“Much of the debate focused on strategy, with participants wondering whether it was better to work toward improving and narrowing conscience clauses or to fight to eliminate them altogether. ... Although reproductive rights activists should still work to improve conscientious objections, their ultimate goal should be getting rid of them.”

The threat to healthcare rights of conscience is real and growing. Currently, federal law and the laws of 47 states provide some protection to healthcare providers and institutions who object to participating in abortions. However, the stated goal of many pro-abortion activists and groups is to abolish these protections and to force healthcare providers to participate in abortions without regard for their deeply held religious, moral, or ethical beliefs. Much of the pro-abortion strategy in recent years has been focused on distorting, weakening, and ultimately eliminating federal laws and regulations that protect freedom of conscience.

Overview of Federal Conscience Protections

Federal law currently provides limited statutory protection for healthcare freedom of conscience. Congress first addressed the issue of conscience protections just weeks after the U.S. Supreme Court handed down Roe v. Wade. In 1973, Congress passed the first of the Church Amendments (named for its sponsor, Senator Frank Church). The Amendment provides that the receipt of funding through three federal programs cannot be used as a basis to compel a hospital or individual to participate in an abortion or sterilization procedure to which the hospital or individual has a moral or religious objection.

Taken together, the original and subsequent Church Amendments protect healthcare providers from discrimination by recipients of U.S. Department of Health and Human Services (HHS) funds on the basis of their objection, because of religious belief or moral conviction, to performing or participating in any lawful health service or research activity.

In 1996, Section 245 of the Public Health Service Act was enacted to prohibit the federal government and state or local governments that receive federal financial assistance from discriminating against individual and institutional healthcare providers, including participants in medical training programs, who refused, among other things, to receive training in abortions; require or provide such training; perform abortions; or provide referrals or make arrangements for such training or abortions. Known as the Coats Amendment (named for its sponsor Senator Daniel Coats), the measure responded to a proposal in 1995 by the Accredid-
tation Council for Graduate Medical Education to mandate abortion training in all obstetrics and gynecology residency programs.

The most recent federal conscience protection, the Hyde-Weldon Amendment, was first enacted in 2005 and provides that no federal, state, or local government agency or program that receives funds in the Labor, Health and Human Services (LHHS) appropriations bill may discriminate against a healthcare provider because the provider refuses to provide, pay for, provide coverage of, or refer for abortion. The Amendment is subject to annual renewal and has survived multiple legal challenges brought by pro-abortion groups.

**Enforcing Federal Conscience Protections**

In 2008, the Department of HHS (under the George W. Bush Administration) implemented regulations designed to allow enforcement of federal conscience laws by requiring that recipients of HHS funding provide written certification of their compliance with federal conscience protections. Then-HHS Secretary Mike Leavitt said:

> [The] proposed regulation is about the legal right of a health care professional to practice according to [his or her] conscience....Doctors and other healthcare providers should not be forced to choose between good professional standing and violating their conscience. Freedom of expression and action should not be surrendered upon the issuance of a health care degree.\(^5\)

In his press release, Secretary Leavitt also noted that the proposed regulation in 2008 would:

- Clarify that nondiscrimination protections apply to institutional healthcare providers as well as to individual employees working for recipients of certain funds from HHS;
- Require recipients of certain HHS funds to certify their compliance with laws protecting provider conscience rights;
- Designate the HHS Office for Civil Rights as the entity to receive complaints of discrimination addressed by the existing statutes and the proposed regulation; and
- Charge HHS officials to work with any state or local government or entity that may be in violation of existing statutes and the proposed regulation to encourage voluntary steps to bring that government or entity into compliance with the law.\(^6\)

In March 2009, the Obama Administration announced that it planned to fully revoke the Bush regulations. HHS received more than 300,000 public comments. Nearly two-thirds of those comments expressed opposition to rescinding the conscience-protecting regulations.

In response, HHS did retain the provision of the Bush regulations designating the Office of Civil Rights (OCR) of HHS to receive complaints of discrimination and coercion based on the federal healthcare provider conscience protection statutes. Though the Obama Ad-
administration had initially proposed rescinding the entirety of the regulations, HHS announced that its decision to retain the complaint process was based on its now agreement with the majority of commenters that “there must be a clear process for enforcement of the health care provider conscience protection statutes.”

The necessity for this enforcement procedure contained in the Bush regulations was highlighted by a 2010 Second Circuit Court of Appeals decision in the case *DeCarlo v. Mt. Sinai*. A nurse at Mt. Sinai hospital in New York, Plaintiff Cathy DeCarlo was forced to participate in a late term abortion despite her conscientious objection. A federal court dismissed her claim, saying that DeCarlo cannot bring suit by herself for a violation of federal law because, the court concluded, the Church Amendments do not provide for a private, individual cause of action. Instead, the court held that HHS can (if they choose) pursue Nurse DeCarlo’s case as allowed for under the 2008 regulations. There is, obviously, question as to how persistent and effective the Obama Administration will be at pursuing such cases.

