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IN THE

INDIANA COURT OF APPEALS

CASE NO. 25A-PL-00782

INDIANA STATE HEALTH COMMISSIONER, in the officer's official capacity, and VOICES FOR LIFE, INC.,	)	Appeal from the Marion Superior Court
Appellants-Defendants,	)	Trial Court Cause No. 49D13-2502-PL-006359
vs.	)	
CAITLIN BERNARD, MD and CAROLINE ROUSE, MD,	)	The Hon. James A. Joven, Judge
Appellees-Plaintiffs.	)	

BRIEF OF *AMICI CURIAE* INDIANA STATE MEDICAL ASSOCIATION AND AMERICAN MEDICAL ASSOCIATION

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STATEMENT OF INTEREST

The Indiana State Medical Association ("ISMA") is an association of over 9,000 physicians and medical students across the State of Indiana whose mission is to maximize the leadership and impact of physicians. ISMA's member physicians practice in 128 different specialties and subspecialties in a wide range of settings, including solo practices, medical groups, clinics, surgical facilities, and integrated health and hospital systems. ISMA provides continuing medical education for its member physicians so they can deliver the best possible care to their patients across this broad spectrum. Since 1849, ISMA has represented the collective interests of its member physicians on matters of public policy and worked to foster a better understanding of physicians and health care issues in the community, in the Indiana General Assembly and state government, and in the courts.

The American Medical Association ("AMA") is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in all areas of medical specialization and in every state, including Indiana.

ISMA and the AMA (collectively, "*amici*") appear in their own capacities and as representatives of the Litigation Center of the AMA and the state medical societies. The Litigation Center is a coalition of the AMA and the state medical societies. Its mission is to advance the interests of patients and physicians in the courts in accordance with AMA policies.

As representatives of Indiana's health care community, *amici* have a strong interest in the outcome of this appeal and the proper application of the Indiana Access to Public Records Act, Ind. Code § 5-4-13, *et seq.* ("APRA"), relative to the private health information contained in patient medical records. This case involves the issue of whether Terminated Pregnancy Reports ("TPRs") submitted to the Indiana Department of Health ("IDOH") under Ind. Code § 16-34-2-5 are excepted from disclosure under APRA. But the legal and social ramifications of this question go far beyond the care detailed in those reports and strike at the very heart of the patient-physician relationship in any health care context. Today it is TPRs. Tomorrow it could be another record documenting a patient's medical history, diagnosis, and treatment.

Amici can assist the Court in evaluating the legal issues, public policy considerations, and practical consequences of allowing a patient's most intimate health information to become a matter of public record. Indeed, the position advanced by IDOH and Voices for Life (collectively, "Appellants") places physicians directly at odds with the standards embodied in the AMA's Code of Medical Ethics, which are crucial to preserving patient trust and public confidence in the medical

profession. *Amici* can also provide a unique perspective on the detrimental impact that targeting physicians – simply for the care they provide to their patients – can have on the health, safety, and well-being of physicians themselves. All of these concerns – the sanctity of a patient's private health information, the integrity of the patient-physician relationship, and the security of the medical profession – are linchpins of an operational health care system that *amici* are well-suited to address in this appeal.

SUMMARY OF ARGUMENT

Health information is one of the most intimate forms of information that individuals can possess and generate over their lifetime. Successful care requires open communication and the utmost candor between patients and physicians. For this to occur, patients must be able to trust that physicians will hold their private health information in confidence. The patient-physician relationship is a covenant of trust, and the Code of Medical Ethics reinforces that bond. The trust that is foundational to the patient-physician relationship can be eroded, if not destroyed, by the prospect that one's private health information may become a matter of public record. Absent trust, patients may delay or forgo treatment or misstate or omit vital information, diminishing personal health outcomes and impairing the health care system as a whole.

The health care system is further undermined when physicians become targets merely because of the care they provide to their patients. Increasingly, physicians have become the objects of harassment, threats, and even violence. This

unfortunate reality affects physicians in many specialties. Websites and online forums often identify physicians by name – if not more – with the objective of stigmatizing the care they provide, isolating them from their peers, and damaging their standing and reputation in the community. Voices for Life seeks to use the information contained in TPRs to do precisely that. This sort of invasive tactic – under the guise of a public records request – does nothing to advance the goal of government transparency under APRA and will only have the effect of reducing physicians' sense of safety, harming physician health and well-being, and destabilizing a medical profession that is essential to maintaining a broad continuum of care here in Indiana.

