



September 25, 2008

Department of Health and Human Services
Office of Public Health and Science
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Re: RIN 0991-AB48, "Provider Conscience Regulation"

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The American Civil Liberties Union ("ACLU") submits these comments on the Proposed Rule (the "Proposed Rule" or the "Rule") published at 73 Fed. Reg. 50, 274 (August 26, 2008), that purports to interpret and implement the Church Amendments, 42 U.S.C. § 300a-7, the Coats Amendment, 42 U.S.C. § 238n, and the Weldon Amendment, Consolidated Appropriations Act, 2008, Pub. L. 110-161, § 508(d), 121 Stat. 1844, 2209 (collectively, the "refusal statutes"). Because of the ACLU's profound respect for religious liberty, reproductive rights, and principles of non-discrimination, the ACLU is particularly well positioned to comment upon the Proposed Rule.

In short, the Proposed Rule seriously jeopardizes access to reproductive health care, as well as other health care services for traditionally marginalized communities. And, it does so unnecessarily, as individuals' religious and moral convictions are already strongly protected in federal law. In addition, the Rule vastly exceeds the authority delegated to the Department of Health and Human Services (the "Department" or "HHS") under the refusal statutes, contravenes congressional intent, creates serious confusion for health care providers, and sets up unnecessary conflicts with other federal laws. The Department should therefore withdraw the Proposed Rule.

The ACLU is a nationwide, nonpartisan public interest organization of almost 600,000 members dedicated to protecting the principles of freedom and equality set forth in the Constitution and in our nation's civil rights laws. The ACLU has a long, proud history of vigorously defending religious liberty, reproductive freedom, and principles of non-discrimination. In Congress and in the courts, we have supported legislation providing stronger protection for religious exercise – even against neutral, generally applicable laws. At the same time, we have participated in nearly every critical case concerning reproductive rights to reach the Supreme Court, and we routinely advocate in Congress and the state legislatures for policies that promote access to reproductive health care. The ACLU is

particularly committed to ensuring that individuals' access to reproductive health services is not compromised because of their race, youth, or economic status. The ACLU is also a leader in the fight against discrimination against those segments of the American population that have traditionally been denied their rights, including people of color, lesbians, gay men, bisexuals and transgender people, women, mental-health patients, prisoners, people with disabilities, and the poor.

Balancing these sometimes competing interests means avoiding the imposition of religious doctrines on those who do not share them, especially when it comes at the expense of the public health. At the same time, it means that an individual's – as opposed to an institution's – religious or conscientious objection to the provision of certain health care services should be accommodated to the maximum possible extent, so long as patients' rights, including their right not to be discriminated against, are not compromised as a result. Whatever their religious or moral beliefs, health care professionals should ensure that patients receive complete and accurate information, obtain appropriate referrals, can effectuate informed health care decisions, and secure immediate care in an emergency.

The Proposed Rule fails to reconcile these interests. Indeed, the Department fails even to pay lip service to the need to protect patients' access to vital health care services and information. For the “government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves,” (HHS: What We Do, <http://www.hhs.gov/about/whatwedo.html/>), this omission is a glaring example of the Department permitting politics to trump public health.

Nor is there any justification for jeopardizing patients' access to health care. As an initial matter, it is simply not accurate to characterize the Proposed Rule, as the Department has attempted to do, as one designed to protect the consciences of health care professionals. See, e.g., http://secretarysblog.hhs.gov/my_weblog/2008/08/index.html (Secretary Leavitt stating that if the Department issues a regulation “it will be directly focused on the protection of practitioner conscience”). Much of the Rule allows individuals and entities to refuse to provide health care services for any reason whatsoever, including reasons based on economics or discriminatory motives. To the extent that the Proposed Rule does apply to individuals who object on religious or moral grounds to the provision of certain services, it is unnecessary. Such individuals have long been protected by the refusal statutes that the Rule purports to interpret, as well as Title VII of the Civil Rights Act of 1964. In addition, the Rule provides corporate entities expansive new rights, rights not justified under the refusal statutes, to refuse to provide health care services to patients.

Moreover, the Proposed Rule dramatically expands the reach of the refusal statutes in ways Congress never intended. In addition, the Department's actions and omissions have created tremendous confusion about the way in which longstanding federal law will now be interpreted. The overly expansive definitions in, and confusion created by, the Proposed Rule threaten to cause significant disruption in the delivery of reproductive and other health care services to the severe detriment of patients, particularly low-income patients. As a matter of law and policy, the Proposed Rule therefore must be withdrawn.

I. The Proposed Rule Exceeds the Department’s Authority, Contravenes Congressional Intent, Creates Confusion and Conflict with Other Federal Law, and Undermines the Public’s Health.

The Proposed Rule exceeds the Department’s authority in three principal ways. First, through explicit redefinition of statutory terms, the creation of confusion, and failure to clarify, the Proposed Rule extends the reach of the refusal statutes in ways that contravene congressional intent, create conflicts with other federal laws, and harm individuals in need of health care services and information.

Second, the Department plays fast and loose with the explicit limitations contained in the refusal statutes. Each section of each of the refusal statutes contains a number of distinct limitations, including:

- (1) the type of individuals and/or entities that are permitted to refuse to provide a health care service(s) or research activity;
- (2) the type of service that the individual or entity is entitled to refuse to provide;
- (3) the permitted justifications for the refusal (i.e. religious beliefs or moral convictions or any reason);
- (4) the degree of involvement the individual or entity must have with the service to trigger the statute’s protection (i.e. the provision of a referral or performance of the procedure itself);
- (5) the action that is prohibited (i.e. prohibition on finding a requirement based on the acceptance of federal funding or “discrimination”);
- (6) the types of entities that are prohibited from taking such actions; and
- (7) the federal funding stream that triggers the statute’s application.

