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Via Electronic Submission

Office of Public Health & Science
Department of Health & Human Services
Att'n: Rescission Proposal Comments
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 716G
Washington, DC 20201

**Re: Proposed Rescission of Provider Conscience Rule
74 Fed. Reg. 10,207 (Mar. 10, 2009)**

Dear Office of Public Health and Science:

On behalf of the American Association of Pro-Life Obstetricians and Gynecologists (“AAPLOG”), this responds to the above-captioned notice of proposed rulemaking (“NPRM”) in which the Department of Health & Human Services (“HHS”) proposed to rescind the “Provider Conscience Rule,” 45 C.F.R. pt. 88, that HHS issued to implement the rights of conscience protected by the Church, Coats, and Weldon Amendments. 42 U.S.C. §§300a-7, 238n; Pub. L. No. 110-161, §508(d), 121 Stat. 1844, 2209 (2008). As indicated under the signature block below, six additional groups have joined these comments. When the new HHS administration has reviewed the record on the Provider Conscience Rule, AAPLOG and the groups joining these comments are confident that HHS will recognize that the rule requires HHS’s ongoing implementation and vigorous enforcement.

Consistent with their Hippocratic Oath to do no harm and not to provide abortions, AAPLOG members are physicians who oppose elective abortions for two interrelated reasons, which follow from their medical training and ethics and from their individual consciences. First, as physicians, AAPLOG members are responsible to their female patients and their unborn children. Although proponents portray elective abortion as a liberating right and good medicine, AAPLOG and the groups joining these comments submit that elective abortions can have serious adverse long-term health effects on the women who undergo those abortions. Second, not only as individuals of faith or conscience but also as physicians, AAPLOG members oppose the unjustified taking of human life by elective abortions.

In joining, members affirm AAPLOG's mission statement:

- That we, as physicians, are responsible for the care and well being of both our pregnant woman patient and her unborn child.
- That the unborn child is a human being from the time of fertilization.
- That elective disruption/abortion of human life at any time from fertilization onward constitutes the willful destruction of an innocent human being, and that this procedure will have no place in our practice of the healing arts.
- That we are committed to educate abortion-vulnerable patients, the general public, pregnancy center counselors, and our medical colleagues regarding the medical and psychological complications associated with induced abortion, as evidenced in the scientific literature.
- That we are deeply concerned about the profound, adverse effects that elective abortion imposes, not just on the women, but also on the entire involved family, and on our society at large.

With at least six hundred (600) dues-paying members and over fifteen hundred (1,500) associated doctors, AAPLOG is one of the largest constituent groups within the American College of Obstetricians and Gynecologists. Like pro-life physicians generally, AAPLOG members overwhelmingly would leave the medical profession – or relocate to a more conscience-friendly jurisdiction – before they would accept coercion to participate or assist in procedures that violate their consciences.

BACKGROUND

Acting quickly after the U.S. District Court for the District of Montana's decision in *Taylor v. St. Vincent's Hospital*, 369 F.Supp. 948 (D. Mont. 1972) (sterilization), as well as the U.S. Supreme Court's decision in *Roe v. Wade*, 410 U.S. 113, *reh'g denied*, 410 U.S. 959 (1973) (abortion), Congress enacted the first Church Amendment to protect the nation's health care providers from having courts or public officials use the receipt of federal funds to coerce participation in abortion and sterilization procedures that violate providers' religious beliefs and moral convictions, as well as to prohibit employment discrimination based on abortion or sterilization. Pub. L. No. 93-45, §401, 87 Stat. 91, 95 (1973). The following year, the second Church Amendment expanded individuals' anti-discrimination rights, primarily against coerced participation in any "health service program" against their religious beliefs or moral convictions. Pub. L. No. 93-348, §214, 88 Stat. 342, 353 (1974). Significantly, that amendment defined "health service program" broadly to include "all programs administered by the Secretary except the Social Security Act." S. REP. NO. 93-381 (1974), reprinted in 1974 U.S.C.C.A.N. 3634,

3677. Finally, in 1979, the third Church Amendment protected applicants and students in certain HHS-funded health education programs. Pub. L. No. 96-76, §208, 93 Stat. 579, 583 (1979).

In 1996, the Accrediting Council on Graduate Medical Education sought to require training in abortion techniques as a condition for accreditation of hospitals and medical residency programs. Senator Dan Coats responded with legislation to prohibit discrimination against a “health care entity” for refusal “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.” Pub. L. No. 104-134, §515(a)(1), 110 Stat. 1321, 1321-245 (1996); 42 U.S.C. §238n(a)(1). The Coats Amendment defines “health care entities” broadly to “include[] an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions.” *Id.* §238n(c)(2) (emphasis added).¹ Because the prohibitions of subsection (a)(1) extend beyond the academic setting (*e.g.*, it prohibits requirements to perform or refer for abortions generally as well as requirements to provide or undergo training in abortions), it is significant that the definition of “health care entity” is not exclusive. Unlike the Church Amendments, however, the Coats Amendment does not require institutions or individuals to rely on moral convictions or religious beliefs as their reason to avoid abortion-related activity. *See* 42 U.S.C. §238n(a)(1). Any subjective reason suffices.

Since 2005, the Weldon Amendment has appeared in the HHS appropriations bill. *See* Pub. L. No. 108-447, § 508(d), 118 Stat. 2809, 3163 (2004); Pub. L. No. 110-161, §508(d), 121 Stat. 1844, 2209 (2008). The Weldon Amendment confirms the broad definition of “health care entities” and prohibits receipt of federal funds by entities that discriminate on the basis of not paying for, referring for, providing, or covering abortions. *Id.* As with the Coats Amendment, the Weldon Amendment’s abortion-related restrictions apply to all abortion-related discrimination, not merely discrimination based on individuals’ or institutions’ religious beliefs or moral convictions. *Id.*

Throughout the history of these related statutes, Congress has responded quickly to instances where courts, public officials, or quasi-public officials have sought to coerce individual and institutional health care providers to engage in activities contrary to religious beliefs or moral convictions. In that context, it is significant that the American College of Obstetrics and Gynecology (“ACOG”) and the American Board of Obstetrics and Gynecology (“ABOG”) took actions that threatened to put obstetricians and gynecologists (“OB/GYNs”) in the position of either engaging in abortion-related activity against their religious beliefs and moral convictions or risking loss of their certification. Specifically, in November 2007, ABOG finalized its annual

¹ Although not relevant here, the Coats Amendment also deems as accredited for federal, state, and local purposes, any “health care entity” that loses its accreditation based solely on its failure to follow an accrediting board’s abortion-related requirements. 42 U.S.C. §238n(b)(1).

bulletin on the maintenance of certification for 2008, which listed “violation of ABOG or ACOG rules and/or ethics principles” as a basis for losing ABOG certification. American Board of Obstetrics & Gynecology, *Bulletin for 2008: Maintenance of Certification*, at 10, ¶5.b (Nov. 2007) (Ex.1). Also in November 2007, ACOG issued an ethics opinion that limits the right of refusal in reproductive medicine. American College of Obstetrics & Gynecology, Committee on Ethics, “*Opinion No. 385: The Limits of Conscientious Refusal in Reproductive Medicine*,” at 3-5 (Nov. 2007) (Ex. 2). Taken together, these two contemporaneous actions threatened conscientious-objector OB/GYNs with losing their ABOG certification for refusing to follow ACOG’s coercion, couched in the form of an ethics opinion.

Because the existing Church, Coats, and Weldon Amendments already provided the necessary statutory protections, but lacked a regulatory enforcement mechanism, HHS proposed and promulgated the Provider Conscience Rule in 2008. 73 Fed. Reg. 50,274 (2008) (proposed rule); 73 Fed. Reg. 78,072 (2008) (final rule). In response both to requests from AAPLOG and to the Provider Conscience Rule, ABOG’s 2009 bulletin removed noncompliance with ACOG ethical standards as a basis for losing ABOG certification in its 2009 bulletin. American Board of Obstetrics & Gynecology, *Bulletin for 2009: Maintenance of Certification*, at 11, ¶6.b (Dec. 2008) (Ex. 3). By contrast, ACOG refused an AAPLOG request to revisit the ethics opinion.

