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IN THE
INDIANA COURT OF APPEALS

No. 25A-PL-00782

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| CAITLIN BERNARD, M.D., and CAROLINE ROUSE, M.D.,<br>Plaintiffs-Appellees,<br><br>v.<br><br>INDIANA STATE HEALTH COMMISSIONER, in the officer's official capacity, and VOICES FOR LIFE, INC.,<br>Defendants-Appellants. | Interlocutory Appeal from the Marion Superior Court<br><br>Case No. 49D13-2502-PL-006359<br><br>Hon. James A. Joven, Judge |

# MEMORANDUM BRIEF OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AND THE SOCIETY FOR MATERNAL-FETAL MEDICINE AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES

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## INTEREST OF *AMICI CURIAE*[1]

The American College of Obstetricians and Gynecologists ("ACOG") is the nation's leading group of physicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit membership organization of more than 62,000 members, ACOG strongly advocates for equitable, exceptional, and respectful care for all people in need of obstetric and gynecologic care, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing patients and their families and communities. ACOG opposes medically unnecessary laws or restrictions that serve to delay or prevent care. Over 800 members of ACOG who live and practice in Indiana are directly affected by laws restricting access to abortion care and other reproductive health care in the state. ACOG has previously appeared as *amicus curiae* in jurisdictions throughout the country, and its briefs and guidelines have been cited by numerous courts as providing authoritative medical data regarding childbirth and abortion.[2]

The Society for Maternal-Fetal Medicine ("SMFM") is the medical professional society for maternal-fetal medicine subspecialists, who are obstetricians with additional training in high-risk pregnancies. SMFM was founded in 1977, and it represents more than 5,500 members,

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[1] No counsel of a party authored this brief in whole or part, and no person other than *amici* or their counsel made any monetary contribution intended to fund the preparation or submission of this brief.

[2] *See, e.g.*, *June Med. Servs. LLC v. Russo*, 591 U.S. 299, 340 (2020); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582, 612–13 (2016); *Stenberg v. Carhart*, 530 U.S. 914, 928 (2000) (quoting ACOG extensively and referring to ACOG's work as among the "significant medical authority" supporting the comparative safety of the abortion procedure at issue); *Whole Woman's Health v. Paxton*, 978 F.3d 896, 910 (5th Cir. 2020); *Planned Parenthood S. Atlantic v. State*, 882 S.E.2d 770, 787–88 (S.C. Jan. 5, 2023) (citing ACOG's practice guidance as authority in opinion considering whether an abortion ban violates the state constitution); *Hodes & Nauser, MDs, P.A. v. Schmidt*, 440 P.3d 461, 505 (Kan. 2019) (Biles, J., concurring) (citing ACOG's practice guidance as medical authority in opinion that considered whether Kansas recognizes the state constitutional right to abortion).

including 50 professionals who live and practice in Indiana, caring for high-risk pregnant people. SMFM provides education, promotes research, and engages in advocacy to advance optimal and equitable perinatal outcomes for all people who desire and experience pregnancy. SMFM and its members are dedicated to ensuring that all medically appropriate treatment options are available for individuals experiencing high-risk pregnancies. SMFM's *amicus* briefs also have been cited by courts in cases raising various medical issues.[3]

## SUMMARY OF ARGUMENT

*Amici* urge this Court to affirm the lower court's decision to issue a preliminary injunction blocking the Indiana Department of Health from releasing Terminated Pregnancy Reports ("TPRs") under Indiana's Access to Public Records Act ("APRA"). Blocking the release of TPRs is necessary to protect public health and to ensure that the people of Indiana have access to essential, confidential medical care.

## ARGUMENT

### I. Pregnancy Termination Reports Contain Highly Sensitive Medical Information; Release of These Reports Will Have a Negative Impact on Public Health.

The medical community recognizes that abortion is a safe, common, and essential component of reproductive health care.[4] Pregnant patients regularly experience health risks and require emergency care, and that care sometimes includes abortion. For example, pregnant patients

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[3] *See, e.g.*, *Mayor of Baltimore v. Azar*, 973 F.3d 258, 285 & n.19 (4th Cir. 2020) (quoting *amicus* brief by SMFM and others supporting challenge to federal rule prohibiting physicians and other providers in Title X programs from referring patients for abortion, and noting that SMFM is a "reputable and nonpartisan medical organization[]").

