Case Nos. 19-1614, 20-1215

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

MAYOR AND CITY COUNCIL OF BALTIMORE, Plaintiff-Appellee, v. ALEX M. AZAR II et al., Defendants-Appellants.	:	On Appeal from the United States District Court District of Maryland

SUPPLEMENTAL *EN BANC* BRIEF OF *AMICI CURIAE* OHIO, ALABAMA, ARKANSAS, INDIANA, KENTUCKY, LOUISIANA, NEBRASKA, OKLAHOMA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, TEXAS, UTAH, AND WEST VIRGINIA IN SUPPORT OF DEFENDANTS-APPELLANTS AND REVERSAL

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INTRODUCTION AND STATEMENT OF AMICI INTEREST

Congress enacted Title X to fund family-planning services. The law expressly prohibits its funds from being "used in programs where abortion is a method of family planning." 42 U.S.C. §300a-6. In 1988, the federal government promulgated rules to "preserve the distinction between Title X programs and abortion as a method of family planning." 53 Fed. Reg. 2922, 2923 (Feb. 2, 1988). Those rules barred recipients from making abortion referrals. And they required Title X recipients who provided abortions to maintain strict financial and physical separation between their non-abortion and abortion services. The Supreme Court upheld those rules in *Rust v. Sullivan*, 500 U.S. 173 (1991). Nonetheless, the federal government replaced the 1988 rules with rules that allowed for a much cozier relationship between Title X funds and abortion services. *See* 58 Fed. Reg. 7462, 7462–68 (Feb. 5, 1993). These replacement rules, once finalized, permitted the co-mingling of Title X and abortion services, allowed Title X grantees to give "information and counseling regarding" abortion, and even allowed for abortion referrals. 42 C.F.R. §59.5(a)(5)(ii) (July 3, 2000).

Finally, in 2019, the federal government adopted new rules that, in essence, reimplemented the Title X regime upheld in *Rust*. 84 Fed. Reg. 7714 (Mar. 4, 2019). Predictably, abortion advocates across the nation sued, hoping to accomplish in

litigation what they could not accomplish through the political process. The *amici* States filed briefs supporting the new rules each step of the way. They did so for two main reasons. First, the *amici* States support the federal government's efforts to implement the Title X that Congress actually passed, as opposed to the Title X that abortion advocates *wish* it had passed. Second, the States have an interest in keeping their citizens' tax dollars from being used to fund (and put the government's imprimatur on) a controversial procedure to which many of those citizens vehemently object. *Cf. Planned Parenthood of Greater Ohio v. Hodges,* 917 F.3d 908, 910 (6th Cir. 2019) (*en banc*).

The States made all these arguments before the three-judge panel and submitted additional printed copies of that brief for the *en banc* Court's consideration. The States will not swell the Court's docket by repeating those arguments here. Instead, the *amici* States submit this *en banc* brief to address the District Court's determination that what it tendentiously called the "gag rule" is arbitrary and capricious in violation of the Administrative Procedure Act. The rule in question prohibits Title X projects from making abortion referrals except in cases of medical necessity, though it permits (without requiring) non-directive counseling regarding abortion. In deeming this rule "arbitrary and capricious," the District Court faulted the government for failing to adequately respond to "grave medical ethics concerns" raised

by medical organizations. *Mayor & City Council of Baltimore v. Azar*, No. RDB-19-1103, Doc. 93 at 17 (D. Md., February 14, 2020) ("Dist. Ct. APA Op.").

In fact, the federal government fully and adequately responded to these concerns, as the *en banc* Ninth Circuit recently held. *See California v. Azar*, 950 F.3d 1067, 1102–03 (9th Cir. 2020) (*en banc*). In concluding otherwise, the District Court implicitly held that the ethical views of leading medical organizations can be rejected only with particularly thorough justifications. But that is not true. The government, not self-appointed experts on medical ethics, makes the rules of medical ethics. The American Medical Association and the American College of Obstetricians and Gynecologists are no more authoritative when it comes to medical ethics than is the American Bar Association with respect to legal ethics. And the States' laws shielding doctors from having to make abortion referrals, not to mention their experience under the rules being challenged here, establish that the ban on abortion referrals fully comports with medical ethics.

