

In the
United States Court of Appeals
for the Eighth Circuit

FREDERICK W. HOPKINS, M.D., M.P.H.,

Plaintiff-Appellee,

v.

LARRY JEGLEY, Prosecuting Attorney for Pulaski County, *et al.*,

Defendants-Appellants.

EAGLE FORUM EDUCATION & LEGAL DEFENSE FUND,

Amicus on Behalf of Appellants.

On Appeal from the United States District Court for the
Eastern District of Arkansas, Little Rock, No. 4:17-cv-00404-KGB.
The Honorable **Kristine G. Baker**, Judge Presiding.

**BRIEF OF AMICI CURIAE BIOMEDICAL ETHICISTS
IN SUPPORT OF PLATITIFF-APPELLEE AND AFFIRMANCE**

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I. INTEREST OF *AMICI CURIAE*¹

Amici curiae are a prominent group of physicians and professors across a variety of disciplines, including law, medicine, and public health, from nationally and internationally recognized universities and institutions whose scholarship includes the field of biomedical ethics. Collectively, *amici* hold a multitude of degrees, including JDs, MDs, PhDs, and MPHs, and have vast experience in this field. *Amici* have researched, published, and taught courses on the intersection of biomedical ethics and women's health, human rights, technology, and the law. Several *amici* serve on national biomedical ethics committees and/or lead centers and institutes devoted to the field of biomedical ethics. All *amici* have made important contributions to the scholarship and practice of biomedical ethics.

This case is a constitutional challenge to four Arkansas statutes that, collectively, prevent physicians from upholding their ethical obligations. *Amici* are well suited to opine on whether these statutes are consistent with biomedical ethics. They also have a strong interest in ensuring that the Court's decision accurately describes the principles of biomedical ethics implicated by the statutes at issue and how they should be applied.

¹ This brief is submitted under Federal Rule of Appellate Procedure 29(a), and undersigned counsel for *amici curiae* have requested leave to file this brief. Undersigned counsel for *amici curiae* certify that this brief was not authored in whole or part by counsel for any of the parties; no party or a party's counsel contributed money for the brief; and no one other than *amici* and their counsel have contributed money for this brief.

A full list of *amici* is attached as an appendix to this brief.

II. INTRODUCTION AND SUMMARY OF ARGUMENT

The four acts at issue in this case, the D&E Ban,² the Medical Records Mandate,³ the Local Disclosure Mandate,⁴ and the Tissue Disposal Mandate⁵ (collectively, the “Acts”) all prevent physicians from upholding their ethical commitments to their patients and professions while complying with the Acts. Appellants contend that each of the Acts—passed in 2017—were enacted with the goal of “protecting medical ethics.” Appellants’ Br. at 32. But as shown below, the Acts achieve the opposite result, forcing physicians to violate their ethical obligations in numerous ways.

The D&E Ban⁶ prohibits physicians from performing the safest and most common abortion method starting early in the second-trimester—D&E—unless the procedure “is necessary to prevent a serious health risk” to a patient. Ark. Code Ann. § 20-16-1803(a). A physician who does not comply with the D&E Ban faces civil and criminal penalties. Ark. Code Ann. § 20-16-804; Ark. Code Ann. § 20-16-1805. The State asserts that the D&E Ban does not preclude the lawful

² Arkansas Act 45 (H.B. 1032), Ark. Code Ann. §§ 20-16-1801-1807-1807.

³ Arkansas Act 733 (H.B. 1434), Ark. Code Ann. §§ 20-16-1801-1810.

⁴ Arkansas Act 1018 (H.B. 2024), Ark. Code Ann. § 12-18-108(a)(1).

⁵ Arkansas Act 603 (H.B. 1566), Ark. Code Ann. § 20-17-801-802.

⁶ D&E is a surgical abortion method in which a physician dilates the cervix, only enough to allow safe passage of instruments and tissue. *See Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1052 (E.D. Ark. 2017). Then, the physician evacuates the uterus using forceps to remove the fetus and remaining contents of the uterus. *Id.*

administration of a D&E procedure, so long as the physician first induces fetal demise, either through digoxin injections, potassium chloride injections, or umbilical cord transections. *See* Appellants’ Br. at 7–8. But mandating any of these procedures before D&E is inconsistent with multiple principles of biomedical ethics.

