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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

SHANDHINI RAIDOO, M.D., M.P.H.; BLISS KANESHIRO, M.D., M.P.H., on behalf of themselves and their patients, *Plaintiffs-Appellees*, v. DOUGLAS MOYLAN, in his official capacity as Attorney General of Guam; NATHANIEL BERG, M.D., in his official capacity as Chair of the Guam Board of Medical Examiners; PHILIP FLORES, in his official capacity as Vice-Chair of the Guam Board of Medical Examiners; ARANIA ADOLPHSON, M.D., in her official capacity as a member of the Guam Board of Medical Examiners; LUIS G. CRUZ, M.D., in his official capacity as a member of the Guam Board of Medical Examiners; ANNETTE DAVID, M.D., M.P.H., in her official capacity as member of the Guam Board of Medical Examiners; JOLEEN AGUON, M.D., in her official capacity as member of the	No. 21-16559 D.C. No. 1:21-cv-00009 OPINION

Guam Board of Medical Examiners; SCOTT SHAY, M.D., in his official capacity as a member of the Guam Board of Medical Examiners,

Defendants-Appellants.

Appeal from the United States District Court
for the District of Guam
Frances Tydingco-Gatewood, Chief District Judge,
Presiding

Argued and Submitted February 16, 2023
Honolulu, Hawaii

Filed August 1, 2023

Before: Carlos T. Bea, Daniel P. Collins, and Kenneth K. Lee, Circuit Judges.

Opinion by Judge Lee

SUMMARY*

Abortion

The panel vacated the district court's preliminary injunction enjoining enforcement of the informed-consent requirement in Guam's Women's Reproductive Health Information Act, which requires that women seeking abortions have an in-person meeting with a physician, or a qualified agent of the physician, who must disclose certain medical as well as other information.

Plaintiffs are Guam-licensed OBGYN physicians in Hawaii who wish to provide abortion services to Guam patients through telemedicine. They point out that women in Guam seeking abortions must obtain chemical abortifacients via telemedicine, given the current lack of doctors who perform abortions in Guam.

Applying rational basis review, the panel concluded that the in-person informed consent requirement does not violate the Due Process Clause because it furthers Guam's legitimate governmental interests in preservation of potential life, protection of maternal health, and promotion of the integrity of the medical profession.

The panel rejected plaintiffs' as-applied challenge under the Due Process Clause, in which plaintiffs argued that the in-person consultation requirement undermines informed consent because of the possibility that non-medical personnel may provide the required medical

* This summary constitutes no part of the opinion of the court. It has been prepared by court staff for the convenience of the reader.

disclosures. The panel held that the requirement does not undermine informed consent because it does not mandate that a non-medical professional provide the in-person medical disclosures, nor does it prevent the treating telemedicine doctor from providing medical information to the patient; it merely requires that patients receive certain information in person before receiving an abortion.

Finally, the panel rejected plaintiffs' argument that Guam's in-person informed-consent law violates their equal protection rights because it irrationally treats physicians who provide abortions differently than similarly situated telemedicine providers. Applying rational basis review, the panel held that Guam can require an in-person consultation for abortions because, unlike other medical procedures, abortion implicates fetal life in addition to the patient's health, and the in-person requirement bears a reasonable relationship to the legitimate governmental interest of safeguarding fetal life.

COUNSEL

Jordan L. Pauluhn (argued) and Heather M. Zona, Assistant Attorneys General; James L. Canto II, Deputy Attorney General; Leevin Taitano Camacho, Attorney General of Guam; Office of the Attorney General, Litigation Division; Tamuning, Guam; for Defendants-Appellants.

Alexa Kolbi-Molinas (argued), Meagan M. Burrows, and Rachel M. Reeves, American Civil Liberties Union Foundation, New York, New York; Vanessa L. Williams, Law Office of Vanessa L. Williams PC, Hagatna, Guam; Chelsea G. Tejada, ACLU Reproductive Freedom Project, New York, New York; for Plaintiffs-Appellees.

OPINION

LEE, Circuit Judge:

In *Dobbs v. Jackson Women's Health Organization*, the Supreme Court made clear that the Constitution does not guarantee a right to an abortion because it is neither enumerated in the constitutional text nor deeply rooted in our nation's history. 142 S. Ct. 2228 (2022). So now the people's representatives—not judges—decide whether to allow, ban, or regulate abortions. And in turn, courts play only a modest and minor role: We merely apply a highly deferential rational basis review in assessing the constitutionality of an abortion-related law.

Under this new legal landscape, we vacate the district court's preliminary injunction against Guam's in-person informed-consent law. That law requires women seeking abortions to have an in-person meeting with a physician—or a qualified agent of the doctor—who must disclose certain medical as well as other information (*e.g.*, medical risks, adoption opportunities) to a patient before she has an abortion. Guam has legitimate interests in requiring an in-person consultation: the consultation can underscore the medical and moral gravity of an abortion and encourage a robust exchange of information. As we learned during the pandemic, a telephonic or video meeting may be a poor substitute for an in-person meeting, whether it be in the classroom, courtroom, or clinic.

