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

NATIONAL INSTITUTE OF FAMILY AND LIFE ADVOCATES, et. al.,	)	
Plaintiffs,	)	No. 16 CV 50310
v.	)	Judge Frederick J. Kapala
BRUCE RAUNER and BRYAN A. SCHNEIDER,	)	Magistrate Judge Iain D. Johnston
Defendants.	)	

DEFENDANTS' COMBINED REPLY IN SUPPORT OF THEIR MOTION TO DISMISS AND RESPONSE TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

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Defendants Bruce Rauner, the Governor of Illinois; and Bryan A. Schneider, the Secretary of the Illinois Department of Financial & Professional Regulation (the "IDFPR"); by their attorney, the Illinois Attorney General, hereby submit this combined reply in support of their motion to dismiss and response to Plaintiffs' motion for a preliminary injunction.

INTRODUCTION

Plaintiffs' response and motion for preliminary injunction reflect a fundamental misunderstanding of the purpose and operation of Senate Bill 1564. Contrary to what Plaintiffs repeatedly claim, the Health Care Right of Conscience Act (the "Conscience Act"), as amended by Senate Bill 1564 (the "Amended Act"), does *not* improperly "target" or "single out" pro-life medical professionals while leaving health care providers without religious objections to procedures "completely unregulated." Dkt. 36 at 1, 25. Plaintiffs' argument misses the point of the amendment and mischaracterizes Illinois law. The Conscience Act benefits religious objectors by protecting them from civil or criminal liability for refusing to provide certain services. Senate Bill 1564 simply clarifies that the Conscience Act's protections do not go so far as to exempt religious objectors from the standards of care that apply to other health care providers in Illinois. As explained below, the ethical guidelines governing the medical profession, which are incorporated into Illinois law, unambiguously require health care providers to disclose all relevant treatment options to their patients. Plaintiffs may exercise their right of conscience, but they are not exempt from complying with the ethical standards of informed consent that apply to other providers.

This Court should grant Defendants' motion to dismiss. Plaintiffs have abandoned their state-law claims, recognizing that the Eleventh Amendment bars such claims in this Court. As the state court in *The Pregnancy Care Center of Rockford v. Rauner* ("*Pregnancy Care Center*")

recently held, intermediate scrutiny, rather than strict scrutiny, applies to Plaintiffs' free speech claims.[1] As discussed below, the Amended Act satisfies this standard, requiring dismissal of Plaintiffs' free speech claims. Plaintiffs' free exercise and equal protection claims likewise fail to state a claim, even if strict scrutiny applies. Plaintiffs' claims under 42 U.S.C. 238n, the Coats-Snowe Amendment, should be dismissed because there is no private right of action to enforce this provision, and even if there were, Plaintiffs could not state a claim. Finally, the Governor is not a proper defendant and the claims against him should be dismissed. Accordingly, Plaintiffs' Complaint should be dismissed and their motion for preliminary injunction should be denied.

ARGUMENT

I. Plaintiffs' Complaint Should Be Dismissed for Failure to State a Claim.

A. Plaintiffs' State-Law Claims Are Barred by the Eleventh Amendment.

In their opening brief, Defendants explained that Plaintiffs' state-law claims are barred by the Eleventh Amendment. Dkt. 16 at 6-7. Plaintiffs do not dispute that their state-law claims are barred under *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 121 (1984), but instead "agree to withdraw their state law claims without prejudice." Dkt. 36 at 7. Plaintiffs' state-law claims should be dismissed accordingly.

B. Plaintiffs' Free Speech Claim Should Be Dismissed.

1. Intermediate Scrutiny Applies to Plaintiffs' Free Speech Claim.

In their opening brief, Defendants explained that intermediate scrutiny applied to regulations of professional speech, and that the requirements of the Amended Act easily satisfied such scrutiny. Dkt. 16 at 18-21. In their response, Plaintiffs assert that the Amended Act should be subject to strict scrutiny because "SB 1564 is a content- and viewpoint-based regulation."

[1] *See* Exhibit A hereto, *Pregnancy Center of Rockford v. Rauner*, No. 2016-MR-741, Mem. Op. and Order at 10-11 (Ill. Cir. Ct. Dec. 20, 2016).

Dkt. 36 at 15. But Plaintiffs' argument ignores the substantial case law holding that intermediate scrutiny should apply to regulations of licensed professionals "when speaking as part of the practice of [their] profession." *King v. Gov. of N.J.*, 767 F.3d 216, 232 (3d Cir. 2014). As the *Pregnancy Care Center* court concluded, "an intermediate standard of review" should apply to the Plaintiffs' free speech claim, because this standard of review "recognizes the State's traditional interest in regulating medical providers while still providing for meaningful protection of the providers' right to be free from compelled speech." Ex. A at 10-11. Moreover, the Conscience Act was amended to ensure that providers with a conscientious objection to providing certain treatments nevertheless provide their patients with sufficient information to make an informed decision regarding their health, and thus is *not* a viewpoint-based regulation. But as the *Pregnancy Care Center* court observed, intermediate scrutiny has been applied to statutes promoting a particular viewpoint – both to statutes that "reflect[] an effort . . . to convince women about the importance of fetal life," as well as to statutes "trying to ensure that patient were informed of their right to opt for abortion." Ex. A at 10.

