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**UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA**

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, in his official
capacity as Secretary of the United
States Department of Health and
Human Services; and UNITED
STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,

Defendants.

Nos. 2:19-cv-0183-SAB

**DEFENDANTS' MOTION TO
DISMISS, OR, IN THE
ALTERNATIVE, FOR
SUMMARY JUDGMENT**

Hearing: November 7, 2019
With Oral Argument: 10:00 AM

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22

INTRODUCTION

1
2 In recognition of the need for tolerance of religious and moral differences
3 in a pluralistic society, Congress has enacted conscience accommodations in a
4 wide range of areas.¹ This case concerns the numerous conscience and anti-
5 discrimination accommodations that Congress has enacted in the health care
6 arena. Collectively, these Federal Conscience Statutes protect individuals and
7 entities with religious, moral, or other views associated with providing (or, in
8 some cases, providing coverage for) certain services in government provided or
9 government-funded health care programs. To name one such provision, the
10 Church Amendments bar the recipients of specific federal funds from, for
11 example, firing a nurse because he or she declines to participate in an abortion
12 for religious or moral reasons. 42 U.S.C. § 300a-7(b). Other Federal Conscience
13 Statutes relate to different health care services, such as assisted suicide, and
14 cover additional health care entities, such as insurers.

15 The Federal Conscience Statutes work by placing conditions on federal
16 funding—those who accept the funds voluntarily accept the anti-discrimination
17 provisions. Plaintiff, the State of Washington, has accepted and plans to continue
18 accepting federal funds subject to the Federal Conscience Statutes. But Plaintiff

19 _____
20 ¹ Cf. Wash. Rev. Code 48.43.065 (“The [Washington] legislature
21 recognizes that every individual possesses a fundamental right to exercise their
22 religious beliefs and conscience.”).

1 | apparently objects to the accompanying federal conditions. Of course, it is
2 | completely routine and unobjectionable for the federal government to encourage
3 | favored conduct through conditions on federal funding—indeed, it is so routine
4 | and unobjectionable that Plaintiff actually cites several of the Federal
5 | Conscience Statutes as examples of appropriate legislation and does not
6 | challenge a single one. Instead, Plaintiff brings a collateral challenge to a recent
7 | regulation issued by the Department of Health and Human Services (HHS), that
8 | describes the agency’s process for enforcing the Federal Conscience Statutes as
9 | to federal funds that HHS administers. Protecting Statutory Conscience Rights in
10 | Health Care; Delegations of Authority, 84 Fed. Reg. 23,170–01 (May 21, 2019)
11 | (the Rule). The Rule provides clarifying definitions and explains how HHS will
12 | take enforcement action, but the Rule is not the source of HHS’s enforcement
13 | power. To the contrary, the Federal Conscience Statutes themselves obligate and
14 | compel HHS to meet the Statutes’ conditions in disbursing HHS funding.
15 | Plaintiff’s challenge to the Rule is therefore misplaced. It is Congress—not
16 | HHS—that has made the policy determination to protect health care entities
17 | against discrimination based on religious, moral, or ethical beliefs.

18 | Even if that were not the case, Plaintiff’s challenge fails on the merits.

19 | *First*, Plaintiff’s cataclysmic predictions about the potential loss of all of
20 | its federal health care funding are not ripe. Before Plaintiff’s fears could possibly
21 | come to pass, multiple speculative events would have to occur. The Court thus
22 | lacks a concrete setting and important factual information to resolve Plaintiff’s

1 claims, such as an alleged violation, the amount of federal funding that Plaintiff
2 stands to lose, and the interaction between any applicable state statutes, the Rule,
3 and the Federal Conscience Statutes.

4 *Second*, the Rule is entirely consistent with the Administrative Procedure
5 Act (APA). The Rule does not change any of the substantive requirements of the
6 Federal Conscience Statutes but simply clarifies HHS’s enforcement process.
7 HHS is acting squarely within its statutory authority to implement the conditions
8 that Congress placed on federal funding. The definitions provided in the Rule,
9 moreover, are consistent with the Federal Conscience Statutes. And the Rule is
10 neither arbitrary nor capricious, because HHS thoroughly considered all of the
11 concerns presented in comments.