On March 10, 2009, under the new administration, HHS proposed to rescind the Provider Conscience Rule, 74 Fed. Reg. 10,207 (2009), but first sought comments on four questions. The following four sections answer HHS’s questions.

I. WIDESPREAD NONCOMPLIANCE REQUIRES A PROTECTIVE RULE

HHS’s first question seeks information on the scope and nature of the problems giving rise to the need for federal rulemaking and how the current rule would resolve those problems. 74 Fed. Reg. at 10,210. AAPLOG and the groups joining these comments respectfully submit that prejudice against pro-life views pervades various institutions within the field of reproductive medicine. Notwithstanding the enactment of the Church, Coats, and Weldon Amendments, that prejudice and the resulting discrimination demonstrate the need for HHS to maintain and vigorously to enforce the Provider Conscience Rule.

In the prior rulemaking, HHS itself cited “the development of an environment in sectors of the health care field that is intolerant of individual objections to abortion or other individual religious beliefs or moral convictions.” 73 Fed. Reg. at 78,073; *accord id.* at 78,088 (hundreds of comments in prior rulemaking demonstrated lack of awareness of the protections found in the Church, Coats, and Weldon Amendments). An article issued today in a prestigious medical journal demonstrates the bias against conscience rights, arguing that those with “[q]ualms about abortion, sterilization, and birth control” should “not practice women’s health.” Julie D. Cantor, *Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine*, NEW

ENG. J. MED. (Apr. 9, 2009). With a prominent journal's giving public voice to prejudice and intolerance that – if it occurred in medical practice or in education – would violate the statutory protections that the Provide Conscience Rule implements, HHS cannot seriously doubt that similar prejudice and intolerance pervade the medical profession.

According to polling of pro-life physicians entered into the record by the Christian Medical Association (“CMA Poll”), 39 percent of pro-life physicians experienced coercion to violate their consciences during their medical education by faculty (with 23 percent experience such discrimination in the application process alone) or administrators, and 32 percent experienced coercion to participate in or refer for procedures that violate their conscience during their professional careers. If HHS needs individual stories, the Freedom2Care.org website has received the following health care personnel stories:

- “25 years ago; as a medical student on my OB/GYN rotation I was randomly assigned to an OR one morning to assist in a procedure. No information was given to me by the intern or resident on service. I found myself witnessing an early second trimester abortion on a women in her late thirties who was obviously distressed. No consideration for my rights of conscience was ever discussed with me; before or after this unfortunate circumstance. Medical students then; and even more so now; are expected to put up or shut up when faced with interventions and therapies they consider morally illicit. This underscores the need for the recent HHS ruling which mandates proper consideration of a health care provider's rights of conscience.”
- “I am a Registered Nurse currently employed at an outpatient podiatry surgery center. Last week; I was told by my administrator that OB/GYN Doctors had signed on to perform surgeries at our center. There is a very large Catholic Hospital across the street that specializes in OB/GYN services. So it was very strange that these doctors would come to our small podiatry center. Our administrator stated there was a [possibility] abortions would be performed at our surgery center. Three of the four nurses stated they wouldn't assist with abortions due to convictions/ethical beliefs. Our administrator responded with ‘if you have a problem assisting with abortions; we have NO PLACE FOR YOU here.’ She stated ‘As nurses; you don't have a CHOICE!’”
- “In May 2005 my professional career as a community pharmacist in the state of Illinois took a dramatic change. I worked for a retail grocery store chain which included a pharmacy for almost 20 years. Following Gov. Blagojevich executive order which forced pharmacies to dispense emergency contraception (Plan B); my practice of pharmacy was forced to change by an action which contradicted the State of Illinois Conscience law. For a year following the executive order I worked to [overturn] the action in the courts in Illinois. I was blocked from doing so because I had not experienced a consequence of the action. I eventually had to leave the State of Illinois and leave community pharmacy

practice because of the inability to exercise my conscience rights. Many of my fellow pharmacists in Illinois were fired and after 4 years are still fighting legal battles in the courts. All this despite the law in Illinois protecting health care professionals. Please protect medical professionals from having to violate their conscience in order to practice in their chosen professions.”

The Provider Conscience Rule’s enforcement process empowers individuals and entities to enforce their rights through HHS, without needing to directly take on their employers, accreditors, certifying boards, or state and local government.

Nonetheless, some have argued that regulations are not necessary because the statutes suffice, by themselves. To the contrary, without the Provider Conscience Rule, conscientious objectors would face daunting economic pressure to conform their conduct to quasi-official coercion. That the coercion occurs demonstrates the need for regulation not only to educate the regulated community but also the beneficiaries.

Comment: HHS regulations are needed both to restrict the illegal actions and inclinations of regulated entities and to protect the civil rights of conscientious objectors.

II. RULE DOES NOT REDUCE ACCESS TO HEALTH CARE SERVICES

HHS’s second question seeks information on whether the current rule reduces access to health care services and information, particularly by low-income women. 74 Fed. Reg. at 10,210. AAPLOG and the groups joining these comments respectfully submit that conscience rights deny very few, if any, patients access to health care services and information. Pro-abortion groups provide only anecdotal evidence that the Provider Conscience Rule will cause a meaningful denial of access to abortion-related information and services for women, including low-income women. Moreover, because HHS’s legitimate concern is for the quality of health-care services and information, HHS must weigh against any lost services or information two negative impacts of rescission: (1) pro-life health-care personnel will leave the field, which will reduce access to health-care services and information, particularly in rural and in economically disadvantaged urban area; and (2) increased access to abortion services and information will lead to increased negative health effects associated with abortion. In addition, while freedom of conscience is a statutorily and constitutionally protected right, there is no right to an abortion and *a fortiori* no right to have a particular health-care provider participate in an abortion.

A. In Balancing Rule’s Impact on Access to Health Care, HHS Must Assess the *Loss* of Access that HHS Would Cause by Rescinding the Rule

In related litigation, AAPLOG’s president has provided sworn testimony that AAPLOG’s members are committed to the sanctity of human life and that it is likely that they would leave

the profession or relocate to more conscience-friendly jurisdictions in response to coercion to participate in medical procedures – such as abortion – that violate their consciences. Polling by the Christian Medical Association of pro-life health-care personnel confirms that view, with more than 95 percent (and even higher rates for OB/GYNs) indicating that they would stop practicing before they would accept coercion to violate their consciences.

Significantly, pro-life physicians represent a disproportionately large cohort of the physicians serving poor, rural, and underserved communities. According to the CMA Poll, 82 percent of pro-life health-care personnel said it was either “very” or “somewhat” likely that they personally would limit the scope of their practice of medicine as the result of rescission; for medical professionals who work full time in serving poor and medically-underserved populations, 86 percent considered it very or somewhat likely that they would limit the scope of their practice. By analogy, coercion of religious – and especially Catholic – hospitals threatens to displace medical institutions from the poor, rural, inner-city, and underserved areas that they now serve, but which they might abandon in response to coercion to violate pro-life tenets of their religious faiths.

Finally, because Americans value having physicians and medical caregivers that share their views, the wholesale elimination of pro-life health-care personnel would damage the diversity of the medical profession. *See* 73 Fed. Reg. at 78,081 (“[a] health care system that is intolerant of individual conscience, certain religious beliefs, ethnic and cultural traditions, or moral convictions serves to discourage individuals with diverse backgrounds and perspectives from entering the health care professions, further exacerbating health care access shortages and reducing quality of care”). For all of the foregoing reasons, AAPLOG and the groups joining these comments respectfully submit that denying conscientious objectors a means to enforce their statutory protections would result in a net loss of access to health-care services and the resulting information in both health care generally and reproductive health specifically. Moreover, given the special-purpose abortion and family-planning groups like Planned Parenthood, HHS’s maintaining the Provider Conscience Rule is unlikely to deny meaningful access to abortion-related services and information for those who seek that information.

Comment: In assessing the increased access to abortion services and information that rescission would provide, HHS must weigh the negative effects on not only OB/GYN care but also medical care generally from the loss of pro-life health-care personnel and institutions that leave the health care field as a result of coerced participation in abortions and work environments hostile to pro-life views.

