Exhibit A

NIFLA Plaintiffs' Responses to Defendant's Proposed Supplemental Findings of Fact

IN THE DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
WESTERN DIVISION

National Institute of Family and Life Advocates, *et al.*, Plaintiffs, v. Mario Treto Jr., Defendant.	Case No. 16-cv-50310 Hon. Iain D. Johnston Magistrate Judge Lisa A. Jensen
Ronald Schroeder, *et al.*, Plaintiffs, v. Mario Treto Jr., Defendant.	Case No. 17-cv-4663 Hon. Iain D. Johnston Magistrate Judge Lisa A. Jensen

NIFLA PLAINTIFFS' RESPONSES TO DEFENDANT'S PROPOSED SUPPLEMENTAL FINDINGS OF FACT

In addition to the responses below, the NIFLA Plaintiffs agree with and incorporate herein all the responses filed by the Schroeder Plaintiffs unless there is a direct conflict.

Legislative and Regulatory History of the Amendments to the Act

1. The Illinois Health Care Right of Conscience Act, 745 ILCS 70/1 *et seq.*, (the "Act") was amended amid concerns that patients experiencing miscarriages were being turned away from Catholic hospitals, causing health issues and leaving patients confused as to what medical care was needed. Def. Trial Ex. 57 at

IDFPR000352; Def. Trial Ex. 58 at IDFPR000472.[1]

Plaintiffs' response: Undisputed that the Illinois legislature considered testimony to this effect. Otherwise disputed as inadmissible hearsay.

2. The amendments to the Act protect "both patients and health care providers when a provider asserts a religious . . . objection to providing a health care service." Def. Trial Ex. 66 at 5:18–21.

Plaintiffs' response: Dispute that the amendments protect health care providers like plaintiffs because they require them to violate their religious beliefs by talking about the benefits of abortion and facilitating access to it—which Defendant does not dispute. Def.'s Resp. to NIFLA Pls.' Suppl. Findings of Facts 5, ¶¶ 18–19, ECF No. 275-2; Def.'s Resp. to Schroeder Pls.' Suppl. Facts 26–27, ¶¶ 43–44, ECF No. 275-3.

3. During an Illinois House of Representatives Committee Hearing, a constituent testified about her traumatic experience when Catholic hospitals refused to terminate her pregnancy in the midst of a miscarriage, despite experiencing pregnancy complications that threatened her life and fertility. Def. Trial Ex. 66 at 13:8–16:12.

Plaintiffs' response: Undisputed that a constituent testified that she thought "these complications could threaten not only my future fertility, but also my life." Disputed that her testimony establishes that the complications actually did so as that is unsupported by the cited testimony and inadmissible hearsay.

4. The constituent testified that, for religious reasons, her doctors and hospital would not help her end the pregnancy, refused to provide a referral to another hospital or provider even though the procedure was medically necessary, and did not counsel her about any options "other than waiting to get sick enough for them

[1] A list of the exhibits that Defendant cited and filed in support of this submission can be found in the Appendix at the end of this document.

to help." Def. Trial Ex. 66 at 14:5–15:20.

Plaintiffs' response: Disputed. The constituent did not testify that the hospital and providers refused to provide a referral to another hospital or refused to counsel her about her options. She testified that the only reason she didn't go to another hospital for an abortion is her insurance wouldn't cover it. Def. Trial Ex. 66 at 14:18–22, ECF No. 275-10. And she did not testify anyone refused to talk to her about options, only that they did not. *Id.* at 15:19. Otherwise undisputed.

5. The constituent testified in favor of amending the Act after she spent five weeks bleeding and being turned away for treatment until her condition qualified as an emergency. Def. Trial Ex. 66 at 15:21–16:12.

Plaintiffs' response: Disputed that she testified that she was "turned away for treatment until her condition qualified as an emergency." Otherwise undisputed.

6. At the same hearing, the chair of the Illinois section of the American College of Obstetricians and Gynecologists ("ACOG") testified that she had seen "patients who were not told about all their treatment options because of a hospital's religious directive." Def. Trial Ex. 66 at 16:17–20:8.

Plaintiffs' Response: Undisputed that was her testimony but inadmissible for the truth of it since it is hearsay that falls within no exception.

7. Before the Act's amendment, the Illinois Department of Financial & Professional Regulation ("IDFPR") also received complaints alleging that some health care personnel harmed patients by not adhering to the medical standard of care or informing patients of legal treatment options. Def. Trial Exs. 55–56, 61–62.

Plaintiffs' Response: Disputed that either of these two complaints prove the medical professionals involved failed to adhere to the medical standard of care or failed to inform patients of legal treatment options. Undisputed that IDFPR

received complaints about an anesthesiologist and a counselor from former patients.

8. IDFPR received complaints alleging that patients were harmed when health care personnel with conscience-based objections failed to refer or transfer the patients or provide them written information about other health care providers who they reasonably believe offer the requested treatment. Def. Trial Exs. 55–56, 61–62.

Plaintiffs' Response: Disputed that these two complaints involved conscience-based objections. The documents referenced do not claim the provider did not provide medical services because of conscience. Undisputed that IDFPR received complaints about an anesthesiologist and a counselor from former patients.

9. For example, in April 2014, a patient and her obstetrician had this challenge after contacting the patient's neurologist to secure a neurological clearance for general anesthesia, which the obstetrician needed to do based on the patient's medical history. Def. Trial Ex. 55.

Plaintiffs' Response: Undisputed that a neurologist refused to authorize his patient for general anesthesia for abortion because it "could result in major complications in regards to her medical health, including intracranial hemorrhage and stroke, with a high likelihood of permanent and severe brain damage and possible death." Def. Trial Ex. 56, ECF No. 275-22. Otherwise disputed.

10. The neurologist, who is licensed to practice medicine in Illinois, refused to authorize his patient for general anesthesia for an abortion because he had a conscience-based objection to abortion. Def. Trial Ex. 56.

Plaintiffs' Response: Disputed. The neurologist refused to authorize his patient for general anesthesia because it "could result in major complications in regards to her medical health, including intracranial hemorrhage and

stroke, with a high likelihood of permanent and severe brain damage and possible death." Def. Trial Ex. 56. No mention is made of a conscience-based objection to abortion.

11. The neurologist told his patient that even though her doctor advised her abortion was "thought to be medically necessary[,]…[t]here is no such thing as a medically necessary abortion." Def. Trial Ex. 55.

Plaintiffs' Response: Undisputed.

12. In October 2014, IDFPR received a complaint alleging that two Illinois crisis pregnancy centers were conducting ultrasounds without a physician's orders and using "bait and switch tactics to lure people in for [medical] services they do not offer." Def. Trial Ex. 59 at IDFPR001888.

Plaintiffs' Response: Undisputed there was a complaint alleging that Care Net Pregnancy Services of Dupage County and My Choice Chicago were operating without a laboratory license, conducting ultrasound medical procedures without a physician's order, and employing practices such as bait and switch to lure people in for services. It is also undisputed that the allegation that the facility was operating without a license was determined by the IDFPR to be unsubstantiated. Def. Trial Ex. 59 at ADFPR001886, ECF No. 275-25, and the complainant apparently did not pursue the other allegations and so the matter was closed by IDFPR over a year later. *Id.* at IFDPR001940.

13. In March 2015, IDFPR received a complaint about a licensed clinical professional counselor who treated the complainant patient for over five years and, based on the counselor's religious beliefs, shamed and criticized the patient for his homosexuality. Def. Tr. Exs. 60, 62.

Plaintiffs' Response: Undisputed IDFPR received a complaint making these allegations. Otherwise disputed as inadmissible hearsay.