TPRs should not be regarded as public records subject to disclosure under APRA. This is the only outcome that will preserve the sanctity of a patient's private health information, the integrity of the patient-physician relationship, and the security of the medical profession. For these reasons, *amici* urge the Court to affirm the trial court's preliminary injunction order.

ARGUMENT

I. Patient Confidentiality and Trust Are Integral to the Patient-Physician Relationship.

As every health care provider knows, successful care requires open communication and the utmost candor between patients and physicians. *See* Am. Med. Ass'n, *Opinion 1.1.4: Patient Responsibilities*, AMA CODE OF MED. ETHICS ("Successful medical care requires ongoing collaboration between patients and

physicians.").[1] "[Patients] should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services." Am. Med. Ass'n, *Opinion 3.2.1: Confidentiality*, AMA CODE OF MED. ETHICS.[2] Physicians can deliver optimal care when patients "[a]re truthful and forthcoming" and "[p]rovide as complete a medical history as they can" to assist with their diagnosis and treatment. Am. Med. Ass'n, *Opinion 1.1.4: Patient Responsibilities*, AMA CODE OF MED. ETHICS.[3]

Given this dynamic, "[t]rust is a fundamental aspect of the patient-physician relationship." Audiey C. Kao et al., *Patients' Trust in Their Physicians: Effects of Choice, Continuity, and Payment Method*, 13 J. GEN. INTERNAL MED. 681, 681 (1998) [hereinafter, Kao et al.].[4] And protecting the confidentiality of a patient's health information is a necessary "prerequisite for trust" within that relationship. Am. Med. Ass'n, *Opinion 3.1.1: Privacy in Health Care*, AMA CODE OF MED. ETHICS.[5] Patients must be able to trust that physicians will hold their private health information in confidence. Indeed, the Code of Medical Ethics describes the patient-

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[1] Available at https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-responsibilities; *see also* Am. Med. Ass'n, *Opinion 8.6: Promoting Patient Safety*, AMA CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/promoting-patient-safety ("Open communication is fundamental to the trust that underlies the patient-physician relationship . . . .").
[2] Available at https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/confidentiality.
[3] Available at https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-responsibilities.
[4] Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC1500897/.
[5] Available at https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/privacy-health-care.

physician relationship as a "covenant of trust." Am. Med. Ass'n, *Opinion 11.2.7*: *Responsibilities to Promote Equitable Care*, AMA CODE OF MED. ETHICS.[6]

Accordingly, physicians are ethically bound to maintain the confidentiality of "[i]nformation gathered and recorded in association with the care of a patient." Am. Med. Ass'n, *Opinion 3.2.4: Access to Medical Records by Data Collection Companies*, AMA CODE OF MED. ETHICS.[7] This is true not only under the ethical canons that govern the medical profession, but also under Indiana's "age-old recognition that medical providers owe a duty of confidentiality to their patients." *See Henry v. Community Healthcare Sys. Cmty. Hosp.*, 134 N.E.3d 435, 437 (Ind. Ct. App. 2019). "[T]here is – and, in modern times, always has been – a common law duty of confidentiality owed by medical providers to their patients." *Id.* at 438. In fact, Indiana's common law duty of patient confidentiality rests in large part on the rules of medical ethics. *See id.* at 438 (citing, among other authorities, the AMA's Code of Medical Ethics *Opinion 3.2.1: Confidentiality* regarding a physician's ethical obligation to preserve the confidentiality of patient information); *see also Canfield v. Sandock*, 563 N.E.2d 526, 529, 529 n.2 (Ind. 1990) (observing that "the ethical rules of the medical profession . . . prohibit disclosure of confidential information in non-judicial settings"); *accord Vargas v. Shepherd*, 903 N.E.2d 1026, 1031-32 (Ind. Ct.