B. In Assessing the Health-Care Impacts of Losing Access to Abortion Services, HHS Must Balance the Negative Impacts of Abortion Services

In assessing the public-health impacts of denial of access to abortion services and information, HHS must balance the harms to medical and mental health caused by access to elective abortions. Such harms include suicide, mood disorders, substance abuse disorders, premature births in subsequent pregnancies, breast cancer, and placenta previa, as well as additional harms for mifepristone abortions:²

- **Suicide:** Abortion carries a sixfold (600 percent) increased risk of suicide compared with birth and a threefold (300 percent) increased risk over the general population. M. Gissler et al., *Pregnancy-Associated Deaths in Finland 1987-1994 – Definition Problems and Benefits of Record Linkage*, 76 ACTA OBSTETRICA & GYNECOLOGICA SCANDINAVICA 651-57 (1997); see also D. Reardon et al., *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*, 95:8 SO. MED. J. 834-41 (2002). Significantly for the low-income women for whom HHS has requested special focus, the Reardon study analyzed Medicaid records for women who either received an induced abortion or delivered children, which showed significantly increased risk of suicide (age-adjusted odds ratio of 3.12) for low-income women who received an induced abortion.
- **Mood disorders:** Women who undergo elective abortions have higher incidence of mood and anxiety disorders than either the general population or women who deliver children. David M. Fergusson, L. John Horwood & Joseph M. Boden, *Abortion and mental health disorders: evidence from a 30-year longitudinal study* 193 BRIT. J. PSYCHIATRY 444-51 (2008); see also D. Reardon et al., *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*, 95:8 SO. MED. J. 834-41 (2002). Significantly for the low-income women for whom HHS has requested special focus, the Reardon study analyzed data for low-income women in California and found that women who had abortions had a higher incidence of psychiatric admissions across all age groups compared with women who delivered children (odds ratio of 2.34) and more depressive psychosis (odds ratio of 3.92) and other psychiatric disorders.
- **Substance Abuse:** Women who undergo elective abortions have higher incidence of substance abuse than either the general population or women who deliver children. Priscilla K. Coleman, David C. Reardon, Vincent M. Rue & Jesse Cogle, *Induced abortion and anxiety, mood, and substance abuse disorders: Isolating the effects of*

² The body of this section cites several leading or recent articles for each of these public-health harms caused by abortions. Additional authorities are collected in Exhibit 4.

abortion in the national comorbidity survey, __ J. PSYCHIATRIC RES. __ (in press/published online).

- **Premature births:** Prior abortions increase the risk of premature births in later pregnancies, including a significantly elevated risk (64 percent) of “very preterm” births prior to 32 weeks gestation. Jay D. Iams, Roberto Romero, Jennifer F. Culhane & Robert L. Goldenberg, *Primary, secondary, and tertiary interventions to reduce the morbidity and mortality of preterm birth*, 371 THE LANCET 164-75 (Jan. 2008); Hanes M. Swingle, Tarah T. Colaizy, M. Bridget Zimmerman & Frank H. Morriss, Jr., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses*, 54 J. REPRODUCTIVE MED. 95-108 (2009); Institute of Medicine, *Preterm Birth: Causes, Consequences, and Prevention*, 519 (National Academy of Science Press, July 2006) (listing abortion as an immutable risk factor for preterm birth). Moreover, among very preterm newborns, the risk of cerebral palsy increases fifty-five fold (5500 percent) over full-term newborns. E. Himpens, C. Van den Broeck, A. Oostra, P. Calders & P. Vanhaesebrouck, *Prevalence, type, and distribution and severity of cerebral palsy in relation to gestational age: a meta-analytic review*, 50 DEVELOPMENTAL MED. CHILD NEUROLOGY 334-40 (2008).
- **Breast cancer:** Induced abortions significantly increase the risk of breast cancer. Kim E. Innes & Tim E. Byers, *First Pregnancy Characteristics and Subsequent Breast Cancer Risk among Young Women*, 112 INT. J. CANCER 306-11 (2004); Janet R. Daling, Kathleen E. Malone, Lynda F. Voigt, Emily White & Noel S. Weiss, *Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion*, 86 J. NAT’L CANCER INST. 1584 (1994).
- **Placenta previa:** Induced abortions correlate with a sevenfold (700 percent) increase in the risk of placenta previa, J. M. Barrett, F. H. Boehm & A. P. Killam, *Induced abortion: a risk factor for placenta previa*, 141(7) AM. J. OBSTET. GYNECOL. 769-72 (1981), the leading cause of uterine bleeding in the third trimester and medically indicated preterm birth. Women who have placenta previa face markedly higher risks of preterm birth, low birth weight, and perinatal death in subsequent pregnancies, as well as increased risk of hemorrhaging (of which placenta previa is a major cause). John M. Thorp, Jr., Katherine E. Hartmann & Elizabeth Shadigian, *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 OB GYN SURVEY 67-79 (2002).
- **Mifepristone:** Even the Food & Drug Administration has acknowledged that mifepristone patients had “significantly more blood loss than did surgical patients,” FDA, *Medical Officer’s Review of Amendments 024 and 033, Final Reports for the U.S. Clinical Trials Inducing Abortion up to 63 Days Gestational Age and Complete*

Responses Regarding Distribution System and Phase 4 Commitments, (finalized November 22, 1999; dated January 27, 2000), which understates mifepristone's documented problems with significantly higher post-procedural rates of persistent bleeding, bleeding requiring post-procedure surgery, and hemorrhaging. J. T. Jensen, S. J. Astley, E. Morgan & M. D. Nichols, *Outcomes of suction curettage and mifepristone abortion in the United States: a prospective comparison study*, 59 *CONTRACEPTION* 153-59 (1999); M. M. Gary & D. J. Harrison, *Analysis of severe adverse events related to the use of mifepristone as an abortifacient*, 40 *ANNALS OF PHARMACOTHERAPY* 191-97 (2006). Mifepristone also increases the risk of septic shock and increases the risk of death tenfold (1000 percent) over surgical abortion. M. F. Greene, *Fatal infections associated with mifepristone-induced abortion*, 353(22) *N. ENGL. J MED.* 2317-18 (2005); M. Fischer, *Fatal toxic shock syndrome associated with Clostridium sordellii after medical abortion*, 353 *N. Engl. J Med.* 2352-60 (2005); R. P. Miech, *Disruption of the innate immune system by mifepristone and lethal toxin of Clostridium sordellii*, at 1-5, *JOURNAL OF ORGAN DYSFUNCTION* (2007); R. P. Miech, *Pathophysiology of Mifepristone-Induced Septic Shock Due to Clostridium sordellii*, 39(9) *ANNALS OF PHARMACOTHERAPY* 1483-88 (2005) The Miech studies discuss the pathophysiological basis both for the increase in hemorrhage and for the profound immunological suppression with mifepristone abortions.

All of the foregoing adverse public-health impacts would undercut the public-health harm from a decreased access to abortion-related services and information, if the Provider Conscience Rule caused such decreased access. Although AAPLOG and the groups joining these comments doubt that HHS will receive credible evidence that the Provider Conscience Rule has decreased access to abortion services and information, HHS must consider abortion's adverse public-health impacts when considering the impact of the Provider Conscience Rule. In considering these issues, moreover, HHS should consider that there is no mandatory reporting of abortion-related complications in the United States. While opponents of the Provider Conscience Rule likely will overstate the rule's impact, the publicly available data certainly understate abortion's adverse public-health impact.

Comment: In assessing the public-health benefit from increased access to abortion services and information, HHS must weigh the negative medical and psychological effects of abortion.

C. Loss of Access to Abortion Services Does Not Deny a Right to Abortions

Pro-abortion groups claim that the HHS rule and similar efforts to protect the conscience rights of health care providers violate women's federal constitutional right of privacy (*i.e.*, that conscience protections deny their "right" to an abortion). In essence, they claim that the U.S. Constitution preempts the HHS rule. The claim lacks merit.

