Center for Practical Bioethics
Board of Directors
July 13, 2022 7:30 AM

Location: In-person or Zoom Conferencing
In-Person: 9th Floor, Shalton Conference Room, Polsinelli PC, 900 W. 48th Place, KC, MO 64112
By Computer: https://us02web.zoom.us/j/9528298699 *Preferred for document screen sharing.*
By Phone: 1 669 900 6833 or 1 646 558 8656
Meeting ID: 952 829 8699

AGENDA *(Attachment 1)*

I. Call to Order — Eva Karp, Chair

II. Minutes of May 11, 2022 Board Meeting *(Attachment 2)*

III. Committee Reports

A. Finance Committee Report — Tresia Franklin, Treasurer
1. Financial Statements – 05.31.22 YTD
   a. Statement of Condition *(Attachment 3)*
   b. Statement of Activities *(Attachment 4)*
   c. Headlines for YTD Performance *(Attachment 5)*
2. Audit Committee update

B. Resource Development Report *(Attachment 6)* — Alan Edelman, Chair & Cindy Leyland *(Attachment 7)*
1. Art of the Wish Annual Event Report
2. Legacy Giving
3. Board Member Visits

C. Governance Committee Reports *(Attachment 8 & 8.1)* — Steve Salanski, Chair & John Carney
1. Review Governance Committee Roles and Responsibilities
2. Board Nomination and Officers election Process
   1. Currently four vacancies to fill in 2023
   2. Recruitment process and skills matrix
   3. Class of 2022 eligible for reappointment
      a. Abiodun Akinwuntan (2017) – 3rd full term
      b. Ed O'Connor (1 year expiring)
      c. Steve Salanski (2017) - 3rd full term
      d. Mark R. Thompson (2020) - 2nd full term
   4. Officers
3. Board Evaluation Questionnaire and Survey for 2022
4. Strategic Thinking and Planning
5. Calendar - Board and Staff Retreat on January 27 and 28, 2023

IV. Chair and President Reports — Eva Karp & John Carney

A. Chair Report
1. Update on Executive Search activities — Eva Karp & Steve Salanski

B. President's Report
1. Discussion on position related to SCOTUS overturning Roe v Wade
   a. Board email of 5.22.2022 - Leaked SCOTUS memo *(Attachment 9)*
   b. CPB Statement – Proposed – SCOTUS Ruling June 2022 *(Attachment 10)*
   c. ABPD Statement on SCOTUS Dobbs ruling *(Attachment 11)*
2. Discussion on Native American land acknowledgment *(Attachment 12)*
3. Flanigan Lecture update (Registrations: 81 virtual; 19 in-person)

V. Adjourn

Upcoming Events:

Ethics Committee Consortium Webinar – *The Ethics of Organ Donation: Insights from Medical Practice,* Thursday, July 14 at 12 noon CDT
28th Annual Flanigan Lecture – *America's Nursing Crisis: What Should Be Done?* Thursday, August 4 at 6 pm CDT in-person at KCU | 7 pm CDT virtual option
Board and Staff Retreat – Friday, January 27 at 12 noon CDT and Saturday, January 28 at 8 am CDT, location TBD

Next Board Meeting: September 14, 2022
Private Link to Board Meeting Materials and Board Book

CENTER FOR PRACTICAL BIOETHICS
GUIDANCE AT THE CROSSROADS OF DECISION

BOARD MEETING of the Board of Directors

May 11, 2022 – 7:30 am Location: Zoom Conference & Polsinelli PC

Item	Key Points	Discussion	Action
I. Call to Order at 7:33 AM		Eva Karp, Chair	
II. Approval of Minutes of 03.09.2022 Board Meeting	Meeting minutes approval		Meeting minutes approved as submitted.
III. Committee Reports A. Finance Committee Report 1. Financial Statements – 03.31.22 YTD a. Statement of Condition b. Statement of Activities c. Headlines for YTD Performance	Finance Committee Treasurer, Tresia Franklin, reported	Tresia Franklin presented the financial statements and summarized operations through end of March. Board members were alerted to the fact that it is likely that the annual event revenue will fall short of goal for the year.	Financial statements received and filed.
B. Resource Development Report 1. Art of the Wish Annual Event a. Run of Show b. Hosting & Hospitality of Board Members c. Update d. Program – Two Sessions e. Symposium	Resource Development Committee Chair, Alan Edelman, reported	A number of the major sponsors from previous years reduced their support in 2022. $246,110 raised for *Art of the Wish*, including $85,000 attributable to organizational affiliate agreements. Anticipating about 180 guests at first session and 85 for second.	Resource Development report received and acknowledged.
C. Governance Committee Report 1. Welcome Ed O'Connor 2. Board Roster	Governance Committee Chair, Steve Salanski, reported	2022 Joan Berkley Bioethics Symposium set for May 24, 2022, at the Leedy-Voulkos Art Center. Eva Karp extended a welcome to Dr. Ed O'Connor, Provost from KCU, who is joining the board to complete a one-year unexpired term. Additional consideration will be given to his reappointment or to another representative from KCU when nominations for 2023 are considered this fall.	Governance Committee report received and acknowledged. New Board roster was included in mailing
IV. Chair and President Report A. President's Report 1. J Carney gave a brief update on progress of the creation of the electronic Maternal Health longitudinal bank record for control by the Mother.	The Center's work will entail the creation of an ethics framework focused on equity and justice for regional implementation that will be led by a diverse group of women from a variety of backgrounds. More than two dozen leaders have been identified. Initial efforts will address guiding principles required to guide the years-long efforts.	Carney reported that numerous meetings have been held in recent weeks because of federal, state initiatives and city of KC and interest in focusing on improving the unacceptable health outcomes for women of child-bearing age in the region. Carney also noted that human capital commitments from the Center will only be available if grant funding to offset those costs can be secured.	Center staff will continue to monitor opportunities for funding that coincides with staffing commitments. The group will be convened upon completion of a one-page description defining the ethical issues.

Item	Key Points	Discussion	Action
2. Leaked SCOTUS ruling on Dobbs v Jackson Women's Center. J. Carney referenced an email sent to the board on Tuesday evening summarizing the ethical issues inherent in the leaked SCOTUS ruling anticipated for release in June.	Carney noted that the summary provided cited statements by professional associations addressing the legal and ethical issues that would predominate in a decision to overturn Roe v Wade. Given the abruptness of the ruling in overturning a precedent of access to abortion for nearly 5 decades, ethical concerns would likely arise for many providers. Trigger states (including Missouri) will also impact services previously available.	The Center has never taken a position on this topic as the issue of abortion was settled law prior to the Center's establishment. Since no decision has been rendered by the SCOTUS at this time, the board agreed to hold discussion on the ethical issues during the July board meeting.	None to report. The item is scheduled to appear on the July Board Agenda.
3. Update on Succession Planning Task Force a. Equity/Diversity/Inclusion Training b. Harvard Implicit Association Test (select the test for Race) c. Facilitated Session with Medell Briggs-Malonson, MD, MPH, MSHS (date to be determined)	Board Chair, Eva Karp, and Vice Chair, Steve Salanski, reported on the status of the Equity and Diversity Training to be offered prior to the continuing process of the CEO succession planning.	Board members are asked to take the Nonprofit Connect training on Equity/Diversity/Inclusion and to take the Harvard Implicit Association Test (for race) in preparation for a facilitated session later this summer with Medell Briggs-Malonson. E. Karp was introduced to Dr. Briggs-Malonson presented at a training Cerner. Tresia suggested EFL also attend the session with Dr. Briggs. John commented that some staff have asked for an update on the CEO search. Steve reported that the CEO job description will soon be distributed to the Board for review.	All Board members are asked to participate in the online asynchronous training by accessing the links in Board the Agenda or minutes The Harvard Implicit Association Test (race) should also be completed (see link). Remote training with Dr. Briggs-Malonson will take place at a future date
4. National Nurses Week – May 6-12, 2022	E Karp reminded all in attendance that this is National Nurses Week. She reported on the Radonda Vaught case.	Acknowledgment of Eva and Tangula. Eva commented on the upcoming sentencing of a nurse convicted in a medication error death.	
V. Adjourn		8:37 AM	Adjourned.

CENTER FOR PRACTICAL BIOETHICS
GUIDANCE AT THE CROSSROADS OF DECISION

BOARD MEETING of the Board of Directors
March 9, 2022 – 7:30 am
Location: Zoom Conferencing & Polsinelli PC

Attendance Roster

Abiodun Akinwuntan	Present (remote)
Norberto (Rob) Ayala-Flores	Present
Mary Beth Blake	Present
Karen Bullock	Present (remote)
Darrin D'Agostino	Present (remote)
Alan Edelman	Present (remote)
Sukumar Ethirajan	Present (remote)
Tresia Franklin	Present
Diane Gallagher	Present (remote)
Eva Karp - Chair	Present

Jane Lombard	Absent (excused – travel)
Sam Meers	Absent
Maggie Neustadt	Absent (reported)
Stephen Salanski	Present
Sandra Stites	Present (remote)
Tangula Taylor	Present (remote)
Mark R. Thompson	Present
John Carney – President	Present
Cindy Leyland – Vice President	Present (remote)

Handout 3

Center for Practical Bioethics, Inc.
Preliminary Unaudited Combining Statement of Condition
as of May 31, 2022

Line #		Funds Without Donor Restrictions 2022	Funds With Donor Restrictions 2022	TOTAL - May 2022	Statement of Condition - May 2021
	Assets				
3	Total Cash & Cash Equivalents	(263,014)	308,948	45,933	30,775
8	Total Accounts Receivable	86,253	-	86,253	97,005
13	Total Pledges and Grants Receivable	43,442	50,828	94,270	37,227
16	Total Short-term Investments	379,661	677,307	1,056,968	1,174,710
19	Total Prepaid Expenses	19,583	-	19,583	19,425
22	Total Other Current Assets	5,219	-	5,219	7,507
23	Total Current Assets	271,144	1,037,083	1,308,227	1,366,650
	Long-term Assets				
28	Total Property & Equipment	29,052	-	29,052	5,887
33	Total Long-term Investments	-	5,721,360	5,721,360	5,969,982
36	Total Other Long-term Assets	213,747	-	213,747	193,983
37	Total Long-term Assets	242,799	5,721,360	5,964,158	6,169,852
	Total Assets	513,943	6,758,442	7,272,385	7,536,503
	Liabilities				
	Short-term Liabilities				
43	Total Accounts Payable	135,728	-	135,728	70,411
46	Total Deferred Revenue	53,766	-	53,766	73,452
52	Total Other Short-term Liabilities	106,653	-	106,653	117,103
53	Total Short-term Liabilities	296,147	-	296,147	260,966
	Long-term Liabilities				
57	Total Notes Payable	-	-	-	-
60	Total Other Long-term Liabilities	213,378	-	213,378	193,627
61	Total Long-term Liabilities	213,378	-	213,378	193,627
	Total Liabilities	509,525	-	509,525	454,593
	Net Assets				
	Beginning Net Assets				
	Net Assets				
62	Permanently Restricted Funds	-	5,693,395	5,693,395	5,466,417
63	Temporarily Restricted Funds	-	1,921,510	1,921,510	1,490,227
64	Unrestricted Funds	65,617	-	65,617	4,172
65	Total Net Assets	65,617	7,614,905	7,680,523	6,960,815
66	Total Beginning Net Assets	65,617	7,614,905	7,680,523	6,960,815
67	**Current YTD Net Income**	(61,199)	(856,463)	(917,662)	121,095
68	**Total Net Assets**	4,418	6,758,442	6,762,861	7,081,910
69	**Total Liabilities and Net Assets**	513,943	6,758,442	7,272,385	7,536,503

