No. 15-1779

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

TAMESHA MEANS,
Plaintiff-Appellant,

v.

UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, ET AL.,
Defendants-Appellees.

On Appeal from the United States District Court for the Western District of Michigan
Case No. 1:15-cv-00353 (Hon. Robert Holmes Bell)

BRIEF OF *AMICI CURIAE* OBSTETRICIAN-GYNECOLOGISTS IN SUPPORT OF PLAINTIFF-APPELLANT AND REVERSAL

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DISCLOSURE OF CORPORATE AFFILIATIONS AND FINANCIAL INTEREST

Pursuant to Federal Rules of Appellate Procedure 26.1(a) and 29(c)(1), and Sixth Circuit Rule 26.1, *amici curiae* Lori J. Day, David L. Eisenberg, Gregory L. Goyert, William A. Grobman, Cassing Hammond, Timothy R.B. Johnson, Maura P. Quinlan, Marjorie C. Treadwell, and Cosmas J. Van De Ven make the following disclosure:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? If yes, list below the identity of the parent corporation or affiliate and the relationship between it and the named party:

   No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest:

   No.

Dated: January 15, 2016

/s/ Jeffrey E. Ostrow
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STATEMENT OF INTEREST OF *AMICI CURIAE*

The *amici curiae* are doctors practicing in the area of obstetrics and gynecology. As such, *amici* have specialized knowledge of the standard of practice in obstetric care, and a professional interest in maintaining those standards. A complete list of *amici* is as follows:

Dr. Lori J. Day, MD, is Assistant Professor of Obstetrics and Gynecology at the University of Michigan. She received her medical degree from Michigan State University-College of Human Medicine, and completed her residency in Obstetrics and Gynecology and a fellowship in Maternal Fetal Medicine at the University of Iowa Hospitals and Clinics. Dr. Day is board certified in Obstetrics and Gynecology and Maternal Fetal Medicine.

Dr. David L. Eisenberg, MD, MPH, is Associate Professor of Obstetrics and Gynecology at the Washington University School of Medicine in St. Louis. He received his medical degree from the University of Alabama School of Medicine, completed his residency in Obstetrics and Gynecology at Northwestern University, and a fellowship in Family Planning and Contraception at Northwestern University Feinberg School of Medicine. He also holds a Master's in Public Health from Northwestern University. Dr. Eisenberg is board certified in Obstetrics and Gynecology and specializes in Gynecologic Surgery, General Gynecology, and Family Planning and Contraception. He has received numerous

teaching awards and been recognized in *St. Louis Magazine*'s "Best Doctor's in St. Louis" and *The Best Doctors in America*® annually since 2013.

Dr. Gregory L. Goyert, MD, is an Obstetrician-Gynecologist at Henry Ford Hospital in Detroit, Michigan. He received his medical degree from the University of Michigan Medical School, and completed his residency in Obstetrics and Gynecology and a fellowship in Maternal Fetal Medicine at Wayne State University. Dr. Goyert is board certified in Obstetrics and Gynecology and Maternal Fetal Medicine.

Dr. William A. Grobman, MD, MBA, is the Arthur Hale Curtis, MD, Professor of Obstetrics and Gynecology at Northwestern University Feinberg School of Medicine. He received his medical degree from Harvard Medical School, completed his residency and fellowship at Northwestern McGaw/ Northwestern Memorial Hospital, and received an MBA from the Kellogg School of Management at Northwestern University. Dr. Grobman is board certified in Obstetrics and Gynecology and Maternal Fetal Medicine.

Dr. Cassing Hammond, MD, is Associate Professor of Obstetrics and Gynecology at Northwestern University Feinberg School of Medicine. He received his medical degree from the University of Missouri-Kansas City and completed his residency at Strong Memorial Hospital, which is part of the University of Rochester Medical Center. Dr. Hammond is board certified in

Obstetrics and Gynecology, and directs the Northwestern Center for Family Planning and Contraception.