The Medical Records Mandate requires that physicians ask each patient if she knows the sex of the embryo or fetus. Ark. Code Ann. § 20-16-1904(a)(1). In addition, it imposes the onerous burden that, before terminating the pregnancy, the physician “request” and spend reasonable time and effort to obtain the patient’s medical records relating “to her entire pregnancy history.” *Id.* § 20-16-1904(b)(1)(B), (2)(A). As shown below, this mandate contravenes principles of biomedical ethics.

The Local Disclosure Mandate amends an existing Arkansas law that requires physicians to preserve tissue from an abortion provided for a patient under 14-years-old and notify local law enforcement. Ark. Code Ann. § 12-18-108(a) (2016). The amendment expands the preservation and reporting requirements to all patients 16-years-old or younger. As explained below, this too is inconsistent with biomedical ethics.

Lastly, the Tissue Disposal Mandate imposes the onerous requirements of the Arkansas Final Disposition Rights Act on physicians who provide abortions.

See Ark. Code Ann. § 20-17-802(a). Either the patient or the physician would have to “make reasonable efforts” to find, notify, and learn how the woman’s sexual partner—or in the event of a minor patient and minor sexual partner, both the patient’s and partner’s parents—would choose to dispose of fetal remains before performing the abortion.⁷ This requirement contains no exceptions for cases of abusive sexual partners. For the reasons below, this provision cannot be ethically justified.

Amici urge this Court to affirm the district court’s decision to enjoin the Acts because their requirements would compel physicians to take actions that are wholly inconsistent with their medical ethics obligations:

First, the D&E Ban contravenes several key tenets of biomedical ethics. By forcing physicians to administer a digoxin or potassium-chloride injection, or attempt umbilical cord transection before a D&E, the D&E Ban prevents physicians from exercising their individualized clinical judgment with respect to the appropriate treatment for each patient. Appellants’ Br. at 36–37. Furthermore, *none* of these methods is feasible for women in Arkansas, who would incur risks

⁷ The Arkansas Final Disposition Rights Act of 2009 “establishes a hierarchy for determining who controls disposition” of human remains. Appellants’ Br. at 11. As described by the Appellants, the Final Disposition Rights Act “generally vests parents with equal power to control disposition of a child’s remains and provides that one parent is vested with sole control when the other parent is absent and ‘reasonable efforts have been unsuccessful in locating’ that parent.” Appellants’ Br. at 12 (citing Ark. Code Ann. § 20-17-102(d)(1)(E)). If both parents are minors, the right passes to the minors’ parents. *Id.*

ranging from increased likelihood of infection to damage to the patient’s heart or the uterus. *See Hopkins*, 267 F. Supp. 3d 1024, 1060, 1062–63. Equally important, the district court concluded that the risks to women from these procedures have no counterbalancing medical benefit, contrary to the maxim of non-maleficence, or “do no harm,” in the medical profession. *See id.* Moreover, the procedures for inducing fetal demise are “invasive[]” and “technically challenging,” *id.* at 1061, 1062-63, or experimental and insufficiently studied during the period of pregnancy when most second-trimester abortions are performed in Arkansas (before 18.0 weeks of pregnancy), *see id.* at 1059, 1063. As explained below, principles of medical ethics prevent physicians from subjecting their patients to experimental medical procedures without obtaining informed consent. By forcing women to undergo invasive medical procedures for which their physician sees risk with no countervailing medical benefit, or giving up their right to an abortion altogether, the D&E Ban makes it impossible for women to truly consent to undergoing an experimental procedure.

Second, the Medical Records Mandate violates the ethical canon of non-maleficence: the obligation of a physician to “do no harm.” This mandate requires physicians to wait for an undetermined period to obtain a patient’s medical records, potentially subjecting patients to higher risks due to delay without any countervailing medical benefit. The mandate violates the principle of non-

maleficence by preventing physicians from performing timely, and therefore safer, procedures that confer the same medical benefits.