14. The patient told IDFPR that during therapy, he "wanted to talk

[about]…coming out of the closet as a gay man," but the counselor "would tell him that he wasn't gay" and "told [the patient] that he didn't condone it," which "made [the patient] ashamed and hurt him mentally." Def. Trial Ex. 61.

Plaintiffs' Response: Undisputed that the complainant made these allegations. Otherwise disputed as inadmissible hearsay.

15. Although the patient asked his counselor for a referral to another counselor who would understand his sexuality, the counselor declined, replying that a referral was unnecessary and that they "were doing fine." Def. Trial Ex. 62 at IDFPR001976.

Plaintiffs' Response: Disputed. The IDFPR investigator said, "I asked the complainant if he ever asked for a referral to another counselor. He said no." Def. Trial Ex. 61 at IDFPR001958, ECF No. 275-27.

16. The patient suffered two mental breakdowns during the course of treatment with the counselor, including one breakdown where the patient had to be placed in a hospital's intensive care unit. Def. Trial Ex. 62 at IDFPR001976, 78.

Plaintiffs' Response: Undisputed that the complainant made these allegations. Otherwise disputed as inadmissible hearsay.

Mission of the Plaintiff CPCs

17. Plaintiff CPCs previously provided only material support and other non-medical resources for pregnant individuals and new parents as part of their pro-life mission. Trial tr. 117:18–118:14; 158:8–159:16; 207:8–14; 215:8–16; 216:1–4; 216:21–217:14; 229:7–10; 252:4–16; 324:9–24; 381:24–382:2.

Plaintiffs' Response: Undisputed.

18. Plaintiff CPCs each chose to start offering free health care services, like ultrasounds and pregnancy testing, as part of their efforts to prevent pregnant individuals from choosing abortion. Trial tr. 95:17–96:9; 117:18–118:12; 158:21–159:16; 175:14–176:6; 207:8–23; 216:25–217:3; 252:4–16; 326:18–22; Wilson Dep.

147:17–148:13.

Plaintiffs' Response: Disputed that the Pregnancy Centers attempt "to prevent pregnant individuals from choosing abortion." That characterization is not supported by testimony cited and does not reflect the purpose of pregnancy centers which is to support women through their pregnancy and afterwards. *See, e.g.*, Trial tr. 94: 22–25. Otherwise, undisputed.

19. Plaintiff TLC provides prenatal care until the 20th week of pregnancy. Trial tr. 175:14–176:5.

Plaintiffs' Response: Undisputed.

20. Plaintiff CPCs rely on the visuals of the ultrasound itself and the health care provider's diagnoses to try to convince pregnant patients to carry to term and not have an abortion. Trial tr. 126:2–5, 207:8–23, 252:12–16, 323:5–13; 406:21–24.

Plaintiffs' Response: Undisputed.

21. Some Plaintiff CPCs changed their names after adding medical services to encourage pregnant patients considering abortion to come to their facilities. Trial tr. 117:18–118:14; 158:13–159:16; 160:5–13; 191:10–15; 217:4–14.

Plaintiffs' Response: Disputed. The record citations do not support this assertion. Undisputed that some Plaintiffs changed their names to better reflect their services.

22. Health care personnel who provide ultrasounds are often trained at pro-life organizations, including the National Institute of Family and Life Advocates ("NIFLA"). Trial tr. 163:21–164:2; 325:22–326:5; 386:18–20.

Plaintiffs' response: Undisputed.

23. In order to join NIFLA, NIFLA members abide by a standard of care specifically set by NIFLA, including agreeing not to perform or refer for abortions. Trial tr. 164:3–9.

Plaintiffs' response: Undisputed members have to agree not to perform or

refer for abortions. Otherwise disputed.

24. NIFLA provides sample documents, policies, and procedures for its members, including some Plaintiff CPCs, to use. Trial tr. 164:10–18; 352:1–4.

Plaintiffs' response: Undisputed.

Plaintiff CPC Messaging

25. Plaintiff CPCs advertise their services through their websites. Trial tr. 128:17–129:3; 166:14–17; 178:15–18; 192:24–193:3; 270:3–10; 382:17–20; Schroeder Trial Ex. 154 at Schroeder_Supp_0038.

Plaintiffs' response: Undisputed.

26. Some Plaintiff CPCs use search engine optimization, meaning they pay search engines like Google for their CPC websites to show up in response to internet searches for certain terms, such as "abortion," "clinic," "pregnancy," and "help." Trial tr. 127:21–128:23, 166:18–22.

Plaintiffs' response: Undisputed.

27. The purpose of Plaintiff CPCs paying for search engine optimization is to direct individuals who think that they are pregnant to Plaintiff CPCs' websites. Trial tr. 127:21–128:23.

Plaintiffs' response: Undisputed.

28. Plaintiff CPCs advertise that their mission is to provide pregnant individuals with complete and accurate information to make a fully informed choice about whether to carry to term or have an abortion. Trial tr. 94:21–25; 159:17–160:2; 160:13–17; 204:8–21, 269:22–271:20, 273:2–10; 369:22–370:4; 381:2–11; Def. Trial Ex. 71 at IDFPR009474; Def. Trial Ex. 38; Schroeder Trial Ex. 154 at Schroeder_Supp_0038; Def. Trial Ex. 69 at IDFPR009432; Def. Trial Ex. 70 at IDFPR009440, 9443; Def. Trial Ex. 71 at IDFPR009460, 9496, 9504; Schroeder Trial Ex. 157-01 at Schroeder_Supp_0050; Schroeder Trial Ex. 157-15 at Schroeder_Supp_0092.

Plaintiffs' response: Undisputed.

29. For example, the Options Now website tells potential patients:

a. "There's a lot of information about abortion online, making it extremely difficult to sift through what's real, what's not, what to believe and who to trust."

b. "This is especially true in Illinois, where laws are not always clear."

c. "When you're looking for abortion information, you shouldn't trust just any article you find."

d. "Place your trust in a team of licensed medical professionals, who can empower you with factual information so you can truly make the best choice for you." Schroeder Trial Ex. 154 at Schroeder_Supp_0038.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

30. Plaintiff PASS specifically claims to discuss all options with a patient for purposes of informed consent, so clients can know those options and ask questions about them. Trial tr. 357:7–17.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

31. Plaintiff CPCs do not provide complete information about abortion and do not counsel on any potential benefits abortion may offer a particular patient. Trial tr. 108:3–8; 162:22–25; 182:1–5; 205:1–3; 233:16–21; 326:23–327:13; 380:15–21.

Plaintiffs' response: Disputed. Plaintiffs are not aware of any benefits to elective abortion.

32. CPCs counsel patients about the risks of abortion, sterilization, and contraception, but not about any benefits of those procedures. Trial tr. 102:5–14;

121:20–122:2; 181:18–182:5; 205:18–206:3; 257:4–9; 258:23–259:2; 264:16–265:22; Def. Trial Ex. 40.

Plaintiffs' response: Undisputed that the NIFLA Plaintiffs counsel about the risks of abortion. Disputed that they counsel about the risks of sterilization and contraception.

33. The CPCs believe that counseling patients about the benefits of abortion or informing patients about how to access that care would make it more likely that patients would choose to have an abortion. Trial tr. 123:4–124:15.

Plaintiffs' response: Undisputed.

34. At times, Plaintiff CPCs may even overstate the risks associated with abortion to dissuade patients from having one, including exaggerating risks of infection or representing that abortion causes breast cancer. Compare Trial tr. 279:13–20 with Trial tr. 633:2–24; Compare Schroeder Trial Ex. 72 and Trial tr. 747:18–749:22 with Trial tr. 633:25–635:15; see also Def. Trial Ex. 26; Def. Trial Ex. 7 at IDFPR00159.