[4] *See, e.g.,* Eds. of the New England Journal of Medicine, ACOG, et al., *The Dangerous Threat to* Roe v. Wade, 381 New Eng. J. Med. 979 (2019) (stating the view of the Editors of the New England Journal of Medicine along with several key organizations in obstetrics, gynecology, and maternal-fetal medicine that "[a]ccess to legal and safe pregnancy termination . . . is essential to the public health of women everywhere"); ACOG, *Abortion Policy* (revised and approved May 2022); SMFM, *Access to Abortion Services* (2020).

may present with a range of serious issues, including pre-term, pre-labor rupture of membranes ("PPROM"); ongoing miscarriage or early pregnancy loss; and excessive bleeding, placental abruption and gestational hypertension and preeclampsia (which complicate 2–8% of pregnancies and are among the leading causes of maternal mortality around the world).[5] In Indiana, abortions are legal in limited circumstances, including when necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life.[6]

When an abortion is performed in Indiana as permitted under state law, physicians must file a Termination of Pregnancy Report ("TPR") with the Indiana Department of Health.[7] TPRs contain detailed medical information including patient demographic data and patient medical history. For example, these reports contain detailed information about the patient, including the patient's age, marital status, education level, race, ethnicity, zip code and date of termination.[8] As specified by the Indiana Department of Health, "[m]edically relevant information collected from the patient and reported to IDOH also includes the patient's number of previous live births of children who are still living, the number of previous live births of children who are deceased, the number of previous spontaneous terminations (i.e., miscarriages), and the number of previously induced terminations (excluding the termination being reported). Patients are asked to list the years of previous spontaneous and induced terminations, and the date last normal menses began." In

[5] ACOG, Practice Bulletin No. 217, *Prelabor Rupture of Membranes* (Mar. 2020); ACOG, Practice Bulletin No. 200, *Early Pregnancy Loss* (Nov. 2018); *FAQs: Bleeding During Pregnancy*, ACOG (last updated May 2021); ACOG, Obstetric Care Consensus No. 7, *Placenta Accreta Spectrum* (last updated 2021); ACOG, Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia* (June 2020).
[6] Ind. Code § 16-34-2-1 (2024).
[7] Ind. Code § 16-34-2-5 (2024); *see, e.g.*, Ind. Dep't of Health, *Terminated Pregnancy Report Jan. 1 – March 31, 2025*, https://www.in.gov/health/vital-records/files/2025-Q1-ITOP-Report.pdf.
[8] *Id.*

response to a statutory change in Indiana law which required the inclusion of over thirty (30) categories of information, including most of the data points listed above, Indiana stopped releasing TPRs to the public because of confidentiality concerns raised by the level of detail contained in reports and the danger of identification of patients from such reports.[9]

While Attorney General Rokita has issued an advisory opinion advocating for the release of TPRs to assist with Indiana law enforcement,[10] there is no indication that Indiana's existing law enforcement tools are insufficient to enforce Indiana's laws. However, release of such reports will have a severe negative impact on public health, violate patient confidentiality and interfere directly in the physician-patient relationship. Indeed, releasing detailed patient information to the public raises a very real threat to patients and the physicians that care for them.

The importance of confidentiality when it comes to private health information is well-documented. The Indiana Access to Public Records Act (Ind. Code § 5-14-3) specifically exempts medical records from its disclosure requirements. The Indiana Medical Records Confidentiality Act (Ind. Code §16-39) requires health care providers to protect the confidentiality of patient health records and states that information released to a department of the Indiana government is confidential.[11]

Similarly, the U.S. Department of Health and Human Services has adopted Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") pursuant to the

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[9] *See* Whitney Downard, *Judge dismisses abortion records lawsuit*, Indiana Capital Chronicle (Sept. 1, 2024), https://indianacapitalchronicle.com/briefs/judge-dismisses-abortion-records-lawsuit/.

[10] Attorney General Todd Rokita, Official Opinion 2024-2, *Nondisclosure of Terminated Pregnancy Reports* (Apr. 11, 2024), https://content.govdelivery.com/attachments/INAG/2024/04/11/file_attachments/2844656/TPR%20Official%20Opinion.pdf.