What is more, the unmistakable effect of interpreting "medical ethics" to require abortion referrals will be to drive anyone with moral objections to that procedure out of obstetrics and gynecology—and perhaps out of medicine altogether. If Baltimore and professional medical organizations wish to exile from medical practice

anyone who declines to be complicit in abortion, they ought to say so frankly instead of hiding behind mealy-mouthed appeals to "medical ethics."

The *amici* States are filing this supplemental brief under Rule 29(a)(2) to elaborate on all this.

ARGUMENT

The Administrative Procedure Act prohibits agency actions that are "arbitrary" and "capricious." 5 U.S.C. §706(2)(A). An agency will be found to have acted arbitrarily and capriciously if it "entirely failed to consider an important aspect of the problem," or "offered an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43 (1983). As this Court recently explained, the arbitrary-and-capricious standard requires agencies to "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Roe v. United States DOD*, 947 F.3d 207, 220 (4th Cir. 2020) (internal quotation omitted).

The District Court concluded that the United States Department of Health and Human Services—HHS, for short—violated the bar on arbitrary-and-capricious actions. In particular, the court faulted HHS for "inadequately explain[ing] its decision to 'disagree'" with "literally all of the nation's major medical organizations,"

who raised "grave medical ethics concerns with the Final Rule." Dist. Ct. APA Op. 17. In fact, HHS did articulate its reasons for parting ways with the ethical views of these organizations. *See California v. Azar*, 950 F.3d 1067, 1102–03 (9th Cir. 2020) (*en banc*). The District Court's contrary decision transmutes the ethical views of medical organizations into binding law under the guise of "arbitrary and capricious" review.

I. HHS properly rejected the medical organizations' ethical concerns with the prohibition on abortion referrals within the Title X program.

This brief focuses on the new provisions codified at 42 C.F.R. §59.14. Collectively, these provisions forbid Title X projects from making abortion referrals (except in cases of medical necessity); they permit, without requiring, non-directive counseling in which the patient and the doctor may discuss the availability of abortion; and they require doctors to make referrals for prenatal care.

At the notice-and-comment stage, the American Medical Association, the American College of Obstetricians and Gynecologists (ACOG), and various other medical groups objected to these provisions. They argued that medical ethics require doctors to make abortion referrals and that the bar on such referrals is thus contrary to medical ethics. HHS considered these arguments and thoughtfully rejected them. For example, the Federal Register contains the following lengthy response:

> The Department disagrees with commenters contending the proposed rule, to the extent it is finalized here, infringes on the legal, ethical, or professional obligations of medical professionals. Rather, the Department believes that the final rule adequately accommodates medical professionals and their ethical obligations while maintaining the integrity of the Title X program. In general, medical ethics obligations require the medical professional to share full and accurate information with the patient, in response to her specific medical condition and circumstance. Under the terms of this final rule, a physician or APP may provide nondirective pregnancy counseling to pregnant Title X clients on the patient's pregnancy options, including abortion. Although this occurs in a postconception setting, Congress recognizes and permits pregnancy counseling within the Title X program, so long as such counseling is nondirective. The permissive nature of this nondirective pregnancy counseling affords the physician or APP the ability to discuss the risks and side effects of each option, so long as this counsel in no way promotes or refers for abortion as a method of family planning. It permits the patient to ask questions and to have those questions answered by a medical professional. Within the limits of the Title X statute and this final rule, the physician or APP is required to refer for medical emergencies and for conditions for which non-Title X care is medically necessary for the health and safety of the mother or child.

84 Fed. Reg. 7714, 7724 (2019). Elsewhere, HHS explained that "it is not necessary for women's health that the federal government use the Title X program to fund abortion referrals, directive abortion counseling, or give to women who seek abortion the names of abortion providers," because "[i]nformation about abortion and abortion providers is widely available and easily accessible, including on the internet." 84 Fed. Reg. at 7746.

