IN THE SUPREME COURT OF FLORIDA

Case Number: SC16-381
Lower Case No. 1D15-3048

GAINESVILLE WOMAN CARE, LLC, ET AL.
Petitioners,

v.

STATE OF FLORIDA, ET AL.,
Respondents.

AMICI BRIEF
IN SUPPORT OF RESPONDENTS

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I. STATEMENT OF INTEREST

The Pellegrino Center for Clinical Bioethics at Georgetown University Medical Center is a university-based ethics resource for those who shape and provide health care. *Principles of Biomedical Ethics* was written by Georgetown faculty, and the Center is strongly associated with the teaching of the principles discussed in this leading book on biomedical ethics. Committed to the dynamic interplay between theory and practice, experience and reflection, the Center brings expertise to ethical challenges that arise in the care of patients.

National Catholic Bioethics Center (NCBC) was established in 1972 and conducts research, consultation, publishing, and education to promote human dignity in health care and the life sciences. Its membership includes hospitals, physicians, churches, and corporate members with whom it consults with across Florida and the United States.

Catholic Medical Association is a national physician-led community of healthcare professionals that informs, organizes, and inspires its members to uphold the highest ethical principles in the science and practice of medicine. Its members and officers include many Florida physicians.

The Florida Conference of Catholic Bishops serves as liaison to the three branches of Florida government on behalf of the bishops of Florida's seven dioceses. The Conference also consults with leaders of Catholic healthcare

organizations and physicians in developing positions on public policies and matters of general interest that affect bioethics and human dignity.

II. SUMMARY OF THE ARGUMENT

This brief responds to an amici brief filed by six professors that argues H.B. 633 violates foundational principles of medical bioethics. Although the professors correctly include autonomy, justice, and non-maleficence as being among the most broadly accepted principles, they do not mention beneficence, which is the last pillar of medical bioethics and is sometimes considered the most important of the four. The professors' claims that H.B. 633 violates the ethical principles wholly ignore the bill's purpose, which is to ensure the informed consent process for an elective abortion is proportionate to the procedure's significant mental health consequences. They also ignore the State's "interest in ensuring so grave a choice is well informed." *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).

For the following reasons, H.B. 633 is consistent with the four traditional principles of medical bioethics and also supports the integrity of the patient-physician relationship: (1) H.B. 633 ensures the decision to have an abortion is both voluntary and informed. Given the abortion procedure's psychological and emotional impact, the waiting period and face-to-face requirements provide patients an opportunity for meaningful dialogue and reflection, thus enhancing their comprehension and, in turn, the autonomy of their decision. (2) H.B. 633 does

not subvert justice, since abortion's uniqueness justifies imposing statutory informed consent requirements. Additionally, other preexisting and uncontroversial statutes also apply only to pregnant women, and several statutes impose similar waiting periods for other emotional life decisions. (3) H.B. 633 bolsters physicians' non-maleficence and beneficence by encouraging them to take abortion's potential impact on mental health seriously, as well as by giving patients an opportunity to learn about, discuss, and hopefully avoid potential harms. (4) Finally, H.B. 633 enhances the patient-physician relationship that underlies these principles. In particular, it ensures informed consent for abortion is meaningful, resembling a mutually engaging process more than a hurried checklist.

III. ARGUMENT

According to the most broadly accepted articulation of medical ethics' foundations, a medical practice must provide for autonomy, justice, non-maleficence, and beneficence to ensure an appropriate level of informed consent. *See* Tom L. Beauchamp & James F. Childress, PRINCIPLES OF BIOMEDICAL ETHICS 13 (7th ed. 2013). H.B. 633 ensures these principles are better fulfilled when women decide whether or not to have an elective abortion. Additionally, it supports the integrity of the patient-physician relationship that underlies these principles as they apply to the informed consent doctrine.

A. H.B. 633 protects a pregnant woman's ability to make autonomous medical decisions.

Beauchamp and Childress elaborate that "personal autonomy is, at a minimum, self-rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice." Tom L. Beauchamp & James F. Childress, PRINCIPLES OF BIOMEDICAL ETHICS 58 (7th ed. 2013). In particular, two conditions are necessary for an individual to make an autonomous choice: (1) liberty, meaning "independence from controlling influences," and (2) agency, meaning "capacity for interntional action." *Id.* The doctrine of informed consent incorporates these two conditions, since patients must have both (1) "free consent" to a medical procedure and (2) the requisite "comprehension" to provide informed consent to that procedure. American College of Obstetricians and Gynecologists, INFORMED CONSENT, ACOG Committee Opinion No. 439, OBSTET GYNECOL 2-3 (Aug. 2009). AS its text and legislative history indicate, H.B. 633 promotes autonomous decision-making by a pregnant woman seeking an elective abortion.

