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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON, Plaintiff, v. ALEX M. AZAR II, in his official capacity as Secretary of the United States Department of Health and Human Services; and UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, Defendants.	NO. 2:19-cv-00183-SAB DECLARATION OF DR. JUDY KIMELMAN IN SUPPORT OF STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION NOTED FOR: July 17, 2019 With Oral Argument at 1:30 p.m.

I, Dr. Judy Kimelman, pursuant to 28 U.S.C. § 1746, hereby declare as follows:

1. I am over the age of 18, competent to testify as to the matters herein, and make this declaration based on my personal knowledge.

2. I obtained my M.D. degree from Stanford University School of Medicine in 1989 and completed my residency at the University of Washington School of Medicine in Obstetrics and Gynecology in 1993. I obtained my B.A. degree with Honors from University of California, Berkeley.

3. I have been licensed to practice medicine in the State of Washington since 1989. Since medical school, my practice has been located in Seattle, focusing on obstetrics and gynecology. I currently practice at Seattle Obstetrics & Gynecology Group within the Swedish Medical Center, where I have worked since 1998. I treated and provided care for approximately 2,200 women in the last year.

4. I am a member of the King County Medical Society, the Seattle GYN Society, the Washington State Medical Association (WSMA), the Washington State Obstetrics Association, and am a fellow with the American College of Obstetricians and Gynecologists (ACOG). I served on the WSMA Board of Trustees from 2007 to 2016. I also was a WSMA PAC member and Chair. I have served in a number of roles with the ACOG Washington Section from 2004 to current, including Secretary, Vice Chair, Chair, and Legislative Chair. I have also served as the ACOG District VIII Secretary and Treasurer.

5. In 2018, I received the Louis M. Hellman Midwifery Partnership Award (a national award presented jointly from ACOG and the American College of Nurse-Midwives). I received the 2017 ACOG National Award for Legislative Advocacy Work, the 2014 ACOG Mentor of the Year Award, the 2013 Washington

State Obstetricians Association Outstanding Leadership Award, and the 2010 ACOG National Award for Legislative Day Conference.

6. I have been published in peer-reviewed journals regarding medical issues in obstetrics and gynecology. A representative publication is *Elevated MSAFP and Midtrimester Placental Abnormalities in Relation to Subsequent Adverse Pregnancy Outcomes*, American Journal of Obstetrics & Gynecology (1992). A true and correct copy of my curriculum vitae is attached to this declaration as Exhibit (Ex.) 1.

7. I am familiar with the rule, Protecting Statutory Conscience Rights in Health Care Delegations of Authority, published in the Federal Register on May 21, 2019 (Final Rule).

8. I submit this declaration to discuss applicable medical guidelines, ethical standards, and standard of care for the medical care and treatment of patients who are seeking reproductive information and care.

9. The Final Rule conflicts with medical standards of care and ACOG guidance because it allows to health care providers and employees to object to providing medical information and care on the basis of religious or moral beliefs, without informing the patient that information is being withheld, or referring the patient to other providers who do not object to providing services.

10. It is my understanding that the Final Rule does not just apply to health care professionals but to all personnel who "assist in the performance" of

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furthering a procedure. It is my understanding that the rule defines assistance broadly to include assisting with scheduling a procedure, transporting a patient to the procedure, or preparing a room for that procedure. Such an interpretation is potentially disruptive to the normal operations of a medical office or other health care facility and impedes the provision of necessary care to patients in a timely manner.

11. The Rule also defines "referral" or "refer" to mean providing any information, "in oral, written, or electronic form . . . where the purpose or reasonably foreseeable outcome of the provision of the information is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular health care service, program, activity, or procedure." It is my understanding that this includes information related to contact information, directions, instructions, descriptions, or other information resources that could help an individual to get the health care service they need.

12. Medical providers are ethically required to provide a patient with "pertinent medical facts and recommendations consistent with good medical practice." Under the medical standards of care and ACOG guidance for appropriate care, it would *not* be considered medically indicated or appropriate to refuse to provide complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion. Providing

this information is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine.[1]

13. By way of example, according to the medical standards of care, medical ethics, and ACOG clinical guidelines, medical practices should provide complete, medically accurate and unbiased information and resources for all of their pregnancy options, including prenatal care, abortion, and other options for which the patient may want information and to answer any questions about what those courses of care might entail.[2] If the woman decides to terminate the pregnancy or indicates that she is considering doing so, then the medically indicated course of care would be to refer her to a clinic that can review with her the options for terminating her pregnancy and provide her with the appropriate care.

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[1] ACOG Committee Opinion 385, "The Limits of Conscientious Refusal in Reproductive Medicine" (true and correct copy attached as Ex. 2).

