NO. 14-1150

United States Court of Appeals

for the

Fourth Circuit

GRETCHEN S. STUART, MD, on behalf of herself and her patients seeking abortions; JAMES R. DINGFELDER, MD, on behalf of himself and his patients seeking abortions; DAVID A. GRIMES, MD, on behalf of himself and his patients seeking abortions; AMY BRYANT, MD, on behalf of herself and her patients seeking abortions; SERINA FLOYD, MD, on behalf of herself and her patients seeking abortions; DECKER & WATSON, INC., d/b/a Piedmont Carolina Medical Clinic; PLANNED PARENTHOOD OF CENTRAL NORTH CAROLINA; A WOMAN'S CHOICE OF RALEIGH, INC.; PLANNED PARENTHOOD HEALTH SYSTEMS, INC.; TAKEY CRIST, on behalf of himself and his patients seeking abortions; TAKEY CRIST, M.D., P.A., d/b/a Crist Clinic for Women,

Plaintiffs-Appellees,

(For Continuation of Caption See Inside Cover)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA AT GREENSBORO
AT CASE NO. 1:11-CV-00804-CCE-LPA
CATHERINE C. EAGLES, U.S. DISTRICT COURT JUDGE

BRIEF OF *AMICUS CURIAE* AMERICAN PUBLIC HEALTH ASSOCIATION IN SUPPORT OF PLAINTIFFS-APPELLEES

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– v. –

PAUL S. CAMNITZ, MD, in his official capacity as President of the North Carolina Medical Board and his employees, agents and successors; ROY COOPER, in his official capacity as Attorney General of North Carolina and his employees, agents and successors; ALDONA ZOFIA WOS, in her official capacity as Secretary of the North Carolina Department of Health and Human Services and her employees, agents and successors; JIM WOODALL, in his official capacity as District Attorney ("DA") for Prosecutorial District ("PD") 15B and his employees, agents and successors; LEON STANBACK, in his official capacity as DA for PD 14 and his employees, agents and successors; DISTRICT ATTORNEY DOUGLAS HENDERSON, in his official capacity as DA for PD 18 and his employees, agents and successors; BILLY WEST, in his official capacity as DA for PD 12 and his employees, agents and successors; C. COLON WILLOUGHBY, JR., in his official capacity as DA for PD 10 and his employees, agents and successors; BENJAMIN R. DAVID, in his official capacity as DA for PD 5 and his employees, agents and successors; ERNIE LEE, in his official capacity as DA for PD 4 and his employees, agents and successors; JIM O'NEILL, in his official capacity as DA for PD 21 and his employees, agents and successors,

Defendants-Appellants,

JOHN THORP,

Intervenor/Defendant.

CORPORATE DISCLOSURE STATEMENT
PURSUANT TO FRAP 26.1 AND LOCAL RULE 26.1

Amicus curiae the American Public Health Association is a non-profit organization, with no parent corporation or publicly traded stock.

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

The American Public Health Association ("APHA") submits this brief as *amicus curiae* in support of Plaintiffs-Appellees, Gretchen M. Stuart, M.D., *et al.*[1]

APHA's mission is to champion the health of all people and all communities, strengthen the profession of public health, share the latest research and information, promote best practices, and advocate for public health issues and policies grounded in research. APHA is the only organization that combines a 140-plus-year perspective, a broad-based member community, and the ability to influence federal policy to improve the public's health.

It has been the longstanding position of APHA that access to the full range of reproductive health services, including abortion, is a fundamental right and integral to the health and well-being of individual women and to the broader public health. APHA opposes legislation that makes abortion services more difficult to obtain or more likely to cause harm to the mental health of individual women. This includes legislation that does not respect a woman's capacity to exercise her own judgment, in consultation with her doctor, about the information that she

[1] Pursuant to Federal Rule of Appellate Procedure 29, the parties have consented to the filing of this *amicus* brief. Also pursuant to Rule 29, undersigned counsel for *amicus curiae* certify that: (1) no counsel for a party authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity—other than *amicus curiae*, its members, and its counsel—contributed money intended to fund the preparation or submission of this brief.

would like to receive prior to receiving medical care, including abortion. APHA opposes legislation that violates patients' rights by imposing any form of coercion in the decision making process, and that their doctors do not, in the exercise of their medical judgment and consistent with their professional ethics, believe is necessary or advisable to convey.