The Proposed Rule treats these limitations as interchangeable, taking from each category the most expansive application and applying it to the prohibitions contained in each of the other statutory provisions.¹ The Department has thus ignored the specific limitations Congress placed on the refusal statutes and greatly expanded their scope beyond Congress’s intent.

Third, the expansion of the refusal statutes and the confusion caused by the Proposed Rule comes at the expense of the public’s health, particularly the health of low-income women. Particularly at a time when more and more Americans are either uninsured or struggling with the soaring cost of health care, the Department should be working to expand access to health care,

¹ This failure to adhere to the statutory limitations is taken to the extreme in the certification requirement which does not clearly track either the statutory prohibitions or even those contained in sections 88.3 and 88.4 of the Proposed Rule. Rather, it could be read to require any entity that is covered by any one of the statutes (as determined by the Department) to certify, in essence, that it will comply will all of the prohibitions contained in the Proposed Rule. Proposed Rule § 88.5(c)(4). The Department should clarify the certification requirement.

not undermine it. There simply can be no justification for the Department erecting barriers to medical care and jeopardizing the public's health.

The remainder of these comments details some of the Proposed Rule's major regulatory excesses and the corresponding threats to public health.

II. The Department Must State that it Does Not Intend to Create a New Right to Refuse to Provide Contraceptive Services.

The Department has created tremendous confusion about whether it intends to radically reinterpret existing refusal laws that pertain to abortion to create a new, potentially limitless, right to refuse to be involved with the provision of contraceptive services. To the extent that the Proposed Rule is intended to create such a new right, it is contrary to congressional intent, other federal laws, and basic scientific and medical understanding. Indeed, in the words of Representative Weldon, to interpret the refusal statutes to reach contraception "is to take essentially a religious entity's doctrine and put that into the statute, and it's not there." 148 Cong. Rec. H6566-01, H6571-80 (Sept. 25, 2002) (statement of Rep. Weldon). Moreover, such an expansion would be severely detrimental to the health and lives of American women and families. The Department should withdraw the Proposed Rule in its entirety. At the very least, however, it must rectify the confusion it created and clearly announce that it intends to abide by the definition of abortion long accepted by the medical community, Congress, and, until now, the Department.

The confusion regarding whether the Proposed Rule's abortion provisions are intended to cover contraception is entirely of the Department's own making. The Proposed Rule comes on the heels of a draft version, (the "Draft Regulation"), which was the subject of much public attention. In the Draft Regulation, the Department stated that the "The Problem" the regulation was designed to address was, in part, state laws that require insurance companies to cover contraceptives on par with other prescription drugs, pharmacies to dispense contraception, and hospitals to provide emergency contraception. See Draft Regulation at 8-10 (July 14, 2008). In order to "fix" this "problem," the Draft Regulation re-defined the term abortion for the purposes of the Church, Coats, and Weldon refusal statutes to include some of the most common methods of birth control, including oral contraceptives (birth control pills) and intrauterine devices (IUDs).

Although the Proposed Rule omits the explicit re-definition of abortion, the Department has failed to clarify whether it intends to enforce the abortion refusal provisions to encompass refusals to provide contraception. In fact, subsequent statements from Secretary Leavitt suggest that the Department intends to leave the door open for entities that wish to use the Rule as protection for their refusal to provide contraceptive services. For example, the Secretary has insisted that the Proposed Rule "does not seek to resolve any ambiguity," an ambiguity created by the Department itself, as to whether health care providers may consider birth control pills, emergency contraception, or other forms of contraception to be equivalent to an abortion. Rob Stein, Protections Set for Antiabortion Health Workers. Opponents Denounce Proposed Regulation Allowing Federal Officials to Pull Funding, WASHINGTON POST, Aug. 22, 2008, at A01. The Secretary has also conceded that "some medical providers may want to [use the

Proposed Rule to] ‘press the definition’ and make the case that some forms of contraception” are equal to an abortion. Jacob Goldstein, Feds Move to Protect Health Workers Who Oppose Abortion, WSJ HEALTH BLOG, Aug. 22, 2008, <http://blogs.wsj.com/health/2008/8/22/feds-move-to-protect-health-workers-who-oppose-abortion>. Numerous organizations have announced their intention to do just that, and the Department has issued no clarifications. See, e.g., Stein, supra; Stephanie Simon, Rules Let Health Workers Deny Abortions, WALL STREET JOURNAL, Aug. 22, 2008, at A3. It now must, if the Department intends to be true to Congress and to science.

The legislative history demonstrates that Congress never intended the refusal statutes to create a right for individuals or institutions to refuse to provide contraceptive services. Indeed, Congress made its intent clear: The abortion refusal statutes should *not* be read to cover contraceptives. For example, in direct response to the assertion that Representative Weldon’s initial attempt at enacting these refusal provisions would bar access to contraceptive services, Representative Weldon provided a lengthy retort:

The other thing I want to comment on is this business about contraception. Contraception is not defined by the FDA as abortion. The morning-after pill [emergency contraception] is not defined by the FDA as abortion. It is defined as contraception. It is something different. So to interpret this statute to claim that is going to prohibit access is to take essentially a religious entity’s doctrine and put that into the statute, and its not there. It is not in the language. . . .

* * *

I think it could be described as a tremendous misinterpretation or a tremendous stretch of the imagination. The provision of contraceptive services has never been defined as abortion in Federal statute, nor has emergency contraception, what has commonly been interpreted as the morning-after pill. Now, some religious groups may interpret that as abortion, but we make no reference in this statute to religious groups or their definitions; and under the current FDA policy that is considered contraception, and it is not affected at all by this statute.

148 Cong. Rec. H6566-01, H6571-80 (Sept. 25, 2002) (statement of Rep. Weldon discussing the Abortion Non-Discrimination Act).