Plaintiffs' response: Disputed. Defendant's expert conceded that there is a risk of infection with abortion, Trial tr. 633:2–24, and that carrying a child to term reduces the chances of breast cancer. Trail tr. 680:25–681:4. Moreover, the information provided by Mosaic Defendant refers to provides a fair assessment of the breast cancer risk, stating: "According to these studies, abortion *may* remove the protection against breast cancer that is gained through carrying a pregnancy to term. However, other studies have failed to find a link between abortion and breast cancer." Def. Trial Ex. 7 at IDFPR00159, ECF No. 275-43 (emphasis added). This is consistent with Defendant's expert's testimony that "I recognize that it is still disputed because there are people who claim it is still an unsettled issue, but I think in the medical community, it is a settled issue." Trial tr. 635:11–13.

35. Educational materials containing medical information must be approved by the CPC's medical director before being provided to patients. Trial tr. 106:25–108:2; 184:3–11; 310:16–311:18; Schroeder Trial Ex. 114 at ONMedPP-006.

Plaintiffs' response: Undisputed.

Plaintiff CPCs Target Individuals Seeking Abortions

36. For some of the Plaintiff CPCs, many patients visit for some kind of abortion counseling. Trial tr. 138:3–14; 163:5–9; 224:9–225:7; 359:14–21; 393:18–24.

Plaintiffs' response: Undisputed.

37. Plaintiff CPCs aim to attract pregnant patients who are in crisis and vulnerable. Trial tr. 119:3–5, 158:16–20; 171:8–12; 191:6–9; 223:12–17, 266:4–267:23; 268:12–21, 309:20–310:1; 352:8–353:4; 395:14–396:1; Def. Trial Ex. 20 at 6; Def. Trial Ex. 71 at IDFPR009486-87.

Plaintiffs' response: Undisputed that pregnancy centers attempt to help women who are vulnerable to being coerced into having an abortion. They do so to provide them the support they need to be able to choose life for their unborn child. Otherwise disputed.

38. Plaintiff CPCs' free prenatal ultrasounds also attract pregnant patients seeking an abortion who have limited financial means, and who may require an ultrasound to have an abortion. Trial tr. 137:4–138:9; Def. Trial Ex. 20 at 6; Def. Trial Ex. 69 at IDFPR009427, 35–36, 9427; NIFLA Trial Ex. 17 at NIFLA 00056; NIFLA Trial Ex. 7 at Sec. 4, p. 12 (PDF p. 7); Schroeder Trial Ex. 157–17 at Schroeder_Supp_0097.

Plaintiffs' response: Undisputed that women sometimes come to pregnancy centers for an ultrasound even though they have already decided to have an abortion because they don't want to have pay for it at the abortion clinic. *See* Defendant's Resp. to NIFLA Pls.' Suppl. Facts 4, ¶ 17. Otherwise disputed.

39. For example, Options Now tells patients and potential patients that the

pregnancy tests and ultrasounds that the CPCs offer are "medical services you will need prior to having the abortion as well as [providing] factual information about abortion costs and procedures." Schroeder Trial Ex. 84 at ONHOF-005. *See also* Def. Trial Ex. 69 at IDFPR009427; Def. Trial Ex. 71 at IDFPR009486-87; NIFLA Trial Ex. 17 at NIFLA 00056.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

40. However, Options Now restricts what medical information can be given in writing to ultrasound patients if that information may be used to obtain an abortion. Schroeder Trial Ex. 104 at ONHOF-292.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

41. Plaintiff Mosaic parks its mobile health care unit next to a Planned Parenthood, which intercepts pregnant individuals going to Planned Parenthood for health care services such as abortion. Trial tr. 113:22–114:17; 137:4–138:9.

Plaintiffs' response: Disputed that Mosaic "intercepts" pregnant women going to Planned Parenthood. Mosaic's director testified that unaffiliated sidewalk counselors sometimes refer pregnant women to the mobile unit for an ultrasound so they don't have to pay for it. The very first thing Mosaic does is inform women who come to the mobile unit that Mosaic doesn't perform abortions or refer them, but will provide ultrasounds, STI testing, and counseling free of charge. Trial tr. 138:19–25; 139:1–6.

42. Plaintiff Focus began as the second location away from its first center, First Way Life Center, to attract patients considering abortion. Trial tr. 217:4–14.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

43. Plaintiff CPCs determine if pregnant patients are "abortion-vulnerable"

(at risk of considering an abortion) or "abortion-minded" (have decided they would like to have an abortion) to convince them not to have an abortion, regardless of their personal medical history or circumstances. Trial tr. 106:5–20; 126:14–127:20; 166:25–167:12; 250:16–20; 252:4–16; 356:16–357:17; 393:25–394:5; Schroeder Ex. 37 at FOCUS-073021-010; Wilson Dep. 128:1–129:2; Def. Trial Ex. 27.

Plaintiffs' response: Disputed. Pregnancy centers do not encourage women not to have an abortion if the unborn baby is threatening the mother's life or health. The Centers promptly refer those women to the emergency room. *See, e.g.,* Trial tr. 113:13–21. Otherwise, undisputed.

44. CPCs may characterize a pregnant person as "abortion vulnerable" if she has an "apparent medical condition that will affect her pregnancy." Trial tr. 393:25–394:5; Schroeder Trial Ex. 89 at ONHOF-038; Wilson Dep. 132:23–133:17; Wilson Dep. Exs. 6–7.

Plaintiffs' response: Disputed. *See* response to ¶ 43.

45. A CPC may automatically consider a patient "abortion vulnerable" if she is under age 18. Schroeder Trial Ex. 89 at ONHOF-038.

Plaintiffs' response: Disputed as unsupported by evidence regarding NIFLA Plaintiffs.

46. In phone calls with pregnant individuals, some Plaintiff CPCs employ talking points to convince those considering abortion to come to their offices for health care services. Trial tr. 126:21–127:9; NIFLA Trial Ex. 46; Schroeder Trial Ex. 84 at ONHOF-008.

Plaintiffs' response: Undisputed.

47. For example, at Options Now, if someone states that they have decided to have an abortion, Options Now tells the potential patient, "There are other risks that you should be aware of and so for your safety, we recommend having a pre-abortion consultation that will help you determine important criteria about your

abortion decision." Schroeder Trial Ex. 84 at ONHOF- 007.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

48. Some Plaintiff CPCs collect data to determine whether their staff were able to dissuade patients from having abortions. *See, e.g.*, Trial tr. 208:3–10; Def. Trial Exs. 19–21; Def. Trial Exs. 10–11; Wilson Dep. Exs. 6–7.

Plaintiff's response: Undisputed.

49. Plaintiff Options Now tracks the patients' intentions for the pregnancy after the ultrasound is provided to determine if the patient is still at risk for having an abortion. Def. Trial Ex. 39.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

Patient Experience at Plaintiff CPCs

50. Health care personnel perform health care services at the Plaintiff CPCs. Trial tr. 96:24–97:16; 154:24–155:5; 165:9–24; 169:12–15; 177:22–178:9; 189:5–190:1; 202:10–25; 231:5–6; 231:18–232:5; 320:15–321:16; 326:23–327:13; 363:15–22; 386:5–8; 397:12–15; Def. Trial Ex. 71 at IDFPR009460, 9487; Schroeder Trial Ex. 157-01 at Schroeder_Supp_0050.

Plaintiffs' response: Undisputed.

51. Plaintiff CPCs' health care services include prenatal ultrasounds performed by health care personnel. Wilson Dep. 88:2–16; Trial tr. 95:17–19; 119:10–12; 165:9–19, 165:22–24;189:14–20; 189:24–190:1; 231:5–6; 320:15–321:5; 370:22–371:9; 385:25–386:8.

Plaintiffs' response: Undisputed.

52. Before performing an ultrasound, health care personnel ask pregnant patients questions regarding their medical history, such as whether they have a history of preeclampsia or eclampsia. Trial tr. 154:24–155:5, 336:4–10, 360:9-18–

362:4.