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[6] Available at https://code-medical-ethics.ama-assn.org/ethics-opinions/responsibilities-promote-equitable-care; *see also* Am. Med. Ass'n, *Opinion 1.1.1: Patient-Physician Relationships*, AMA CODE OF MED. ETHICS, https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-physician-relationships ("The relationship between a patient and a physician is based on trust . . . .").
[7] Available at https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/access-medical-records-data-collection-companies.

App. 2009) (reciting argument that medical providers assume a duty to abide by ethical guidelines, including obtaining patient consent before disclosing any medical information).

The trust that is foundational to the patient-physician relationship can be eroded, if not destroyed, by the prospect that one's private health information may become a matter of public record. The damage to the covenant of trust between patient and physician is even more grievous when the patient's private health information is weaponized by advocacy groups, journalists, and members of the public to further their own agendas. Appellants' failure to appreciate this impact on the patient-physician relationship ignores basic medical ethics and the realities of health care.

While Voices for Life concedes that APRA's exemption of medical records from public disclosure requirements "is intended to protect the patient's privacy[,]" Voices for Life sidesteps this protection by constraining a patient's privacy to only those "records that identify [the] individual patient" by name. (Voices for Life's Br., p. 25.) Following this flawed reasoning, Voices for Life concludes that IDOH's release of TPRs to the public does not implicate any patient's privacy because "the TPR does not name the individual patient who received the care described in the TPR." (Voices for Life's Br., p. 25.) According to Voices for Life, there are "no patient privacy interests to protect" if the patient's personal health information is released to the public without the patient's name attached. (Voices for Life's Br., p. 20.)

These arguments demonstrate Voices for Life's misunderstanding of patient confidentiality.[8]

Patients have a right to confidentiality under the Code of Medical Ethics. Am. Med. Ass'n, *Opinion 1.1.3: Patient Rights*, AMA CODE OF MED. ETHICS.[9] Moreover, "[p]atients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services" – not for purposes unrelated to their medical history, diagnosis, and treatment. Am. Med. Ass'n, *Opinion 3.2.4: Access to Medical Records by Data Collection Companies*, AMA CODE OF MED. ETHICS.[10] "Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in

[8] In a public statement issued on November 30, 2022, the Indiana Attorney General accused one of the plaintiff physicians, Dr. Caitlin Bernard, of violating "her patient's trust . . . and the standards for the medical profession" when she discussed a case involving a 10-year-old girl without disclosing the patient's name. *See* https://events.in.gov/event/the_office_of_attorney_general_todd_rokita_issues_statement_regarding_dr_caitlin_bernard_case_6974. The Attorney General took the position that "[s]imply concealing the patient's name" does not rectify what he perceived to be a breach of "legal and ethical duties here." Voices for Life, through its counsel, has expressed similar sentiments. *See* https://www.thomasmoresociety.org/case/caitlin-bernard-m-d-and-caroline-rouse-m-d-v-indiana-state-health-commissioner-and-voices-for-life (noting that Dr. Bernard's discussion of the case without disclosing the patient's name "rais[ed] serious concerns about patient confidentiality and professional ethics"). Voices for Life offers no explanation for this double standard.

[9] Available at https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights.

[10] Available at https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/access-medical-records-data-collection-companies.

association with the care of the patient." Am. Med. Ass'n, *Opinion 3.2.1: Confidentiality*, AMA CODE OF MED. ETHICS.[11]

None of these hallmarks of patient confidentiality are conditioned on the patient's *name* being associated with the private health information at the time of the information's disclosure to a third party.[12] Rather, the patient's right to confidentiality and the physician's ethical obligation to maintain that confidentiality are triggered by the patient-physician relationship itself – even before the patient shares his or her private health information with the physician. The whole point of patient confidentiality is to keep the patient's health information private from others outside the covenant of trust between patient and physician.

If a third party obtains information about the patient's medical history, diagnosis, and treatment without the patient's consent, the patient's confidentiality has been breached irrespective of whether his or her name is attached. Under Voices for Life's faulty logic, a physician could publish a patient's private health information and the patient would have no grounds to assert a breach of confidentiality so long as the physician redacted the patient's name from the documents. This narrow interpretation of patient confidentiality is contrary to the

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[11] Available at https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/confidentiality.