In addition to contravening congressional intent, any attempt to include contraception within the abortion refusal provisions would be contrary to medical and scientific understanding. The Draft Regulations proposed to define an abortion as “any of the various procedures – including the prescription and administration of any drug or the performance of any procedure or any other action – that results in the termination of a life of a human being in utero between conception and natural birth, *whether before or after implantation.*” Draft Regulations at 17 (emphasis added). But on the question of when a woman is considered pregnant, the scientific and medical communities and the federal government have long shared the same view: Pregnancy is established *only after* a fertilized egg has been implanted in the wall of a woman’s

uterus. See, e.g., F.G. CUNNINGHAM ET AL., WILLIAMS OBSTETRICS 20 (21st ed. 2001); see also Rachel Benson Gold, Special Analysis: The Implications of Defining When a Woman is Pregnant, THE GUTTMACHER REPORT ON PUBLIC POLICY at 7, May 2005 (stating that medical experts, including the American College of Obstetricians and Gynecologists (“ACOG”), agree that the establishment of a pregnancy . . . is not complete until a fertilized egg is implanted in the lining of the uterus”). And, an abortion is the termination of an established pregnancy. Common methods of contraception, including birth control pills, emergency contraception, and IUDs, do not disrupt established pregnancies, and therefore, are not abortions. See, e.g., Gold, supra, at 10 (quoting ACOG); James Trussell and Beth Jordan, Editorial, Mechanisms of Action of Emergency Contraception Pills, 74 CONTRACEPTION 87 (2006) (reviewing medical research to conclude that emergency contraception does not interrupt an established pregnancy).

And Congress has never adopted a different definition of pregnancy – nor by extension, of either contraception or abortion – as part of any federal law. In fact, Congress has consistently rebuffed attempts to impose the definition included by the Department in the Draft Regulations. See Gold, supra, at 7. Even the Department itself has never enforced such a radical definition. For example, rules promulgated by this Department to protect pregnant women in federally-funded research programs, which remain in effect today, state that pregnancy “encompasses the period of time from implantation until delivery.” 45 C.F.R. § 46.202(f). Similarly, the regulations designed to implement the Hyde Amendment – the provision that blocks the use of public funds to pay for abortion services for low-income women – say that although funding is not available for abortions, it is available for “drugs or devices to prevent implantation of the fertilized ovum.” 45 C.F.R. § 441.207.

To the extent that the Department intends for the Proposed Rule to create a new federal right to refuse to be involved with the provision of contraceptive services, such a right could significantly impede women’s access to health services. This is particularly so if the Department interprets the Rule, as it suggested in the Draft Regulations, to undermine state laws that increase access to contraceptive services including those that require insurance companies to cover contraceptives, pharmacies to fill prescriptions for contraceptives, and hospitals to provide sexual assault survivors with information about and access to emergency contraception. See Draft Regulations at 8-10.

In addition, the expansion of the refusal statutes to reach contraception could be used to undermine the Title X family planning program. As discussed more fully in Section III below, by expanding the reach of the refusal statutes to contraception, the Proposed Rule may make it difficult for Title X clinics to ensure that their staff is willing to participate in the primary purpose of the Title X program, namely the provision of contraceptive services. Moreover, the Rule, depending on how it is interpreted, could make it easier for entities that refuse to provide women with contraceptive services to compete for scarce family planning resources. See infra Section V.

The Department should not permit its Rule to be used by those who seek to impose new roadblocks to women’s access to contraceptives. Access to safe and effective contraception is a critical component of basic health care for women. Indeed, more than 90% of American women will use contraceptives at some point in their lifetime. Mosher WD et al., Use of contraception

and use of family planning services in the United States: 1982-2002, Advance Data from Vital and Health Statistics, No. 350. (2004). They do so to the benefit of their own lives and those of their children. Since 1965, when the U.S. Supreme Court first protected a woman's access to contraception, maternal and infant mortality rates have declined. In fact, the Centers for Disease Control and Prevention has declared family planning one of the ten most significant public health achievements of the 20th century. Ten Great Public Health Achievements – United States, 1900 - 1999, 48 MORBIDITY & MORALITY WKLY. REP. 241, 242 (1999), available at <http://www.cdc.gov/mmwr/PDF/wk/mm4812.pdf>.

The denial of access to contraceptive services has severe repercussions for women's right to live their lives and their ability to participate equally in society. Simply put, reproductive health care is essential to a woman's opportunity – the opportunity to obtain a good education, to improve her economic circumstances, to participate in public life, to define her family, to decide what makes a meaningful life, and to live that life. Moreover, because the Rule affects, in large part, health care services supported by federal funds, its impact will be felt most acutely by low-income women because such women are far less likely to have alternative means to access the health care services they need when faced with a provider's refusal.

As the United States government's principal health care agency, the Department has an obligation to Americans of all faiths and backgrounds to put science and the public health before politics and ideology, and withdraw the Proposed Rule. At a minimum, it should clarify that the term "abortion" does not encompass contraception.

III. The Proposed Rule's Failure to Reference Patient Needs Creates Tremendous Confusion and Puts Patients' Access to Health Services in Jeopardy.

The ACLU supports the accommodation of individuals' religious and conscientious objections, provided that safeguards exist to ensure that patients are still able to access care in a safe and timely manner. The Proposed Rule, however, is unnecessary, as federal law has long protected individuals' consciences. For more than four decades, Title VII of the Civil Rights Act of 1964 has required employers to attempt to accommodate current and prospective employees' religious² and moral objections to the provision of any health care service so long as the accommodation does not pose an undue hardship to the employer's business. 42 U.S.C. § 2000e-(2)(a)(1); 42 U.S.C. § 2000e(j). An undue hardship is defined under Title VII as a circumstance in which the proposed accommodation in a particular case poses a "more than de minimus cost or burden" on the employer's business. EEOC Guidelines, 29 C.F.R. § 1605.2(e)(1). Thus, under existing law, health care providers must already accommodate religious objections unless doing so would result in the imposition of more than a de minimus burden in order to enable the employer to provide proper health care services to its patients. This careful balance between the needs of employees and employers is critical to ensuring that health care employers are able to provide quality health care to their patients.

