No. 19-417

IN THE

Supreme Court of the United States

EMW WOMEN'S SURGICAL CENTER, P.S.C., *et al.*,

Petitioners,

v.

ADAM MEIER,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF OF BIOMEDICAL ETHICISTS RUTH R. FADEN, PH.D., M.P.H., ET AL., AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

B. JESSIE HILL
Counsel of Record
CASE WESTERN RESERVE UNIVERSITY
SCHOOL OF LAW
11075 East Boulevard
Cleveland, OH 44106
(216) 368-0553
bjh11@case.edu

Counsel for Amici Curiae

292123

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

TABLE OF CONTENTS

TABLE OF CITED AUTHORITIES

Page

CASES

STATUTES

RULES

OTHER AUTHORITIES

Cited Authorities

Page

Page

INTEREST OF AMICI CURIAE

Amici curiae are 137 scholars in the field of biomedical ethics. They hold appointments across the United States at a variety of universities; in bioethics institutes and programs; in schools of medicine, public health, nursing, and law; and in departments of philosophy, among others.

They submit this brief in support of Petitioners EMW Women's Surgical Center, P.S.C., et al., in order to inform the Court about the principles of biomedical ethics, particularly in relation to the history and tradition of informed consent. Amici believe that their shared knowledge of bioethical principles, including the historical scope and moral purposes of informed consent, can shed light on the question whether Kentucky House Bill 2, also known as the Ultrasound Informed Consent Act ("H.B. 2"), is in fact an informed consent requirement. *See Nat'l Inst. of Fam. & Life Advocs. v. Becerra*, 138 S. Ct. 2361, 2373 (2018) (stating that traditional informed consent requirements constitute an exception to the rule of searching First Amendment scrutiny for laws compelling physician speech).

A full list of Amici is attached as an appendix to this brief.[1]

---

1. Pursuant to Sup. Ct. R. 37.6, Amici state that no party's counsel authored the brief in whole or in part, and no party's counsel contributed money that was intended to fund preparing or submitting the brief. Greg Rose and Pat Wilson, two individuals who are not affiliated with any party or counsel for any party, contributed funds to cover the cost of preparing and submitting the brief. All parties have been given at least 10 days' notice of Amici's intention to file and have consented to the filing of this brief.

SUMMARY OF THE ARGUMENT

Longstanding principles of biomedical ethics require that the patient's autonomy and well-being are at the center of the informed consent process. That process consists of a dialogue between the patient and the physician[2]—a dialogue designed to provide the patient with an understanding of the nature, risks, and benefits of the medical intervention, as well as of alternatives to the intervention. This understanding enables the patient to make a medical decision that aligns with her own values, beliefs, and interests.

H.B. 2, which mandates that particular information be given to patients who are lying on the examination table, half-naked, usually in the midst of a vaginal ultrasound probe, before receiving an abortion, bears no relationship to the traditional, established understanding of informed consent. H.B. 2 compels doctors, in every case, to perform an ultrasound and describe the physical features of the fetus, as well as to play the sound of the fetal heartbeat, regardless of the patient's wishes. In so doing, H.B. 2 violates the core moral principles of respect for patients and their autonomy, beneficence, and nonmaleficence that are widely recognized as foundational to biomedical ethics. Moreover, by providing that patients may avoid the mandated information, but *only* by covering their ears

2. In some circumstances, the physician may delegate responsibility for obtaining informed consent to another medical professional, such as a medical resident or a physician assistant, who works closely with the physician. However, because primary responsibility for ensuring informed consent remains with the physician, this brief uses only the term "physician" or "doctor" when describing the informed consent process.

and closing their eyes, H.B. 2 undermines any possible argument that the mandated information is somehow essential to patients' understanding of the nature, risks, or benefits of the abortion procedure. Finally, by violating the trust between physicians and their patients and creating a risk that doctors will be legally compelled to cause harm and distress to their patients, H.B. 2 forces doctors to violate their professional ethical duties.

ARGUMENT

I. H.B. 2 Bears No Relationship to the Traditional Principle of Informed Consent.

Kentucky's Ultrasound Informed Consent Act imposes certain requirements on medical personnel before an abortion can be performed. In particular, at least twenty-four hours prior to the procedure, an ultrasound must be performed, and the physician must display the ultrasound so that it is visible to the patient. Ky. Rev. Stat. §§ 311.725(1), 311.727(2). Then, the physician is required to "[p]rovide a simultaneous explanation of what the ultrasound in depicting," including "a medical description of the ultrasound images, which shall include the dimensions of the embryo or fetus and the presence of external members and internal organs, if present and viewable." *Id.* § 311.727(2)(b), (e). In addition, the physician must "[a]scultate [*sic*] the fetal heartbeat … so that the pregnant woman may hear the heartbeat if the heartbeat is audible." *Id.* § 311.727(2)(d). There is no exception other than for a medical emergency; thus, the physician must perform this ritual regardless of whether the woman wishes to receive the information or whether the physician believes it is appropriate to provide this information. *Id.*

§ 311.727(5). The statute merely provides that nothing "prevent[s] the pregnant woman from averting her eyes from the ultrasound images or requesting the volume of the heartbeat be reduced or turned off." *Id.* § 311.727(3). These requirements are in addition to the informed consent requirements imposed by Kentucky law which require that, at least twenty-four hours prior to an abortion, the woman be provided with information such as the probable gestational age of the fetus or embryo and the risks of and alternatives to the procedure. *Id.* § 311.725(1).

Notwithstanding its name, the Ultrasound Informed Consent Act is simply not recognizable as an informed consent requirement. Informed consent is a concept that carries a long pedigree; it has developed over decades of study and practice in fields such as medicine, law, philosophy, and biomedical ethics. Central to the practice of informed consent is the principle of respect for patient autonomy—meaning that the patient must be treated in such a way as to be able to make a decision about medical care that reflects her judgment of what is in her best interests. For this to occur, the patient must be both sufficiently "informed" to be able to determine her best interests, and she must give free and voluntary "consent" to the medical intervention. H.B. 2 advances neither of these prongs of the traditional informed consent requirement.