[12] As an aside, federal privacy rules promulgated under the Health Insurance Portability and Accountability Act ("HIPAA") require the de-identification of a host of information beyond just the patient's name, social security number, and address, in recognition of the fact that patients can be identified in many ways, including through identifiers such as birth date, admission date, discharge date, medical record numbers, and account numbers. 45 C.F.R. § 164.514(b)(2)(i).

rules of medical ethics and Indiana's common law duty of confidentiality.[13] *See* *Henry*, 134 N.E.3d at 438.

Voices for Life's insistence that no third-party recipient of a TPR has ever "disclosed the identity of a patient" likewise misses the point of patient confidentiality and provides little solace for patients and providers. (Voices for Life's Br., p. 12.) Patients expect and must trust that physicians will hold their private health information in confidence from others outside the patient-physician relationship – and that undoubtedly includes advocacy groups, journalists, and members of the public. Indeed, physicians are required to obtain a patient's consent before disclosing private health information to the patient's own family and friends. *See* Am. Med. Ass'n, *Opinion 3.2.1: Confidentiality*, AMA CODE OF MED. ETHICS.[14] The non-binding assurance that a member of the public will not disclose the identity of the patient downstream does nothing to rectify the breach of patient confidentiality that will have occurred by virtue of IDOH's initial release of private health information in response to a public records request under APRA.

IDOH dismisses as "speculative" the link between a loss of patient confidentiality and the corresponding chilling effect on the patient-physician

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[13] It also ignores the fact that simply redacting a patient's name does not prevent re-identification of the patient when other data about the patient is published, especially in today's technology age. *See* n.12, *supra.*

[14] Available at https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/confidentiality; *see also* 45 C.F.R. § 164.510(b) (HIPAA privacy regulation under which health care providers must generally obtain the patient's consent before disclosing private health information to family and friends, and even then only disclose information that is directly relevant to that person's involvement with the patient's care or payment related to the patient's care).

relationship. (IDOH's Br., pp. 26-27.) IDOH further discounts the fact that patients are less likely to reveal medical information if there is a risk the information could be disclosed as a public record under APRA. (IDOH's Br., pp. 26-27.) Voices for Life makes similar arguments. (Voices for Life's Br., pp. 10-12.) IDOH goes so far as to suggest that patients make decisions about what information to share with their physicians independent of the covenant of trust between patient and physician, and without regard to where that information may end up or how it may be used. (*See* IDOH's Br., pp. 27-28) (describing patient's decision as an "intervening cause" by an independent third party). Appellants' assessment once again ignores the realities of health care and the widely accepted research regarding the patient-physician dynamic.

It is well established that, "without confidence that their physical and mental health concerns and conditions will be held in secret, patients may delay or forgo essential services, with detriment to their health." Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality*, 15 IND. HEALTH L. REV. 139, 144 (2018) [hereinafter, Beletsky]; *see also* Katrina Armstrong et al., *Distrust of the Health Care System and Self-Reported Health in the United States*, 21 J. GEN. INTERNAL MED. 292, 294 (2006) [hereinafter, Armstrong et al.] (discussing study showing that distrust of the health care system "is strongly associated with worse self-reported health, even after adjusting for age, sex, race, education, income, and insurance coverage")[15]; Thomas A. LaVeist et al.,

[15] Available at https://pubmed.ncbi.nlm.nih.gov/16686803/.

Mistrust of Health Care Organizations Is Associated with Underutilization of Health Services, 44 HEALTH SERVS. RSCH. 2093, 2102 (2009) ("Conceptually, mistrust of the medical care system contributes to delay in care seeking, which complicates the care process and often worsens patient outcomes. Delays in seeking care can lead patients to initiate care at later stages of disease progression, increasing the costs of treatment.")[16]; *id.* at 2100 (observing that "[h]igher mistrust scores lead to greater odds of underutilization of health services"). Moreover, "the lack of trust can produce dangerous gaps in patient-provider communication, whereby patients may misstate or omit important information. Such gaps can hamper appropriate diagnosis, treatment, and follow-up." Beletsky, 15 IND. HEALTH L. REV. at 144; *cf.* Bradley E. Iott et al., *Trust and Privacy: How Patient Trust in Providers Is Related to Privacy Behaviors and Attitudes*, 2019 AM. MED. INFORMATICS SYMP. 487, 490 (2020) (finding that "trust in [patient] confidentiality is associated with lower odds of having ever withheld info[rmation from a health care provider]").[17]