The rights protected by the Church, Coats, and Weldon Amendments are not preempted by *Roe v. Wade*, 410 U.S. 113, 162-64 (1973), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 855-59 (1992), which by their terms do not purport to provide women a right to an abortion performed by whomever a woman chooses. *Poelker v. Doe*, 432 U.S. 519, 520-21 (1977). As HHS noted in its original rulemaking, to the extent that a health care provider's refusal to provide sterilization or abortion services "infringes upon any constitutionally cognizable right to privacy, such infringement is outweighed by the need to protect the freedom of religion of denominational hospitals with religious or moral scruples against sterilizations and abortions." 73 Fed. Reg. at 50,276 (quoting *Taylor v. St. Vincent's Hospital*, 523 F.2d 75, 77 (9th Cir. 1975)) (interior quotations omitted); 73 Fed. Reg. at 78,088 n.4 (same). *Roe* and *Casey* "do[] not create or identify a corresponding duty on the part of any provider to be involved in the procedure in any way." 73 Fed. Reg. at 78,088. Because nothing in *Roe* or *Casey* outweighs health care providers' religious beliefs and moral convictions, nothing in those decisions preempts the Provider Conscience Rule or the Church, Coats, and Weldon Amendments.

Comment: The federal "right" to an abortion does not preempt the Provider Conscience Rule because the right of conscience protected by the Provider Conscience Rule outweighs the right to compel any specific individual or institutional health care provider to participate in abortions.

D. Loss of Access to Abortion Services Does Not Discriminate by Gender

Pro-abortion groups claim that the HHS rule and similar efforts to protect the conscience rights of health care providers violate women's federal constitutional rights of equal protection (*i.e.*, that conscience protections constitute unlawful gender discrimination). In essence, they claim that the U.S. Constitution preempts the proposed regulations. These claims lack merit.

Under federal law, discrimination because of pregnancy (or the ability to get pregnant) constitutes discrimination because of sex only in the employment context. *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669, 684 (1983) ("Pregnancy Discrimination Act has now made clear that, for all Title VII purposes, discrimination based on a woman's pregnancy is, on its face, discrimination because of her sex"); 42 U.S.C. §2000e(k) ("For the purposes of [Title VII]... [t]he terms 'because of sex' or 'on the basis of sex' include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions"). Outside the employment context, disparate treatment of a potentially pregnant person because one opposes abortion is not discrimination *because of that person's gender*. *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 271-72 (1993) (citing cases). "While it is true... that only women can become pregnant, it does not follow that every... classification concerning pregnancy is a sex-based classification." *Bray*, 506 U.S. at 271 (interior quotations omitted, citing *Geduldig v. Aiello*, 417 U.S. 484, 496, n.20 (1974)); accord *Harris v. McRae*, 448 U.S.

297, 322 (1980) (restrictions on abortion funding are not discrimination because of gender); *Poelker v. Doe*, 432 U.S. 519, 520-21 (1977) (no equal-protection violation for city to provide public funding for childbirth but not for elective abortions). Instead, to find the required “[d]iscriminatory purpose” one must find that “the decisionmaker... selected or reaffirmed a particular course of action at least in part *because of*, not merely *in spite of*, its adverse effects upon an identifiable group.” *Bray*, 506 U.S. at 271-72 (interior quotations omitted, emphasis added, citing *Personnel Administrator of Mass. v. Feeney*, 442 U.S. 256, 279 (1979)). The refusal to participate in what conscientious objectors consider the unjustified taking of human life has nothing to do with the gender of the victim’s consenting mother and everything to do with the conscientious objector’s religious beliefs and moral convictions.

Comment: The Equal Protection Clause does not preempt the Provider Conscience Rule because no action taken under the rule qualifies as action taken *because of* gender.

III. LACK OF CLARITY OR CONFUSION WARRANTS CLARIFICATION, NOT RESCISSION

HHS’s third question asks whether the current rule provides sufficient clarity to minimize harmful ambiguity and confusion. 74 Fed. Reg. at 10,210. AAPLOG and the groups joining these comments respectfully submit that the Provider Conscience Rule would benefit from HHS’s clarification of issues that HHS declined to consider in the initial rulemaking in 2008 (Sections III.A-III.C, *infra*), but that the contents of the Provider Conscience Rule itself are neither ambiguous nor confusing (Sections III.E-III.H, *infra*). To the extent that HHS or regulated entities find the certification process unwieldy, HHS could revise the enforcement mechanism to comport with the time-tested HHS regulatory enforcement mechanism for other civil rights legislation (Section III.D, *infra*).

A. HHS Should Clarify that the Rule Does Not Require Administrative Exhaustion or Displace Constitutional Remedies

In addition to the federal statutory protections at issue in this rulemaking, conscientious health care providers have rights under the First Amendment, *see, e.g., Wisconsin v. Yoder*, 406 U.S. 205, 214 (1972) (religious freedom is a fundamental right), as well as the laws of most states. Maureen Kramlich, *The Abortion Debate Thirty Years Later: from Choice to Coercion*, 31 *FORDHAM URB. L.J.* 783, 802-03 & n.125 (2004) (citing conscience protections under the laws of 46 states). Indeed, under 42 U.S.C. §1988(a), conscientious objectors may rely on state-law protections in defending and defining the scope of their civil rights under federal law, provided that the state-law protections are “not inconsistent” with federal law. *Wilson v. Garcia*, 471 U.S.

261, 267 (1985).³ Under the Ninth and Tenth Amendments, respectively, a federal enumeration of rights does not “deny or disparage others retained by the people” and powers neither delegated to nor prohibited to the federal government “are reserved to the States... or to the people.” U.S. CONST. amend. IX, X. Finally, in the related area of enforcing the statutory protections of other funding-based federal civil rights laws such as Title IX and Title VI, the availability of an administrative remedy with a federal agency does not preclude a party’s proceeding directly to court to enforce statutory protections, without first exhausting the administrative remedy. *Cannon v. Univ. of Chicago*, 441 U.S. 694, 706-08 (1979). All of these provisions provide important alternate avenues for health care providers to enforce their rights of conscience.

Comment: HHS should clarify that its provider conscience regulations neither preempt whatever rights providers have to enforce their rights of conscience under federal and state law nor require that providers exhaust their administrative remedy with HHS before filing suit.

B. HHS Should Clarify the Scope of Protected Activity for Abortions and Pregnancy

Because the Church, Coats, and Weldon Amendments all refer to abortion, they beg the question of when an abortion (or a pregnancy) takes place. In the prior rulemaking, commenters supported rival definitions, based on fertilization or implantation of the embryo, but HHS declined to promulgate a definition of when pregnancy begins for these statutory protections. *See* 73 Fed. Reg. at 78,077 (“Department declines to add a definition of abortion to the rule”). As explained in the following three subsections, medical science and religious thought counsel for a fertilization-based definition, not an implantation-based definition, but substantial policy reasons counsel for a definition that defers to individuals’ reasonable subjective beliefs.

1. Pregnancy Begins at Fertilization

To have an abortion (*i.e.*, to end a pregnancy), a woman first must be pregnant. Consistent with the weight of both medical and religious authority, HHS should adopt a fertilization-based definition of pregnancy (and thus abortion).