A. History, Scope, and Purpose of Informed Consent

Informed consent is one component of the ethical provision of medical treatment. It falls under the larger umbrella of biomedical ethics, which is the study of ethical

issues in clinical care, biomedical science, and public health and health policy. Informed consent also falls under the more particular umbrella of medical ethics, which focuses singularly on the ethics of the doctor-patient relationship and the moral obligations of physicians. There is general consensus that four moral principles play a critical role in biomedical ethics broadly, and medical ethics in particular: respect for autonomy, beneficence, nonmaleficence, and justice.[3] Autonomy refers to "an individual's right to hold views, to make choices, and to take actions based on her own personal values and beliefs."[4] The principles of beneficence and nonmaleficence are essentially two aspects of the same overriding idea—that the physician must act in ways that promote the patient's well-being. Specifically, beneficence refers to the physician's obligation to act in ways that are likely to advance the welfare of the patient and thereby benefit the patient, and nonmaleficence refers to the physician's obligation to avoid harming the patient. Finally, the principle of justice refers to the physician's obligation to treat all patients equitably and may require consideration of how scarce resources should be allocated.[5] As discussed at greater length below, the moral foundations of informed consent rest on the first three of these principles, and H.B. 2 clearly violates those principles.

---

3. Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* (8th ed. 2019).

4. Am. Coll. of Obstetricians & Gynecologists ("ACOG"), Comm. on Ethics, Comm. Op. No. 390: Ethical Decision Making in Obstetrics and Gynecology, at 3 (Dec. 2007, reaffirmed 2019), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co390.pdf?dmc=1&ts=20191017T1741361149.

5. *Id.* at 4-5.

"The values underlying informed consent—autonomy and concern for individual well-being—are deeply embedded in American culture, in our religious traditions, and in Western moral philosophy."[6] Thus, in order to understand the contemporary application of informed consent, it is important to understand its history. The current understanding and practice of informed consent derives from the long history and tradition of consent practices, policies, and theories.[7]

The modern conception of informed consent has largely developed in the twentieth century, but consent practices in connection with medical treatment stretch back much further. Although medicine in the ancient world was primarily driven by a desire to help patients and not to harm them (beneficence and nonmaleficence), even some ancient traditions appeared to take patient autonomy into consideration to some degree.[8] However, the notion that patients should be given information pertinent to their care first appeared on the scene during the Enlightenment in the eighteenth century. Although the desirability of patient understanding was not, at that time, coupled with an expectation of autonomous patient consent, physicians began in the Enlightenment era to recognize the value of information and dialogue with the patient in improving the patient's care.[9] By the middle of the nineteenth century, the practice of obtaining consent to major treatments had

6. Jessica W. Berg & Paul S. Appelbaum, *Informed Consent: Legal Theory and Clinical Practice* 14 (2d ed. 2001).

7. Ruth R. Faden, Tom L. Beauchamp & Nancy M.P. King, *A History and Theory of Informed Consent* 54 (1986).

8. *Id.* at 62-63.

9. *Id.* at 64-67.

become routine, although the notion of autonomy and its connection to consent was not yet developed.[10] In many cases, however, physicians respected patients' refusals of treatment, even when that refusal contravened the physician's beliefs and preferences.[11]

The modern concept of informed consent first appeared in American medicine over sixty years ago, in the 1950s, which is around the same time that the concept emerged in case law.[12] This emergence reflected numerous social and cultural realities. It resulted, at least in part, from horror at the Nazi atrocities during World War II, as well as at domestic cases of abuse of research subjects.[13] The rise of informed consent was also likely related to the ascendancy of the civil rights movement, with its focus on individual liberty and dignity. Since that time, medical ethics has included a focus on the patient's rights, which entails respect for the patient's autonomy. For example, the American Hospital Association's Bill of Rights, published in 1973, asserted a right of patients to be informed and to be involved in making decisions about their care.[14] In 1981, the American Medical Association published its official policy on informed consent, which recognized that "[t]he patient's right of self-decision can be

10. *Id.* at 76.

11. *Id.* at 81.

12. *Id.* at 86.

13. *Id.* at 87; *see also* Presidential Comm'n for the Study of Bioethical Issues, *Informed Consent Background* at 7-10 (Sept. 30, 2016), https://bioethicsarchive.georgetown.edu/pcsbi/sites/default/files/1%20Informed%20Consent%20Background%209.30.16.pdf.

14. Faden, Beauchamp & King, *supra*, at 94.

effectively exercised only if the patient possesses enough information to enable an intelligent choice."[15]

Around the same time, the U.S. Congress authorized creation of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, which in an influential report "used, as an axiomatic premise, the position that decisions about health care must finally rest with competent and informed patients."[16] This report thus contained the basic outline of informed consent doctrine as it is still understood today.

Building on this history, the term "informed consent" today refers to the autonomous authorization or permission-giving by the patient to the physician to do something the physician would not otherwise be permitted to do. Informed consent is both an ethical (or philosophical) concept and a legal concept. The philosophical framework for informed consent provides the moral justification for the existence of the legal requirement and therefore also provides the standard against which the legal requirement should be judged.

Informed consent serves two primary moral functions. First, obtaining informed consent demonstrates respect for patients as autonomous moral agents who have control over their bodies, their lives, and their values.[17] This notion

---

15. Judicial Council of the Am. Med. Ass'n, *Current Opinions of the American Medical Association* 29-30 (1984); *see also* Faden, Beauchamp & King, *supra*, at 96.

16. Faden, Beauchamp & King, *supra*, at 97.

17. *See, e.g.*, ACOG, Comm. on Ethics, Comm. Op. No. 439: Informed Consent, at 1 (Aug. 2009, reaffirmed 2015) ("ACOG

of honoring the patient's independent moral status thus instantiates one of the primary pillars of medical ethics: respect for patient autonomy.[18] Second, when a physician obtains a patient's informed consent, that physician promotes the patient's welfare and advances her interests. Because the physician is in a fiduciary relationship with the patient, the physician has an obligation to promote the patient's best interests—which entails a requirement that the physician understand and acknowledge the patient's priorities and values as they inform the patient's medical decision.[19] Of course, the obligation to act in the patient's best interest also includes an obligation not to inflict harm upon the patient. In advancing the patient's welfare, the physician thus applies the second and third pillars of bioethics: beneficence and nonmaleficence. Together, these two moral functions of informed consent ensure that the patient is able to act in her own best interests and that the physician is able to work to promote the patient's best interests.