[2] *See* American College of Obstetricians & Gynecologists, Abortion Policy Statement (2014) (true and correct copy attached as Ex. 3); *see also* American College of Obstetricians & Gynecologists, Committee Opinion No. 528, Adoption (2012, reaffirmed 2018) (true and correct copy attached as Ex. 4); *see also* American College of Obstetricians & Gynecologists, FAQ 168: Pregnancy Choices: Raising the Baby, Adoption, and Abortion (true and correct copy attached as Ex. 5).

14. The Final Rule therefore conflicts with policy adopted by medical professional associations including ACOG, which assert that physicians have an ethical responsibility to place patients' welfare above the physicians' own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their welfare.[3] If a provider fails to provide such information on the grounds of moral or religious objection, they have failed in their "fundamental duty to enable patients to make decisions for themselves."[4]

The Final Rule expands the application of existing conscience protections laws in a way that is likely to create serious barriers to patients accessing care, particularly patients seeking comprehensive reproductive health care.

DATED this 18th day of June, 2019, at Kingston, Washington.

DR. JUDY KIMELMAN

[3] American Medical Association, Code of Medical Ethics Opinion 1.1.1 (true and correct copy attached as Ex. 6).

[4] ACOG Committee Opinion 385, "The Limits of Conscientious Refusal in Reproductive Medicine" (true and correct copy attached as Ex. 2); *see also* American Medical Association, Code of Medical Ethics Opinion 1.1.7 (true and correct copy attached as Ex. 7) (stating that physicians should "[u]phold standards of informed consent and inform the patient about all relevant opinions for treatment, including options to which the physician morally objects.").

DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 24th day of June, 2019, at Seattle, Washington.

s/ Paul Crisalli
PAUL CRISALLI, WSBA #40681
Assistant Attorney General

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Exhibit 1

CURRICULUM VITAE

Judy Kimelman, M.D.
9242 SE 46th St.
Mercer Island, WA 98040
206/915-8320

Education

July 1989 - June 1993	University of Washington, Seattle, WA Obstetrics & Gynecology Residency
Sept 1984 - June 1989	Stanford Medical School, Stanford, CA Medical Degree
Sept 1979 - June 1983	University of California, Berkeley, Berkeley, CA B.A. Biology Honors

Employment

Aug 1998 - Current	Seattle OB/GYN Group, Seattle, WA Obstetrics and Gynecology
Sept 1993- July 1998	Medalia, Healthcare for Women, Seattle, WA Obstetrics and Gynecology

Professional Organizations

Fellow of the American College of Obstetrics & Gynecology (ACOG)

King County Medical Society

Seattle GYN Society

Washington State Medical Association
Washington State OB association

Professional Positions

2017-current	ACOG District VIII Treasurer
2014-2017	ACOG District VIII Secretary
2013-current	ACOG WA Section Legislative Chair
2010-2013	ACOG WA Section Chair
2007-2010	ACOG WA Section Vice Chair
2004-2007	ACOG WA Section Secretary
2009-Current	Organizer for the OB/GYN Legislative Day
2007-2016	WSMA Board of Trustees WSMA PAC member and Chair
2014-current	Swedish QA Committee

Talks

2018	ACOG Congressional Leadership Conference - Advocacy session facilitator

2017	**Washington State Ob Association - Advocacy panel**
2017	**ACOG Congressional Leadership Conference - Advocacy panel**
2016	**ACOG Congressional Leadership Conference Advocacy facilitator**
2015	**Swedish Medical Center Leadership Retreat - Advocacy**
2011-2017	**ACOG District VIII CLC - legislative issues**
1995	**Guest Lecturer - Highline Community College**
	Guest Lecturer - Seafirst Athletic Club health Series
1994	**Guest Lectuer - Seattle Community College**

Honors and Awards

2018	**Louis M. Hellman Midwifery Partnership Award (a National award presented jointly from ACOG and ACNM)**
2017	**ACOG National Award for Legislative Advocacy Work**
2014	**ACOG Mentor of the Year Award**
2013	**Washington State Ob Assoc Outstanding Leadership Award**
2010	**ACOG National Award for Legislative Day Conference**
1995	**Fellow of American College of Obstetric and Gynecology**
1987	**Ciba Geigy Student Award for Public Service**
1987	**Stanford University Dean's Service Award**
1986	**March of Dimes Research Program Scholarship**
1985	**Medical Scholar**
1983	**President's Undergraduate Fellowship for Research**
1983	**Mortar Board Senior Honor Society**
1983	**Prytanean Women's Honor Society**
1983	**Phi Beta Kappa – U.C. Berkeley**
1983	**Graduate High Honors in Biology – U.C. Berkeley**

Publications

Williams, Hickok, Zingheim, Luthy, Kimelman, Nyberg, Mahoney
Elevated MSAFP and midtrimester placental abnormalities in relation to subsequent adverse pregnancy outcomes
AM JO OB GYN 1992; 167: 1032-1037

Williams, Hickok, Zingheim, Mittendorf, Luthy, Kimelman, Nyberg, Mahoney
Elevated MSAFP, placental abnormalities and preterm delivery
OB GYN 1992; 80: 745-749

