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

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, et al., Plaintiffs, v. MARIO TRETO JR., Defendant.	)	Case No. 16-cv-50310 Hon. Iain D. Johnston Magistrate Judge Lisa A. Jensen

RONALD L. SCHROEDER, et al., Plaintiffs, v. MARIO TRETO JR., Defendant.	)	Case No. 17-cv-04663 Hon. Iain D. Johnston Magistrate Judge Lisa A. Jensen

BRIEF OF *AMICUS CURIAE*
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
IN SUPPORT OF DEFENDANT MARIO TRETO JR.

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INTEREST OF *AMICUS CURIAE*

The American College of Obstetricians and Gynecologists ("ACOG") is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit membership organization of more than 60,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all women and people in need of obstetric and gynecologic care; 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 patients and their families and communities. ACOG's Illinois section has over 2,400 members who, together with their patients, are directly affected by laws restricting access to abortion care and other reproductive health care. ACOG has appeared as *amicus curiae* in courts throughout the country, including twice previously in these consolidated cases. ACOG's briefs and practice guidelines have been cited by numerous courts as an authoritative voice of science and medicine relating to obstetric and gynecologic health care.

ARGUMENT

Standards of care based on Illinois law and professional ethics require health care providers to give patients all relevant information about their medical circumstances and treatment options—including the risks, benefits, and alternatives associated with such options. Health care professionals who fail to do so may be subject to malpractice suits and professional discipline.

In 1977, Illinois adopted the Health Care Right of Conscience Act ("HCRCA"), to accommodate one category of health care providers—those with religious objections to certain health care services—and exempt them from liability and discipline when they refuse to provide treatment that violates their conscience. Unfortunately, religious health care facilities, physicians

and other medical professionals took HCRCA as a license to withhold standard of care information, at the expense of their patients' health and autonomy. Patients suffered actual harm.

In 2016, the Illinois General Assembly amended HCRCA with a narrow set of protections for patients ("HCRCA Amendments" or "the Amendments"). In legislative hearings, patients and providers testified about the harms to patients caused by providers who invoked HCRCA's broad protections. The proponents of the bill that eventually became the HCRCA Amendments consulted with diverse stakeholders including major religious organizations, who did not oppose the final bill. To the contrary, they felt that it would have little effect because many religious health care institutions already followed the practices the Amendments set forth. The Amendments ensure that when health care providers rely on HCRCA's protections to deny treatment on conscience grounds, their patients will nevertheless learn about their condition, prognosis, and legal treatment options consistent with the standards that apply to all health care professionals.

ACOG files this amicus brief to help the Court understand: 1) the medical and ethical principles and the legal standards violated when health care providers withhold essential information from patients who come to them for guidance and care; 2) the importance of abortion as a medical treatment option for many patients; and 3) the careful balance the HCRCA Amendments strike between patient health and religious liberty across the health care sector.

I. THE HCRCA AMENDMENTS REQUIRE PLAINTIFFS TO ADHERE TO STANDARDS OF CARE THAT APPLY TO ALL HEALTH CARE PROFESSIONALS.

At trial, the Court heard testimony from multiple witnesses regarding the medical services plaintiffs purport to provide by and/or under the supervision of Illinois licensed medical professionals.[1] They take medical histories, screen for sexually transmitted infections, and perform

[1] *See, e.g.*, Trial Tr. vol. 1, 116, 119, 129, 164-66, 202, 236-37, 249, 270-71; Trial Tr. vol. 2, 371-72, 397.

abdominal or transvaginal ultrasounds to diagnose and date pregnancies.[2] Although plaintiffs do not provide abortion care, they purport to offer "options counseling" to pregnant individuals.[3] When plaintiffs are performing these medical services, the HCRCA Amendments "merely impose[] an obligation that the standard of care already requires of other medical professionals in other contexts." *Nat'l Inst. of Fam. and Life Advoc. v. Schneider*, 484 F. Supp. 3d 596, 613 (N.D. Ill. 2020). These standards do not depend on a health care provider's religious belief, but rather turn on the unique circumstances of each patient who has placed their trust in the physician.