[11] *See* I.C. § 16-39-5-3 (2024) (Provider's Use of Records; Confidentiality; Violations).

federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191. HHS's summary of the Privacy Rule states:

> A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing.[12]

The Privacy Rule provides rigorous de-identification standards for information that may be released by covered facilities under the statute precisely because re-identification is a known threat. Section 164.514(a) of the HIPAA Privacy Rule provides that health information that identifies an individual, *or* health information with respect to which there is a reasonable basis to believe that the information could be used to identify an individual, constitutes individually identifiable health information.[13] The HHS's Office for Civil Rights' Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the HIPAA Privacy Rule ("HHS De-Identification Guidance") acknowledges the persistent risk of re-identification, emphasizing that even under rigorous de-identification methods, the goal is to achieve a risk that is "very small . . . not zero."[14]

Removal of identifiers that are not unique to one individual is suggested to lower the risk of identification precisely because seemingly innocuous data points, when combined, can lead to re-identification.[15] This possibility is increased for certain individuals: for example, patients in

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[12] U.S. Dep't of Health and Human Services, *Summary of HIPAA Privacy Rule* (revised May 2003), https://www.hhs.gov/sites/default/files/privacysummary.pdf.
[13] 45 C.F.R. § 164.514(a) (2024).
[14] Office for Civil Rights (OCR) of the U.S. Dep't of Health and Human Services (HHS), *Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability (HIPAA) Privacy Rule*, at 6 (Nov. 26, 2012), https://www.hhs.gov/hipaa/for-professionals/special-topics/de-identification/index.html; *see also* § 164.514(a) of the HIPAA Privacy Rule.
[15] *See* OCR, *Guidance Regarding Methods for De-Identification*, *supra* n.13 at 27–28.

rural areas and small towns with a smaller pool of individuals associated with demographic information, or patients with rare medical conditions or unique medical histories. HIPAA's guidance on satisfying the Safe Harbor method for de-identification under the Privacy Rule includes the removal of ZIP code for all geographic units containing 20,000 or fewer people, directly acknowledging that small populations inherently increase re-identification risk.[16]

Privacy protections, while already fulsome under HIPAA and Indiana law, require even more vigilance and reinforcement when applied to reproductive health. This is because the disclosure of such sensitive data, even if purportedly anonymized, can create a chilling effect, deterring individuals from seeking essential medical services out of fear that their private health information could be used against them or publicly exposed. This concern is not theoretical— it directly impacts patients' willingness to engage openly and honestly with reproductive health care providers, thereby undermining the very foundation of effective medical care. Privacy in the area of reproductive health care is not merely a preference; it is a fundamental component of ensuring public health and safety.

## II. Uncertainty Regarding Privacy Creates a Barrier to Reproductive Health Care

Despite legal protections, abortion care remains highly stigmatized. If individuals believe their private medical conditions and decisions could become public knowledge, even indirectly, they may delay or avoid seeking care to escape public scrutiny, social stigma, threats and harassment, or discrimination from their communities, employers, or even family members. The uncertainty regarding privacy extends beyond abortion services, potentially leading individuals to postpone or forego other essential reproductive health care, including prenatal care, postpartum care, and treatment for pregnancy complications.

[16] 45 C.F.R. § 164.514(b) (2024).

The danger of a delay or avoidance of necessary health care is critically compounded by the alarming state of maternal mortality rates in the United States. The U.S. already faces a maternal mortality crisis, with rates significantly higher than other developed nations, and persistent racial and ethnic disparities. In 2022, the maternal mortality rate was 22.3 deaths per 100,000 live births, a rate that remains unacceptably high. Moreover, maternal mortality disproportionately affects Black women whose rate was 49.5 deaths per 100,000 live births in 2022, more than double the national average.[17] When individuals, particularly those in vulnerable communities already facing barriers to care, fear that seeking medical attention for a pregnancy-related issue could lead to public exposure of highly personal information, this hesitation can create an additional, formidable barrier to essential reproductive health care.

Reluctance to engage with the health care system over uncertainty regarding potential re-identification has direct and severe public health consequences. Patients may avoid follow-up appointments, neglect to disclose critical medical history, or even opt against seeking emergency care if they believe interactions could result in release of their private health information.[18] Given

[17] Donna L. Hoyert, Nat'l Ctr. for Health Stat., CDC, *Maternal Mortality Rates in the United States, 2022* (May 2024), https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2022/maternal-mortality-rates-2022.pdf. Indiana's Maternal Mortality Review Committee reported a 100.1 pregnancy-associated mortality ratio and a 17.5 pregnancy-related mortality ratio for 2021. Consistent with national rates, Indiana's maternal mortality rates are significantly higher for Black women. *See* Div. of Fatality Review and Prevention, Indiana Maternal Mortality Review Committee, *2023 Annual Report* (2023), MMRC-Annual-Report-2023.pdf .