Informed consent also serves a third, related function: building trust between the doctor and patient. Trust is an essential characteristic of a good doctor-patient relationship for at least two reasons. First, studies indicate that patient outcomes from treatment are not as good

---

Op. 439"), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Ethics/co439.pdf?dmc=1&ts=20160408T1635464999.

18. Alan Meisel & Mark Kuczewski, *Legal and Ethical Myths About Informed Consent*, 156 Archives of Internal Med. 2521, 2522 (1996).

19. Linda Farber Post, Jeffrey Blustein & Nancy Neveloff Dubler, *Handbook for Health Care Ethics Committees* 51 (2007).

when trust is lacking.[20] Second, even apart from outcomes, trust is a defining feature of a fiduciary relationship: in a fiduciary relationship, the patient must be able to trust that the physician is acting in her best interests and a respectful informed consent process is critical to building and maintaining that trust.[21]

For a morally meaningful informed consent to occur, the patient's authorization (consent) must be 1) her own autonomous decision and 2) based on a sufficient understanding of what is at stake for her.[22] Informed consent may be best understood as a "process" rather than an "event."[23] As the American College of Obstetricians and Gynecologists (ACOG) explains, "[i]nformed consent should be looked on as a process rather than a signature on a form," which "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."[24] Wherever possible, physicians and patients

---

20. *See, e.g.*, Ngaire Kerse et al., *Physician-Patient Relationship and Medication Compliance: A Primary Care Investigation*, 2 Ann. Fam. Med. 455, 459 (2004); *cf.* Sheldon Greenfield et al., *Expanding Patient Involvement in Care: Effects on Patient Outcomes*, 102 Ann. Internal Med. 520, 526 (1985) (finding that increased patient involvement in care resulted in improved patient outcomes).

21. Post, Blustein & Dubler, *supra*, at 51.

22. Additionally, the patient must have the mental capacity to understand and to provide that authorization. This third requirement is presumed to be present in the case of a mentally competent, mature patient.

23. Berg & Appelbaum, *supra*, at 168-73.

24. ACOG Op. 439, *supra*, at 1.

should arrive at a course of treatment through a process of shared decision-making.[25] Of course, patients typically do not approach their medical care in a relational vacuum; they often make consequential medical decisions together with their loved ones. But in the end, the final decision-making authority rests with the patient.

The requirement of an autonomous decision corresponds to the "consent" portion of informed consent. In order to be autonomous, the patient's decision must be free of coercion and pressure.[26] Specifically, there are three requirements for autonomous action: the action must be intentional; the actor must understand the nature and consequences of her action; and the action must not be controlled by anyone other than the person taking it.[27] In order to ensure these requirements are met, a physician must take care to avoid unduly influencing the patient's decisions with the physician's personal points of view that go beyond the physician's technical medical expertise. The physician is not in any way precluded by this requirement from sharing her professional medical opinion about which course of action is most likely to advance the patient's medical best interests; in most medical contexts, the physician is obligated to do just that. What is precluded is any attempt by the physician to insert her personal non-medical values into the consent process or otherwise

25. Berg & Appelbaum, *supra*, at 11 ("The concept [of informed consent] also implies that the physician must be prepared to engage in—indeed to initiate—a discussion with the patient about the available therapeutic options and to provide relevant information on them."); Meisel & Kuczewski, *supra*, at 2522.

26. Berg & Appelbaum, *supra*, at 3.

27. Faden, Beauchamp & King, *supra*, at 241-62.

attempt to influence the patient's decision in the direction of those non-medical values.

The requirement that the patient possess sufficient understanding relates to the "informed" portion of informed consent. In order for the patient's understanding to be adequate, the patient needs to know the nature of the intervention that she is consenting to, including any associated physical burdens like pain or need for bed rest; the risks (if any), including side effects; the likely benefits of the intervention (the "why" of the intervention); and alternatives to the proposed intervention. Physicians are morally required to disclose the information patients need to develop a reasonable understanding of each of these elements.

Knowing precisely how much information to provide with respect to each of these elements is a matter of medical judgment. Providing *too much* information is just as problematic as providing too little.[28] If a physician provides more information than a patient reasonably needs and can digest, this excess of information can overwhelm the patient in ways that actually undermine, rather than advance, understanding.[29] There is an extensive literature,

---

28. *See, e.g.*, N. Lynöe & K. Hoeyer, *Quantitative Aspects of Informed Consent: Considering the Dose Response Curve When Estimating Quantity of Information*, 31 J. Med. Ethics 736, 736 (2005); Ruth Macklin, *Understanding Informed Consent*, 38 Acta Oncologica 83, 85 (1999) ("Too much information can be as bad as too little; both tend to interfere with the ability of research participants to grasp what is relevant.").

29. *See* Presidential Comm'n for the Study of Bioethical Issues, *supra*, at 12.

for example, on the negative impact of lengthy informed consent forms on patient understanding. Too much information overwhelming the patient and compromising understanding is particularly likely to occur when individuals are under stress during the informed consent process. Multiple techniques have been developed to improve the disclosure component of the informed consent process and aid in patient understanding, particularly for complicated or high stakes medical decisions. Common to these techniques is a focus on the information that is most important to the basic elements of understanding relevant to informed consent.[30]

Moreover, it is perfectly consonant with the moral requirement of informed consent to respect the wishes of a patient who indicates, at a certain point, that she does not wish to receive any further information. A patient who understands *what* she is consenting to, including significant risks, side effects, and alternatives, is capable of deciding when she has heard enough information in order to authorize the intervention.[31] "Withholding information from patients when they request that it not be given respects their autonomy as much as providing information to patients who want it."[32]

---

30. *See, e.g.*, Meisel & Kuczewski, *supra*, at 2523.

31. Am. Med. Ass'n, *AMA Code of Medical Ethics,* Op. 2.1.1(b), https://www.ama-assn.org/delivering-care/ethics/informed-consent (stating that physicians seeking informed consent should "[p]resent relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information" and should include information about the diagnosis, nature and purpose of the intervention, and risks and benefits of the intervention).

32. Meisel & Kuczewski, *supra*, at 2525.

B. H.B. 2 Contravenes the Longstanding Meaning and Purpose of the Informed Consent Requirement.

The framework for patient-physician communication mandated by H.B. 2 bears no relation to the traditional concept of informed consent. It contravenes the scope of information required to ensure the patient's understanding, and it fails to respect the patient's moral agency.