Other portions of the Bush regulations were not salvaged. For example, HHS eliminated the definitions of the Bush regulations, claiming that they were “overbroad and unclear.” However, without definitions, the rights of healthcare providers—rather than being well-defined—will be determined on a case-by-case basis.

Further, believing the certification requirement would be costly and create too much paperwork, HHS announced it would substitute the requirement with an education campaign. While the scope of an education campaign led by an Administration that takes a narrow view of conscience is suspect, mere “education” certainly lacks the accountability that certification contains.

In additon, HHS appears to be perpetrating discrimination itself. The grant stipulation from the HHS Administration of Children and Families, Office of Refugee Resettlement, states it will give priority to organizations that will offer victims of human trafficking the “full range of legally permissible gynaecological and obstetric care....” The translation is that HHS intends to discriminate against organizations that do not support and refer for abortion. Ultimately, trafficking victims—who have been largely aided by pro-life Catholic organizations—will pay the price for that discrimination.

The case of Cathy DeCarlo, the uncertainty created by the Obama Administration’s partial rescission, and an emerging pattern of discrimination by HHS itself all underscore the need for Congressional action to write into the law an adequate enforcement mechanism for conscience protection. Enforcement of the basic civil right to provide care for patients without being required to participate in life-destroying and unethical activities should not hinge on who sits in the White House.

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Violations of Conscience Created by the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), the federal healthcare bill enacted in March 2010, presents an unprecedented threat to the conscience rights of insurers and purchasers of insurance. Though the PPACA makes a limited exception for certain religious groups who object to participating in government health programs generally, the law does not allow insurance purchasers, plan sponsors, and others with conscientious objections to decline providing or obtaining coverage for specific items or services.

Instead, the PPACA marks the first time that the federal government has sought to impose specific coverage or care requirements that infringe on the rights of conscience of insurers and purchasers of insurance. For example, through the Obama Administration’s interpretation of the “preventive services” for women provision contained in the PPACA, nearly all insurance plans will be required to provide full coverage for certain abortion-inducing drugs and devices.

The guidelines issued by the Health Resource Service Administration (HRSA), a sub-agency of the HHS, mandate that insurance plans cover, without a co-pay, “all FDA-approved contraceptives.” These guidelines explicitly include sterilization and so-called “emergency contraception” such as the abortion-inducing drug Ulipristal Acetate (ella), which can kill a human embryo even after implantation.

The limited conscience protection applied by HHS for what it has defined as “religious employers” is exceedingly narrow and leaves vulnerable many insurers and purchasers of insurance who object to such funding. Most religiously-affiliated schools, hospitals, and charitable organizations would not be included in the exceptions’ protection. Moreover, non-religiously affiliated institutions—whose pro-life consciences are nonetheless violated by the mandate—are unquestionably left unprotected by the limited conscience protection.

In addition, the PPACA falls short of the protection encompassed in the Hyde-Weldon Amendment, because it fails to prescribe discrimination by government entities. Further, the PPACA fails to ensure that its provisions will not preempt state law conscience protections.

Rather, a provision of the PPACA may be used to thwart state conscience protections regarding abortion. The PPACA provides that “[n]othing in this Act shall be construed to relieve any healthcare provider from providing emergency services as required by State or Federal law, including... EMTALA.” Abortion-advocacy groups are lobbying to reinterpret EMTALA, the Emergency Medical Treatment and Active Labor Act, to coerce participation in abortion. For example, American Civil Liber-
ties Union (ACLU) has asked the Centers for Medicaid and Medicare Services to construe EMTALA to force healthcare providers to perform abortions.\textsuperscript{14}

Although EMTALA does not require healthcare providers to perform abortions (and, properly read, its requirement to respond to an emergency in which a pregnant woman or “her unborn child” is in distress directs healthcare personnel to stabilize the condition of both mother and child),\textsuperscript{15} explicitly conditioning the conscience protections of the PPACA opens the door to the ACLU’s exploitation project.

Moreover, since the PPACA states that “nothing” relieves a healthcare provider from a duty to provide “emergency services” as defined by state or federal law, the conscience protections contained in the PPACA would be moot if a state passed a law (or reinterpreted its law) to define abortion as an “emergency service.”

To address these conscience-threatening measures in the PPACA, the “Protect Life Act” and the “Respect for Rights of Conscience Act” have been introduced in both the U.S. House and Senate.

**Protections for Military Healthcare Providers**

Notably, federal law also provides protections for military healthcare providers. Pursuant to Department of Defense (DOD) and individual service directives, military healthcare providers may refuse to participate, directly or indirectly, in medical procedures that they find morally or religiously objectionable. As with other rights of religious accommodation, this right will be balanced against military necessity and the potential adverse affect on unit readiness, individual readiness, unit cohesion, morale, discipline, safety, or health. Any refusals to provide medical care based on religious objections should be disclosed in advance to the provider’s chain of command and to patients as the need arises.


1. A provider who disagrees with a patient’s wishes [as a treatment], as a matter of conscience, should arrange for transfer of care to another qualified provider willing to proceed according to the patient’s wishes within the limits of the law and medical ethics.