Plaintiffs point out that women in Guam seeking abortions must obtain chemical abortifacients via telemedicine, given the current lack of doctors who perform abortions on the island. Plaintiffs argue that the law may thus thwart informed consent because the treating doctor off

the island may have to pick a non-medical agent to provide the in-person medical disclosures. But nothing in the law prevents the treating doctor from providing the same or additional information as that required in the in-person meeting when the doctor meets with patient via videoconference or phone. The law sets a minimum, not a maximum, disclosure requirement, and does not prohibit the doctor from communicating additional information that the doctor believes is required under another law or professional obligation. In short, Guam's law passes muster under the low bar of rational basis review.

Plaintiffs' equal protection challenge fails as well. Guam can require an in-person consultation for abortions—but not for other medical procedures—because abortion is different, as it involves what *Dobbs* described as the "States' interest in protecting fetal life." *Id.* at 2261. People across the United States and its territories may in good-faith strongly disagree on abortion, but the people of Guam can make the policy choice to treat abortion differently from other medical procedures.

I. BACKGROUND

A. Guam requires in-person informed consent for abortions.

In 2012, Guam enacted the Women's Reproductive Health Information Act, which requires in-person informed consent from women seeking abortions. 10 Guam Code Ann. § 3218.1. The statute provides that "consent to an abortion is voluntary and informed if and only if" certain conditions are met. 10 Guam Code Ann. § 3218.1(b). This statute has two key provisions governing the disclosure of information.

First, as relevant here, the woman seeking an abortion must receive certain medical information in person at least 24-hours before the procedure. 10 Guam Code Ann. § 3218.1(b)(1). The required medical information includes "medically accurate information that a reasonable person would consider material to the decision of whether or not to undergo the abortion," such as immediate and long-term medical risks associated with abortion, the likely gestational age of the fetus, and medical risks associated with carrying the child to term. *See* 10 Guam Code Ann. § 3218.1(b)(1)(B)–(E).

Second, section (b)(2) requires in-person disclosure of information about social services and other assistance available to an expectant mother. 10 Guam Code Ann. § 3218.1(b)(2). For example, a woman seeking an abortion must be informed of medical assistance benefits, public assistance for her child, adoption services, and the father's liability for child support. *See* 10 Guam Code Ann. § 3218.1(b)(2)(A)–(F).

Relevant here, both sections (b)(1) and (b)(2) require the physician who will perform the abortion—or a "qualified person"—to provide the information in person. 10 Guam Code Ann. § 3218.1(b)(1), (2). The statute defines a "qualified person" as "an agent of a physician who is a psychologist, licensed social worker, licensed professional counselor, registered nurse, or physician." 10 Guam Code Ann. § 3218.1(a)(13).

B. No doctor in Guam will perform an abortion but women can obtain medication abortions via telemedicine.

In 2018, the last physician known to provide abortions in Guam retired. And no physician has since been known to provide abortions on the island.

In 2017, the Guam Attorney General concluded that Guam-licensed physicians located off the island can provide medical care to patients in Guam using telemedicine. *See* Guam Att'y Gen. Op. No. 17-0531, 2–3 (Nov. 6, 2017). In 2021, the Guam Attorney General specifically stipulated in another lawsuit that Guam law permits the use of telemedicine to provide medication abortions.

Plaintiffs Shandhini Raidoo, M.D., M.P.H., and Bliss Kaneshiro, M.D., M.P.H., are Guam-licensed OBGYN physicians in Hawaii who wish to provide abortion services, including medication abortions, to Guam patients through telemedicine. They believe that they are the only doctors who are willing to provide abortion services to women in Guam. But Plaintiffs acknowledge that supportive physicians in Guam are "willing to provide pre- and post-abortion care." Guam law requires in-person informed-consent for abortions, even if women use chemical abortifacients obtained via telemedicine.

C. The district court enjoins the Guam law in reliance on *Roe* and *Casey*.

In January 2021, Plaintiffs filed a complaint alleging that the in-person informed-consent requirement violates their patients' right to an abortion under *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). The complaint

also alleged that the law violates the Equal Protection Clause of the Fourteenth Amendment.

A week later, Plaintiffs moved for a preliminary injunction. And in September 2021, the district court enjoined enforcement of the in-person informed-consent provision, ruling that the law imposed an "undue burden" on a woman's right to an abortion under *Casey*. It found that Guam failed to show any "real justification or benefits of the in-person requirement" while the burdens imposed were "substantial."

Guam then appealed the district court's grant of a preliminary injunction. We have jurisdiction under 28 U.S.C. § 1292(a)(1).

II. STANDARD OF REVIEW

We review the district court's grant of a preliminary injunction for abuse of discretion. *See Porretti v. Dzurenda*, 11 F.4th 1037, 1046 (9th Cir. 2021). We review legal questions de novo, *Bouman v. Block*, 940 F.2d 1211, 1220 (9th Cir. 1991), and factual findings for clear error, *United States v. Hinkson*, 585 F.3d 1247, 1259 (9th Cir. 2009) (en banc).

To obtain a preliminary injunction, a plaintiff must establish (1) a likelihood of success on the merits, (2) a likelihood of irreparable harm in the absence of preliminary relief, (3) that the balance of equities favors the plaintiff, and (4) that an injunction serves the public interest. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). "A preliminary injunction is an extraordinary remedy never awarded as of right." *Id.* at 24.

III. DISCUSSION

We vacate the district court's grant of a preliminary injunction enjoining enforcement of the in-person informed-consent requirement of 10 Guam Code Ann. § 3218.1.