12 *Third*, the Rule comports with the Constitution. Plaintiff’s constitutional
13 claims are facial, and therefore to succeed Plaintiff must show that the Rule is
14 invalid in all applications—a difficult task given that Plaintiff’s claims rely on a
15 series of outlandish hypotheticals about HHS’s potential enforcement actions.
16 The Federal Conscience Statutes, which Plaintiff endorses, offer recipients a
17 simple deal: federal funds in exchange for nondiscrimination. This offer is well
18 within the bounds of the Spending Clause. If the Statutes do not violate the
19 Spending Clause, then a rule faithfully implementing them also does not.
20 Moreover, it is beyond dispute that when the government acts to preserve
21 neutrality in the face of religious differences, it does not “establish” or prefer
22 religion.

1 Plaintiff is welcome to structure its own health care systems in the lawful
2 manner of its choice—the Federal Conscience Statutes and the Rule are not
3 universal requirements binding on the world. But the Statutes and Rule do
4 require that, if Plaintiff accepts federal funds, it must extend tolerance and
5 accommodation to objecting individuals and health care entities. These
6 conditions are longstanding. If Plaintiff is unwilling to afford such tolerance to
7 protected parties, or has become unwilling, then it has the straightforward
8 remedy of no longer accepting the conditioned federal funds. What Plaintiff may
9 *not* do is accept the benefit of its bargain, and then balk at fulfilling its anti-
10 discrimination obligations.

11 The Court should dismiss this case or, in the alternative, grant summary
12 judgment to Defendants.

13 LEGAL AND FACTUAL BACKGROUND

14 I. Statutory History of Relevant Conscience Protections

15 Congress has long acted to protect the rights of individuals and entities to
16 maintain the free exercise of their religious, moral, and ethical beliefs in
17 providing government-funded health care. The Rule gives effect to various
18 conscience protection provisions put in place by Congress—known collectively
19 as the Federal Conscience Statutes. The four key laws addressed by the Rule and
20 discussed below, are (1) the Church Amendments (42 U.S.C. § 300a-7); (2) the
21 Coats-Snowe Amendment (42 U.S.C. § 238n(a)); (3) the Weldon Amendment
22 (*see, e.g.*, Departments of Defense and Labor, Health and Human Services, and

1 Education, and Related Agencies Appropriations Act, 2019, Div. B., sec. 507(d),
2 Pub. L. No. 115-245, 132 Stat. 2981, 3118 (Sept. 28, 2018)); and (4) the
3 conscience protection provisions in the Patient Protection and Affordable Care
4 Act (ACA) (*i.e.*, 42 U.S.C. § 18113; 42 U.S.C. § 14406(1); 26 U.S.C. § 5000A;
5 42 U.S.C. § 18081; 42 U.S.C. § 18023(b)(1)(A) and (b)(4)).²

7 ² Other statutes implemented by the Rule include: conscience protections
8 for Medicare Advantage organizations and Medicaid managed care
9 organizations with moral or religious objections to counseling or referral for
10 certain services (42 U.S.C. §§ 1395w-22(j)(3)(B) and 1396u-2(b)(3)(B));
11 conscience protections related to the performance of advanced directives (42
12 U.S.C. §§ 1395cc(f), 1396a(w)(3), and 14406(2)); conscience and
13 nondiscrimination protections for organizations related to Global Health
14 Programs, to the extent such funds are administered by the Secretary of Health
15 and Human Services (Secretary) (22 U.S.C. § 7631(d)); conscience protections
16 attached to federal funding regarding abortion and involuntarily sterilization, to
17 the extent such funding is administered by the Secretary, (22 U.S.C. § 2151b(f),
18 *see, e.g.*, the Consolidated Appropriations Act, 2019, Pub. L. No. 116-6, Div. F,
19 sec. 7018, 133 Stat. 13, 307); conscience protections from compulsory health
20 care or services generally (42 U.S.C. §§ 1396f and 5106i(a)), and under specific
21 programs for hearing screening (42 U.S.C. § 280g-1(d)), occupational illness
22