Dr. Timothy R.B. Johnson, MD, is the Bates Professor of the Diseases of Women and Children and Chair of Obstetrics and Gynecology at the University of Michigan. He is also Arthur F. Thurnau Professor, Professor of Women's Studies, and Research Professor in the Center for Human Growth and Development. He received his medical degree from the University of Virginia, completed his residency in Obstetrics and Gynecology at the University of Michigan Health System, and a fellowship in Maternal Fetal Medicine at Johns Hopkins Hospital. In 2005, Dr. Johnson was awarded the Distinguished Service Award, the highest honor of the American College of Obstetricians and Gynecologists. He is Past President of the Association of Professors of Gynecology and Obstetrics, an elected member of the National Academy of Medicine, and board certified in Obstetrics and Gynecology and Maternal Fetal Medicine.

Dr. Maura P. Quinlan, MD, MPH, is Assistant Professor of Obstetrics and Gynecology at Northwestern University Feinberg School of Medicine. She received her medical degree from Loyola University Stritch School of Medicine, completed her residency in Obstetrics and Gynecology at the University of Chicago Hospitals, and received a Master's in Public Health from Yale University. Dr. Quinlan is Chair of the Illinois Section of the American College of

Obstetricians and Gynecologists and is board certified in Obstetrics and Gynecology.

Dr. Marjorie C. Treadwell, MD, is Professor of Obstetrics and Gynecology at the University of Michigan. She received her medical degree from the University of Michigan Medical School, and completed her residency in Obstetrics and Gynecology and a fellowship in Maternal Fetal Medicine at Hutzel Women's Hospital, which is part of the Detroit Medical Center. Dr. Treadwell is board certified in Obstetrics and Gynecology and Maternal Fetal Medicine.

Dr. Cosmas J. Van De Ven, MD, is Professor of Obstetrics and Gynecology at the University of Michigan. He received his medical degree from the University of Leiden, completed his residency in Obstetrics and Gynecology at Henry Ford Hospital, and a fellowship in Maternal Fetal Medicine at Duke University Medical Center. He is board certified in Obstetrics and Gynecology and Maternal Fetal Medicine, and his clinical interests include hypertension, preeclampsia, and critical care. Dr. Van De Ven heads the Maternal Fetal Medicine Division at the University of Michigan Health System.

Amici have no stake in the parties or in the outcome of the case.[1]

[1] No party's counsel authored this brief in whole or part; no party or party's counsel contributed money intended to fund preparing or submitting the brief; and no person other than amici, their members, or counsel contributed money intended to fund preparing or submitting the brief. Fed. R. App. P. 29(c)(5).

SUMMARY OF ARGUMENT

Organizations involved in the delivery of healthcare must ensure that their patients are provided with access to emergency medical treatment and information regarding important therapeutic alternatives. Pregnant women receiving medical care in Catholic hospitals pursuant to the Ethical and Religious Directives for Catholic Health Care Services (the "Directives") deserve no less. These women should not be categorically denied information about pregnancy termination as a medical option that may be necessary to protect and preserve their health. Nor should doctors in these hospitals be denied the ability to perform the standard emergency medical treatment clearly called for by their training. Such denials are particularly egregious where they jeopardize the very life of a pregnant woman despite no chance of a viable birth. Put simply, to the extent the Directives compel doctors to deny patients this crucial access and information, they require conduct that dramatically departs from the standard of practice in the medical profession.

For these and the reasons set forth below, *amici* urge this Court to reject the district court's opinion. Any entity that establishes or adopts policies governing the delivery of healthcare must be held responsible for improperly placing its own interest, religious or otherwise, above that of patient health. This is particularly so where doctors are required to follow such policies regardless of the risk they present to a patient's life.