The standard definitions have pregnancy starting at the union of an ovum and spermatozoon, with that union described as both fertilization and conception. *See, e.g.*, DORLAND’S ILLUSTRATED MEDICAL DICTIONARY (25th ed. 1974) (pregnancy means “condition of having a developing embryo or fetus in the body, after union of an ovum and spermatozoon”); DORLAND’S ILLUSTRATED MEDICAL DICTIONARY (31st ed. 2007) (same); MOSBY’S MEDICAL DICTIONARY (7th ed. 2006) (pregnancy means “gestational process, comprising the growth and

³ The “Title 24” in §1988(a) includes 28 U.S.C. §1343 and 42 U.S.C. §1983. *See Lynch v. Household Fin. Corp.*, 405 U.S. 538, 544 n.7 (1972).

development within a woman of a new individual from conception through the embryonic and fetal periods to birth,” and conception means “beginning of pregnancy, usually taken to be the instant that a spermatozoon enters an ovum and forms a viable zygote... the act or process of fertilization”). Other medical dictionaries have flirted with an implantation-based definition and returned to the fertilization-based definition. *Compare* STEDMAN’S MEDICAL DICTIONARY (21st ed. 1966) (conception means “act of conceiving, or becoming pregnant; the fecundation of the ovum”) *with* STEDMAN’S MEDICAL DICTIONARY (22nd ed. 1972) (conception means “Successful implantation of the blastocyst in the uterine lining”); *see also* STEDMAN’S MEDICAL DICTIONARY (24th ed. 1982) (conception means “act of conceiving, or becoming pregnant; the fertilization of the oocyte (ovum) by a spermatozoon”); STEDMAN’S MEDICAL DICTIONARY (28th ed. 2006) (conception means “Fertilization of oocyte by a sperm”). At least one medical dictionary appears to have switched from fertilization to an implantation-based definition. *Compare* TABER’S CYCLOPEDIA MEDICAL DICTIONARY (18th ed. 1997) (conception means “union of the male sperm and the ovum of the female; fertilization”) *with* TABER’S CYCLOPEDIA MEDICAL DICTIONARY (19th ed. 2001) (conception means “onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall”). As HHS is aware, no new scientific discoveries explain the changes in definition. Zygotes are as alive today as their predecessors were in the 1970s. While some definitional semantics supports an implantation-based definition, those changes reflect political manipulations,⁴ not scientific developments, and do not represent the weight of authority or common understanding. *See* Christopher M. Gacek, J.D., Ph.D., *Conceiving “Pregnancy:” U.S. Medical Dictionaries and their Definitions of “Conception” and “Pregnancy”* (Family Research Council Apr. 2009) (Ex. 5).

A fertilization-based definition also is consistent with the religious beliefs and moral convictions that the Church, Coats, and Weldon Amendments seek to protect. For example, although Southern Baptists and Catholics do not command the obedience of other faiths, their position on this subject suffices to demonstrate the reasonableness of a fertilization-based definition for religious purposes: “The Bible affirms that the unborn baby is a person bearing the image of God from the moment of conception.” Southern Baptist Convention, Resolution on Thirty Years of *Roe V. Wade* (June 2003) (citing Psalm 139:13–16 and *Luke* 1:44) (Ex. 6); *see also* Southern Baptist Convention, Resolution on Human Embryonic and Stem Cell Research (June 1999) (“Bible teaches that... protectable human life begins at fertilization”) (Ex. 7).

In this context, it is not possible to anaesthetize consciences, for example, concerning the effects of particles whose purpose is to prevent an embryo’s implantation or to shorten a person’s life....
In the moral domain, your Federation is invited to address the issue

⁴ *See, e.g.,* Robert G. Marshall & Charles A. Donovan, *Blessed Are the Barren: the Social Policy of Planned Parenthood*, 291-302 (1991) (Ex. 8).

of conscientious objection, which is a right your profession must recognize, permitting you not to collaborate either directly or indirectly by supplying products for the purpose of decisions that are clearly immoral such as, for example, abortion or euthanasia.

Pope Benedict XVI, *Address of His Holiness Benedict XVI to Members of the International Congress of Catholic Pharmacists* (Oct. 29, 2007) (Ex. 9); *see also* Pontifical Academy for Life, *Statement on the So-Called ‘Morning-After Pill’* (Oct. 31, 2000) (“the proven ‘anti-implantation’ action of the *morning-after pill* is really nothing other than a chemically induced abortion [and] from the ethical standpoint the same absolute unlawfulness of abortifacient procedures also applies to distributing, prescribing and taking the *morning-after pill*”) (emphasis in original) (Ex. 10). Religious and moral opposition to abortion provides the driving force behind the Church, Coats, and Weldon Amendments and thus should guide HHS in regulating under those laws.⁵

Comment: HHS should adopt the prevailing fertilization-based definition of pregnancy and abortion.

2. Implantation-Based Definitions Are Inapposite

Contrary to a fertilization-based definition of pregnancy (and thus abortion), pro-abortion groups seek to impose a definition that has pregnancy begin at implantation of the fertilized egg in its mother’s uterine wall. To support an implantation-based definition, these groups cite medical dictionaries, federal regulations, and “science.” None of these authorities supports an implantation-based definition of pregnancy.

First, as indicated in the prior section, the weight of medical definitions supports a fertilization-based definition of pregnancy and, thus, abortion. Indeed, even HHS has used fertilization-based definitions, both before and after enactment of the statutes at issue here:

All the measures which impair the viability of the zygote at any time between the instant of fertilization and the completion of labor constitute, in the strict sense, procedures for inducing abortion.

⁵ Although the religious views supported here fall squarely within mainstream religious faiths and morality, that is not necessary to trigger our nation’s fundamental First Amendment rights or the rights protected by the Church, Coats, and Weldon Amendments. *See, e.g., Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 524 (1993) (finding unlawful restriction of a faith with animal sacrifice as a principal form of devotion).

U.S. Dep't of Health, Education & Welfare, Public Health Service Leaflet No. 1066, 27 (1963); *accord* 45 C.F.R. §457.10 (for SCHIP, “*Child* means an individual under the age of 19 including the period from conception to birth”); *see also* 67 Fed. Reg. 61,956, 61,963-64 (2002) (finding it unnecessary to define “conception” as “fertilization” in SCHIP because HHS did “not generally believe there is any confusion about the term ‘conception’”). Having itself acknowledged in some contexts that pregnancy begins with fertilization, HHS cannot credibly deny the right of health care providers to have their religious beliefs and moral convictions guide them to that same conclusion.

Second, pro-abortion groups often cite HHS’s definition of pregnancy at 45 C.F.R. §46.202(f) for the proposition that pregnancy begins at implantation, rather than fertilization. That federal regulation simply does not support the weight that pro-abortion groups place on it to define “pregnancy” for all purposes under federal law. At the outset, the regulation expressly applies by its terms only to “this subpart,” namely Subpart B of the HHS regulations at 45 C.F.R. pt. 46. More importantly, HHS’s predecessor did not reject a fertilization-based definition for all purposes and retained the implantation-based definition only “to provide an administerable policy” for a specific purpose (namely, obtaining informed consent for participation in federally funded research) under technology then present:

It was suggested that pregnancy should be defined (i) conceptually to begin at the time of fertilization of the ovum, and (ii) operationally by actual test unless the women has been surgically rendered incapable of pregnancy.

While the Department has no argument with the conceptual definition as proposed above, it sees no way of basing regulations on the concept. Rather in order to provide an administerable policy, the definition must be based on existing medical technology which permits confirmation of pregnancy.

39 Fed. Reg. 30,648, 30,651 (1974). Thus, HHS’s predecessor had “no argument” on the merits against recognizing pregnancy at fertilization, but declined for administrative ease and then-current technology. The resulting “administerable policy” merely sets a federal floor for obtaining the informed consent of human subjects in federally funded research.⁶ In its response

⁶ To the extent that HHS finds that its human-subject protection rules require HHS to use 45 C.F.R. §46.202(f)’s implantation-based definition for the Church, Coats, and Weldon Amendments, HHS must also recognize that the Dickey-Wicker Amendment provides protection from fertilization. *See* Pub. L. No. 110-161, §509(b), 121 Stat. 1844, 2209 (2007) (“For purposes of this section, the term ‘human embryo or embryos’ includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by

to comments on the final rule, HHS's predecessor acknowledged that another of its pregnancy-related definitions served "interests of both consistency and clarity, although it may vary at times from legal, medical, or common usage." 40 Fed. Reg. 33,526 (1975). A decision to set an arguable floor (based on 1970s technology) for administrative expedience obviously cannot translate to the conscience context, where the question is whether individuals or institutions want to avoid participating in activities against *their* religious beliefs or moral convictions. Finally, the enacting Congress expressly indicated that these definitions would not trump religious beliefs and moral convictions under the Church Amendment. S. REP. NO. 93-381 (1973), *reprinted in* 1974 U.S.C.C.A.N. 3634, 3655 ("It is the intent of the Committee that guidelines and regulations established by... the Secretary of HEW under the provisions of the Act do not supersede or violate the moral or ethical code adopted by the governing officials of an institution in conformity with the religious beliefs or moral convictions of the institution's sponsoring group").