First, there is no established norm of informed consent according to which a physician is required to show every patient medical images in advance of the patient's making a treatment decision. This is because the value or disvalue that medical imaging adds to patient decision-making will vary from patient to patient, and from decision context to decision context. Moreover, the information that H.B. 2 requires to be provided—such as pointing out the internal organs and external members—is not information that a woman needs in order to make an informed decision whether to terminate a pregnancy. This information does not pertain to the risks, benefits, or alternatives of abortion, and it is certainly not necessary in order for the patient to understand what an abortion procedure is. Of course, some patients may wish to view those images anyway, and it is perfectly consonant with informed consent principles to offer them for viewing and to explain them if the woman wishes. But medical imaging has never been considered to be the sort of information that patients must review prior to providing an informed consent or refusal to a medical intervention. For some patients, viewing medical imaging may even undermine their ability to focus on information that is considered important to understanding the treatment, and it may

constitute excessive information that undermines their ability to process relevant information.

Second, H.B. 2 violates patient autonomy, as well as the principles of beneficence and nonmaleficence, by mandating that the doctor continue to speak even if the patient has indicated a desire not to hear the information that is being offered. H.B. 2 requires the doctor to speak the mandated script, regardless of whether the woman objects. To be sure, a physician could properly *offer* to share the information, including auscultation of the cardiac tone and an explanation of the ultrasound image. But longstanding principles of medical ethics inclusive of informed consent dictate that if a patient does not wish to receive certain information, the physician is to stop speaking. As explained above, the patient is an autonomous, competent moral agent who is capable of deciding for herself when she has heard enough information. In prohibiting the physician from respecting the patient's wishes with respect to the kind and amount of information she wishes to receive, as dictated by her own values, H.B. 2 contravenes fundamental principles of informed consent. This assaultive, unwanted speech overrides rather than respects the patient's autonomy.

H.B. 2 also violates the principles of beneficence and nonmaleficence by forcing the physician to act in a way that is profoundly disrespectful of the patient and possibly inflicting harm. The physician's speech, which should induce the patient's trust and contribute to the patient's ability to act in her own best interests, instead causes suffering in some cases. Not only can patients sense the disrespect being afforded them, but many patients also feel distress due to the nature of the information

they are forced to receive. For example, a woman who is terminating a wanted pregnancy due to a lethal fetal anomaly may suffer deeply from being forced to view and study the features of her fetus. What is more, all of this mandated speech occurs while the woman is in an extremely vulnerable position—mostly naked, prone, on an examination table with her legs in stirrups and a probe on her abdomen or inside her vagina. There is simply no justification in medical ethics for requiring a doctor to cause such harm and distress to a patient without any offsetting benefit.

At the same time, it is impossible to understand how H.B. 2 could constitute an informed consent provision in light of the law's caveat that the woman may cover her ears and close her eyes so as to avoid the information. If the information required by H.B. 2 is so vital for the protection of the patient's rights and interests that the doctor must proceed with providing it, even in the face of objections by the patient, then how can it also be acceptable for the patient to reject the information in this manner? The Commonwealth of Kentucky cannot have it both ways: either this information is absolutely essential for every woman to have before proceeding to an abortion, or it is not. Obviously, according to traditional informed consent principles—and according to the legislation itself—it is not.

Indeed, established informed consent principles imply a measure of discretion for the doctor to tailor the information and its delivery to the particular patient before her. The doctor's overriding ethical obligation is to advance the interests of the individual patient. Thus, unless a particular piece of information is so vital to a patient's understanding that it is absolutely necessary

for every patient to receive the information, regardless of the harm the information may cause, it contradicts the practice of professional ethics to mandate that information in every case. Certainly, the information required by H.B. 2 does not fall into that category—in fact, it is irrelevant to informed consent. At the same time, if it were information necessary for informed consent, it would then make no sense to allow an abortion to proceed after a woman has chosen to reject the information by covering her ears and closing her eyes.

II. H.B. 2 Forces Physicians to Violate Their Ethical Duties to Patients.

Because the necessity to tailor medical treatment to each individual patient's interests is a general requirement of medical ethics, and not only an aspect of informed consent, H.B. 2's mandate not only lies outside the scope of informed consent, but it also forces physicians to violate their general professional ethical duties. The American Medical Association's principles of medical ethics require the physician, in caring for a patient, to "regard responsibility to the patient as paramount."[33] Yet, H.B. 2 prevents doctors from tailoring the treatment to the specific individual woman and instead mandates an unnecessary and even harmful requirement in all cases. It deprives the woman of the autonomy to direct the conversation and to seek only the information that she requires in order to make a decision in accordance with her values and beliefs.

---

33. Am. Med. Ass'n, *AMA Code of Medical Ethics,* AMA Principles of Medical Ethics ¶ VIII, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf.

To be sure, there are contexts in the practice of medicine in which it may be appropriate for a doctor to encourage a patient to seek sources of information about a medical treatment choice that extend beyond a conventional understanding of medical risks, benefits, and alternatives. For example, a patient who is resistant to the idea of undergoing a life-saving double limb amputation might be encouraged to meet with double amputees in order to better understand the experience and to gain a sense of how individuals live and flourish in that circumstance. However, if the patient declined to do so, that patient would not be forced to listen to the unwanted information anyway, or be placed in front of a video containing this information and told that she could look away and cover her ears to avoid its message. To *offer* additional sources of information that may assist patients to make decisions in alignment with their values, beliefs, and interests is the essence of the ethical practice of medicine. To *force* information on unwilling patients is the precise opposite: it is unethical medical practice.

Finally, H.B. 2 is unethical in that its mandate, in yet another way, engages the physician in conduct that lies outside the ethical bounds of the physician-patient relationship. Physicians regularly interact with patients who are emotionally vulnerable, for example, when they must deliver bad medical news or when attending to patients who are proceeding with courses of action that patients find difficult. In those contexts, the physician is obligated to do everything possible to avoid intentionally exacerbating the patient's emotional distress and help the patient cope with her emotional distress however the physician can. This is especially true if the patient needs to make and act upon a medical decision. In complying

with the mandates of H.B. 2, the physician is not only at risk of causing the harm of emotional distress to the patient and thus violating the principle of nonmaleficence; the physician is also undermining the patient's ability to proceed to a decision of her choosing. A requirement that a woman, while in a physically vulnerable state, listen to the fetal cardiac heart tone, view the fetal ultrasound, and listen to description of the fetal anatomy is designed to manipulate a woman's decision through the elicitation of disturbing emotions, essentially by inducing emotional distress, not to empower her to make a reasoned decision based on her own values. The cumulative effect of all of these factors—inducing difficult emotions in the service of contested, non-medical values; the vulnerability of the patient who is on an examination table and possibly at a stressful juncture in her life; and the coercive nature of the ultrasound mandate—is to require the physician to violate the physician's ethical responsibility toward the patient. In mandating this procedure, H.B. 2 is using the physician to force on the patient the state's values and the state's view of what is at stake in the abortion, rather than promoting the patient's understanding and autonomy.