Williams, Hickok, Zingheim, Luthy, Kimelman, Nyberg, Mahoney
Elevated MSAFP, placental abnormalities, and preterm delivery
Society of Perinatal Obsdtetrics, 1991 *(Abstract)*

Clarke, Kimelman, Raffin
The elevation of fever in the intensive care unit
Cest vol. 100, p. 213-200, July 1991

Trautman, Kimelman, Bernfield
Developmental expression of syndecan, an integral membrane proteoglycan, correlates with cell differentiation
Development 111, 213-218 (1991)

Trautman, Kimelman, Bernfield
Isolation and characterization of fetal bovine retinal pericytes at varying oxygen concentrations
Pediatric Research 105, 379A (1987)

Trautman, Kimelman, Bernfield
The core protein antigen of cell surface proteoglycan is developmentally regulated in a pattern similar to cell-cell adhesion molecules
Journal Cell Biology 105:4, 132A (1987)

Hirt, Kimelman, Birnbaum, Chen, Seeburg, Eberhardt, Barta
The human growth hormone gene locus; structure, evolution, and allelic variations
DNA 6(1), 59-70 (1987)

Exhibit 2

ACOG COMMITTEE OPINION

Number 385 • November 2007

The Limits of Conscientious Refusal in Reproductive Medicine

Committee on Ethics

Reaffirmed 2016

ABSTRACT: Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers 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 patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.

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Women's Health Care Physicians

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. *Conscience* has been defined as the private, constant, ethically attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her *moral integrity*—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity-conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider–patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clear-

ly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a prima facie value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

2. Effect on Patient Health

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special *fiduciary duties*, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to "first, do no harm," their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations "in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second" (19).

3. Scientific Integrity

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice.

Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that preovulatory use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay, flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

4. Potential for Discrimination

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory manner. One conception of justice, sometimes referred to as the *distributive paradigm*, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, per se. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (1). Rather, institutions and

professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions "act affirmatively to protect patients from unexpected and disruptive denials of service" (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals' refusals to provide standard reproductive services.

Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals' consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and 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.
5. In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

References

1. Charo RA. The celestial fire of conscience—refusing to deliver medical care. N Engl J Med 2005;352:2471–3.
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ISSN 1074-861X

Exhibit 3

College Statement of Policy

As issued by the College Executive Board

ABORTION POLICY

The following statement is the American College of Obstetricians and Gynecologists' (ACOG) general policy related to abortion. The College's clinical guidelines related to abortion and additional information are contained in the relevant Practice Bulletins, Committee Opinions, and other College documents.

Induced abortion is an essential component of women's health care. Like all medical matters, decisions regarding abortion should be made by patients in consultation with their health care providers and without undue interference by outside parties. Like all patients, women obtaining abortion are entitled to privacy, dignity, respect, and support.

The College continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus for sustained survival outside the woman's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible health care provider.

While ACOG recognizes and respects that individuals may be personally opposed to abortion, health care providers should not seek to impose their personal beliefs upon their patients nor allow personal beliefs to compromise patient health, access to care, or informed consent.

Informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships.

A pregnant woman who may be ambivalent about her pregnancy should be fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion. The information conveyed should be appropriate to the duration of the pregnancy. There is an ethical obligation to provide accurate information that is required for the patient to make a fully informed decision. The professional must avoid introducing personal bias.

Medical knowledge and patient care are not static. Innovations in medical practice are critical to the advancement of medicine and the improvement of health. Medical research is the foundation of evidence-based medicine and new research leads to improvements in care. ACOG is opposed to laws and regulations that operate to prevent advancements in medicine. For example, laws that prohibit health care providers from following current evidence-based protocols for medical abortion disregard scientific progress and prevent providers from offering patients the best available care. Likewise, the state and federal laws that prohibit specific surgical abortion procedures disrupt the evolution of surgical technique and prevent physicians from providing the best or most appropriate care for some patients.

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If abortion is to be performed, it should be performed safely and as early as possible. ACOG supports access to care for all individuals, irrespective of financial status, and supports the availability of all reproductive options. ACOG opposes unnecessary regulations that limit or delay access to care. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.

ACOG opposes the harassment of abortion providers and patients.

ACOG strongly supports those activities which prevent unintended pregnancy.

Approval by the Executive Board
General policy: January 1993
Reaffirmed and revised: July 1997
Intact D & X statement: January 1997
Combined and reaffirmed: September 2000
Reaffirmed: July 2004
Reaffirmed: July 2007
Reaffirmed: July 2011
Revised and approved: November 2014

Exhibit 4

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 528 • June 2012 (Replaces No. 368, June 2007)
Reaffirmed 2018

Committee on Ethics

This Committee Opinion was developed by the Committee on Ethics of the American College of Obstetricians and Gynecologists as a service to its members and other practicing clinicians. Although this document reflects the current viewpoint of the College, it is not intended to dictate an exclusive course of action in all cases. This Committee Opinion was approved by the Committee on Ethics and the Executive Board of the American College of Obstetricians and Gynecologists.