Third, pro-abortion groups often appeal to "science" as supporting their view that pregnancy begins at implantation. In doing so, these groups do not specify what "science" they reference, other than the foregoing definitional semantics, which reflect neither medical science nor medical consensus. The pre-implantation communications or "cross talk" between the mother and the pre-implantation embryo establish life before implantation, *see, e.g.*, Eytan R. Barnea, Young J. Choi & Paul C. Leavis, "Embryo-Maternal Signaling Prior to Implantation," 4 EARLY PREGNANCY: BIOLOGY & MEDICINE, 166-75 (July 2000) ("embryo derived signaling... takes place prior to implantation"); B.C. Paria, J. Reese, S.K. Das, & S.K. Dey, "Deciphering the cross-talk of implantation: advances and challenges," SCIENCE 2185, 2186 (June 21, 2002); R. Michael Roberts, Sancai Xie & Nagappan Mathialagan, "Maternal Recognition of Pregnancy," 54 BIOLOGY OF REPRODUCTION, 294-302 (1996), as do the embryology texts. *See, e.g.*, Keith L. Moore & T.V.N. Persaud, *The Developing Human: Clinically Oriented Embryology*, 15 (8th ed. 2008) ("Human development begins at fertilization when a male gamete or sperm unites with a female gamete or oocyte to form a single cell, a zygote. This highly specialized, totipotent cell marked the beginning of each of us as a unique individual."). Moreover, non-uterine pregnancies such as ectopic pregnancies demonstrate that uterine implantation cannot mark the beginning of pregnancy.

Even if the term "conception" is redefined in human beings to mean "the point of implantation," defying all other known biological use of the term in other living creatures, that redefinition cannot change the reality that biological life begins at fertilization. Since the mechanism by which mammals reproduce has been known for at least the last 150 years, any biologist in the world can tell you that a mammal's life begins when the sperm from the father unites with the egg from the mother. This process is called fertilization, and when the DNA from

fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells"); Pub. L. No. 111-8, §509(b), 123 Stat 524, 803 (2009) (same).

a human father and a human mother combine, the egg is called a “fertilized egg” or “zygote.” When the zygote splits into two cells, it is called a “two celled embryo.” When it splits into four cells, it is called a “four celled embryo,” etc. The definition of “embryo” is “the youngest form of a being.” If this being is nourished and protected, it will proceed uninterrupted through the developmental stages of embryo, fetus, newborn, toddler, child, adolescent, adult, and aged adult: one continuous existence. This being never develops into a pig, a frog, or a tree, but only into a human. This being is therefore, by definition, a living human being.

In summary, none of the bases for an implantation-based definition support the claim that the pro-abortion groups’ preferred definition has any application in defining the religious beliefs or moral convictions of individuals and institutions who do not share the pro-abortion groups’ views. The right to conscience would be a poor thing if limited to the right to believe what someone else tells us.

Comment: Even if it declines to adopt a fertilization-based definition, HHS should clarify that neither 45 CFR §46.202(f) nor any other federal or medical definition justifies the use of an implantation-based definition of “abortion” for the Church, Coats, and Weldon Amendments.

3. HHS Should Allow Rights-Holder’s Reasonable Subjective View

Although HHS clearly must adopt the fertilization-based definition of pregnancy if HHS elects to define pregnancy, a formal definition is perhaps unnecessary. Honest people undoubtedly differ on the meaning of life, the timing of life, and the permissibility of ending life in certain contexts. In other contexts – such as the lawfulness of abortion – government must take sides in the debate on when life begins. In this context, however, HHS need only recognize that the reasonable subjective view of the individual or institution should govern any assessment of that individual’s or institution’s invocation of religious beliefs or moral convictions.

The Provider Conscience Rule itself does not require HHS to define pregnancy and abortion for itself, for Congress, and for each citizen. Indeed, HHS may find it inappropriate to go any further than to recognize the reasonableness of a subjective belief in a fertilization-based definition:

If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.

West Virginia State Board of Education v. Barnette, 319 U.S. 624, 642 (1943); cf. *Harris v. McRae*, 448 U.S. 297, 321 (1980) (free-exercise claim “requires the participation of individual members” because “it is necessary in a free exercise case for one to show the coercive effect of

the enactment as it operates against him in the practice of his religion”) (citations and interior quotations omitted). Under these authorities, HHS might conclude that it need not conclusively define the terms. For the reason set forth in Section III.B.1, *supra*, a fertilization-based definition unquestionably is reasonable on both religious and medical grounds.

HHS’s “SCHIP” rulemaking on the allowable definition of “child” provides precedent for this approach. In defining “child” to allow states to go back to conception, HHS “disagree[d] with [the] contention that there is only one appropriate interpretation of the statutory term at issue, and [HHS] believe[d] the range of comments supports [its] view that States should have the option to include unborn children as eligible targeted low income children.” 67 Fed. Reg. at 61,960. Moreover, when a commenter suggested that the SCHIP regulations define “conception” to mean “fertilization” because “there are other potentially confusing definitions being used,” HHS responded that it did “not generally believe there is any confusion about the term ‘conception’” but that “[t]o the extent that there is... [HHS] believe[s] States should have flexibility to adopt any reasonable definition of that term.” 67 Fed. Reg. at 61,963-64. At a minimum, individuals and institutions deserve that same flexibility.

Comment: HHS should make clear that the definition of abortion (and thus the protections afforded by the Church, Coats, and Weldon Amendments) lies in the reasonable subjective religious beliefs or moral convictions of each health care provider.

C. HHS Should Add Federal Entities to §88.4(e)

The first Church Amendment prohibits both courts and public officials from using receipt of funding under three federal statutes, including the Public Health Service Act, as the basis for requiring an individual or an entity to participate or make its facilities available for sterilization or abortion against the individual’s or entity’s religious belief or moral convictions. 42 U.S.C. §300a-7(b); *see also* H.R. REP. NO. 93-227 (1973), *reprinted in* 1973 U.S.C.C.A.N. 1464, 1464 (“H.R. 7806 as amended would... deny *any* court, public official, or public authority the right to require individuals or institutions to perform abortions or sterilizations contrary to their religious beliefs or moral convictions because an individual or institution had received assistance under the Public Health Service Act [and two other statutes]”) (emphasis added); *id.*, *reprinted at* 1973 U.S.C.C.A.N. 1464, 1473 (“Subsection (b) of 401 would prohibit a court or a public official, *such as the Secretary of Health, Education, and Welfare*, from using receipt of assistance under the three laws amended by the bill (the Public Health Service Act [and two other statutes]) as a basis for requiring an individual or institution to perform or assist in the performance of sterilization procedures or abortions, if such action would be contrary to religious beliefs or moral conviction”) (emphasis added). Although the Church Amendment’s definition of “public official” is in no way limited to state and local government, and the legislative history expressly includes HHS’s predecessor, §88.4(e) expressly lists state or local governments, without expressly listing HHS and the federal government.

Comment: HHS should add itself and other federal agencies to the entities subject to §88.4(e).

D. HHS Could Cure Any Perceived Confusion from Certifications by Conforming the Provider Conscience Rule with Civil Rights Statutes

Several groups opposed to the Provider Conscience Rule have focused on the rule's certification requirements. In this respect, Congress did not enact the funding-based restrictions of the Church, Coats, and Weldon Amendments against a blank slate. Instead, going back to Title VI of the Civil Rights Act of 1964, Congress has required recipients of federal funds to refrain from discriminatory conduct on a variety of bases (*e.g.*, race in Title VI, gender in Title IX of the Education Amendments of 1972, etc.). As the Supreme Court has recognized, Congress would have intended these civil rights statutes to be interpreted in light of each other. *See, e.g., Grove City College v. Bell*, 465 U.S. 555, 575 (1984) ("Regulations authorizing termination of assistance for refusal to execute an Assurance of Compliance with Title VI had been promulgated and upheld long before Title IX was enacted, and Congress no doubt anticipated that similar regulations would be developed to implement Title IX"), *abrogated by statute on other grounds*, 20 U.S.C. §1687; *CBOCS West, Inc. v. Humphries*, 128 S.Ct. 1951, 1958-59 (2008) (Congress would have expected similar anti-discrimination statutes to be interpreted similarly); *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 176 (2005) (same). In general, if HHS finds any confusion or burden from the Provider Conscience Rule's certification process, HHS could amend the rule to conform the regulatory enforcement regime for the Church, Coats, and Weldon Amendments to the regulatory enforcement mechanisms for other federal civil-rights legislation under the Spending Clause.