Plaintiffs' other arguments for applying strict scrutiny (Dkt. 36 at 22) all fail as well. First, the fact that Plaintiffs offer their services free of charge does not change the analysis. Whether or not they charge for their services, the Plaintiffs are licensed medical professionals and can be regulated accordingly. *Nat'l Inst. of Family & Life Advocates v. Harris* ("*NIFLA*"), 839 F.3d 823, 841 (9th Cir. 2016) (plaintiffs' "non-profit status does not change the fact that they offer medical services in a professional context").

Second, while the doctor-patient relationship may be "sacrosanct" (Dkt. 36 at 22), it is the very importance of this relationship that justifies the State's reasonable regulation of doctors. In *Conant v. Walters*, 309 F.3d 629, 637 (9th Cir. 2002), the court struck down a regulation

forbidding doctors from telling patients that marijuana might be a beneficial treatment in their case. Here, in contrast, medical providers are not barred from offering any opinion; nor are they required to offer any opinion. The Amended Act merely clarifies that medical providers must still meet their pre-existing ethical obligation to provide all relevant information to their patients.

Finally, Plaintiffs' claim that the Amended Act "is not an informed consent law such as can be required before an abortion" (Dkt. 36 at 23) is completely wrong. As discussed in Defendants' opening brief, a medical provider's duty to inform his or her patients is not limited to surgical procedures; providers must give patients full information necessary to make informed medical decisions, including any reasonable alternatives. *See* Dkt. 16 at 11, *see also Crim ex rel. Crim v. Dietrich*, 2016 IL App (4th) 150843, ¶ 48 (Court erred in directing verdict to defendant in informed consent action where plaintiff presented evidence that C-section could have mitigated injuries to the infant and mother testified that she would have chosen C-section if adequately informed of the risks and options.); *Allen v. Harrison*, 374 P.3d 812, 817 (Ok. 2016) (emergency room physician who counseled patient who accidentally swallowed a nail to eat fiber and let the nail pass but did not disclose alternative medical options should have explained the associated risks of proposed treatment and all medically reasonable alternatives). Accordingly, intermediate scrutiny should apply here as well.

2. The Amended Act Survives Intermediate Scrutiny.

a. The State has a substantial interest in regulating the medical profession and protecting patients' health.

To survive intermediate scrutiny, a law concerning speech (1) must "directly advance[] a substantial governmental interest"; and (2) must not burden substantially more speech than necessary to further that interest. *Sorrell v. IMS Health Inc*., 564 U.S. 552, 572 (2011); *see also* Ex. A at 12. As the *Pregnancy Care Center* court held, the State's interest in "protecting the

health and autonomy of its citizens by ensuring that they receive the information that they need to make informed medical decisions" is a substantial government interest. *Id*. The "power of the legislature to license and regulate the provision of health care is long-standing and beyond doubt." *Id*., *see also NIFLA*, 839 F.3d at 841 ("California has a substantial interest in the health of its citizens, including ensuring that its citizens have access to and adequate information about constitutionally-protected medical services like abortion.").

Plaintiffs argue that the Amended Act "does not serve a compelling interest because it singles out conscientious objectors rather than imposing its mandate on all medical facilities." Dkt. 36 at 18. But the Amended Act merely clarifies that health care providers must continue to fulfill their pre-existing ethical duties to their patients, even when they have conscience-based reasons for declining to provide certain services. The Amended Act applies only to providers with conscience-based objections because other providers are already subject to their ethical obligations to provide information to patients and to provide referrals for care when necessary. *See St. John's United Church of Christ v. City of Chicago*, 502 F.3d 616, 632-33 (7th Cir. 2007) (Amendment to the Illinois Religious Freedom Restoration Act ("RFRA") that only applied to a single religious cemetery was neutral because "secular cemeteries presumably would have no extraordinary defense to the power of eminent domain to begin with.").

Finally, Plaintiffs argue that the Amended Act does not serve the government's interest in "ensuring that health care providers conform to the ethical standards of their professions" because it "reaches further than standard ethical requirements when it requires Plaintiffs to provide information about abortion doctors, as well as information about the 'benefits' of abortion." Dkt. 36 at 19. This argument is wrong because, as discussed in Defendants' opening brief, both of the Amended Act's requirements mirror the ethical standards of the medical

profession. In their opening brief, Defendants cited to ethical guidelines of four respected professional associations for medical providers, all of which unambiguously state that medical ethics require medical providers to disclose all relevant treatment options, including treatment options to which the provider objects. *See* Dkt. at 9-10. Indeed, while Plaintiffs seek to rely on the American Medical Association's Code of Ethics (Dkt. 36 at 19), the very section that Plaintiffs quote from includes the following directive: "In following conscience, physicians should: . . . [u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects."[2] Nor are these four organizations alone in taking this position: the World Medical Association[3] and the American College of Obstetricians and Gynecologists,[4] among others,[5] all agree that medical

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[2] *See* American Medical Association, *Code of Ethics* ("AMA Code of Ethics"), Section 1.1.7 Physician Exercise of Conscience (available online at https://www.ama-assn.org/sites/default/files/media-browser/code-2016-ch1.pdf (last visited March 29, 2017).