HHS thus recognized that, as the American Medical Association and the other groups suggested, "medical ethics obligations require the medical profession to

share full and accurate information with the patient, in response to her specific medical condition and circumstance." It simply determined that the bar on referrals is consistent with this requirement because it leaves patients free "to ask questions and to have those questions answered by a medical professional" in a non-directive manner. While physicians can decline to engage in non-directive counseling, nothing in the rules permits doctors who *do* counsel patients to be anything less than truthful. And although no Title X provider can make an abortion referral (except in a medical emergency), the provider is "always free to make clear that advice regarding abortion is simply beyond the scope of the program." *Rust v. Sullivan*, 500 U.S. 173, 200 (1991). Given the widespread availability of information about abortion providers, HHS determined that women's health would not be negatively affected by forbidding the giving of abortion referrals within the Title X program. *California*, 950 F.3d at 1103 (quoting 84 Fed. Reg. at 7746). "These statements show HHS examined the relevant considerations arising from commenters citing medical ethics and rationally articulated an explanation for its conclusion." *Id.*

Rust confirms the sufficiency of HHS's response. The rules under review in that case were materially identical to the rules at issue here, 53 Fed. Reg. 2922, 2923–24 (Feb. 2, 1988), and medical ethics have not changed on the relevant points during the intervening years. Indeed, some of the same medical groups that object to the

current rules objected to the 1988 rules on the same medical-ethics grounds. For example, the American Medical Association, ACOG, and the American Academy of Family Physicians, among others, filed an *amicus* brief raising these concerns. *See Amicus Brief of the AMA, et al.*, in *Rust v. Sullivan*, Case Nos. 89-1391 and 1392 (U.S.), 1990 U.S. S. Ct. Briefs LEXIS 1213. They argued in *Rust*, just as they do here, that the ban on referrals would "force physicians to deviate from accepted standards of medical practice and ethics," *id.* at *7, including by "restricting physicians from providing information and counseling about a particular treatment," *id.* at 11 n.2. The Supreme Court rejected these arguments, noting that a "doctor's ability to provide, and a woman's right to receive, information concerning abortion and abortion-related services outside the context of the Title X project remains unfettered." *See* 500 U.S. at 203. That determination bound the District Court. It binds this Court, too.

In any event, HHS's conclusion that medical ethics do not require doctors to give abortion referrals is consistent with state law and state experience.

Start with the law. Many States have laws that protect doctors and other healthcare providers from having to participate in, perform, or even refer for abortions. *See, e.g.*, Ariz. Rev. Stat. §36-2154(A); Conn. Agencies Regs. §19-13-D54(f); Fla. Stat. §390.0111(8); Ky. Rev. Stat. §311.800(4); La. Rev. Stat. §40:1061.2; Mont.

Code Ann. §50-20-111(2); N.Y. Civ. Rights Law §79-i; Ohio Rev. Code §4731.91; Or. Rev. Stat. §435.485; 18 Pa. Cons. Stat. §3213(d); Wis. Stat. §253.09(1). Those state laws are binding, unlike the ethical codes promulgated by medical organizations. And these state laws confirm that sound medical ethics does not require complicity in abortion. In fact, *Maryland itself* has a law that entitles doctors not to "refer" patients for "any medical procedure that results in … termination of pregnancy." Md. Health-General Code Ann. §20-214. While that law has an exception that requires referrals when the failure to provide one would be "contrary to the standards of medical care," §20-214(d), that exception proves the rule: even in the judgment of Maryland itself, doctors can decline to make abortion referrals without necessarily acting "contrary to the standards of medical care."

The States' experience with the new Title X rules fully accords with all this. If the rules really did require physicians to act contrary to their patients' interests, one would have expected to see a large exodus from the Title X program following the new rules' implementation. After all, everyone seems to agree that the entities who provided Title X services before the new rules cared about their patients. It follows that those entities would be unwilling to participate in any program that required the provision of inadequate care or that undermined patient interests. Yet, there has been no mass exodus, or really much of any exodus at all. In Ohio, *every*

single one of the State's many subgrantees—private and public alike—reenlisted in the Title X program after the new rules went into effect in the Buckeye State. Other States have likewise seen continued participation. *See* Office of Population Affairs, *Title X Family Planning Directory* (January 2020), online at www.hhs.gov/opa/sites/default/files/Title-X-Family-Planning-Directory-January2020.pdf (last visited Apr. 9, 2020).