As this Court has acknowledged, "the decision [to have an abortion] clearly is fraught with intense emotional and societal consequences." *In re T.W.*, 551 So.2d 1186, 1195 (Fla. 1989). Speakers at each legislative hearing prior to H.B. 633's passage described their own abortion experiences as being rushed and

impersonal; one speaker had not even met or seen the operating physician until she was on the operating table. *Hearing on H.B. 633 Before the H. Health Quality Subcomm.*, 2015 Leg., 179th Reg. Sess. (2015) (statement of Sherri Daume, Director of Client Services, Lifeline Pregnancy Center); *see Hearing on H.B. 633 Before the H. Health Quality Subcomm.*, 2015 Leg., 179th Reg. Sess. (2015) (statement of Tiffany Wiley-Conn, A Women's Pregnancy Center). Such experiences do not reflect respect for patient autonomy, especially in the context of reproductive health care, where relational aspects of a patient's decision-making are at the forefront. American College of Obstetricians and Gynecologists, INFORMED CONSENT, ACOG Committee Opinion No. 439, OBSTET GYNECOL 4 (Aug. 2009).

Abortion is a uniquely intense procedure. Requiring a face-to-face dialogue with a physician who has confirmed her pregnancy, determined the fetus' gestational age, and discussed the recommended procedure, and allowing time for reflection on that information, helps to ensure a patient's decision is autonomous. *See* Vincent M. Rue, Induced abortion and traumatic stress: A preliminary comparison of American and Russian women, 10(10) MED. SCIENCE MONITOR SR5-AR16 (2004) (finding that 64% of American women felt pressured to abort and that American women are more likely than Russian women to feel they need more time to decide). Additionally, these requirements reduce the extent to which

the abortion decision is rashly made during an "outcry phase," which is typical of patients who have very recently discovered that they are pregnant and causes panic, confusion, emotional numbing, and a rushed decision to abort. Maureen Curley, An Explanatory Model to Guide Assessment, Risk and Diagnosis of Psychological Distress after Abortion. OBSTET. GYNECOL, 945, 949 (2014).

Nothing in H.B. 633's text removes the decision to have an abortion from the patient. On the contrary, it seeks to ensure that a woman's decision is truly voluntary and informed. Nor does it purport to affect the procedure's accessibility, instead bolstering pre-existing informed consent requirements to accommodate abortion's unique significance more appropriately than current practice provides. *See Hearing on H.B. 633 Before the H. Health Quality Subcomm.,* 2015 Leg., 179th Reg. Sess. (2015) (statement of Sherri Daume, Director of Client Services, Lifeline Pregnancy Center); *see* Hearing on H.B. 633 Before the H. Health and Human Services Comm., 2015 Leg., 179th Reg. Sess. (2015) (statement of Tiffany Wiley-Carr, A Women's Pregnancy Center).

The amici brief filed by the six professors states that "in some cases of difficult or weighty decisions, physicians and patients together may decide that it is appropriate to have a discussion, have some waiting period to reflect, and then meet again to make a final decision. But that is for doctor and patient to decide." Brief at p. 6. This statement overlooks the State's interest in assuring that "weighty

decisions" are not rushed, particularly when they involve a major, life-altering decision, such as the decision to give up one's (future) child.

H.B. 633's requirements are similar to Florida's statutory requirements concerning a mother's decision to place her newborn infant for adoption, both imposing a waiting period for the woman's decision and protecting the autonomy of that decision. Namely, Section 63.082(4)(b), Florida Statutes (2016), provides that the mother cannot provide consent to an adoption of her child until 48 hours after birth.