1 **A. The Church Amendments**

2 The Church Amendments, which were enacted beginning in the 1970s,
3 apply to entities that receive certain federal funds and to health service programs
4 and research activities funded by HHS. 42 U.S.C. § 300a–7. The Church
5 Amendments require those entities not to discriminate based on religious beliefs
6 or moral convictions regarding sterilization procedures, abortions, or health
7 service or research activities, including based on an individual’s performance (or
8 assistance in) such a procedure or activity, based on an individual’s refusal to
9 perform (or assist in) such a procedure or activity, and an individual’s religious
10 beliefs or moral convictions about such procedures more generally. *Id.* The
11 Church Amendments contain provisions explicitly protecting the rights of both
12 individuals and entities. *Id.* Examples of discrimination barred by the Church
13 Amendments include the threat of an individual losing his or her job and the
14 threat of an entity being forced to provide abortions as a condition of receiving
15 government funding. *See generally id.* Although the statute codifying the Church
16 _____

17 testing (29 U.S.C. § 669(a)(5)), vaccination (42 U.S.C. § 1396s(c)(2)(B)(ii)), and
18 mental health treatment (42 U.S.C. § 290bb-36(f)); and protections for religious,
19 nonmedical health care providers and their patients from certain requirements
20 under Medicare and Medicaid that may burden their exercise of their religious
21 beliefs regarding medical treatment (*e.g.*, 42 U.S.C. §§ 1320a-1(h), 1320c-11,
22 1395i-5, 1395x(e), 1395x(y)(1), 1396a(a), and 1397j-1(b)).

1 Amendments does not define its terms, parts of it apply explicitly to both the
2 “performance” of such procedures or activities and “assist[ing] in the
3 performance of” such procedures or activities. 42 U.S.C. § 300a-7(b)(1), (b)(2),
4 (c)(1)(B), (c)(2)(B), (d), (e).

5 **B. The Coats-Snowe Amendment**

6 Section 245 of the Public Health Service Act, known as the Coats-Snowe
7 Amendment, was enacted by Congress with bipartisan support in 1996. It
8 applies nondiscrimination requirements to the federal government and to certain
9 State and local governments. 42 U.S.C. § 238n. The sponsor of the statute,
10 Senator Snowe, described her goal as to “protect those institutions and those
11 individuals who do not want to get involved in the performance or training of
12 abortion,” while still maintaining adequate medical training standards for
13 women’s gynecological care. Balance Budget Downpayment Act, II, 142 Cong.
14 Rec. S2268 (Statement of Sen. Snowe) (Mar. 19, 1996).

15 Specifically, the Coats-Snowe Amendment prohibits the federal
16 government and any State or local government that receives federal financial
17 assistance from discriminating against a health care entity that, among other
18 things, refuses to perform induced abortions; to provide, receive, or require
19 training on performing induced abortions; or to provide referrals or make
20 arrangements for such activities. 42 U.S.C. § 238n(c)(1). The Coats-Snowe
21 Amendment defines the term “health care entity” as *including* (and, therefore,
22 not being limited to) an “individual physician, a postgraduate physician training

1 program, and a participant in a program of training in the health professions.” *Id.*
2 The Coats-Snowe Amendment also applies to accreditation of postgraduate
3 physician training programs. *Id.* § 238n(b)(1).

4 C. The Weldon Amendment

5 Since 2004, Congress has also included nondiscrimination protections,
6 referred to as the Weldon Amendment, in every appropriations bill for the
7 Departments of Labor, Health and Human Services, and Education. *See, e.g.,*
8 Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, Title V,
9 sec. 508(d)(1)–(2), 118 Stat. 2809, 3163 (2004); Pub. L. No. 115-245, Div. B.,
10 sec. 507(d), 132 Stat. at 3118. The Weldon Amendment provides, in pertinent
11 part, that “[n]one of the funds made available in this Act may be made available
12 to a federal agency or program, or to a State or local government, if such agency,
13 program, or government subjects any institutional or individual health care entity
14 to discrimination on the basis that the health care entity does not provide, pay
15 for, provide coverage of, or refer for abortions.” *Id.* The Weldon Amendment’s
16 scope and definitions are broad, defining the term “health care entity” as
17 “includ[ing] an individual physician or other health care professional, a hospital,
18 a provider-sponsored organization, a health maintenance organization, a health
19 insurance plan, or any other kind of health care facility, organization, or plan.”
20 *Id.* The Weldon Amendment is a restriction on HHS’s use of funds, and thus,
21 HHS must abide by the Weldon Amendment in its use and distribution of funds,
22 through grant programs or otherwise.