2. Military treatment facilities and Tri-care [health insurance system for military dependents and retirees and their dependants] network providers and facilities shall disclose to patients… matters of conscience … that could influence medical advice or treatment decisions.

While individual healthcare providers may refuse to participate in certain medical procedures, these procedures will still generally

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be provided by the military treatment facility (MTF) or an affiliated civilian facility or provider. Elective abortion is the only exception to this rule. Abortions are not performed in MTFs unless the mother’s life is endangered by a continued pregnancy or the pregnancy results from rape or incest.

Unfortunately, healthcare professionals serving in the military are not immune from the radical agenda of pro-abortion advocates. For example, in 2010, Congress considered a version of the DOD authorization bill that contained a provision, known as the “Burris Amendment,” that would have changed the law regarding abortion in military facilities and sanctioned the use of military medical facilities, equipment, and personnel for elective abortions. The Amendment failed, but legislation similar to the “Burris Amendment” will likely continue to be introduced by abortion advocates. It remains a top objective for abortion activists to require that MTFs (both in the U.S. and overseas) provide elective abortions (paid for or subsidized at taxpayer expense as is all military medical care). To achieve this objective, they would also need to circumvent DOD protections for healthcare rights of conscience as a majority of military physicians would likely refuse to provide or participate in the abortions.

Finally, MTFs (both in the continental United States and at overseas locations) provide a range of contraceptive options to military members and their dependents, including sterilization. Recently, DOD issued a directive requiring “emergency contraception” be carried at all MTFs and military pharmacies.

**Overview of State Conscience Protections**

The battle over healthcare rights of conscience is being waged primarily in the 50 states. Currently, 47 states provide some degree of protection for certain healthcare providers to decline to provide or participate in abortions. However, only 2 states—Louisiana and Mississippi—provide comprehensive protections for all healthcare providers and for all healthcare procedures and services. Further, only 3 states—Alabama, New Hampshire, and Vermont—provide no protection for healthcare rights of conscience.

However, an increasing number of states are considering measures to force providers—primarily pharmacists—to provide services in violation of their consciences. These attacks are originating from the governors’ mansions, the state legislatures, and state medical governing and licensing agencies.

For example, in 2005 then-Illinois Governor Rod Blagojevich signed an Executive Order requiring pharmacists and pharmacies to fill prescriptions for contraceptives, including “emergency contraception,” “without delay.” Governor Blagojevich’s coercive measure was struck down by an Illinois circuit court in April 2011. The court found that the rule was improperly aimed at pharmacists and pharmacies holding religious convictions. Moreover, despite arguments claiming the rule was necessary in order to ensure availability of “emergency contraception,” the court noted that not a single person has ever been unable to obtain “emergency contraception” because of a pharmacist’s religious objection. In addition, the court held that the case “clearly falls within the reach” of the Illinois Healthcare Right of Con-
science Act. The court found the “plain language” of the statute applied to “pharmacists and pharmacies.” Though the court’s decision was a victory for conscience rights, abortion advocates remain on the attack and the Illinois Attorney General has appealed the decision.

Another example comes out of the state of Washington, where conscience rights have recently been in flux. In 2007 the State Board of Pharmacy in Washington issued a rule requiring pharmacies to fill, regardless of conscience or other objections, prescriptions for any drug including contraceptives or, if the particular drug is not in stock, to facilitate the patient’s access to that drug. In 2010, the State Board of Pharmacy, facing a protracted legal battle over the constitutionality of the rule, re-opened the rule-making process to consider changes that would both ensure patient access and protect individual conscience. However, later in 2010 the Board stopped the process of attempting to revise the regulation and the case is now proceeding to trial in fall 2011.

Endnotes
1 See I. Glasser, Director, American Civil Liberties Union, Conscientious Exemptions and Reproductive Rights, EXECUTIVE SUMMARY 10 (2002). Glasser was reporting on a 2002 national meeting involving the ACLU Reproductive Freedom Project, the Pro-Choice Resource Center, and the George Gund Foundation.
3 42 U.S.C. § 238n.
6 Id.
8 Id.
9 Cenzon-DeCarlo v. Mount Sinai Hosp., 626 F.3d 695 (2d Cir. N.Y. 2010).
11 Id. at §1311(d)(4)(H).
12 Both ella and the FDA-approved abortion drug mifepristone (RU-486) are Selective Progesterone Receptor Modulators (SPRMs). Both work by blocking progesterone (a hormone necessary to build and maintain the uterine wall during pregnancy), and can either prevent a developing human embryo from implanting in the uterus, or kill an implanted embryo by starving it to death. D. Harrison & J. Mitroka, Defining Reality: The Potential Role of Pharmacists in Assessing the Impact of Progesterone Receptor Modulators and Misoprostol in Reproductive Health, 45 ANNALS PHARMACOTHERAPY 115 (Jan. 2011) (“The mechanism of action of ulipristal in human ovarian and endometrial tissue is identical to that of its parent compound mifepristone.”). Despite this scientific fact, the FDA approved ella as a “contraceptive.”
13 PPACA, supra, at §1303(d).
15 42 U.S.C 1395dd (b)(1)(A)&(B).