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

An expectation of trust lies at the center of the relationship between a health care provider and their patient, giving rise to duties that promote the values of personal well-being and self-determination. This expectation is embodied in the doctrine of "informed consent," which requires providers to give their patients all relevant information about their medical circumstances and treatment options.[4] Personal autonomy and choice are the foundations of informed consent, and the guiding standard is what a patient requires to make an intelligent decision.[5]

Ethical guidelines from leading medical professional organizations reflect these principles, affirming that providers must give patients full, accurate, and relevant medical information to

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[2] *See, e.g.*, Trial Tr. vol. 1, 155; Trial Tr. vol. 2, 351, 361, 387 (medical histories); Trial Tr. vol. 1, 95, 113, 139, 175, 217, 279 (STI screening); Trial Tr. vol 1, 36, 95-97, 113, 125-27, 149, 155, 165, 195, 217, 231; Trial Tr. vol. 2, 320-23, 351, 361, 371-72, 387-89 (ultrasounds).

[3] *See, e.g.*, Trial Tr. vol. 1, 121, 232, 258-59, 272; Trial Tr. vol. 2, 348, 356-57, 360.

[4] *See* President's Comm'n for the Study of Ethical Problems in Med. and Biomed. Behav. Rsch., *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*, at 2 (1982) ("[P]atients who have the capacity to make decisions about their care must be permitted to do so voluntarily and must have all relevant information regarding their condition and alternative treatments, including possible benefits, risks, costs [and] other consequences[.]"), https://repository.library.georgetown.edu/bitstream/handle/10822/559354/making_health_care_decisions.pdf.

[5] *Id*. at 2-4.

facilitate informed decision-making. For example, ACOG's Code of Professional Ethics provides:

> The obstetrician-gynecologist must present to the patient . . . pertinent medical facts and recommendations consistent with good medical practice. Such information should be presented in reasonably understandable terms and include alternative modes of treatment and the objectives, risks, benefits, possible complications, and anticipated results of such treatment.[6]

Similarly, the American Medical Association's ("AMA") Code of Medical Ethics states:

> Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. . . . [P]hysicians should . . . [p]resent relevant information accurately and sensitively, . . . [including] information about: (i) the diagnosis (when known); (ii) the nature and purpose of recommended interventions, and (iii) the burdens, risks, and expected benefits of all options[.][7]

Illinois common law incorporates these foundational principles. It recognizes that physicians are "learned, skilled and experienced in subjects of vital importance to the patient but about which the patient knows little or nothing." *Goldberg ex rel. Goldberg v. Ruskin*, 471 N.E.2d 530, 537 (Ill. App. Ct. 1984). Physicians thus take on an affirmative duty to "advise the patient in accordance with proper medical practice," *id*., using "the same degree of knowledge, skill and ability as an ordinarily careful professional would exercise under similar circumstances." *Jones v. Chi. HMO Ltd. of Ill.*, 730 N.E.2d 1119, 1130 (Ill. 2000). They must give patients the information they need to make informed decisions about which, if any, treatment to accept—including information about the foreseeable risks and benefits of a recommended intervention, as well as any

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[6] ACOG, *Code of Professional Ethics*, at 2 (2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf.

[7] AMA, *Code of Medical Ethics*, *2.1.1 Informed Consent* (2016), https://code-medical-ethics.ama-assn.org/sites/amacoedb/ files/2022-08/2.1.1.pdf. *See also* Am. Nurses Ass'n, *Code of Ethics for Nurses*, §§ 1.4, 2.1 (2015), http://nursingworld.org/DocumentVault/Ethics-1/Code-of-Ethics-for-Nurses.html; Am. Acad. of Physician Assistants, *Guidelines for Ethical Conduct for the Physician Assistant Profession*, at 5, 7 (2013), https:// www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf; Am. Coll. of Nurse-Midwives, *Code of Ethics* (2013), http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000048/Code-of-Ethics.pdf.

reasonable alternatives. *See Guebard v. Jabaay*, 452 N.E.2d 751, 755 (Ill. App. Ct. 1983); *see also In re Estate of Longeway*, 549 N.E.2d 292, 297 (Ill. 1989).