After the district court issued its order, the Supreme Court announced in *Dobbs* that abortion statutes are no longer subject to *Casey*'s undue burden standard. *Dobbs*, 142 S. Ct. at 2242. Rather, an abortion-related law must only survive rational basis review. *Id.* at 2284. And under that deferential standard, Plaintiffs cannot show a likelihood of success on the merits because Guam has legitimate interests in imposing an in-person requirement and the law is rationally related to those goals.

A. We apply rational basis review in assessing Guam's in-person informed-consent requirement for abortions.

The Supreme Court in *Dobbs* overturned *Roe* and *Casey*, rejecting a constitutional right to an abortion and casting aside *Casey*'s undue burden test for assessing abortion laws. *Dobbs*, 142 S. Ct. at 2242, 2283. Now, abortion laws—"like other health and welfare laws"—are decided by the people and their elected representatives, and are generally subject only to rational basis review by the courts. *Id.* at 2284.

Rational basis review is "a paradigm of judicial restraint," *FCC v. Beach Commc'ns, Inc.*, 508 U.S. 307, 314 (1993), that is "highly deferential to the government," *Erotic Serv. Provider Legal Educ. & Rsch. Project v. Gascon*, 880 F.3d 450, 457 (9th Cir. 2018) (citing *United States v. Hancock*, 231 F.3d 557, 566 (9th Cir. 2000)). We must uphold a law under rational basis review if the government has a legitimate interest in enacting the statute, and the law

is rationally related to that interest. Under this deferential standard, laws enacted by the people are "entitled to a 'strong presumption of validity.'" *Dobbs*, 142 S. Ct. at 2284 (internal citation omitted). Challengers of the law "have the burden 'to negative every conceivable basis which might support it.'" *Beach Commc'ns, Inc.*, 508 U.S. at 315 (quoting *Lehnhausen v. Lake Shore Auto Parts Co.*, 410 U.S. 356, 364 (1973)).

It matters not that judges may think the law unwise or believe it could have been drafted more narrowly or differently. Indeed, a law survives rational basis review so long as some conceivable legitimate purpose could have supported it—regardless of a legislature's actual purpose in enacting a statute. *Beach Commc'ns, Inc.*, 508 U.S. at 315. The legislature does not need proof that the statute will achieve its asserted purpose: a statute will pass muster if the purpose of the law rests on "rational speculation," even if the speculation is "unsupported by evidence or empirical data." *Id.* A law thus survives rational basis review even if it requires "rough accommodations" that may be "illogical" or "unscientific," and that may even appear "unjust and oppressive." *Metropolis Theater Co. v. City of Chicago*, 228 U.S. 61, 69–70 (1913).

B. Guam's in-person informed-consent law survives rational basis review.

In assessing the constitutionality of Guam's in-person informed-consent requirement, we examine whether the law furthers any legitimate governmental purpose and is rationally related to that goal. *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). We may find a law unconstitutional under rational basis review, for example, if the means employed are "directly contrary to the [law's] basic purpose" or if the

means are "wholly unconnected to any legitimate state interest." *Silveira v. Lockyer*, 312 F.3d 1052, 1089–91 (9th Cir. 2003). Guam's law easily meets that bar.

1. Guam has valid and legitimate state interests in requiring an in-person consultation before a patient undergoes an abortion.

We reject Plaintiffs' argument that an in-person informed-consent requirement for women seeking an abortion is not rationally connected to any legitimate governmental interest.

Guam identifies three legitimate purposes that the in-person requirement furthers: (1) preservation of "potential life," (2) protection of maternal health, and (3) promotion of the integrity of the medical profession. Guam contends that a "private, in-person setting is the appropriate and solemn setting for a patient to fully appreciate the information being provided," and the "same level of formality is not present when the information is being provided over video conferencing" or other similar media.

Each of Guam's asserted interests constitutes a legitimate governmental interest. The Supreme Court has recognized that legitimate governmental interests include "respect for and preservation of prenatal life at all stages of development; the protection of maternal health and safety; . . . [and] the preservation of the integrity of the medical profession." *Dobbs*, 142 S. Ct. at 2284. This case therefore turns on whether Guam's in-person informed-consent law is rationally related to any of those interests. We believe it is.

Guam could reasonably conclude that communication in a face-to-face setting has a different impact than in virtual

spaces.[1] It could rationally determine that face-to-face meetings can facilitate clearer communication, as well as enhance the ability to read body language and other non-verbal cues.[2] And it could likewise reasonably believe that in-person settings encourage more frank and robust discussions, enable connectedness between those having the discussion, and ensure a more focused and undistracted setting.[3]

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[1] *See, e.g.*, Anne Bowen Poulin, *Criminal Justice and Videoconferencing Technology: The Remote Defendant*, 78 Tul. L. Rev. 1089, 1124–25 (2004) (explaining how video interactions versus in-person interactions can affect how a person acts or is perceived to be acting).

[2] Ed Spillane, *The End of Jury Trials: Covid-19 and the Courts*, 18 Ohio St. J. Crim. L. 537, 542 (2021) (stating that "there is a difference between in-person interaction and virtual interactions" and noting that "[c]hildren testifying via remote closed-circuit television have been found to be less credible and accurate than children testifying in-person according to a mock jury"); Elizabeth G. Thornburg, *Observing Online Courts: Lessons from the Pandemic*, 54 Fam. L.Q. 181, 202–03 (2020) (explaining how presentation and argument is received differently in person as compared to over Zoom).