This experience confirms that, at least in the view of the professionals providing these services, there is nothing unethical about providing family-planning services but declining to make abortion referrals.

II. The District Court's arbitrary-and-capricious finding implicitly rests on the incorrect view that the ethical views of medical organizations are owed special deference.

The District Court held that HHS acted arbitrarily and capriciously by failing to "provide a reasoned basis for its disagreement with medical ethics concerns outlined by the nation's major medical organizations." Dist. Ct. APA Op. 21. As the rather-lengthy excerpt from the Federal Register above shows, HHS *did* provide a reasoned basis. The District Court's opinion all but ignores HHS's reasoning. The fact that the District Court felt the need to support its ruling by misrepresenting HHS's work is a good sign that something is wrong with its analysis.

And indeed, something is quite seriously wrong. The District Court concluded that HHS had to "provide a reasoned explanation for its disagreement with the medical ethics concerns of every major medical association in the country, *while simultaneously* finding the Final Rule consistent with medical ethics." Dist. Ct. APA Op. 21 (emphasis added). Reading between the lines, the District Court seems to be suggesting that HHS engaged in only the second part of the analysis; it is suggesting HHS concluded that the new rules were consistent with medical ethics without explaining why it rejected the concerns of the various medical groups.

This criticism misses the mark. The way to express reasoned disagreement with the organizations' ethical concerns was to explain why the new rules comport with medical ethics. HHS did that. In requiring HHS to do even more, the District Court *sub silentio* imposed a heightened burden on any agency that dares to part ways with the American Medical Association, ACOG, or their peer organizations on matters of medical ethics. *Those* organizations' concerns, the District Court's opinion suggests, can be rejected only with particularly weighty justifications. That is wrong: medical organizations do not get to impose binding rules of medical ethics on the nation.

A. Medical organizations do not dictate the "medical ethics" that bind the medical profession.

1. It is important to begin with a better understanding of what "medial ethics" means in the context of this case. When we speak of "ethics" in our daily lives, we speak in terms of morality—standards for judging whether human behavior is right or wrong. But that is not the sense of "ethics" at issue here. After all, "moral philosophy" cannot be "neatly distilled into a pocket-sized, *vade mecum* 'system of metrics.'" *Glossip v. Gross*, 135 S. Ct. 2726, 2748 (2015) (Scalia, J., concurring). And so ethical views in the philosophical sense are not the sort of "data" or "evidence" with which the Administrative Procedure Act requires agencies to contend. Were it otherwise, every set of Title X rules would have to address—and every federal court tasked with reviewing those rules would have to examine under the arbitrary-and-capricious standard—the morality of directly or indirectly funding (or declining to fund) abortion.

Here, the relevant sense of "medical ethics" is this: medical ethics are the legal rules that ensure doctors act, and that patients (along with doctors themselves) are treated, in a manner that accords with good public policy and a basic sense of fairness. *That* is the sense of "ethics" that matters when talking about the government's substantial interest in "protecting the integrity and ethics of the medical profession." *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (internal quotation mark).

No one should expect government actors—executive administrators, judges, legislators, or anyone else—to solve philosophical debates that have divided great minds for millennia. But everyone can demand that government actors legislate and regulate for the common good.

Medical ethics in that sense—the correct sense—are to be determined by the government, not the regulated industry. The medical profession has long "been subjected to licensing and regulation for the reason that the services customarily rendered … are so closely related to the public health, welfare and general good of the people, that regulation is deemed necessary to protect such interests." *Lasdon v. Hallihan*, 377 Ill. 187, 193 (1941). Doctors offer a tremendously important service. But they also wield tremendous power—they have training their patients do not, and they stand in a position of authority ripe for abuse. "The community" is thus "concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but protection against" practices tending to undermine the public trust necessary for the medical profession to have its maximum benefit. *Semler v. Or. State Bd. of Dental Exam'rs*, 294 U.S. 608, 612 (1935).