Illinois statutes reinforce the obligation to practice medicine according to ethical standards. Both the Medical and Nurse Practice Acts expressly oblige providers to follow current standards of ethical medical practice. *See* 225 ILCS 60/22(A)(5) (physicians may be disciplined for "dishonorable, unethical, or unprofessional conduct"); 225 ILCS 65/70-5(b)(7) (nurses may be disciplined for "dishonorable, unethical, or unprofessional conduct"). *See also* 225 ILCS 65/60-35(8) (scope of practice for RN includes "[p]racticing ethically according to the American Nurses Association Code of Ethics"). The Medical Patient Rights Act also codifies patients' right to obtain care that is consistent with current standards of medical practice—including the right "[t]o receive information concerning his or her condition and proposed treatment[.]" 410 ILCS 50/3(a).

The HCRCA Amendments thus do not create new duties for health care providers with conscience objections. They reaffirm that even when providers take advantage of Illinois' broad accommodations for religious health care professionals, they must still ensure that their patients remain at the center of the professional relationship. Providers must fully inform patients about conditions and treatments in accordance with the standard of care.

B. Standards of Care do not Depend on a Provider's Individual Religious Beliefs.

Plaintiffs try to escape their professional responsibilities by conflating the standards of care for the services they perform with the informed consent that the provider who is performing an abortion is required to obtain. *See, e.g.*, NIFLA Pls.' Post-Trial Mem. of Law, ECF No. 271, 3-4. The plaintiffs have testified that they provide patients with pregnancy testing and dating, and counseling regarding their treatment options for pregnancy.[8] Those services have their own ethical

[8] *See, e.g.*, Trial Tr. vol. 1, 121, 169, 229-32, 272-73; Trial Tr. vol. 2, 314, 321, 348, 356-57, 360-61, 363.

obligations and standard of care, apart from whatever obligations also may be imposed on the abortion provider. The standards of care for medical counseling are based on the needs and wishes of the patient, not the physician's personal beliefs.[9]

These principles are reflected in ethical guidelines of leading medical organizations, which affirm that counseling must include information about treatment options to which a provider has conscience objections, when those options are relevant to a patient's medical decision-making. ACOG's Committee on Ethics has concluded that the ethical practice of reproductive medicine requires that providers with conscience objections still "must impart accurate and unbiased information so that patients can make informed decisions about their health care" and "must disclose scientifically accurate and professionally accepted characterizations of reproductive health services."[10] Nondirective counseling that imparts accurate information about all options that are relevant to a patient's expressed needs accords with a provider's ethical duties to maintain a trusting patient-physician relationship as well as to obtain informed consent.[11] Similarly, the AMA Code of Medical Ethics states physicians refusing to provide care based on conscience objections "should . . . [u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects."[12]

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[9] *See* President's Comm'n, *supra* n.4, at 69-72.

[10] ACOG, Comm. on Ethics, *Committee Opinion Number 385: The Limits of Conscientious Refusal in Reproductive Medicine*, at 5 (Nov. 2019), https://www.acog.org/clinical/clinical-guidance/committee-opinion/ articles/2007/11/the-limits-of-conscientious-refusal-in-reproductive-medicine.

[11] ACOG, *Code of Professional Ethics*, *supra* n.6, at 2.

[12] AMA, *Code of Medical Ethics*, *1.1.7 Physician Exercise of Conscience*, at 1 (2016), https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.7.pdf. *See also* AMA, *Code of Medical Ethics, 1.1.1 Patient-Physician Relationships* (2016) ("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[.]"), https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.1.pdf.

Given the range of factors to be considered in making decisions about reproductive health, patients need timely and comprehensive counseling tailored to their personal circumstances to make informed decisions about their care. Withholding information can lead to delays that increase risks, decrease the effectiveness of treatment, or even, in the case of time-sensitive treatments such as emergency contraception or abortion, deprive a patient of the treatment altogether. *See, e.g.*, *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 990 (W.D. Wis. 2015) (delayed access to abortion means that some patients are receiving abortions later in gestation, which increases health risks, and some could be prevented from having an abortion at all).[13]

C. Standard of Care Counseling for Patients Includes Providing Referrals.

Throughout the medical field, standard of care patient counseling encompasses providing necessary referrals. For example, a patient diagnosed with a genetic susceptibility to cancer "should be offered counseling and follow-up, with referral as appropriate, to ensure delivery of care consistent with current standards."[14] Proper counseling for a patient diagnosed with diabetes includes referral to a registered dietitian nutritionist.[15] Indeed, delay or failure to refer a patient for appropriate treatment is a common ground for malpractice claims.[16]