[3] *See, e.g.*, Stephanie Riegg Cellini, *How does virtual learning impact students in higher education?*, Brookings: Brown Center Chalkboard (August 13, 2021) (explaining that online learning often leads to "negative learning impacts, reduced course completion, and lack of connection with other students and faculty" which "could ultimately reduce college completion rates"); *see also* Kelli A. Bird, Benjamin L. Castleman & Gabrielle Lohner, *Negative Impacts from the Shift to Online Learning During the COVID-19 Crisis: Evidence from a Statewide Community College System.*, 8 AERA Open 1, 3 (2022) ("The lack of in-person interaction in online courses can lead to a sense of isolation and disconnectedness from a learning community, and can make it more difficult for students to engage with and learn from peers and instructors." (citation omitted)).

It is thus reasonable for Guam to prefer an in-person meeting before a pregnant woman moves forward with the weighty decision of having an abortion. For example, an in-person meeting can advance the state's goal of protecting the health of the mother because a face-to-face meeting can feel less rushed and more intimate than a phone call or a virtual meeting. A pregnant woman may ask more follow-up questions in a face-to-face meeting, leading to a more detailed discussion about the potential impact of an abortion (or giving birth) on her health. *See Dobbs*, 142 S. Ct. at 2284 ("legitimate interests include . . . the protection of maternal health and safety").

Similarly, in the more solemn context of a face-to-face meeting—unlike a Zoom call—a pregnant woman may decide against an abortion after having a candid conversation at the clinic about the gestational age of her fetus and concluding that the fetus represents human life. *See* 10 Guam Code Ann. § 3218.1(b)(1)(B)–(F) (requiring, among other things, disclosure of gestational age of her fetus). Or a pregnant woman may take more time to reconsider an abortion after learning of social welfare programs that assist mothers with newborns. *See* 10 Guam Code Ann. § 3218.1(b)(2)(A)–(F) (requiring disclosure of information, among other things, about medical assistance benefits, public assistance for her child, adoption options, and the father's liability for child support). It also may turn out that the in-person meeting does not affect a woman's decision and may even reaffirm her conviction to move forward with an abortion. Regardless of the law's actual impact on a given woman's decision, we cannot deny that the in-person requirement could rationally serve a legitimate state interest in protecting fetal life. *Dobbs*, 142 S. Ct. at 2284.

Finally, a face-to-face meeting can further the legitimate state goal of "the preservation of the integrity of the medical profession." *Id.* While telemedicine has been a boon for many patients, it can implicate certain ethical issues for physicians. *See*, *e.g.*, Danielle Chaet, Ron Clearield, James E. Sabin & Kathryn Skimming, *Ethical Practice in Telehealth and Telemedicine*, 32 J. Gen. Internal Med. 1136 (2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5602756/. The ethical questions can range from privacy protection (*e.g.*, virtual calls may not be as secure as a meeting in a doctor's office) to more serious problems (*e.g.*, questions about transparency and informed consent in a potentially more rushed virtual setting). *Id.* Guam's law could potentially place a guardrail against such potential problems.

In sum, so long as the law rests on "rational speculation," we must uphold it under rational basis review. *Beach Commc'ns, Inc.*, 508 U.S. at 315. Guam has met that low legal bar of offering a rational basis for requiring an in-person consultation before a pregnant woman moves forward with an abortion. Ultimately, we cannot "substitute [our] social and economic beliefs for the judgment of legislative bodies." *Dobbs*, 142 S. Ct. at 2284.

2. Plaintiffs' as-applied challenge fails because enforcement of the in-person requirement does not undermine informed consent.

Plaintiffs also offer a more nuanced argument that the in-person consultation requirement undermines informed consent here because of the possibility that non-medical personnel may provide the required medical disclosures. This argument, too, fails.

Informed consent is grounded in "the patient's interest in achieving his [or her] own determination on treatment," *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972), and "is meant to ensure that each patient has the information she needs to meaningfully consent to medical procedures." *Stuart v. Camnitz*, 774 F.3d 238, 251 (4th Cir. 2014) (cleaned up). Informed consent thus generally imposes a duty to disclose all material facts related to a patient's treatment or procedure. *See, e.g.*, *Harbeson v. Parke Davis, Inc.*, 746 F.2d 517, 522 (9th Cir. 1984).

Because no physicians currently provide abortion services in Guam, Plaintiffs contend that the in-person requirement undermines the very purpose of Guam's informed-consent statute to provide "complete and accurate information material to her decision to undergo an abortion." Guam Pub. L. 31-235 (2012). Plaintiffs assert that Guam's law would effectively mean that a Guam-based counselor, psychologist, or social worker—not the treating physician—would convey medical information to a woman considering an abortion.

But Guam's law does not mandate that a non-medical professional provide the in-person medical disclosures, nor does it prevent the treating telemedicine doctor from providing medical information to the patient. Indeed, doctors generally have an ethical duty to patients to provide all relevant information and answer questions. *See, e.g.*, *Harbeson*, 746 F.2d at 522; *see also* Committee on Ethics, American College of Obstetricians and Gynecologists, *Informed Consent and Shared Decision Making in Obstetrics and Gynecology*, 137 Obstetrics & Gynecology e34, e35 (2021) (Committee Opinion No. 819) (stating that "[m]eeting the ethical obligations of informed consent requires that an obstetrician–gynecologist gives the patient

adequate, accurate, and understandable information"). In other words, Guam's statute sets a minimum disclosure requirement for informed consent, not a maximum. It does not prevent the treating doctor from providing the same information or more information; it merely requires that patients receive certain information in person before receiving an abortion. *See generally* 10 Guam Code Ann. § 3218.1.