² Religion is very broadly defined under Title VII. It includes not only theistic beliefs, but also non-theistic "moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views." EEOC Commission Guidelines, 29 C.F.R. § 1605.1.

The Proposed Rule, however, does not reference, let alone expressly adopt, this careful approach. The Rule says only that entities cannot “discriminate” or “require” services in the face of refusals, but provides no definition of these terms. What is more, the Department charged with “protecting the health of all Americans,” makes no mention of patient needs: To the contrary, the Department simply states that the Proposed Rule is “to be interpreted and implemented broadly” to protect the “conscience rights of health care entities.” Proposed Rule § 88.1. This has created tremendous uncertainty about whether the Proposed Rule is intended to create a more absolute right to refuse – one that undermines the careful balance reflected in Title VII and takes patients’ needs out of the equation.³

The Department must therefore clarify that its Rule is to be read in harmony with Title VII and the extensive guidance on religious discrimination recently issued by the Equal Employment Opportunity Commission. EEOC Compliance Manual § 12 (2008). The Department must clarify that it is not “discrimination” for a health care provider to refuse to hire an otherwise qualified job applicant or to fire a current employee who refuses to perform a large part of his or her job. For example, the Department must clarify that it not “discrimination” for a family planning clinic to decline to hire a nurse who refuses to provide contraceptive services when a large part of the job would be to provide those services. Similarly, the Department must clarify that it is not “discrimination” to transfer or reassign an employee in an attempt to accommodate her refusal to provide particular services. For instance, the Department must make clear that it is not “discrimination” for a family planning project in a state health department to transfer a pregnancy counselor who refuses to provide any information about abortion to a project in the health department that does not entail pregnancy counseling.

Without such clarification health care providers will be put in an untenable position. They can risk their federal funding (and the imposition of other sanctions) by certifying that they do not “discriminate” within the meaning of the Proposed Rule on the (perhaps incorrect) assumption the Rule adopts the same definition of discrimination as does Title VII. They can hire individuals who refuse to perform large parts of their job, thereby making it difficult, if not impossible, for them to provide appropriate care. Or they can reject federal funding thereby

³ Statements by the Department of Justice (“DOJ”) support the need for HHS to clarify its intent in this area. As DOJ explained in litigation over the Weldon Amendment, “it is by no means clear that agency officials responsible for enforcing the Weldon Amendment would necessarily look upon the reassignment of objecting individuals to duties that did not require them to engage in abortion counseling and referral as ‘discrimination,’ rather than an accommodation of individual moral conviction or religious belief that is entirely in keeping with the Weldon Amendment’s spirit.” Brief of Department of Justice at 31, NFPHRA v. Gonzales, Civ. No. 04-2148, 2004 WL 3633834 (D.C. Dist. Ct.) (filed Dec. 24, 2004) (internal citation omitted). But DOJ has also recognized that the only sensible interpretation of the refusal statutes is one that is harmonious with Title VII. Brief of Department of Justice at 23 n.1, NFPHRA v. Gonzales, Civ. No. 05-5406, 2006 WL 1662404 (D.C. Cir. 2006) (filed May 30, 2006) (asserting that interpreting the Weldon Amendment to bar re-assignment of an employee who objects to performing services called for by the job “is not a sensible interpretation of the statute”). It is manifestly unfair for the Department to require entities to certify their compliance without providing clarification about what the law means.

making it even more difficult for the federal government to provide – and low-income and uninsured individuals to receive – quality health care services. In order to avoid further disruption in the provision of health care services (as well as the conduct of federally-funded research), the Department must therefore clarify that its Rule is to be read in harmony with Title VII’s reasonable accommodation/undue hardship standard.⁴

The Department must also clarify what it means to “discriminate” against an institution, and how, if at all, patients’ needs are to be taken into account when an institution refuses to provide health care services to a patient. For example, is it “discrimination” for a state health department that is a Title X grantee to refuse to award a contract to an organization that provides pregnancy tests, but refuses to provide non-directive options counseling? If so, how does such a grantee refrain from discriminating while at the same time ensuring that the requirements of the Title X program are met? See, e.g., Pub. L. No. 110-161, Division G, Title II (2008) (requiring that within the Title X program “all pregnancy counseling shall be non-directive”). Similarly, is it “discrimination” for a state simply to enforce its own laws? Would it be “discrimination,” for example, for a state to require that a hospital offer a rape survivor emergency contraception, or to require an insurance company to cover contraceptives on par with other prescriptions on its plan?

IV. The Proposed Rule Must Clarify that Any Right to Refuse to Participate in Health Care Services Does Not Apply to Emergency Care.

The Proposed Rule must be revised to clarify that it does not authorize institutions or individuals to abandon patients in need of emergency care. In the absence of such an explicit statement, some institutions and individuals might take the Proposed Rule as license to avoid their legal, professional, and ethical duties to provide emergency care, including emergency abortions, to which they object. Permitting them to do so would put the public’s health at risk, conflict with the Emergency Medical Treatment and Active Labor Act (“EMTALA”), and contravene medical ethics.

As Congress has recognized, the refusal to treat patients facing an emergency puts their health, and, in some cases, their lives, at serious risk. Thus, Congress enacted EMTALA, which requires hospitals with an emergency room to provide stabilizing treatment to any individual experiencing an emergency medical condition or to provide a medically beneficial transfer. 42 U.S.C. § 1395dd (a)-(c).