3 *See* World Medical Association, *Medical Ethics Manual*, at 43 (3d ed. 2015) (physician must ensure informed consent, which "involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language, ensuring that patients understand the treatment options, including the advantages and disadvantages of each"), available at https://www.wma.net/wp-content/uploads/2016/11/Ethics_manual_3rd_Nov2015_en.pdf (last visited March 29, 2017).

4 *See* American College of Obstetricians and Gynecologists, *Code of Professional Ethics*, 1-5 (2011), (physician's duty to obtain informed consent includes the duty to provide information about "alternative modes of treatment and the objectives, risks, benefits, possible complications, and anticipated results of each treatment."), available at https://www.acog.org/-/media/Departments/National-Officer-Nominations-Process/ACOGcode.pdf?dmc=1&ts=20161118T1256054925 (last visited March 29, 2017).

[5] *See, e.g.*, Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 FR 9968-02, at 9973 ("The doctrine of informed consent requires that a health care provider inform an individual patient of the risks and benefits of any health care treatment or procedure. In order to give informed consent, the patient must be able to understand and weigh the treatment or procedure's risks and benefits, and must understand available alternatives."), available online at https://www.gpo.gov/fdsys/pkg/FR-2011-02-23/pdf/2011-3993.pdf; U.S. President's Commission for the Study of Ethical Problems in Medical and Biomedical Behavioral Research, *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship*, 2 (1982) (Patients "must have all relevant information regarding their condition and alternative treatments, including possible benefits, risks, costs, other consequences, and significant uncertainties regarding any of this information."), available at https://repository.library.georgetown.edu/bitstream/handle/10822/559354/making_health_care_decisions.pdf?sequence=1&isAllowed=y (last visited March 29, 2017).

providers must provide their patients with information about all relevant options. In fact, while these ethical codes may differ somewhat in their description of a medical provider's referral duty, they are absolutely consistent in their discussion of a medical provider's duty to inform patients of their treatment options, and Plaintiffs do not cite anything that suggests otherwise.

Illinois law affirmatively requires medical providers to conform to these ethical duties. The Medical Practice Act provides that the IDFPR may take disciplinary action against a physician who engages in "dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public." 225 ILCS 60/22(A)(5). In determining what constitutes such conduct, the IDFPR should consider whether the questioned activities are "violative of ethical standards of the profession," including ethical standards requiring physicians to "respect the rights of patients." 68 Ill. Admin. Code 1285.240(a)(1)(A). "Questionable activities" under this standard include "[c]ommitting any other act or omission that breaches the physician's responsibility to a patient according to accepted medical standards of practice." *Id.* at (a)(2)(E). The Nurse Practice Act contains an identical prohibition on unethical conduct (*see* 225 ILCS 65/70-5(b)(7)), and the Administrative Code implementing this provision "incorporates by reference the 'Code for Nurses with Interpretive Statements', July 2001, American Nurses Association." 68 Ill. Admin. Code 1300.90(c). The 2001 Code for Nurses states that patients "have the moral and legal right . . . to be given accurate, complete, and understandable information in a manner that facilitates an informed decision, and to be assisted with weighing the benefits, burdens, and available options in their treatment."[6] Thus, the Medical Practice Act and the Nurse Practice Act require medical providers to comply with ethical standards of care.

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[6] American Nurses Association, *Code of Ethics for Nurses* Section 1.4 (July 2001), available online at https://courseweb.pitt.edu/bbcswebdav/institution/Pitt%20Online/Nursing/NUR%202008/Module%2001/Readings/ANA_ethics.pdf (last visited March 29, 2017).

Moreover, as discussed in Defendants' opening brief, the ethical standards for informed consent are also reflected in the common law. *See* Dkt. 16 at 16. As the Fourth Circuit observed, informed consent "requires that the physician convey adequate information about the diagnosis, the prognosis, alternative treatment options (including no treatment), and the risks and likely results of each option." *Stuart v. Camnitz*, 774 F.3d 238, 251-52 (4th Cir. 2014). Although Plaintiffs repeatedly claim that the Amended Act requires providers to promote the "benefits" of abortion (*e.g.,* Dkt. 36 at 1, 22), the requirement that providers discuss the "benefits and risks" of all treatment options is a standard formulation of the informed consent requirement, not an effort by the State to promote any particular procedure.[7]

The requirement that providers give patients information about other providers that the provider reasonably believes may offer the objected-to services is similarly rooted in the medical providers' ethical duties. As discussed in Defendants' opening brief, medical providers generally have a duty to provide a referral for health care services that he or she does not perform. Dkt. 16 at 12. Here, the Amended Act does *not* require the medical provider to refer the patient, but merely to provide some written information about other providers on request. This lower requirement accommodates providers who object to providing a referral while ensuring that patients who need the information receive it.