Plaintiffs' response: Undisputed.

53. These prenatal ultrasounds are either transvaginal—in which an ultrasound wand is inserted in the vagina of the patient—or abdominal. Trial tr. 322:13–16, 388:2–389:2.

Plaintiffs' response: Undisputed.

54. CPCs' ultrasound procedures for patient care change in part based on whether a patient intends to carry to term or is perceived by the CPC to be at risk of choosing an abortion. Trial tr. 253:13–254:9; Def. Trial Ex. 32; Schroeder Trial Ex. 129 at ONUSPP_003, 005; Schroeder Trial Ex. 130.

Plaintiffs' response: Disputed. The NIFLA plaintiffs generally provide ultrasounds to any patient who requests one. *See*, *e.g.*, Trial tr. 133:9–11.

55. For example, Options Now's ultrasound policy changes the timeframe of when they encourage a patient to have to have an ultrasound based on whether the patient intends to carry to term or is perceived by the CPC to be at risk of choosing an abortion or "abortion vulnerable." Schroeder Trial Ex. 129 at ONUSPP_003, 005; Schroeder Trial Ex. 130.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

56. Plaintiff CPCs' health care personnel conduct pregnancy options counseling with patients, often in conjunction with a prenatal ultrasound. Trial tr. 121:10–23, 183:23–25, 202:10–19, 231:15–232:22, 326:23–327:17, 357:2–17; Def. Trial Ex. 68 at IDFPR009417, 9424; Def. Trial Ex. 70 at IDFPR009443.

Plaintiffs' response: Undisputed that options counseling is provided by pregnancy center medical personnel.

57. Plaintiff CPCs typically do not advise pregnant patients about any medical risks of carrying their pregnancies to term. Trial tr. 112:25–113:1, 124:17–

21, 326:23–327:17.

Plaintiffs' response: Undisputed.

58. If the ultrasound does not successfully convince the patient to carry to term, Options Now sonographers are directed to try to schedule a second ultrasound with the patient. Schroeder Trial Ex. 104 at ONHOF-292.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

Qualifications of Dr. Paul Burcher

59. Dr. Paul Burcher completed medical school at the University of Arizona, completed his residency in obstetrics and gynecology ("OB/GYN") at the University of Rochester, and has been practicing as an OB/GYN since 1991. Trial tr. 571:14–21; 575:15-18.

Plaintiffs' response: Undisputed.

60. In his OB/GYN practice, Dr. Burcher counseled pregnant patients about their medical options and has delivered approximately 6,000 babies. Trial tr. 575:19–25.

Plaintiffs' response: Undisputed.

61. Dr. Burcher also has a Ph.D. in philosophy with a concentration in ethics from the University of Oregon and completed a clinical ethics fellowship at the University of Chicago. Trial tr. 571:14–21.

Plaintiffs' response: Undisputed.

62. He is currently the OB/GYN residency director and heads the bioethics committee at WellSpan York Hospital, a seven-county hospital system in Pennsylvania. Trial tr. 571:22–572:9.

Plaintiffs' response: Undisputed.

63. Dr. Burcher has published in the fields of medical ethics and obstetrics and gynecology, including on the subjects of informed consent and doctor-patient

communication. Trial tr. 576:1–9.

Plaintiffs' response: Undisputed.

Ethical Foundations of the Standard of Care

64. The medical standard of care consists of both clinical and ethical standards of care, which are "intertwined in the sense that you have to uphold both sides of that equation to remain within the [medical] standard of care." Trial tr. 582:23–583:2.

Plaintiffs' response: Undisputed.

65. General ethical principles govern the entire medical profession. Trial tr. 415:1–11; 582:5–8.

Plaintiffs' response: Undisputed.

66. The central approach to biomedical ethics is the "principlist theory," or the principles of autonomy, beneficence, nonmaleficence, and justice. Trial tr. 581:11–582:4.

Plaintiffs' response: Dispute that it is the "central" approach, but undisputed that it is one of three approaches that Defendant acknowledges are valid. *See* Def. Resp. Schroeder Facts 36-39.

67. The principles of autonomy, beneficence, nonmaleficence, and justice apply for all medical care. Trial tr. 582:5–8.

Plaintiffs' response: Undisputed that this is one approach to biomedical ethics. *See* Def. Resp. to Schroeder Pls.' Suppl. Facts 36–39.

68. Patient autonomy allows a patient is to make a medical decision by understanding all the salient options and their risks and benefits. Trial tr. 583:11–584:6.

Plaintiffs' response: Undisputed.

69. Patient autonomy is a central tenet of biomedical ethics. Trial tr. 581:11–14; 583:11–584:6.

Plaintiffs' response: Disputed. None of the principal ethical theories claims patient autonomy as the primary value in medical ethics or clinical practice. All three theories require a balancing of values/goods. Pellegrino describes this balancing as between "beneficence-in-trust" and the patient's wishes. Trial Tr. 431:21–432:9 (Fernandes). Defendant does not specifically dispute this assertion. Def. Resp. to Schroeder Pls.' Suppl. Facts 38–39, ¶ 75.

70. Patient autonomy is not the same thing as doing whatever the patient requests in that it is filtered through medical standards of care. Trial tr. 585:7–23.

Plaintiffs' response: Undisputed.

71. While patients have a right to refuse care, their ability to make requests is limited in cases where the request is not medically appropriate. Trial tr. 585:7–586:10.

Plaintiffs' response: Undisputed.

72. Beneficence is acting in the good of the patient, or to benefit the patient. Trial tr. 622:3–623:17.

Plaintiffs' response: Undisputed.

73. Nonmaleficence is the reduction of harm. Trial tr. 622:3–623:17.

Plaintiffs' response: Undisputed.

74. Generally accepted principles of medical ethics are espoused in *Principles of Biomedical Ethics* by Beauchamp and Childress, the seminal text of bioethics in America. Trial tr. 574:16–22.

Plaintiffs' response: Dispute that it is the "seminal text," but undisputed that it espouses one of three approaches to medical ethics that Defendant acknowledges are valid. *See* Def. Resp. to Schroeder Pls.' Suppl. Facts 36–39.

75. Health care personnel utilize resources like the American Medical Association Code of Ethics as an easier, more easily indexed reference that is similar to *Principles of Biomedical Ethics*. Trial tr. 592:22–593:3.

Plaintiffs' response: Undisputed that ethical standards promulgated by professional organizations do not establish standards of professional conduct, but are intended to guide or inform an individual doctor's ethical judgments. Most standards explicitly state as much. Trial Tr. 472:21–473:20, 464:9–12 (Fernandes); 32:20–33:19, 33:24–18 (Lee). See also, NIFLA Ex. 32a at NIFLA 01751, ECF No. 275-17 ("The opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of practice or rules of law."); NIFLA Ex. 32b at 1769 (same). *See* Def. Resp. to Schroeder Pls.' Suppl. Facts 40–41, ¶ 79. Otherwise disputed.

76. The AMA Code of Ethics are not binding professional or legal standards, but they provide a normative set of guidelines within the medical profession that health care professionals consult to inform their practice. Trial tr. 425:23–425:14; 592:14–593:20; 611:15–612:5.

Plaintiffs' response: Undisputed that ethical standards promulgated by professional organizations do not establish standards of professional conduct, but are intended to guide or inform an individual doctor's ethical judgments. Most standards explicitly state as much. Trial Tr. 472:21–473:20, 464:9–12 (Fernandes); 32:20–33:19, 33:24–18 (Lee). See also, NIFLA Ex. 32a at NIFLA 01751 ("The opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of practice or rules of law."); NIFLA Ex. 32b at NIFLA 01769, ECF No. 275-18 (same). *See* Def. Resp. to Schroeder Pls.' Suppl. Facts 40–41, ¶ 79. Otherwise disputed.