Nothing in the text of the refusal statutes indicates an intent to override the requirements of EMTALA or similar state laws that require health care providers to treat patients in emergencies. As a federal district court in California held in litigation over the meaning of the Weldon Amendment, “[t]here is no clear indication, either from the express language of the Weldon Amendment or from a federal official or agency, that enforcing [a state law requiring

⁴ The Department has greatly exacerbated the potential for disruption through its expansive definitions of “assist in the performance,” see Section V, infra, “individual,” and “workforce,” Proposed Rule § 88.2. Particularly if the Department fails to clarify that the Rule should be read in harmony with Title VII, the Department should narrow these definitions.

emergency departments to provide emergency care] or the EMTALA to require medical treatment for emergency medical conditions would be considered ‘discrimination’ under the Weldon Amendment if the required medical treatment was abortion related services.” California v. U.S., Civ. No. 05-00328, 2008 WL 744840, at *4 (N.D. Cal. March 18, 2008). Indeed, after the California suit was filed, Representative Weldon stated that his Amendment was not intended to reach emergency abortions and that EMTALA requires critical-care health facilities to provide appropriate treatment to women in need of emergency abortions, the Weldon Amendment notwithstanding. See 151 Cong. Rec. H176-02 (Jan. 25, 2005) (statement of Rep. Weldon) (“The Hyde-Weldon Amendment is simple. It prevents federal funding when courts and other government agencies force or require physicians, clinics, and hospitals and health insurers to participate in *elective* abortions.”) (emphasis added); id. (the Amendment “ensures that in situations where a mother’s life is in danger a health care provider *must* act to protect a mother’s life.”) (emphasis added); id. (discussing the fact that the Weldon Amendment does not affect a health care facility’s obligations under EMTALA); see also 150 Cong. Rec. H10087-02, H10090 (Nov. 20, 2004) (“[t]he policy simply states that health care entities should not be forced to provide *elective* abortions”) (statement of Rep. Weldon) (emphasis added). Nor were the other refusal statutes intended to affect the provision of emergency care. See 142 Cong. Rec. S2268-01, S2269 (March 19, 1996) (statement of Senator Coats in support of his Amendment) (“a resident needs not to have performed an abortion on a live, unborn child, to have mastered the procedure to protect the health of the mother if necessary”); id. at S2270 (statement of Senator Coats) (“[T]he similarities between the procedure which [residents] are trained for, which is the D&C procedure, and the procedures for performing an abortion are essentially the same and, therefore, [residents] have the expertise necessary, as learned in those training procedures, should the occasion occur and an emergency occur to perform an abortion.”).⁵

Medical ethics similarly require that health care professionals ensure that patients receive the care they need in emergencies. The ACOG Committee on Ethics recently opined that “[i]n an emergency in which a referral is not possible or might negatively affect a patient’s physical or mental health, providers have an obligation to provide medically indicated care regardless of the provider’s personal moral objections.” The Limits of Conscientious Refusal in Reproductive Medicine, ACOG Committee Opinion No. 385, Recommendation 5 (Nov. 2007). Similarly, the policy of the American Medical Association (“AMA”) permits physicians to withdraw from treating a patient if the treatment requires the doctor “to perform an act violative of . . . personally held moral principles,” “*so long as the withdrawal is consistent with good medical practice.*” Am. Med. Ass’n, H-5.993: Right to Privacy in Termination of Pregnancy (emphasis added).

The Proposed Rule, however, makes no mention of emergency care and fails otherwise to make any exception to its prohibitions. The failure to clarify that the refusal statutes do not apply in medical emergencies puts patients’ health and lives at risk. Unfortunately, this risk is far from hypothetical. For example, an article in the American Journal of Public Health recounts several instances of Catholic hospitals, which operate 15.2% of the nation’s hospital beds and are

⁵ To the extent that the emergency care needed is an abortion, failing to include an emergency exception renders the law unconstitutional. See Ayotte v. Planned Parenthood, 546 U.S. 320, 327-28 (2006); Planned Parenthood v. Casey, 505 U.S. 833, 846-879 (1992).

increasingly the only hospitals in certain regions, refusing to provide proper medical care to very sick women experiencing miscarriages. Such refusals came despite the fact that the women were hemorrhaging, had become septic, and/or had dangerously high temperatures. See Lori K. Freedman et al., When There's a Heartbeat: Miscarriage Management in Catholic-owned Hospitals, 98 AMERICAN JOURNAL OF PUBLIC HEALTH 1774 (Oct. 2008). In order to protect the health of patients facing medical emergencies (as well as to avoid conflict with federal and state laws and to ensure compliance with medical ethics), the Department must clarify that the refusal statutes offer no protection for providers who abandon their patients in this manner.

V. The Proposed Rule's Definition of "Assist in the Performance" Exceeds the Department's Regulatory Authority and Threatens to Deny Patients Access to Basic Information about their Health and Treatment Options.

Like many other definitions in the Proposed Rule, the Proposed Rule's definition of "assist in the performance" exceeds congressional intent. Particularly when put together with the Department's other unauthorized expansions of the refusal statutes, the Proposed Rule could be read to give carte blanche to any individual, and some institutions, to deny patients access to any service or information related to their health.

Subsections (b), (c), and (d) of the Church Amendments provide certain rights to refuse "to perform or assist in the performance" of specified procedures, services, or research activities. 42 U.S.C. §§ 300a-7(b), (c)(1), (c)(2), (d). But the Proposed Rule gives the term "assist in the performance" a definition far broader than the words reasonably can bear. Under the Proposed Rule, "assist in the performance" "means to participate in any activity with a reasonable connection to a procedure, health service or health service program, or research activity" and includes "counseling, referral, training, and other arrangements for the procedure, health service, or research activity." Proposed Rule § 88.2. This interpretation far exceeds congressional intent. Had Congress wanted, for example, to prevent "discrimination" against individuals or entities who object to participating in any way in a health service, it would have used far more direct language. Indeed, that is precisely what Congress did in subsection (e) of the Church Amendments which prohibits discrimination against applicants who are reluctant "to counsel, suggest, recommend, assist or in any way participate in the performance of abortions or sterilizations." 42 U.S.C. § 300a-7(e). The Department must, therefore, revise the Rule to give effect to Congress's decision to use the far more limited phrase "assist in the performance" in subsections (b), (c), and (d).