There is, to be sure, substantial overlap between the philosophical and policy-based conceptions of "the integrity and ethics of the medical profession." *Gonzales*, 550 U.S. at 157. After all, when doctors behave in ways that the public deems

immoral (in the philosophical sense), they "undermine the trust that is essential to the doctor-patient relationship." *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997). Therefore, the government legitimately takes account of these moral views when announcing principles of medical ethics. Still, the government's ultimate responsibility is not the rather-lofty task of divining moral truths, but instead the rather-earthly task of regulating the medical industry for its own good and the good of the public.

The States have "great latitude under their police powers to legislate" in furtherance of that task. *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006) (quoting *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996)). Through the exercise of those powers, the States have developed a considerable degree of expertise. Most (perhaps all) States promulgate or adopt ethical standards to which doctors must adhere. *See, e.g.,* Ohio Rev. Code §4731.22(B); Ala. Code §34-24-360; Ark. Code Ann. §17-95-409; Ind. Code Ann. §25-1-9-4; Md. Health Occupations Code Ann. §14-401.1. States typically set up specialized bodies to enforce medical ethics and other medical regulations. Such bodies are often made up of doctors, who represent the views of the profession, and non-doctors, who represent the conscience of the community more broadly. For example, Ohio's Medical Board includes eight doctors and four non-doctor members. Ohio Rev. Code §4731.01. Maryland's State Board of Physicians includes at least fourteen doctors, five "consumer members," one representative of

the department of health, and one "public member knowledgeable in risk management or quality assurance matters appointed from a list submitted by the Maryland Hospital Association." Md. Health Occupations Code Ann. §14-202. This division of authority reflects the fact that medical ethics are not the responsibility of the medical profession alone: the general public also has an interest in "protecting the integrity and ethics of the medical profession." *Gonzales*, 550 U.S. at 157.

2. Because (in this context) the question of what "medical ethics" requires is a question of law and policy for the States to work out on their own, there is no definitive code of medical ethics. To be sure, many professional organizations—the American Medical Associations and ACOG, for example—promulgate ethical guidelines. These organizations are as free as any other citizen group to opine on these issues. And they may of course urge medical authorities to adopt their views as law—sometimes they even do so successfully. But these interest groups are not lawmakers, and their views are not binding on anyone without the government's say so. (In this sense, these groups are no different than the American Bar Association, which promulgates an ethical code for lawyers that some States adopt in full and others do not. *See, e.g., States split on new ABA Model Rule limiting harassing or discriminatory conduct*, ABA Journal, Oct. 1, 2017, available at https://www.abajournal.com/magazine/article/ethics_model_rule_harassing_conduct (last visited Apr. 8,

2020).) Again, the question whether a particular practice will undermine "the integrity and ethics of the medical profession," *Gonzales*, 550 U.S. at 157, has a lot more to do with the public's perspective than the profession's. And so the views of these groups, while entitled to respectful consideration just like the views of any other citizen group, are not owed heightened deference.

That is particularly true in the abortion context. Abortion is a morally contentious procedure about which people of good-faith hold strong, diametrically opposed views. Thus, any organization that claims to speak authoritatively on medical ethics in the abortion context is unlikely to be a neutral observer. And certain of these groups do not even claim to be neutral observers. ACOG, which is particularly active in offering opinions on the application of medical ethics to abortion, admits to supporting the pro-abortion movement. *See, e.g.*, ACOG, *In the Courts* (last visited April 9, 2020), online at https://www.acog.org/advocacy/in-the-courts. Its policy statements call for on-demand access to abortion with no interference from state actors. *See, e.g.*, ACOG, *Abortion Policy: Statement of Policy* (last visited April 9, 2020), https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2017/abortion-policy. ACOG has all the right in the world to express its opinions on matters of policy, and the States do not fault it for doing so. But ACOG's

role as cheerleader for the abortion movement belies any claim that its opinions arise from the untainted application of neutral principles.

What is more, these groups tend to address ethical dilemmas with standards that are vague to the point of vacuity. As a result, they are able to take positions that are, as far as the law is concerned, *contrary to* medical ethics.

