Office of the General Counsel
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September 12, 2008

Office of Public Health and Science
Department of Health and Human Services
Attention: Brenda Destro
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 728E
Washington, DC 20201

Subj: Provider Conscience Regulation

Dear Ms. Destro:

On behalf of the United States Conference of Catholic Bishops ("Conference" or "USCCB"), we offer the following comments on the proposed rule to protect the conscience rights of health care professionals and institutions. 73 Fed. Reg. 50274 (Aug. 26, 2008).

Interest of the United States Conference of Catholic Bishops

The Conference is a nonprofit corporation organized under the laws of the District of Columbia. All active Catholic bishops in the United States are members of the Conference. The Catholic Church, the largest religious denomination in the United States, has over 67 million adherents in over 18,000 parishes throughout the country. The Conference advocates and promotes the pastoral teaching of the bishops in such diverse areas as education, family, health care, social welfare, immigration, civil rights, the economy, and respect for human life at its most vulnerable stages. The Conference participates in rulemaking proceedings of importance to the Catholic Church and its people and institutions in the United States.

Religious freedom and the right of conscience are among the values the Catholic Church seeks to promote and protect. As the Pontifical Council for Justice and Peace has said: "Unjust laws pose dramatic problems of conscience for morally upright people: *when they are called to cooperate in morally evil acts they must refuse*. Besides being a moral duty, such a refusal is also a basic human right which, precisely as such, civil law itself is obliged to recognize and protect. 'Those who have recourse to conscientious objection must be protected not only from legal penalties but also from any negative effects on the legal, disciplinary, financial and professional plane.'"[1] Protection of this

[1] *Compendium of the Social Doctrine of the Church* (2005), no. 399, citing Pope John Paul II, *Evangelium vitae* (1995), no. 73. Cf. *Catechism of the Catholic Church* (2d ed., 2000), no. 2242.

basic right of conscience takes on even greater urgency when members of the healing professions are subjected to pressure, or risk being pressured, to participate in the taking of innocent human life, conduct which is directly inimical to the role and function of medicine. Individuals and institutions committed to healing should not be required to take the very human life that they are dedicated to protecting.

In light of these important considerations, we offer the following comments in strong support of the proposed rule.

Comments

1. In the Present Environment, the Proposed Regulations are Critical.

We strongly commend the Secretary for publishing these proposed regulations. For over three decades, through enactments such as the Church Amendment (42 U.S.C. § 300a-7), Congress has sought to ensure that health care institutions and professionals will not have to choose between abandoning medicine and violating their conscience, particularly with respect to abortion and sterilization. The proposed regulations would implement these longstanding federal statutory protections, and thus help guarantee that health care institutions and professionals are not pushed into this Hobson's choice.

Negative public reaction to an earlier leaked version of the regulations by pro-abortion groups and some editorial writers attests to their need. The adverse reaction demonstrates, at best, a deplorable lack of understanding about the federal legislative rights of conscience on which the proposed regulations are based, at worst outright hostility to those statutory rights. Judging from much of the public commentary, one would think that rights of conscience in health care are a recent invention, and that the statutes implemented through this rule simply did not exist. The regulations are therefore all the more critical to ensure that Congress's intent will be carried out.

That there is a need for regulatory enforcement is also demonstrated by growing hostility on the part of some professional organizations and advocacy groups to rights of conscience in health care. The following examples are illustrative:

- In November 2007, the American College of Obstetricians and Gynecologists issued an opinion (Committee Opinion No. 385) asserting that it is unethical for obstetricians-gynecologists to decline to provide or refer for abortion or sterilization.

- The American Civil Liberties Union has developed a report and advocacy kit aimed at requiring all hospitals, including those with a conscientious objection, to provide abortions. The report argues that the "law should not

permit an institution's religious strictures to interfere with the public's access to reproductive health care."[2]

•NARAL Pro-Choice America claims that conscience clauses, which it and other advocacy groups pejoratively label "refusal clauses," are "dangerous for women's health."[3]

•Physicians for Reproductive Choice and Health claims that "the right of the patient to timely and comprehensive reproductive healthcare must *always* prevail" over a health care provider's rights of conscience, and that "[s]everal other leading national medical and public health associations hold similar beliefs."[4]

Hostility to conscience rights is not confined to professional organizations and advocacy groups. State and local governments have exerted pressure upon health care professionals and institutions to provide abortions and other services in the face of conscientious objections. In recent litigation on the Weldon Amendment, ultimately dismissed on procedural grounds, the Attorney General of California claimed that hospitals in some circumstances had a duty under state law to provide abortions. *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840 (N.D. Cal. March 18, 2008). In 2003, two bills were introduced in the New York legislature (A. 4945 & S. 4031) to allow the state health commissioner in licensing decisions to discriminate against hospitals that do not participate in abortions. In 1999, a bill was introduced in California (AB 525) to strip hospitals that decline to participate in abortion from receiving public financing or state-funded health care contracts.

In the face of such undisguised hostility to conscience rights, we commend the Secretary for his proposal to provide regulatory enforcement of existing federal statutes protecting conscience.

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[2] American Civil Liberties Union Reproductive Freedom Project, "Religious Refusals and Reproductive Rights," p. 9 (2002), at www.aclu.org/reproductiverights/religion/12679pub20020122.html (visited Sept. 9, 2008). *See* Maureen Kramlich, "The Abortion Debate Thirty Years Later: From Choice to Coercion," 31 Fordham Urban L. J. 783, 787 (March 2004) (discussing the ACLU report and related threats to conscience rights with regard to abortion).