Third, physicians are obligated to ensure that all patients have access to the requisite care, regardless of economic status. The Medical Records Mandate and the Tissue Disposal Mandate impose costly burdens on low-income patients, undercutting a physician's duty to ensure that all patients who need care are able to receive it.

Fourth, the Tissue Disposal Mandate, the Local Disclosure Mandate, and the Medical Records Mandate force physicians to disclose to third parties confidential medical information pertaining to their patients. In doing so, physicians would be forced to breach the trusted patient-physician relationship and violate the ethical principle of physician-patient confidentiality. Physicians would also be forced to subject their patients to increased risk of physical or psychological harm.

III. ARGUMENT

A. The D&E Ban Is Inconsistent with Principles of Biomedical Ethics.

1. The D&E Ban Prevents Physicians from Selecting the Appropriate Course of Medical Treatment for their Patients.

The D&E Ban threatens core tenets of medical ethics. The ban on D&E absent fetal demise vitiates a bedrock principle that physicians must exercise individualized clinical judgment in their patients' best interests. *See, e.g.*, Tom L.

Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 333 (7th ed. 2013) (hereinafter *Principles of Biomedical Ethics*) (“[T]he physician has the responsibility to act in the best interests of present patients.”). The D&E Ban also strips physicians of their ability to satisfy the duty to “provide guidance about what [the physician] consider[s] the *optimal course of action for the patient* based on the physician[‘s] objective professional judgment.” *AMA, Chapter 1: Opinions on Patient Rights*, *AMA Code of Medical Ethics* (hereinafter *AMA Code*) § 1.1.3(b) (June 2001) (emphasis added). Instead, the D&E Ban imposes an unreasonable and unfulfillable requirement that physicians ensure fetal demise before *all* D&Es, regardless of whether it is medically appropriate or the optimal course of action for the patient.

Further, under the three mandates mentioned above, women are deprived of the ability to privately disclose important information to their physicians without the risk of forced additional disclosures to third parties, thus preventing doctors from providing the most accurate diagnosis and tailored treatment plan available to that individual patient.

The bedrock ethical obligations that the D&E Ban threatens arise from the relationship of trust between a physician and a patient: “The relationship between a patient and physician is based on trust, which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or

obligations to others, to use sound medical judgments on patients' behalf, and to advocate for their patients' welfare." *Id.* § 1.1.1. By banning D&E except where physicians can first effect fetal demise, regardless of the appropriateness of the fetal demise procedure, the D&E Ban imperils that trust and deprives physicians of the ability to treat their patients' health as the paramount consideration in treatment. *See* World Medical Association, *Declaration of Geneva* (1948) (establishing "Modern Hippocratic Oath" that requires physicians to attest, "at the time of being admitted as [] member[s] of the medical profession," that the "health of [their] patient[s] will be [their] first consideration").⁸

By requiring physicians to treat all patients alike, irrespective of their particular clinical needs, the D&E Ban contravenes established biomedical ethics standards.

⁸ *See also* WMA, *International Code of Medical Ethics* ("A physician shall always exercise his/her independent professional judgment"); *id.* ("A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her."); American College of Physicians ("ACP"), *The Physician and the Patient, ACP Ethics Manual* (6th ed. 2012) ("The patient-physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians possess, the confidential nature of the relationship, and the imbalance of power between patient and physician."); *id.* at *The Changing Practice Environment* ("The physician's professional role is to make recommendations on the basis of the best available medical evidence and to pursue options that comport with the patient's unique health needs, values, and preferences.").

2. The D&E Ban Violates the Principle of Non-Maleficence by Forcing Physicians to Expose Patients to Unnecessary Risk of Harm.