Center for Bioethics, Inc.
Preliminary Unaudited Statement of Activities
For the Five Months Ended May 31, 2022

A	B	C	D	E	F	G	H	I	J	K	L
					Actual vs. Budget						updated
		2022	ACTUAL	Budget	Favorable/(Unfavorable)		Notes	ACTUAL	Variance	Variance	Notes
		Budget	1.1.22 thru 5.31.22	1.1.22 thru 5.31.22	Dollars	Percentage	2022 Budget vs. Actual Variance	1.1.21 thru 5.31.21	Dollars	Percentage	2022 Actual vs. 2021 Actual
	Revenues										
1	*Program/Grant funds released from Restrictions*	$ 248,347	$ 103,776	$ 103,776	$ -	0.00%	*Grant funds released were for AI grants ($68.8k), Francis Chair grant ($34.5k) and Art of the Wish ($.5k)*	63,750	$ 40,026	62.79%	*Grant funds released were for AI (Sunderland)*
	Endowment Income										
2	Francis Endowment Income	$ 161,155	$ 66,240	$ 66,242	$ (2)	0.00%		$ 62,465	3,775	6.04%	
3	Foley Investment Account Income	99,000	60,000	60,000	-	N/A	*Draw is related to CEO Search*	-	60,000	N/A	*No draw in 2021*
4	Flanigan Endowment Income	147,226	61,344	61,344	0	0.00%	*2022 draw is 6%.*	55,507	5,837	10.52%	
5	Total Endowment Income	$ 407,381	$ 187,584	$ 187,586	$ (1)	0.00%		$ 117,972	$ 69,612	59.01%	
	Earned Income										
6	Earned Income	$ 217,500	$ 90,233	$ 89,708	$ 525	0.59%	*Actual includes: KCU, CARE (Evergy and Hallmark), Center for Applied Social Research (OU), and KU Hospital.*	$ 81,422	8,812	10.82%	*Actual primarily includes: KCU, CARE, KU Hospital and Francis Chair.*
6a	Provider Ethics Services	$ 206,625	75,507	72,323	3,184	4.40%	*Includes Advent Health, KU Med, Liberty, Mosaic, North Kansas City, Midwest Transplant, Salina Regional, Stormont Vail, St. Luke's, Truman and VNA. Ethics Plus revenue is also included.*	42,088	33,419	79.40%	*Conversion to Ethics Services began in 2020.*
7	Honoraria & Fees	5,000	750	1,250	(500)	N/A		300	450	N/A	
8	Workshop & Lecture Fees, Other	-	-	-	-	N/A		-	-	N/A	
11	Total Earned Income	$ 429,125	$ 166,490	$ 163,281	$ 3,209	1.97%		$ 123,810	$ 42,681	34.47%	
	Development										
12	Donations	$ 290,000	$ 21,955	$ 19,000	$ 2,955	15.55%	*Includes $2.5k of memorial and honorary contributions*	$ 17,865	4,090	22.89%	
12a	Leadership Fund	-	-	-	-	N/A		-	-	N/A	
12b	Major Gifts Campaign	-	-	-	-	N/A		-	-	N/A	
	Payroll Protection Funds	-	-	-	-	N/A		99,117.00	(98,962)	-100.00%	*No PPP funds in 2022*
13	Membership-Institutional	15,000	-	-	-	N/A		-	-	N/A	
14	Membership-Individual	1,500	155	625	(470)	-75.20%		40.00	115	N/A	
15	Total Development Revenues	$ 306,500	$ 22,110	$ 19,625	$ 2,485	12.66%		$ 117,022	$ (94,757)	-81.11%	
	Special Event Fundraising										
16	Annual Event	$ 315,000	$ 161,360	$ 315,000	$ (153,640)	-48.77%	*Annual Event was held on May 12. Includes accrued and in-kind revenue of $12k.*	$ 233,507	(72,147)	-30.90%	*2021 Event held in February.*
17	Other Special Events	-	-	-	-	N/A		-	-	N/A	
18	Total Fundraising	$ 315,000	$ 161,360	$ 315,000	$ (153,640)	-48.77%		$ 233,507	$ (72,147)	-30.90%	
19	*Total Communications Revenues*	$ 15,000	$ 5,091	$ 6,250	$ (1,159)	-18.54%		$ 6,274	$ (1,183)	-18.85%	
	Other Income										
20	Other Revenue/Reimbursements	$ 3,000	$ 1,577	$ 1,050	$ 527	50.17%		$ 629	948	150.87%	
21	Interest Income	100	62	42	20	48.25%		71	(10)	-13.39%	
22	Miscellaneous Income	500	209	154	56	36.23%		181	28	15.70%	
23	Total Other Income	$ 3,600	$ 1,848	$ 1,245	$ 603	48.39%		$ 881	967	109.80%	
25	**Total Revenues**	**$ 1,724,953**	**$ 648,260**	**$ 796,763**	**$ (148,504)**	**-18.64%**		**$ 663,215**	**$ (14,800)**	**-2.25%**	
	Expenses										
39	Total Salaries, Benefits, Other Staff Costs	$ 1,225,405	$ 498,801	$ 510,492	$ 11,691	2.29%	*457(b) performance offset by Search Expense*	$ 409,459	$ 89,342	21.82%	*Additional program staff and CEO Search offset by 457(b) performance in 2022.*
44	Total Occupancy Expenses	56,779	22,841	23,524	683	2.90%		23,053	(211)	-0.92%	
51	Total Professional-Contract Service Fees	180,156	78,207	74,982	(3,226)	-4.30%	*Primarily additional fees related to website*	154,910	(76,702)	-49.51%	*2021 includes support for AI grant, Annual Event, and additional IT and marketing support*
55	Total Supplies	10,205	6,566	6,565	(1)	-0.01%		929	5,637	606.83%	
56	Telephone	6,665	2,817	2,735	(82)	-2.98%		2,503	314	12.54%	
61	Total Postage & Shipping	6,445	2,136	2,435	299	12.28%		1,409	726	51.54%	
66	Total Equipment & Maintenance	11,555	4,800	5,046	246	4.88%		4,944	(144)	-2.92%	
73	Total Printing & Promotions	37,115	27,660	26,510	(1,150)	-4.34%		34,462	(6,802)	-19.74%	*Primarily 2021 Annual Event Audio/Visual Production*
81	Total Travel & Transportation	17,570	771	10,370	9,599	92.56%	*Budgeted travel related to CEO Search*	47	724	N/A	
90	Total Conferences, Conventions & Mtgs	90,875	19,084	39,350	20,266	51.50%	*2022 Annual Event expenses were lower than anticipated.*	23,534	(4,450)	-18.91%	
94	Total Memberships & Subscriptions	19,710	8,813	8,405	(408)	-4.85%		8,414	399	4.74%	
101	Total Insurance	17,026	7,066	7,066	0	0.00%		7,152	(87)	-1.21%	
105	Total Interest Expense	-	-	-	-	N/A		225	(225)	N/A	
110	Total Misc Operating Expenses	23,552	5,765	5,850	85	1.45%		20,299	(14,534)	-71.60%	*2021 includes PTO carrover*
112	**Total Operating Expenses**	**$ 1,703,058**	**$ 685,327**	**$ 723,330**	**$ 38,003**	**5.25%**		**$ 691,341**	**$ (6,014)**	**-0.87%**	
113	**Net of Operating Revenue (Expense)**	**$ 21,895**	**$ (37,067)**	**$ 73,433**	**$ (110,500)**	**150.48%**		**$ (28,126)**	**$ (8,786)**	**24.12%**	
120	Total Other Income (Expense)	-	(24,132)		$ (24,132)	N/A		10,055	(34,152)	N/A	
121	**Net of Revenue (Expense)**	**$ 21,895**	**$ (61,199)**	**$ 73,433**	**$ (134,632)**	**219.99%**		**$ (18,070)**	**$ (43,128)**	**70.47%**	

HEADLINES FOR MAY 2022 FINANCIAL PERFORMANCE

REVENUE

Through the month of May, actual revenue is $648,260, which is unfavorable to budget by approximately ($148.5k). Revenues are on track in most areas. The main variance is in the following category:

- Annual Event – Revenue of $161.4k, which is behind our target by ($153.6k).

Positive variances are in the Earned Income, Development Revenues and Other Income areas, with a combined positive variance to budget of approximately $6.3k. This is offset somewhat by the variance in Communications Revenue, which is approximately ($1.2k) behind our plan at this point.

EXPENSES

Total actual operating expenses through May are $685,327, which is favorable to budget overall by $38k. The primary variances to budget are in the following categories:

- Salaries and Benefits - $11.7k positive variance overall. This variance is primarily due to the positive variance in the 457(b) account due to performance, offset by the overage in the CEO Search expense. The CEO Search Budget is $60k overall, with $50k budgeted in the Search Expense category and $10k budgeted in Other Travel. There is a corresponding positive variance of $9.7k in the Other Travel category due to the CEO Search.
- Conferences, Conventions and Meetings - $20.3k positive variance overall. This variance is primarily due to lower expenses than anticipated for the Annual Event.

OPERATIONS THROUGH MAY 2022

Net unrestricted operating revenue over expenditures for May is ($37,067). Combined with the other investment income primarily related to the Center's 457(b) plan, our net operating revenue over expenditures is ($61,199).

We had anticipated having net unrestricted revenue of $73.4k through May, so we are about ($134.6k) behind our plan. At this time last year, the Center had net unrestricted operating revenue of ($18.1k), so we are about ($43.1k) behind where we were at the end of May 2021.

All results are stated as of May 31, 2022 with the exception of the Francis Family Endowment Beneficial Interest, which is stated as of March 31, 2022.

Center for Practical Bioethics

Resource Development Committee Report

for July 13, 2022 Board Meeting

Art of the Wish – May 12, 2022

The ***Art of the Wish*** event was a spectacular friend-raising event. With the exhibit spanning three months, multiple private events at the gallery, nearly a dozen presentation opportunities in front of scores of individuals, and implementation of a robust marketing and communications plan, including social media, the reach of the Center for Practical Bioethics was significantly increased.

Financially, the net amount raised is approximately **$128,000**. Revenue is estimated at nearly $177,000, which is significantly less than the $315,000 budgeted. Positively, expenses of approximately $48,000 are 30% below budget of almost $69,000. While these figures are estimates, staff is in the process of reconciling revenue and expenses.

A major portion of the exhibit will soon be displayed at the Epsten Gallery at Village Shalom, and some of it will travel with the support of the Mid-America Arts Alliance; additional details are forthcoming on both opportunities. We anticipate that support for the Center through ***Art of the Wish*** will continue throughout the year.

We learned important lessons from this year's annual event. We tried something new, which resonated with attendees. Many people reported this was "the best event" we've ever done. The change in venue and format was appealing to many, and visually depicting a core value was meaningful.