1. HHS Could Adopt the Title VI Enforcement Process

In adopting the implementing regulations for Title IX, HHS's predecessor simply incorporated by reference the enforcement mechanism that it had adopted for Title VI in 1964. *See* 45 C.F.R. §86.71 (incorporating 45 C.F.R. §§80-6 through -11 and 45 C.F.R. pt. 81 into 45 C.F.R. pt. 86); 45 C.F.R. §§80-6 through -11; 45 C.F.R. pt. 81. Given the essentially contemporaneous enactment of the Church Amendments with these other funding-based anti-discrimination statutes, HHS should consider taking the same approach for the enforcement mechanism for the Church, Coats, and Weldon Amendments. The approach would have several advantages for HHS, regulated entities, and beneficiaries alike. First, the enforcement mechanism is time tested and well understood by all concerned. Second, the approach has been very successful in negotiating voluntary compliance with regulated entities and provides a relatively simple complaint process for beneficiaries to utilize without the need to engage counsel. Third, the Title VI enforcement mechanism includes third-party retaliation protections:

No recipient or other person shall intimidate, threaten, coerce, or discriminate against any individual for the purpose of interfering

with any right or privilege secured by [the Act] or this part, or because he has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding or hearing under this part. The identity of complainants shall be kept confidential except to the extent necessary to carry out the purposes of this part, including the conduct of any investigation, hearing, or judicial proceeding arising thereunder.

45 C.F.R. §80.7(e). All of these reasons would combine to streamline the process, to ensure expeditious compliance, and to protect the important civil rights at issue here.

Comment: If HHS has new-found concerns about the Provider Conscience Rule's certification requirements, HHS should consider incorporating by reference Title VI's administrative-enforcement process as HHS's regulatory enforcement mechanism for the Church, Coats, and Weldon Amendments.

2. HHS Should Rely on Existing Civil Rights Educational Methods

HHS's notice of final rulemaking recognized the need for an education and outreach program *in addition* to the promulgation of a regulatory enforcement mechanism. *See* 73 Fed. Reg. at 78,079; *see also* Section IV, *infra*. HHS should implement its conscience-protection regulations in the same manner as other civil rights regulatory regimes. For example, 45 C.F.R. §80.6(d) requires recipients to make information available to beneficiaries regarding Title VI's protections in such a manner as HHS finds necessary to apprise them of the statutory and regulatory protections against discrimination. In addition, 45 C.F.R. §86.3(c)-(d) requires Title IX recipients to prepare a self evaluation within one year to ensure compliance with the Title IX regulations and further requires them to correct anything that does not comply. To the extent that entities already have affirmative-action officers, departments, websites, training, and/or handbooks to implement other civil rights statutes, those same organs should address the civil rights protections afforded by the Church, Coats, and Weldon Amendments and their implementing regulations.

Comment: HHS should implement and enforce the Provider Conscience Rule in the manner that federal agencies implement and enforce other civil rights laws.

E. Title VII's "Reasonable Accommodation" Standard Is Neither Relevant Nor Applicable to the Church, Coats, and Weldon Amendments

Opponents of the Provider Conscience Rule have argued that HHS should incorporate into the rule (and thus into the Church, Coats, and Weldon Amendments) the reasonable-accommodation/undue-hardship framework from Title VII of the Civil Rights Act of 1964:

For the purposes of this subchapter [*i.e.*, Title VII] -- ... The term “religion” includes all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate to an employee’s or prospective employee’s religious observance or practice without undue hardship on the conduct of the employer’s business.

42 U.S.C. §2000e(j). As the plain language of Title VII’s §701(j) makes clear, however, that provision applies to Title VII.

Although Congress enacted all of the conscience protections at issue here after Congress enacted Title VII generally in 1964 and §701(j) in 1972,⁷ Congress did not include a similar limitation in the conscience-protection statutes. As HHS recognized, “Congress in this context imposed a choice not between reasonable accommodations and undue burden, but between accommodation of religious belief or moral convictions and federal funding.” 73 Fed. Reg. at 78,085. HHS has long recognized that Congress has made similar choices in other civil rights laws imposed under the Spending Clause, *see, e.g.*, 45 C.F.R. §86.6(a) (“obligations imposed by this part are independent of, and do not alter, obligations not to discriminate on the basis of sex imposed by ... Title VII of the Civil Rights Act of 1964 ... and any other Act of Congress or Federal regulation”), and HHS could no more import Title VII’s limitations on employer size into these statutes than it can import the undue-burden test.

Agencies, like “courts[,] are not at liberty to pick and choose among congressional enactments, and when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective.” *Morton v. Mancari*, 417 U.S. 535, 551 (1974) (“specific statute will not be controlled or nullified by a general one, regardless of the priority of enactment”). As it happens, *Morton v. Mancari*’s hornbook principle of law arose in a case that involved Title VII and a statute enacted *prior* to Title VII. Moreover, in its 1972 amendments to Title VII, Congress indicated that “Title VII was envisioned as an independent statutory authority,” which (with respect to public entities liable to discrimination suits under 42 U.S.C. §1983 and the Equal Protection Clause) did “not affect existing rights that [plaintiffs] have already been granted by previous legislation.” H.R. REP. NO. 92-238 (1971), *reprinted in* 1972 U.S.C.C.A.N. 2137, 2154. If Title VII did not limit *previous*, independent legislation that did not include Title VII’s limiting features, it borders on the frivolous to argue that *future*, independent legislation should include those limitations, notwithstanding that Congress choose not to add or reference them.

⁷ Congress added §701(j) to Title VII in the Equal Employment Opportunity Act of 1972, Pub. L. No. 92-261, §2(7), 86 Stat. 103 (1972), which also imposed public entities to Title VII.

Comment: Like the Church, Coats, and Weldon Amendments, the Provider Conscience Rule is not limited by an undue-burden or reasonable-accommodation test. Recipients of federal funds have the choice of complying with these laws or foregoing federal funds.

F. Provider Conscience Rule Is Neither Overbroad Nor Vague

Groups opposed to conscience rights have claimed that the Provider Conscience Rule is overbroad in its reach and impermissibly vague. These objections are misplaced. Contrary to a cramped reading of the conscience rights under the Church, Coats, and Weldon Amendments, Congress would expect courts and agencies to interpret those anti-discrimination statutes broadly under the “familiar canon of statutory construction that remedial legislation should be construed broadly to effectuate its purposes.” *Tcherepnin v. Knight*, 389 U.S. 332, 336 (1967). As to vagueness, AAPLOG and the groups joining these comments respectfully submit that neither the Provider Conscience Rule nor the underlying statutes are vague, but even if they were, that vagueness would go to the lack of a private cause of action to enforce the regulations and the statutes under 42 U.S.C. §1983, *see, e.g., Suter v. Artist M.*, 503 U.S. 347, 356 (1992), not to HHS’s regulatory regime for enforcing the statutes in an administrative proceeding.

In addition to failing on these general legal principles, the over-breadth and vagueness arguments also fail on their specifics. For example, as to the individuals covered by the Provider Conscience Rule, some have claimed hyperbolically that the rule could extend to cashiers in a supermarket. As HHS made clear, however, the rule requires that protected “individuals ... have a reasonable connection to the procedure, health service or health service program, or research activity to which they object.” 73 Fed. Reg. at 78,090. Similarly, although some have claimed that the Coats Amendment does not reach hospitals generally, the statutory language and legislative history support HHS’s longstanding interpretation. *See* 73 Fed. Reg. at 78,091; 42 USCA § 238n(c)(2).

Comment: The Provider Conscience Rule is neither vague nor overbroad, and vagueness and over-breadth arguments would not preclude HHS’s enforcing the Provider Conscience Rule in administrative enforcement proceedings.

