

March 27, 2018

The Honorable Alex M. Azar, II  
Secretary  
U.S. Department of Health & Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Protecting Statutory Conscience Rights in Health Care; Delegations of Authority (RIN 0945-ZA03), 83 Fed. Reg. 3880 (January 26, 2018)

Dear Secretary Azar:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments to the Department of Health and Human Services (HHS) in response to the Notice of Proposed Rulemaking (Proposed Rule or Proposal) on “Protecting Statutory Conscience Rights in Health Care; Delegations of Authority,” issued by the Office of Civil Rights (OCR). In its Proposed Rule, OCR proposes to revise existing regulations and create new regulations to interpret and enforce more than 20 federal statutory provisions related to conscience and religious freedom. Under OCR’s broad interpretation of these provisions, individuals, health care organizations, and other entities would be allowed to refuse to provide or participate in medical treatment, services, information, and referrals to which they have religious or moral objections. This would include services related to abortion, contraception (including sterilization), vaccination, end-of-life care, mental health, and global health support, and could include health care services provided to patients who are lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ).

For the reasons discussed below, the AMA believes the Proposed Rule would undermine patients’ access to medical care and information, impose barriers to physicians’ and health care institutions’ ability to provide treatment, impede advances in biomedical research, and create confusion and uncertainty among physicians, other health care professionals, and health care institutions about their legal and ethical obligations to treat patients. We are very concerned that the Proposed Rule would legitimize discrimination against vulnerable patients and in fact create a right to refuse to provide certain treatments or services. Given our concerns, we urge HHS to withdraw this Proposal.

The AMA supports conscience protections for physicians and other health professional personnel. We believe that no physician or other professional personnel should be required to perform an act that violates good medical judgment, and no physician, hospital, or hospital personnel should be required to perform any act that violates personally held moral principles. As moral agents in their own right, physicians are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. According to the [AMA Code of Medical Ethics](#), “physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.”

Conscience protections for medical students and residents are also warranted. The AMA supports educating medical students, residents, and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal, and psychological principles associated with termination of pregnancy, while maintaining that the observation of, attendance at, or any direct or indirect participation in abortion should not be required.

Nonetheless, while we support the legitimate conscience rights of individual health care professionals, the exercise of these rights must be balanced against the fundamental obligations of the medical profession and physicians' paramount responsibility and commitment to serving the needs of their patients. As advocates for our patients, we strongly support patients' access to comprehensive reproductive health care and freedom of communication between physicians and their patients, and oppose government interference in the practice of medicine or the use of health care funding mechanisms to deny established and accepted medical care to any segment of the population.

According to the AMA *Code of Medical Ethics*, physicians' freedom to act according to conscience is not unlimited. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician. The Code provides guidance to physicians in assessing how and when to act according to the dictates of their conscience. Of key relevance to the Proposed Rule, the *Code* directs physicians to:

- Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- Be mindful of the burden their actions may place on fellow professionals.
- Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
- Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

The ethical responsibilities of physicians are also reflected in the AMA's long-standing policy protecting access to care, especially for vulnerable and underserved populations, and our anti-discrimination policy, which opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age. We are concerned that the Proposed Rule, by attempting to allow individuals and health care entities who receive federal funding to refuse to provide *any* part of a health service or program based on religious beliefs or moral convictions, will allow discrimination against patients, exacerbate health inequities, and undermine patients' access to care.

We would like to note that no statutory provision requires the promulgation of rules to implement various conscience laws that have been in existence for years. We believe physicians are aware of their legal obligations under these requirements and do not think that the promulgation of this rule is necessary to enforce the conscience provisions under existing law. OCR has failed to provide adequate reasons or a satisfactory explanation for the Proposed Rule as required under the Administrative Procedure Act (APA). As OCR itself acknowledges, between 2008 and November 2016, OCR received 10 complaints alleging violations of federal conscience laws; OCR received an additional 34 similar complaints between November 2016 and January 2018. In comparison, during a similar time period, from fall 2016 to fall 2017, OCR received over 30,000 complaints alleging violations of either HIPAA or civil rights. These numbers demonstrate that the Proposed Rule to enhance enforcement authority over conscience laws is not necessary.