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[13] *See also* Laura Ungar, *It's taking longer to schedule abortions in the US. Doctors fear riskier, more complex procedures*, Associated Press (Dec. 9, 2023) (discussing increased wait times in Illinois and other states where abortion remains available), https://apnews.com/article/abortion-care-wait-times-us-roe-dobbs-7b0a328bb34b0acb3d37e359a63712fc; Mark R. Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis* 105 (2011) ("[W]hen time is of the essence, as in the case of [emergency contraception], by the time the patient finds out about the option, it may be too late or the probability of its effectiveness may have been significantly reduced.").

[14] ACOG, Comm. on Ethics and Comm. on Genetics, *Committee Opinion Number 410: Ethical Issues in Genetic Testing*, at 1 (June 2008, *reaff'd* 2020), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2008/06/ethical-issues-in-genetic-testing.

[15] Eileen Stellefson Myers, *Nutrition Counseling for Patients with Prediabetes or Diabetes*, Pharmacy Times (Oct. 27, 2016), https://www.pharmacytimes.com/view/nutrition-counseling-for-patients-with-prediabetes-or-diabetes.

[16] *See* Xiao Xu et al., *The Effect of Medical Malpractice Liability on Rate of Referrals Received by Specialist Physicians*, 8:4 Health Econ. Pol'y Law 453, 454 (2013) ("[F]ailure or delay in referral are among the reasons most cited for medical negligence claims in the United States[.]"), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3706535/.

In the reproductive health context in particular, referral is an integral part of patient counseling, as reflected in clinical guidance from leading medical organizations.[17] An ethical duty to make appropriate and timely referrals follows from health care professionals' broader ethical duties to ensure patient welfare, respect patient autonomy, provide the patient with information sufficient for informed consent, and do no harm. Thus, for example, ACOG's Code of Professional Ethics states that an OB/GYN should "exercise all reasonable means to ensure that the more appropriate care is provided to the patient" and should "consult, refer, or cooperate with other physicians, health care professionals, and institutions to the extent necessary to serve the best interests of their patients."[18] The AMA has also affirmed that "referring patients to other professional to provide care" can be a part of the physician's "fiduciary obligation to promote patients' best interests and welfare."[19]

This ethical duty to refer applies even when a health care professional has a conscience objection to a treatment option. ACOG's Committee on Ethics concludes that "[p]hysicians and

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[17] *See, e.g.*, ACOG, Comm. on Adolescent Health Care, *Committee Opinion Number 710: Counseling Adolescents About Contraception*, at 4 (Aug. 2017, *reaff'd* 2021) ("Obstetrician-gynecologists have the duty to refer patients in a timely manner to other health care providers if they do not feel that they can provide the standard reproductive services that their patients request."), https://www.acog.org/en/clinical/clinical-guidance/committee-opinion/articles/2017/08/counseling-adolescents-about-contraception; ACOG, *Position Statement: Counseling Patients with Zika Infection* (2016) ("All pregnant women infected or presumptively infected with Zika virus should be offered comprehensive counseling, including a thorough discussion of pregnancy continuation, termination of pregnancy, and adoption. . . . [O]bstetric care providers who do not provide abortion care should be prepared to refer patients."), https://www.acog.org/clinical-information/policy-and-position-statements/position-statements/2016/counseling-patients-with-zika-infection; Am. Acad. of Pediatrics, Comm. on Adolescence, *Policy Statement: Options Counseling for the Pregnant Adolescent Patient*, 150:3 Pediatrics 1 (2022) ("Counseling includes . . . referring the adolescent to appropriate resources and services."), https://doi.org/10.1542/peds.2022-058781; ACOG, Comm. on Ethics, *Committee Opinion Number 528: Adoption*, at 1, 3 (June 2012, *reaff'd* 2018) ("Physicians have a responsibility to provide information about adoption to appropriate patients" and "often may best fulfill their obligations to patients through referral to other professionals who have the appropriate skills and expertise to address the complex issues raised by adoption.") https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/06/adoption.

[18] ACOG, *Code of Professional Ethics*, *supra* n.6, at 2-3 (2018).