Adoption

ABSTRACT: Obstetrician–gynecologists may find themselves at the center of adoption issues because of their expertise in the assessment and management of infertility, pregnancy, and childbirth. The lack of clarity about both ethical issues and legal consequences may create challenges for physicians. Therefore, the Committee on Ethics of the American College of Obstetricians and Gynecologists discusses ethical issues, proposes safeguards, and makes recommendations regarding the role of the physician in adoption.

Adoption is a commonly used alternative strategy for family building. Although adoption is not a medical event per se, obstetrician–gynecologists may find themselves at the center of adoption issues because of their expertise in the assessment and management of infertility, pregnancy, and childbirth. There are several specific roles that the obstetrician–gynecologist may be asked to assume regarding adoption. Physicians commonly provide information, advice, and counsel, and they refer birth parents and prospective adoptive parents to adoption agencies. Sometimes, they are asked to provide information about prospective adoptive parents to adoption agencies. Additionally, the obstetrician may deliver the infant to be relinquished. In each of these roles, it is important that obstetrician–gynecologists consider the rights, responsibilities, and safety of all concerned parties: the child, the birth parents, the prospective adoptive parents, and themselves. However, their primary responsibility is to their own individual patients. To clarify the role of the physician in adoption, the Committee on Ethics of the American College of Obstetricians and Gynecologists makes the following recommendations:

- Physicians have a responsibility to provide information about adoption to appropriate patients. The information provided should be accurate and as free as possible of personal bias and opinions.
- A physician's primary responsibility in caring for a woman considering adoption is to her and not to the prospective adoptive parents.
- Physicians should be aware of adoption resources in their areas and refer patients to licensed adoption agencies.
- When physicians complete medical screening forms for prospective adoptive parents, the physician's role is to provide truthful, accurate information to screening agencies.
- Because of ethical issues related to undue influence, competing obligations, and lack of expertise, physicians should not serve as brokers of adoptions.

Developments in Adoption Practices

Principles in Adoption

Consent of the birth mother and placing the child with suitable adoptive parents remain stable and consistent practices. However, many principles that have historically guided adoption practices are undergoing redefinition and reconsideration. The evolving context around adoption has led to new layers of complexity (1):

- Although consent of the birth mother has been a necessary precondition for adoption, presumed waiver of consent by absent birth fathers had been routine. More recently there has been an increased emphasis on the rights of biologic fathers and less reliance on a waiver process to release a child for adoption when the biologic father cannot be located.
- Historically, adoption practices were based on altruism, and all financial transactions suggestive of

purchase of a child were prohibited. Presently, the unmet demand for adoptive infants, as well as more straightforward desires to support the birth mother, can lead to offers of subsidy for medical care and other support. This can raise concerns about inducements and can make the altruistic nature of adoption less clear and free of financial conflict.

- In the past, relinquishing birth mothers and prospective adoptive parents were assured that their confidentiality and anonymity would be protected. In other words, the adoptions were "closed." However, it is no longer possible to guarantee absolute confidentiality to either birth or adoptive parents. Many states have laws that give adopted individuals access to their birth records.
- Traditionally, relationships with adoptive parents were expected to substitute entirely for relationships with biologic parents. However, in some cases, adoption may include ongoing relationships with birth parents. Even in a "closed" adoption, the adopted child and adoptive parents may need to have access to relevant genetic and medical information about the biologic parents.
- Adoptive relationships were presumed to be permanent once they were finalized in court. Adoption is usually irrevocable, but rare cases have arisen in which adoptive relationships were terminated by adoptive parents, biologic parents, or adopted children after a final adoption decree had been granted.

Models of Adoption

There are many types of adoption, and the face of adopted families is changing, including same-sex couples, single-parent families, and older relatives raising a child. In this Committee Opinion, the Committee on Ethics addresses issues regarding prospective adoptive parents and recognizes that the adoptive parent may be an individual man or woman. In addition to the classic adoption of newborns, other models of adoption are becoming more common, including kinship adoptions, relinquishment of children through social service removal, and international adoptions. Most physicians are not experts in these varied adoption processes and laws. However, it is important to be aware of these complex family dynamics and to be able to refer patients to appropriate resources.

Domestic adoptions still account for most adoptions in the United States, but international adoption is increasing in popularity (2). Children who are adopted internationally often come from developing countries that are politically and economically unstable. For this reason, the opportunities for adoption from various countries are continuously in a state of flux. International adoption is regulated by The Hague Convention as well as by each involved country's own laws. There are a variety of organizations that specialize in international adoptions to which physicians can refer their interested patients (see Resources).