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7 *See*, *e.g*., notes 2-6 above; *see also* AMA *Code of Ethics*, Section 1.1.3 Patient Rights (Patients have the right to "receive information from their physicians" and "to discuss the benefits, risks, and costs of appropriate care, including the risks, benefits and costs of foregoing treatment") ; American Academy of Pediatrics Committee on Bioethics, *Policy Statement - Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience,* PEDIATRICS Vol. 124 No. 6 at 1691 (Dec. 2009) ("One responsibility of the physician's role is providing medical information, including risks, benefits, and alternatives, during the informed-consent process."), available online at http://pediatrics.aappublications.org/content/pediatrics/124/6/1689.full.pdf (last visited March 29, 2017).

b. The Amended Act is narrowly tailored.

Plaintiffs argue that the Amended Act is not narrowly tailored because the "State has completely failed to pursue a wide range of less restrictive alternatives." Dkt. 36 at 29. But there is no less restrictive alternative that will provide patients with the information that they need to make informed decisions about their health. Physicians are "learned, skilled and experienced in subjects of vital importance to the patient but about which the patient knows little or nothing." *Goldberg v. Ruskin*, 128 Ill. App. 3d 1029, 1039-40 (1st Dist. 1986). Only a patient's treating provider understands the patient's circumstances, medical condition, and needs, as well as the possible treatment options that may be appropriate given the patient's circumstances. If providers send patients away without all of relevant information about their condition, patients may not know that they should ask another provider about additional treatment options.

The *Pregnancy Care Center* court has suggested that the Amended Act may not be narrowly tailored it part because "some of the more dire hypothetical circumstances" were already covered by the emergency exception of the Conscience Act. Ex. A at 12. "Consequently, the benefit to be achieved by the statute is limited to non-emergency situations in which a patient may desire, or might benefit from, additional information about the 'legal treatment option' of abortion." *Id*. However, this statement misunderstands the scope of the emergency exception. As the appellate court found in *Morr-Fitz, Inc. v. Quinn*, the emergency exception applies only when there is "an imminent danger to the patient or the need for immediate attention," such as "a ruptured appendix or surgical shock." 2012 IL App (4th) 110398 ¶ 78, ¶ 76, *quoting Gaffney v. Bd. of Trustees of the Orland Fire Protection Dist.*, 2012 IL 110012, ¶ 62. The court specifically held that emergency contraception did not fall within the emergency exception, even though its effectiveness was limited to the first 72 hours after unprotected sex. *Id*. ¶¶ 77-78. Similarly, an

ectopic pregnancy may not fall within the emergency exception unless the patient's fallopian tube had already ruptured. Thus, many cases may be quite urgent without falling within the emergency exception. In these cases, patients rely on their medical providers to give them accurate, complete, and timely information so that the patients can make the best possible decisions. The Amended Act is narrowly tailored to protect patients' health and autonomy.

Plaintiffs further argue that the Amended Act is not narrowly tailored because it "applies to all pro-life medical providers and pro-life Pregnancy Care Centers across the board without reference to whether such a center has engaged in, or even been accused of, wrongdoing." Dkt. 36 at 30. Plaintiffs' apparent argument that the State must wait until patients are actually harmed by their providers' failure to disclose treatment options is both wrong and disturbing, given that it is made on behalf of doctors who taken an oath to protect their patients from harm. As the *Pregnancy Care Center* court recognized, the "power of the legislature to license and regulate the provision of health care is long-standing and beyond doubt." Ex. A at 12. Moreover, the State's regulation of the medical profession is intended to protect patients *from* harm, not just to punish medical providers *after* they have harmed patients.

Plaintiffs cite to two cases striking down physician disclosure requirements, but these cases are easily distinguished. In *Stuart v. Camnitz*, physicians challenged a requirement that doctors perform an ultrasound before an abortion and describe the fetus in detail, even if the patient chose to cover her eyes and ears. 774 F.3d at 243. The physicians in *Stuart* did not challenge the informed consent provision of the Act, which required that a doctor or qualified professional explain to the woman seeking the abortion the risks of the procedure, the risks of carrying the child to term, "and any adverse psychological effects" of abortion at least twenty-four hours before an abortion is to be performed. *Id.* at 243. The physicians were also subject to

North Carolina's general informed consent requirements, which required physicians to "inform[] each patient about the nature of the abortion procedure, its risks and benefits, and the alternatives available to the patient and their respective risks and benefits" and "counsel[] the patient to ensure that she was certain about her decision to have an abortion." *Id.* at 244.

The Fourth Circuit struck down this ultrasound requirement, finding that it "reache[d] beyond the modified form of informed consent" that the Supreme Court approved in *Planned Parenthood of Se. Pa. v. Casey,* 505 U.S. 833, 884 (1992). *Stuart*, 774 F.3d at 252. "The most serious deviation" from traditional informed consent requirements was the requirement that the physician provide the required information "to a woman who has through ear and eye covering rendered herself temporarily deaf and blind." *Id*. at 252. This "starkly compelled speech . . . impedes on the physician's First Amendment rights with no counterbalancing promotion of state interests." *Id*. Such "forced speech to unwilling or incapacitated listeners does not bear the constitutionally necessary connection" to the state's interest in the protection of fetal life. *Id*. at 253. The state could not "commandeer the doctor-patient relationship to compel a physician to express its preference to the patient." *Id*. *Stuart* is thus easily distinguished. As discussed above, the Amended Act does not impose any requirements on medical professionals beyond their pre-existing ethical duties. Far from "commandeer[ing] the doctor-patient relationship," the Amended Act merely seeks to ensure that patients receive the information needed to make medical decisions, even when the medical professional has conscientious objections.