CONCLUSION

The question whether H.B. 2 is an informed consent law is not a close one. A mandated ultrasound, accompanied by a narration and heartbeat auscultation that are required to be performed regardless of the patient's wishes and needs, reflects no understanding of informed consent that has ever existed in the long history of that concept.

For these reasons, Amici respectfully submit that this Court should grant the petition for a writ of certiorari.

Respectfully submitted,

B. Jessie Hill
Counsel of Record
Case Western Reserve University
School of Law
11075 East Boulevard
Cleveland, OH 44106
(216) 368-0553
bjh11@case.edu

Counsel for Amici Curiae

APPENDIX

APPENDIX — LIST OF AMICI CURIAE[1]

Alison Bateman-House, Ph.D., M.P.H, M.A.
Division of Medical Ethics,
Department of Population Health
NYU Langone Health

Tom L. Beauchamp, Ph.D.
Professor emeritus of Philosophy and Bioethics
Georgetown University

Edward J. Bergman, J.D.
Adjunct Assistant Professor
Perelman School of Medicine
University of Pennsylvania
Affiliated Faculty
Wharton School of Business
University of Pennsylvania

Justin Bernstein, Ph.D.
Hecht-Levi Postdoctoral Research Fellow
Berman Institute of Bioethics
Johns Hopkins University

Hilary Bok, Ph.D.
Associate Professor
Department of Philosophy
Johns Hopkins University

---

1. The institutional affiliations of Amici are supplied for the purpose of identification only. The positions set forth in this brief are solely those of Amici and not of their institutions.

Appendix

Jeffrey R. Botkin, M.D., M.P.H.
Professor of Pediatrics and Medical Ethics
University of Utah
S.J. Quinney College of Law

Dan Brock, Ph.D.
Director Emeritus
Harvard Center for Bioethics

Amy E. Caruso Brown, M.D., M.Sc., MSCS
Associate Professor of Pediatrics, Bioethics and Humanities
Center for Bioethics and Humanities
Department of Pediatrics, Division of Pediatric Hematology/Oncology
SUNY Upstate Medical University

Mara Buchbinder, Ph.D.
Associate Professor
Department of Social Medicine
University of North Carolina at Chapel Hill

Alyssa Burgart, M.D., M.A., FAAP
Medical Director, LPCH Clinical Ethics
Department of Anesthesiology, Perioperative, and Pain Management
Lucile Packard Children's Hospital at Stanford
Stanford Center for Biomedical Ethics
Stanford University

Appendix

Jean Cadigan, Ph.D.
Associate Professor of Social Medicine
Core Faculty, Center for Bioethics
University of North Carolina at Chapel Hill

Arthur Caplan, Ph.D.
Drs. William F. and Virginia Connolly Mitty
Professor of Bioethics
Director, Division of Medical Ethics,
Department of Population Health
NYU Langone Medical Center

Alisa Carse, Ph.D.
Associate Professor, Philosophy
Director of Graduate Studies, Philosophy
Faculty Affiliate, The Kennedy Institute of Ethics
Georgetown University

Kathy L. Cerminara, J.D., J.S.D.
Professor of Law
Shepard Broad College of Law
Nova Southeastern University

Helen Stanton Chapple, Ph.D., R.N., M.A., M.S.N.
Professor, Center for Health Policy and Ethics,
Professor, Interdisciplinary Studies Department
College of Nursing
Creighton University

R. Alta Charo, J.D.
Warren P. Knowles Professor of Law
University of Wisconsin Law School

Appendix

Brietta R. Clark, J.D.
Professor of Law
Loyola Law School,
Loyola Marymount University, Los Angeles

Ellen Wright Clayton, M.D., J.D.
Craig-Weaver Professor of Pediatrics
Professor of Law
Professor of Health Policy
Center for Biomedical Ethics and Society
Vanderbilt University

Carl H. Coleman, J.D., A.M.
Professor of Law
Seton Hall Law School

Dena S. Davis, J.D., Ph.D.
Endowed Presidential Chair in Health
(Humanities-Social Sciences)
Professor of Bioethics
Professor, Religion Studies
Lehigh University

Colleen Denny, M.D.
Assistant Clinical Professor
NYU School of Medicine

Douglas S. Diekema M.D., M.P.H.
Professor of Pediatrics and Bioethics & Humanities
University of Washington
Director of Education, Treuman Katz
Center for Pediatric Bioethics
Seattle Children's Research Institute

Appendix

Kelly K. Dineen, R.N., J.D., Ph.D.
Director of Health Law Program
and Assistant Professor of Law
Creighton University

Greer Donley, J.D.
Assistant Professor of Law
University of Pittsburgh

Elizabeth Dzeng, Ph.D., M.D., M.P.H.
Assistant Professor, Division of Palliative Medicine
Social and Behavioral Science, Sociology Program
University of California, San Francisco (UCSF)
Visiting Research Fellow, King's College London
Department of Global Health and Social Medicine

Brownsyne Tucker Edmonds, M.D., M.S., M.P.H.
Associate Professor of Obstetrics and Gynecology
Indiana University School of Medicine

Kelly A. Edwards, Ph.D.
Affiliate Professor, Bioethics
and Environmental Health
Director, Community Engagement Core,
EDGE Center
UW Schools of Medicine and Public Health
University of Washington

Appendix

Ezekiel J. Emanuel, M.D., Ph.D.
Vice Provost for Global Initiatives
Diane v.S. Levy and Robert M. Levy
University Professor
Chair, Department of Medical Ethics
and Health Policy
Co-Director, Healthcare Transformation Institute
University of Pennsylvania