The revenue deficit is due to several factors, including the ongoing pandemic, economic realities and forecast, and insufficient focus on outreach to corporations and major donor prospects. A number of major donors (>$1k) gave less than last year, and some gave nothing. For example, seven entities gave a total of nearly $70,000 less than in 2021.

The shortfall to be addressed throughout the rest of this year offers opportunities for board and staff involvement in implementation of different strategies outlined in the *Marketing, Fundraising and Communications Plan*. Specifically:

- John and Alan are meeting individually with **board** members to review personal financial commitments to the Center. Thank you to each of you who have already responded.
- A Summer 2022 **Donor Report** was recently mailed to nearly 500 constituents who had contributed to the Center since 2019. We made no ask in this report, instead offering gratitude for and recognition of the value of each donor's investment in the Center.
- Staff are laying the foundation for the **year-end campaign**, ***In Times Like These***. Components include:

- Personal letters
- Personal and Constant Contact emails
- Social media
- Outreach to corporations
- **Legacy Giving**, with acknowledgement by current Legacy society members of their commitments and a target of fifteen (15) prospects toward a goal of twelve (12) confirmed Planned Gifts
- **Mini targeted proposals** featuring specific programs and initiatives (i.e., Ethics Committee Consortium, Ethical AI, Advance Care Planning in the Hispanic Community)

Grant writing remains a focus of development staff, with several new prospective opportunities having been identified in the last couple of weeks.

February 25, 2021 A Private Broadcast Celebration	
REVENUE*	
Sponsors	$307,730
Crossroads Jewelry Drawing	$1,455
Silver Ticket Get Away	$5,493
Equity & Ethics Fund	$4,028
Total Revenue	**$318,706**
Organizational Affiliates	
☐ Saint Luke's - $35,000	
☐ NKCH - $25,000	
☐ HCA - $25,000	
☐ TUKHS - $5,000	$90,000
Annual Event Revenue	**$226,706**
EXPENSES*	**$71,368**
Net Total to Center*	**$157,338**
*As of March 3, 2021	

124 sponsors, ranging from $20 to $35,000
~350 households online, with 250 staying on consistently
(Donna Thomason has never seen this level of consistency.)

Survey Monkey results overwhelmingly positive re: main show, less positive about Virtual Reception.

May 12, 2022 An Exhibit Celebrating the Wishes of Elders	
REVENUE*	
Sponsors	$253,510
Raffle	$6,360
Venmo	$1,210
Other Reimbursements	$582
Total Revenue	**$261,662**
Organizational Affiliates	
☐ Saint Luke's - $35,000	
☐ NKCH - $25,000	
☐ TUKHS - $25,000	$85,000
Annual Event Revenue	**$176,662**
EXPENSES*	**$48,074**
Net Total to Center*	**$128,588**
Note : 7 entities gave $66,500 less in 2022 than in 2021	

142 gifts from 163 sponsors, ranging from $20 to $35,000; approximately 500 "pairs of eyes" on the exhibit

Survey Monkey results overwhelmingly positive, with overall ratings of 82% excellent and 18% very good.

Governance Committee Meeting
Friday, June 10, 2022

Chair: Steve Salanski

Attending: Chair Steve Salanski and members Karen Bullock, Tangula Taylor, Mark Thompson, Maggie Neustadt, Jane Lombard
Absent: Abiodun Akinwuntan, Mary Beth Blake, Sukumar Ethirajan,

Staff: John Carney

Summary Report

1) Chair Salanski reviewed the role and responsibilities of Governance Committee (Section 5.5 Governance of the Bylaws). They include:
    a. Responsible for board development and evaluation.
    b. Nominations to fill all vacancies in board of director and officer positions
    c. Board education and strategic planning (annual retreat)
        i. Committee shall review and make recommendations on long-term strategies for the corporation, community relations, and corporate mission, and the services and policies of the corporation.

2) In response to 1.b. above, Salanski noted that the current vacancy on the board remained, with a need to recruit someone with financial background and experience still a priority. In addition, Salanski noted that Ed O'Connor, the new appointee representing KCU, was completing a one-year unexpired term and that Sandra Stites will be completing her maximum term of 9 years on the board at the same time that she completes her term as Immediate Past Chair. [NOTE: Subsequent to this meeting, Sam Meers has submitted his resignation effective immediately.] Carney noted that the Governance Committee usually begins the nomination process mid-year, so the board nomination process for these vacancies needs to begin within the next month.

   The first activity that needs to be completed is to ensure that the board members whose terms expire in 2022 and are eligible to re-elect agree to do so. Salanski noted that the Governance Committee also is responsible for nomination for corporate Officers. Specific language regarding selection and recruitment are contained **Section 3.4 Nominations** of the By-laws.

   Next will be an update of the Board matrix (experience/expertise, race/culture, faith, gender, etc.).

3) In response to 1.a. and c. above, the Committee reviewed the biennial Self Evaluation tool that was last completed in 2019 (for years 2020 and 2021) and would have been conducted in the fall 2021 (for the two-year period of 2022 and 2023) but was delayed due to the announcement in early 2021 that CEO John Carney would retire at the end of 2022.

   Rather than engaging the board in updating its self-assessment by reissuing its questionnaire instrument in the fall of 2021, activities related to Board Governance in 2021 were directed to CEO Succession planning efforts throughout the calendar year. With most of the that work now in place, Governance Committee members felt the questionnaire and evaluation instrument could be reissued in 2022 after being reviewed and revised as follows:

A new section in the 64-item board questionnaire would be added to address self-evaluation dealing with board Diversity, Equity, and Inclusion.

a. It should be added as an additional section to the tool while maintaining the baseline performance data on the current five areas of the instrument.
b. Staff were tasked with reviewing the existing instrument to determine how to reduce the overall number of questions to accommodate the addition of the new section without jeopardizing baseline data on the existing five sections.
c. Currently the self-evaluation tool addresses five areas of board performance with a single open comment question at the end:
    i. Board overall performance on its strategic role (Items 1-10)
    ii. Board execution of its activities and meetings (Items 11-23)
    iii. Board relationship with the CEO (Items 24-34)
    iv. Feedback from the Board members to Board Chair (Items 35-46)
    v. Self-evaluation of individual Board members (Items 47-63)

4) In response to item 1(c.) the Governance Committee also reviewed the Board's responsibilities related to strategic planning and the setting of the Annual Retreat. Carney reported that the Retreat is usually set for the last Friday of January afternoon beginning with a Noon board meeting to receive the preliminary year end financials and adoption of the current year budget (beginning January 1). Historically, the retreat begins immediately following the board meeting with the addition of staff and concludes on Day 1 at either 5 or a later time accompanied by a reception or social event. The staff and board reconvene on Saturday at 8:00 and deliberations conclude at Noon. For the last two years (2021 and 2022), we have held the retreat virtually. If we used these dates and held the event in person this coming year, we need to reserve January 27 and 28, 2023, on calendars and notify new board candidates of those reserved dates.

5) Further discussion took place regarding the adoption of a formal strategic plan and review that took place when John Carney was appointed to the CEO role at the end of 2011. In 2012, he executed on the one-year program plan that was adopted immediately prior to his appointment. He also began a "months-long process" of dialogue by convening more than 50 community meetings with a diverse group of CPB's stakeholders. That dialogue resulted in the adoption of a traditional multi-year strategic plan beginning in 2013 identifying four strategies and nine goals supported by annual performance plans to execute on those goals.

   In 2018, the board retreat focused on a different approach to identifying and adopting board strategies by looking at Strategic Thinking as opposed to the more traditional model of crafting a multi-year strategic plan. The article presented and discussed at the 2018 Board retreat will be attached for review by the Governance Committee for its next meeting.

   The primary differences address the need to accept environmental volatility in the way the organization focuses on its vision and services and to spend more time identifying how fluidity in a highly changing environment positions small organizations to take advantage of relationships with collaborators (and board influencers) in achieving their mission, while also recognizing that they are unlikely to be able to chart a course on their own. Carney provided some examples in the Center's work where unexpected circumstances (e.g., the death of Dr. Richard Payne) completely redirected initiatives and strategic priorities of the organization due to one individual's status. Pivoting during COVID has also underscored the need to be nimble and to respond quickly to environmental shifts. The article highlighted other strategic thinking concepts that have proven helpful in the process of how the retreats have been developed over the last five years. That more fluid process also resulted in the identification of the Succession Plan strategies identified in April 2021 that appear below.

STRATEGIC GOALS AND PROGRAMMING (see April 2021 Succession Plan for more details on strategic goals)

Four components of our strategic goals are addressed. The first item is foundational and undergirds the three areas of programming that address our services. Relationships remain essential, as do grant funding and earned revenues.

- Sustainability
- Legacy programming (ethics education and training in professional and lay arenas)
- Population Health Ethics and Democratic Deliberation
- Ethical.AI Framework for Justice

6) Based on the Governance Committee's interest in setting some expectations about the Board's role in setting the stage for the new CEO and the agenda for the 2023 Board and Staff retreat, the group agreed to meet again on July 8, prior to the board meeting, to discuss work for July- December. Primary goals for the period, as described above, are:
    a. How the DEI training impacts our work going forward – in selecting a CEO and Board recruitment and selection (with a minimum of three board seats available).
    b. Finalizing the Board self-evaluation instrument and process (including DEI elements). (John and Cindy will review and edit current instrument.)
    c. Reviewing/identifying strategies for the future in a Strategic Thinking model.
    d. Developing and finalizing a Retreat Agenda.

Governance Committee Meeting
Friday, July 8, 2022

Chair:	Steve Salanski
Members Present:	Abiodun Akinwuntan, Karen Bullock, Sukumar Ethirajan, Maggie Neustadt, Tangula Taylor, Mark R. Thompson
Members Absent:	Mary Beth Blake, Jane Lombard
Staff:	John Carney, Cindy Leyland

SUMMARY

1) ***Finalize Board Self Evaluation Instrument and Process***
Reviewed and revised new DEI questions. Original 2019 survey instrument had fewer questions than proposed updated survey. Ask staff to revise proposed instrument to mirror the original shorter version, allowing longitudinal review; finalize at August Governance Committee meeting and then email to Board for return in a timely fashion so results can be addressed within the 2022 calendar year and presented at 2023 Board Retreat.

2) ***Strategic Thinking***
JC gave examples of situations in the past where stakeholder and/or Center staff changes affected the ability to fulfill strategic plan initiatives. Committee members discussed the Strategic Thinking article sent out and are favorable to continuing the strategic thinking process as opposed to strategic planning. MT suggests a one-year operational plan for Strategic Thinking, similar to a one-year budget, for review and monitoring periodically at Board meetings throughout the year. JC tasked with bringing the elements of Strategic Thinking into a document for presentation at the next meeting. The Committee noted that as the Board approves current strategic thinking goals and priorities for the Center, this allows a new CEO the flexibility to provide input into other new Center initiatives.

3) ***Impact of DEI training on work going forward***
Discuss at August meeting.

Next Meeting
Friday, August 12, 2022 at 8:00 am

Copy of Board Email on 5/22/2022 RE: Leaked SCOTUS Ruling
Preparation for July 2022 Board Meeting Discussion

At the July Board meeting (post-ruling) we plan to have a discussion focusing on the ethical implications and whether or not the Center will make any statement or take a position regarding the ethical concerns. Please familiarize yourself with the issues addressed below and the concerns raised around health ethics – e.g., principles of beneficence, non-maleficence, justice, equity, privacy (HIPAA), respect for person (i.e., rights of women, rights of the unborn), conscientious objection, patient safety, professional standards, patient-physician relationship, religious liberty, and the intrusion of government in the practice of medicine….to name a number.