Plaintiffs' citation to *Evergreen Ass'n, Inc. v. City of New York*, 740 F.3d 233 (2014), is similarly unavailing. In *Evergreen*, the Second Circuit upheld a requirement that pregnancy services centers disclose whether or not they "have a licensed medical provider on staff who provides or directly supervises the provision of all of the services at such pregnancy services

center." *Id*. at 246. The court held that this disclosure requirement was "the least restrictive means to ensure that a woman is aware of whether or not a *particular* pregnancy services center has a licensed medical provider at the time that she first interacts with it" (*id*. at 247 (emphasis in original)), and the requirement therefore survived either strict or intermediate scrutiny. *Id*. at 245. However, the court struck down requirements that the center disclose upfront the reproductive services it provides or does not provide, because this required disclosure "mandat[ed] the manner in which the discussion of these issues begins." *Id*. at 249. The Court also struck down a requirement that the center tell clients that the government "encourages women who are or who may be pregnant to consult with a licensed provider," finding that this required the center to communicate a particular message from the government, a message that the government could communicate equally well on its own. *Id*. at 249. Here, in contrast, the Amended Act does not require disclosure of any information beyond that required by the provider's pre-existing ethical duties, nor does it conscript private persons or entities to convey the government's message.

Finally, Plaintiffs' citation to *Sorrell v. IMS Health Inc*. (Dkt. 36 at 24) is also easily distinguished. In *Sorrell*, Vermont's Prescription Confidentiality Law restricted the sale of pharmacy records that reveal the prescribing practices of individual doctors. While the expressed purpose of the law was to protect physicians' privacy, the law allowed pharmacies to share such information with anyone as long as the information was not to be used for marketing purposes. 564 U.S. at 572-73. Because the information was "available to an almost limitless audience," except for a "narrow class of disfavored speakers," the State's asserted interest in physician confidentiality did not justify the burden that the law placed on protected expression. *Id*. at 573. Here, in contrast, the Amended Act is narrowly drawn to protect the State's compelling interests while also protecting the medical provider's rights.

C. Plaintiffs' Free Exercise Claim Should Be Dismissed.

In their opening brief, Defendants explained that the Amended Act did not violate the free exercise clause of the First Amendment because it placed a reasonable limitation on a benefit rather than imposing a substantial burden. Dkt. 16 at 12-13, 17-18, *citing Our Savior Evangelical Lutheran Church v. Saville*, 397 Ill. App. 3d 1003, 1020 (2d Dist. 2009). In response, Plaintiffs argue that "the government is providing an important benefit when it permits conscientious objectors to refuse to provide medical services or refer for such services that violate their religious beliefs, but it has impermissibly conditioned that benefit on the relinquishment of religious beliefs." Dkt. 36 at 25. But as the Illinois Supreme Court has observed, a statute that is "concerned with a legitimate governmental purpose is not vitiated merely because as an incidental effect it may place at some disadvantage persons of a particular religious faith." *Dep't of Mental Health v. Warmbir*, 37 Ill. 2d 267, 269-70 (1967). In that case, the "benefit which one must forego[] is attributable not to the statute but to the religion or to the individual's own choice." *Id*. (holding that a provision of the mental health code that made spouses liable for services rendered to patients did not violate the free exercise rights of woman whose religion prohibited her from obtaining a divorce); *see also Mefford v. White*, 331 Ill. App. 3d 167, 180 (4th Dist. 2002), *quoting Warmbir*, 37 Ill. 2d at 269-70. As discussed above, the purpose of the Amended Act is to ensure that medical providers' exercise of "conscience-based objections do not cause impairment of patients' health." 745 ILCS 70/6.1. As the *Pregnancy Care Center* court has already held, this is a substantial government interest. Ex. A at 12. Thus, any burden on the Plaintiffs is caused by a conflict between the Plaintiffs' religious beliefs and the ethical standards of the medical profession – not by the Amended Act.

Plaintiffs also argue that strict scrutiny should apply to the Amended Act because it is neither neutral nor generally applicable (Dkt. 36 at 25), but Plaintiffs' argument misunderstands the test under *Church of the Lukumi Babalu Aye v. City of Hialeah*, 508 U.S. 520, 532 (1993). Under *Lukumi*, a "law is not neutral if it is intended 'to infringe upon or restrict practices because of their religious motivation." *Id.* at 533. But as discussed above, the purpose of the Amended Act is to protect patients, not to infringe on the Plaintiffs' religious beliefs or practices. While the Amended Act only applies to medical providers with conscientious objections to providing medical services, this fact alone does not make the law hostile to religion. This case is similar to *St. John's*, 502 F.3d at 632-33, in which the Seventh Circuit held that an amendment to RFRA that only applied to a single religious cemetery was nevertheless neutral because "secular cemeteries presumably would have no extraordinary defense to the power of eminent domain to begin with." Here, the Amended Act applies only to providers with conscience-based objections because other providers are already subject to their ethical obligations to provide information to patients and to provide referrals for care when necessary.