Appellants' misconception about the importance of patient confidentiality to the patient-physician relationship also contradicts Indiana precedent, which has long recognized "the societal value of protecting the confidences existing within that professional relationship." *See Canfield*, 563 N.E.2d at 529; *see also Schlarb v. Henderson*, 4 N.E.2d 205, 206 (Ind. 1936) (stating that purpose of common law duty of patient confidentiality is to ensure open communication between patient and

[16] Available at https://pubmed.ncbi.nlm.nih.gov/19732170/.
[17] Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC7153104/.

physician "without the danger of publicity concerning such private and intimate affairs"). As the Supreme Court has explained, patient confidentiality "encourages free communications and frank disclosure between patient and physician which, in turn, provide assistance in proper diagnosis and appropriate treatment." *Collins v. Blair*, 268 N.E.2d 95, 98 (Ind. 1971). More than half a century ago, the Supreme Court cautioned that the failure to preserve patient confidentiality could "cause one suffering from a particular ailment to withhold pertinent information of an embarrassing or otherwise confidential nature for fear of being publicly exposed." *Id.* The Supreme Court has repeatedly reinforced this concern. *See, e.g.*, *Canfield*, 563 N.E.2d at 530 (emphasizing that without confidentiality, "[p]atients would be unwilling to discuss their problems with their physicians candidly for fear that this sort of intensely private information could be subject to revelation").

The Supreme Court's appraisal is in line with the realities of health care and the research-backed findings regarding the patient-physician dynamic. As the AMA recounted in a recent policy statement:

> Health care information is one of the most personal types of information an individual can possess and generate . . . . We must always ask whether relaxing privacy controls will encourage patients to seek care or potentially deter them. Privacy risks include re-identification of patients through de-identified (or partially de-identified) data; . . . patient perception of loss of their privacy leading to a change in their behavior; [and] embarrassment or stigma resulting from an unwanted disclosure of information or from fear of a potential unwanted disclosure . . . .[18]

[18] The sensitive information contained in patient medical records is personal to the patient; it is not just "data" to be mined by "researchers and [the] media." (*See*

Comment Letter from James L. Madara, MD, Am. Med. Ass'n, to The Honorable Elinore F. McCance-Katz, MD, PhD, Assistant Sec'y for Mental Health & Substance Use, U.S. Dep't of Health & Human Servs. Regarding Confidentiality of Substance Use Disorder Patient Records (Oct. 25, 2019).[19]

Significantly, the breakdown in the patient-physician relationship and the underutilization of health services attributable to a lack of patient confidentiality and trust can occur in all facets of health care. These considerations are not isolated or unique to any specific type of care. *See, e.g.*, *id.* (noting that "confidentiality rules are critical to encouraging those with opioid and other [substance abuse disorders] to enter treatment"; "[p]olicies that undermine a patient's autonomy by sharing records against the patient's wishes may jeopardize the patient's trust in his or her physician, stall recovery, or prevent a patient from seeking treatment in the first place"); Nelson Shen et al., *Patient Privacy Perspectives on Health Information Exchange in a Mental Health Context: Qualitative Study*, 6 JMIR MENTAL HEALTH e13306 (2019) ("Privacy and trust are critical for patients with mental health conditions" because "[f]ear of the stigma and discrimination may cause them to withhold information from health care providers or avoid seeking care altogether . . . .").[20] It is not difficult to imagine the many areas of health care in which patients may feel especially anxious to share information with a provider, including

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IDOH's Br., p. 52) (arguing that "the public, including researchers and media, [is] interested in the data contained in [TPRs]").

[19] Available at https://searchlf.ama-assn.org/finder/letter/search/*/date/1/.

[20] Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC6881785/.

prescription medications, chronic conditions, sexually transmitted diseases, sexual dysfunction, domestic violence, substance abuse, birth control, infertility, eating disorders, genetic testing, mental health, and psychiatric conditions. *See, e.g.*, Steve Alder, *Patients Holding Back Health Information Over Data Privacy Fears*, THE HIPAA J. (Jan. 5, 2017) (discussing survey of 12,090 adult consumers in which respondents expressed concerns that their pharmacy prescriptions (90%), mental health notes (99%), and chronic conditions (81%) were being shared with the government, retailers, and employers).[21] The Supreme Court has likewise acknowledged that patients can be fearful of disclosing all sorts of "potentially embarrassing or ruinous information" about their health and medical history to a physician. *See Canfield*, 563 N.E.2d at 530 (e.g., being tested for a sexually transmitted disease).