[18] *See* ACOG*, Code of Professional Ethics of the American College of Obstetricians and Gynecologists* (2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf?rev=efb878bf939d46b1a05f8775eff49c0b; ACOG, Committee Opinion 803, *Confidentiality in Adolescent Health Care* (2020); ACOG, Committee Opinion 711, *Opioid Use and Opioid Use Disorder in Pregnancy* (2017, reaffirmed 2021); ACOG, Committee Opinion 633, *Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice* (2015, reaffirmed 2021).

that over 80% of pregnancy-related deaths are preventable,[19] the ability of patients to seek timely, confidential, and comprehensive care is paramount to improving maternal health outcomes. The public release of TPRs would directly undermine these efforts by creating an environment of mistrust and fear, ultimately increasing preventable morbidity and mortality for pregnant people across Indiana. This would be directly at odds with the Indiana Department of Health's own commitment to reducing maternal morbidity and mortality in the state[20] and recognition that infant mortality is one of "Indiana's Ongoing Health Threats."[21]

## III. Release of TPRs Could Increase the Danger of Violence Against Abortion Providers and Patients in Need of Abortion Care

Publicizing TPRs places both physicians and patients at a heightened risk of threats, harassment, and violence. The landscape surrounding abortion care is already fraught with aggression. The suspect in the assassination of Minnesota state lawmaker Melissa Hortman earlier this month reportedly had a list of targets that included abortion providers in Minnesota.[22] In 2023 and 2024 alone, the National Abortion Federation reported 38 instances of assault and battery against abortion providers, 3,582 reports of harassment against abortion providers, and 296 reported incidents of death threats or other threats of harms directed at abortion providers and patients.[23] This pervasive climate of intimidation already compromises the safety of those

[19] CDC, *Preventing Pregnancy Related Deaths* (Sept. 25, 2024), https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html.
[20] Ind. Dep't of Health, *Indiana Maternal Mortality Review Committee 2023 Annual Report*, https://www.in.gov/health/safesleep/files/MMRC-Annual-Report-2023.pdf.
[21] Ind. Dep't of Health, *Indiana State Health Assessment and Improvement Plan 2022–2026*, https://www.in.gov/health/files/2022-2026-Indiana-State-Health-Assessment-and-Improvement-Plan-_FINAL.pdf.
[22] Anushka Patil, *Suspect in Minnesota Killings Had Named Dozens of Potential Targets* (June 15, 2025), NY Times, https://www.nytimes.com/2025/06/15/us/minnesota-shootings-suspect-targets.html.
[23] National Abortion Federation, *NAF 2023/2024 Violence & Disruption Report*, https://prochoice.org/our-work/provider-security/2024-naf-violence-disruption/.

providing and seeking care. Providing the general public with TPRs, which they lack the medical training and education to properly understand or contextualize, serves no demonstrable public policy purpose while amplifying the existing danger.

The public release of TPRs would endanger physicians, including Plaintiff-Appellees, by suggesting that health care providers offering abortion services are subject to public scrutiny beyond established regulatory frameworks. Because the state already has access to the information in TPRs, there is no need for "citizens to monitor potential violations of Indiana laws regulating abortion, to bring apparent violations to the attention of public officials, and to hold their public officials accountable to enforce the law."[24] As a matter of public policy, tasking members of the public with monitoring compliance with the law is both fraught with complications and unnecessary, given the existing channels of governmental and professional oversight under which doctors who provide abortions practice medicine. An environment in which the public is tasked with monitoring physicians not only potentially endangers the physical safety of medical professionals, but it also creates a significant barrier for qualified practitioners to provide essential legal health care services, ultimately limiting access to care for all pregnant individuals.