1 **D. Conscience Protections in the ACA**

2 Congress separately included several conscience protections in the ACA,
3 including:

4 **Section 1553** of the ACA provides that the federal government, and any
5 State or local government or health care provider that receives federal financial
6 assistance under the ACA, or any health plan created under the ACA:

7 may not subject an individual or institutional health care entity to
8 discrimination on the basis that the entity does not provide any
9 health care item or service furnished for the purpose of causing, or
for the purpose of assisting in causing, the death of any individual,
such as by assisted suicide, euthanasia, or mercy killing.

10 42 U.S.C. § 18113. In § 1553, Congress again defined the term “health care
11 entity” broadly to “include [] an individual physician or other health care
12 professional, a hospital, a provider-sponsored organization, a health maintenance
13 organization, a health insurance plan, or any other kind of health care facility,
14 organization, or plan.” *Id.* Section 1553 also specifically designates HHS’s
15 Office for Civil Rights (OCR) to receive complaints of discrimination relating to
16 participation in assisted suicide. *Id.*

17 **Section 1303** declares that the ACA does not require health plans to
18 provide coverage of abortion services as part of “essential health benefits.” 42
19 U.S.C. § 18023(b)(1)(A)(i). Furthermore, no qualified health plan offered
20 through an ACA exchange may discriminate against any individual health care
21 provider or health care facility because of its unwillingness to provide, pay for,
22

1 provide coverage of, or refer for, abortions. *See id.* § 18023(b)(4). The ACA also
2 clarified that nothing in the Act is to be construed to “have any effect on federal
3 laws regarding—(i) conscience protection; (ii) willingness or refusal to provide
4 abortion; and (iii) discrimination on the basis of the willingness or refusal to
5 provide, pay for, cover, or refer for abortion or to provide or participate in
6 training to provide abortion.” *Id.* § 18023(c)(2)(A)(i)–(iii).

7 *Section 1411* designates HHS as the agency responsible for issuing
8 certifications to individuals who are entitled to an exemption from the individual
9 responsibility requirement imposed under section 5000A of the Internal Revenue
10 Code, including when such individuals are exempt based on a hardship (such as
11 the inability to secure affordable coverage without abortion), are members of an
12 exempt religious organization or division, or participate in a “health care sharing
13 ministry[.]” 42 U.S.C. § 18081(b)(5)(A); *see also* 26 U.S.C. § 5000A(d)(2).

14 **II. Unchallenged Rules that Require Compliance with the Federal** 15 **Conscience Statutes**

16 HHS has issued several rules, in addition to the challenged Rule, that require
17 recipients of federal funds to comply with federal law, including the Federal
18 Conscience Statutes. For example, HHS promulgated the Uniform
19 Administrative Requirements, Cost Principles, and Audit Requirements for HHS
20 Awards (UAR), which impose consistent and enforceable requirements for
21 governed recipients. *See* Federal Awarding Agency Regulatory Implementation
22 of Office of Management and Budget’s Uniform Administrative Requirements,

1 Cost Principles, and Audit Requirements for Federal Awards, 79 Fed. Reg.
2 75,872-01, 75,889 (Dec. 19, 2014). These requirements are broad-ranging, and
3 include records retention and management, property, and procurement standards;
4 fiscal and program management standards; and importantly for this litigation,
5 statutory and national policy requirements and remedies for noncompliance. The
6 UAR states, “The Federal awarding agency must manage and administer the
7 Federal award in a manner so as to ensure that Federal funding is expended and
8 associated programs are implemented *in full accordance with U.S. statutory and*
9 *public policy requirements*: Including, but not limited to, . . . prohibiting
10 discrimination.” 45 C.F.R. § 75.300(a) (emphasis added). It also lists remedies
11 for noncompliance:

12 If a non-Federal entity fails to comply with *Federal statutes,*
13 *regulations, or the terms and conditions of a Federal award,* the
14 HHS awarding agency or pass-through entity may impose
15 additional conditions, as described in § 75.207. If the HHS
16 awarding agency or pass-through entity determines that
17 noncompliance cannot be remedied by imposing additional
18 conditions, the HHS awarding agency or pass-through entity may
19 take one or more of the following actions, as appropriate in the
20 circumstances:

18 (a) Temporarily withhold cash payments pending correction
19 of the deficiency by the non-Federal entity or more severe
20 enforcement action by the HHS awarding agency or pass-
21 through entity.