The decision to give up one's (future) child--whether through having an abortion or through adoption--is one of the most consequential, if not the most consequential, decision a woman will ever face. Like Section 63.082(4)(b), H.B. 633 ensures that the irrevocable decision to have an abortion is not made under pressure or in haste. [1]

B. H.B. 633 does not subvert justice.

The six professors begin Section III. B. of their brief by simply stating: "H.B. 633 subverts justice. *Tom L. Beauchamp and James F. Childress,* PRINCIPLES OF BIOMEDICAL ETHICS 250-51 (7th ed. 2013)." An even cursory

[1] In *In re T.W.*, 551 So.2d 1186 (Fla. 1989), this Court noted that, like abortion, the decision to give one's child up for adoption "is fraught with intense emotional and societal consequences." *Id.* at 1195. By enacting H.B. 633, the Legislature is treating the decisions to have an abortion and to give a baby up for adoption consistently, imposing a brief waiting period for both.

review of the cited pages from PRINCIPLES OF BIOMEDICAL ETHICS plainly demonstrates that they do not support their claim. Namely, the authors begin the justice section of their book by stating, "Common to all theories of justice is a minimal requirement traditionally attributed to Aristotle: Equals must be treated equally, and unequals be treated unequally." Tom L. Beauchamp & James F. Childress, PRINCIPLES OF BIOMEDICAL ETHICS 250 (7th ed. 2013). According to the six professors, this principle directly supports the claim that H.B. 633 subverts justice. However, immediately after introducing this principle, upon which the six professors' second argument is wholly based, Beauchamp and Childress state that it "lacks all substance" when governments face decisions on "which differences are relevant in comparing individuals or groups." *Id*. at 251. In fact, Beauchamp and Childress include "pregnant women" as an example of a group that "[v]irtually all accounts of justice in health care hold" should receive special services and have access to special delivery programs. *Id*.

The six professors are correct in contending there must be a morally relevant difference that makes a group's disparate treatment in societal protections, such as statutory informed consent requirements, fair. *Id*. at 252. However, they dispute the existence of a morally relevant difference between pregnant women and other patients. While H.B. 633 indeed applies only to female patients, the bill does not suggest a patient's sex provides the morally relevant difference that justifies a

statutory waiting period. Instead, it is the woman's *pregnancy* that is the relevant difference.

H.B. 633 is by no means the only Florida statute which provides additional protections and safeguards for pregnant women. *See* § 760.08, Fla. Stat. (2016) (protecting pregnant women from discrimination in public accommodations); § 951.175, Fla. Stat. (2016) (requiring supplemental food and clothing for pregnant prisoners, as well as exclusion from inappropriate work assignments); § 384.31, Fla. Stat. (2016) (requiring medical professionals to test pregnant women for STIs throughout pregnancy except in case of explicit refusal); § 784.045, Fla. Stat. (2016) (elevating simple battery to aggravated battery when person knows or should know victim is pregnant); § 782.071, Fla. Stat. (2016) (providing for vehicular homicide conviction when unborn child is killed, even if mother is not); § 922.08, Fla. Stat. (2016) (requiring Governor to stay death penalty sentence if convicted woman is allegedly pregnant).

Additionally, the six professors err in stating that no other medical decisions involve a waiting period mandated by law. To be reimbursed, Medicaid recipients must have waited at least 30 days between signing a consent form and undergoing vasectomy or hysterectomy procedures, both of which fall in the broader reproductive context. 42 C.F.R. § 441.258 (2016). Women affected by H.B. 633's requirements are also treated comparably to other individuals making definitive

and intensely emotional life decisions. As noted earlier, an infant's birth mother must wait at least 48 hours before consenting to place the infant for adoption. § 563.082(4)(b), Fla. Stat. (2016). In addition to these reproductive health decisions, Florida citizens must wait at least 3 days to receive a marriage license when they have not completed a premarital preparation course. § 741.04(3), Fla. Stat. (2016).

What people subject to these statutory waiting periods have in common is a life-changing decision. In *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007), the U.S. Supreme Court stated:

> Whether to have an abortion requires a difficult and painful moral decision. . . . While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. . . . Severe depression and loss of esteem can follow.
>
> (citations omitted).