Vulnerable patients would also face a disproportionately heightened risk from disclosure of TPRs, especially survivors of intimate partner violence (IPV). The alarming reality is that one in five pregnant patients report experiencing interpersonal violence, with a domestic partner being the aggressor in the majority of these cases.[25] Indeed, homicide and suicide have surpassed medical causes as the leading contributors to maternal mortality in the United States, with rates for Black

[24] Voices for Life Br. at 28.
[25] Petrone P, Jiménez-Morillas P, Axelrad A, Marini CP, *Traumatic injuries to the pregnant patient: a critical literature review*. Eur J Trauma Emerg Surg (Sept. 2019); ACOG Committee Opinion 518, *Intimate Partner Violence* (2012, reaffirmed 2025).

pregnant people roughly four times the national average.[26] For these individuals, privacy is not merely a preference but a critical component of their safety.[27] Publicizing TPRs can facilitate IPV, because the reports, even if nominally de-identified, may be combined with other readily available data to identify a patient. A domestic partner, knowing or suspecting a pregnancy occurred, could use publicly available TPR data to deduce if, when, and where a termination took place, potentially using this information to control, punish, or locate the survivor. This can put survivors into an untenable situation: having to weigh concerns regarding their health against concerns regarding their safety. The state should not facilitate such a perilous dilemma by eroding the confidentiality of medical records.

## IV. Release of TPRs Under APRA is at Odds with Ethical Principles Underpinning the Practice of Medicine

The release of TPRs upon public request is at odds with the ethical principles that underpin the practice of medicine: the sanctity of the physician-patient relationship, the principles of beneficence and non-maleficence, and respect for patient autonomy.

### a. Erosion of Patient Privacy and Confidentiality Results in Harm to the Physician-Patient Relationship

ISCH argues that Plaintiff-Appellees have failed to provide evidence that release of the TPRs will harm them personally in any way.[28] To the contrary, grave harm will result to the relationship between reproductive health care providers in Indiana—including Plaintiff-Appellees—and their patients if TPRs are released to the public.

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[26] National Study Reveals Homicide and Suicide as Leading Causes of Maternal Mortality in the U.S., Science Magazine, June 26, 2025, National Study Reveals Homicide and Suicide as Leading Causes of Maternal (accessed on June 26, 2025).
[27] ACOG Committee Opinion 554, *Reproductive and Sexual Coercion* (2013, reaffirmed 2025).
[28] ISCH Brief at 48–49.

A strong patient-physician relationship is critical for the provision of safe and quality reproductive health care.[29] For centuries, the patient-clinician relationship has been the foundation of medical practice. This relationship, as embodied in the clinical encounter, has an ethical foundation and is built on trust, confidentiality, and honesty.[30]

Clinicians are obligated not only to center the interests of their patients but also "to serve as the patient's advocate and to exercise all reasonable means to ensure that the most appropriate care is provided to the patient."[31] When trust is established, patients feel comfortable sharing deeply personal information with their physician, which leads to the best, individualized course of treatment. ACOG opposes laws that interfere with or threaten the patient-physician relationship.

Patient confidentiality is central to this relationship and is vital in the context of reproductive health care. Without clear confidentiality protections, patients will not share the intimate and personal information that allows clinicians to counsel patients to the best of their abilities, based on a patient's best interests and the best available scientific evidence.[32] Rules protecting confidential patient communications are among the most ancient and enduring components of medical ethics codes.[33] These rules are based on the principle of respect for patient

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[29] ACOG, *Statement of Policy, Legislative Interference with Patient Care, Medical Decisions, and the Patient-Physician Relationship* (May 2013, reaffirmed and amended Aug. 2021) ("ACOG, Legis. Policy Statement").
[30] AMA, Code of Medical Ethics, *Opinion 1.1.1: Patient Physician Relationships*, https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/1.1.1.pdf; ACOG, *Code of Professional Ethics of the American College of Obstetricians and Gynecologists*, Code of Conduct § I.3 (2018), https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/acog-policies/code-of-professional-ethics-of-the-american-college-of-obstetricians-and-gynecologists.pdf?rev=efb878bf939d46b1a05f8775eff49c0b ("ACOG Code of Conduct").
[31] ACOG Code of Conduct § I.2.
[32] AMA, *Code of Medical Ethics* (revised June 2001), Principles § IV ("A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.").
[33] ACOG, Committee Opinion No. 390, *Ethical Decision Making in Obstetrics and Gynecology* (2007, reaffirmed 2019); ACOG Code of Conduct § I.7.

autonomy, which includes a patient's right to privacy, and on the physician's responsibility to act as an advocate for their patients and safeguard patient information.[34] Rules of confidentiality are also justified by their impact: the assurance of privacy in communications encourages patients to fully disclose information that may be essential in making an accurate diagnosis and planning appropriate treatment.[35] Amici strongly oppose the interpretation of policies or laws in ways that interfere with a clinician's ethical requirement to protect private medical information.