Plaintiffs imply that Guam's informed-consent statute could be more effective if it required a physician to provide the state-mandated information. But it does not matter under rational basis review that the "fit between [the] means and [the] ends" of the statute may be "imperfect": "courts are compelled" to uphold the statute if it bears a rational relationship to some legitimate governmental purpose. *Aleman v. Glickman*, 217 F.3d 1191, 1201 (9th Cir. 2000) (cleaned up). And Guam's informed-consent statute bears a rational relationship to the preservation of fetal life and health of the mother because an in-person requirement ensures a more intimate setting for a woman to receive information before she makes the final decision to terminate fetal life.

In any event, it is unclear from the record that Guam patients will receive informed-consent information from only non-medical professionals. To start, the law does not require a non-medical professional to provide the medical information. The treating physician chooses his or her qualified agent to provide the information, and presumably the doctor will select the appropriate person under the patient's unique circumstances. As Plaintiffs themselves state, "there is nothing intrinsically unreasonable about a physician delegating the responsibility for the informed

consent conversation to another physician or health care professional who is sufficiently knowledgeable about the relevant treatment or procedure to facilitate the informed consent process."

Further, Plaintiffs' declarations make clear that there are "multiple supportive physicians in Guam who are willing to provide pre- and post-abortion" care, even if they do not want to personally perform abortions. Put another way, nothing in the record shows that those same physicians are unwilling to provide the state-mandated informed-consent information to patients.[4] In the end, Plaintiffs have not met their burden "to negative every conceivable basis which might support" the law. *Beach Commc'ns, Inc.*, 508 U.S. at 315.

In short, the in-person requirement does not violate the Due Process Clause as it furthers Guam's legitimate state interests and does not undermine informed consent.

3. Plaintiffs' equal protection claim also fails because abortion is meaningfully different from other medical procedures.

Finally, Plaintiffs assert that Guam's in-person informed-consent law violates their equal protection rights because it irrationally treats physicians who provide abortions "differently than similarly situated telemedicine providers." That claim also fails.

[4] At oral argument, Plaintiffs stated for the first time that the physicians who provide pre- and post-abortion care would not be willing to provide in-person consultations because they would have to formally associate themselves with abortion providers and that they refuse to do so. But the record is silent about this contention.

We review equal protection challenges under rational basis unless the law "impermissibly interferes with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class." *Mass. Bd. of Ret. v. Murgia*, 427 U.S. 307, 312 (1976). Heightened scrutiny does not apply here because abortion is not a fundamental right, and no suspect class is at play. *See United States v. Whitlock*, 639 F.3d 935, 940 (9th Cir. 2011).

Under rational basis review, a legislative "classification must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification." *Gallinger v. Becerra*, 898 F.3d 1012, 1017 (9th Cir. 2018) (emphasis omitted) (quoting *Heller v. Doe*, 509 U.S. 312, 320 (1993)). Put another way, a law that differentiates between similarly situated groups is constitutional if it "bears a reasonable relationship to a legitimate governmental interest." *United States. v. LeMay*, 260 F.3d 1018, 1031 (9th Cir. 2001).

Even assuming that doctors who perform abortions are otherwise similarly situated to doctors who perform other medical services, it was rational for the Guam legislature to treat them differently because abortion presents different considerations than other medical procedures. Unlike other medical procedures, abortion implicates fetal life in addition to the patient's health. *See Dobbs*, 142 S. Ct. at 2277 ("'[A]bortion is a unique act' because it terminates 'life or potential life.'"); *Harris v. McRae*, 448 U.S. 297, 325 (1980) ("Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life."). The in-person requirement "bear[s] a reasonable relationship to [the] legitimate governmental interest" of safeguarding fetal life. *Whitlock*, 639 F.3d at 940 (cleaned up). Guam's law thus

survives rational basis review and does not violate the Equal Protection Clause.

IV. CONCLUSION

As the Supreme Court has instructed, abortion policy is best left to the people's representatives. *Dobbs*, 142 S. Ct. at 2243. And when the legislature, as it must, "engage[s] in a process of line-drawing," *United States R.R. Ret. Bd. v. Fritz*, 449 U.S. 166, 179 (1980), the Supreme Court has routinely emphasized that the legislature "must be allowed leeway" in its approach, *Beach Commc'ns, Inc.*, 508 U.S. at 316. Guam can enact laws that it believes are best for its people, even if some people might strenuously oppose such laws or think them unwise.

We hold that Plaintiffs have failed to show a likelihood of success on the merits that the in-person informed-consent requirement of 10 Guam Code Ann. § 3218.1 fails rational basis review. We thus vacate the district court's grant of a preliminary injunction. *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (en banc).

VACATED.