APHA has 707 members in North Carolina, and also has maintained a connection to the public health community in North Carolina through its affiliate, the North Carolina Public Health Association ("NCPHA"), which has provided over 100 years of public health service. APHA has previously been granted leave to appear as *amicus curiae* in various courts throughout the country on matters relating to reproductive health, including in the Fourth Circuit and in the United States Supreme Court.

SUMMARY OF ARGUMENT

It is critical to the public health interests of the United States that all women have meaningful access to reproductive health services, including abortion. By imposing medically unjustified requirements on physicians providing abortion care, North Carolina's Display of Real-Time View Requirement compels physicians to compromise their medical judgment, their ethical obligations, and the integrity of the physician-patient relationship and may endanger their patients' mental health. In doing so, the Requirement not only violates the constitutional

rights of doctors, as Plaintiffs-Appellees argue, but poses a grave risk to public health.

ARGUMENT

I. Reproductive Health Services, Including Abortion, Are Critical to a Fully Functioning Public Health System.

APHA opposes the Display of Real-Time View Requirement because it jeopardizes the public health in North Carolina by imposing restrictions on the provision of safe and legal abortion without medical justification. Without safe, legal abortion, women of reproductive age face significantly increased risks to their health, including risks of major physical and mental health complications from pregnancy and childbirth, and increased risks of death. Abortion is a component—and an essential one—of comprehensive reproductive care.

Comprehensive health care—including abortion—furthers the goals of public health, including preventing disease, promoting health, and prolonging life among the population as a whole. Legal abortion is extremely safe.[2] Like other

[2] *See* Bonnie Scott Jones & Tracy Weitz, *Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences*, 99 Am. J. Pub. Health 623, 623 (2009) ("Abortion is very safe in both the first and second trimesters. Mortality risk is approximately .6 deaths per 100,000 abortions, and the risk of major complication is less than 1%. The risk associated with abortion increases with the weeks of pregnancy . . . . Second-trimester abortion, however, is still a very safe procedure."); World Health Org., *Safe Abortion: Technical and Policy Guidance for Health Systems* 67 (2012), *available at* http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf ("Both vacuum aspiration and medical abortion can be provided at the primary-

forms of health care, safe, legal abortion reduces the risk of a range of negative and even life-threatening outcomes, including psychological complications like maternal depression,[3] premature delivery, and low birth weight.[4]

Since 1967, APHA has recognized that availability of safe abortion services is a public health issue, and has called for increases in federal funding for abortion and protection of abortion as a woman's reproductive choice.[5] APHA approaches abortion as a question of public health and, in doing so, has long recognized that affordable and acceptable reproductive health services, including abortion, are critical to a fully functioning public health system.[6] In addition to reproductive

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care level on an outpatient basis and do not require advanced technical knowledge or skills, expensive equipment such as ultrasound, or a full complement of hospital staff (e.g. anesthesiologist)."); Gail Erlick Robinson et al., *Is There an "Abortion Trauma Syndrome?"*, 17 HARV. REV. PSYCHIATRY 268, 268 (2009) ("The relative risk of death in the United States from an abortion is . . . lower than childbirth, appendectomy, or tonsillectomy.").

[3] Jessica D. Gipson, et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 STUD. FAM. PLAN. 18, 28 (2008).

[4] *Id*. at 24.

[5] Am. Pub. Health Ass'n, *Policy Statement No. 2008–Need for State Legislation Protecting and Enhancing Women's Ability to Obtain Safe, Legal Abortion Services Without Delay or Government Interference* (Oct. 2008), *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1369.

[6] *See, e.g.*, Am. Pub. Health Ass'n , *Policy Statement No. 6808–Abortion* (Jan. 1968), *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=595.

care, the Requirement implicates two other critical components of public health: mental health and the physician-patient relationship. APHA has long recognized that it is critical to public health that physicians act in accordance with their medical ethics and judgment and not undertake, much less be legislatively compelled to undertake, actions that they believe would be harmful to their patients.[7] APHA also recognizes that mental health forms a critical component of public health.[8] Accordingly, in furtherance of its mission, APHA strongly opposes implementation of the Display of Real-Time View Requirement.

