

## Proposed ‘Conscience’ Regulation Opposed Widely as Threat to Reproductive Health and Beyond

The Bush administration has formally proposed a new federal regulation on the topic of providers’ “conscience” rights that has the potential to seriously undermine the U.S. health care system and impede access to services and information. The August 26 action came after a month of controversy over a draft leaked in mid-July—controversy that, by the end of the public comment period on September 25, reportedly generated over 200,000 letters in opposition from a long list of medical associations, advocacy groups, policymakers and other individuals and groups (see box, page 18), along with an unknown number of letters in support.

According to the proposed regulation, the Department of Health and Human Services (DHHS) believes there is widespread ignorance of three long-standing federal laws that allow individuals and institutions to refuse to provide certain services, explicitly abortions and sterilizations, to which they object on religious or moral grounds. The stated purpose of the regulation, in response, is to clarify, raise awareness of and require certification of compliance with these laws, but in “clarifying” them, opponents argue, the administration is redefining key terms and expanding the laws’ reach.

### Obstructing Access to Care

When the draft regulation was originally leaked in July, reproductive health providers and advocates were alarmed by how the underlying laws were being interpreted to challenge

limited but important federal and state safeguards related to abortion. This interpretation, intact in the regulation as formally proposed, implicitly undermines standing requirements that Title X–supported family planning centers provide nondirective counseling on all of a pregnant woman’s options, including abortion, and referral upon request; that state Medicaid programs fund abortions in cases of life endangerment, rape and incest; and that hospitals provide emergency care, including care that would result in abortion. Predictably, the regulation’s supporters endorse such an interpretation: Indeed, the Family Research Council (FRC) and Concerned Women for America (CWA), along with other allied groups, have called for the regulation to *explicitly* state that the Title X requirement is illegal, and the United States Conference of Catholic Bishops (USCCB) cited requirements to provide emergency abortions as evidence of “hostility to conscience rights.”

Yet, most of the initial outcry stemmed from the regulation’s potential impact on access to contraceptive services. The July draft defined the term “abortion” to include any action that prevents the implantation of a fertilized egg, effectively including the birth control pill, other hormonal contraceptives and the intrauterine device. (Although preventing implantation is not their primary mode of action, these methods may sometimes act post-fertilization.) Defining abortion in this manner would have been con-

trary to long-standing federal precedent and the consensus of the mainstream medical community as to when pregnancy begins and what constitutes its prevention, rather than its termination (related article, May 2005, page 7).

In his official blog on August 7, DHHS Secretary Michael Leavitt denied that his intent was to define contraceptives as abortion. Yet, the regulation as formally proposed does not correct the problem; instead, it sidesteps the issue by including no definition of the term abortion at all. This ambiguity leaves a door open for antiabortion, anti-family planning advocates who conflate most modern contraceptives with abortion. Leavitt himself has acknowledged that such conflation, and concomitant efforts to expand refusal rights to the provision of contraceptives, will continue. Indeed, several major groups, including FRC, CWA, USCCB and the National Catholic Bioethics Center (NCBC), devoted large sections of their comment letters to calling for reinstatement of an expansive definition of abortion, or one explicitly deferring to individual belief.

Conflating contraception with abortion could have far-reaching consequences. In describing the purported problems to be solved by the regulation, the July draft pointed to dozens of state policies mandating that insurance plans cover prescription contraceptive drugs and devices if they cover other prescription drugs; requiring emergency rooms to pro-

## Organizations Opposed to the Regulation

Although a full accounting of the comments offered on this regulation may be weeks or months away, initial reports indicate that a broad range of organizations and individuals submitted letters strongly opposing the rule (among them the Guttmacher Institute). They include:

- dozens of medical professional associations, such as the American Medical Association (along with at least 27 state medical societies), the American Nurses Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics and the American Psychiatric Association;
- civil and human rights groups, such as the American Civil Liberties Union, Human Rights Campaign and Human Rights Watch;
- associations of state health officials, such as the Association of Maternal and Child Health Programs, the National Alliance of State and Territorial AIDS Directors and the National Association of County and City Health Officials;

- international assistance and advocacy groups, such as the Elizabeth Glaser Pediatric AIDS Foundation, Population Services International, the International Women's Health Coalition and the Global AIDS Alliance (DHHS provides substantial funding for global AIDS programs);
- religious groups, such as the Unitarian Universalist Association of Congregations and the United Methodist Church;
- state officials, including at least 14 state attorneys general and seven governors;
- roughly 150 members of Congress, including Sens. Barack Obama (D-IL) and Joe Biden (D-DE);
- other federal agencies, including the Equal Employment Opportunity Commission; and
- every major national reproductive health or woman's advocacy group in the country.

vide information about and access to emergency contraceptives for victims of sexual assault; requiring pharmacies to ensure customers' access to lawfully prescribed drugs, including contraceptives; and allowing officials to intervene in hospital mergers to ensure communities' continued access to their current range of health care services. These supposed problems are not mentioned in the introduced version of the regulation; nevertheless, the policies at issue may be undermined by insurers, hospitals, pharmacies and other health care institutions that choose to define contraceptives as abortifac-

ients. (Indeed, Karen Brauer, president of Pharmacists for Life, was quoted in *The Wall Street Journal* as saying that "it would be pretty excellent" if states were to lose federal funding over their pharmacy access policies, and NCBC attached to its comment letter a table summarizing these state laws as evidence of the need for the regulation.) Similarly, the regulation could undermine federal requirements under Title X, Medicaid and the community health centers program intended to guarantee clients' access to family planning services.