The adoption of older children is increasing and usually involves a less-conventional model of adoption. One type of adoption is kinship adoption, whereby a relative adopts a child from another relative. Another important source of adoptive children is the foster care system. For example, it is estimated that there are more than 26,000 preteens available for adoption (3). Adoptive children enter the foster care system through either social service removal or relinquishment at safe havens. Safe havens are locations, such as hospitals or fire stations, where parents (and sometimes other individuals) may leave infants anonymously without fear of prosecution for abandonment or neglect. Most states have enacted safe haven laws, but the specifics vary by state (4).

Physician Roles in Adoption

The lack of clarity about both ethical issues and legal consequences may create challenges for physicians. In the following sections, the different roles that the obstetrician–gynecologist may be asked to play in adoption are described, ethical issues are discussed, and safeguards are proposed.

Education and Counseling

Adoption may be relevant in myriad situations, and physicians have the responsibility to educate appropriate patients about this option. These obligations can be met, for some patients, by placing literature about adoption in the reception area, thereby validating adoption as a legitimate, respected choice. A discussion of the risks and benefits of adoption may be indicated for other patients. In some situations, a referral to another professional with relevant expertise, such as social work, may be appropriate. Regardless of how information is conveyed, it should be clear and accurate.

Physicians have a responsibility to provide information about adoption to appropriate patients. The information provided should be accurate and as free as possible of personal bias and opinions (5). Pregnant women who may be ambivalent about their pregnancies should be informed in a balanced manner about their full range of reproductive options. Physicians should not advocate for or against any particular option, including adoption. Nor should they avoid discussing these issues when they are appropriate to the patient's situation. There is an ethical obligation to provide accurate information that is required for the patient to make a fully informed decision.

Adoption should also be considered an option for certain patients who are looking to build their families. For example, a discussion about adoption may be appropriate for patients who are infertile or for patients in whom pregnancy may be dangerous (6). Fact sheets are available to support this educational role (7, 8). Patients often ask their physicians, "Doctor, what do *you* think I

should do?" (9). There may be a temptation to advocate for a specific position, but it should be avoided. The physician's role is to provide accurate, unbiased information that is appropriate for the situation. This may include infertility treatments, adoption, and child-free living. The patient can decide which course is most consonant with her own values and life circumstances.

Physicians may have both positive and negative personal biases about adoption for various reasons. For example, physicians with personal experience of adoption in their own families of origin, or who have chosen adoption as their own method of family building, may present this option either positively or negatively, depending on their individual experiences. Physicians should be aware of how their own experiences may influence their attitudes and should disclose this information when appropriate.

Patients count on the guidance of physicians for medical decisions. Adoption, however, is only tangentially a medical matter, and few physicians are experts in this field. Furthermore, for the physician, the particular encounter with an individual patient or couple occurs only during a finite point in time. The patients will be living with the lifelong consequences of these decisions. Therefore, when discussing the option of adoption with patients, physicians should guard against advocating for a particular course of action. The best counsel will permit the involved parties to explore their options fully and make a decision that arises out of their own beliefs, values, needs, and circumstances.

Referrals

The physician's role in referrals is to identify appropriate resources. Physicians 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. For example, referral to a mental health professional for short-term counseling provides an opportunity for both birth and prospective adoptive parents to explore their emotional reactions and the ways that different alternatives may affect their lives. Some patients may feel more comfortable having a discussion of this type with someone who is not involved with their ongoing medical care.

Physicians should be aware of adoption resources in their areas and refer patients to licensed adoption agencies (10). There are many sources of information available to assist physicians in developing their own lists of referral alternatives (see Resources). Also, many local hospitals maintain referral rosters.

Screening

When working with patients who have decided to pursue adoption, physicians are sometimes asked by those patients to fill out forms requesting information about their psychologic and medical suitability as prospective adoptive parents. The physician's role in such cases is to provide truthful, accurate information to screening agencies, whose responsibilities are to safeguard and protect the needs and interests of adoptive children. Physicians are bound by ethical precepts to be truthful and to act in their patients' best interests, and in some circumstances, these may be in conflict with each other. For example, a patient may request that a physician not reveal to the agency the extent of her chronic illness and its potential effect on her life expectancy. Although a physician may wish to advocate for a patient, there is an obligation to be truthful and to let patients know that relevant information cannot be hidden.

Some agency forms may request the treating physician to certify that the individual or couple is fit to parent. If the physician believes that he or she does not have enough information to make a judgment, the agency may count that as evidence against the couple. The physician must be honest and speak accurately to the questions asked with the information that is available. One approach is for the physician to disclose to the patient what will be written in the report before it is filed.

Hospital Care for Birth Mothers Relinquishing Infants

Obstetrician–gynecologists may find themselves caring for a patient who has made the choice to relinquish her child after delivery. These women should be supported in making a decision that is often extremely difficult. In addition to the usual demands of labor and delivery, she may be coping with feelings of grief and loss. This may leave the woman in a vulnerable position, and it is the physician's duty to advocate for his or her patient and to set a kind and caring tone. A physician's primary responsibility in caring for a woman considering adoption is to her and not to the prospective adoptive parents.

