assess fetal viability. Unless those ultrasounds were performed at least four hours, and not more than 72 hours, prior to the abortion, the Requirement forces physicians to perform *another* ultrasound on the patient. Physicians should not compel patients to undergo redundant medical procedures that serve no diagnostic purpose. In *no other medical practice* are physicians required to breach medical ethics by subjecting a patient to a medical procedure that the patient does not want to undergo and which the physician believes is not medically appropriate or necessary. Indeed, in any other area of medical practice, forcing an unnecessary medical procedure upon an unwilling patient would constitute medical malpractice. In light of these considerations, there is simply no medical reason why a patient opting for an abortion should first have to undergo an ultrasound with a narrative description, as the Requirement mandates. Forcing

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[60] ACOG Comm. on Ethics, *Comm. Op. No. 439*.

physicians to comply with the Requirement in such circumstances is squarely at odds with physicians' ethical obligations.

B. Forcing Physicians To Convey Information That Patients Do Not Wish To Receive Undermines Trust And Creates An Adversarial Relationship, Which Is Counter To The Doctrine Of Informed Consent And To Providing The Best Medical Care

The patient-physician relationship is grounded on confidentiality, trust, and honesty.[61] Patients rely on their physicians for advice about the most intimate and important medical decisions. "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] well-being, in terms of contemplated treatment, is well-nigh abject."[62]

However, the Act necessarily introduces an adversarial element to the patient-physician relationship by requiring physicians to force information and images upon unwilling patients.[63] Trust and respect are critical for a healthy patient-physician relationship and yet, forcing information on patients completely undermines these values. Requiring a patient to undergo an unnecessary and

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[61] *See* ACOG Code of Professional Ethics at 2; AMA Code of Medical Ethics, *Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship*.

[62] *See Canterbury*, 464 F.2d at 780.

[63] *See* Minkoff & Ecker, *supra* n.26, at 649 ("Prescriptions for counseling and caring can lead a therapeutic relationship to deteriorate into an adversarial one.").

invasive procedure and hear information that she has unequivocally stated is not relevant to her decision is insulting and demeaning to the patient.[64] Should the patient decide that she is not interested in the information, her only option is to avert her eyes and cover her ears. In so doing, the patient is placed in the awkward position of protecting herself against something the physician is doing or saying to her. This constitutes an unwarranted and unnecessary intrusion into the patient's personal decision-making process and creates a dynamic of distrust between the patient and her physician. Physicians would not be able to alleviate this tension by simply informing patients that they disagree with the Act's requirements. For a patient who has made the difficult decision to terminate her pregnancy and who then must hear details about the fetus against her wishes from her own physician, the damage has already been done.

The Act requires that physicians in North Carolina force information and ultrasound images upon all patients seeking an abortion, irrespective of whether they desire such information or whether such information would be harmful to the patient. By interfering with the patient-physician relationship, the Requirement undermines sound medical care and is at odds with physicians' ethical obligations.

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[64] Lazzarini, *South Dakota's Abortion Script — Threatening the Physician–Patient Relationship*, 359 N. Engl. J. Med. 2189 (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.").

CONCLUSION

For the foregoing reasons, *amici curiae* urges the Court to affirm the district court's decision.

Respectfully submitted,

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July 1, 2014

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because this brief contains 6,534 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point font size and Times New Roman type style.

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CERTIFICATE OF SERVICE

I hereby certify that, on July 1, 2014, I electronically filed the foregoing Brief of *Amici Curiae* American College of Obstetricians and Gynecologists and the American Medical Association in Support of Plaintiffs-Appellees and In Support of Affirmance with the Clerk of Court by using the CM/ECF system, which will send a notice of electronic filing to counsel for the parties and *amici curiae*.

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