Katelyn Esmonde, Ph.D.
Hecht-Levi Postdoctoral Fellow
Johns Hopkins Berman Institute of Bioethics

Rachel E. Fabi, Ph.D.
Assistant Professor
Center for Bioethics and Humanities
SUNY Upstate Medical University

Ruth R. Faden, Ph.D., M.P.H.
Berman Institute Founder and inaugural
Andreas C. Dracopoulos Director (2014-2016)
Philip Franklin Wagley Professor
of Biomedical Ethics
Core Faculty
Berman Institute of Bioethics
Johns Hopkins University

Martha J. Farah, Ph.D.
Director, Center for Neuroscience & Society
Walter H. Annenberg Professor in the Natural
Sciences
University of Pennsylvania

Eric A. Feldman, J.D., Ph.D.
Deputy Dean for International Programs
Heimbold Professor of International Law
Professor of Medical Ethics & Health Policy
University of Pennsylvania Law School

Robert I. Field, Ph.D., J.D., M.P.H.
Professor of Law, Kline School of Law
Professor of Health Management and Policy,
Department of Health Management and Policy,
Dornsife School of Public Health
Drexel University

Autumn Fiester, Ph.D.
Associate Professor
Associate Chair for Education & Training
Department of Medical Ethics & Health Policy
Perelman School of Medicine
University of Pennsylvania

Jill A. Fisher, Ph.D.
Associate Professor
Department of Social Medicine
and Center for Bioethics
University of North Carolina at Chapel Hill

Jacqueline Fox, J.D., LL.M.
Professor, School of Law
University of South Carolina

Appendix

Lori Freedman, Ph.D.
Associate Professor
University of California, San Francisco
ANSIRH/Bixby/ Department of Obstetrics,
Gynecology and Reproductive Sciences

Lance Gable, J.D., M.P.H.
Associate Professor of Law
Wayne State University Law School

Elena Gates, M.D.
Professor
Department of Obstetrics, Gynecology
and Reproductive Sciences
University of California, San Francisco

Gail Geller, Sc.D., M.H.S.
Professor, Berman Institute of Bioethics
and School of Medicine
Johns Hopkins University

Leonard H. Glantz, J.D.
Professor Emeritus of Health Law, Bioethics
and Human Rights
Boston University School of Public Health

Sara F. Goldkind, M.D., M.A.
Research & Clinical Bioethics Consultant
Goldkind Consulting, L.L.C.
Former Senior Bioethicist at FDA,
Office of the Commissioner

Appendix

Jesse Goldner, J.D.
John D. Valentine Professor of Law Emeritus
Saint Louis University

Melissa M. Goldstein, J.D.
Associate Professor
Department of Health Policy and Management
Milken Institute School of Public Health
George Washington University

Kenneth W. Goodman, Ph.D.
Professor and Director, Institute for Bioethics
and Health Policy
University of Miami

Susan Dorr Goold, M.D., M.H.S.A., M.A., FACP
Professor of Internal Medicine and Health
Management and Policy
Center for Bioethics and Social Sciences in Medicine
University of Michigan

Mark Greene, Ph.D.
Department of Philosophy
University of Delaware

Leslie C. Griffin, Ph.D., J.D.
William S. Boyd Professor of Law
University of Nevada, Las Vegas
William S. Boyd School of Law

Lindsey Grubbs, Ph.D.
Hecht-Levi Postdoctoral Fellow
Berman Institute for Bioethics
Johns Hopkins University

Mitra Haeri, M.D., MBE
University of Maryland Medical Center
Department of Neurology

Lisa H Harris, M.D., Ph.D.
F. Wallace and Janet Jeffries Collegiate
Professor of Reproductive Health
Department of Obstetrics and Gynecology
Professor, Department of Women's Studies
University of Michigan

Yaniv Heled, J.S.D.
Associate Professor of Law
Co-Director, Center for Intellectual Property
Center for Law, Health & Society
Georgia State University College of Law

Leslie Meltzer Henry, J.D., Ph.D.
Professor of Law
University of Maryland Carey School of Law
Core Faculty
Johns Hopkins Berman Institute of Bioethics

Laura Hermer, J.D., LL.M.
Professor of Law
Mitchell Hamline School of Law

Appendix

Diane E. Hoffmann, J.D., M.S.
Jacob A. France Professor of Health Law
Director, Law & Health Care Program
University of Maryland Carey School of Law

Sharona Hoffman, J.D., LL.M., S.J.D.
Professor of Law & Bioethics
Edgar A. Hahn Professor of Jurisprudence
Co-Director, Law-Medicine Center
Case Western Reserve University School of Law

Nicole Huberfeld, J.D.
Professor of Health Law, Bioethics & Human Rights
Boston University School of Public Health
Professor of Law

Casey Jo Humbyrd, M.D.
Chief, Foot and Ankle Division
Johns Hopkins Orthopedics
Associate Faculty, Berman Institute of Bioethics
Johns Hopkins University

Elisa A. Hurley, Ph.D.
Executive Director
Public Responsibility in Medicine and Research
(PRIM&R)

Brian Hutler, J.D., Ph.D.
Hecht-Levi Postdoctoral Fellow
Berman Institute of Bioethics
Johns Hopkins University

Adnan A. Hyder, M.D., M.P.H., Ph.D.
Senior Associate Dean for Research
Professor of Global Health
Milken Institute School of Public Health
George Washington University

Lisa C. Ikemoto, J.D., LL.M.
Martin Luther King, Jr. Professor
UC Davis School of Law
Director, UC Davis Ethics Commons
University of California, Davis

Peter D. Jacobson, J.D., M.P.H.
Professor Emeritus of Health Law and Policy
Director, Center for Law, Ethics, and Health
University of Michigan School of Public Health
Department of Health Management and Policy

Jonathan Kahn, J.D., Ph.D.
Professor of Law and Biology
Northeastern University School of Law

Andrea Kalfoglou, Ph.D.
Associate Professor
Department of Sociology, Anthropology
& Public Health
University of Maryland Baltimore County

Nancy E. Kass, Sc.D.
Vice-Provost for Graduate and Professional Education
Johns Hopkins University
Phoebe R. Berman Professor of Bioethics
and Public Health
Johns Hopkins Berman Institute of Bioethics and
Johns Hopkins Bloomberg School of Public Health