APHA is not alone in recognizing that safe, legal abortion is essential to public health. The American College of Obstetricians and Gynecologists ("ACOG") also supports "reproductive health services for all women, including strategies to reduce unintended pregnancy and to improve access to safe abortion services."[9] The American Women's Health Association ("AMWA") "considers

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[7] *See* Am. Pub. Health Ass'n , *Policy Statement No. 20083–Need for State Legislation Protecting and Enhancing Women's Ability to Obtain Safe, Legal Abortion Services Without Delay or Government Interference* (Oct. 2008), *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1369.

[8] *See* Am. Pub. Health Ass'n , *Policy Statement No. 7633(PP) –Policy Statement on Prevention* (Jan. 1976), *available at* http://www.apha.org/advocacy/policy/policysearch/default.htm?id=835.

[9] Am. Coll. Obstetricians & Gynecologists, *Committee Opinion No. 424 – Abortion Access and Training* 1 (Jan. 2009).

such procedures to be a part of comprehensive healthcare for women."[10] The Association of Reproductive Health Professionals ("ARHP") has recognized that "[a]bortion care is a critical component of comprehensive reproductive health care, and ARHP supports a woman's right to choose to have an abortion."[11] The American Psychiatric Association ("APA") "affirms that the freedom to act to interrupt pregnancy must be considered a mental health imperative with major social and mental health implications."[12] Like APHA, these organizations recognize abortion as a necessary component of reproductive health and public health more generally.

II. The Display of Real-Time View Requirement Is Detrimental to Psychological and Public Health.

The "Display of Real-Time View Requirement" requires North Carolina physicians to display fetal ultrasound images to their patients—while the patient is partially unclothed, supine and with a probe either in her vagina or on her abdomen—and to narrate the dimensions of the fetus and the presence of external appendages and internal organs at least four hours prior to an abortion procedure.

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[10] Gayatri Devi, Michele Glodowski, & Elizabeth Shin, *AMWA Position Statement on Abortion and Reproductive Rights*, 18 J. WOMEN'S HEALTH, 229, 229 (2009).

[11] Ass'n Reprod. Health Prof., Position Statement, *Access to Reproductive Health* (June 2012), *available at* http://www.arhp.org/about-us/position-statements#1.

[12] Am. Psychiatric Ass'n, *Abortion and Women's Reproductive Healthcare Rights*, AM J. PSYCHIATRY, June 2010, at 726.

A physician must display and describe the images even if the patient objects and even if the physician believes it will harm that patient. This forced ultrasound, display, and narration, imposed upon women even if they directly object, has a direct impact on mental health—as would any invasive medical procedure imposed for no medical reason on any patient. APHA joins in opposing the State's attempt to force unwanted and harmful speech on patients and their doctors because of the risks that kind of state-imposed speech poses to public health.

A. The Requirement Creates an Adversarial Relationship Between Doctor and Patient, and Undermines Patients' Psychological Health.

The right to receive medically sound abortion care is a public health imperative and a mental health imperative. Abortion itself does not carry any greater risk of adverse psychological consequences than does carrying a pregnancy to term,[13] but if the provision of abortion care is compromised by the state's forced narration of unwanted images to their patients, that new, compromised process will pose a real and immediate threat to patients'

[13] *See* Acad. Med. Royal Coll., INDUCED ABORTION AND MENTAL HEALTH: A SYSTEMATIC REVIEW OF THE MENTAL HEALTH OUTCOMES OF INDUCED ABORTION, INCLUDING THE PREVALENCE OF ASSOCIATED FACTORS 125 (2011); Brenda Major, et al., *Abortion and Mental Health: Evaluating the Evidence*, 64 AMERICAN PSYCHOLOGIST 863, 863 (2009); Trine Munk-Olsen et al., *Induced First Trimester Abortion and Risk of Mental Disorder*, 36 NEW ENG. J. MED. 332, 332 (2011); Robinson et al., *supra* note 2, at 276.

