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

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) (state

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. . . .
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> 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 woc-.0023 Tw .0haonsidered prgnaent, the scietrifie)]TJ-20.02

uterus. See, e.g., F.G. CUNNINGHAM ET AL.,

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 Departme

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 trere irif

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).

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 tereeds,xt4(reer)]fete. e(dTj-19.0001 duTc-.ov)Tj160

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.

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).

- 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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