Physicians – whether general practitioners or board-certified specialists in their field – encounter this trepidation from patients every day. Individuals who seek any type of health care from a physician often do so at a highly vulnerable point in their lives. The health care community's apprehension regarding APRA's chilling effect on the patient-physician relationship is not about the "loss of income" due to the underutilization of health services, as IDOH implies. (IDOH's Br., p. 27) (criticizing plaintiff physicians for not producing evidence of injury through lost income). It concerns the irreparable damage to the covenant of trust between

[21] Available at https://www.hipaajournal.com/patients-holding-back-health-information-over-fears-of-data-privacy-8634/.

patient and physician – which prevents physicians from being able to deliver the best possible care in accordance with the ethical and legal obligations governing their practice. Physicians have an "imperative to care for [their] patients" and an "ethical responsibility to place [their] patients' welfare above [their] own self-interest or obligations to others." Am. Med. Ass'n, *Opinion 1.1.1: Patient-Physician Relationships*, AMA CODE OF MED. ETHICS.[22] The position advanced by Appellants in this appeal places physicians directly at odds with the standards embodied in the Code of Medical Ethics, which are crucial to preserving patient trust and public confidence in the medical profession.

In short, patient confidentiality and trust are integral to the patient-physician relationship. The loss of those fundamentals diminishes personal health outcomes and impairs the health care system as a whole. *See* Armstrong et al., 21 J. GEN. INTERNAL MED. at 296 (concluding that "health care related distrust may interfere with the effective functioning of the health care system, by leading to lower rates or delayed utilization of beneficial health care services, such as preventive health care, as well as increased use of unnecessary and potentially harmful health care services");[23] *cf.* Kao et al., 13 J. GEN. INTERNAL MED. at 685 ("Systems of care that foster patient trust enhance the quality of the patient-physician relationship.") Allowing TPRs to be released as public records under

[22] Available at https://code-medical-ethics.ama-assn.org/index.php/ethics-opinions/patient-physician-relationships.
[23] Available at https://pubmed.ncbi.nlm.nih.gov/16686803/.

APRA will create distrust in the patient-physician relationship and have a detrimental impact on the health care environment in Indiana.

II. Targeting Physicians Merely for the Care They Provide to Their Patients Does Not Advance the Goal of Government Transparency Under APRA And Further Undermines the Health Care System.

The health care system is further undermined when physicians become targets merely because of the care they provide to their patients. Increasingly, physicians have become the objects of harassment, threats, and even violence. This unfortunate reality is not limited to any one type of health care. *See, e.g.*, Regina Royan et al., *Physician and Biomedical Scientist Harassment on Social Media During the COVID-19 Pandemic*, 6 JAMA NETWORK OPEN e2318315 (2023) [hereinafter, Royan et al.].[24] The topics provoking harassment run the gamut from childhood vaccinations, masking, substance abuse disorders, fertility treatments, LGBTQ matters, and end-of-life care to issues like obesity, firearm safety, and wearing bicycle helmets. *See, e.g.*, *id.*; Elizabeth Chuck, *Bombing at IVF Clinic Should Be a Security Wake-up Call for Fertility Centers, Experts Say*, NBC NEWS (May 19, 2025, 6:44 PM EDT) (reporting on bombing at fertility clinic as "raising fears that the threat of violence that has long loomed over abortion providers is now extending to other areas of reproductive health") [25]; Shannon Bond, *Children's Hospitals Are the Latest Target of Anti-LGBTQ Harassment*, NPR (Aug. 26, 2022, 3:30 PM ET) (reporting on large volume of hostile internet activity, telephone calls,

[24] Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10267768/.
[25] Available at https://www.nbcnews.com/news/us-news/bombing-ivf-clinic-security-wake-call-fertility-centers-experts-say-rcna207675.