OCR's stated purpose in revising existing regulations is to ensure that persons or entities are not subjected to certain practices or policies that violate conscience, coerce, or discriminate, in violation of federal laws. We believe that several provisions and definitions in the Proposed Rule go beyond this stated purpose and are ambiguous, overly broad, and could lead to differing interpretations, causing unnecessary confusion among health care institutions and professionals, thereby potentially impeding patients' access to needed health care services and information. The Proposed Rule attempts to expand existing refusal of care/right of conscience laws—which already are used to deny patients the care they need—in numerous ways that are directly contrary to the stated purpose of the existing laws. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in “any lawful health services or research activity” based on religious beliefs or moral convictions specifically related to the service or research activity to which they object. But the Proposed Rule attempts to broaden this provision to allow individuals to refuse to perform aspects of their jobs based on a mere reference to a religious or moral belief regardless of whether it relates to the specific biomedical or behavioral service or research activity they are working on. Such an attempted expansion goes beyond what the statute enacted by Congress allows.

We are concerned that the scope of the services and programs that would be covered under the Proposed Rule is broader than allowed by existing law. While OCR claims that it is trying to clarify key terms in existing statutes, it appears that they are actually redefining many terms to expand the meaning and reach of these laws. For example, “health program or activity” is defined in the proposed regulatory text to include “the provision or administration of any health-related services, health service programs and research activities, health-related insurance coverage, health studies, or any other service related to health or wellness whether directly, through payments, grants, contracts, or other instruments, through insurance, or otherwise.” Likewise, “health service program” is defined in the proposed regulatory text to include “any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by [HHS].” These definitions make clear that OCR intends to interpret these terms to include an activity related in any way to providing medicine, health care, or any other service related to health or wellness, including programs where HHS provides care directly, grant programs such as Title X, programs such as Medicare where HHS provides reimbursement, and health insurance programs where federal funds are used to provide access to health coverage, such as Medicaid and CHIP. The definitions inappropriately expand the scope of the conscience provisions to include virtually any medical treatment or service, biomedical and behavioral research, and health insurance.

Furthermore, the Proposed Rule's new and expanded definitions often exceed, or are not in accordance with, existing definitions contained within the existing laws OCR seeks to enforce. For example, "health care entity" is defined under the Coats and Weldon Amendments to include a limited and specific range of individuals and entities involved in the delivery of health care. However, the Proposed Rule attempts to combine separate definitions of "health care entity" found in different statutes and applicable in different circumstances into one broad term by including a wide range of individuals, e.g., not just health care professionals, but any personnel, and institutions, including not only health care facilities and insurance plans, but also plan sponsors and state and local governments. This impermissibly expands statutory definitions and will create confusion.

We are also concerned that the proposed rule expands the range of health care institutions and individuals who may refuse to provide services, and broadens the scope of what qualifies as a refusal under the applicable law beyond the actual provision of health care services to information and counseling about health services, as well as referrals. For example, "assist in the performance" is defined as "participating in any program or activity with an articulable connection to a given procedure or service." The definition also states that it includes "counseling, referral, training, and other arrangements for the procedure, health service, or research activity." While "articulable connection" is not further explained, OCR states in the preamble that it seeks to provide broad protection for individuals and that a narrower definition, such as a definition restricted to those activities that constitute direct involvement with a procedure, health service, or research activity, would not provide sufficient protection as intended by Congress.