One of the most profound moral questions of our time and certainly one of the most difficult and private matters of health that has predominated American society over the last 50 years is the Roe v Wade decision regarding the right of women to seek an abortion in the U.S. With the leaked Supreme Court Draft Document on the Mississippi case of Dobbs v Jackson Women's Health Organization, it appears that decision may be overturned in the coming weeks. A host of ethical issues accompany the decision, due in large part to language in the document indicating the position that the original ruling should have never been issued, reverses decades long standards of care, professional practice standards and codes of conduct, along with privacy protections encoded into HIPAA regulatory requirements.

The Center, as many health care organizations and public or secular ethics centers (those holding no religious or spiritual basis) has not taken positions on the matter since the Roe v Wade decision was issued in January of 1973. In fact, the original court ruling has been widely described as nonpartisan and non-ideological. For decades however, right to life and religious groups have work tirelessly to overturn the ruling, despite now nearly 50 years of what are now widely accepted practice standards, professional codes of conduct and privacy protections ensuring the rights of women to access a broad spectrum of contraceptive prescriptions, devices, and procedures for women in terminating pregnancy for a host of reasons, including rape, incest, and health risks.
Most national health organizations maintain positions allowing for their members to exercise conscience clauses, so long as information and referrals to other services and providers are given to women who seek abortion services. Statements from some of the most prominent organizations appear below.

Ethical Dimensions of the issue involved in the Dobbs case (see reference below) that have already been laid out in the Friends of the Court briefs include the following:

- The ban forces Clinicians to make an impossible choice between upholding their ethical obligation and following the law;
- Undermines the Patient Physician Relationship
- Violates the Principles of Beneficence and Non-Maleficence
- Violates the Ethical Principle of Respect for Patient Autonomy

Additional ethical concerns in the leaked ruling have amplified the above ethical issues and posed additional ethical concerns such as:

- Immediately undermining of reproductive services for families seeking to have families,
- Increased discrimination of poor women and women of color whose health outcomes, mortality and morbidity are worse in the United States that in most countries of the world (including third world countries).
- Immediacy of harm, particularly in "trigger states" where right to abortion services dissolve or erode (in some cases immediately) with the broader repeal of Roe v Wade that appears in the narrative of the leaked document.
- Criminalizing individual providers who perform abortion services or refer patients to abortion provider including mail order prescription, through legislative mechanisms enabling citizens to report violators.
- Other ethical considerations are described above.

Below are documents that we are providing as background for our discussion in July – after the ruling has been issued.

AMA statement on the leaked draft Supreme Court opinion.

- Asks the court to *"reject the premise of the draft opinion and affirm precedent that allows patients to receive the critical reproductive health care that they need. Allowing the lawmakers of Mississippi or any other state to substitute their own views for a physician's expert medical judgment puts patients at risk and is antithetical to public health and sound medical practice."*
- Earlier statement (October 13, 2021) from the AMA specifically on the Dobbs case (MS law banning abortions post 15 weeks). https://www.ama-assn.org/about/leadership/unconstitutional-attack-reproductive-health-must-not-stand
    - Notes *"that the issue of supporting or opposing abortion is a matter for AMA members to decide for themselves, based on their own personal values and beliefs. But at the same time, our AMA will always take action opposing any attempt to compromise or obstruct access to safe reproductive health care for all patients, including patients of color, those with limited means, and those living in rural areas, each of whom is placed at greatest peril by attempts to ban or severely limit abortion rights."*

ACOG (American College of Obstetrics and Gynecology) https://www.acog.org/news/news-articles/2022/05/a-message-to-the-acog-community-regarding-the-future-of-abortion-care-and-acogs-role

- May 2022 Statement addresses organizational efforts to *"defend our members, your patients, and the patient–physician relationship. From supporting member advocacy to serving as a powerful voice in the courts, ACOG has long fought in defense of comprehensive reproductive medical care and against legislative interference in the patient–physician relationship*."
- ACOG Abortion Policy (originally adopted in January 1993 with amendments through 2020) https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2020/abortion-policy#:~:text=If%20abortion%20is%20to%20be,or%20delay%20access%20to%20care The document affirms "the legal right of a woman to obtain an abortion prior to fetal viability."
  Note: this policy could be considered null and/or voided with the Supreme Court ruling described in the leaked document

National Medical Association https://www.nmanet.org/news/604230/National-Medical-Association-Statement-on-SCOTUS-Abortion-Law-Leak.htm

- "As African American physicians, we are devastated by the impact the overturn of Roe v. Wade will have on our communities, our patients, and our profession. The decision to seek abortion care is a highly personal medical decision – a decision that should stay between patient and doctor – not the federal government. Restricting reproductive rights directly interferes with the ability of physicians to provide the best possible care for our patients. The results will be catastrophic for women everywhere, especially Black and brown women, and set a chilling precedent for the medical field."

AAMC: https://www.aamc.org/news-insights/press-releases/aamc-reaffirms-statement-patient-physician-relationship-and-reproductive-health-care

- Statement avoids the issue of abortion directly and instead reaffirms the American Association of Medical Colleges with "its commitment to the critical relationship between patient and physician as the basis of safe, effective, and evidence-based health care. As we indicated in our September 2021 statement, policies that interfere in that relationship by limiting access to legal abortion care put the patient at risk and will exacerbate existing health inequities."

Society for Maternal and Fetal Medicine:
https://s3.amazonaws.com/cdn.smfm.org/media/3502/SCOTUS_leak_public_statement_PDF_version.pdf

- High-risk pregnancies are more likely to result in medical complications for the pregnant person, fetus, or both and can lead to increased morbidity and mortality.

National Nurses United https://www.nationalnursesunited.org/press/likely-supreme-court-ruling-on-reproductive-rights-poses-major-threat-to-patients-health

- Addresses concerns about general access to contraception and high-risk pregnancies for women of color. Economic discrimination is also cited and a claim that "banning reproductive care would also accelerate a national scandal of shockingly high maternal and infant mortality rates, again especially for women of color, that are among the worst in the developed world."

ASRM (American Society for Reproductive Medicine) :https://www.reproductivefacts.org/news-and-publications/news-and-research/press-releases-and-bulletins/asrm-issues-statement-regarding-roe-v.-wade-and-its-possible-implications-on-access-to-reproductive-care/

- Addresses unintended consequences: "… there is a clear and present danger that measures designed to restrict abortion could end up also curtailing access to the family building treatments upon which our infertility patients rely to build their families."

Friends of the Court brief filed in the Dobbs (MS State Health Officer v Jackson Women's Health Organization)
https://www.supremecourt.gov/DocketPDF/19/19-1392/193074/20210920174518042_19-1392%20bsacACOGetal.pdf

- AMERICAN COLLEGE OF MEDICAL GENETICS AND GENOMICS,
- AMERICAN COLLEGE OF NURSE-MIDWIVES,
- AMERICAN COLLEGE OF OSTEOPATHIC OBSTETRICIANS AND GYNECOLOGISTS,
- AMERICAN COLLEGE OF PHYSICIANS,
- AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY,
- AMERICAN MEDICAL WOMEN'S ASSOCIATION,
- AMERICAN PSYCHIATRIC ASSOCIATION,
- AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE,
- ASSOCIATION OF WOMEN'S HEALTH,
- OBSTETRIC AND NEONATAL NURSES,
- COUNCIL OF UNIVERSITY CHAIRS OF OBSTETRICS AND
- GYNECOLOGY, GLMA: HEALTH PROFESSIONALS ADVANCING LGBTQ EQUALITY,
- NORTH AMERICAN SOCIETY FOR PEDIATRIC AND ADOLESCENT GYNECOLOGY,
- NATIONAL MEDICAL ASSOCIATION,
- NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN WOMEN'S HEALTH,
- SOCIETY FOR ACADEMIC SPECIALISTS IN GENERAL OBSTETRICS AND GYNECOLOGY,
- SOCIETY OF FAMILY PLANNING,
- SOCIETY OF GENERAL INTERNAL MEDICINE,
- SOCIETY OF GYNECOLOGIC ONCOLOGY
- SOCIETY OF OB/GYN HOSPITALISTS

Few if any local groups have made statements to date Health Forward Blog from Fri May 6 carried the following item:

The fight over abortion rights is a Black issue

> If the court overturns Roe v. Wade, it would have a severe effect on Black communities. Black women receive about a third of all abortions in the country — the largest proportion of any racial group, according to the latest data from the U.S. Centers for Disease Control and Prevention. The rate of abortions among Black women is more than three times that of white women. Limited access to comprehensive sex education, health care, and adequate insurance coverage contribute to the high abortion rate, experts said — structural issues that contribute to unplanned pregnancies.

Continue reading ...

Center for Practical Bioethics Board Discussion on
Developing a Statement on the SCOTUS ruling on Dobbs v Jackson Women's Health Organization
Overturning Roe v Wade and Planned Parenthood v Casey

Board Meeting Agenda Item - July 13, 2022
Prepared for the Board by John G Carney, President and CEO

The recent SCOTUS decision overturning Roe v Wade (1973) and Planned Parenthood v Casey 1992) has sent the issue of abortion into territory that it has not been in for nearly 50 years. The impact is being felt in deeply personal ways but also within the broader sphere of society due to its legal/regulatory, social, clinical (professional standards), spiritual (and religious), and moral (normative) implications.

The Court's decision declaring there is no constitutional right to abortion and its decision to grant "authority to regulate abortion to the people and their elected representatives" complicates an already divisive and volatile issue.

Context and History
For nearly 50 years, Americans have lived with the 1973 Supreme Court Ruling of Roe v Wade that "held the Constitution protected a woman's right to an abortion prior to the viability of the fetus."

> "The Supreme Court, in a decision written by Justice Blackmun, recognized a privacy interest in abortions. In doing so, the court applied the right to privacy established in Griswold v Connecticut (1965). At stake in this matter was the fundamental right of a woman to decide whether or not to terminate her pregnancy. The underlying values of this right included decisional autonomy and physical consequences (i.e., the interest in bodily integrity)."

With the ruling of the Supreme Court on Dobbs v Jackson, on July 24, 2022, the 1973 decision on Roe v Wade and the 1992 Planned Parenthood v Casey decision upholding that right to abortion were overturned, and the Court in a 5-4 majority "held the Constitution does not confer a right to abortion; Roe and Casey are overruled; and the authority to regulate abortion is returned to the people and their elected representatives."
Legal Information Institute (Cornell Law School)

The Center for Practical Bioethics was established in 1984, nearly 10 years after the Roe v Wade Supreme Court ruling, and as such, the matter was considered "settled law" for the entire history of the organization. CPB has never taken a formal position in favor of or against women's right to abortion.

However, the basis of the original SCOTUS decision being tied to privacy and bodily autonomy provided an environment for the Center to remain outside the zone of controversy that has continued for those opposing the 1973 ruling for the last five decades.