Finally, Plaintiffs argue that the Amended Act is not generally applicable because it is "does not require its disclosures of all medical facilities and professionals treating pregnancy, nor even of all that refrain from abortions." Dkt. 36 at 26. But as discussed above and in Defendants' opening memorandum, all medical providers are required to adhere to the same ethical standards. The Amended Act simply provides a means of ensuring that providers who exercise a conscientious objection to providing certain services nevertheless meet their patients' needs.

Moreover, even if strict scrutiny applied to Plaintiffs' free exercise claim, the Amended Act survives strict scrutiny because it is the least restrictive means of protecting the State's

compelling interests. Because Plaintiffs have not even come close to demonstrating a violation of their free exercise rights, Plaintiffs' free exercise claim should be dismissed.

D. Plaintiffs' Equal Protection Claim Should Be Dismissed.

Plaintiffs offer no substantive response to Defendants' argument regarding their equal protection claim. Dkt. 16 at 21-22. Plaintiffs admit that to state an equal protection claim, they must compare two groups that are "similarly situated." Dkt. 36 at 7. But Plaintiffs do not, and cannot, explain how health care providers who refuse to provide information to their patients are similarly situated to health care providers who are willing to provide such information. Of course, these two groups are *not* similarly situated, especially given that the purpose of the Act is to ensure that conscience-based objections "do not cause impairment of patients' health." Dkt. 16 at 22, *citing* 745 ILCS 70/2; 745 ILCS 70/6.1. Plaintiffs' equal protection claim fails for this reason alone. In any event, Plaintiffs do not dispute that their equal protection claim adds nothing to their other constitutional claims, so that a separate equal protection analysis is unnecessary. Dkt. 16 at 22. Plaintiffs' equal protection claim should therefore be dismissed accordingly.

E. Plaintiffs' Claim Under the Coats-Snowe Amendment Should Be Dismissed.

As Defendants established in their opening brief, Plaintiffs' claims under the Coats-Snowe Amendment, 42 U.S.C. § 238n, should be dismissed because there is no private right of action. Dkt. No. 16 at 22-25. In response, Plaintiffs do not identify a *single* case, from any jurisdiction, finding a private right of action to enforce Coats-Snowe. Plaintiffs ignore that Coats-Snowe is Spending Clause legislation enforced by the Office for Civil Rights of the Department of Health and Human Services. Dkt. 16 at 23-24, *citing Gonzaga Univ. v. Doe*, 536 U.S. 273, 281, 289-90 (2002) (recent Supreme Court decisions "have rejected attempts to infer enforceable rights from Spending Clause statutes"). Plaintiffs do not even acknowledge, much

less distinguish, the multiple cases holding that similar right-of-conscience legislation, the Church Amendment, is not enforceable through a private right of action. *Id.* at 24.[8]

Plaintiffs base their argument for a private right of action on the four factors set out in *Cort v. Ash*, 422 U.S. 66, 78 (1975). But the Supreme Court has moved away from the approach in *Cort*, and now focuses solely on legislative intent. *See Alexander v. Sandoval*, 532 U.S. 275, 286-27 (2001) (statutory intent is "determinative"); *Thompson v. Thompson*, 484 U.S. 174, 189 (1988) (J. Scalia, concurring in the judgment) (calling *Cort* "effectively overruled"); *Int'l Union of Operating Eng'rs Local 150, AFL-CIO v. Ward*, 563 F.3d 276, 285 (7th Cir. 2009) (Supreme Court has "distanced itself" from the approach discussed in *Cort*). To create new enforceable rights, Congress must do so in "clear and unambiguous terms." *Doe*, 536 U.S. at 290. Courts look to the text and structure of the statute at issue. *Alexander*, 532 U.S. at 289. "Statutes that focus on the person regulated rather than the individuals protected 'create no implication of an intent to confer rights on a particular class of persons.'" *Id.*, *citing Calif. v. Sierra Club*, 451 U.S. 287, 294 (1981); *see also Cannon v. Univ. of Chicago*, 441 U.S. 677, 692-93 (1979).

Here, as Plaintiffs' response confirms, Coats-Snowe focuses on the "person regulated" rather than the "individuals protected," and therefore does not create a private right of action. Coats-Snowe states that "[t]he Federal Government, and any State or local government that receives federal financial assistance, may not subject any health care entity to discrimination" on certain grounds. 42 U.S.C. § 238n. While an individual physician (included in the definition of "health care entity") may benefit from Coats-Snowe, the focus of the statute is on recipients of federal financial assistance. Plaintiffs themselves acknowledge as much. Dkt. 36 at 10 (Coats-

[8] Indeed, the case against a private right of action is even stronger here than for the Church Amendment. Unlike Coats-Snowe, subpart (d) of the Church Amendment refers to "individual rights." 42 U.S.C. 300a-7(d). Even with such language, courts have refused to find a private right of action under the Church Amendment. Dkt. 16 at 24 (collecting cases).

Snowe "forbids the government from discriminating"), *id.* at 11 (Coats-Snowe "prohibits any government entity receiving federal funding from discriminating"). This focus on the regulated entity confirms that Congress did not intend to create a private right of action. *Alexander*, 532 U.S. at 289.