This excess of regulatory authority is particularly alarming because it appears to create a new right for individuals and institutions to refuse to provide information and counseling to patients.⁶ Legal and ethical principles of informed consent require health care professionals to

⁶ Of course, under Title VII, employees and job applicants (as opposed to institutions) have the right to seek an accommodation from their employer if they object on religious or moral grounds to any participation in any activity. But this does not allay the concerns raised by the Department's broad interpretation of the refusal statutes. First, as discussed above, the employee's right under Title VII is not absolute. An employer need not accommodate the employee's refusal if doing so would cause an undue hardship on the employer's business, including a health care provider's ability to provide quality health care services to its patients. As noted above, the Department's failure to reference Title VII raises

ensure that patients receive information about all treatment options, including those to which they object or those they do not provide. Indeed, ethical standards of care set forth by ACOG direct that when a conscientious refusal conflicts with the standards of care and practice, the patient's well-being is always paramount and accommodation of a refusal is only permissible if "the primary duty to the patient can be fulfilled." ACOG Committee Opinion No. 385, Recommendation 1 (Nov. 2007). Without exception, "health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services." *Id.* at Recommendation 2.

By expanding the definition of "assist in the performance" to include information and counseling without any mention of patient needs, the Proposed Rule seems designed to do away with such essential safeguards. As a result, providers may attempt to claim an absolute right to deny patients basic information about their health and treatment options and patients may never be able to access such health care – or even know about their option to do so. Thus, for example, a health care provider may attempt to seek protection under the Rule for:

- failing to inform a woman for whom pregnancy may seriously endanger her health or life about the option of sterilization;
- refusing to provide a pregnant woman with test results that show that her fetus has a severe genetic anomaly for fear that she might decide to have an abortion;
- failing to tell a rape survivor about the existence of emergency contraception;
- refusing to tell a gay adolescent about the importance of using condoms to protect himself against HIV.

Moreover, to the extent the Proposed Rule impermissibly expands this new right to institutions, it conflicts with federal statute. Sections 88.3 and 88.4 prohibit state and local governments and other public entities from using the receipt of certain federal funds as a basis to find that an institution is obligated to provide personnel to, *inter alia*, give women information about abortion.⁷ But Congress has long required, for example, that within the Title X family planning program, "all pregnancy counseling shall be nondirective." *See, e.g.*, Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, 121 Stat. 1844, 2170 (2007); Omnibus Consolidated Appropriations Act, 1997, Pub. L. No. 104-208, 110 Stat. 3009, 243 (1996). In other words, Congress requires the provision of complete, factually accurate, and neutral

concerns that it intends to upset this delicate balance between respecting religious belief and an employer's ability to protect patients' access to health care. Moreover, an employee's Title VII rights apply against the employer. They do not negate a health care professional's legal and ethical obligations to his or her patients.

⁷ Section 88.5(c)(4) of the Proposed Rule appears to apply the prohibition on "discrimination" against institutions far more broadly. It appears to require that any entity that receives federal funds (including state and local governments, and facilities that receive Title X grantees, among others) certify that it will not discriminate against another entity based on the entity's refusal to assist in the performance (broadly defined to include the provision of the information) in abortion or sterilization. Such an expansion to reach all federally-funded entities is wholly unauthorized by the refusal statutes.

information and counseling related to pregnancy within the Title X program. The Proposed Rule appears to undermine this requirement, going so far potentially as to permit entities that perform pregnancy tests to seek Title X funding even if they refuse to provide information and counseling related to abortion.

For all of these reasons, if the Department goes forward, it should revise the Rule in accordance with Congress's limited intent.

VI. The Proposed Rule Impermissibly Expands Subsection (d) of the Church Amendments to Create a Dangerous New Right to Refuse to Provide Any Health Care Service.

Sections 88.3(g) and 88.4(d)(1) of the Proposed Rule vastly expands the prohibitions contained in subsection (d) of the Church Amendments in a manner that is contrary to the legislative language, the statutory scheme, and congressional intent. This broad interpretation, coupled with the Department's failure to explain how the Rule interacts with Title VII, threatens to seriously disrupt the provision of health care services and the conduct of federally-funded research.⁸ If left to stand, individual health care employees could effectively bar a health care organization from providing needed services and, in some instances, bar certain services from reaching entire communities, particularly those in remote or isolated locations.

The Proposed Rule prohibits any "physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a post graduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, laboratory or any other kind of health care organization or facility," or a state or local government that "carries out any part of any health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services" from requiring "any individual to perform or assist in the performance [broadly defined] of any part of a health service program or research activity funded by the Department if such service or activity would be contrary to his religious beliefs or moral convictions. Sections 88.2; 88.3(g)(2); 88.4(d)(1). As written, the Proposed Rule could be read to tie the hands of federally-funded health care entities and research institutions when faced with an individual's refusal to provide any health care service or research activity.

Contrary to the suggestion in the Proposed Rule, however, subsection (d) of the Church Amendments was not intended to provide a blanket, unqualified right for individuals who refuse to participate in health services or research conducted in programs supported with federal funds. Rather, the text and statutory scheme of the Church Amendments, as well as other federal laws, demonstrate that this section provides individuals only a limited exemption from certain federal requirements. Indeed, that section is captioned "[i]ndividual rights respecting *certain requirements* contrary to religious beliefs or moral convictions." 42 U.S.C. § 300a-7(d) (emphasis added). To read the statute as giving individuals an unlimited right to refuse to

⁸ This threat is even more severe given the expansive definitions of "assist in the performance," "individual," and "workforce" contained in the Proposed Rule. Proposed Rule § 88.2.

participate in any service to which they object, as the Department proposes, would render the words “certain requirements” superfluous.