To take one example, some of the organizations to which the District Court deferred have openly supported the legality of an abortion method known as "dilation and extraction" or "intact dilation and evacuation." *See Brief of Amici Curiae American Medical Women's Ass'n, American Public Health Ass'n, et al.*, in *Gonzales v. Carhart*, No. 05-1382 (U.S.), online at 2006 U.S. S. Ct. Briefs LEXIS 922; *Brief of ACOG as Amicus Curiae*, in *Gonzales v. Carhart*, No. 05-1382 (U.S.), online at https://tinyurl.com/ACOGab (last visited April 10, 2020). In these abortions, the doctor fully delivers the unborn child, except for her head; he slides his fingers up the spine to the base of the skull; he grabs a pair of scissors and splits open the skull, sometimes causing the unborn child to recoil or flinch; finally, the doctor vacuums out the brain and delivers the corpse. *Gonzales*, 550 U.S. at 138. This "method of killing a human child—one cannot even accurately say an entirely unborn human child—… is so horrible that the most clinical description of it evokes a shudder of revulsion." *Stenberg v. Carhart*, 530 U.S. 914, 953 (2000) (Scalia, J., dissenting). It bears a

"disturbing similarity to the killing of a newborn infant." *Gonzales*, 550 U.S. at 158 (internal quotation marks omitted). And the medical profession's being associated with so grotesque an act would undermine the public's confidence in doctors. As a result, many States have deemed the practice unethical and forbidden it, with approval from the courts. *See, e.g.,* Ohio Rev. Code §2919.151; *Women's Med. Professional Corp. v. Taft*, 353 F.3d 436, 438 (6th Cir. 2003). In so holding, these courts recognize that the States have a very real interest in "protecting the integrity and ethics of the medical profession," *Gonzales*, 550 U.S. at 157—an interest at odds with giving "abortion doctors unfettered choice in the course of their medical practice," which would "elevate" abortion doctors' "status above other physicians in the medical community," *id.* at 163.

More recently, ACOG, joined by the American Medical Association and other groups, invoked the principles of medical ethics to argue that States are *ethically required* to permit eugenic abortions. In a case now pending before the *en banc* Sixth Circuit, these groups felt it in accord with the views of their members to file an *amicus* brief calling for the invalidation of a law that prohibits doctors from performing abortions they *know* are motivated by a Down syndrome diagnosis. See *En Banc* Brief of ACOG, et al., *Preterm-Cleveland v. Acton*, No. 18-3329 (6th Cir.). Appealing to infinitely pliable principles like "beneficence" and "non-malfeasance," *id.* at 7, these

groups argued that Ohio could not pass a law designed to keep abortion, as Judge Batchelder put it in her panel dissent, from being "use[d] to cleanse" the population "of babies whom some would view—ignorantly—as sapping the strength of society." *Preterm-Cleveland v. Himes*, 940 F.3d 318, 325 (6th Cir. 2019) (Batchelder, J., dissenting) (internal quotation omitted), *vacated for rehearing en banc* 944 F.3d 630 (6th Cir. 2019).

These examples show why neither the States nor the federal government leave medical ethics to the medical profession. If they did, they would be forced to conclude that medical ethics *requires* allowing doctors to perform procedures that bear a "disturbing similarity to the killing of a newborn infant," *Gonzales*, 550 U.S. at 158 (internal quotation marks omitted), and that turn doctors into "witting accomplices to the deliberate targeting of Down Syndrome babies," *Preterm*, 940 F.3d at 326 (Batchelder, J., dissenting). These professional organizations are entitled to their views, just as the tens of millions of citizens who regard abortion as the immoral taking of an innocent life are entitled to theirs. But the organizations' views are not entitled to any more weight in the regulatory process than those of any other private citizen or private group. The agency need not dedicate special space in the Federal Register to assuaging the concerns of professional medical organizations. The

District Court's ruling, without saying so expressly, elevates the recommendations of professional organizations to something resembling law.