However, this definition goes well beyond what was intended by Congress. Specifically, the Church Amendments prohibit federal funding recipients from discriminating against those who refuse to perform, or "assist in the performance" of, sterilizations or abortions on the basis of religious or moral objections, as well as those who choose to provide abortion or sterilization. The statute does not contain a definition for the phrase "assist in the performance." Senator Church, [during debate](#) on the legislation, stated that, "the amendment is meant to give protection to the physicians, to the nurses, to the hospitals themselves, if they are religious affiliated institutions. There is no intention here to permit a frivolous objection from someone unconnected with the procedure to be the basis for a refusal to perform what would otherwise be a legal operation." Read in conjunction with the rest of the proposed rule, it is clear this definition is intended to broaden the amendment's scope far beyond what was envisioned when the amendment was enacted. It allows any entity involved in a patient's care—from a hospital board of directors to the receptionist that schedules procedures—to use their personal beliefs to determine a patient's access to care.

In a similar fashion, the proposed definition of "workforce" extends the right to refuse not only to an entity's employees but also to volunteers and trainees. When both of these definitions are viewed together, this language seems to go well beyond those who perform or participate in a particular service to permit, for example, receptionists or schedulers to refuse to schedule or refer patients for medically necessary services or to provide patients with factual information, financing information, and options for medical treatment. It could also mean that individuals who clean or maintain equipment or rooms used in procedures to which they object would have a new right of refusal and would have to be accommodated. We believe this could significantly impact the smooth flow of health care operations for physicians, hospitals, and other health care institutions and could be unworkable in many circumstances.

The AMA is concerned that the Proposed Rule fails to address the interaction with existing federal and state laws that apply to similar issues, and thus is likely to create uncertainty and confusion about the rights and obligations of physicians, other health care providers, and health care institutions. Most notably, the Proposal is silent on the interplay with Title VII of the Civil Rights Act of 1964 and guidance by the Equal Employment Opportunity Commission, which along with state laws govern religious discrimination in the workplace. Title VII provides an important balance between employers' need to accommodate their employees' religious beliefs and practices—including their refusal to participate in specific health care activities to which they have religious objections—with the needs of the people the employer must serve. Under Title VII, employers have a duty to reasonably accommodate an employee or applicant's religious beliefs or practices, unless doing so places an "undue hardship" on the employer's business. It is unclear under the Proposed Rule if, for example, hospitals would be able to argue that an accommodation to an employee is an undue hardship in providing care. The Proposed Rule also could put hospitals, physician practices, and other health care entities in the impossible position of being forced to hire individuals who intend to refuse to perform essential elements of a job. Under Title VII, such an accommodation most likely would not be required.

Additional concerns exist for physicians with respect to their workforce under this Proposal. The Proposed Rule is unclear about what a physician employer's rights are in the event that an employee alleges discrimination based on moral or religious views when in fact there may be just cause for adverse employment decisions. For example, if a physician declines to hire an individual based on a lack of necessary skill, compensation and/or benefit requests out of the physician's budget, or simply because the individual is not a good fit in the office, but the individual also happens to be opposed to providing care to LGBTQ patients, does the physician open him/herself up to risk of a complaint to OCR? If so, physicians will be forced to substantially increase their documentation related to hiring and other decision-making related to human resources, adding administrative burden to already overworked practices. These considerations must not be overlooked by regulators, as OCR's enforcement mechanisms include the power to terminate federal funding for the practice or health care program implicated.

Adding to a practice's administrative burden is the Proposal's requirement that physicians submit both an assurance and certification of compliance requirements to OCR. Despite its reasoning in the preamble that HHS is "concerned that there is a lack of knowledge" about federal health care conscience and associated anti-discrimination laws, it remains unclear why OCR would require physicians to make two separate attestations of compliance to the same requirements, particularly given the administration's emphasis on reducing administrative burden in virtually every other space in health care. At the very least, OCR should (1) streamline the certification and assurance requirements with those already required on the HHS portal; and (2) expand the current exemptions from such requirements to include physicians participating not only in Medicare Part B, but also in Medicare Part C and Medicaid, as was the case in the 2008 regulation implementing various conscience laws. We reiterate, however, that we believe the overall compliance attestation requirements are unnecessary. If HHS' concern is about lack of awareness of the conscience laws, the AMA stands ready to assist with the agency's educational efforts in place of increased administrative requirements.