[19] AMA, *Code of Medical Ethics, 1.2.3 Consultation, Referral, and Second Opinions* (2016), https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.2.3.pdf.

other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request."[20] The American Academy of Pediatrics' Committee on Bioethics has stated that "[p]hysicians who consider certain treatments immoral have a duty to refer patients who desire these treatments in a timely manner when failing to do so would harm the patients."[21]

Notably, the HCRCA Amendments do not even require health care providers to meet the minimum obligations of these ethical guidelines. They state only that HCRCA's safe harbor protects only those conscience objectors with protocols *either* to refer, transfer, *or* provide written information about other health care providers they reasonably believe may offer a service to a patient who seeks it. They certainly require no more of health care professionals than to act according to the standard of care.[22]

II. PREGNANCY TERMINATION IS A MEDICALLY RELEVANT AND NECESSARY TREATMENT OPTION FOR MANY PATIENTS.

Pregnancy can lead to a host of medical, psychological, and social complications that make termination medically necessary for many patients. Abortion can improve quality and length of life, protect the future ability to have healthy children, and for some pregnant people be lifesaving. While plaintiffs repeatedly testified that they could think of no benefit to abortion, and that it is never an appropriate treatment option,[23] science contradicts these claims. Women are at least 14

[20] ACOG, *Committee Opinion Number 385*, *supra* n.10, at 1, 5.
[21] Am. Acad. of Pediatrics, Comm. on Bioethics, *Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience*, 124:6 Pediatrics 1689, 1692 (2009), https://publications.aap.org/pediatrics/article/124/6/1689/72225/Physician-Refusal-to-Provide-Information-or.
[22] *See also* AMA, *Code of Medical Ethics, 1.1.7 Physician Exercise of Conscience*, at 2 (2016) ("When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services."), https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.7.pdf.
[23] *See e.g.*, Trial Tr. vol. 1, 42, 108-09, 121-22, 182, 205, 233, 259, 283; Trial Tr. vol. 2, 330, 380.

times more likely to die during childbirth than during any abortion procedure.[24] A peer-reviewed, evidence-based report from the National Academy of Science, Engineering, and Medicine documents that "the risk of death subsequent to a legal abortion (0.7 [deaths] per 100,000 [patients]) is a small fraction of that for childbirth (8.8 [deaths] per 100,000 [patients])."[25]

Even under the best circumstances, pregnancy and childbirth impose significant physiological changes that can exacerbate underlying preexisting conditions, lead to the development of new conditions, and can severely compromise health both during and after pregnancy. For example, diabetes developed during pregnancy is one of the most common complications for pregnant patients. Some 7% of pregnant people experience complications from diabetes, and 86% of those cases were cases of gestational diabetes.[26] Those who develop gestational diabetes have a higher risk of developing diabetes again later in life, with over 70% developing diabetes within 22-28 years following pregnancy.[27] These patients are also at higher risk for preeclampsia,[28] a hypertensive condition that can occur both during and immediately after pregnancy, and is one of the most common causes of maternal and perinatal death.[29] Other forms of trauma can also occur during pregnancy and birth. For example, tearing in the vaginal and/or anal region during vaginal birth occur in 53-79% of vaginal births, and can require stitches or even surgical repair in more serious cases.[30]

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[24] Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119:2-1 Obstet. & Gynecol. 215, 216-17 (2012) ("[T]he risk of death associated with childbirth is approximately 14 times higher than that with abortion[.]").
[25] Nat'l Acads. of Sci., Eng'g. & Med. *et al.*, *The Safety and Quality of Abortion care in the United States* 45, 74 (2018), https://www.ncbi.nlm.nih.gov/books/NBK507236/.
[26] ACOG, *Practice Bulletin No. 190: Gestational Diabetes Mellitus*, at e49 (Feb. 2018).
[27] *Id.*
[28] *Id.*
[29] ACOG, *Practice Bulletin No. 222: Gestational Hypertension and Preeclampsia*, at e237 (June 2020).
[30] ACOG, *Practice Bulletin No. 198: Prevention and Management of Obstetric Lacerations at Vaginal Delivery* (Sept. 2018, *reaff'd* 2022).