Abortion procedures can result in detrimental mental health effects. *See* Sharain Suliman et al., Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anaesthesia versus intravenous sedation, 7 BMC Psychiatry 24 (2007) (finding that, three months after having an abortion, the number of South African women with PTSD among 155 had increased by 61 percent compared to the number before the abortion); Priscilla K. Coleman, Abortion and mental health: quantitative synthesis and analysis of research published *1995-2009*, 199(3) BRIT J. OF

PSYCHIATRY, 180, 180-186 (2011) (finding that British women who had undergone an abortion experienced an 81-percent increased risk of mental health problems, and nearly 10 percent of mental health problems were attributable to the abortion procedure); Jonathan Klick, Mandatory Waiting Periods for Abortions and Female Mental Health, 16 HEALTH MATRIX 183, 193 (2006) (finding that an American state's adoption of a waiting period for abortion reduces the state's female suicide rate by almost 10 percent).[2]

H.B. 633 does not affect pregnant women's ability to access abortion services, nor does it coerce pregnant women into making any specific health decision. It simply protects those women from physicians who could otherwise restrain their autonomy, and also their liberty, by rushing a procedure that often has serious mental health consequences. *See Hearing on H.B. 633 Before the H. Health Quality Subcomm.*, 2015 Leg., 179th. Reg. Sess. (2015) (statement of Sherri Daume, Director of Client Services, Lifeline Pregnancy Center).

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[2] *See* M.J. Korenromp et al., *Psychological consequences of termination of pregnancy for fetal anomaly:* similarities *and differences between patients*, 25(13) PRENAT DIAGN 1226, 1226-33; David M. Fergusson et al., *Abortion in young women and subsequent mental health*, 47(1) J. OF CHILD PSYCHOL. & PSYCHIATRY 16, 16-24 (2006); Carlo V. Bellieni & Giuseppe Buonocore, *Abortion and subsequent mental health: review of the literature*, 67(5) PSYCHOL. & CLINICAL NEUROSCIENCES 301, 301-10 (2013); A. Kerstinga et al., *Grief after termination of pregnancy due to fetal malformation*, 25(2) J. OF PSYCHOSOMATIC OBSTET & GYNECOL 163, 163-69 (2004); D.C. Reardon, *Psychiatric admissions of low-income women following abortion and childbirth*, 168(1) CMAJ 1253, 1253-56 (2003).

Further, H.B. 633 affords these patients the same measure of autonomy as individuals in similarly emotional circumstances, who already face uncontroversial statutory waiting periods. Indeed, it only restricts those patients' ability to obtain an abortion on the same day that they give consent, which aligns with existing practice for comparable procedures. *See* Debate on H.B. 633, 2015 Leg., 179th Reg. Sess. (Apr. 22, 2015) (statements by Rep. Cary Pigman and Rep. Julio Gonzalez). Even if such a reasonable restriction qualified as an "inequality," the 24-hour waiting period benefits both the patient and the public by combatting the mental health consequences that rushed abortions have.

C. H.B. 633 bolsters abortion-providing physicians' non-maleficence and also encourages their beneficence.

The professors' discussion of non-maleficence confuses the principle by failing to distinguish it from beneficence. Beauchamp and Childress state that "conflating non-maleficence and beneficence into a single principle obscures critical moral distinctions," namely that between a physician's obligation not to harm patients, defined as non-maleficence, and a physician's obligation to help patients affirmatively, defined as beneficence. Tom L. Beauchamp & James F. Childress, PRINCIPLES OF BIOMEDICAL ETHICS 151 (7th ed. 2013). In fact, the professors' brief neglects to mention beneficence as a unitary principle at all, notwithstanding it being considered one of the four most widely accepted

foundational principles of biomedical ethics. *See id*.; Susan Fox Buchanan, Medical Ethics at the Millennium: a Brief Retrospective, 1997 COLO. LAW. 141, 142-43 ("The 'first principle' of medical ethics is to 'do good' for the patient. Beneficence is of venerable origin in the oath of Hippocrates . . . ."). They also err by dismissing H.B. 633 as providing no medical benefits to justify any inconveniences it might cause to rural or low-income women, which they assert are prohibitive despite the U.S. Supreme Court having held otherwise. *Planned Parenthood of Southeastern Pennsylvania, et al., v. Casey*, 505 U.S. 833, 887 (1992) (holding an informed consent provision requiring a 24-hour waiting period does not create an undue burden).