ARGUMENT

I. WHERE THE STANDARD PRACTICE OF PREGNANCY TERMINATION IS IGNORED, WOMEN LIKE TAMESHA MEANS SUFFER NEEDLESS PAIN AND DRAMATIC HEALTH RISKS

In December 2010, Plaintiff-Appellant Tamesha Means sought medical attention three times over the course of two days at Mercy Health Partners ("MHP"), a Catholic hospital subject to the Directives and the only hospital in Muskegon County, Michigan. Ms. Means first visited MHP when her water broke and she began having contractions at just 18 weeks of gestation. Doctors at the hospital diagnosed her with preterm premature rupture of membranes ("PROM"), a rupture of the amniotic sac, and oligohydramnios, a related decrease in the volume of amniotic fluid, but offered only pain medication and discharge. No one at MHP informed Ms. Means that this diagnosis represented a significant risk to her health and the near certainty that her fetus would not survive, much less explained that pregnancy termination was a standard treatment option in such circumstances. Ms. Means returned to MHP the next morning due to extreme pain and bleeding, and her treating physician suspected that she was suffering from a PROM-related bacterial infection known as chorioamnionitis, which creates serious maternal health risks including infertility and death. She was again sent home without discussion of the seriousness of her health risks or the option of pregnancy termination. That night, Ms. Means returned to the hospital once again due to

extreme pain and regular contractions. Although MHP initiated yet another discharge, Ms. Means went into an extremely painful, feet-first breech delivery at the hospital. Her baby died less than 3 hours after birth. *See* Complaint, *Means v. U.S. Conference of Catholic Bishops*, No. 1:15-cv-00353-RHB, ¶¶ 2-3, 12-49 (W.D. Mich. Nov. 29, 2013), ECF No. 1 [hereinafter Complaint].

Preterm PROM broadly describes a rupture of membranes before 37 weeks of gestation and complicates approximately 3% of pregnancies in the United States. American College of Obstetricians and Gynecologists ("ACOG"), Practice Bulletin No. 160, *Premature Rupture of Membranes*, 127 Obstetrics & Gynecology e39, e39 (2016). More narrowly, periviable PROM describes the rupture of maternal membranes between 14 and 24 weeks of gestation. Thaddeus P. Waters & Brian M. Mercer, *The Management of Preterm Premature Rupture of the Membranes Near the Limit of Fetal Viability*, 201 Am. J. of Obstetrics & Gynecology 230, 230 (2009), *available at* http://www.ajog.org/article/S0002-9378(09)00693-0/pdf. Further, a delivery that is within this range but prior to 20 weeks of gestation is not yet even considered periviable, *i.e.*, *near* the limit of viability. ACOG/Society for Maternal-Fetal Medicine ("SMFM"), *Periviable Birth*, 213 Am. J. of Obstetrics & Gynecology 604, 604 (2015), *available at* http://www.ajog.org/ article/S0002-9378(15)00905-9/pdf. For such unequivocally

*pre*viable deliveries, like that of Ms. Means at 18 weeks, there is no chance of neonatal survival.

Although previable PROM occurs in less than 1% of pregnancies, it frequently leads to serious maternal health complications. ACOG, Practice Bulletin No. 160, *supra*, at e40. One specific complication is chorioamnionitis, also known as intraamniotic infection, a diagnosis that Ms. Means' physician suspected and that was later confirmed by her placental pathology report. Complaint ¶¶ 38, 47. This inflammation of the fetal membranes occurs in approximately 15-25% of women with preterm PROM, and the incidence of infection is even higher for women at earlier gestational stages like Ms. Means. ACOG, Practice Bulletin No. 160, *supra*, at e40; *see also* Waters & Mercer, *supra*, at 231 (noting an approximately 37% incidence of chorioamnionitis after periviable PROM). Due to the serious maternal health risks associated with it, clinical chorioamnionitis is among the "clear indications for delivery" and, in cases of previable PROM, "[i]mmediate delivery *should be offered*." ACOG, Practice Bulletin No. 160, *supra*, at e42, e45 (emphasis added).[2]

[2] Other significant complications from previable PROM include endometritis (inflammation of the lining of the uterus), abruptio placentae (premature separation of the placenta from the uterus), retained placenta (when all or part of the placenta stays inside the uterus after birth), and maternal sepsis (a whole-body inflammatory response to infection). *See id*. at e40. The long-term consequences of these complications can include infertility, recurrent miscarriage (early