77. Health care personnel use the AMA Code of Ethics as a standard set of digestible guidelines for clinical practice and for biomedical ethics. *See, e.g.,* Trial tr. 44:11–45:2, 49:3–8; 425:23–425:14; 435:7–436:9, 437:9–24; 592:14–593:20; 595:17–596:16; 606:3–607:4; 611:15–612:5; 614:25–615:21; 616:4–7; 618:11–620:4; 769:9–771:6.

Plaintiffs' response: Undisputed that ethical standards promulgated by professional organizations do not establish standards of professional conduct, but are intended to guide or inform an individual doctor's ethical judgments. Most standards explicitly state as much. Trial Tr. 472:21–473:20, 464:9–12 (Fernandes); 32:20–33:19, 33:24–18 (Lee). *See also* NIFLA Ex. 32a at NIFLA 01751 ("The opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of practice or rules of law."); NIFLA Ex. 32b at NIFLA 01769 (same). *See* Def. Resp. to Schroeder Pls.' Suppl. Facts 40–41, ¶ 79. Otherwise disputed.

78. Committee opinions issued by the American College of Obstetricians and Gynecologists ("ACOG") are ethical guidelines that contribute to the ethical standard of care for OBGYNs. Trial tr. 597:5–12.

Plaintiffs' response: Undisputed that ethical standards promulgated by professional organizations do not establish standards of professional conduct, but are intended to guide or inform an individual doctor's ethical judgments. Most standards explicitly state as much. Trial Tr. 472:21–473:20, 464:9–12 (Fernandes); 32:20–33:19, 33:24–18 (Lee). See also, NIFLA Ex. 32a at NIFLA 01751 ("The opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of practice or rules of law."); NIFLA Ex. 32b at NIFLA 01769 (same). *See* Def. Resp. to Schroeder Pls.' Suppl. Facts 40–41, ¶ 79. Otherwise disputed.

Patient Trust in Health Care Personnel

79. "The relationship between a patient and a physician is based on trust." Trial Tr. 769:24–770:6; NIFLA Trial Ex. 32(a) at AMA 1.1.1.

Plaintiffs' response: Undisputed.

80. The doctor-patient relationship "gives rise to physicians' ethical

responsibility to place patients' welfare above the physician's own self-interest or obligations to others." Trial Tr. 770:7–13; NIFLA Trial Ex. 32(a) at AMA 1.1.1.

Plaintiffs' response: Undisputed.

81. Patients have the right to "[b]e advised of any conflicts of interest their physician may have in respect to their care." Trial Tr. 771:3–6; NIFLA Trial Ex. 32(a) at AMA 1.1.3.

Plaintiffs' response: Undisputed.

82. Medical information is available online, but may be incorrect, misleading, or not relevant to a particular patient. Trial tr. 68:10–21; 643:3–14.

Plaintiffs' response: Undisputed.

83. Patients rely on physicians to filter medical information that is accurate and contextualized to their condition. Trial tr. 643:3–644:15.

Plaintiffs' response: Undisputed.

84. Doctors are "obligated to use sound medical judgment on the patients' behalf." Trial Tr. 770:14–17; NIFLA Trial Ex. 32(a) at AMA 1.1.1.

Plaintiffs' response: Undisputed.

85. Patients have the right to "[b]e able to expect that their physician will cooperate in coordinating medically-indicated care with other health care professionals." Trial Tr. 770:18–22; NIFLA Trial Ex. 32(a) at AMA 1.1.3.

Plaintiffs' response: Undisputed that AMA 1.1.3 contains the quoted language, but it must be read with AMA 1.1.7 that recognizes, "Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities," which includes the

ability "to decline to refer." NIFLA Trial Ex. 32(a) at AMA 1.1.7.

86. "[T]he health and wellbeing of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance." Trial tr. 63:5–10; 770:23–771:2; NIFLA Trial Ex. 32(a) at AMA 1.1.3.

Plaintiffs' response: Undisputed.

87. A patient needs all relevant information for their specific context to make the best decision for themselves based upon their values and their circumstance. Trial tr. 62:6–11; 596:5–16.

Plaintiffs' response: Disputed. Undisputed that the standard of care is determined on a case-by-case basis, and medical professionals should use their discretion, clinical judgment, and training to determine the standard of care for each patient. *See* NIFLA Pls.' Supplemental Findings of Facts at ¶¶ 27–30; 32, 35, 36, ECF No. 271-1.

88. "Patients have the right to receive information, ask questions about treatments so that they can make well considered decisions about care." NIFLA Ex. 32(b) at 2.1.1; Trial Tr. 593:21–594:19, 596:5–16, 598:17–599:7.

Plaintiffs' response: Undisputed.

89. Withholding relevant medical information from a patient violates patient autonomy because a patient may have relied on that information to make a self-governing decision. Trial tr. 596:5–16.

Plaintiffs' response: Disputed. *See* ¶ 90.

90. "Except in emergency situations in which a patient is incapable of making an informed decision, withholding information without the patient's knowledge or consent is ethically unacceptable." NIFLA Trial Ex. 32(b) at AMA 2.1.3; Trial tr. 595:17–596:16; 656:24–657:4.

Plaintiffs' response: Undisputed that withholding information *with* a patient's knowledge is ethically acceptable.

91. "Withholding pertinent medical information from patients in the belief that disclosure is medically contraindicated creates a conflict between the physician's obligations to promote patient welfare and to respect patient autonomy." NIFLA Trial Ex. 32(b) at AMA 2.1.3. Trial tr. 595:17–596:16; 656:24–657:8.

Plaintiffs' response: Undisputed that withholding information *with* a patient's knowledge is ethically acceptable. Otherwise disputed.

92. When counseling a patient about medical treatment options, even if the health care provider does not offer the treatment options, it would violate the standard of care if the health care provider withheld relevant information during the counseling. Trial tr. 767:20–768:14.

Plaintiffs' response: Disputed. *See* ¶ 90.

Ethics Related to Medical Options Counseling and Informed Consent

93. "A patient-physician relationship exists when a physician serves a patient's medical needs." Trial tr. 768:21–24; NIFLA Trial Ex. 32(a) at AMA 1.1.1.

Plaintiffs' response: Undisputed that "A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate)." NIFLA Trial Ex. 32(a) at AMA 1.1.1.

94. When a health care provider counsels a patient on medical treatment options that the health care provider does not offer, the counseling serves the patient's medical needs and is a form of health care. Trial tr. 766:25–768:24; 769:4–20.

Plaintiffs' response: Disputed. Trial Tr. 50:21–51:14 (Lee); 731:2–734:19 (Boles); 419:8–13 (Fernandes); 462:11–464:7 (Fernandes); 465:6–469:17, 459:14–461:14 (Fernandes); 454:14–455:12, 507:15–25, 509:25–514:9, 550:24–552:8 (Fernandes).

95. When a health care provider counsels a patient about treatments that

the provider does not offer, the health care provider is subject to medical standards of care. Trial tr. 769:4–20.

Plaintiffs' response: Disputed. Trial Tr. 50:21–51:14 (Lee); 731:2–734:19 (Boles); 419:8–13 (Fernandes); 462:11–464:7 (Fernandes); 465:6–469:17, 459:14–461:14 (Fernandes); 454:14–455:12, 507:15–25, 509:25–514:9, 550:24–552:8 (Fernandes).

96. Medical options counseling consists of a health care provider presenting a patient with medically appropriate treatment options for their condition and the risks and benefits of those options specific to the patient. Trial tr. 61:11–62:15, 590:6–25.