The question now is does the reversing of the decision put the Center in a position to:

- remain in neutral territory (if ever we were),
- require something more of us in terms of a statement clarifying a position,
- argue for an ethical stance that focuses only on the implications of this decision on the women impacted and the clinicians and providers serving them, or
- take a stance altogether different, including a decision to be silent
    - Or one that entails a prudential judgment, a course requiring accompaniment without endorsement? (This final option would likely put us back in the realm of third bullet.)

Clearly, the overturning of the previous rulings wipes out the notion that the right to abortion remains "settled law," at least at the national level, placing the issue squarely back in the arena of 50 state "laboratories".

For the purposes of this discussion, the states' laboratory comparison is familiar territory for the Center and one we have straddled with questions related to "right to die" since our inception.

While the Supreme Court ruled in the Cruzan case that each of us has a right to refuse life-prolonging treatment (along with recognizing the state's interest in setting the bar for the evidence of that claim), the corollary of the right to choose to end one's life prematurely is not Constitutionally protected. That has led to a patchwork of states allowing for physician aid in dying while remaining prohibited in most others. The ruling in the Cruzan case, as it still stands, allows individual states to determine how open or restrictive laws/statutes are related to the right to die as a matter of choice and what level of protection or interference the state takes for those whose wishes cannot be known.

The comparison with Cruzan does not cover the expanse of issues raised by the Dobbs case (reversing Roe), but it may provide some framework for our discussion. If we indeed agree that we are nation governed by laws, protecting us from the rule of "men" (powers of self-interest), then can the issue of abortion, like right to die, appropriately proceed under the aegis of a "power reserved for the state"?

There seems to be little room for us not to make a statement, given that "settled law" from a national stance is no longer in place. However, there may be some merit in considering the argument from the standpoint of powers reserved to the states. That does not, however, remove the ethical concerns associated with the immediacy of upending a 50-year ruling. Justice Roberts' dissent on this aspect of the ruling arguing for judicial restraint would certainly have eased concerns on the urgency around dealing with the consequences of the overturning. So, the question remains how ought the Center respond to questions seeking guidance from our institutional affiliates, individual constituents, ethics committee members and other publics we serve?

The standards of care that have been built over the last 50 years regarding reproductive health, especially as they relate to privacy concerns, maternal fetal conflict and viability, patient health and safety, high risk pregnancies and protections for women who miscarry, disproportionate impact on health outcomes for poor women and women of color, contraception (all types), and bodily autonomy, deserve ethical deliberation. This list, admittedly, is not exhaustive.

As suggested above, one approach the board could consider is adopting a statement addressing a select list of ethical concerns about the most salient foreseen and/or unintended consequences of the ruling.

- Do we believe that harms will occur as result of this ruling?
- Because of its immediate impact on clinical practice and adherence to standards of care that have been created over the last half century, ought the Center to recognize as essential to women's reproductive health, the need to safeguard professional ethical obligations and standards related to duty of care, including non-abandonment?
- Ought we to take a stance that criminalizing referrals to other/out-of-state providers or violating covenantal relationships on confidentiality is not optional?
- Do we hold that the immediate disappearance of women's reproductive health services based on trigger laws means that ethical obligations are also immediately extinguished?
- Are there conscience provisions or even religious freedoms that should be taken into account for women who believe that life does not occur until the child's first breath takes place?

The Association of Bioethics Program Directors (ABPD), a national bioethics group composed of leaders in the field that the Center belongs to, has taken the position of addressing the Dobbs ruling from the perspective of the consequences of the ruling in light of current clinical practice and societal realities. This statement may provide some starting point for our consideration about using this vantage point in developing a statement.

Obviously, the selection of the facts and figures cited in the position statement are sympathetic to the concerns raised by virtually every professional medical and professional society in opposition to the ruling. However, the statement does address the complications associated with undoing standards created over the last 50 years. The statement was influenced by bioethicists from academic medical centers within Catholic Health; however, it is unknown if those representatives supported the adopted statement. I provide ABPD's statement purely for purposes of discussion.

I offer it as one option to consider in beginning our conversation. We are reserving time on the agenda during the July board meeting to discuss this and other considerations you may have. I look forward to our dialogue.

See ABPD Statement on Dobbs 06.28.2022

BIOETHICS GUIDANCE FOR THE POST-*DOBBS* LANDSCAPE

June 22, 2022

The Association of Bioethics Program Directors (ABPD) comprises the leadership of nearly 100 academic bioethics programs at medical centers and universities across North America. Individual members, and the academic and health care institutions where they work, reflect multiple jurisdictions, cultures, and moral viewpoints.

Although we are a diverse group of bioethics professionals, we share dismay that the healthcare landscape is being radically disrupted by the *Dobbs v. Jackson* decision with no accompanying policy structures to prevent widespread collateral harms. Nearly half of all U.S. pregnancies are unintended, while "nearly one in four women in the United States" have had an abortion by age 45. The APBD affirms a commitment to reproductive health care services in accordance with core healthcare ethics principles. The ABPD thus offers the following healthcare ethics guidelines for health care providers, budgets, and policymakers moving forward in a post-*Dobbs* landscape, cross-referenced with some of the relevant expected harms and patients' needs.

Previous research indicates that persons who seek and are denied access to abortion suffer a variety of negative consequences, including increased risks of poverty, staying in contact with physically abusive partners, and worsening health in general. Extrapolating from other countries that have banned abortion, we can also expect a surge in deaths from pregnancy complications.

1. The doctrine of informed consent obligates practitioners to counsel their prenatal patients about all available options within the medical standards of care[1] available in the United States, including all FDA-approved medications.
2. Professional ethics standards obligate practitioners to disclose any conflicts of interest, conflicts of commitment, or conscientious objections when treating prenatal patients, and to refer patients accordingly for the medical standard of care they cannot provide.
3. When the medical standard of care is not available in a particular jurisdiction or state, patients should be counseled about where such care is available[2], and unimpeded interstate travel for reproductive services should be supported by all jurisdictions without consequences to referring clinicians.
4. Affordable access to FDA-approved contraception should be ensured. The American College of Obstetricians and Gynecologists has backed proposals to make hormonal contraceptives available over-the-counter, which is one promising step toward increased access, though cost remains prohibitive for many.
5. The autonomous decisions of pregnant patients ought to be respected; patients who are constrained by state jurisdictions to involuntarily remain pregnant should be treated with respect and directed to other jurisdictions for care, including referral to mental health providers when appropriate.
6. Practitioners have a duty to care for their patients' welfare through well-earned trusting relationships. Physicians should avoid contributing to civil or criminal legal processes that serve to punish, threaten, or harass prenatal patients.
7. Scientifically and medically accurate sexual and reproductive health education should be provided to all patients, particularly adolescents[3].
8. Patients seeking fertility treatment should be referred to jurisdictions where full access to reproductive care is offered. Fertility practices in states where reproductive healthcare is limited or constrained should consider relocation to jurisdictions where the medical standard of care is available without constraints.
9. Clinicians should prepare for an increased need to identify and intervene in cases of intimate partner violence, child abuse, and suicidal ideation.

B) Pregnant persons in the US die of complications at nearly four times the rate of other wealthy countries; the rate of death from complications among non-Hispanic Black pregnant persons is even higher. Economic equity for the childbearing parent is weakly protected by U.S. policies because paid maternity leave is rare and childcare expectations tend to push postpartum parents out of the workforce. The cost of raising a child was approximately $13,000 per child each year before the recent inflation increased these figures.

1. All prenatal patients who present to hospitals or healthcare providers in labor require affordable access to obstetrical care, and informed consent for all medical options for safe labor and deliveries; obstetricians are obligated to respect the pregnant patient's autonomy, and to protect their life in catastrophic labors and/or deliveries.
2. Practitioners have a duty to advocate for legal changes that would advance the welfare of their patients.
3. Paid maternity leave should be offered for one year for any postpartum patient regardless of parental responsibilities, which is the international standard for wealthy countries.
4. Unwanted and/or abandoned neonates who become wards of the state must be provided with free healthcare for all their neonatal and future pediatric needs until/unless they are adopted or become adults at age 18.
5. Neonatal patients without parental representation require state-appointed guardians until/unless a parental authority can be designated.
6. All postpartum patients should be counseled about postpartum healthcare options and needs, and provided affordable access to mental health care, social services, and economic assistance; involuntary birthing patients should be provided with free legal services to opt out of parental responsibilities.
7. Expanded investment in childcare facilities, tax credits and other childcare support measures are essential for ensuring that children can thrive. This need is even more pressing if abortion restrictions force parenthood upon many.

C) Patients grieving over miscarriages may face the threat of criminal investigations from police and prosecutors. This problem will get worse and more widespread in the absence of legal protections. Patients seeking abortions outside their home jurisdictions will contend with a daunting and unclear legal landscape, with a patchwork of state regulations and laws and looming efforts to criminalize patients crossing jurisdictions to get care or to criminalize the efforts of others to help patients get the care they seek (including clinicians).

1. Confidentiality, in accordance with core bioethics principles, rights to privacy, and HIPAA, should be upheld in treating prenatal patients; state-imposed registries that make the names and personal health information of patients and their practitioners public for certain types of reproductive care contradict and violate basic healthcare ethics principles of confidentiality.
2. Practitioners seeing out-of-state patients for prenatal care banned in other states have a duty to treat them and to uphold confidentiality; such practitioners should consult their institutional legal counsel about their state's healthcare asylum policies for patients requiring it.
3. Prenatal patients in any state presenting with miscarriage should be treated with respect; confidentiality must be upheld.
4. Patient referral for healthcare services must remain legally protected. To classify such advice as "abetting" a crime would be catastrophic for the patient-caregiver relationship.

Notes:

1. The medical standard of care is defined by clinical practice guidelines, relevant medical associations, and evidence-based science and practice. Socio-economic and regional health disparities may influence whether patients can access the standard of care, but do not change the standard of care.
2. If patients can more easily obtain the standard of care in Canada because it is closer, this should be considered; Canada offers prenatal asylum to any American patient requiring prenatal care.
3. Informed consent of the parent or guardian is not required for contraception; what defines adolescent patients is the age of onset of puberty, which may vary.

Email signature version:
The Center for Practical Bioethics occupies the land of the Kaw (Kanza or Kansa), Jiwere (Otoe), Nutachi (Missouria), Shawnee, Delaware (Lenape), and Wahzhazhe (Osage) people, and recognizes that other Tribes may have called these lands home.

Medium-length version:
The Center for Practical Bioethics recognizes we occupy the stolen ancestral lands of the Kaw (Kanza or Kansa), Jiwere (Otoe), Nutachi (Missouria), Shawnee, Delaware (Lenape), and Wahzhazhe (Osage) people. We acknowledge that other Indigenous Tribes not named here may have historically resided in the area. As an ongoing attempt to better understand who has called the Kansas City metropolitan area home, we invite you to share your knowledge of the local native experience with us.

Longer version (for the website):
Creating and sharing an organizational land acknowledgment is becoming a more common practice to recognize the violent history of colonizers and industries occupying stolen land. In Kansas City, several major institutions have drafted land acknowledgments in collaboration with local Indigenous people and organizations whose Tribes were forced out of this area. In our effort to recognize this violence and our place in it, we studied a collection of local land acknowledgments and created an acknowledgment informed by these responsibly created statements.