J Gen Intern Med. 2017 Oct; 32(10): 1136–1140.
Published online 2017 Jun 26. doi: 10.1007/s11606-017-4082-2
PMCID: PMC5602756
PMID: 28653233

Ethical practice in Telehealth and Telemedicine

Danielle Chaet, MSB,[1] Ron Clearfield, MD, FACR,[2] James E. Sabin, MD,[3,4] Kathryn Skimming, MD, MA,[5] and on behalf of the Council on Ethical and Judicial Affairs American Medical Association

Abstract

This article summarizes the report of the American Medical Association's (AMA) Council on Ethical and Judicial Affairs (CEJA) on ethical practice in telehealth and telemedicine. Through its reports and recommendations, CEJA is responsible for maintaining and updating the AMA *Code of Medical Ethics* (*Code*). CEJA reports are developed through an iterative process of deliberation with input from multiple stakeholders; report recommendations, once adopted by the AMA House of Delegates, become ethics policy of the AMA and are issued as Opinions in the *Code*. To provide enduring guidance for the medical profession as a whole, CEJA strives to articulate expectations for conduct that are as independent of specific technologies or models of practice as possible. The present report, developed at the request of the House of Delegates, provides broad guidance for ethical conduct relating to key issues in telehealth/telemedicine. The report and recommendations were debated at meetings of the House in June and November 2015; recommendations were adopted in June 2016 and published as Opinion E-1.2.12, Ethical Practice in Telemedicine, in November 2016. A summary of the key points of the recommendations can be found in Appendix A (online), and the full text of the opinion can be found in Appendix B (online).

Electronic supplementary material

The online version of this article (doi:10.1007/s11606-017-4082-2) contains supplementary material, which is available to authorized users.

KEY WORDS: ethics, policy, telemedicine, professionalism, AMA (American Medical Association)

Innovation in information technology is radically changing the ways in which patients perceive time and distance and is reshaping how they interact with and relate to others, including the ways they engage with medicine. As the public becomes increasingly fluent in utilizing novel technologies in all aspects of daily life, evolving applications in health care are altering when, where, and how patients and physicians engage with one another.

Prior to recent innovations in information technology, individuals who had a medical concern turned to hardcopy publications, spoke with family or friends, or made an appointment to see their physician. Now, a growing number of these individuals are seeking answers online and can obtain them at virtually any time from virtually anywhere.[1] Evolving technologies also allow patients to receive care remotely through telemedicine applications, which offer opportunities for patients who are homebound, who live in rural or underserved areas, or who face other impediments that limit their access to care. Likewise, new technologies make it possible for patients who have rare medical disorders to obtain care from distant specialists.[2 – 4] Even patients who have access to care in person may find telemedicine a welcome convenience.[5]

While such innovations have significant potential to benefit patients, they also raise ethical challenges. In particular, concerns have been raised that exchanging health information and providing care electronically could create new risks to quality, safety, and continuity of care, all of which could weaken patient-physician relationships.[4, 6 – 9]

Telehealth and Telemedicine: New Ways to Deliver Health Care

"Telehealth" and "telemedicine" incorporate technologies and activities that offer new ways to deliver medical care. Although the two are distinguished in current usage, the reasons for doing so are largely administrative. The Health Resources and Services Administration defines "telehealth" broadly as involving electronic and telecommunications technologies to "support and promote long-distance clinical health care, patient and professional health-related education, and public health and administration."[10] For purposes of reimbursement, the Centers for Medicare & Medicaid Services defines "telemedicine" narrowly as activities involving "two-way, real time interactive communication between the patient and the physician or practitioner at [a] distant site."[11]

In telehealth and telemedicine as in other modes of care, patient-physician interactions give rise to differing levels of accountability for physicians. At one end of the telehealth or telemedicine continuum are health-related websites where any interaction between an individual seeking health information and a physician who provides it is indirect. The physician has broad obligations to all website users, but is not specifically accountable to any individual information seeker. For example, on some websites, physician experts are responsible for ensuring the accuracy and quality of content, but are not expected to be responsible for how individuals act on the information they find on the website. The analogy is to seeking information from a book or journal article whose author has ensured the accuracy of the content but is not held to account for readers' individual interpretations.

Farther along the continuum are interactions that are more direct, give rise to greater accountability, and carry greater potential for unethical behavior. An example would be an online health website or service where a patient could pose a specific personal health question to which a physician affiliated with the website or service offers an individualized response, which, of course, might include a recommendation to see a physician in person. This interaction might occur in real time or within an established time frame. In such scenarios, the physician, by tailoring the response specifically to the individual, takes on a greater accountability than one who posts general health content for public consumption. This situation might be similar to, though more formal than, a "cocktail party consult" in which a physician is approached for guidance. Disclaimers to the effect that the consultation does not establish a legally recognized patient-physician relationship, which some websites provide, do not obviate the physician's ethical responsibility.

Still farther along the continuum, in a teleradiology or teledermatology consultation, for example, a specialist accesses images that are ideally accompanied by information from the patient's history, reviews them, and offers insight in real time or asynchronously using store-and-forward technology.[2] The underlying expectation is that the specialist's response will directly inform decisions about the patient's care, for which the specialist will then share accountability with the treating physician in keeping with expectations for in person consultations.