Equally central to the physician-patient relationship is the principle of non-maleficence: the obligation to “do no harm.” This requires a physician to inflict the least harm possible to reach a beneficial outcome. *See Principles of Biomedical Ethics* 150-54; L. Snyder, American College of Physicians Ethical Manual, 156 (Pt. 2) *Ann. Intern. Med.* 73, 74-75 (6th ed. 2012). While non-maleficence does not preclude physicians from inflicting *any* harm, physicians must strive to *minimize* their patients’ exposure to risk of injury. *See Principles of Biomedical Ethics* at 154 (“Obligations of nonmaleficence include not only obligations not to inflict harms, but also obligations not to impose *risks* of harm.” (emphasis in original)). When two procedures offer a patient identical benefits but differing degrees of risk, physicians should be able to pursue the lower-risk treatment. *See id.* at 151 (explaining that harm inflicted by a physician can only be justified by concomitant benefits).

Not only does the D&E Ban interfere with a physician’s ability to tailor treatment to the individual patient, but the course of treatment it requires actually involves subjecting patients to potentially harmful procedures that have *no* countervailing medical benefits. *See, e.g.,* L. Snyder, American College of Physicians Ethical Manual, 156 (Pt. 2) *Ann. Intern. Med.* 73, 74-75 (6th ed. 2012)

(“The physician’s primary commitment must always be to the patient’s welfare and best interests”); *see also* AMA Code § 1.1.3(b) (“The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to *alleviate suffering*.”) (emphasis added).

Appellants contend that subjecting women to unnecessary procedures that increase their risk of injury is justified by the “State’s interest in protecting medical ethics.” Appellants’ Br. at 32. In fact, the D&E Ban achieves the exact opposite result, undermining fundamental biomedical ethical obligations and the physician-patient relationship, as outlined by the American College of Physicians and the AMA.

First, digoxin injections “confer[] no medical benefit.” *Hopkins*, 267 F. Supp. 3d at 1059 (citing Am. Coll. of Obstetricians & Gynecologists (“ACOG”), *Practice Bulletin Number 135: Second Trimester Abortion*, 121(6) *Obstetrics & Gynecology* 1394, 1396, 1406 (2013) (“No evidence currently supports the use of induced fetal demise to increase the safety of second trimester medical or surgical abortion.”)). *Second*, digoxin injections can be extremely difficult or impossible, in some instances, as the district court noted. *Hopkins*, 267 F. Supp. 3d at 1060-61. For example, digoxin injections can be dangerous for obese women, or women with cardiac conditions. *See id.* Even in patients who can tolerate injections,

digoxin is not effective in 5% to 10% of all cases in which it is used to induce fetal demise. *See id.* *Third*, the injection itself poses significant risks, including infection and accidental absorption into the patient's circulation, which may cause serious medical complications for the patient. *See id.* Forcing physicians to perform digoxin injections subjects their patients to a procedure that confers "no medical benefit," yet poses material medical risks. The treatment is thus deeply troubling to *amici* and contrary to the critical physician maxim of non-maleficence.

Ethical considerations are similarly undermined by potassium-chloride injections to attempt to induce fetal demise. Again, as the district court concurred, this procedure is "an unnecessary and potentially harmful medical procedure with *no counterbalancing medical benefit* for the patient." *Id.* at 1062–63 (emphasis added). Specifically, the presence of obesity, fetal and uterine positioning, or uterine fibroids present significant challenges that may prohibit the safe and effective administration of potassium chloride injections. *Id.* More concerning, though, is that the misplaced injection may be fatal if it enters a woman's bloodstream. *See id.* at 1062. As such, it is not an ethically acceptable option for treatment of many women.

The final method of attempting to induce fetal demise, umbilical cord transection, is likewise ethically problematic in that it exposes patients to serious medical risks with "no medical benefits." *Id.* at 1063. Depending on the

placement of the umbilical cord, the procedure may be difficult and risky. *See id.* Furthermore, umbilical cord transection exposes the patient to “an increased risk of uterine perforation, cervical injury, and bleeding,” while unnecessarily delaying the D&E procedure itself. *Id.*

Given the serious problems raised by each of these extra procedures, none of which “increase[s] the safety of second-trimester [abortion],” *id.* at 1064, physicians would be required to violate ethical standards in order to comply with the law, without any ethically viable alternative. The only alternative to standard D&E is an induction procedure, in which physicians use medication to “induce labor and delivery of a non-viable fetus.” *Id.* at 1057–58. But this procedure requires a woman to go through labor, is painful, psychologically challenging for some women, and “medically contraindicated for some women.” *Id.* By effectively eliminating the D&E option, the D&E Ban leaves patients and physicians with a single option that presents significant risks for patients, in violation of a physician’s fundamental obligation to do no harm.