Postpartum complications may also be life threatening, such as postpartum hemorrhaging, the loss of 1000ml or more of blood in the first 24 hours after delivery.[31] This is the leading cause of maternal death worldwide, and can lead to acute renal failure or fertility loss, including the need for a hysterectomy.[32] Some postpartum hemorrhaging is caused by placenta accreta spectrum, a condition where the placenta does not detach spontaneously following birth and cannot be removed without causing massive and potentially life-threatening bleeding.[33] Postpartum pain is another common complication that can make it difficult to care for infants, and can lead to issues such as increased risk of opioid use, postpartum depression, and development of persistent pain.[34]

The risk of both complication and death—which are higher across the board for live birth than for abortion[35]—are even higher for low-income patients and patients of color, the very patients that crisis pregnancy centers are most likely to see.[36] Pregnant people of color are at an increased risk of complex health issues occurring in pregnancy, including each of the conditions discussed above.[37] Low-income pregnant people and pregnant people of color are less likely to

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[31] ACOG, *Practice Bulletin No. 183: Postpartum Hemorrhage* (Oct. 2017).
[32] *Id*.
[33] ACOG, *Obstetric Care Consensus No. 7: Placenta Accreta Spectrum* (Dec. 2017, *reaff'd* 2021); *see also* Maddalena Morlando & Sally Collins, *Placenta Accreta Spectrum Disorders: Challenges, Risks, and Management Strategies*, 2020:12 Int. J. Womens Health 1033-1045 (2020), https://doi.org/10.2147%2FIJWH.S224191.
[34] ACOG, *Clinical Consensus No. 1: Pharmacologic Stepwise Multimodal Approach for postpartum Pain Management*, at 507 (Sept. 2021), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/clinical-consensus/articles/2021/09/pharmacologic-stepwise-multimodal-approach-for-postpartum-pain-management.pdf.
[35] Between 1998 and 2005, the pregnancy associated mortality rate for pregnant persons was 8.8 deaths per 100,000 live births, while the mortality rate for abortion in the same period was 0.6 deaths per 100,000 abortions. Raymond & Grimes, *supra* n.24 at 216. Pregnant people who had a live birth versus an abortion were 1.3x more likely to develop mental health conditions, 1.8x more likely to develop a urinary tract infection, 4.4x more likely to have postpartum hemorrhage, 5.2x more likely to develop an obstetric infection, 24x more likely to develop a hypertensive disorder, 25x more likely to develop antepartum hemorrhage, and 26x more likely to develop anemia. *Id.*
[36] *See* ACOG, *Issue Brief: Crisis Pregnancy Centers*, at 2 (Oct. 2022), https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/cpc-issue-brief.pdf. *See also* Trial Tr. vol.1, 180; Trial Tr. vol. 2, 374-75.
[37] ACOG, *Practice Bulletin No. 190*, *supra* n. 26, at e49.

have access to abortion services generally.[38] Thus, people in these communities are more likely to carry unwanted pregnancies to term, which in turn leads to lower levels of appropriate prenatal care and poorer health outcomes.[39]

Black people suffer from the greatest risk of maternal mortality.[40] Nationwide, Black patients' pregnancy-related mortality rate is at least 3.2 times higher than that of white patients with significant disparities persisting even in areas with low overall mortality rates and among patients with higher levels of education.[41] This is attributable to factors such as higher incidences of preexisting conditions, lack of access to quality prenatal and birthing care, and chronic exposure to stressors related to discrimination.[42]

Denial of abortion care also causes nonmedical harms. Patients who are denied requested abortions are more likely to experience intimate partner violence compared with patients who were able to access abortion.[43] Denial of an abortion can also exacerbate patients' economic hardships.[44]

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[38] Christine Dehlendorf & Tracy Weitz, *Access to Abortion Services: A Neglected Health Disparity*, 22 J. Health Care for the Poor and Underserved 415 (May 2011), https://www.teachtraining.org/resources/Dehlendorf.AccessAB-Disparity.2011.pdf.

[39] *Id.* at 418-19; Rachel K. Jones et al., *COVID-19 Abortion Bans and Their Implications for Public Health*, 52:2 Persps. on Sexual and Reprod. Health 65-68 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7272883/pdf/PSRH-52-65.pdf.