At the far end of the continuum are interactions in which a physician participates directly in a patient's clinical care in real time via telecommunications and is held accountable for the care he or she provides as a treating physician. Telepsychiatry is one example, in which care is electronically mediated, but is not necessarily institutionally based.[12] Teleoncology provides a second example, in which a specialist provides care for a patient in a remote clinic or other institutional setting, in coordination with on-site professionals involved in the patient's care team.[3] Physicians are also developing new formats to follow patients with chronic health conditions that take advantage of asynchronous communication to enhance care, provide greater convenience for patients or their surrogates, and enable physicians to make effective use of limited clinical time.[13]

Familiar Challenges, New Context

Proponents of telehealth and telemedicine highlight how these technologies open new channels of access to care and offer new opportunities for truly patient-centered care.[1, 5, 9, 14] Critics are more cautious, expressing concern about new or exacerbated risks to privacy and confidentiality, the limitations of electronically mediated interactions for physical examination, and the potential for disruption of the patient-physician relationship.[4, 7, 15, 16]

Risks to Privacy and Confidentiality

Electronic health and medicine encounters involve a wider range of third parties than traditional health care encounters. Notably, telecommunications service providers and possibly their business affiliates, in addition to health care personnel at one or both ends of the interaction, are in-

volved. Some encounters are protected under privacy laws and regulation, but others may not be protected and may carry additional risks. For example, websites that offer health information may not actually be as anonymous as visitors think; they may leak information to third parties through code on a website or implanted on patients' computers.[8] Similar concerns may apply to home monitoring devices and mobile health applications to which current privacy protections may not apply.[7]

Matching the Mode of Care to the Patient

Telemedicine will not be the right model of care for every patient. To begin with, a patient or surrogate must have the resources, including access to and ability to use requisite technology, necessary health care professionals or others present during interactions, access to emergency care, and an acceptable level of comfort in obtaining care in this way.[12 , 17 , 18]

Despite its promise, telemedicine is not an appropriate model of care for all medical conditions.[4] For example, telemedicine is inappropriate for encounters when a hands-on physical examination is crucial or critical data can be gleaned only through direct physical contact. More broadly, telemedicine is *not* the preferred approach when the technology does not allow physicians to meet established clinical standards.

Whether telemedicine is appropriate for a given patient may also depend on what access the individual otherwise has to health care. For some patients, in some situations, it simply may not be feasible to receive care in person. When the options for a patient are to receive care that may be less than ideal via telemedicine or not to receive care at all, telemedicine services can be appropriate even though the physician, patient, or their surrogate, would prefer that care be provided in person. For example, for a crewmember aboard a submarine or an astronaut in space, telemedicine—whatever its limitations—may be the only way to provide medical services. For a person in an isolated rural setting a 6-h drive from a specialist, telemedicine may be preferable even when an in-person encounter would be marginally superior.

Trust and Ethical Practice in Telehealth and Telemedicine

While new technologies and new models of care continue to emerge, physicians' fundamental ethical responsibilities do not change. The practice of medicine is inherently a moral activity, founded in a "covenant of trust" between patient and physician.[19] In any model of care, patients and their surrogates need to be able to trust that physicians will place patient welfare above other interests (fidelity), provide competent care, provide the information patients and their surrogates need to make well-considered decisions about care (transparency), respect patient privacy and confidentiality, and take steps to ensure continuity of care.[20 , 21] The task is to understand how these fundamental responsibilities may play out differently in the context of telehealth and telemedicine than they do in in-person patient-physician interactions.

Fidelity

The obligation to put patient interests first requires that physicians who participate in telehealth activities or telemedicine programs take steps to minimize conflicts of interest and bias. It is important that physicians disclose financial or other interests that may influence them in their roles with commercial health websites and services and take active steps to manage or eliminate conflicts of interest.[22]

Competence

The obligation to provide competent care has different implications at different points along the continuum of electronic interactions between physicians and patients or prospective patients. Thus, physicians who provide general health information for online websites have a responsibility to ensure that the content they provide is accurate and objective, just as they would for a professional publication. Physicians who provide personalized responses to individual health queries have additional responsibilities in keeping with their greater accountability to the individual who is seeking guidance. In this context, the obligation of competence requires that the physician who responds to an individual query about a specific health concern have appropriate clinical qualifications and experience and have some means of obtaining the crucial information needed to offer a well-considered professional recommendation. Physicians should bear in mind that state law may further define specific expectations for competence in these situations.

For physicians who provide clinical services, fulfilling the obligation to provide competent care further entails being proficient in the use of the relevant technologies and being comfortable using technology to interact with patients. Competency also includes physicians' responsibility to be aware of the limitations of the telemedicine technologies they use and recognition of limitations in caring for an individual patient. Physicians must use professional judgment in determining what modality of care is best for a given patient, including determining when to shift from telehealth or telemedicine to in-person care.

Transparency and Informed Consent

Physicians also have a responsibility to be transparent with patients and prospective patients. At one end of the continuum, this may mean no more than disclosing one's credentials as the author of health information. At the other end, it will entail obtaining the patient's informed consent for clinical services that are delivered electronically. In the context of telehealth or telemedicine, patients need to have information not only about medical issues and treatment options, but also about some of the distinctive features of telemedicine.

For example, patients or their surrogates need to have a basic understanding of the credentials of the physicians and other health care professionals who provide telehealth and telemedicine services. Patients also need to be aware of how telemedicine technologies will be used in their care and the limitations of those technologies. Importantly, patients themselves (or their surrogates) or their family members may be asked to play a different role in telemedicine than in traditional care, for example, by learning how to use monitoring devices at home, a factor that may influence decision making. Physicians' responsibility to ascertain whether the patient or family

has the skills needed to participate in the care plan may be stronger in the context of telehealth and telemedicine than in other encounters,[23] especially when telehealth websites or mobile health applications connect physicians and patients with whom there is no prior relationship and or expectation of follow-up.