II. INSTITUTIONAL CONSCIENCE CANNOT EXCUSE THE FAILURE TO MEET THE CLEAR STANDARD OF PRACTICE

In repeatedly discharging Ms. Means without raising even the possibility of pregnancy termination, the care provided at MHP fell short of the clear standard of practice for previable PROM. To the extent the Directives were responsible for this failure, they contradict broadly recognized medical standards of ethics and professionalism, regardless of their foundation in religious belief. Perhaps most fundamentally, when an individual comes to a hospital with an emergency medical condition, the hospital has a legal obligation under the Emergency Medical Treatment and Active Labor Act to provide treatment to stabilize that condition, that is, to prevent the likelihood of further "material deterioration of the condition." *See* 42 U.S.C. § 1395dd. This federal law makes no exception for a hospital's religious objection to a particular treatment, or for any other refusal to treat based on individual or institutional conscience.

Moreover, doctors themselves report that the Directives compromise their ability to provide the treatment that they believe is necessary for their patients, including in emergency situations precisely like the one Ms. Means faced. Indeed, one national survey found that 52% of obstetrician-gynecologists working in Catholic hospitals experience some level of conflict with the Directives' impact on

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pregnancy loss), pelvic pain, dysmenorrhea, mental health conditions, and even death.

the care they can provide. Lori R. Freedman & Debra B. Stulberg, *Conflicts in Care for Obstetric Complications in Catholic Hospitals*, Am. J. of Bioethics Primary Res., Oct.-Dec. 2013, at 1, 1, *available at* http://www.tandfonline.com/doi/pdf/10.1080/21507716.2012.751464. In-depth interviews conducted during a separate study revealed some physicians' "outright shock about the way the Directives impacted their ability to offer treatment to women experiencing certain obstetric emergencies, such as pregnancy-related health problems, miscarriage, or previable premature rupture of membranes." *Id*. at 4. Physicians who "did not consider themselves abortion providers or even necessarily abortion rights supporters" still experienced conflict with Catholic hospitals over the provision of "what the physician considered to be standard and morally acceptable treatment for women with these pregnancy complications." *Id*. at 7. In fact, "even the providers most opposed to abortion" noted Catholic hospitals' failure to "draw a moral distinction between emergency obstetric care and abortion," and to respect that they "were trained to offer or even recommend treatments that help bring about the end of pregnancy" when faced with serious "maternal health risks such as cancer or infection." *Id*.[3]

[3] *See also* Council on Resident Educ. in Obstetrics and Gynecology, *Educational Objectives: Core Curriculum in Obstetrics and Gynecology* 17, 78 (10th ed. 2013) (requiring that accredited comprehensive residency education in obstetrics and gynecology include learning "to counsel pregnant patients on alternatives available

Further, in the medical profession broadly, it is accepted that "[t]he relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, . . . holding the best interests of the patient as paramount." American Medical Association ("AMA"), Code of Medical Ethics, Opinion 10.015, *The Patient-Physician Relationship*, *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page?. In practice, this means that organizational objections to particular procedures do not limit the ethical obligation to (1) provide a patient with the information to weigh—***for herself***—the proper course of treatment, and (2) facilitate the delivery of such treatment. Although "the dictates of conscience . . . [are] important for preserving the integrity of the medical profession," they do not abridge duties to "inform the patient about all relevant options for treatment" that "a patient might otherwise reasonably expect the practice to offer," and to either "refer a patient to another physician or institution to provide treatment the physician declines to offer" or "offer impartial guidance to patients about how to inform themselves regarding access to desired services." AMA, Code of Medical Ethics, Opinion 10.06, *Physician Exercise of Conscience*,

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to them, including induced abortion," even for those "who decide not to provide this service because of a moral objection").

available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1006.page?.