Plaintiffs' response: Disputed. Trial Tr. 50:21–51:14 (Lee); 731:2–734:19 (Boles); 419:8–13 (Fernandes); 462:11–464:7 (Fernandes); 465:6–469:17, 459:14–461:14 (Fernandes); 454:14–455:12, 507:15–25, 509:25–514:9, 550:24–552:8 (Fernandes).

97. Medical options counseling constitutes part of the overall course of medical care that is provided to the patient. Trial tr. 61:11–17; 516:21–25; 585:3–6; 769:9–16.

Plaintiffs' response: Undisputed that medical options counseling can be part of the overall course of medical care provided to the patient. Disputed that it is always part of the overall course of medical care provided to the patient. Trial Tr. 50:21–51:14 (Lee); 731:2–734:19 (Boles); 419:8–13 (Fernandes); 462:11–464:7 (Fernandes); 465:6–469:17, 459:14–461:14 (Fernandes); 454:14–455:12, 507:15–25, 509:25–514:9, 550:24–552:8 (Fernandes).

98. Under the medical standard of care, a health care provider filters options to counsel a particular patient using their medical expertise, not their personal values or biases, which the patient may not share. Trial tr. 425:23–426:14; 588:13–589:9; 646:16–25; NIFLA Ex. 32K at NIFLA 01879-80.

Plaintiffs' response: Disputed. Withholding information based on personal values *with* a patient's knowledge is ethically acceptable. NIFLA Trial Ex. 32(b) at AMA 2.1.3.

99. A health care provider should also discuss the option of forgoing treatment and the risks and benefits of forgoing treatment in medical options counseling. NIFLA Ex. 32B at NIFLA 01769-70; Trial tr. 599:1–7; NIFLA Ex. 32K at NIFLA 01880.

Plaintiffs' response: Undisputed unless the provider is withholding information based on personal values *with* a patient's knowledge, which is ethically acceptable. NIFLA Trial Ex. 32(b) at AMA 2.1.3.

100. A health care provider must thoroughly discuss relevant medical treatment options with a patient, and violates the standard of care if they only discuss the risks of a treatment—even if the health care provider has a religious objection to the treatment. Trial tr. 767:25–768:14.

Plaintiffs' response: Disputed. Trial Tr. 50:21–51:14 (Lee); Trial Tr. 731:2–734:19 (Boles); 419:8–13 (Fernandes); Trial Tr. 462:11–464:7 (Fernandes) Trial Tr.465:6–469:17, 459:14–461:14 (Fernandes).

101. A physician must keep the standard of care in mind and base counseling on the best medical evidence. Trial tr. 62:12–15.

Plaintiffs' response: Undisputed.

102. The amendments to the Act are a reiteration of the ethical principles that health care personnel will either counsel on all relevant treatment options or otherwise advise patients on where they can receive unbiased medical counseling. Trial tr. 647:21–651:4.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Findings of Facts 5, ¶¶ 30–32.

103. The provisions of the Act relating to medical records and adopting written

protocols are consistent with biomedical ethics and the standard of care. Trial tr. 651:7–24; 652:4–653:1.

Plaintiffs' response: Undisputed with regard to medical records. Disputed regarding written protocols. *See* NIFLA Pls.' Suppl. Statement of Facts 5, ¶¶ 30–32.

104. Medical options counseling in accordance with the standard of medical care also enables informed consent because it facilitates the patient's authorization to undergo a specific medical intervention. NIFLA Ex. 32B at AMA 2.1.1, NIFLA 01769-70; NIFLA Ex. 32K: ACOG Committee Op. 390 at NIFLA 01879-80; Trial tr. 584:18-23; 593:21-594:19, 602:24-604:12.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–5, ¶¶ 27–30.

105. When conducted in compliance with the medical standard of care, medical options counseling promotes and protects patient autonomy by disclosing all relevant facts so a patient can exercise personal choice and informed decision-making. Trial tr. 583:11–585:6; NIFLA Ex. 32K at NIFLA 01879.

Plaintiffs' response: Disputed that patient autonomy is the only consideration in a patient's informed decision-making. None of the principal ethical theories claims patient autonomy as the primary value in medical ethics or clinical practice. All three theories require a balancing of values/goods. Pellegrino describes this balancing as between "beneficence-in-trust" and the patient's wishes. Trial Tr. 431:21–432:9 (Fernandes). Defendant does not specifically dispute this assertion. Def. Resp. to Schroeder Pls.' Suppl. Facts 38–39, ¶ 75.

106. Informed consent is the practical application of the concept of autonomy because when the patient has all the facts they are better able to make a self-governed decision. Trial tr. 62:21–63:4; 584:7–23.

Plaintiffs' response: Undisputed.

107. Informed consent is not limited to seeking authorization for an imminent medical procedure. Trial tr. 605:2–12; NIFLA Trial Ex. 32(a) at AMA 1.1.7(e).

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–5, ¶¶ 27–30.

108. The concept of informed consent can apply to counseling both about a specific medical intervention by a health care provider or more broadly about different relevant medical options available to a patient, because both involve choosing a treatment option or a plan of care. Trial tr. 603:13–19.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–5, ¶¶ 27–30.

109. Health care personnel are obligated to advise patients of risks and benefits of relevant procedures and treatment options, even if those treatments are not available at that particular medical facility. Trial tr. 637:21–639:5.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–5, ¶¶ 27–30.

110. For example, if a patient requires treatment for an ectopic pregnancy, the physician should describe and explain the risks of an ectopic pregnancy and why treatment is needed. Trial tr. 54:9–11; 54:25–55:3.

Plaintiffs' response: Undisputed if the provider is performing the procedure. *See* testimony cited.

111. Similarly, if an obstetrician determines that a patient would be better suited to see a maternal fetal medicine specialist, the obstetrician should explain those benefits to a patient. Trial tr. 46:4–20.

Plaintiffs' response: Undisputed.

112. If a health care provider is unable to counsel about a treatment option,

medical ethics dictates that the provider has a duty to refer the patient where they can receive counseling or provide information about how to find that service. Trial tr. 606:5–607:4; 618:11–24; 696:24–699:10; NIFLA Trial Ex. 32(b) at AMA 1.1.7; NIFLA Trial Ex. 32(d) at NIFLA 01824-25.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

113. If health care personnel can only partially counsel about a treatment option, that provider has a duty to refer the patient so they can receive complete counseling. Trial tr. 620:12–22.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

114. Health care personnel that do not direct a patient to where they can receive counseling violate the medical standard of care. Trial tr. 620:23-621:13.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4-6, ¶¶ 27–32, 35–37.

115. Disclaimers that health care personnel do not perform a particular procedure or offer a certain treatment is not sufficient to satisfy the standard of care or the obligation to refer. Trial tr. 602:3–19, 621:14–25.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

116. In practice, this means that health care personnel who decline to discuss the risks or benefits of a relevant treatment option based on their own values violate the medical standard of care for their patient. Trial tr. 602:3–19.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

117. The rule of not withholding information applies to all types of patient-physician communication, not just informed consent. Trial tr. 605:13-25.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

118. A health care provider who withholds medical information during medical options counseling that may be relevant to a patient's specific circumstances violates the medical standard of care. Trial tr. 596:5–16, 766:25–768:24; NIFLA Ex. 32B at NIFLA 01771-72.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Findings of Facts 4–6, ¶¶ 27–32, 35–37.

119. Health care personnel do not need to counsel a patient about a treatment option if the treatment is not medically appropriate for the specific patient or not appropriate considering the patient's specific circumstances, goals, and values. Trial tr. 599:8–602:2.

Plaintiffs' response: Undisputed.

Conscientious Objections

120. The medical standard of care does not vary based on the conscience beliefs of the health care provider, but rather based on the context of the patient. Trial tr. 514:5–10; 583:3-7, 606:3–607:4.