psychological wellbeing.[14] Forced narration of images against a woman's express will and her physician's recommendation poses an inherent risk of mental health trauma even in the absence of any heightened risk factors, by devaluing both the medical expertise of the doctor and the patient's capacity to make her own informed decision in a context in which the patient is already vulnerable—she is partially clothed, supine, and in the midst of a vaginal or abdominal exam. Unwanted speech at that moment and in that manner could be difficult to bear for even the most resilient patient. For many women, however, the risk of psychological harm is even more acute. The Requirement is likely to be psychologically damaging to a woman who desires to bring a healthy pregnancy to term but whose fetus has severe or fatal abnormalities or whose life or health is threatened by her pregnancy.[15] The Requirement also threatens particular harm to

[14] *Stuart v. Loomis*, 1:11-CV-804, 2014 WL 186310, at n.32 (M.D.N.C. Jan. 17, 2014) ("It is undisputed that some women in particular mental health or physical circumstances are at risk of suffering serious and lasting psychological or emotional harm if they watch the display and hear the description in the inflexible mode and manner required by the speech-and-display provision, especially if the message is delivered without their consent or over their objection.").

[15] *See, e.g.*, Joint Appendix ("JA") 432 ("In particular, I remember a woman with a wanted pregnancy who was devastated to learn that her fetus had anencephaly, a fatal medical condition in which the fetus lacks the cerebral hemispheres of the brain. . . . I cannot imagine having to tell this woman that before I can provide her the care she needs, I must perform an ultrasound and describe the details of the fetus to her."); JA 335–36; JA 414.

those patients who are seeking abortions because of severe fetal anomalies, such as anencephaly, a fatal medical condition in which the fetus lacks the cerebral hemispheres of the brain,[16] or pregnancy disorders, such as cardiac malfunction, that threaten the life of the mother.[17] A woman impregnated by rape or incest, for example, has already undergone unmistakable psychological trauma. Forcing her to endure a narrated ultrasound in which her doctor must describe and demonstrate the size and characteristics of the fetus is an additional, state-imposed ordeal that exacerbates her feelings of loss of control and dignity.[18]

The Requirement does not just risk causing substantial individual anguish – it also threatens to damage the collective public health by fundamentally subverting the trust that is at the core of the physician-patient relationship and that plays a critical role in health care of every form. The Requirement inevitably – and indeed intentionally – disrupts the doctor-patient relationship by forcing

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[16] JA 432.

[17] JA 413 ("For these women, although they have come to a firm decision to have an abortion, it is often an incredibly difficult and anguished decision, because the woman has a desired pregnancy that she cannot keep without risking her life or health.").

[18] *Loomis*, 2014 WL 186310 at n.35 ("It seems unexceptionable to conclude, for example, that serious psychological harm could result from requiring a woman who became pregnant as a result of rape to lie half-undressed with a vaginal probe inside her while she listens to an unwanted message from a medical professional who has refused to listen to her wishes, especially if she were blindfolded to avoid the message.").

doctors to provide patients with information even if doing so is against their own ethical requirements and medical judgment and against their patient's wishes.[19] That creates a dynamic of distrust that undermines the provision of health care. The "blindfold" provision—the statute's allowance that a patient may try to avoid seeing and hearing the narrative ultrasound—further damages public trust in the medical profession by giving the patient the impression that the physician disapproves of the patient's medical decisions. Women who perceive that their physicians disapprove of their personal decisions are more likely to suffer declines in their post-abortion mental health.[20]

Moreover, the blindfold provision damages public trust and endangers public health by encouraging patients to refuse to hear information their physician offers them. In doing so, the Requirement makes it potentially more likely that patients will distrust or dismiss information that—unlike the statutory narrative—physicians ***do*** think it is in the patient's best interest to hear and consider.[21]

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[19] Women's attitudes towards and experiences of abortion are intimately tied to their individual religious and moral values. Major, et al., *supra* note 13, at 866.

[20] Although abortion itself is not correlated with negative psychological consequences, perception of social stigma is predictive of a decline in post-abortion mental health. *See* Am. Psychol. Ass'n, REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION 4, 85 (2008).

[21] *See* Susan Dorr Goold & Mack Lipkin, Jr., *The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies*, 14 J. GEN. INTERN. MED. 26 (1999), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496871/.