Privacy and Confidentiality

The obligation to protect privacy and confidentiality is at least as important in the context of telehealth and telemedicine as in hospital and office settings. Specific responsibilities vary across the continuum of telehealth/telemedicine interactions. Thus, health information websites are expected to publish their privacy policies so that users will know what information is collected from them (if any) and how that information is to be used.[24] Physicians who provide content for health websites have a responsibility to be satisfied that websites with which they are affiliated have relevant privacy policies. Physicians should refrain from participating in websites that do not make these policies available to website users.

Physicians who answer individual health queries or provide personalized health guidance electronically must be confident that the websites with which they affiliate have appropriate mechanisms in place to protect the confidentiality of individual information exchanged through the website. They should also inform website users that there are potential risks to privacy when personal health information is communicated electronically, for example, through a written disclaimer on the site.

Physicians who provide clinical services via telemedicine must adhere to sound privacy practices themselves and must assure themselves that health care professionals at remote websites with whom they collaborate do likewise. They must further assure themselves that the telemedicine services they work with have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information. Physicians should alert telemedicine patients or their surrogate that issues of data security and access can arise and inform them of steps taken to protect confidential information.

Continuity of Care

Fulfilling the obligation not to abandon the patient and to provide for continuity of care[20] may also take on a new dimension in the context of telemedicine. Physicians who author general health content do not enter into a patient-physician relationship with information seekers; they therefore have no specific responsibilities regarding continuity of care. Physicians who respond to individual health queries should understand that they are responsible for encouraging the patient to seek in-person care when the physician deems that to be needed. Some telehealth and telemedicine services may also identify physicians whom service users can contact to arrange in-person care.

Physicians who provide clinical services through telemedicine should discuss with patients or their surrogates the importance of preserving information for future episodes of care, and

whether patients prefer to take responsibility for this or want the physician to do so, by communicating directly with the patient's primary care physician. Information should include recommendations for follow-up care when appropriate. Telemedicine programs that rely on collaboration among the physician, patient, or surrogate and the telemedicine team and that routinely convey the plan to patients' primary physicians if they are not a member of the team are in a better position to develop plans of care that ensure appropriate follow-up. Physicians who provide clinical telehealth and telemedicine services in settings where the encounter will not be documented in an existing medical record should consider writing a note after each clinical encounter for their own files.

The Evolving World of Patient Care

Many may feel that telehealth and telemedicine, with their technological sophistication, continuous change, and rapid expansion, are standing medicine on its head. However, it may be more appropriate to see the evolution of telecommunications in patient care as part of the history of technology in medicine, and an opportunity to enhance access to care, quality of care, and satisfaction for both patients and physicians. Thoughtfully implemented, telehealth and telemedicine have the potential to enable physicians to use that most valuable of commodities, time spent in person with patients, to greater effect.[13]

For individuals who are comfortable with electronic technology, telehealth and telemedicine have the potential to increase access to health care by making expert attention available to patients who would otherwise have limited or no access to such care. Yet telehealth and telemedicine cannot enhance access to high-quality care if patients who might benefit from these innovations do not have access to or the ability to use telecommunications technologies effectively. These may include elderly individuals or others who have diminished perceptual, cognitive, or psychomotor abilities[23,25] or members of communities that tend not to have ready access to or to adopt internet technologies.[6,26–29] Medicine as a profession can play an important role in advocating for initiatives that will help make the needed technologies more readily available to all patient populations who want to utilize telehealth and telemedicine services.

Achieving the promise and avoiding the pitfalls of electronically mediated care is not the responsibility of individual physicians alone. It requires coordinated effort across the profession, active engagement of specialty and professional organizations not only in medicine but also information technologies, and appropriate education and support for practicing clinicians.[15,23] The ethical analysis discussed in this article was adopted by the House of Delegates of the American Medical Association, and the recommendations of the report establish ethics guidance in this area. A summary of the key points of the recommendations can be found in Appendix A (online), and the full text of the opinion can be found in Appendix B (online).

Electronic supplementary material

ESM 1 (18K, docx)

(DOCX 18 kb)

Acknowledgements

This article was supported by the American Medical Association. This article summarizes a report written by the Council on Ethical and Judicial Affairs of the American Medical Association and was presented to the AMA's House of Delegates and adopted in June 2016. The authors, on behalf of the Council, are grateful for input and comments provided by members of the AMA during the drafting stages of the report.

Author Contributions

Ms. Chaet, MSB, has access to all of the data used to prepare the report and takes responsibility for the integrity of the interpretation. American Medical Association.Study Concept and Design.All authors.Acquisition of Data.All authors.Analysis and Interpretation of Data.All authors.Drafting of the Manuscript.Danielle Chaet.Critical Revision of the Manuscript for Important Intellectual Content.All authors.

Compliance with Ethical Standards

Funding

The study was funded from the operating budget of the American Medical Association, which employs Ms. Chaet.

Conflict of Interest

The authors declare that they have no conflict of interest.

Footnotes

Ron Clearfield has retired already

Electronic supplementary material

The online version of this article (doi:10.1007/s11606-017-4082-2) contains supplementary material, which is available to authorized users.

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