1. H.B. 633 Supports informed consent.

When conducting their harm-benefit analysis, the professors fail to mention the harms H.B. 633 is designed to ameliorate. Namely, the Legislature considered statements by former abortion patients whose informed consent processes and subsequent procedures were rushed. *See* Hearing on H.B. 633 Before the H. Health Quality Subcomm., 2015 Leg., 179th Reg. Sess. (2015) (statement of Rep. Jennifer Sullivan). Aside from any benefit a physician might realize by rushing a routine procedure, "patients may [also] feel pressure to sign the consent form because the clinician is waiting and feel hesitant to ask questions because a delay may disrupt the flow of a busy clinic or operating suite." *Id*.

To address the reality of modern informed consent processes, then, modern bioethicists typically prefer the "process model" of informed consent to the traditional "event model." Lidz CW et al., *Two models of implementing informed consent*, 148 ARCH. INTERN. MED. 1385, 1385-89 (1988). Although the latter may be legally sufficient, it is less effective at improving a client's comprehension, enhancing patient-physician communication, and encouraging patient participation in the decision-making process. *See id.*; *see also* Snyder, AMERICAN COLLEGE OF PHYSICIANS ETHICS MANUAL, 156 (2) ANN. INTERN. MED. 73, 75 (2012) ("The care of the patient and satisfaction of both parties are best served if physician and patient discuss their expectations and concerns.").

Abortion is indisputably susceptible to the dangers of an insufficient informed consent process, given its tendency to impact patients' long-term mental health. *See Planned Parenthood Minn, et al., v. Rounds, et al.*, 686 F.3d 889, 898-99 (2012). ("The studies submitted by the State [were] sufficiently reliable to support the truth of the proposition that the relative risk of suicide and suicide ideation is higher for women who abort their pregnancies compared to women who give birth or have not become pregnant."); Sharain Suliman et al., *Comparison of pain, cortisol levels, and psychological distress in women undergoing surgical termination of pregnancy under local anesthesia versus intravenous sedation*, 7 BMC Psychiatry 24 (2007) (finding that, three months after having an abortion, the

number of South African women with PTSD among 155 had increased by 61 percent compared to the number before the abortion); Priscilla K. Coleman, *Abortion and mental health: quantitative synthesis and analysis of research published 1995-2009*, 199(3) BRIT. J. OF PSYCHIATRY 180, 180-186 (2011) (finding that British women who had undergone an abortion experienced an 81-percent increased risk of mental health problems, and nearly 10 percent of mental health problems were attributable to the abortion procedure); Jonathan Klick, *Mandatory Waiting Periods for Abortions and Female Mental Health*, 16 HEALTH MATRIX 183, 193 (2006) (finding that an American state's adoption of an abortion waiting period reduces its female suicide rate by almost 10 percent). Beauchamp and Childress point out that even relatively narrow definitions of "harm" in the context of physician non-maleficence include such psychological interests. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 154 (7th ed. 2013).

"Introducing social costs to protect the public health" from psychological harms can be justified in some circumstances. *Id*. at 151. While H.B. 633 might inconvenience some women, the realities of modern informed consent, particularly as they apply to abortion procedures, *see Hearing on H.B. 633 Before the H. Health and Human Services Subcomm.*, 2015 Leg., 179th Reg. Sess. (2015) (statement of Sherri Daume, Director of Client Services, Lifeline Pregnancy

Center); *Hearing on H.B. 633 Before the H. Health and Human Services Subcomm.*, 2015 Leg., 179th Reg. Sess. (2015) (statement of Tiffany Wiley-Carr, A Women's Pregnancy Center), justify statutory protection of abortion patients as a whole. *See* Erin Bernstein, *The Upside of Abortion Disclosure Laws*, 24 STAN. L. & POL'Y REV. 172, 178 (2013) ("By mandating an early disclosure—an informed conversation at an early decision point, perhaps even before a woman has decided to terminate—disclosure laws could ensure truly informed consent . . . ."). The bill's exception for documented cases of rape, incest, and human trafficking, as well as a pre-existing exception for emergencies, § 390.0111, Fla. Stat. (2016), also serve to reduce these inconveniences.

2. H.B. 633 Supports Beneficence.

Although patients considering whether to have an abortion must make their decision autonomously, "the term 'beneficence' is often understood to cover acts of kindness or charity that go beyond strict obligation." The Nat. Comm'n for the Protection of Human Subjects of Biomedical and Behavioral Research, "The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research," C.2. (Apr. 18, 1979), http://www.hhs.gov/ohrp/regulations-and-policy/belmont-report.