[3] NARAL Pro-Choice America, "Refusal Clauses: Dangerous for Women's Health", stating (p. 6) that failure to provide abortions, sterilizations, and other procedures, "even for religious reasons," is "wrong and may jeopardize patient health."

[4] Physicians for Reproductive Choice: "Church and Medicine: Medical and Public Health Associations on Refusal Clauses" (emphasis added), at http://www.prch.org/content/index.php?pid=129 (visited Sept. 10, 2008), with links to similar statements by other organizations.

2. The Regulations Should Define Abortion to Include Any Procedure that the Objector Reasonably Believes May Take the Life of a Human Being *in Utero* At Any Time Between Conception and Birth.

We believe the regulations would be strengthened by defining abortion to mean any drug, procedure, or other act that the objector reasonably believes may take the life of a human being *in utero* at any time between conception (fertilization) and natural birth.

As stated in the preamble, the regulations are intended to give broad protection to the conscience of institutional and individual health care providers. The protections they provide therefore should not become ineffective when the abortifacient procedure at issue operates before implantation. Abortion, as defined by the American Medical Association, is the "voluntary termination of a pregnancy."[5] A pregnancy, in turn, is the "process of carrying a developing embryo or fetus in the uterus *from conception on.*"[6] "Conception" is defined as the "fertilization of an egg by a sperm that initiates pregnancy."[7] Based on these definitions, many health care providers reasonably understand abortion to mean the destruction of an embryo *in utero*, whether *before or after* implantation.[8]

The Catholic Church, which sponsors the largest system of nonprofit health care in the nation, sees abortion in precisely this light. Catholic moral teaching rejects the deliberate destruction of a member of the human species at any stage after fertilization:

> Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, *which, in its moral context, includes the interval between conception and implantation of the embryo.* Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation.[9]

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[5] AMA COMPLETE MEDICAL ENCYCLOPEDIA 99 (2003).

[6] *Id.* at 1011 (emphasis added).

[7] *Id.* at 392.

[8] For additional arguments and authority on these points, see the comments on the proposed regulations submitted by the Thomas More Society (comment number 806f9634). See also USCCB Secretariat for Pro-Life Activities, "What is an Embryo?", available at www.usccb.org/prolife/issues/bioethic/fact298.shtml (citing contemporary textbooks on embryology and additional authority).

[9] ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (USCCB 2001), no. 45. These directives provide a national policy for Catholic health care facilities.

Catholic teaching does not state which drugs or devices, if any, act by directly interfering with implantation. That is a scientific question on which there may be conflicting and changing evidence. But it is important to defend the principle that conscientious objection to abortion should be protected at every stage, especially as new drugs or devices may emerge in the future that clearly would act chiefly by disrupting implantation and therefore pose a very direct new challenge to consciences.

For these reasons, we believe the regulations should be modified to define abortion as any procedure, drug, or other act which the objector reasonably believes may result in the embryo's destruction *in utero*.

3. We Recommend Some Technical Corrections.

We suggest the following technical corrections. Suggested wording changes are indicated in italics.

•Section 88.4(a)(2) should be amended to provide that entities to which that subsection applies shall not "subject any institutional or individual health care entity to discrimination for attending or having attended a post-graduate physician training program, or any other program of training in the health professions, that does not or did not *perform induced abortions, or* require attendees to perform induced abortions or require, provide, or refer for training in the performance of induced abortions, or make arrangements for the provision of such training...." Adding the italicized language would ensure that this particular provision more closely tracks the statute (42 U.S.C. 238n(a)(3)) on which it is based. The italicized language is important because there is a distinction between a health care entity that does not permit the performance of induced abortion in its program and facilities, and a health care entity that does not require attendees to perform abortions. Section 238n(a)(3) protects both entities by ensuring that those who attend them will not be subjected to discrimination.

•Section 88.4(d)(1) should be amended to provide that entities to which that subsection applies shall not "require any individual to perform or assist in the performance of any part of a health service program or research activity funded *in whole or in part* by the Department if *his performance or assistance in the performance of* such service or activity would be contrary to his religious beliefs or moral convictions." Adding the italicized language would ensure that this particular provision better tracks the statute (42 U.S.C. 300a-7(d)) on which it is based, and is consistent with the way in which subsequent subsections (see sections 88.4(d)(2) and (e)) are structured. The phrase "in whole or in part" is particularly important

because any amount of funding triggers the protection, and this will be made clear by incorporating the italicized language.

•The proposed section 88.3(a) provides that "[t]he Department of Health and Human Services is required to comply with section 88.4(a), (b)(1), and (d)(1)...." Section 88.3(a) should be amended by adding section 88.4(e) to the list of provisions with which HHS is required to comply. Section 88.4(e) implements 42 U.S.C. § 300a-7(b), which applies to "any court or any public official or other public authority." Consistent with section 300a-7(b), the proposed Section 88.3(e) states that "any ... public entity must comply with section 88.4(e)." Because they are public authorities or entities, HHS and all other federal agencies and officials are bound by section 300a-7(b), and therefore should be bound by section 88.4(e).

•The proposed regulation, by an apparent omission, currently does not specify what sort of entity Section 88.4(c) applies to. The final regulation should correct the omission by stating what sort of entity section 88.4(c) applies to.

Conclusion

We commend the Secretary for promulgating the proposed regulations. It is critically important, as the Secretary has recognized, that statutory rights of conscience be enforced. To ensure broad protection for conscience, we request that "abortion" be defined to include any drug, procedure, or other act that the objector reasonably believes may result in the destruction of the embryo *in utero* at any time between conception and natural birth. Finally, we request the adoption of the technical changes discussed above.

Thank you for the opportunity to comment.

Sincerely,

Anthony R. Picarello
General Counsel

Michael F. Moses
Associate General Counsel