Physicians should be familiar with their hospitals' policies regarding adoptive parents and the care of women relinquishing their infants. In the past, it was thought best to remove the baby before the woman had a chance to see or hold her infant. This was thought to make it easier for her to relinquish the child. Views on the treatment of the birth mother have significantly changed. Now, depending on her preferences, the birth mother may choose options such as holding the baby, keeping the infant with her until she leaves the hospital, or breastfeeding. Appropriate acceptance and support of the birth mother can prevent the disenfranchised grief that relinquishing an infant may cause her (11).

Limits to the Physician's Role

Because of ethical issues related to undue influence, competing obligations, and lack of expertise, physicians should not serve as brokers of adoptions. In fact, many hospitals have bylaws prohibiting staff physicians from direct involvement as adoption brokers.

One of the reasons physicians should not act as brokers is the power of undue influence. If a physician has acted as a broker and the adoption agreement falls through, he or she will be aware of the loss experienced by the other party, may feel responsible, and may be tempted to use the power of the physician–patient relationship to influence the patient to fulfill the original promise. The physician's ability to provide current or future medical care for this patient may be compromised by these events.

Although both birth parents and prospective adoptive parents generally view the adoption agreement as binding, either or both parties may find themselves unable or unwilling to fulfill that agreement after delivery of the child. The pregnant woman who agreed to relinquish her child may have done so in good faith with the best knowledge available to her at that time. She may not know whether she can really do what she agreed to until she has given birth to this child, held him or her, and experienced the extent of loss. The couple who agreed to accept a child may regret that decision and feel unable to keep their part of the agreement if, for example, the child is born with serious medical problems. For these and similar reasons, no adoption is final until after the birth of the child.

Physicians should avoid matching prospective adoptive parents with women who are choosing to relinquish their children and should instead refer patients to agencies or other adoption resources. Physicians should receive only the usual compensation for medical and counseling services. Referral fees and other arrangements for financial gain beyond usual fees for clinical services are inappropriate.

When physicians also are prospective adoptive parents, there may be a temptation to adopt an infant from one of their own patients. This arrangement is ethically problematic. It takes advantage of the physician–patient relationship and the power differential inherently built into this relationship. Physicians are advised to delegate to an independent authority all responsibility for matching pregnant women with prospective adoptive parents.

Conclusion

Obstetricians who care for pregnant women considering adoption play an important role in providing the medical and emotional support these women deserve. Supporting these women through the process of relinquishing their children while sharing in the joy of the adoptive parents can be a challenge, but one that embraces the art and science of medicine. The obstetrician's obligation to the pregnant woman, however, remains paramount.

Resources ⇦

Arcus D. Adoption. In: Strickland B, editor. The Gale encyclopedia of psychology. 2nd ed. Detroit (MI): Gale Group; 2001. p. 15–9.

Child Welfare Information Gateway
Children's Bureau/ACYF
1250 Maryland Avenue, SW, Eighth Floor
Washington, DC 20024
(800) 394-3366
http://www.childwelfare.gov

The Child Welfare Information Gateway, a comprehensive resource on all aspects of adoption, is a service of the U.S. Department of Health and Human Services.

National Council for Adoption
225 North Washington Street
Alexandria, VA 22314-2561
(703) 299-6633
https://www.adoptioncouncil.org

The National Council for Adoption is a nonprofit agency that focuses on adoption.

Perspectives Press
PO Box 90318
Indianapolis, IN 46290-0318
(317) 872-3055
http://www.perspectivespress.com

Perspectives Press concentrates on issues related to adoption.

Resolve, The National Infertility Association
1760 Old Meadow Road, Suite 500
McLean, VA 22102
(703) 556-7172
http://www.resolve.org

Resolve is an organization for infertile couples. It maintains a directory of nationally and locally recognized and accredited organizations and individuals who provide adoption support.

United States Department of State
Bureau of Consular Affairs
Office of Children's Issues
SA-29
2201 C Street, NW
Washington, DC 20520
(888) 407-4747; (202) 501-4444
http://adoption.state.gov

The Office of Children's Issues is part of the Bureau of Consular Affairs at the U.S. Department of State. It serves as the U.S. Central Authority for the Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption. The office produces and maintains country-specific information about intercountry adoption; issues adoption notices and alerts to inform prospective adoptive parents about developments in a country; serves as a resource to prospective adoptive parents, adoption service providers, and members of Congress; works with U.S. embassies and consulates on adoption-related diplomatic efforts; and monitors complaints against Hague-accredited adoption service providers.

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ISSN 1074-861X

Adoption. Committee Opinion No. 528. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:1320–4.

Exhibit 5

The American College of Obstetricians and Gynecologists

FAQ

FREQUENTLY ASKED QUESTIONS
FAQ168
PREGNANCY

Pregnancy Choices: Raising the Baby, Adoption, and Abortion

What are my options if I find out that I am pregnant?

There are three options available to you if you discover you are pregnant: 1) you can give birth to the baby and raise the baby, 2) you can give birth to the baby and place the baby for adoption; 3) you can end the pregnancy by having an abortion.