Evidence shows that abortion procedures require greater beneficence in the informed consent process. Abortion patients have a threat of serious mental health

consequences, and the State of Florida, aware of those consequences, can promote greater beneficence by adjusting the informed consent process accordingly.

D. H.B. 633 Supports the Patient-Physician Relationship's Integrity.

Although it does not stand alone as one of medical bioethics' four primary principles, the patient-physician relationship is where each of the four principles previously discussed are most clearly put into practice. The professors make the illogical assertion that H.B. 633 interferes with the process by which physicians counsel abortion patients when, in fact, H.B. 633 only bolsters the relationship between abortion-providing physicians and their patients. As was discussed during H.B. 633's passage, abortion patients previously experienced highly impersonal relationships with their physicians and, according to one testimony, might not have even met their physicians before being on the operating table. *Hearing on H.B. 633 Before the H. Health Quality Subcomm.*, 2015 Leg., 179th Reg. Sess. (2015) (statement of Sherri Daume, Director of Client Services, Lifeline Pregnancy Center).

On page 5 of their brief, the professors cite to *American College of Obstetricians and Gynecologists, Informed Consent, ACOG Committee*, Opinion No. 439, OBSTET GYNECOL (Aug. 2009). That article states as follows:

> Informed consent should be looked on as a process rather than a signature on a form. This process includes a mutual sharing of information over time between the

> clinician and the patient to facilitate the patient's autonomy in the process of making ongoing choices.

Id. at 1. The professors' brief ignores that, for most women seeking an abortion, there is not an established relationship with the abortion provider, and, thus, in the absence of H.B. 633, no opportunity for "a mutual sharing of information *over time* between the clinician and the patient to facilitate the patient's autonomy in the process of making ongoing choices." *Id.* (emphasis added).

According to the ACP Ethics Manual that the professors cite, "the care of the patient and satisfaction of both parties are best served if physician and patient discuss their expectations and concerns." Snyder, *American College of Physicians Ethics Manual*, 156(2) ANN. INTERN. MED. (6th ed. 2012). H.B. 633 provides an appropriate window for ensuring such discussion is properly informed, given the abortion procedure's significant potential for long-term mental health consequences. H.B. 633 also ensures that informed consent is obtained, as it definitively should be, through a "process," not a by a "medical Miranda warning" or a checklist. Meisel & Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156(22) ANN. INTERN. MED. 2521, 2521-26 (1996).

While some women might have decided to terminate their pregnancies before arriving at an abortion clinic, physicians are obligated not to approach a patient's informed consent process with a goal of obtaining that patient's consent. *Id*. Instead, "physicians are obligated to obtain not only informed consent but also

informed refusal. . . . [T]he most important part of informed consent is information about options and their consequences and a refusal of treatment is a choice to do nothing, which has predictable consequences too." *Id*. Therefore, by discussing patients' options with them in-person, and also by allowing a reflection period, physicians acting pursuant to H.B. 633 will facilitate the extent to which patients' decisions are truly autonomous and informed.

H.B. 633 provides the critical step between a checklist approach and the ideal "process model" of informed consent, *id*; *see* Lidz CW et al., *Two models of implementing informed consent*, 148 ARCH. INTERN. MED. 1385-89 (1988); "what is critical is that patients be given information and that they have a chance to use it in formulating a decision, to ask questions about it, and to gather further information." Meisel & Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156(22) ANN. INTERN. MED. 2521, 2521-26 (1996). H.B. 633 also does so without interfering with patients' autonomy, since it does not attempt to sway patients' decisions whether or not to abort. Rather, by providing women a period to reflect on information received, H.B. 633 demonstrates the government's respect for patients facing a uniquely emotional and consequential life decision. *See* Erin Bernstein, *The Upside of Abortion Disclosure Laws*, STAN. L. & POL'Y REV. 172, 178 (2013) ("Regulation requiring that ob-gyns and other primary care physicians impart information about abortion—where otherwise they may not have been

engaging on the subject—communicates greater government respect for women as subjects competent and entitled to decide great questions concerning their lives.").

CONCLUSION

For the reasons stated above, the foundational principles of medical bioethics support H.B. 633.

CERTIFICATE OF TYPE SIZE AND STYLE

This Brief is typed using Times New Roman 14 point, a font which is not proportionately spaced.

Respectfully submitted this 1st day of August, 2016.

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I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished electronically to the following this 1st day of August, 2016.

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