20 (b) Disallow (that is, deny both use of funds and any
21 applicable matching credit for) all or part of the cost of the
22 activity or action not in compliance.

1 (c) Wholly or partly suspend (suspension of award activities)
2 or terminate the Federal award.

3 (d) Initiate suspension or debarment proceedings as
4 authorized under 2 CFR part 180 and HHS awarding agency
5 regulations at 2 CFR part 376 (or in the case of a pass-
6 through entity, recommend such a proceeding be initiated by
7 a HHS awarding agency).

8 (e) Withhold further Federal awards for the project or
9 program.

10 (f) Take other remedies that may be legally available.

11 45 C.F.R. § 75.371 (emphasis added). The UAR also describes how HHS may
12 terminate a federal award. *See* 45 C.F.R. §§ 75.372–75.375. And last, the UAR
13 sets forth standards for auditing nonfederal entities expending federal awards.
14 *See* 45 C.F.R. §§ 75.501–75.520.

15 The Federal Acquisition Regulation (FAR), C.F.R. Title 48, allows the
16 government to enforce contractor compliance with federal law. The FAR applies
17 to all acquisitions, which are defined, in part, as the acquiring by contract with
18 appropriated funds of supplies or services by and for the use of the federal
19 government through purchase or lease. 48 C.F.R. § 2.101. The FAR provides for
20 the inclusion of a contract clause, specifically for the purchase of commercial
21 items, that a “Contractor shall comply with all applicable Federal, State and
22 local laws, executive orders, rules and regulations applicable to its performance
under this contract.” 48 C.F.R. § 52.212-4(q). The FAR also requires inclusion,
for example, of a clause in contracts that requires contractors to promote an

1 organizational culture that encourages ethical conduct and a commitment to
2 compliance with the law. 48 C.F.R. § 52.203-13. The FAR provides a variety of
3 mechanisms that may be used to enforce such contract provisions. 48 C.F.R. Part
4 49.

5 HHS has also issued its own acquisition regulation, the HHS Acquisition
6 Regulations (HHSAR), 48 C.F.R. Ch. 3, pursuant to 48 C.F.R. § 1.103. The
7 HHSAR requires contractors to comply with various aspects of federal law. The
8 HHSAR additionally includes a nondiscrimination clause for conscience
9 objections relating to receiving assistance under section 104A of the Foreign
10 Assistance Act of 1961, the United States Leadership Against HIV/AIDS,
11 Tuberculosis, and Malaria Act of 2003, the Tom Lantos and Henry J. Hyde
12 United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria
13 Reauthorization Act of 2008, or any amendment to the foregoing Acts for
14 HIV/AIDS prevention, treatment, or care, 48 C.F.R. § 352.270-9.

15 **III. HHS Conscience Protection Regulations**

16 **A. 2008 and 2011 HHS Conscience Protection Regulations**

17 In 2008, HHS issued regulations clarifying the applicability of the Church,
18 Coats-Snowe, and Weldon Amendments and designating OCR to receive
19 complaints and coordinate with applicable HHS funding components to enforce
20 the Federal Conscience Statutes. *See* 45 C.F.R. § 88 *et seq.* (2008 Rule);
21 Ensuring That Department of Health and Human Services Funds Do Not
22 Support Coercive or Discriminatory Policies or Practices in Violation of Federal

1 Law, 73 Fed. Reg. 78,072-01 (Dec. 19, 2008). The 2008 Rule recognized (1) the
2 lack of consistent awareness of these statutory protections among federally
3 funded recipients and protected persons and entities, and (2) the need for greater
4 enforcement mechanisms to ensure that HHS funds do not support morally
5 coercive or discriminatory policies or practices in violation of the Federal
6 Conscience Statutes. 73 Fed. Reg. at 78,078–81.