[40] Emily E. Petersen et al., U.S. Dep't of Health & Human Servs., Ctrs. for Disease Control & Prevention, *Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016*, 68 Morbidity & Mortality Weekly Rep. 762, 763 (Sept. 6, 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm; Marian F. MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 11 Am. J. Pub. Health 1673, 1676-77 (2021), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2021.306375.

[41] Peterson, *supra* n. 40, at 763.

[42] *Id*.

[43] *See* Sarah C.M. Roberts et al., *Risk of Violence from the Man Involved in the Pregnancy After Receiving or Being Denied an Abortion*, 12:144 BMC Med. 1, 6 (2014), https://doi.org/10.1186/s12916-014-0144-z.

[44] *See* Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who are Denied Wanted Abortions in the United States*, 112:9 Am. J. Pub. Health 1290, 1294-95 (2018), https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304247.

Finally, abortion occurs in a variety of contexts and for a variety of reasons. Treatment for early pregnancy loss or miscarriage can include procedural or medication abortion.[45] A person carrying a fetus with a severe anomaly where the fetus might not survive or thrive after delivery may also decide that the risk presented of carrying the pregnancy to term requires abortion care. A person may also decide to continue a pregnancy despite the presence of severe, even fatal fetal anomalies and the risks to health. But law and medical ethics require those risks to be taken voluntarily, with full knowledge of the available options.

III. THE HCRCA AMENDMENTS REFLECT A CAREFUL BALANCING OF PATIENT HEALTH AND RELIGIOUS LIBERTY FOR THE ENTIRE HEALTH CARE SECTOR.

Plaintiffs' lawsuits aim to disrupt the delicate balance struck during the legislative process that led to the HCRCA Amendments, which brought diverse stakeholders to the table to balance patient harms with health care professionals' conscience objections. Even if the Court finds the HCRCA Amendments unconstitutional as applied to these specific plaintiffs (which plaintiffs have not demonstrated), it must not invalidate the Amendments on their face based on their effect on this small group of facilities that are not representative of the larger health care sector.

Before the HCRCA Amendments, members of ACOG regularly treated Illinois patients who were harmed when health care providers refused to provide standard of care information or treatment on conscience grounds. Such refusals can cause serious physical and emotional trauma for patients. Here are just a few examples:

- Mindy Swank's water broke at 20 weeks of pregnancy and she learned her fetus suffered from severe anomalies. Despite the risks of life-threatening hemorrhaging and infection, as well as risks to her future fertility, doctors at the hospitals where she sought care—which were subject to Catholic health care restrictions—would not perform an abortion unless and until she became sicker. Nor would they help her obtain care from another provider. Mindy repeatedly returned to the hospital for weeks as she experienced increasingly painful and heavy bleeding.

[45] *See* Lyndsey S. Benson et al., *Early Pregnancy Loss in the Emergency Department, 2006-2016*, 2 JACEP Open e 12549 at 6-7 (2021), https://doi.org/10.1002/emp2.12549.

The doctors agreed to terminate her pregnancy only after she returned with a collection of bloody pads as proof of her severe hemorrhaging.[46]

- During her pregnancy, Angela Valavanis advised her OB-GYN that she wanted to have her tubes tied if she had to give birth via c-section, as that is the safest time to perform the procedure. However, no one told her she could not do so at the Catholic-affiliated hospital where her doctor performed deliveries. She only learned this after three days of labor as she was being wheeled to the operating room for a c-section.[47]

- Melanie Jones slipped in the bathroom and experienced days of severe pain, cramping and vaginal bleeding. She visited a doctor who told her that her intrauterine device ("IUD") that she used for birth control had been dislodged and needed to be removed. However, the doctor refused to do so because she worked at a Catholic-affiliated hospital. The doctor did not inform Melanie that leaving the IUD in place put her at risk for infection, lacerations, and scarring, and would not refer her to another health care provider. Melanie spent two weeks in unrelenting pain, bleeding, and in emotional distress, before she was able to see a doctor who removed the IUD in seconds.[48]

The General Assembly passed the HCRCA Amendment to address pervasive problems like these.[49] At the same time, the General Assembly was sensitive to the importance of health care professionals' freedom of conscience. Various stakeholders, including both religious and non-religious health care providers, were consulted to negotiate a bill that balanced medical ethics, the rights of patients, and the rights of providers. The bill ultimately passed without objections from traditionally conservative health care associations and Catholic organizations.[50] These

[46] *See generally* Pls.' Stm't of Undisputed Facts, Ex. C, Illinois State House: Human Services Committee Hearing on SB 1564, May 13, 2015 at 4–5, *NIFLA v. Treto*, No. 16-cv-50310 (N.D. Ill. 2019), ECF No. 92-4.