Kansas City Public Schools, The Nelson-Atkins Museum of Art, Visit KC, and various departments and programs at the University of Kansas informed and guided this draft of the land acknowledgment for the Center for Practical Bioethics.

We continue to study other organizations' land acknowledgments to create the most thoughtful, inclusive, and accurate land acknowledgment possible. If you have knowledge about the history of Indigenous peoples and Tribes in the region to share with us, we invite you to email center@practicalbioethics.org or call 816-221-1100.

Our land acknowledgment:

The Center for Practical Bioethics occupies the land of the Kaw (Kanza or Kansa), Jiwere (Otoe), Nutachi (Missouria), Shawnee, Delaware (Lenape), and Wahzhazhe (Osage) people, and recognizes that other Tribes may have called these lands home.

IMPACT OF DOBBS ON THE RIGHT TO ABORTION AND BIRTH CONTROL

This memo is a review of Missouri's abortion law to explain what impact the overturning of *Roe v. Wade* has on the right of a woman to choose to have an abortion or to choose the birth control device that best fits her healthcare needs.

I. KEY PRINCIPLES OF ABORTION LAW REVIEW

MISSOURI'S DEFINITION OF TERMS

Central to the analysis of Missouri's abortion law and its consequences are the definitions of the terms used in Chapter 188 RSMo. The following terms are defined in §188.015 of HB 126:

"Abortion",
"Abortion facility",
"Conception",
"Department",
"Down Syndrome",
"Gestational age",
"Medical emergency",
"Physician",
"Reasonable medical judgment",
"Unborn child",
"Viability" or "viable",
"Viable pregnancy" or
"viable intrauterine pregnancy".

The definitions for the following words and/or phrases are of particular significance to the analysis:

Abortion,
Conception,
Gestational age,
Medical emergency,
Unborn child,
Viability,
Viable pregnancy or
viable intrauterine pregnancy.

1. The Definition of Abortion.

Webster's Third New International Dictionary ("Webster"s) (the dictionary the Missouri Supreme Court often refers to determine the "plain and ordinary meaning" of a word) defines "abortion" very simply as "*the expulsion of a nonviable fetus*."

However, the Missouri statute defines abortion differently and more broadly.

Missouri has adopted two definitions for "Abortion"[1] in §188.015(1) RSMo, and neither is as simple to understand as Webster's:

> (a) **The act of using or prescribing** any instrument, device, medicine, drug, or any other means or substance **with the intent to destroy** *the life of an embryo or fetus* in his or her mother's womb; or
>
> (b) **the intentional termination of the pregnancy** of a mother **by using or prescribing** any instrument, device, medicine, drug, or other means or substance *with an intention other than to increase the probability of a live birth or to remove a dead unborn child*;[2]

§188.015(1)(a) is focused on the destruction of an embryo or fetus, while §188.015(1)(b) is focused on acting "*...with an intention other than to increase the probability of a live birth or to remove a dead unborn child*".

2. Key words within the definition of abortion.

The first key words within the definition of "abortion" to be defined are: "embryo", "fetus", "pregnancy" and "unborn child", so we can determine at what point in the timing of biological reproduction does the ban on abortion begin. "Unborn child" is the only term of the four that is set out specifically as a defined term. The terms "embryo" and "fetus" are stages of development referenced in the definition of "Unborn child", and "pregnancy" is defined within the definition of "Gestational age". Most of the distinct stages of development referenced in the definition of "unborn" child occurred "pre-viability". A "fetus" could be both viable and not viable, depending upon the stage of development.

"Pregnancy," while it is not segregated as a defined term it statutorily defined in §188.015 RSMo, within the definition for "Gestational age" which is defined as "…length of pregnancy as measured from the first day of the woman's last menstrual period" therefore "gestational age" is the "length of pregnancy"

[1] §188.015(1) RSMo 2019.
[2] §188.015(1) RSMo 2011.

so we can ascertain when, under Missouri law, pregnancy begins, not at fertilization of the egg, but from the first day of the woman's last menstrual period.

"Unborn child" is defined as "…the offspring of human beings from the moment of conception until birth and at every stage of its biological development, including the human conceptus, zygote, morula, blastocyst, embryo, and fetus.

The significance of listing "…every stage of its biological development…" differentiates the human conceptus, the fertilized ovum, zygote, morula, blastocyst, from the embryo and fetus, as each biological term relates to a specific time period of development of the fertilized ovum ("post fertilization"), and then with the definition of "pregnancy" within the definition of "Gestational age", one might argue constructs three distinct periods of time that are intended to be captured by Missouri, pre-fertilization, pre-implantation of the embryo to the uterine wall, a fetus, a viable fetus.

None of the terms used within the definition of "unborn child" are defined in statute so we use their plain and ordinary meaning which basically delineates periods of development of the fertilized egg prior to implantation to the uterine wall at which point it is called an "embryo" until about the eighth week at which point it is called a "fetus".

Understanding now that the time period for the prohibition of abortions may actually be triggered pre-fertilization, the impact of the use of the phrase "…using or prescribing any instrument, device, medicine, drug, or any other means or substance…" is better understood as a "morning after" pill or an IUD or a birth control pill designed to prevent fertilization and/or implantation to the uterine wall, *as all are utilized to decrease the probability of a live birth and are not used to remove a dead* zygote morula, blastocyst, embryo or fetus and all can be used to prevent the implantation of the fertilized egg to **the uterine wall.**

3. What are the differences between §188.015(1)(a) RSMo and §188.015(1)(b) RSMo?

The first definition, §188.015(1)(a) RSMo., of abortion is:

> (a) The act of using or prescribing any instrument, device, medicine, drug, or any other means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb;

The first definition defines an abortion as conduct (prescribing any instrument, device, medicine, drug, or any other means or substance) performed with an intent as to a particular object (the intent to destroy the life of an embryo or fetus) and in a specific location (in his or her mother's womb). The conduct that constitutes one definition of an abortion as defined in Missouri, is an act committed with the intent to destroy the life of an embryo or fetus, and the embryo or fetus is located in his or her mother's womb.

Interestingly enough, the first definition does not require the life of the embryo or fetus to be destroyed, only that an attempt to destroy was made.

The second definition of abortion, §188.015(1)(b) RSMo 2019, is:

> (b) The intentional termination of the pregnancy of a mother by using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth or to remove a dead unborn child;

The second definition requires the termination of the pregnancy, pregnancy being defined by Black's Law Dictionary, (also used for reference by the Missouri Supreme Court) as the "condition resulting from the fertilized ovum. The existence beginning at the moment of conception and terminating with delivery of the child." However, §188.015(6) RSMo., has redefined pregnancy in the way it is defined within the definition of "Gestational age" as "the length of *pregnancy* as measured from the first day of the woman's last menstrual period". Pregnancy does not begin from the "date of fertilization".

A liberal interpretation of time period encompassed by §188.015(1)(b) RSMo, would include the time period between the "first day of the woman's last menstrual period…" and fertilization, as opposed to limiting the time period to the development of an embryo and then fetus as is limited by §188.015(1)(a).RSMo.

§188.015(1)(b) RSMo, also states that the use or prescription of any instrument, device, medicine, drug, or other means or substance was done *with an intention* other than, one, to increase the probability of a live birth, or two, remove a dead unborn child. §188.015(1)(b) RSMo 2019. (*Emphasis added*.). HB 126, enacted in 2019, removes the previously existing exception of a "dying" "unborn child", as that would really mean a dying zygote to a dying fetus, a zygote is dying if it cannot implant itself on the uterine wall, and a fetus may die for a number of medical reasons. However, when Roe is overturned a doctor will have to wait for the fetus to die, before it is removed from the woman. §188.015(1)(b) RSMo, broadens the target of protection from an embryo or fetus targeted in §188.015(1)(a) RSMo, to include the human conceptus, zygote, morula and blastocyst, in addition to the embryo and fetus.

Also interesting about §188.015(1)(b) RSMo and its application to certain forms of birth control is to compare its language to the language in the Connecticut statute found unconstitutional in *Griswold v. Connecticut*, 381 U.S. 479, 480, 85 S.Ct. 1678, 1679, 14 L.Ed.2d 510 (1965).

Missouri law:

> The intentional termination of the pregnancy of a mother by *using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth* or to remove a dead unborn child

The Connecticut statute that criminalized the use of certain birth control methods at issue in Griswold:

> Any person who *uses any drug, medicinal article or instrument for the purpose of preventing conception* shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned.

To summarize, the second definition of abortion, §188.015(1)(b) RSMo 2019, which states a purpose of the "…*intentional termination of pregnancy*…", in a time period by which pregnancy is measured as "… *from the first day of the woman's last menstrual period*", pre-fertilization of the egg, with the added "*intention*" being defined within §188.015(1)(b) RSMo 2019 as "*an intention other than to increase the probability of a live birth or to remove a dead unborn child* (human conceptus (fertilized ovum), zygote, morula, blastocyst, embryo or fetus) can be interpreted as a ban on certain birth control devices.

4. Distinguishing the two alternative definitions for "abortion" – a Summary.

Therefore, the two alternatives as to how an abortion is defined can be differentiated in multiple ways.

(i) Target of protection. In (a) it is an implanted embryo or fetus, while (b) targets a fertilized egg not yet implanted, and possibly simply an egg.

(ii) Time period. (a) is measured from the time of implantation of the embryo to the uterine wall because of the use of the terms embryo and fetus, (b) is measured from the moment of the first day of the woman's last menstrual period because of the use of the term pregnancy, human conceptus, zygote, morula and blastocyst in addition to the embryo and fetus.

(iii) "Destroy" v. "Intentional Termination." In (a), the use of the word "destroy" and in (b) the use of the words "intentional termination". Why? What is the significance?

(iv) Focus of intent. In (a), one intends to destroy an embryo or fetus, in (b), one intends to something other than to increase the probability of a live birth or to remove a dead fertilized ovum. Why? What is the significance?

(v) Required result. In (a), destruction of the embryo or fetus does not have to occur, only that the means or substances were used with the intent to destroy the embryo or fetus, while (b) use or prescription of means or substances used with the intent other than to increase the probability of a live birth or to remove a dead fertilized ovum. It requires an intentional "termination of the pregnancy".

However, given the definitions, the use of any device to prevent implantation, (and possibly fertilization given the use of the word pregnancy in the second alternative but not the first alternative), and the lack of a pregnancy beyond 5-8 weeks, (absence of a corpus) a zealous prosecuting attorney could assert that as a result of the use or prescription of an instrument, device, medicine, drug, or other means or substance coupled with an intent other than to increase the probability of a live birth or to remove a dead fertilized ovum, an abortion occurred, or the individuals are guilty of "attempted abortion".

As a result, the second definition use of the terms "*…instrument, device, medicine, drug, or other means or substance…*" include emergency contraception pills and devices known as "morning after" pills, certain IUD's and other birth control pills and devices as abortion mechanisms.