and harassment emails, including threats of violence, towards clinicians and staff at children's hospitals in Boston, Seattle, Chicago, and Portland, Oregon related to gender-affirming care).[26] The targeting of physicians was especially rampant during the COVID-19 pandemic. *See* Royan et al., 6 JAMA NETWORK OPEN at e2318315[27]; *see also* Comment Letter from James L. Madara, MD, Am. Med. Ass'n, to Vice Admiral Vivek Murthy, MD, Surgeon General, U.S. Dep't of Health & Human Servs. Regarding Impact of Health Misinformation in the Digital Information Environment in the United States Throughout the COVID-19 Pandemic (May 2, 2022) (reporting that health care workers were frequently the subject of targeted threats and harassment by COVID-19 "deniers" and anti-vaccine advocates).[28]

The frequency of harassment and threats against physicians has become so commonplace that the AMA has had to develop policies to address this ongoing concern. *See* Am. Med. Ass'n Policy Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997 (2019) (opposing violence and acts of intimidation directed against physicians and their families as well as violence directed against medical facilities).[29] The AMA has pledged to "act to reduce the incidence of antagonistic actions against physicians . . . , including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those

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[26] Available at https://www.npr.org/2022/08/26/1119634878/childrens-hospitals-are-the-latest-target-of-anti-lgbtq-harassment.
[27] Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10267768/.
[28] Available https://searchlf.ama-assn.org/finder/letter/search/*/date/1/.
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which appear motivated simply by their identification as health care workers," and to "educate the general public on the prevalence of violence and personal harassment against physicians." Am. Med. Ass'n Policy Protecting Physicians and Other Healthcare Workers in Society H-515.950 (2023).[30] The ISMA, in partnership with other local organizations such as the Indiana Hospital Association, Suburban Health Organization, Indiana Rural Health Association, and Indiana State Nurses Association, has similarly advocated for heightened awareness and protection of health care providers here in Indiana. *See* S.B. No. 419, 124th Gen. Assemb., Reg. Sess. (Ind. 2025) (proposing law that would make it a felony to commit battery against a health care provider).

The internet and the rise of social media platforms have made it even easier to target physicians with harassment and threats. Harassment of physicians takes many forms, including doxxing,[31] leaving false or defamatory online reviews, sending intimidating messages, and threatening them with violence. *See* Royan et al., 6 JAMA NETWORK OPEN at e2318315[32]; Albert E. Zhou et al., *Ethics of Doxxing and Cyberbullying in Dermatology*, 42 CLINICS IN DERMATOLOGY 730, 731 (2024) [hereinafter, Zhou et al.] (reporting that "[d]oxxing remains a significant concern

[30] Available at https://policysearch.ama-assn.org/policyfinder/detail/H-515.950%20?uri=%2FAMADoc%2FHOD.xml-H-515.950.xml.
[31] Doxxing or doxing is the act of publicly identifying or publishing private information about an individual especially as a form of punishment or revenge. *See Dox*, MERRIAM-WEBSTER DICTIONARY (June 21, 2025), https://www.merriam-webster.com/dictionary/dox.
[32] Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10267768/.

post-pandemic, especially as digital engagement continues to be pervasive").[33] Again, the issue has become so prevalent that the AMA has pledged to "work with partners to support data privacy and anti-doxxing laws to prevent harassment, threats, and non-consensual publishing of information for all physicians and medical students." *See* Am. Med. Ass'n Policy Anti-Doxxing Data Privacy Protection H-80.990 (2024).[34]

Particularly apt to this case, websites and online forums often identify physicians by name – if not more – with the objective of stigmatizing the care they provide, isolating them from their peers, and damaging their standing and reputation in the community. Voices for Life seeks to use the information contained in TPRs to do precisely that. Voices for Life maintains a webpage that is populated with information about the physicians providing reproductive health care gleaned from the TPRs it has obtained through public records requests under APRA. Voices for Life then finds and posts on its website photographs of the physicians whose names are listed in the TPRs. Voices for Life's use of information obtained through public records requests for this purpose does nothing to advance the goal of government transparency under APRA and will only have the effect of reducing physicians' sense of safety, harming physician health and well-being, and destabilizing a medical profession that is essential to maintaining a broad

[33] Abstract available at https://pubmed.ncbi.nlm.nih.gov/38885851/.
[34] Available at https://policysearch.ama-assn.org/policyfinder/detail/Anti-Doxxing%20Data%20Privacy%20Protection?uri=%2FAMADoc%2FHOD.xml-H-80.990.xml.

continuum of care here in Indiana. *See* Ind. Code § 5-14-3-1 (stating that purpose of APRA is transparency "regarding the affairs of government and the official acts of those who represent them as public officials and employees"). Today it is TPRs. Tomorrow it could be another record documenting a patient's medical history, diagnosis, and treatment.