[47] *See generally* Anna Maria Barry-Jester & Amelia Thomson-DeVeaux, *Why Religious Health Care Restrictions Often Take Patients By Surprise*, FiveThirtyEight (Aug. 2, 2018), https://fivethirtyeight.com/features/why-religious-health-care-restrictions-often-take-patients-by-surprise/.

[48] *See generally* Melanie Jones, *The Religious Directives Are an Assassination on Women's Rights and Women's Character*, Birthright (May 14, 2019), https://www.birthrightfilm.com/news/2019/4/2/the-religious-directives-are-an-assassination-on-womens-rights-and-womens-character.

[49] In fact, Mindy Swank testified about her experience before legislative committees. Senate Floor Debate Transcript, 99th Gen. Assemb., Reg. Sess. (Ill. Apr. 22, 2015) at 207, http://www.ilga.gov/Senate/transcripts/Strans99/09900031.pdf; House Floor Debate Transcript, 99th Gen. Assemb., Reg. Sess. (Ill. May 25, 2016) at 57, http://www.ilga.gov/house/transcripts/htrans99/09900136.pdf.

[50] Ill. State Med. Soc'y, *2016 Updates on ISMS Legislative Activity in the Illinois General Assembly*, at 20 (2016) (stating both the Illinois State Medical Society and the Illinois Catholic Health Association were

stakeholders did not suggest that the Amendments imposed new duties on providers beyond existing standards of care.[51] Indeed, many religious health care providers already had protocols for handling conscience-based denials of care similar to those required by the HCRCA Amendments.[52]

Under the HCRCA Amendments, health care professionals may still refrain from providing particular medical services; they must simply follow ethical guidelines and legally-mandated standards of care for providing information that apply to all health care providers in order to safeguard patient health. Because of the careful balancing during the legislative process, the HCRCA Amendments constitutionally protect both patient health and religious liberty.

CONCLUSION

Amicus curiae American College of Obstetrician Gynecologists respectfully urges this Court to reject plaintiffs' claims and uphold the Amendments to the Health Care Right of Conscience Act.

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neutral on the bill that ultimately passed the General Assembly), https://www.isms.org/ISMS.org/media/ISMSMediaLibrary/Custom%20content/Advocacy%20Guide/2016EndofSessionLegislativeReport-August.pdf; Cath. Conf. of Ill., *Agreement reached on conscience rights* (Apr. 16, 2015) ("Catholic health care ethicists and Catholic hospital lawyers participated in the negotiations."), https://www.ilcatholic.org/agreement-reached-on-conscience-rights.

[51] *Id*.

[52] Cath. Conf. of Ill., *Agreement reached on conscience rights*, (Apr. 16, 2015) (the negotiated agreement reached on the final bill "reflects the current medical practices in Catholic hospitals"), https://www.ilcatholic.org/agreement-reached-on-conscience-rights. *See also* Senate Floor Debate Transcript, 99th Gen. Assemb., Reg. Sess. (Ill. Apr. 22, 2015) at 193, (Senator Nybo stated, in support of the bill: "I don't think [this] bill really changes much" and "what [the bill is] proposing . . . is essentially the way that Catholic hospitals operate currently"), http://www.ilga.gov/Senate/transcripts/Strans99/09900031.pdf.

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Respectfully Submitted,

/s/ Ameri R. Klafeta
Counsel for *Amicus Curiae*

Ameri R. Klafeta
Rebecca K. Glenberg
Emily Werth
Mason Strand
ROGER BALDWIN FOUNDATION OF ACLU, INC.
150 N. Michigan Ave., Suite 600
Chicago, IL 60601
(312) 201-9740
aklafeta@aclu-il.org
rglenberg@aclu-il.org
ewerth@aclu-il.org
mstrand@aclu-il.org