Patients who dislike or distrust their physician are also less likely to disclose important medical details to their physicians, further endangering their health.[22] Conversely, patients who feel comfortable and engaged in the medical encounter enjoy better physical and mental health.[23]

The Requirement provides a disincentive for women to seek medical care, including psychological care. The Requirement creates an adversarial relationship between physician and patient,[24] and potentially forces a patient into the position of needing to protect or defend herself from something her physician is saying or doing as part of a medical procedure the physician is performing on her. A legally-compelled situation in which the physician is directly at odds with the patient is damaging to the patient's psychological wellbeing, as well as her physical health. The costs to the individual patient's mental and physical health of the Requirement are just too high. The Requirement does nothing to advance public health and much to damage it.

B. The Display of Real-Time View Requirement Violates the Accepted Medical Standard of Care for Informed Consent.

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[22] *See id.*

[23] *See id.*

[24] *See Loomis*, 2014 WL 186310, at * 9 ("[P]roviders appear to have adopted the state's message, and patients are likely to assume that the provider's speech delivered during a medical procedure conveys ideas and messages the provider endorses and has deemed 'worthy of presentation'.").

The Display of Real-Time View Requirement violates the accepted medical standard of care, endangering public health and the health of individual patients. It is standard medical practice to obtain a patient's informed consent prior to performing an abortion by providing detailed, one-on-one counseling[25] and offering her an opportunity to view an ultrasound.[26] It is not standard medical practice to describe the ultrasound images unless the patient so requests.[27] No more than two hours typically elapse between the ultrasound and the abortion procedure.[28]

By altering this standard without medical justification and forcing some women to see and hear information they do not want at that time, the Display of Real-Time View Requirement endangers public health, not only by making safe, legal abortion much more onerous to obtain, but also by negatively impacting the mental health of patients who do proceed despite the Requirement. Moreover, the Display of Real-Time View Requirement may result in multiple, superfluous

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[25] *See Loomis*, 2014 WL 186310, at *5.

[26] *Id.*

[27] *See* Howard Minkoff, MD & Jeffrey Ecker, MD, *When Legislators Play Doctor: The Ethics of Mandatory Preabortion Ultrasound Examinations*, 120 OBSTETRICS & GYNECOLOGY 647, 648–49 (2012).

[28] JA 326.

ultrasounds being performed, which contravenes standard medical practice,[29] lacks medical justification,[30] and may cause additional psychological harm to patients. It does all this without providing any information that a patient would otherwise be unable to access if she so chose.[31]

C. The Display of Real-Time View Requirement Requires Doctors to Violate Basic Requirements of Medical Ethics.

The Requirement damages public health by forcing physicians to violate central tenets of medical ethics, including obligations (*i*) to respect the patient's autonomy by obtaining her informed consent; (*ii*) to inflict no harm on the patient; and (*iii*) to act in the patient's best interests as a competent patient has defined those interests for herself.[32]

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[29] *See, e.g.*, Steven E. Weinberger et al., *Legislative Interference with the Physician-Patient Relationship*, 367 NEW ENG. J. MED. 1557, 1558 (2012) (condemning legislation mandating the performance of medically unnecessary diagnostic tests or medical interventions).

[30] *See Loomis*, 2014 WL 186310, at n.39 ("There is no evidence that in the ordinary case the description serves any diagnostic purpose, affects the kind of procedure undertaken, or has any other medical purpose. Indeed, all the evidence is to the contrary.").

[31] *See id.* at *5 (noting that standard medical practice in North Carolina already requires physicians to offer to display the ultrasound and answer patients' questions prior to performing an abortion).

[32] *See, e.g.*, Tom L. Beauchamp & James F. Childress, PRINCIPLES OF MEDICAL ETHICS 12 (5th ed. 2001).

The obligation to respect patient autonomy requires a physician to enable the patient to make an informed, autonomous choice and to respect that choice by refraining from coercive action.[33] The Display of Real-Time View Requirement does not provide patients with information they would otherwise be unable to access[34] and does not further fully informed consent.[35] It is not sound medical or ethical practice to mandate that a patient view an image of his or her own body in order to make an informed medical decision.[36] Rather, unnecessary disclosure of medical details such as, for example, the precise details of an appendectomy surgery, can in fact undermine a patient's ability to make informed decisions about her medical care.[37] The Requirement does not further fully informed consent and

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[33] *See*, *e.g.*, *id.* at 58–60.