That this language was meant to refer only to certain federal requirements is reinforced by comparing the language of the other sections of the Church Amendments, and, in particular, subsection (c)(2), with the language of subsection (d). Subsections (c) and (e) of the Church Amendments make amply clear that their prohibitions run against all entities that receive specified federal funds. 42 U.S.C. § 300a-7(c)(1) (“No entity which receives a grant, contract, loan, or loan guarantee under [three specified acts], may . . . discriminate”); 42 U.S.C. § 300a-7(c)(2) (“No entity which receives . . . a grant or contract for biomedical or behavioral research . . . may . . . discriminate”); 42 U.S.C. § 300a-7(e) (“No entity which receives . . . any grant, contract, loan, or loan guarantee, or interest subsidy under [three specified acts] may deny admission . . .”). Subsection (d) of the Church Amendments, in contrast, does not prohibit federally-funded entities from doing anything. Rather, it provides individuals an exemption from certain federal requirements that are contrary to their religious or moral beliefs. Indeed, if Church (d) were read as the Proposed Rule suggests, (c)(2) and (d) would be largely redundant. Such an interpretation must be avoided, particularly where, as here, the two provisions were adopted by Congress at the same time.

Failure to revise the Proposed Rule threatens to disrupt the provision of certain health care services and the conduct of some federally-funded research. If health care and research employers must retain employees who refuse to perform large parts of their jobs, it will make it difficult, if not impossible, for these employers to provide health care services to patients effectively or to conduct important research.⁹

The ACLU is particularly concerned that the Proposed Rule’s expansive interpretation of Church subsection (d) could be used by those whose religious or moral objection runs not to providing a particular health care service, but to the individuals seeking the services. To illustrate the point, we are concerned that the Rule could be invoked by:

- A physician who offers treatment to Medicaid patients living with HIV/AIDS, but refuses to provide such treatment to gay men because of her religious beliefs about homosexuality;
- A nurse at a Title X clinic who refuses to provide contraceptives to a white woman whose husband is African-American because of the nurse’s moral opposition to interracial marriage; or
- A physician at a state health department’s federally-supported family planning unit that refuses to provide treatment of sexually transmitted infections to unmarried individuals because of his opposition to non-marital sex.

⁹ As noted above, Title VII provides certain rights to object on religious grounds to participating in any job function. But, as explained in note 6 above, those rights are not absolute and permit an employer to take into account patient or research needs.

Nothing in the statute or the legislative history supports the Proposed Rule's broad interpretation of Church (d). Moreover, it threatens to impose new barriers to health care, particularly for communities that have traditionally faced discrimination. If the Department goes forward with this Rule, it should substantially narrow its interpretation of Church (d) in line with these comments and, at the very least, clarify that the Proposed Rule does not give individuals permission to violate anti-discrimination principles.

VII. The Proposed Rule Expands the Term "Federal Agency or Program" Beyond Recognition and Congressional Intent.

Sections 88.3(c) and 88.4(b)(2) of the Proposed Rule impermissibly expand the scope of the Weldon Amendment far beyond the words of the statute or Congress's intent. By its terms, the Weldon Amendment's prohibitions apply only to "Federal agenc[ies] or program[s]" and "State or local government[s]" that receive funding under the Labor, Health, and Human Services, and Education, and Related Agencies Appropriations Act, 2008. Pub. L. No. 110-161, Div. G, Sec. 508(d), 121 Stat. 1844, 2208-09 (2007). Its language thus stands in marked contrast to other federal statutes, such as Title VI and the Age Discrimination Act, whose prohibitions run to any "program or activity receiving Federal financial assistance." 42 U.S.C. §§ 2000d, 6102.

The Proposed Rule, however, seeks to avoid this difference. It characterizes the Weldon Amendment as reaching "[a]ny entity that receives federal funds appropriated through the appropriations act for the Department of Health and Human Services to implement any part of any federal program." Proposed Rule §§ 88.3(c), 88.4(b)(2). It simply cannot do this in the face of the actual language of the Weldon Amendment. For as the civil rights statutes make clear, if Congress had meant for the Weldon Amendment to have such reach, it knew how to say so – and it did not.

The expansion is even less supportable when the new definition of "entity" is considered. The Proposed Rule defines "entity" to include "physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a post graduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, laboratory or any other kind of health care organization or facility." Proposed Rule § 88.2. In other words, under the Proposed Rule the term "federal agency or program" includes every doctor, hospital, and other health care facility that is reimbursed by Medicaid, as well as every clinic that receives Title X funding.

Such an expansive interpretation of the term "federal agency or program" is wholly unsupported. Indeed, as the Department of Justice has stated, "there is nothing on the face of the Weldon Amendment itself to compel the conclusion that an individual Title X clinic would constitute a 'Federal agency or program.'" Brief of Department of Justice at 28, NFPRHA v. Gonzales, Civ. No. 04-2148 (D.C. Dist. Ct.), 2004 WL 3633834 (filed Dec. 24, 2004). Rather, as DOJ has explained, the definition of federal program in other federal statutes tends to "refute, the notion that individual Title X clinics . . . should also be considered 'Federal . . . program[s]"

for purposes of the Weldon Amendment.” Brief of Department of Justice at 29.¹⁰ (DOJ’s analysis applies equally to individual and institutional Medicaid providers.) The Department must abandon this attempt to stretch the meaning of the term “federal agency or program” in a manner inconsistent with the language of the Weldon Amendment. See 150 Cong. Rec. H10087-02, H10095 (Nov. 20, 2004) (statement of Rep. Smith) (the Weldon Amendment “promotes rights of conscientious objection by forbidding *government* bodies to coerce the consciences of health care providers”) (emphasis added).