B. The ethical arguments raised by these groups, and relied upon by the District Court, ought to be rejected.

1. Even putting all this aside, the supposedly "grave medical ethics concerns" raised by these organizations and cited by the District Court do not withstand scrutiny. For example, the District Court quotes ACOG's objection that the ban on referrals "would put the patient-physician relationship in jeopardy by placing restrictions on the ability of physicians to make available important medical information, permitting physicians to withhold information from pregnant women about the full range of their options, and erecting greater barriers to care, especially for minority populations." Dist. Ct. APA Op. 18 (quoting AR268838). Along the same lines, the American Medical Association objected that the ban on referrals "would not only undermine the patient-physician relationship, but also could force physicians to violate their ethical obligations … to counsel patients about all of their options in the event of a pregnancy." Dist. Ct. APA Op. 18 (quoting AR269332) (alteration in original).

Again, many States' laws, including Maryland's, empower doctors *not* to give referrals or otherwise become complicit in the provision of abortions. This shows that the medical organizations' insistence that doctors have an ethical duty to refer

patients who seek an abortion referral is more aspirational than descriptive. Regardless, all of these objections fail to appreciate that Title X is a program of limited scope. It exists to provide family-planning services but *not* to facilitate or promote abortions. Any patient-physician relationship within the program is thus similarly limited, and is therefore not jeopardized by restricting the ability of physicians "to make available important medical information" [read: "to make abortion referrals"], or to "counsel patients about all of their options in the event of a pregnancy" [read: "to make abortion referrals"]. The suggestion that Title X permits doctors "to withhold information from pregnant women about the full range of their options" [read: "to refuse to counsel on or refer for an abortion"] is similarly unpersuasive. The rules "permit[] the patient to ask questions and to have those questions answered by a medical professional," 84 Fed. Reg. at 7724, they simply stop the medical professional from providing one particular piece of information—information regarding where to get an abortion—that falls outside of Title X's scope. Finally, the referral ban does not pose any "barriers to care." Title X does not prohibit providing any form of care to any patient, it just forbids promoting one procedure (an abortion) *as part of* the Title X project. Ultimately, ACOG and its peer organizations are suggesting that Title X participants must be allowed to *facilitate*

abortion—a suggestion at odds with Title X's prohibition on funding "programs where abortion is a method of family planning." 42 U.S.C. §300a-6.

In sum, given the ready availability of information about abortion and abortion providers, HHS correctly determined that "it is not necessary for women's health that the federal government use the Title X program to fund abortion referrals, directive abortion counseling, or give to women who seek abortion the names of abortion providers." 84 Fed. Reg. at 7746. Because the refusal to give this information within Title X will not jeopardize women's health, it is consistent with medical ethics.

2. The medical organizations' objections are worse than wrong; they are unavoidably discriminatory, in effect if not intent. According to the medical organizations, any doctor that declines to be complicit in abortion—any doctor who declines to make referrals or counsel on abortion, and instead tells the patient to seek advice elsewhere—engages in the unethical practice of medicine. If States or the federal government were to adopt such a view, then many people with moral objections to abortion would be unable to practice obstetrics and gynecology, and perhaps unable to practice in any other field that *might* implicate abortion.

The American Academy of Nursing, for its part, commented that HHS must "remain religiously and morally neutral in its funding, policies, and activities to

ensure that individuals [] do not receive a limited scope of services and that the ethical obligations of healthcare providers are not compromised." Dist. Ct. APA Op. 18 (quoting AR107975). The new rules are "religiously and morally neutral" in every sense that counts: they do not discriminate on the basis of religion, codify religious or moral doctrine, or otherwise take sides in religious and moral debates. All the rules do is respect the scope of Title X by declining to fund "programs where abortion is a method of family planning." 42 U.S.C. §300a-6. That has the side effect of allowing those with religious or moral objections to abortion to participate in the program. But the government does not cease to be "religiously and morally neutral" when it implements a program so as to maximize opportunities for participation by people of diverse faiths and moral views.

The contrary suggestion is appalling. So is any view of medical ethics that would drive out of the medical field any doctor, nurse, or other healthcare provider whose religious or moral views require her not to be complicit in the provision of abortion. "If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein." *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943). Let us keep it that way.

CONCLUSION

This Court should reverse the District Court.

Respectfully Submitted

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UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

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4th Cir. Case Number(s) 19-1614, 20-1215

I am the attorney or self-represented party.

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Ohio Solicitor General

UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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