Plaintiffs' response: Disputed. AMA 1.1.7 recognizes that "Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities," which includes the ability "to decline to refer." NIFLA Trial Ex. 32(a) at AMA 1.1.7.

121. Ethical standards of care state that when doctors exercise conscience objections, doctors still have ethical duties to ensure that patients' rights and health

are still protected. Trial tr. 606:5–607:4; 615:9–21; 616:4–617:3; 689:18–690:25; NIFLA Trial Ex. 32(a) at AMA 1.1.7; Def. Trial Ex. 72 (ACOG Committee Op. 390) at IDFPR009520.

Plaintiffs' response: Undisputed.

122. If a physician has a conscience objection that impedes objective medical options counseling, that physician must inform the patient. Trial tr. 65:2–6; 621:2–13; 771:3-–6; Def. Trial Ex. 72 (ACOG Committee Op. 390) at IDFPR009520.

Plaintiffs' response: Undisputed.

123. Similarly, a health care provider must inform a patient of all relevant treatment options, including those to which the provider conscientiously objects. Trial tr. 514:5–10; 614:25–617:3; NIFLA Ex. 32A at AMA 1.1.7, NIFLA 01755-56.

Plaintiffs' response: Disputed. Trial Tr. 462:13–464:7, 715:10–716:18 (Fernandes); 48:2–6 (Lee) Trial Tr. 717:10–719:12 (Fernandes); Trial Tr. 726:12–728:1 (Boles).

124. Physicians have an ethical responsibility to place patient welfare above their own self-interest or obligations to others. Trial tr. 684:16–685:11; 770:7–13.

Plaintiffs' response: Undisputed.

125. In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. Trial tr. 615:9–21; 696:24–697:20; NIFLA Trial Ex. 32(a) at AMA 1.1.7; NIFLA Trial Ex. 32(d) at NIFLA 1825; Def. Trial Ex. 72 (ACOG Committee Op. 390) at IDFPR009520.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

126. When a conscience-objecting physician declines to make a referral due to religious beliefs, they "should offer impartial guidance [to the patient] . . . about how to inform themselves regarding access to desired services. NIFLA Trial Ex. 32(a) at AMA 1.1.7; Trial tr. 606:5–607:19; 696:24–697:25.

Plaintiffs' response: Undisputed.

127. A health care provider who only discusses risks and not benefits of a particular treatment option is doing more harm to the patient than not discussing a treatment option at all. Trial tr. 602:9–19.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

128. When health care personnel only provide partial counseling that is not patient- centered it "poison[s] the well" for a later, more balanced discussion of risks, benefits, and options with other health care personnel. Trial tr. 602:9–19.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

129. If a health care provider declines to discuss the risks or benefits of a certain treatment based upon the provider's own values, the health care provider violates the standard of care. Trial tr. 602:3–8.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

130. Health care personnel must remain objective and fact-based because they have "so much influence over the patient's decision-making," since "patients listen to and expect their" provider "to have their best interests at heart and to be counseling them in a way that is beneficial to the [patient]." Trial tr. 432:12–24; 591:3–592:9.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

131. Obstructing a patient or not aiding a patient's choice, either by failing to counsel or directing them to relevant information, will very likely delay appropriate patient care. Trial tr. 622:3–623:17.

Plaintiffs' response: Disputed. The testimony cited is mere speculation with

no evidence of delay or the results of delay. The only testimony presented at trial is that all of the patients who asked Dr. Lee about abortion were able to obtain one. Trial Tr. 41:11–15.

Benefits of Abortion and Risks of Carrying to Term

132. The medical definition of abortion is the termination of any pregnancy before 20 weeks. Trial tr. 576:15–18.

Plaintiffs' response: Disputed. Abortion commonly refers to the elective termination of a viable pregnancy. Trial Tr. 37:3–10, 86:19–87:20 (Lee); see also, 333:23–335:12, 338:7–14 (Schroeder).

133. Abortions are divided into two categories: a spontaneous abortion (also known as a miscarriage) and an induced abortion. Trial tr. 576:19–577:1.

Plaintiffs' response: Disputed. Abortion commonly refers to the elective termination of a viable pregnancy. Trial Tr. 37:3–10, 86:19–87:20 (Lee); *see also* 333:23–335:12, 338:7–14 (Schroeder).

134. Some doctors categorize induced abortions based upon the patient's reason to have an abortion: specifically, an abortion for a medical reason or "an elective abortion," when a woman has chosen to have an abortion, though the difference between the two is a gray area. Trial tr. 577:10–578:1.

Plaintiffs' response: Disputed. Abortion commonly refers to the elective termination of a viable pregnancy. Trial Tr. 37:3–10, 86:19–87:20 (Lee); *see also* 333:23–335:12, 338:7–14 (Schroeder).

135. Two factors to consider when determining whether to counsel on abortion are the patient's reaction about the pregnancy and a review of the patient's medical history to determine, among other things, whether pregnancy is contraindicated to the patient's health. Trial tr. 629:13–630:2.

Plaintiffs' response: Undisputed that these are two factors that may be considered by medical professionals who have no conscientious objections to

providing such counseling.

136. A discussion of the benefits and risks of abortion in any medical setting is central, because the information assists a patient in deciding whether to continue a pregnancy. Trial tr. 619:4–15.

Plaintiffs' response: Disputed. *See* NIFLA Pls.' Suppl. Statement of Facts 4–6, ¶¶ 27–32, 35–37.

137. Terminating a pregnancy can have medical benefits if a pregnant patient is experiencing a medical emergency that risks their life. Trial tr. 65:12–66:8; 79:16–80:11; 623:18–624:1; 628:19–629:6.

Plaintiffs' response: Undisputed that inducing early delivery before a fetus is viable can have medical benefits if a pregnant patient is experiencing a medical emergency that risks their life.

138. There are times when a doctor must induce labor before a fetus is viable. Trial tr. 37:6–10; 86:19–87:11.

Plaintiffs' response: Undisputed that inducing early delivery before a fetus is viable can have medical benefits if a pregnant patient is experiencing a medical emergency that risks her life.

139. Pre-eclampsia, eclampsia, ectopic pregnancy, cervical incompetence, premature rupture of membranes, pulmonary hypertension, dilated descending aorta, heart disease, and pericardium cardiomyopathy are medical conditions that pose significant medical risks, including death, for the pregnant patient. Trial tr. 65:12–66:8; 623:23–625:20.

Plaintiffs' response: Undisputed as to preeclampsia, eclampsia, and ectopic pregnancy. Otherwise disputed.

140. Patients with conditions that contraindicate pregnancy should be advised about terminating a pregnancy as a relevant treatment option. Trial tr. 66:9–23.

Plaintiffs' response: Undisputed that inducing early delivery before a fetus is viable can have medical benefits if a pregnant patient is experiencing a medical emergency that risks her life.

141. Patients may medically benefit from abortion for important psychological and personal reasons other than physical health. Trial Tr. 629:13–630:21.

Plaintiffs' response: Disputed. Trial Tr. 42:5–22 (Lee); 458:23–459:13 (Fernandes); 763:12–765:3 (Boles); *see also* Schroeder Ex. 174 (medical studies showing adverse impacts); *See* Schroeder Exs. 175–178.

142. The mortality rate for women who carry pregnancy to term is higher than women have an abortion. Trial tr. 640:2–25; 762:23–764:4.

Plaintiffs' response: Disputed. There are serious problems with the study claiming that elective abortion is substantially safer than childbirth. Trial Tr. 487:10–490:20 (Fernandes); 742:8–745:3 (Boles); *see also* Schroeder Ex. 175 (study laying out these concerns).

143. The risk of infection with an abortion is less than 1 or 2 percent, even if the patient has a sexually transmitted infection, because patients are prophylactically given antibiotics before and after the procedure. Trial tr. 633:2–24.