3. The D&E Ban Compels Physicians to Subject Women to Experimental Procedures for which They Cannot Provide Voluntary Informed Consent.

Where untested and experimental procedures are involved, physicians necessarily risk violating the principle of non-maleficence because the benefits and risks of experimental procedures are largely unknown. As a result, numerous

conditions must be met for the use of experimental procedures to be “[e]thically justified.” *Principles of Biomedical Ethics* at 333. Chief among these is the requirement that patients freely give informed consent to any experimental treatment. *Id.*; see also *Chapter 7: Opinions on Research & Innovation, AMA Code § 7.1.1(b)(iii)* (physicians participating in research have an obligation to “[e]nsure that voluntary consent has been obtained from each participant,” including by “mak[ing] clear that the individual may refuse to participate”); *id.* § 7.1.2 (“[N]o person may be used as a subject in research against his or her will [and] [p]hysicians must ensure that the participant . . . has given *voluntary*, informed consent” (emphasis added)).

Informed consent is vital to a patient’s self-determination, and physicians must counsel, advise, and assist the patient so that the patient is enabled to express a decision that best reflects her life choices. American College of Obstetricians and Gynecologists, *Informed Consent*, ACOG Committee Opinion No. 439, OBSTET GYNECOL (Aug. 2009), at 114:401–08.

Digoxin injections and umbilical transection attempted before 18.0 weeks of pregnancy are experimental. As the district court concluded, those procedures have not been sufficiently studied or tested for use before 18.0 weeks of pregnancy. See *Hopkins*, 267 F. Supp. 3d at 1059 (“There are virtually no reported studies...on using digoxin in the first weeks of the second trimester, when most

second trimester abortions are performed.”). By requiring women to undergo such procedures before a D&E abortion, the most common method of administering abortions starting early in the second trimester, the D&E Ban violates the ethical construct that patients must *voluntarily* consent to undergo experimental treatment. In addition, the AMA Code highlights that physicians have a duty to “make clear” that the patient “may refuse to participate.” *Chapter 7: Opinions on Research & Innovation, AMA Code § 7.1.1(b)(iii)*. Here, women do not have a meaningful choice: they are forced to either undergo an experimental procedure or forfeit their right to an abortion altogether. This Hobbesian choice violates the core aspect of informed consent.

Appellants contend that if either digoxin or umbilical cord transection attempts are not appropriate because they are experimental, medical providers may induce fetal demise through potassium chloride injection. *See* Appellants’ Br. at 39. But as explained above, that option is neither ethically appropriate (*see infra* Section 2), nor practically viable because, as the district court noted, Little Rock Family Planning Services—the only provider of outpatient second-trimester abortion care in Arkansas—possesses neither the advanced, hyper-specialized medical training nor the equipment necessary to perform potassium chloride injections. *Hopkins*, 267 F. Supp. 3d at 1066–67. Thus, the ethical concerns raised by subjecting patients to experimental procedures are not allayed by an unavailable

potassium-chloride option, which raises its own ethical concerns. By mandating that physicians guarantee fetal demise without an ethically appropriate way for doing so, the D&E Ban effectively eliminates physicians' ability to perform D&Es—an ethically troubling result.

B. The Medical Records Mandate Forces Physicians to Delay Treatment, Thereby Exposing Patients to Increased Risk of Harm.

Much like the D&E Ban, the Medical Records Mandate violates the principle of non-maleficence by subjecting patients to unnecessary delay that will expose them to increased risks of harm without conferring any medical benefit.

Principles of Biomedical Ethics at 154.