Before I begin to make a decision about my pregnancy, is there anything I should do?

Before making any decisions, you need to be sure that you are pregnant. If you took a home pregnancy test and the results show you are pregnant, you should see a health care provider to confirm the result. The health care provider will find out how far along you are in your pregnancy.

What factors should I consider when making a decision about pregnancy?

Your age, values, beliefs, health, current situation, and future goals all play a role in your decision. How far along you are in your pregnancy may limit your options. If you choose to have an abortion, it should be done early in pregnancy when there are fewer risks. If you have a medical condition, pregnancy may pose risks to your health and increase the risk of complications for the baby.

Is there anything I need to do while I am making a decision about my pregnancy?

While you are deciding, start taking a multivitamin with 600 micrograms of folic acid. This helps to protect the baby from certain birth defects. Do not drink alcohol, smoke, or take drugs. Talk to your health care provider about any prescription drugs or over-the-counter medications you are taking to make sure they are safe for the baby. If you choose to raise the baby or give the baby up for adoption, it is best to begin ***prenatal care*** as soon as you can.

Why is prenatal care important?

Good prenatal care makes it more likely that you will have a healthy baby. Prenatal care also includes learning about labor and delivery and choosing a birth control method to use after the baby is born.

What should I think about if I am considering raising the baby?

You may want to think about the following:

- Who can help you with child care? Do you have a partner or family members who can help you?
- Where will you and the baby live? Will you have to change your living arrangements?
- If you have other children, how will raising this child affect them?

It costs money to raise a child. You will need to have a means of financial support. If you have a full-time job, you will need to arrange care for the child while you are working. If you do not have a job or your job does not pay enough, you may be able to get help from government agencies or private organizations.

How does adoption work?

Each state has its own laws about adoption. The general process is that shortly after the baby is born, the birth mother (the woman who gives birth to the baby) signs papers that end her rights to the child and give her consent for the adoption. If the birth father is known and he admits to being the father, he also signs consent forms.

Sometimes the baby leaves the hospital with the adoptive parents. Sometimes the baby is first placed in foster care. During this time, the adoptive parents file legal papers asking to adopt the baby. A judge approves the adoption after a waiting period (usually 1–6 months). At this time, the adoption is final.

What are the types of adoption that are available?

There are three types of adoptions: 1) open, 2) closed, and 3) semi-open. In open adoption, the birth mother and the adoptive parents may meet and share names and addresses. In a closed adoption, the birth mother and the adoptive parents do not meet or know each others' names. The adoptive parents only get information about the birth parents' medical information or family history—nothing that would identify them. In a semi-open adoption, the adoption agency will provide the birth mother with information about the baby from the adoptive parents and vice versa, but there is no direct contact between the birth mother and the baby. Identities usually are kept hidden.

How are adoptions arranged?

An adoption can be arranged by an agency or, in some states, independently. Most agencies choose the adoptive parents after carefully screening and studying people who apply to adopt a baby. Some agencies let birth mothers participate in this process. In independent adoptions, babies are placed in the adoptive parents' home without an agency. This may be done through lawyers, health care providers, counselors, or independent organizations. Before the adoption is final, the new parents and the home setting must be approved by the state agency that handles adoptions and by the court.

If I choose adoption, is financial help available?

If you arrange an adoption through an agency, ask the agency what kind of financial help—both medical and legal—is offered. If you cannot afford a private lawyer to help you with the adoption, you may be able to find legal aid. Most states allow the adopting parents to pay the birth mother's legal and medical fees. Some states allow other fees and expenses to be paid, such as counseling. However, it is not legal for anyone to make money from an adoption.

If I am considering abortion, what should I know about my state's laws?

State laws vary about access to abortion. Some states require that girls younger than 18 years notify their parents or guardian or get permission from a court of law to have an abortion. Some states require that a woman receive counseling before an abortion. Some states have waiting periods (usually 24 hours) between the time when a woman receives counseling about abortion and when the procedure is performed.

What happens during an abortion procedure?

In an abortion procedure, the ***embryo*** or ***fetus*** is removed from a woman's ***uterus***. If you decide to have an abortion, it should be done as early as possible. After 12 weeks, an abortion requires more steps and takes longer to perform.

What are the different types of abortion procedures?

Some abortion procedures are done by surgery. Some are done with medication. The type of abortion you have depends on your choice, your health, and how long you have been pregnant. See the FAQ Induced Abortion for detailed information about each type of abortion procedure.

When can each type of abortion be performed?

The most common type of surgical abortion is called ***vacuum aspiration***. It can be performed up to 14 weeks of pregnancy in a health care provider's office or clinic.

After 14 weeks of pregnancy, the abortion procedure is called a ***dilation and evacuation (D&E)***. A D&E takes longer to perform than a vacuum aspiration and it may require more than one visit. This procedure can be done in a health care provider's office, clinic, or hospital. You usually can go home within a few hours after the procedure is completed.