Jaime S. King, J.D., Ph.D.
Bion M. Gregory Chair in Business Law
and Professor of Law
UC Hastings College of the Law
Associate Dean and UC Hastings Faculty Director
UCSF/UC Hastings Consortium on Law,
Science, and Health Policy

Nancy M. P. King, J.D.
Professor, Department of Social Sciences
& Health Policy
and Wake Forest Institute for Regenerative Medicine
Co-Director, Center for Bioethics, Health, & Society
and Graduate Program in Bioethics
Wake Forest University

Daniel B. Kramer, M.D., M.P.H.
Cardiac Electrophysiology
Assistant Professor of Medicine
Harvard Medical School

Joan H. Krause, J.D.
Dan K. Moore Professor of Law
University of North Carolina at
Chapel Hill
School of Law

Rebecca Kukla, Ph.D., M.A.
Professor of Philosophy
Senior Research Scholar in the
Kennedy Institute of Ethics
Georgetown University

Emily A. Largent, J.D., Ph.D., R.N.
Assistant Professor of Medical Ethics
and Health Policy
Department of Medical Ethics and Health Policy
Perelman School of Medicine
University of Pennsylvania

Sylvia A. Law, J.D.
Elizabeth K. Dollard Professor of Law,
Medicine and Psychiatry, Emerita
Co-Director, Arthur Garfield Hays
Civil Liberties Program
NYU Law School

Joan Liaschenko, Ph.D., R.N., HEC-C, FAAN
Professor, Center for Bioethics and School of Nursing
Director, Ethics Consult Service
Co-Chair, Ethics Committee
University of Minnesota M Health, Fairview

Margaret Little, Ph.D.
Senior Research Scholar, Kennedy Institute of Ethics
Professor, Philosophy Department
Georgetown University

Holly Fernandez Lynch, J.D., MBe
John Russell Dickson, MD Presidential Assistant
Professor of Medical Ethics
Assistant Faculty Director of Online Education
Department of Medical Ethics and Health Policy
Perelman School of Medicine
University of Pennsylvania

David Magnus, Ph.D.
Thomas. A. Raffin Professor of Medicine and
Biomedical Ethics and Professor of Pediatrics
Director, Center for Biomedical Ethics
Stanford University

Maya Manian, J.D.
Visiting Professor, Howard University School of Law
Ph.D. Candidate, Medical Sociology
Department of Social and Behavioral Sciences
University of California, San Francisco

Wendy K. Mariner, J.D., LL.M., M.P.H.
Edward R. Utley Professor of Health Law
Boston University School of Public Health
Professor of Law
Boston University School of Law
Professor of Medicine
Boston University School of Medicine

Mary Faith Marshall, Ph.D., HEC-C, FCCM
Emily Davie and Joseph S. Kornfeld Professor and
Director, Center for Health Humanities and Ethics
Director, Program in Biomedical Ethics
Co-Director, Studies in Reproductive
Ethics and Justice
Professor of Public Health
Professor of Nursing
Professor of Law (University Faculty)
University of Virginia

Karen J. Maschke, Ph.D.
Research Scholar
Editor, Ethics & Human Research
The Hastings Center

Anna Mastroianni, J.D., M.P.H.
Professor, School of Law, University of Washington
Adjunct Professor, Department of Bioethics and
Humanities, and Department of Pediatrics,
UW School of Medicine
Adjunct Professor, Department of Health Services,
UW School of Public Health
Associate Director, UW Institute
for Public Health Genetics

Thomas Wm. Mayo, J.D.
Altshuler University Distinguished
Teaching Professor
Professor of Law, SMU/Dedman School of Law
Adjunct Professor, Internal Medicine, UT-
Southwestern Medical School

Amy L. McGuire, J.D., Ph.D.
Leon Jaworski Professor of Biomedical Ethics
Director, Center for Medical Ethics and Health Policy
Baylor College of Medicine

Maxwell J. Mehlman, J.D.
Distinguished University Professor
Arthur E. Petersilge Professor of Law
Director, The Law-Medicine Center
Case Western Reserve University
School of Law
Professor of Bioethics
Case Western Reserve University
School of Medicine

Michelle M. Mello, J.D., Ph.D.
Professor of Law, Stanford Law School
Professor of Medicine, Center for Health
Policy/Primary Care and Outcomes Research
Department of Medicine
Stanford University School of Medicine

Maria W. Merritt, Ph.D.
Core Faculty, Johns Hopkins Berman
Institute of Bioethics
Associate Professor, Johns Hopkins
Bloomberg School of Public Health,
Department of International Health
Johns Hopkins University

Jon F. Merz, M.B.A., J.D., Ph.D.
Associate Professor
Department of Medical Ethics & Health Policy
Perelman School of Medicine at the
University of Pennsylvania

Steven H. Miles, M.D.
Professor Emeritus of Medicine and Bioethics
University of Minnesota

Carol Moeller, Ph.D.
Associate Professor of Philosophy
Moravian College

Seema Mohapatra, J.D., M.P.H.
Associate Professor
Indiana University Robert H. McKinney
School of Law

Abigail R. Moncrieff, J.D.
Visiting Scholar, Law School
University of Texas at Austin

Stephanie Morain, Ph.D., M.P.H.
Assistant Professor
Center for Medical Ethics and Health Policy
Baylor College of Medicine

Appendix

Jonathan D. Moreno, Ph.D.
David and Lyn Silfen University Professor
Department of Medical Ethics and Health Policy
Department of History and Sociology of Science
Department of Philosophy (by courtesy)
University of Pennsylvania

Thomas H. Murray, Ph.D.
President Emeritus
The Hastings Center

Michelle Oberman, J.D., M.P.H.
Katharine and George Alexander Professor of Law
Santa Clara University School of Law

David Orentlicher, M.D., J.D.
Cobeaga Law Firm Professor
UNLV William S. Boyd School of Law
Director, UNLV Health Law Program

Pilar N. Ossorio, Ph.D., J.D.
Professor of Law and Bioethics
Law School and Department of Medical History and
Bioethics in the School of Medicine and Public Health
Morgridge Institute for Research,
Bioethics Scholar-in-Residence
University of Wisconsin-Madison

Lisa S. Parker, Ph.D.
Professor of Human Genetics
Director, Center for Bioethics & Health Law
University of Pittsburgh