[34] All physicians in North Carolina are required by law to comply with statutory provisions for informed consent as well as standards of medical practice, which require that physicians offer patients the opportunity to ask questions and view the ultrasound prior to the abortion procedure. *Loomis*, 2014 WL 186310, at *4–5.

[35] *See Loomis*, 2014 WL 186310, at *4 ("To the extent the Act requires providers to speak the state's message to women who cover their ears and eyes to avoid the state's message, it is performative rather than informative, and it does not serve any legitimate purpose.").

[36] Scott Woodcock, *Abortion Counseling and the Informed Consent Dilemma*, 25 BIOETHICS 495, 500 (2011) ("Details are routinely omitted in other contexts, unless patients ask for them, because of the . . . odds that they will affect patient decisions, e.g., the intricate surgical details of an appendectomy.").

[37] *Id.* at 497 (2011); *see also* O. O'Neill, *Some Limits of Informed Consent*, 29 J. MED. ETHICS 4, 6 (2003) ("Genuine consent is apparent where patients can

will force physicians to violate the principle of autonomy by performing a medically unnecessary narration and ultrasound against the will of a competent patient.

Physicians are obligated to "do no harm" to their patients—a moral, ethical, and professional obligation that the State of North Carolina would compel them to breach by forcing them to provide narration even when doing so would cause significant psychological harm to certain patients. The statute purports to ameliorate this harm by allowing a patient the 'option' to use a blindfold and earplugs to avoid seeing or hearing the narrative ultrasound, but that is nothing more than a demeaning charade. No patient should be forced to close her eyes and cover her ears to avoid information that in her own considered judgment she does not wish to see or hear. A patient's decision that she does not wish to see or hear the information should be enough.[38] A doctor's inability to comply with her adult patient's clearly expressed desire is harmful to that patient's mental health.

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control the amount of information they receive and what they allow to be done."); JA 365("In a breadth of such cases, disclosure of potentially disturbing information (for instance, about the force required to open the chest of a cardiac patient) is not required to establish informed consent and in fact its provision is likely to undermine it.").

[38] *See* Zita Lazzarini, *South Dakota's Abortion Script—Threatening the Physician–Patient Relationship*, 359 NEW ENG. J. MED. 2189, 2191 (2008) ("By assuming that women are incapable of making decisions about abortion as competent adults in consultation with their physicians, these statutes tend to

The Display of Real-Time View Requirement will force physicians to act against their patients' best interests by potentially exposing patients to psychological harm and medically unnecessary delays, and may result in serious consequences for the patient's health. The State of North Carolina's attempt to require its doctors to violate their ethical and professional obligations and act against—not for—their patients fundamentally compromises the public health, and especially the public mental health, and should be rejected.

CONCLUSION

For the foregoing reasons, *amicus curiae* APHA joins Plaintiffs-Appellees in urging the Court to affirm the district court's decision.

Dated: July 1, 2014
New York, N.Y.

Respectfully submitted,

/s/ Courtney M. Dankworth

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reduce women to their reproductive capacity and suggest that they need the paternalistic protection of legislatures and society.").

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because this brief contains 3,814 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point font size and Times New Roman type style.

Dated: July 1, 2014

/s/ Courtney M. Dankworth
Courtney M. Dankworth

Counsel for the American Public Health Association as Amicus Curiae

United States Court of Appeals
for the Fourth Circuit

14-1150, *Gretchen S. Stuart, M.D. v. Paul S. Camnitz, M.D., et al.*

CERTIFICATE OF SERVICE

I, Maryna Sapyelkina, being duly sworn according to law and being over the age of 18, upon my oath depose and say that:

On **July 1, 2014**, Counsel for Amicus Curiae have authorized me to electronically file the foregoing **Brief of *Amicus Curiae* American Public Health Association in Support of Plaintiffs-Appellees** with the Clerk of Court using the CM/ECF System, which will send notice of such filing to the following registered CM/ECF users:

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July 1, 2014

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UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

APPEARANCE OF COUNSEL FORM

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(party name)

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CERTIFICATE OF SERVICE

I certify that on 7/1/2014 the foregoing document was served on all parties or their counsel of record through the CM/ECF system if they are registered users or, if they are not, by serving a true and correct copy at the addresses listed below:

/s/ Courtney M. Dankworth Signature	July 1, 2014 Date

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