Plaintiffs' response: Disputed. Undisputed that surgical abortion carries a risk of infection, bleeding, pain, bowel injury, and perforation of the uterus, Trial tr. 675:4–7 (Burcher), and that Dr. Burcher speculated that the risk of infection "depends [on] what type of abortion, what gestational age the patient has, and what type of abortion would be chosen for her. In general, the risk of infection with abortion is quite low; it is probably less than 1 or 2 percent, but it is a risk." Trial tr. 633:2–24.

144. Abortion does not increase the rate of breast cancer. Trial tr. 633:25–634:19; 635:8–13.

Plaintiffs' response: Disputed. Defendant's expert conceded that carrying a child to term reduces the chances of breast cancer. Trail tr. 680: 25–681:4.

145. Although patients may experience abortion regret, there are greater instances of maternal regret for women who wished to have an abortion but carried to term instead. 635:24–636:20.

Plaintiffs' response: Disputed. Trial Tr. 458:23–459:13 (Fernandes);763:12–765:3 (Boles); *see also* Schroeder Ex. 174 (medical studies showing adverse impacts); *See* Schroeder Exs. 175–s178. There are serious methodological flaws in the study cited by Dr. Burcher authored by Foster et al, entitled "Socioeconomic Outcomes of Women Who Receive and Women who are Denied Wanted Abortions in the United States," which relied on data from a research study commonly referred to as the "Turnaway Study." Trial Tr. 754:17–758:5.

Medical Options Counseling for Pregnant Patients

146. When patients visit a Plaintiff CPC, the visit is medical in substance. Trial tr. 609:24–610:4; Def. Trial Ex. 71 at IDFPR009460, 9487; Schroeder Trial Ex. 157-01 at Schroeder_Supp_0050 (Focus homepage).

Plaintiffs' response: Undisputed that some patient visits to pregnancy centers are medical in substance. Many patients visit pregnancy centers for other free services like a post-abortive recovery program, parenting classes for both men and women, and practical help such as diapers, clothing, formula. NIFLA Pls.' Suppl. Statement of Facts 2, ¶ 12.

147. For example, where a patient visit includes taking a history, performing a medical procedure (such as an ultrasound), and counseling about the results or medical options, the encourage [sic] would be a medical visit. Trial tr. 610:5-10; 688:21-689:12.

Plaintiffs' response: Undisputed that a patient visit that includes performing a medical procedure (such as an ultrasound) is a medical visit.

Otherwise disputed.

148. In particular, "the decision to establish prenatal care would qualify as a specific medical intervention" in the context of medical options counseling for pregnant patients. Trial tr. 603:3–12.

Plaintiffs' response: Disputed. Trial Tr. 452:16–454:13, 494:21–496:6, 546:20–547:12, 719:13–720:9 (Fernandes); 728:2–22, 740:2–741:18 (Boles).

149. Even though Plaintiff CPCs do not perform abortions, the medical standard of care does not change because appropriate counseling requires presenting a patient with all relevant treatment options for their circumstances and medical history. Trial tr. 509:14–511:19, 612:11–613:4, 637:21–639:5, 769:9–20.

Plaintiffs' response: Disputed. AMA 1.1.7 recognizes that "Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities," which includes the ability "to decline to refer." NIFLA Trial Ex. 32(a) at AMA 1.1.7.

150. Nurses and registered diagnostic medical sonographers are engaged in the practice of medicine. Trial tr. 610:25–611:5.

Plaintiffs' response: Disputed. Trial Tr. 553:23–554:8 (Fernandes).

151. Ultrasound determinations are medical diagnoses. Trial tr. 579:6–9; 731:23–732:20.

Plaintiffs' response: Undisputed that the doctors who read pregnancy center ultrasound scans performed by pregnancy centers provide a medical diagnosis.

152. Health care personnel at the Plaintiff CPCs also provide pregnancy options counseling, which is subject to the medical standard of care. Trial tr. 195:2–

197:1; 516:12–517:9; 609:20–610:24; 769:9–20; Def. Trial Ex. 69 at IDFPR009432-33; Def. Trial Ex. 71 at IDFPR009460, 9487; Schroeder Trial Ex. 157-01 at Schroeder_Supp_0050.

Plaintiffs' response: Disputed. Trial Tr. 452:16–454:13, 494:21–496:6, 546:20–547:12, 719:13–-720:9 (Fernandes); 728:2–22, 740:2–741:18 (Boles).

153. When advising a patient on options for pregnancy management, the standard of care does not change if health care personnel do not perform abortions. Trial tr. 612:11–613:4.

Plaintiffs' response: Disputed. AMA 1.1.7 recognizes that "Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities," which includes the ability "to decline to refer." NIFLA Trial Ex. 32(a) at AMA 1.1.7.

154. Failing to provide a pregnant patient with information required under the standard of care, the resulting delay in obtaining care can cause the patient to be unable to obtain a surgical abortion due to increased medical risks or cost. Trial tr. 622:3-623:17.

Plaintiffs' response: Disputed. The testimony cited is mere speculation with no evidence of delay or the results of delay. The only testimony presented at trial is that all of the patients who asked Dr. Lee about abortion were able to obtain one. Trial Tr. 41:11–15.

155. Failing to discuss the benefits and risks of abortion based on a conscience objection violates patient autonomy and falls beneath the standard of care. Trial tr. 619:23-620:4.

Plaintiffs' response: Disputed. AMA 1.1.7 recognizes that "Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities," which includes the ability "to decline to refer." NIFLA Trial Ex. 32(a) at AMA 1.1.7.

Benefits of contraceptives and sterilization

156. Oral contraceptives reduce the risk of ovarian cancer, uterine cancer, and endometrial cancer by 50 percent, as well as lowering the risk of anemia and improving skin conditions. Trial tr. 631:17–632:1.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

157. Condoms reduce the risk of sexually transmitted diseases. Trial tr. 631:19-632:1.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

158. Removal of the fallopian tube significantly reduces the risk of ovarian cancer. Trial tr. 632:2–11.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

159. Contraception and sterilization effectively prevent pregnancy, and to state that they have no benefits is empirically wrong. Trial tr. 631:17–632:22; 773:14–21.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

Plaintiffs' Experts

160. Plaintiffs' experts Dr. Lee and Dr. Fernandes personally support the missions and goals of the CPCs. Trial tr. 72:7–16; 541:22–542:9.

Plaintiffs' response: Undisputed.

161. Dr. Fernandes testified at trial that it is difficult for him "not to admire the steadfast courage of people who work at crisis pregnancy centers" and that such "centers have provided an unequivocally positive service for vulnerable women." Trial tr. 542:10–16.

Plaintiffs' response: Undisputed.

162. In April of 2023, Dr. Fernandes gave remarks at an event for a CPC in strong support of the center's mission. Trial tr. 544:2–20.

Plaintiffs' response: Undisputed.

163. Dr. Fernandes was a board member and is currently a trustee of Ohio Right to Life. Trial tr. 543:11–15.

Plaintiffs' response: Undisputed.

164. Plaintiffs retained their expert Dr. Boles because of his reputation as a pro-life speaker and author, including speaking at conferences and testifying in front of numerous bodies for pro-life causes. Trial tr. 772:11–25; 775:6–13.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

165. Dr. Boles has written multiple books intended to persuade people not to choose to have an abortion. Trial tr. 773:1–6.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.

166. One of Dr. Boles's books describes his proposed strategy for making all "elective induced abortions" illegal, which includes "help[ing] our friends punish our

enemies and aveng[ing] ourselves on traitors." Trial tr. 774:7–776:9.

Plaintiffs' response: NIFLA Plaintiffs defer to the Schroeder plaintiffs for this response and incorporate it by reference.