These general principles of medical ethics are both explicitly recognized and especially significant in the field of reproductive medicine, where "[c]onscientious refusals have been particularly widespread." ACOG, Committee Opinion No. 385, *The Limits of Conscientious Refusal in Reproductive Medicine* 1 (Nov. 2007). In this context in particular, "conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients" and "should be accommodated only if the primary duty to the patient can be fulfilled." *Id*. As such, medical institutions and organizations involved in reproductive medicine cannot deny emergency care to pregnant women and otherwise have an express ethical obligation to ensure "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." *Id*. at 4-5; *see also* ACOG/SMFM, *Periviable Birth*, *supra*, at 608 (noting generally that in treating even periviable birth, "the option of pregnancy termination should be reviewed with the patient" and that although "institutions may have objections to discussing or providing this option, . . . there should be a system in place to allow families to receive counseling about their options and access to such care.").

The Directives, like any other policies governing the provision of healthcare, cannot both impose religious beliefs on unaware patients and comport with mainstream medical ethics. Rather, ethical conscientious refusal policies must be designed so as to preserve, not subvert, informed patient decisions and ensure that doctors can provide the emergency care they deem necessary. To the extent the Directives erect boundaries to emergency procedures and referral systems for patients like Ms. Means, whose primary medical resource is a Catholic hospital, *see* Complaint ¶¶ 2, 15 (noting that MHP is the only hospital within thirty minutes of her home or in Muskegon County, Michigan), they violate an unambiguous duty to those patients.

III. TERMINATION REPRESENTS AN IMPORTANT OPTION IN THE FACE OF SEVERAL PREGNANCY COMPLICATIONS AND PREEXISTING MATERNAL MEDICAL CONDITIONS

Beyond the complications that Ms. Means faced, a variety of other pregnancy complications and preexisting maternal medical conditions worsened by pregnancy also represent serious health risks that may necessitate pregnancy termination to protect a woman's life or health. Thus, in these cases too, when the Directives exclude termination from counseling discussions and emergency treatment options, they further deprive pregnant women of critical healthcare.

Another critical complication that can arise in the context of previable and periviable pregnancy is the hypertensive disorder preeclampsia, which is a "leading

cause" of illness and death for pregnant women worldwide. Steven G. Gabbe et al., Obstetrics: Normal and Problem Pregnancies 822 (Saunders, 6th ed. 2012). The rate of preeclampsia has increased 25% domestically in the last twenty years, and it remains a serious medical condition. ACOG, *Preeclampsia and Hypertension in Pregnancy: Resource Overview*, *available at* http://www.acog.org/Womens-Health/Preeclampsia-and-Hypertension-in-Pregnancy. Preeclampsia can lead to seizures—a condition known as eclampsia—and hemolysis, elevated liver enzymes, and low platelet count, or HELLP syndrome, a life-threatening situation in which "red blood cells are damaged or destroyed, blood clotting is impaired, and the liver can bleed internally." ACOG, FAQ No. 34, *Preeclampsia and High Blood Pressure During Pregnancy* (Sept. 2014), *available at* http://www.acog.org/ Patients/FAQs/Preeclampsia-and-High-Blood-Pressure-During-Pregnancy.

Like PROM, preeclampsia represents a serious risk to maternal health and thus requires medical counseling that includes the option of pregnancy termination. Specifically, pregnant women suffering from this complication must understand that medical practice clearly recognizes immediate delivery as an appropriate course of treatment. *See* Robert K. Creasy et al., Creasy and Resnik's Maternal-Fetal Medicine: Principles and Practice 770-71 (Saunders, 7th ed. 2013). Indeed,

where preeclampsia worsens early in pregnancy, "prompt delivery will be needed." ACOG, FAQ No. 34, *supra*.