The Medical Records Mandate requires that, before terminating a pregnancy, the physician ask the patient if she knows the sex of the embryo or fetus. Ark. Code Ann. § 20-16-1904(a)(1). Separately, the physician must “request, and spend reasonable time and effort” to “obtain the patient’s medical records relating to her entire pregnancy history.” *Id.* § 20-16-1904(b)(1)(B), (2)(A). This would create an onerous undertaking of indeterminate length. Even after a physician expends effort to obtain the records, there is “[n]othing in the Medical Records Mandate [that] explains what a doctor is to do with these records.” *Hopkins*, 267 F. Supp. 3d at 1077. The requirements apply “even where abortion is necessary to prevent a serious health risk to the woman[.]” *Id.* at 1074–75. Thus, every single woman

who has seen previous providers of pregnancy care will experience delays in treatment.

These delays will impose greater risks of harm for all such patients, as the district court found. The “risks associated with legal abortion utilizing current methods increase as pregnancy progresses,” especially where the delay pushes the patient from a first to second trimester procedure. *Id.* at 1073; *see also* Brief for American Public Health Association and American College of Obstetricians and Gynecologists as *Amici Curiae* Supporting Appellees, *Planned Parenthood of Arkansas & Eastern Oklahoma v. Jegley, et. al.*, No. 16-2234 (2016) (“Making abortion more difficult to obtain . . . imperils the health of women by . . . delaying abortion until later in pregnancy, and causing some women to carry unwanted pregnancies to term, with all of the attendant serious risk to health.”).

Even the Arkansas legislature has found that it “is undisputed that abortion risks to maternal health increase as gestation increases.” *Id.* at 34. In addition, these forced delays may “cause a woman’s time to obtain abortion care in Arkansas to expire.” *Id.* at 37. By imposing delays that increase risks to patients or potentially preclude patients from receiving procedures at all, the Medical Records Mandate undermines biomedical ethics.

C. The Acts Unjustly Threaten to Impose on Patients Undue Costs and Burdens.

The field of biomedical ethics recognizes the formal principle that “equals must be treated equally.” *See Principles of Biomedical Ethics* 250–51. Physicians have an “ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.” *Code of Medical Ethics Opinion 11.1.4*, American Medical Association. This responsibility extends to a woman’s reproductive health. *See* Ruth Macklin, *Ethics and Reproductive Health: A Principled Approach*, *World Health Statistics Quarterly* 151—52 (1996), available at http://apps.who.int/iris/bitstream/10665/54277/1/whsq_49_1996_p148-153_eng.pdf (“The principle of justice mandates that all individuals who need family planning and health services should have equal access to them.”). A distribution of reproductive health services rooted in this principle “requires that methods be accessible to poor women as well as those who are better off, to the less educated as well as those who are better educated, to rural as well as urban residents.” *Id.* at 152.

Yet both the Medical Records Mandate and the Tissue Disposal Mandate impose costly burdens on many patients who cannot afford them. Little Rock Family Planning Services serves many low-income patients who “struggle in their lives and in their efforts to access the medical care they need.” *Hopkins*, 267 F. Supp. 3d at 1061. The district court found it likely that the Tissue Disposal

Mandate, if its sweeping and vague requirements could ever be fully effectuated, would result in “additional costs associated with abortion care” due to the “increased burden of administrative costs to be incurred by the provider in setting up systems to attempt to comply with the notice provisions [and] document compliance” *Id.* at 1108. The Medical Records Mandate would also “drain providers’ resources,” *id.* at 1075, by forcing them to incur fees for medical records not otherwise necessary—fees that may or may not be passed on to patients who can ill afford additional costs. Such costs may include “per-page copying fees and separate fees for retrieval of records from storage” and the staffing and processing costs involved in “requesting records and attempting to compile all the records for the great majority of patients.” *Id.*

Imposing these additional, medically unnecessary costs saddles patients with yet another burden and undermines physicians’ duty to ensure that all who need care can receive it. From a biomedical ethics perspective, this is yet another instance in which the Acts’ provisions are deeply troubling.