Importantly, "online threats are not and should not be seen as harmless. . . . [O]nline threats can incite actual threats of physical violence and jeopardize the safety of both medical professionals and the communities they serve." Vineet Arora et al., *From Doxxing to Doctor Death Threats – Online Harassment of Physicians and Scientists Goes Beyond Trolling*, MED PAGE TODAY (June 22, 2023).[35] "Moreover, online attacks of medical . . . professionals take an emotional toll on a workforce that is already facing a high degree of burnout and depression." *Id.*; *see also* Zhou et al., 42 CLINICS IN DERMATOLOGY at 731 (reporting that "[d]oxxing can stress an already overburdened medical workforce, worsening burnout and increasing the risk of mistakes").[36] "Physician burnout was already high and well-documented before COVID." Ass'n of Am. Med. Colleges, THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2021 TO 2036 21 (2024).[37] The "seeming indifference of the public to provider safety and well-being have exacerbated the problem." *Id.*

[35] Available at https://www.medpagetoday.com/opinion/second-opinions/105131.
[36] Available at https://pubmed.ncbi.nlm.nih.gov/38885851/.
[37] Available at https://www.aamc.org/media/75231/download.

It is well recognized that "[s]afeguarding the health, safety and well-being of health workers" can "improv[e] the quality and safety of care" in the communities they serve and "contributes to improving the productivity . . . and retention of health workers." *Occupational Health: Health Workers*, WORLD HEALTH ORG. (Nov. 7, 2022).[38] It stands to reason that policies which devalue physician health, safety, and well-being will only diminish the quality and safety of care in the communities they serve and reduce the productivity and retention of health care workers. This outcome does not bode well for a health care system that is already facing potential shortages in medical professionals over the long term. *See* Ass'n of Am. Med. Colleges, THE COMPLEXITIES OF PHYSICIAN SUPPLY AND DEMAND: PROJECTIONS FROM 2021 TO 2036 vi (2024) (finding that "[p]hysician demand is projected to continue to grow faster than supply under the most likely scenarios, leading to a total projected shortage of between 13,500 and 86,000 physicians by 2036").[39]

Indiana has a "vital" interest in the continued "availability of the professional services of physicians and other health care providers." *See Johnson v. St. Vincent Hosp., Inc.*, 404 N.E.2d 585, 590 (Ind. 1980) (upholding protections in the Medical Malpractice Act as furthering "the public health and wellbeing of the community"). The Supreme Court has long understood that "preventing a reduction of health care services" in Indiana is critical to preserving "the health of the citizens of this State." *See id.* at 597. Allowing APRA to be used as a sword for targeting physicians merely

[38] Available at https://www.who.int/news-room/fact-sheets/detail/occupational-health--health-workers.
[39] Available at https://www.aamc.org/media/75236/download.

because of the care they provide to their patients will jeopardize that compelling state interest.

CONCLUSION

TPRs should not be regarded as public records subject to disclosure under APRA. This is the only outcome that will preserve the sanctity of a patient's private health information, the integrity of the patient-physician relationship, and the security of the medical profession. For these reasons, the Court should affirm the trial court's preliminary injunction order.

Respectfully submitted,

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WORD COUNT CERTIFICATE

The undersigned counsel verifies that the foregoing Brief of *Amici Curiae* (excluding cover page, table of contents, table of authorities, word count certificate, certificate of service, and signature block) contains 5,442 words as determined by the word count of the word processing system used to prepare this Brief, specifically Microsoft Word, which is no more than the 7,000 words permitted by Indiana Appellate Rule 44(E).

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was served electronically upon the following counsel of record through the Indiana E-filing System (IEFS), at the email addresses listed, this 26th day of June, 2025:

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