5. Plain and ordinary meaning of certain terms undefined by statute.

The plain and ordinary meaning of:

a. "conception" is the process of becoming pregnant involving fertilization or implantation or both;

b. "human conceptus" is undefined used together, but human is a human being and conceptus is defined in Merriam Webster's Dictionary as a fertilized egg, embryo or fetus;

c. "zygote"a fertilized ovum; the new cell formed when a sperm cell joins with an egg cell;

d. "morula" is defined as a solid ball of cells resulting from division of a fertilized ovum, and from which a blastula is formed;

e. "blastocyst", is the modified blastula of a placental mammal having an outer layer composed of the trophoblast; blastula is defined as an early metazoan embryo typically having the form of a hollow fluid-filled rounded cavity bounded by a single layer of cells; the first nine days after fertilization;

f. "embryo" the developing human individual from the time of implantation to the end of the eighth week after conception; implantation occurs between the fifth and tenth day after fertilization;

g. "fetus" is a developing human from usually two months after conception to birth.

To illustrate the plain meaning of the statute I insert the plain language definitions instead of the statutory words:

1. Notwithstanding any other provision of law to the contrary, no ***act of using or prescribing any instrument, device, medicine, drug, or any other means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb, or the intentional termination of the condition resulting from the fertilized ovum* of a mother by using or prescribing any IUD or a Plan B or Ella Pill or any other contraception drug or device with an intention other than to increase the probability of a live birth or to remove a dead offspring of***

human beings from the moment of conception until birth and at every stage of its biological development, including human conceptus, zygote, morula, blastocyst, embryo, and fetus at eight weeks gestational age or later, shall be performed or induced upon a woman except in cases of medical emergency. Any person who knowingly performs or induces the use or prescription ***of any instrument, device, medicine, drug, or any other means or substance with the intent to destroy the life of an embryo or fetus in his or her mother's womb, or cause the intentional termination of the condition resulting from the fertilized ovum**** of a mother by using or prescribing ***an IUD or a Plan B or Ella Pill or any other contraception drug or device*** with an intention other than to increase the probability of a live birth or to remove a dead ***offspring of human beings from the moment of conception until birth and at every stage of its biological development, including the human conceptus, zygote, morula, blastocyst, embryo, and fetus*** in violation of this subsection shall be guilty of a class B felony, as well as subject to suspension or revocation of his or her professional license by his or her professional licensing board. A woman upon whom an abortion is performed or induced in violation of this subsection shall not be prosecuted for a conspiracy to violate the provisions of this subsection.

A. KEY PROVISIONS OF CHAPTER 188

1. Eliminates a woman's right to an abortion and makes the performance or inducement of an abortion a crime from the moment of conception

The only exception is if there is a "medical emergency" which is defined as:

> "a condition which, based on reasonable medical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the pregnant woman or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman;"

The Legislature did not create an exception for rape or incest.

B. PROSECUTION OF THE FEMALE AND STRICT LIABILITY

The woman is subject to prosecution because the law only states that she cannot be prosecuted for a conspiracy to violate the provisions of this subsection. A female that uses any contraceptive drug or device could be prosecuted, *whether or not she was actually pregnant* because she was utilizing the drugs or the IUD "*with an intention other than to increase the probability of a live birth or to remove a dead fertilized ovum, zygote, morula, blastocyst, embryo, or fetus*.

This is not to say the woman would be prosecuted, but if a prosecutor believes she should be prosecuted he has the authority to do so.

Below is an example of a zealous prosecutor who believes Missouri law included birth control pills or devices could make to the Court:

"Your honor, prior to *Roe v. Wade* and *Planned Parenthood v. Casey* being overturned, there were legal abortions and illegal abortions. The demarcation line for illegality was viability of the fetus. I will explain:

A quote from Casey, 505 U.S. 833, 870, 112 S. Ct. 2791, 2816:

"Liberty must not be extinguished for want of a line that is clear. And it falls to us to give some real substance to the woman's liberty to determine whether to carry ***her pregnancy to full term***.

*[16] *870* ***We conclude the line should be drawn at viability, so that before that time the woman has a right to choose to terminate her pregnancy***. *We adhere to this principle for two reasons. First, as we have said, is the doctrine of stare decisis. Any judicial act of line-drawing may seem somewhat arbitrary, but Roe was a reasoned statement, elaborated with great care. We have twice reaffirmed it in the face of great opposition.*

The second reason is that the concept of viability, as we noted in Roe, is the time at which there is a realistic possibility of maintaining and nourishing a life outside the womb, so that the independent existence of the second life can in reason and all fairness be the object of state protection that now overrides the rights of the woman.

A quote from Casey at pg 2817, or page 872:

"Roe established a trimester framework to govern abortion regulations. Under this elaborate but rigid construct, almost no regulation at all is permitted during the first trimester of pregnancy; regulations designed to protect the woman's health, but not to further the State's interest in potential life, are permitted during the second trimester; and during the third trimester, when the fetus is viable, prohibitions are permitted provided the life or health of the mother is not at stake."

from Casey at pg 2812 or page 860:

*"Whenever it may occur, the attainment of viability may continue to serve as the critical fact, just as it has done since Roe was **2812 decided; which is to say that no change in Roe's factual underpinning has left its central holding obsolete, and none supports an argument for overruling it."*

A fertilized egg becomes a fetus generally around the 8th week after the egg is fertilized. Viability at the time of *Casey* was generally considered to be around the 23rd or 24th week after fertilization of the egg. The issue of "when" someone first became pregnant, or when did pregnancy begin was not the issue, viability of the fetus, a particular stage of development, was the issue.

Prior to viability the State's interest in potential life was secondary to the woman's liberty interest in the decision to have an abortion or not.

In prohibiting the abortion of a "viable" "unborn child" prior to the overturning of *Roe* and *Casey* the following Missouri statutory section applied:

"Prior to performing or inducing an abortion upon a woman, the physician shall determine the gestational age of the unborn child in a manner consistent with accepted obstetrical and neonatal practices and standards…." §188.030.2(1) RSMo.

The gestational age is defined in as:
"length of pregnancy as measured from the first day of the woman's last menstrual period." §188.015.(1) RSMo

Gestational age was also used when the State of Missouri defined when a woman's liberty interest is extinguished in three "trigger" sections §188.056, §188.057 and §188.058.

Those three specific "trigger" provisions that utilize the term "gestational age" as follows:

§188.056 RSMo: Notwithstanding any other provision of law to the contrary, no abortion shall be performed or induced upon a woman at eight weeks gestational age or later, except in cases of medical emergency

§188.057 RSMo: Notwithstanding any other provision of law to the contrary, no abortion shall be performed or induced upon a woman at fourteen weeks gestational age or later, except in cases of medical emergency.

§188.058 RSMo: Notwithstanding any other provision of law to the contrary, no abortion shall be performed or induced upon a woman at eighteen weeks gestational age or later, except in cases of medical emergency.

However §188.017 RSMo is now in effect that prohibits abortion at any gestational age:

Notwithstanding any other provision of law to the contrary, no abortion shall be performed or induced upon a woman, except in cases of medical emergency. Any person who knowingly performs or induces an abortion of an unborn child in violation of this subsection shall be guilty of a class B felony, as well as subject to suspension or revocation of his or her professional license by his or her professional licensing board. A woman upon whom an abortion is performed or induced in violation of this subsection shall not be prosecuted for a conspiracy to violate the provisions of this subsection.

Abortion is defined as:

(b) The intentional termination of the pregnancy of a mother by using or prescribing any instrument, device, medicine, drug, or other means or substance with an intention other than to increase the probability of a live birth or to remove a dead unborn child. §188.015(1)(b) RSMo

Pregnancy as provided for within the definition of gestational age, the term utilized by at least four other sections prohibiting abortion, begins the first day of the woman's last menstrual period as §188.015.(6) RSMo states the "length of pregnancy as measured from the first day of the woman's last menstrual period." That establishes when pregnancy begins. Gestational age is not defined as when the egg is fertilized as it could have been.

Pregnancy is defined as beginning the first day of Defendant Jane Doe's last menstrual period.

Jane Doe is pregnant as defined in §188.015.(6) RSMo, using an IUD or other form of birth control with an intention other than to increase the probability of live birth.

Defendant Jane Doe was prescribed by Defendant Dr. John Doe an IUD that she used with the intention other than to increase the probability of a live birth.

The drafters knew what they were doing when they defined "gestational age" and knew it would likely be challenged. How do we know, see §188.018:

Severability clause. — If any one or more provisions, sections, subsections, sentences, clauses, phrases, or words of this chapter or the application thereof to any person, circumstance, or period of gestational age is found to be unenforceable, unconstitutional, or invalid by a court of competent jurisdiction, the same is hereby declared to be severable and the balance of this chapter shall remain effective notwithstanding such unenforceability, unconstitutionality, or invalidity. The general assembly hereby declares that it would have passed each provision, section, subsection, sentence, clause, phrase, or word thereof, irrespective of the fact that any one or more provisions, sections, subsections, sentences, clauses, phrases, or words of this chapter, or the application of this chapter to any person, circumstance, or period of gestational age, would be declared unenforceable, unconstitutional, or invalid.

Below would be what the courts, prosecutors and defense attorneys refer to as "jury instructions", i.e., guidance to jurors when determining the guilt or innocence of a defendant.

EXHIBIT A
VERDICT DIRECTOR CRIMINAL TRIAL OF THE WOMAN

If you find and believe from the evidence beyond a reasonable doubt:

First, that on or about August 29, 2022 in the State of Missouri, Jane Doe, with the intent to terminate a pregnancy of Jane Doe, used an IUD or a birth control pill; and

Second, Jane Doe's intention was other than to increase the probability of a live birth or to remove a dead unborn child; and

Third, Jane Doe was not suffering from a medical emergency,

then you will find Jane Doe guilty of performing or inducing an abortion.

However, unless you find and believe from the evidence beyond a reasonable doubt each and all of these propositions, you must find Jane Doe not guilty of performing or inducing an abortion.

As used in this instruction, the term "medical emergency" means a condition which, based on reasonable medical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the pregnant woman, or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman. The fact that Jane Doe was a victim of [rape] [incest] does not constitute a medical emergency.

EXHIBIT B
VERDICT DIRECTOR CRIMINAL TRIAL OF THE DOCTOR

If you find and believe from the evidence beyond a reasonable doubt:

First, that on or about August 29, 2022 in the State of Missouri, Dr. John Smith, with the intent to terminate a pregnancy of Jane Doe, prescribed an IUD or a birth control drug for Jane Doe's use; and

Second, Dr. John Smith's intention was other than to increase the probability of a live birth or to remove a dead unborn child; and

Third, Jane Doe was not suffering from a medical emergency,

then you will find Dr. John Smith guilty of performing or inducing an abortion.

However, unless you find and believe from the evidence beyond a reasonable doubt each and all of these propositions, you must find Dr. John Smith not guilty of performing or inducing an abortion.

As used in this instruction, the term "medical emergency" means a condition which, based on reasonable medical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert the death of the pregnant woman, or for which a delay will create a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman. The fact that Jane Doe was a victim of [rape] [incest] does not constitute a medical emergency.

Ethical Health Care After Roe

Can physicians meet their obligations to patients when abortion is criminalized?

The New Yorker – July 8, 2022

By Isaac Chotiner

The Supreme Court's decision to overturn Roe v. Wade sent the issue of abortion policy back to individual states—which has already led to a flurry of laws in red states limiting or banning women from having the procedure. Last week, I spoke to Louise Perkins King, a surgeon and bioethicist at Harvard, and the vice-chair of the ethics committee at the American College of Obstetricians and Gynecologists (ACOG). Her work focusses on the ethical obligations and quandaries faced by medical professionals; the Court's decision raises significant questions about how doctors who support abortion rights should approach their responsibilities to patients and the law going forward. During our conversation, which has been edited for length and clarity, we discussed how bioethicists think about abortion, how the medical community should approach its own members who are opposed to abortion, and whether it's ever appropriate for doctors to break the law.