D. The Acts Undermine Physician-Patient Confidentiality by Forcing Physicians to Disclose Medical Information to Third Parties.

Various provisions of the Acts would also force physicians to violate the essential principle of physician-patient confidentiality. This principle “prevents redisclosure of information originally disclosed within a confidential relationship,” providing the patient with the “legitimate expectation that the confidant will not

further disclose the information to anyone without the confider’s authorization.” *Principles of Biomedical Ethics* at 316. Physician-patient confidentiality rules date back “as early as the Hippocratic oath⁹” and are present in both “national and international codes.” *Id.* at 317. This concern for the protection of patient confidentiality is precisely the impetus behind the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). *See* 65 Fed. Reg. 82, 462 (Dec. 28, 2000) (asserting that HIPAA privacy “protections will begin to address growing public concerns that...evolution in the health care industry are resulting, or may result, in a substantial erosion of the privacy surrounding individually identifiable health information.”). Patients must be able to “trust that physicians will protect information shared in confidence” and that once that information is shared physicians will uphold their “ethical obligation to preserve the confidentiality of information” *Code of Medical Ethics Opinion 3.2.1*, American Medical Association. To protect this confidentiality, physicians should “obtain the consent of the patient” before making any disclosures about the patient’s personal health information. *Id.* at 3.2.1(e). Similarly, medical records kept “in association with

⁹ Despite the fact that the Hippocratic oath dates back to 460–370 BC, Appellants contend that the district court’s recognition of a patient’s right to information privacy is “newly discovered.” *See* Appellants’ Br. at 56. Not so. *See, e.g., Hammonds v. Aetna Cas. & Sur. Co.*, 243 F. Supp. 793, 801-02 (N.D. Ohio 1965) (“To promote full disclosure, the medical profession extends the promise of secrecy...The candor which this promise elicits is necessary to the effective pursuit of health”).

the care of a patient” are confidential, and those records should be released “only in keeping with the ethics guidance for confidentiality.” *Id.* at 3.3.2.

The Medical Records Mandate, Tissue Disposal Mandate, and Local Disclosure Mandate all impose requirements on physicians that force them either to violate core principles of confidentiality or refuse their patients the requested medical care. In a Committee Opinion titled “Ethical Decision Making in Obstetrics and Gynecology,” ACOG explained that the “[r]ules of confidentiality are among the most ancient and widespread components of codes of medical ethics.” *Ethical Decision Making in Obstetrics and Gynecology*, ACOG Committee Opinion No. 390, American College of Obstetricians and Gynecologists (reaffirmed 2016) (“ACOG Committee Opinion 390”).¹⁰ These rules are “based on the principle of respect for patient autonomy[,]” including “a patient’s right to privacy, and on the physician’s fidelity-based responsibility to respect a patient’s privacy.” *Id.* ACOG points to the good effects of physician-patient confidentiality as further justification for the rules ensuring it. Importantly, the “[a]ssurance of confidentiality encourages patients to disclose information that may be essential in making an accurate diagnosis and planning appropriate treatment.” *Id.*

¹⁰ Available at <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Ethical-Decision-Making-in-Obstetrics-and-Gynecology> (reaffirmed in 2016)

The Tissue Disposal Mandate, Medical Records Mandate, and Local Disclosure Mandate, if effectuated, all contain provisions that will force physicians to disclose confidential patient information to third parties, including a patient's past pregnancy care providers, sexual partners, parents, and local law enforcement. These forced disclosures are antithetical to the fundamental principle of physician-patient confidentiality and deprive women of their rights to seek an "accurate diagnosis" and "appropriate treatment" because they can no longer safely confide in their physicians without fear that the information will be disclosed to third parties.