Plaintiffs rely heavily on *Cannon v. University of Chicago*, but this case actually supports Defendants' position. In *Cannon*, the Supreme Court found a private right of action under Title IX, which states that "[n]o person in the United States" shall be "subjected to discrimination under any education program or activity receiving Federal financial assistance." 441 U.S. at 681. But in doing so, the Court emphasized that its finding hinged on Title IX's "unmistakable focus" on the benefitted class:

> There would be far less reason to infer a private remedy in favor of individual persons if Congress, instead of drafting Title IX with an unmistakable focus on the benefitted class, had written it simply as a ban on discriminatory conduct by recipients of federal funds or as a prohibition against the disbursement of public funds to educational institutions engaged in discriminatory practices.

Id. at 692-93. Unlike Title IX, Coats-Snowe does not focus on individual rights. Instead, it is written as a "ban on discriminatory conduct by recipients of federal funds" (*id.*), which weighs against finding a private right of action.[9]

Because Coats-Snowe is Spending Clause legislation which has an administrative enforcement mechanism and does not focus on individual rights, this Court should not infer a private right of action. *Alexander*, 532 U.S. at 288-291. But even if there were a private right of action, plaintiffs' claims would still fail. Dkt. No. 16 at 24. To start, Plaintiffs do not dispute that,

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[9] For similar reasons, plaintiffs' reliance on *Allen v. State Board of Elections*, 393 U.S. 544 (1969), finding a private right of action to enforce the Voting Rights Act of 1965, is misplaced. Like Title IX, the Voting Rights Act focused on individual rights rather than simply prohibiting certain conduct by the regulated entity. *See Allen*, 393 U.S. at 555, *Cannon*, 441 U.S. at 690 (noting that the dispositive language in the Voting Rights Act was "remarkably similar" to the language used in Title IX).

except for Dr. Gingrich, they are not "individual physicians" covered by Coats-Snowe. Dkt. 16 at 23 n.16. Moreover, none of the Plaintiffs can state a claim under Coats-Snowe because the Amended Act does not create a referral requirement. *Id.* at 24-25. Plaintiffs assert, without any support, that requiring providers who assert conscience-based objections to provide information to their patients "about other health care providers who they reasonably believe" may offer the objected-to-service is the same as a referral requirement. Dkt. 36 at 9. But this is incorrect, because nothing in the Amended Act requires providers with conscience objections to endorse or recommend other providers (as with a referral), and the Amended Act itself makes clear that the Illinois General Assembly did not intend to create a referral requirement. Dkt. 16 at 24-25, citing 745 ILCS 70/4.

Finally, Plaintiffs cannot state a claim under Coats-Snowe because the Amended Act does not "discriminate" against entities which refuse to provide referrals for abortions. Dkt. 16 at 25. Plaintiffs argue that the Amended Act discriminates against them because it "subjects only conscientious objectors to abortion to its requirements." Dkt. 36 at 9. But, again, this misunderstands the purpose and operation of the Amended Act. The Conscience Act *benefits* religious objectors, and the Amended Act, SB 1564, only clarifies that such objectors must comply with their pre-existing ethical obligations so that "conscience-based objections do not cause impairment of patients' health." 745 ILCS 70/6.1.

F. Plaintiffs' Claims Against the Governor Should Be Dismissed Because He Is Not a Proper Defendant.

In their opening brief, Defendants argued that the Governor should be dismissed because he is not a proper defendant in this case. Dkt. 16 at 25-26. Plaintiffs' only response is to observe that then-Governor Pat Quinn was one of the defendants in *Morr-Fitz*, 2012 IL App (4th) 110398, and that therefore the current Governor is a proper party here. Dkt. 36 at 22. But

whether the governor was a proper party was never an issue in *Morr-Fitz (see generally* 2012 IL App (4th) 110398), and *Morr-Fitz* therefore provides no guidance on this issue. The courts that have considered this issue have repeatedly held that a state official is not a proper defendant for a constitutional challenge unless that official has a special relation to the challenged statute. *See, e.g., Children's Healthcare is a Legal Duty, Inc. v. Deters*, 92 F.3d 1412, 1416 (6th Cir. 1996), *quoting Ex Parte Young,* 209 U.S. 123, 157 (1908). Similarly, the *Pregnancy Care Center* court declined to enter a preliminary injunction against the Governor, finding that there was "no necessity that this injunction be entered as to Defendant Rauner." Ex. A at 15. Because Plaintiffs have not alleged that the Governor has any "special relation" to the Conscience Act, the Governor should be dismissed from this action.

II. Plaintiffs' Motion for a Preliminary Injunction Should Be Denied.

A preliminary injunction is "an extraordinary and drastic remedy, one that should not be granted unless the movant, *by a clear showing*, carries the burden of persuasion." *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997) (emphasis in original). To obtain a preliminary injunction, a plaintiff must establish that: (1) he is likely to succeed on the merits; (2) he is likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in his favor; and (4) an injunction is in the public interest. *Winter v. Natural Res. Def. Council*, 555 U.S. 7, 20 (2008); *Judge v. Quinn*, 612 F.3d 537, 546 (7th Cir. 2010). The court "must balance the competing claims of injury and must consider the effect on each party of granting or withholding the requested relief," paying "particular regard for the public consequences in employing the extraordinary remedy of injunction." *Winter*, 555 U.S. at 24. The balance of these factors clearly shows that Plaintiffs are not entitled to a preliminary injunction.