Placenta accreta, also known as a morbidly adherent placenta, represents yet another pregnancy complication that may warrant termination in the interest of maternal health. In this "potentially life-threatening" condition, "part of the placenta, or the entire placenta, invades and is inseparable from the uterine wall." ACOG, Committee Opinion No. 529, *Placenta Accreta* 1 (July 2012). The incidence of placenta accreta has increased in recent years, and it carries a maternal mortality rate of up to 7%. *Id.* (noting incidence of 1 in 533 pregnancies during 1982 to 2002). Moreover, many patients with placenta accreta in the setting of placenta previa, where the placenta covers or extends close to the cervix, ultimately "require emergency preterm delivery" due to the "sudden onset of massive hemorrhage." *Id.* at 2. Thus, patient counseling "should include discussion of the potential need for hysterectomy, the risks of profuse hemorrhage, and possible maternal death." *Id*. at 3. In emergency situations, such as where there is profuse bleeding early in the pregnancy, termination is the standard of care. *See* Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 Am. J. of Pub. Health 1774, 1775 (2008).

Additional significant pregnancy complications and preexisting maternal medical conditions worsened by pregnancy are described below:

- **Thromboembolic Disease:** Venous thromboembolism ("VTE"), the formation of blood clots in the vein, accounts for almost 20% of pregnancy-related deaths of women in the United States. *See* Creasy et al., *supra*, at 906. One study reported a prevalence of 1 per 1627 births, with 77% of those cases involving deep venous thrombosis and 23% involving acute pulmonary embolism. *Id.* Pregnancy termination may be required for a pregnant woman with VTE, especially when continuing the pregnancy will significantly threaten her life or health. Freedman et al., *supra*, at 1775.
- **Hemorrhage:** Obstetrical hemorrhage "is one of the leading causes of maternal morbidity and mortality throughout the world." Gabbe et al., *supra*, at 415. In addition to placenta accreta and placenta previa discussed above, another form that such bleeding may take is abruptio placentae, in which the placenta separates from the wall of the uterus before birth. *See* Creasy et al., *supra*, at 738-39. The "overall incidence" of abruptio placentae is 1 in 100 births, Gabbe et al., *supra*, at 417, and placental abruption may constitute a medical emergency that requires immediate treatment, ACOG, FAQ No. 34, *supra*, including pregnancy termination, *see* Freedman, et al., *supra*, at 1776-77; *see also* Gabbe et al., *supra*, at 419 (noting complications including "blood loss, consumptive coagulopathy [a condition that can cause excessive clotting and severe bleeding], need for transfusion, end-organ damage, and death").

- **Cardiovascular Disease:** Cardiovascular diseases that complicate pregnancy include pulmonary hypertension, congenital obstructive lesions, rheumatic heart disease, aortic valve disease, cardiomyopathy, coronary artery disease, heart failure, and Marfan syndrome. *See* Creasy et al., *supra*, at 852, 861, 865-66, 868-69, 871-74. In particular, women with Eisenmenger syndrome, Marfan syndrome with a dilated aorta, and pulmonary hypertension with right heart dysfunction have "a very high risk for maternal mortality." Gabbe et al., *supra*, at 848. Standard care for these complications is to offer the option to terminate. *See* Freedman & Stulberg, *supra*, at 6.
- **Malignant Diseases:** Pregnancy complicated by cancer is not uncommon. *See* Gabbe, et al., *supra*, at 1063 (noting around 1 in 1000 pregnancies are complicated by cancer). The most prevalent forms found in a pregnant patient are breast cancer, cervical cancer, melanoma, ovarian cancer, thyroid cancer, leukemia, lymphoma, and colorectal cancer. *Id.* Moreover, the standard care, especially when the patient requires immediate cancer treatment, is to "offer or even recommend treatments that help bring about the end of pregnancy." Freedman & Stulberg, *supra*, at 4, 7.

CONCLUSION

For the foregoing reasons, *amici* urge the Court to reject the district court's decision.

Dated: January 15, 2016

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitations of Fed. R. App. P. 29(d) and 32(a)(7)(B) because it contains 3,704 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

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

Dated: January 15, 2016

/s/ Jeffrey E. Ostrow
Jeffrey E. Ostrow

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on January 15, 2016, I electronically filed the foregoing document through the court's electronic filing system, and that it has been served on all counsel of record through the court's electronic filing system.

/s/ Jeffrey E. Ostrow
Jeffrey E. Ostrow

Counsel for Amici Curiae