## 'Clarifying' or 'Expanding'?

Although the controversy over contraception garnered most of the headlines, other concerns about the proposed regulation generated equally strong opposition but little or no acknowledgment by supporters of the regulation. For example, many organizations, led by the American Medical Association, the American College of Obstetricians and Gynecologists and the country's other major medical associations, highlighted the possibility that the regulation could undermine the principle of informed consent throughout the U.S. health care system. They pointed to DHHS' overly broad definition of what it means to "assist" in a given procedure, a definition that explicitly includes counseling and, implicitly, the provision of even basic, factual information. Under this definition, individuals could justify their refusal to provide information or counseling about any service they find objectionable, from vaccination to blood transfusion to end-of-life pain management. Alternatively, they might refuse to provide information about specific services to specific patients—information about Pap tests or cervical cancer to women they believe should be abstinent, or about assisted reproductive technologies to lesbians.

The regulation also uses expansive definitions of key terms to extend a right to refuse to employees only tangentially related to the provision of health care or the conduct of research. By so doing, it would grant refusal rights, for example, to staff members tasked with scheduling appointments, completing and filing insurance forms, or cleaning surgical instruments. Because the regulation places no conditions on these refusal rights, family planning programs

could be forced to hire employees unwilling to schedule appointments for contraception, and pharmacies could be forced to hire clerks refusing to ring up purchases for AIDS medication. Further, health care entities could be hindered in their efforts to comply with federal and state antidiscrimination laws.

Similarly extreme scenarios could affect research institutions. Research laboratories could be forced to hire staff members who refuse to support research involving not only reproductive health, but also animal testing, vaccination, protection from biological weapons or anything else to which some Americans may object. In fact, the regulation appears to apply the laws even to DHHS-funded economic and social science research, including program evaluations, economic projections and infrastructure assessments.

Finally, the regulation's requirements could be attached to international, foreign and multilateral organizations. This would generate conflict with policies promulgated by other federal agencies and create a severe compliance burden on organizations that work with local subgrantees in other countries, and it could directly conflict with the laws and policies of other countries.

### **Tipping the Scales**

These scenarios stem from the fact that in the regulation as proposed, DHHS has failed to even hint at any ethical or legal limits of conscientious refusal. This absolutist standpoint—also held by many of the regulation's supporters outside of DHHS—runs contrary to the ethical standards promulgated by numerous U.S. and international health professional associations, which also take

into account providers' obligations to their patients' health, well-being and autonomy (related article, August 2005, page 7).

Although not always spelled out in one place, these standards promote a balancing of rights and responsibilities that leads to several clear obligations: Health care professionals must provide all patients with accurate and unbiased information, prior notice of professionals' objections and timely referral in cases of refusal, and medically indicated care in an emergency. More generally, the right to withdraw from services cannot— from an ethical standpoint, even if it is allowed by law—be used as a pretext for blocking or denying patients' access to care. Groups like Pharmacists for Life and the American Association of Pro-Life Obstetricians and Gynecologists exist in large part to dispute these principles, as they have in supporting the regulation.

The regulation also contradicts an extensive body of laws, regulations and court precedent—most importantly, Title VII of the Civil Rights Act—which carefully balances employees' rights to be free from religious discrimination in the workplace with the legitimate needs of employers, including their ability to serve their clients. Numerous organizations—including the Equal Employment Opportunity Commission (EEOC), which implements Title VII—objected to this regulation specifically because it fails to acknowledge this body of policy and precedent, and the measured balance included therein. EEOC Commissioners Stuart J. Ishimaru and Christine M. Griffin asserted that, "The issuance of the proposed regulations would throw this entire body of law into question,

resulting in needless confusion and litigation.... In the healthcare context, the balancing of interests that characterizes the Title VII analysis is particularly essential, because of the need to ensure the continuity of medical care for citizens without unnecessary and potentially life-threatening denials or delays."

### **An Unclear Future**

Despite its potentially sweeping impact on health care policy and practice, DHHS has provided no evidence that the regulation is necessary or justified. The only example offered of any tangible problem has been a repeatedly discredited DHHS charge that physicians were being forced to provide referrals for abortion in order to be certified by the American Board of Obstetrics and Gynecology (related article, Spring 2008, page 2). In truth, DHHS appears to be using the public comment process itself as a means of gathering information to justify its actions retroactively.

The timeframe to finalize the regulation is uncertain. Federal law requires that DHHS review and address all comments, a daunting process if taken seriously, considering the reported volume of response. Secretary Leavitt has made no promises—except that the regulation will be finalized before he leaves office.—*Adam Sonfield*