VIII. The Proposed Rule Extends the Coats Amendment in Unauthorized and Potentially Dangerous Ways.

Section 88.4(a)(1) of the Proposed Rule impermissibly expands the language and purpose of subsection (a) of the Coats Amendment. The statute passed by Congress prohibits “discrimination” against a limited group of individuals and institutions that object to participating in specified activities related to abortion training. The Proposed Rule vastly expands the scope of the Amendment by ignoring both congressional intent and the plain terms of the statute.

As Senator Coats explained, “[w]hat I was trying to do with my amendment was simply address the question of training for induced abortions.” 142 Cong. Rec. S2261-06, S2262 (March 19, 1996). Indeed, the title of the statute is “Abortion-related discrimination in governmental activities regarding *training and licensing of physicians*.” 42 U.S.C. § 238n (emphasis added). Senator Coats offered the amendment in direct response to a newly adopted standard of the Accrediting Council for Graduate Medical Education that required all obstetrics and gynecology residency programs to provide abortion training. 142 Cong. Rec. S2261-06, S2263 (March 19, 1996) (Statement of Sen. Frist) (“My colleague has proposed an amendment that will protect medical residents, individual physicians, and medical training programs from abortion-related discrimination in the training and licensing of physicians [T]his amendment arose out of controversy over accrediting standards for obstetrical and gynecological programs.”). Because the Amendment’s scope was limited to prohibiting discrimination against individuals and entities that objected to participating in abortion training, it contained a very specific definition of those whom it protected: “an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.” 42 U.S.C. § 238n(c)(2). The relevant provisions of the Coats Amendment prohibit discrimination against this limited set of individuals and entities who refuse to “undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions.” 42 U.S.C. § 238n(a)(1).

The Proposed Rule ignores both the statutory language and intent of Congress in three ways.

¹⁰ The Proposed Rule’s unauthorized and expansive interpretation of “federal agency or program” will have particularly severe repercussions should the Department fail to clarify the confusion concerning the definition of abortion and the Rule’s interaction with Title VII.

- First, it replaces the limited statutory definition contained in the statute with the Proposed Rule’s all-encompassing definition of entities which includes “an individual physician or other health care professional, health care personnel, a participant in a program of training in the health professions, an applicant for training or study in the health professions, a postgraduate physician training program, a hospital, a provider-sponsored organization, a health maintenance organization, laboratory or any other kind of health care organization or facility,” and “may also include components of State or local governments.” Proposed Rule §88.2. Surely, if Congress had meant the Amendment to apply to every conceivable person and entity involved in the delivery of health care, it would not have defined the covered entities as “an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.” 42 U.S.C. § 238n(c)(2).

- Second, it extends the law’s reach for all of these entities should they object to “perform[ing], refer[ring] for, or mak[ing] other arrangements for, abortions” *outside* the training context. Compare Proposed Rule §§ 88.4(a)(1)(B) and (c) with § 88.4(a)(1)(A) (which applies only to the training context).¹¹

- Finally, the ACLU is seriously concerned that by omitting the modifier “induced” before the word “abortion” in section 88.4(a)(1), the Department intends to create a defense for individuals and institutions that violate their legal and ethical obligations to care for women suffering miscarriages. Although only the Coats Amendment uses the term “induced abortions,” all three of the refusal statutes apply only to such abortions. See, e.g., 150 Cong. Rec. H10087-02, H10090 (Nov. 20, 2004) (statement of Rep. Weldon concerning the Weldon Amendment) (“The policy simply states that health care entities should not be forced to provide elective abortions . . .”). Nonetheless, because the Coats Amendment itself and the Draft Regulations included the “induced” modifier, and sections 88.4(a)(2) and (3) retain this terminology, the ACLU is concerned that by deleting the term from 88.4(a)(1), the Department intends to create a new right to refuse to treat or train physicians to treat women experiencing miscarriages. Such a new right would be directly contrary to the language of the Coats Amendment, which is expressly limited to induced abortions. This language reflects what is clear from the legislative history – that Congress intended to afford protections to those who object to participating in abortion training, but not to undermine other legal and professional requirements that hospitals and health care professionals be prepared to treat a woman suffering a spontaneous miscarriage. See 142 Cong. Rec. S2268-01, S2269 (March 19, 1996) (statement of Senator Coats in support of his Amendment) (“a resident needs not to have performed an abortion on a live, unborn child,

¹¹ These differences are not rendered irrelevant by the existence of the Weldon Amendment. First, the language of the Weldon Amendment does not prohibit discrimination based on refusals to “make other arrangements” for abortions; such language is found only in the Coats Amendment. Second, the Coats Amendment applies to any state or local government that receives any “federal financial assistance,” whereas Weldon’s prohibitions reach only those governments that receive funds appropriated under the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2008. Moreover, the Department should be particularly wary of conflating two separate provisions where, as here, the Weldon Amendment is not a permanent statute, but rather an appropriations rider that may or may not be enacted in subsequent years.

to have mastered the procedure to protect the health of the mother if necessary”); *id.* at S2270 (statement of Senator Coats) (“[T]he similarities between the procedure which [residents] are trained for, which is the D&C procedure, and the procedures for performing an abortion are essentially the same and, therefore, [residents] have the expertise necessary, as learned in those training procedures, *should the occasion occur and an emergency occur to perform an abortion.*”) (emphasis added). Indeed, permitting hospitals and other health care providers to abandon women experiencing miscarriages would create a conflict between EMTALA and similar laws that require hospitals to provide emergency care, as well as legal and ethical obligations of health care institutions and professionals.

If the Department goes forward with the Proposed Rule, it must revise the Rule to conform to the limitations in the Coats Amendment.

* * *

For all of these reasons, the Department should withdraw the Proposed Rule. At a minimum, it must modify the Proposed Rule in accordance with these comments.

Sincerely,



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