A. Plaintiffs Have a Minimal Chance of Success on the Merits of Their Claims.

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits." *Winter*, 555 U.S. at 20. To meet their initial burden, Plaintiffs must show that they have a "better than negligible" chance of success on the merits. *Roland Mach. Co. v. Dresser Indus.*, 749 F.2d 380, 387 (7th Cir. 1984). Where it is more likely than not that a defendant will prevail, injunctive relief is improper, particularly where the balance of harms tips decidedly in favor of the defendant. *See Boucher v. Sch. Bd. of Sch. Dist. of Greenfield*, 134 F.3d 821, 826-27, 829 (7th Cir. 1998). Even if a plaintiff makes the required showing, however, the court must determine how likely it is that the plaintiff actually will succeed: "The more likely the plaintiff is to win, the less heavily need the balance of harms weigh in his favor; the less likely he is to win, the more need it weigh in his favor." *Roland Mach. Co*., 749 F.2d at 387. Moreover, when there are "two equally credible versions of the facts the court should be highly cautious in granting an injunction without the benefit of a full trial." *Lawson Prods., Inc. v. Avnet, Inc*., 782 F.2d 1429, 1440 (7th Cir. 1986) (citation omitted).

For the reasons explained in Defendants' opening brief and above, Plaintiffs fail to establish a likelihood of success on the merits of their claims. Since Plaintiffs have little if any chance of success on the merits, the balance of harms must weigh very heavily in their favor. However, as discussed below, the balance of harms actually weighs *against* granting a preliminary injunction.

B. Plaintiffs Have Not Demonstrated Irreparable Harm to Warrant a Preliminary Injunction.

Plaintiffs' motion should be denied because they cannot establish irreparable harm. *Winter*, 555 U.S. at 2 (Plaintiffs must "demonstrate that irreparable injury is *likely* in the absence of an injunction") (emphasis in original). As discussed above and in Defendants' opening brief,

the Amended Act places reasonable limitations on medical providers' ability to refuse to provide health care services based on their religious objections to those services. But rather than create new duties, the Amended Act merely reflects health care providers' pre-existing ethical obligations to give their patients full, accurate, and relevant medical information. It is difficult to understand how Plaintiffs will be harmed by the requirement that they fulfill their ethical duties to their patients. Nor does the requirement that medical providers develop a protocol for dealing with religious objections cause irreparable harm. Because the Amended Act only requires that health care providers fulfill their ethical duties, it is not unreasonable to ask those providers to develop a plan for how they will fulfill those duties when they have (or an employee has) a religious objection to providing a medical service.

Moreover, after filing this lawsuit in September 2016, Plaintiffs waited five months before filing this motion for preliminary injunction, and waited two months after *Pregnancy Care Center* court held that the preliminary injunction entered in that case only applied to the plaintiffs in that case. Ex. A at 15. Plaintiffs' lengthy delay in moving for a preliminary injunction "undercuts [their] claims of irreparable harm" and "may be considered as circumstantial evidence that the potential harm to [Plaintiffs] is not irreparable or as great as claimed." *Fenje v. Feld*, No. 01 C 9684, 2002 WL 1160158, at *2 (N.D. Ill. May 29, 2002).10 Their delay further confirms that they cannot establish irreparable harm.

C. A Preliminary Injunction Will Cause Irreparable Harm to the State and the Public.

Under the "balance of harms" portion of the analysis, Plaintiffs must establish that "the harm they would suffer without the injunction is greater than the harm that preliminary relief would inflict on the defendants." *Mich. v. U.S. Army Corps of Eng'g*, 667 F.3d 765, 769 (7th Cir.

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[10] Attached as Exhibit B hereto.

2011). Because a movant need not establish that it is more likely than not that they will succeed on the merits to obtain injunctive relief, a movant "must compensate for the lesser likelihood of prevailing by showing the balance of harms tips *decidedly* in favor of the movant." *Boucher*, 134 F.3d at 826 n.5 (emphasis in original). The court also should consider whether a preliminary injunction would cause harm to the public interest. *Platinum Home Mort. Corp. v. Platinum Fin. Group, Inc*., 149 F.3d 722, 726 (7th Cir. 1998).

As discussed above, the State has a compelling interest in regulating the practice of medicine and protecting the health of its citizens, interests that will be harmed if the Amended Act is enjoined. Moreover, the public may also suffer irreparable harm if the law is enjoined. As discussed above, the Conscience Act was amended to ensure that "conscience-based objections do not cause impairment of patients' health." 745 ILCS 70/6.1. The Amended Act places minimal limitation on the permissible scope of such religious objections. Enjoining the law would permit religiously-affiliated providers to turn patients away without information about their medical circumstances and treatment options and then claim a blanket exemption from liability for any resulting harm to the patient. Therefore, the balance of hardships does not weigh in favor of granting preliminary injunctive relief.

CONCLUSION

For the foregoing reasons, as well as those given in Defendants' opening brief, Defendants respectfully request that this Honorable Court dismiss Plaintiffs' First Amended Complaint with prejudice and deny Plaintiffs' motion for a preliminary injunction.

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