The Proposed Rule also seems to set up a conflict between conscience rights and federal, state, and local anti-discrimination laws, as well as policies adopted by employers and other entities and ethical codes of conduct for physicians and other health professionals. These laws, policies, and ethical codes are designed to protect individuals and patients against discrimination on the basis of race, gender, gender

identity, sexual orientation, disability, immigration status, religion, and national origin. It is unclear under the Proposed Rule how these important anti-discrimination laws, policies, and ethical codes will apply in the context of the expanded conscience rights proposed by OCR. The Proposed Rule also fails to account for those providers that have strongly held moral beliefs that motivate them to treat and provide health care to patients, especially abortion, end-of-life care, and transition-related care. For example, the Church Amendment affirmatively protects health care professionals who support or participate in abortion or sterilization services yet there is no acknowledgement of it in the Proposal.

Moreover, the Proposed Rule appears to conflict with, and in fact contradict, OCR's own [mission](#), which states that "The mission of the Office for Civil Rights is to improve the health and well-being of people across the nation; *to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination*; and to protect the privacy and security of health information in accordance with applicable law" (emphasis added). In the past, HHS and OCR have played an important role in protecting patient access to care, reducing and eliminating health disparities, and fighting discrimination. There is still much more work to be done in these areas given disparities in racial and gender health outcomes and high rates of discrimination in health care experienced by LGBTQ patients. The Proposed Rule is a step in the wrong direction and will harm patients.

Likewise, the Proposed Rule does not address how conscience rights of individuals and institutions apply when emergency health situations arise. For example, the federal Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals that have a Medicare provider agreement and an emergency room or department to provide an appropriate medical screening to any patient requesting treatment to determine whether an emergency medical condition exists, and to either stabilize the condition or transfer the patient if medically indicated to another facility. Every hospital, including those that are religiously affiliated, is required to comply with EMTALA. By failing to address EMTALA, the Proposed Rule might be interpreted to mean that federal refusal laws are not limited by state or federal legal requirements related to emergency care. This could result in danger to patients' health, particularly in emergencies involving miscarriage management or abortion, or for transgender patients recovering from transition surgery who might have complications, such as infections.

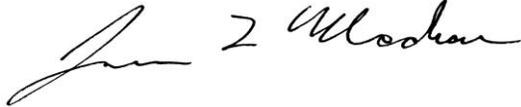
We are also concerned that the Proposed Rule could interfere with numerous existing state laws that protect women's access to comprehensive reproductive health care and other services. For example, the Proposed Rule specifically targets state laws that require many health insurance plans to cover abortion care (e.g., California, New York, and Oregon). OCR overturns previous guidance that was issued by the Obama administration providing that employers sponsoring health insurance plans for their employees were not health care entities with conscience rights; OCR argues that the previous guidance misinterpreted federal law, and, as discussed previously, proposes to add plan sponsors to the definition of health care entities. Likewise, the Proposed Rule could conflict with, and undermine, state laws related to contraceptive coverage. In addition, the Proposed Rule requires entities to certify in writing that they will comply with applicable Federal health care conscience and associated anti-discrimination laws. Under the broad language of the rule, hospitals, insurers, and pharmacies could claim they are being discriminated against if states attempt to enforce laws that require insurance plans that cover other prescription drugs to cover birth control, ensure rape victims get timely access to and information about emergency contraception, ensure that pharmacies provide timely access to birth control, and ensure that

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hospital mergers and sales do not deprive patients of needed reproductive health services and other health care services.

In conclusion, the AMA believes that, as currently drafted, the Proposed Rule could seriously undermine patients' access to necessary health services and information, negatively impact federally-funded biomedical research activities, and create confusion and uncertainty among physicians, other health care professionals, and health care institutions about their legal and ethical obligations to treat patients. Given our concerns, we urge HHS to withdraw this proposed rule. If HHS does decide to move forward with a final rule, it should, at the very least, reconcile the rule with existing laws and modify the provisions we have identified to ensure that physicians and other health providers understand their legal rights and obligations.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive, flowing style.

James L. Madara, MD