G. Regulations Do Not Conflict with Title X

Some opponents of conscience rights have cited the HHS’s regulations under Title X of the Public Health Service Act, which require recipients to counsel and refer for abortions, 45 C.F.R. §59.5(a)(5)(i)(C), (ii), (b)(1), (8), as conflicting with the Provider Conscience Rule. As HHS acknowledged, 73 Fed. Reg. at 78,087, 78,088, these Title X regulatory provisions violate statutory provisions of the Coats and Weldon Amendments. 42 U.S.C. §238n(a); Pub. L. No. 110-161, §508(d), 121 Stat. at 2209. As HHS further acknowledged, “requirements and prohibitions contained in a regulation cannot be enforced in derogation of conflicting statutes.”

73 Fed. Reg. at 78,088; *accord Nat'l Family Planning & Reprod. Health Ass'n v. Gonzales*, 468 F.3d 826, 828 (D.C. Cir. 2006) (“the government notes, and plaintiff doesn’t contest, that in the event of conflict the regulation must yield to a valid statute”). Thus, any confusion is created by the unlawful Title X requirements, not by the Provider Conscience Rule.

Comment: Although the Title X regulations concededly include unlawful requirements, the Provider Conscience Rule does not conflict with any *lawful* requirements of the Title X regulations.

H. Provider Conscience Rule Should Not Require Prior Registration of Conscientious Objections

Some states have claimed that the Provider Conscience Rule conflicts with state laws that require conscientious objectors to “register” their objections in writing. In promulgating the Provider Conscience Rule, HHS declined to adopt registration requirement, noting the “vast array of circumstances and settings” covered by the rule. 73 Fed. Reg. at 78,083. Certainly, in some of those circumstances and settings, the underlying statutes would preempt state-law requirements, as for example in medical education, which the Church and Coats Amendments would protect.

Although the Supreme Court found that the Hippocratic Oath did not evidence universal opposition to abortion, even in Hippocrates’ time, *Roe*, 410 U.S. at 715-16, the Court nonetheless recognized the Oath that “I will not give to a woman an abortive remedy” or that “I will not give to a woman a pessary to produce abortion” as a “long-accepted and revered statement of medical ethics.” *Id.* The various adverse health impacts from abortion cited in Section II.B, *supra*, as well as the religious and scientific issues cited in Section III.B, *supra*, provide ample reason for an individual to decline to participate in abortions. Medicine is a healing art, which many believe is inconsistent with abortion. Given the heavily politicized nature of the abortion debate, HHS should not require health-care professionals in any field to wear a badge that would single them out for religious, moral, philosophical, or ethical persecution.

Comment: HHS should not amend the Provider Conscience Rule expressly to allow or to require pre-registration of conscientious objections.

IV. NON-REGULATORY OUTREACH AND EDUCATION CANNOT ACCOMPLISH RULE’S OBJECTIVES

HHS’s fourth question asks whether non-regulatory means, such as outreach and education, might accomplish the current rule’s objectives. 74 Fed. Reg. at 10,210. Given the pervasiveness of prejudice and discrimination against pro-life views documented in the record and summarized in Section I, *supra*, AAPLOG and the groups joining these comments

respectfully submit that education and outreach are necessary, but not sufficient by themselves, to enforce the Church, Coats, and Weldon Amendments.

At the outset, the CMA Poll found that 87 percent of the statutory beneficiaries – *i.e.*, those health-care personnel on the ground, in hospitals and clinics across the country – felt that non-regulatory “outreach and education” alone would be insufficient to protect their rights of conscience. Because Congress intended to protect these health-care personnel, their belief that the statutes alone would not suffice confirms that rescission will have a chilling effect on their asserting their statutory rights. On the other hand, ABOG’s retreat in its 2009 bulletin from the position taken in its 2008 bulletin provides evidence that a credible threat of enforcement will protect beneficiaries like AAPLOG’s members.

Regulatory enforcement and non-regulatory education and outreach are not mutually exclusive. Indeed, HHS itself recognized the need for an education and outreach campaign *in conjunction* with the Provider Conscience Rule. 73 Fed. Reg. at 78,079. A regulatory enforcement regime provides numerous advantages for all stakeholders over the purely non-regulatory means suggested by HHS’s fourth question. First, for beneficiaries, a regulatory enforcement mechanism provides a low-cost way to enforce statutory rights within HHS’s existing civil-rights framework. For its part, HHS remains free to seek prospective compliance and the cessation of ongoing discrimination, rather than the termination of federal funding. Although recipients that violate federal law face loss of federal funding, equitable relief, and other consequences for their noncompliance, they face those consequences in a framework that values compliance over than punishment. Under the non-regulatory means suggested by HHS’s fourth question, recipients would face few if any consequences unless a beneficiary brought suit in state or federal court, which would be demonstrably less favorable to recipients than HHS’s regulatory enforcement.

Even if HHS rescinds the Provider Conscience Rule, the preamble to the notice of final rulemaking and HHS’s post-rescission education and outreach campaign should make clear that beneficiaries may file administrative complaints against recipients with HHS’s Office of Civil Rights. In filing those complaints, HHS should allow interested groups to file on behalf of their members and should keep a complainant’s identity from the recipient unless such disclosure is required by the nature of the complaint. *Cf.* 45 C.F.R. §80.7(b) (individual or class complaints filed in individual or representative capacity); *see also* §81.21 (HHS enforces complaints); §§81.22-.23 (complainants may participate as *amici curiae*). In addition, rescission of the regulations would heighten, not lessen, the need to address issues – such as the definition of abortion – in the preamble to the notice of final rulemaking or in post-rescission guidance under the outreach and education program envisioned by HHS’s fourth question.

Comment: HHS should encourage the Administration expeditiously to approve the Paperwork Reduction Act Information Collection Request for the Provider Conscience Rule’s

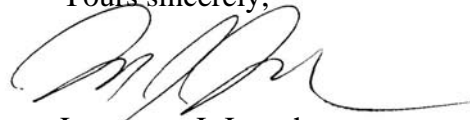
certification requirement, and HHS should undertake an extensive education and outreach campaign – without rescinding the Rule – to ensure a smooth transition that allows recipients to comply fully with their obligations under the Church, Coats, and Weldon Amendments.

CONCLUSION

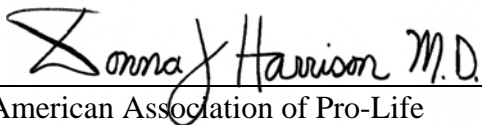
In summary, the Church, Coats, and Weldon Amendments provide important protections that sectors of the health care industry and pro-abortion groups seek to circumvent. The health care industry urgently needs HHS to begin to enforce the Provider Conscience Rule not only to assist and ensure compliance by regulated entities but also to protect the beneficiaries' fundamental rights of religious belief and moral conviction.

Please contact us with any questions about this matter.

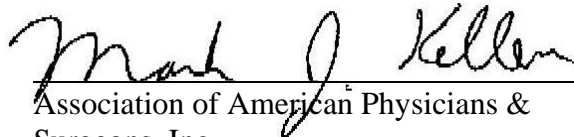
Yours sincerely,



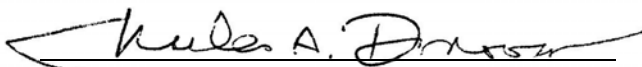
Lawrence J. Joseph



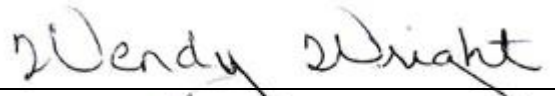
American Association of Pro-Life
Obstetricians and Gynecologists
Donna J. Harrison, M.D., President



Association of American Physicians &
Surgeons, Inc.
Mark J. Kellen, M.D., President



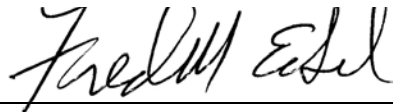
Family Research Council
Charles A. Donovan, Executive Vice President



Concerned Women for America
Wendy Wright, President



Safe Drugs for Women
Christopher M. Gacek, President



Christian Pharmacist Fellowship International
Fred M. Eckel, Executive Director

Enclosures