Appendix

Wendy E. Parmet, J.D.
Matthews University Distinguished Professor of Law
Professor of Public Policy and Urban Affairs
Northeastern University

Kimani Paul-Emile, J.D., Ph.D.
Professor, Fordham University School of Law
Associate Director, Center on Race, Law & Justice
Faculty Co-Director, Stein Center for Law & Ethics

Govind Persad, Ph.D., J.D.
Assistant Professor
University of Denver Sturm College of Law

Hanna Pickard, D.Phil.
Bloomberg Distinguished Professor
of Philosophy and Bioethics
William H. Miller III Department of
Philosophy and the Berman Institute of Bioethics
Johns Hopkins University

Barbara A. Reich, J.D.
Professor of Law
Western New England University School of Law

Travis N. Rieder, Ph.D.
Assistant Director of Education Initiatives
& Research Scholar
Johns Hopkins Berman Institute of Bioethics

Appendix

Suzanne M. Rivera, Ph.D., M.S.W.
Vice President for Research
and Technology Management
Associate Professor of Bioethics
Case Western Reserve University

Jessica L. Roberts, J.D.
Leonard Childs Chair
Director, Health Law & Policy Institute
University of Houston Law Center
Professor of Medicine
University of Houston College of Medicine

Karen Rothenberg, J.D., M.P.A.
Marjorie Cook Professor Emeritus of Law
University of Maryland Carey School of Law
Visiting Professor, Johns Hopkins
Berman Institute of Bioethics

Mark A. Rothstein, J.D.
Herbert F. Boehl Chair of Law and Medicine
Director, Institute for Bioethics,
Health Policy and Law
University of Louisville School of Medicine

Lainie Friedman Ross, M.D., Ph.D.
Carolyn and Matthew Bucksbaum
Professor of Clinical Ethics
Professor, Departments of Pediatrics,
Medicine, and Surgery
Co-Director, Institute for Translational Medicine
Associate Director, MacLean Center
for Clinical Medical Ethics
University of Chicago

Appendix

Cynda H. Rushton, Ph.D., R.N., FAAN
Anne & George Bunting Professor of Clinical Ethics
Johns Hopkins University

Yashar Saghai, Ph.D., M.A.
Senior Scholar
The Millennium Project: Global
Futures Research and Studies

Nadia N. Sawicki, J.D., MBE
Georgia Reithal Professor of Law
Academic Co-Director, Beazley Institute
for Health Law and Policy
Loyola University Chicago School of Law

Harald Schmidt, Ph.D.
Assistant Professor, Department of
Medical Ethics and Health Policy
Research Associate, Center for Health
Incentives and Behavioral Economics
Perelman School of Medicine, University of
Pennsylvania

Elizabeth Sepper, J.D., L.L.M.
Professor of Law
University of Texas at Austin, School of Law

Miriam Shapiro, M.D.
Assistant Professor, Pediatrics
Affiliate Faculty, Center for Bioethics
University of Minnesota

Appendix

Margie Hodges Shaw, J.D., Ph.D., HEC-C
Associate Professor, Law and Bioethics
Division of Medical Humanities and Bioethics
University of Rochester School of
Medicine and Dentistry
University of Rochester Medical Center

Lois Shepherd, J.D.
Wallenborn Professor of Biomedical Ethics
Professor of Law, Professor of Public Health Sciences
Co-director, Studies in Reproductive
Ethics and Justice
Center for Biomedical Ethics and Humanities
University of Virginia

Michael S. Sinha, M.D., J.D., M.P.H.
Research Fellow, Harvard Medical School
Adjunct Professor of Law, Northeastern
University School of Law

Dominic A. Sisti, Ph.D.
Director, The Scattergood Program for Applied
Ethics of Behavioral Health Care
Assistant Professor, Department
of Medical Ethics & Health Policy
Perelman School of Medicine at
the University of Pennsylvania

Roy G. Spece, Jr., J.D.
John D. Lyons Professor
University of Arizona James E. Rogers
College of Law

Appendix

Kayte Spector-Bagdady, J.D., MBe
Department of Obstetrics and Gynecology
Center for Bioethics & Social Sciences in Medicine
University of Michigan Medical School

Ronit Y. Stahl, Ph.D.
Assistant Professor
Department of History
University of California, Berkeley

Lloyd Steffen, Ph.D.
Professor, Religion Studies
University Chaplain & Director, Dialogue Center/
Lehigh Prison Project
Lehigh University

Sonia M. Suter, J.D., M.S.
Kahan Research Professor
George Washington University

Lance Tibbles, J.D.
Professor of Law Emeritus
Capital University Law School

Yoram Unguru, M.D., M.S., M.A.
Division of Pediatric Hematology/Oncology
The Herman and Walter Samuelson
Children's Hospital at Sinai
Chairman, Sinai Hospital Ethics Committee
Berman Institute of Bioethics
Johns Hopkins University

Appendix

Robert M. Veatch, Ph.D.
Professor of Medical Ethics, Emeritus,
and Senior Research Scholar
The Kennedy Institute of Ethics
Georgetown University

Rebecca Walker, Ph.D.
Professor of Social Medicine
University of North Carolina at Chapel Hill

Jennifer Walter, M.D., Ph.D., M.S.
Assistant Professor of Pediatrics and Medical Ethics
University of Pennsylvania School of Medicine

Katie Watson, J.D.
Associate Professor of Medical Social Sciences,
Medical Education, and Ob/Gyn
Faculty, Medical Humanities
& Bioethics Graduate Program
Northwestern University Feinberg School of Medicine

Elliott M. Weiss, M.D., MSME
Assistant Professor of Pediatrics,
Division of Neonatology
University of Washington
Treuman Katz Center for Pediatric Bioethics
Seattle Children's Hospital & Research Institute

Danielle M. Wenner, Ph.D.
Assistant Professor of Philosophy
Associate Director, Center for Ethics & Policy
Carnegie Mellon University

Appendix

Daniel Wikler, Ph.D.
Mary B. Saltonstall Professor of Ethics
and Population Health
Department of Global Health & Population
Harvard T.H. Chan School of Public Health

Lawrence Wissow, M.D., M.P.H.
Professor
Division of Child and Adolescent Psychiatry
University of Washington

Stuart J. Youngner, M.D.
Professor of Bioethics and Psychiatry
Department of Bioethics
Case Western Reserve University