In a medical abortion, certain drugs are taken to cause an abortion. For this option, a woman usually must be no more than 9 weeks pregnant.

What are the risks associated with abortion?

In general, abortion is a low-risk procedure. Risks and complications depend on how early the abortion is done and the method that is used. Fewer than 1 in 100 women have complications from an abortion performed before 14 weeks of pregnancy. For later abortions, up to 2 in 100 women have complications. In most cases, the risks from an abortion are less than the risks of giving birth to a baby. Most health care providers agree that having one abortion does not affect later pregnancies or a woman's future health. However, the longer a woman waits to have an abortion, the more risk it carries for her.

What should I expect after having an abortion?

You usually will have a follow-up visit with your health care provider after the abortion. Be aware that you can get pregnant soon after having an abortion. You should use a birth control method to prevent pregnancy right away.

Glossary

Dilation and Evacuation (D&E): A procedure in which the cervix is opened and the contents of the uterus are removed with suction or other surgical instruments.

Embryo: The developing organism from the time it implants in the uterus up to 8 completed weeks of pregnancy.

Fetus: The developing organism in the uterus from the ninth week of pregnancy until the end of pregnancy.

Prenatal Care: A program of care for a pregnant woman before the birth of her baby.

Uterus: A muscular organ located in the female pelvis that contains and nourishes the developing fetus during pregnancy.

Vacuum Aspiration: A procedure in which part of the uterine lining or the entire contents of the uterus is removed with suction through a tube inserted into the uterus.

If you have further questions, contact your obstetrician–gynecologist.

Exhibit 6

CHAPTER 1: OPINIONS ON PATIENT-PHYSICIAN RELATIONSHIPS

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

1.1 Responsibilities of Physicians & Patients

1.2 Special Issues in Patient-Physician Relationships

1.1.1 Patient-Physician Relationships

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. The relationship between a patient and a 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 judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

(a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.

(b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.

(c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

AMA Principles of Medical Ethics: I,II,IV,VIII

1.1.2 Prospective Patients

As professionals dedicated to protecting the well-being of patients, physicians have an ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status. Physicians should not decline patients for whom they have accepted a contractual obligation to provide care.

However, physicians are not ethically required to accept all prospective patients. Physicians should be thoughtful in exercising their right to choose whom to serve.

A physician may decline to establish a patient-physician relationship with a prospective patient, or provide specific care to an existing patient, in certain limited circumstances:

(a) The patient requests care that is beyond the physician's competence or scope of practice; is known to be scientifically invalid, has no medical indication, or cannot reasonably be expected to achieve the intended clinical benefit; or is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethics guidance on exercise of conscience.

(b) The physician lacks the resources needed to provide safe, competent, respectful care for the individual. Physicians may not decline to accept a patient for reasons that would constitute discrimination against a class or category of patients

(c) Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by his or her other patients. The greater the prospective patient's medical need, however, the stronger is the physician's obligation to provide care, in keeping with the professional obligation to promote access to care.

(d) The individual is abusive or threatens the physician, staff, or other patients, unless the physician is legally required to provide emergency medical care. Physicians should be aware of the possibility that an underlying medical condition may contribute to this behavior.

AMA Principles of Medical Ethics: I,VI,VIII,X

Exhibit 7

1.1.6 Quality

As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

While responsibility for quality of care does not rest solely with physicians, their role is essential. Individually and collectively, physicians should actively engage in efforts to improve the quality of health care by:

(a) Keeping current with best care practices and maintaining professional competence.

(b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.

(c) Monitoring the quality of care they deliver as individual practitioners—e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.

(d) Demonstrating commitment to develop, implement, and disseminate appropriate, well- defined quality and performance improvement measures in their daily practice.

(e) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.

AMA Principles of Medical Ethics: I,V,VII,VIII

1.1.7 Physician Exercise of Conscience

Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, physicians should:

(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.

(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.

(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.

(d) Be mindful of the burden their actions may place on fellow professionals.

(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.

(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. 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.

(g) Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

AMA Principles of Medical Ethics: I,II,IV,VI,VIII,IX

1.1.8 Physician Responsibilities for Safe Patient Discharge from Health Care Facilities

Physicians' primary ethical obligation to promote the well-being of individual patients encompasses an obligation to collaborate in a discharge plan that is safe for the patient. As advocates for their patients, physicians should resist any discharge requests that are likely to compromise a patient's safety. The discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations. Physicians also have a long-standing obligation to be prudent stewards of the shared societal resources with which they are entrusted. That obligation may require physicians to balance advocating on behalf of an individual patient with recognizing the needs of other patients.

To facilitate a patient's safe discharge from an inpatient unit, physicians should:

(a) Determine that the patient is medically stable and ready for discharge from the treating facility; and

(b) Collaborate with those health care professionals and others who can facilitate a patient discharge to establish that a plan is in place for medically needed care that considers the patient's particular needs