The district court's findings highlight the unethical nature of the third-party disclosure requirement. The Tissue Disposal Mandate imposes the onerous requirements of making "reasonable efforts" to find, notify, and learn how the patient's sexual partner—or if the patient and her sexual partner are both minors, both the patient's and partner's parents—would choose to dispose of the embryonic remains before performing the abortion. This requirement contains no exceptions for cases of abusive sexual partners. *See Hopkins*, 267 F. Supp. 3d at 1101 ("The law mandates disclosure to a woman's partner or spouse, even if that person is no longer in her life or is a perpetrator of sexual assault.") Thus, the mandate both requires violation of physician-patient confidentiality and also creates a significant risk of harm to women in Arkansas. Forcing women to notify

their sexual partners regarding the embryonic tissue disposal could subject women to “physical and psychological abuse.” *Id.* at 1099. This same risk of abuse pertains to minor patients where potentially abusive parents—hers or her sexual partner’s—are notified about the abortion.

Furthermore, disclosure to local law enforcement under the Local Disclosure Mandate “is itself a harm,” as the district court found, unless the physician sees “indication of child maltreatment.” *Id.* at 1088. The mandate subjects 14–16-year-olds to a range of potential “negative reactions that can occur in response to the revealed decision to end a pregnancy.” *Id.* In addition to violating the principle of confidentiality, the shame and humiliation the Local Disclosure Mandate forces a patient to endure also contravenes biomedical ethics. Physicians have an ethical duty to demonstrate respect for a patient’s autonomy, which requires acknowledging “an individual’s right to hold views, to make choices, and to take actions based on her own personal values and beliefs.” *See* ACOG Committee Opinion 390. The Local Disclosure Mandate undermines this principle, forcing physicians to label every teen patient as a victim, every teen’s sexual partner as a suspect, and the tissue resulting from the patient’s abortion as evidence of a crime, regardless of whether there are any facts to support such a portrayal. As the district court noted, disclosure to local law enforcement “can engender fear” in these young patients, *Hopkins*, 267 F. Supp. 3d at 1088., and will also create new

concerns for young patients who use the judicial process to obtain permission for an abortion without needing parental consent. *See id.*

The Medical Records Mandate also requires violation of physician-patient confidentiality by forcing physicians to “disclose the fact of the woman’s pregnancy and her abortion decisions to all her previous and current pregnancy related health care providers.” *Id.* at 1075–76. As the district court found, “women fear hostility or harassment from their health care providers for deciding to seek an abortion” and, thus, do not want their medical records shared. *Id.* at 1076. This mandate will thus “cause women to forego abortion in Arkansas rather than risk disclosure to medical providers who they know oppose abortion or who are family friends or neighbors.” *Id.*

As shown above, all three of these provisions jeopardize the integrity of the physician-patient relationship rooted in the promise of confidentiality. Because patients will have no assurance that their conversations with their physicians will remain confidential—and in fact could be disclosed to sexual partners, family members, family friends, and neighbors—patients may, unfairly, be forced to elect to avoid this result by withholding important information from their physicians. In turn, because physicians will lack necessary information about their patient, they will be unable to provide the tailored diagnosis and treatment they are ethically required to administer. As underscored by the district court, disclosure could

jeopardize the health and safety of women in Arkansas, directly in conflict with a physician's duty of non-maleficence. This result is contrary to biomedical ethics as a whole.

IV. CONCLUSION

Each of the Acts requires physicians to violate their ethical duties to their patients, including bedrock obligations to do no harm, provide individualized and appropriate care of each patient, obtain informed consent, provide equal access to care irrespective of financial means, and protect patient privacy. Meanwhile, the Acts subject patients to increased risks and deprives them of meaningful choices of treatment, all while providing no medical benefit to the patients. As such, the Acts are deeply troubling to *amici*, who join Appellees in urging the Court to affirm the district court's decision.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 5,425 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

This brief also complies with the typeface requirements of Fed. R. App. P. 32(a)(5)(A) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in Times New Roman font size 14.

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CIRCUIT RULE 28A(h) CERTIFICATION

The undersigned hereby certifies that I have filed electronically, pursuant to Circuit Rule 28A(h), a version of the brief in non-scanned PDF format. I hereby certify that the file has been scanned for viruses and that it is virus-free.

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was filed electronically with the Court's CM-ECF system on the 27th day of February, 2018. Service will be effectuated by the Court's electronic notification system upon all parties and counsel of record.

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