Does the decision to strike down Roe v. Wade change the ethical obligations of doctors in the United States?

It doesn't change our ethical obligations; it makes them more challenging, because to meet our ethical obligations, to provide abortion—which is health care—in some states physicians will be facing criminal and financial penalties. And, from a utilitarian standpoint, if you meet your ethical obligations and ignore the law and risk those criminal and financial penalties, it may be that you're then no longer available to treat other patients. Figuring out how to thread that needle is difficult, as is figuring out when you can legally treat women who are pregnant, if they're facing various emergencies, because it is very difficult to know what you can and cannot do.

Before this decision, the majority of states in the country had some legal restrictions on abortion. How were those existing restrictions—which often limit abortion in the third trimester—balanced with the ethical obligation to provide health care?

My personal opinion is that many of the legislative approaches to abortion that existed were inappropriate. The actual legislation that we have in Massachusetts—the one that I support, and I'm very glad that we have here—is called the ROE Act, and it allows for abortion up to twenty-four weeks. After that time frame, meaning essentially in the third trimester, abortion is still permitted when necessary to save the life of a person who's pregnant or in the setting of lethal anomalies or anomalies not compatible with life. That allows meaningful access to abortion, the meaningful exercise of people's rights to bodily autonomy, and a meaningful interaction with teams of doctors, midwives, and other health-care professionals who can help people reach decisions on these matters and who can help determine in that third trimester when abortion is truly necessary—which is exceptionally rare but sometimes important.

One of the criticisms of Roe was that it set standards that were somewhat arbitrary, including the trimester divisions. Ethically, why would the third trimester be different from the first one?

That's a great question. This concept of viability, which is, from a medical standpoint, an ever-changing and fluid concept—it can't possibly serve as a line in the sand. The trimester system is just something that is divided into threes, but any particular pregnancy might not correspond to those time frames, might not follow those patterns. There are innumerable complexities that come up in a pregnancy that might lead to different decision-making and different needs at different times.

As an ethicist, I think that there shouldn't be these lines in the sand. There's been a dearth of deference to medical expertise, dating back to Gonzales v. Carhart, where they're simply ignoring what anybody who practices this type of medicine is trying to say. It's complicated. I can understand the desire for these lines in the sand from both legislators and the public, but that's not an ethical way to move forward on such a complex issue.

When you sit down with anyone who really wants to create some firm boundaries around abortion because they feel they have to, and then you start explaining to them how complicated things can become, if you're dealing with severe hydrocephalus, severe cardiomyopathy, hypertension, diabetes, eclampsia, preeclampsia, hemorrhage—and I could go on—all of these nuances of the various complications and difficulties that arise in pregnancy don't lend themselves to lines in the sand. From an ethics perspective, there really shouldn't be very many legislative, if any, restrictions on abortion, personally. That's my view. We should have very clear training for all of our providers and for the public about why that should be the case, whether we can achieve it or not. But a good way to achieve essentially that is what we have in Massachusetts through the ROE Act.

What I'm trying to understand from what you just said is whether the reason a legislative approach to this issue is bad is that pregnancy is really complicated, and you can't just have a blunt instrument addressing it—or, instead, that a woman should be able to do what she wants with her body. Whatever medical issues she may be having, or whatever complications there are medically, those are not that important to you as an ethicist, because it's her body and she can do what she wants.

I'll preface again and say these are my personal views. In terms of a pregnant person's right to bodily autonomy—in my personal opinion, that is absolute. And so I don't ask reasons if somebody, for example, is asking for an abortion earlier on in pregnancy. As you get further along in pregnancy, things become more complicated. I don't know if I would feel comfortable performing a third-trimester abortion for a patient where, if that infant was born, it would probably survive, and the person in front of me is saying, "I just don't want to be pregnant now." That would be a little bit difficult.

There are gradations, and there are points at which a pregnant person's right to bodily autonomy can be called into question. The difficulty that arises for me personally is that if I say no to any abortion, I'm saying to someone, "I think that your right to make a decision about the risk that you wish to take, about the risk of death that you wish to face, is no longer your right." That's a statement I don't think I could make, either. If someone came to me and said, "You are the only match for a kidney, or for bone marrow, or name your body part, for my daughter," I would have an absolute choice of whether or not I wished to donate that fundamental tissue to her.

In those instances, the risks that I would incur, even if I were having a kidney removed or a portion of my lung or liver removed, are less than when I carried my daughter to term and delivered her. Even after my death, I can refuse to let you use any of those organs to help a family member or anybody else. And yet, if I'm pregnant, at a certain point in time, depending on which legislation you're looking at, you will be able to say to me, "You no longer have the right to manage the risks for your body, to

manage the risks of passing a grown infant through the vaginal canal, the risks of tearing, prolapse, sexual dysfunction, hemorrhage, and death. You no longer get to control whether you're going to take those risks or not."

Obviously, if I'm sitting in front of somebody who is in the very early stages of pregnancy, this question is very simple for me. In the early stages of a pregnancy, if they don't wish to take on those risks, a hundred per cent, they have an absolute right to bodily autonomy in those decisions. If we're getting into later stages of pregnancy, it becomes quite complex, but really that's almost a red herring, because it just doesn't happen. Even with the incredible lack of access that we have in this country to sexual education and contraception, women are not presenting for elective termination in their third trimester. So that question doesn't happen, and, because it doesn't, as an ethicist, even though I find a lot of difficulty in that space, in my analysis, I don't actually have to answer that question. It becomes a red herring, because it constantly does get brought up, even though it's not really the true issue. It's an interesting, difficult question to grapple with, but it just doesn't happen.

I assume you want medical professionals to have a certain amount of autonomy to make their own decisions, and you don't want them questioning every decision, because then the whole system would break. I'm curious how you think about what role doctors have in making their own decisions about whether they are going to do specific abortion procedures.

It's a really tough one. Each individual physician obviously needs to be able to govern what they feel comfortable doing. But when that discomfort impedes access to care for so many people in our country, we've let the pendulum of professional autonomy swing too far. In the United States, only twelve to fourteen per cent of ob-gyns provide abortion care, and that's not O.K. We need to have a workforce of obstetrics and gynecology professionals who are not only trained but willing to conscientiously provide this care. And that we don't is a failing of our professional obligation. So you're right. I would never say to any individual provider, "You must provide this care." But when I speak to medical students who are thinking about these questions and trying to figure out where they want to go in their careers, I encourage them to think carefully about their duty, not only as individuals but as members of a group of people providing care.

If they really feel that they cannot provide abortion care, there are many ways to be an excellent women's-health physician without compromising the access to care for women. It does involve all of us working together. My point of view on this is slightly different from many of my colleagues who provide abortion care. I have to say that, over the years, they're wearing me down a little bit. The reason I say that is because my position is typically the majority position of most institutions like ACOG—that conscientious objection is appropriate, that we need a professional society to insure we have enough access, but that certain individual physicians could conscientiously object to provide the care.

But that puts an enormous burden on those who do provide the care. And, in this country, that puts a burden on them that includes not being able to disclose their work to people, or their home addresses. I have one colleague who is very circumspect about what she does for a living, because she doesn't want to put her children at risk. Their lives can be on the line, given the violence that has occurred. If that's where this is going, then, at the end of the day, I'm starting to come around to the opinion that, as a professional society, we simply can no longer accommodate what I still would defend ethically: conscientious objection.

Can you say more about the real-world manifestation of the difference of opinion you have with the people in your field? What are they arguing?

They might not all believe this, but many of them who have spoken to me have shared that they do not think that you should match into obstetrics and gynecology if you are conscientiously opposed to providing abortion care. It's a fundamental portion of our training. It's a fundamental portion of the care that we provide to patients. So, if that's your strong belief, there are many other opportunities in medicine. There's no reason for somebody who conscientiously opposes the provision of abortion care to go into a discipline in which that care should be a fundamental part.

I've never held that view, because it's important that we have varied viewpoints within our disciplines, and that we are open to hearing challenges. But when those different viewpoints cross into wholesale removal of rights from half our population, or violence against those who are providing the care, or obstructing care, as is happening in so many different states, then the balance of how we address the issue of conscientious objection has to change. I've been slowly modifying my view. I don't know where I stand.

Just to clarify, when you said that people were wearing you down, you didn't mean irritating you—you meant making you think hard about this question and its many complications.

I meant bringing me around to their viewpoint.

You broached something earlier that I want to come back to. A doctor may choose not to follow an unethical or immoral law. One of the problems with not following laws, even if they're bad laws, is that they create all these other second- and third-order utilitarian consequences that can be really, really problematic—which is why, broadly speaking, people should not evaluate every single law every second of the day and just broadly follow the law. I think that's what most ethicists would say.

True.

Can you talk more about this problem?

Sure. The laws in various states are all slightly different, but, at the end of the day, they're going to put doctors in a position of deciding when a woman is sick enough for them to intervene, and that's incredibly difficult to figure out. Sepsis, for example, proceeds very slowly until it doesn't, and then it kills. That's the story that happened with Savita Halappanavar in Ireland. The law moves very slowly in its clarification process, through things happening, cases going forward, and then courts deciding whether something was legal or not legal. In the moment, when you're sitting in front of someone who may be dying, and you're being told that it might be illegal to help them, that's not a moment when you can rely on the law to give you guidance.

A physician faced with somebody in exactly Savita's situation of sepsis—but with electrical activity [in the fetus] and not being able to proceed forward with the termination that would save her life—might go through with that procedure and then, if they're prosecuted, go through years of the legal process, of trying to figure out if they've broken the law or not. During that time, they might not be able to provide care meaningfully to other patients because they're consumed with defending themselves in court.

From a utilitarian perspective, they're going to have to adhere as closely to the law as they can and see if they can pinpoint that moment when the life of the patient is truly in danger under the laws that would not allow intervention otherwise. That's an impossible place to be put in. The moral injury that will ensue for these physicians is equally damaging. We are seeing physicians and midwives leave practice, nurses leave practice, because of all the moral injuries that have happened over the

course of our pandemic. This will still surely add to that problem, so we are going to have fewer and fewer people providing care.

What else from a bioethical point of view have you been thinking about since the decision came down?

A lot of stuff, but the main thing I would share with you is that there's been a lot of talk about how we move on from here. I have a lot of conversations with people who disagree with me, especially students, but also other ethicists, and frequently those discussions are very fruitful. I have an honest respect for people who come to their belief that abortion is morally fraught. I believe them, that they really honestly believe that. What I've found has been problematic in discussions of late and has led me to be a bit more circumspect is just a callousness that I hadn't fully appreciated before—this callousness of, "Well, this decision is a good thing because it will save lives."

It must come from a place of simply not understanding all the complexities, because we know from very clear statistics that many people will die because of this decision. And so there are all these calls for constructive discussion and being open, but we can only move forward if people on all sides of this topic will accept the clear facts that are established and can be looked up in the W.H.O. or in *The New England Journal* [*of Medicine*]. This will lead to death and severe morbidity. We have to start from that spot and not be debating that any longer, and then figure out where we're going to go from there. ♦