Allowing the release of TPRs to the public would have a serious negative impact on and interfere with the necessary trust and confidentiality embodied in the patient-physician relationship. A confidential, trusting, and open dialogue between patient and physician is essential to achieving the best health care outcomes.

***First***, as noted *supra* Part I, reports that contain information like age, gestational duration, reason for termination, and/or location could, in combination with other publicly available information, allow for re-identification of individuals, especially in small communities or unique circumstances. Exposing information that puts patients at a risk of re-identification directly violates the fundamental principle of patient confidentiality that undergirds the physician-patient relationship.

***Second***, even if the anonymization process could be successful, the *impact* on the patient-physician relationship is still damaged by public disclosure of TPRs. Patients rely on the assurance that their medical information will remain private. Removing that assurance of privacy will inevitably cause patients to become less willing to disclose relevant information. If trust in the

[34] ACOG, Committee Opinion No. 390.
[35] *Id.*

patient-physician relationship is breached, individuals may become hesitant to seek necessary reproductive health services, fearing exposure or judgment.

**b. The Disclosure of Termination Reports Violates the Principles of Beneficence and Non-Maleficence**

Beneficence, the obligation to promote the well-being of others, and non-maleficence, the obligation to do no harm and cause no injury, have been cornerstones of the medical profession since the Hippocratic traditions began nearly 2,500 years ago.[36] Both principles arise from the foundation of medical ethics, which requires that the welfare of the patient form the basis of all medical decision-making.[37]

Obstetricians, gynecologists, and other clinicians providing abortion care respect these ethical duties by engaging in patient-centered counseling; providing patients with non-judgmental information about risks, benefits, and pregnancy options; and ultimately empowering patients to make decisions informed by both medical science, their individual condition and their lived experiences.[38]

Release of TPRs to the public pursuant to APRA compromises these principles of beneficence and non-maleficence by requiring physicians to sacrifice their patients' confidentiality in favor of a "public interest" in the confidential information. As explained *supra* Part IV.a, confidentiality is the underpinning of the physician-patient relationship that allows physicians to ensure the best possible health care outcomes based on as much pertinent information as possible. When that confidentiality is eroded, it impacts a physician's ability to promote the well-being of

[36] AMA, *Code of Medical Ethics*, Principles; ACOG, Committee Opinion No. 390.
[37] ACOG Code of Conduct; AMA, Code of Medical Ethics, *Opinion 1.1.1. Patient-Physician Relationships*.
[38] ACOG, Practice Bulletin No. 162, *Prenatal Diagnostic Testing for Genetic Disorders*, 127 Obstetrics & Gynecology e108 (May 2016).

his or her patients. Requiring a physician to disclose confidential information in a TPR that is subsequently made public is contrary to the long-standing ethical rule that "patients are entitled to decide whether and to whom their personal health information is disclosed".[39] Such requirements "interfere with the ability of physicians to have open, honest, and confidential communications with their patients."[40] Because the information in their TPRs may be disclosed to the public, patients will be justified in any reluctance to share sensitive information.

By undermining the patient-physician relationship, violating the principles of beneficence and non-maleficence, and threatening clinicians' ability to respect patient autonomy, disclosure of TPRs to the public harms both the ethical practice of medicine and patient health and safety while not advancing a legitimate public interest.

## CONCLUSION

This Court should affirm the trial court's grant of a preliminary injunction blocking the Indiana Department of Health from releasing TPRs under Indiana's APRA.

RESPECTFULLY SUBMITTED this 11th day of July, 2025.

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[39] AMA, Code of Medical Ethics Opinion 3.2.1, *Confidentiality* (2016).
[40] ACOG, Committee Opinion No. 819, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology* (Feb. 2021).

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**Word Count Certification**

I verify that this brief contains no more than 7,000 words.

*/s/ Mark W. Sniderman*
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## CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing has been served through the court's e-filling system on this 11th day of July 2025, upon:

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