7 In 2011, however, HHS rescinded the 2008 Rule in part and issued a new
8 rule with a more limited scope and enforcement mechanism after noting
9 concerns about whether the 2008 Rule was consistent with the new
10 administration’s priorities. *See* Regulation for the Enforcement of Federal Health
11 Care Provider Conscience Protection Laws, 76 Fed. Reg. 9968-02 (2011 Rule);
12 *see also* Rescission of the Regulation Entitled “Ensuring That Department of
13 Health and Human Services Funds Do Not Support Coercive or Discriminatory
14 Policies or Practices in Violation of Federal Law”; Proposal, 74 Fed. Reg.
15 10,207 (Mar. 10, 2009). The preamble to the 2011 Rule expressed HHS’s
16 support for conscience protections for health care providers and indicated the
17 need for enforcement of the Federal Conscience Statutes. *See, e.g., id.* at 9968–
18 69. Nevertheless, the 2011 Rule created ambiguity regarding OCR’s
19 enforcement tools and removed the definitions of key statutory terms. *Id.*

20 **B. Notice of Proposed Rulemaking**

21 On January 26, 2018, HHS published a Notice of Proposed Rulemaking
22 (NPRM) to revise and expand earlier regulations, in order to properly implement

1 the Federal Conscience Statutes in programs funded by HHS. *See generally*
2 NPRM, Protecting Statutory Conscience Rights in Health Care; Delegations of
3 Authority, 83 Fed. Reg. 3880 (Jan. 26, 2018). HHS’s stated goals were to (1)
4 “effectively and comprehensively enforce Federal health care conscience and
5 associated anti-discrimination laws[,]” (2) grant OCR overall enforcement
6 responsibility to ensure compliance with these federal laws; and (3) clear up
7 confusion caused by certain OCR sub-regulatory guidance. *Id.* at 3881, 3890. In
8 particular, “there [wa]s a significant need to amend the 2011 Rule to ensure
9 knowledge, compliance, and enforcement of the Federal health care conscience
10 and associated anti-discrimination laws.” *Id.* at 3887. For example, the 2011
11 Rule was inadequate because it covered only three of the Federal Conscience
12 Statutes. Following a sixty-day comment period, HHS analyzed and carefully
13 considered all comments on the NPRM and made appropriate modifications
14 before finalizing the Rule. *See* 84 Fed. Reg. at 23,180.

15 C. Final Rule

16 The Rule implements federal nondiscrimination protections for
17 individuals, health care providers, and health care entities with objections—
18 including religious or moral objections—to providing, participating in, paying
19 for, or referring for certain health care services, and also provides procedures for
20 the effective enforcement of those protections. The Rule clarifies the
21 requirements of the Federal Conscience Statutes, addresses the inadequate
22 enforcement of conscience rights under existing federal laws, and educates

1 individuals and entities who presently lack knowledge of their statutory and civil
2 rights or obligations under HHS-funded or administered programs. 84 Fed. Reg.
3 at 23,175–79. The Rule does not change the substantive law of the Federal
4 Conscience Statutes, as established by Congress. *See* 84 Fed. Reg. 23,256 (“This
5 rule holds States and local governments accountable for compliance with [the
6 Federal Conscience Statutes] by setting forth mechanisms for OCR investigation
7 and HHS enforcement related to those requirements. The Rule does not change
8 the substantive conscience protections or anti-discrimination requirements of
9 these statutes.”).

10 The Rule has five principal provisions.

11 *First*, the Rule sets forth, in a single place, the various statutory
12 conscience protections that apply to particular HHS-funded health programs. *See*
13 45 C.F.R. § 88.

14 *Second*, it defines various terms in the Federal Conscience Statutes in a
15 way that implements the plain text and spirit of those Statutes and fully protects
16 religious and moral conscience objections. Among the statutory terms defined in
17 the Rule are “assist in the performance,” “discriminate or discrimination,”
18 “health care entity,” and “referral or refer for.” *See* 45 C.F.R. § 88.2. Other than
19 “health care entity,” Congress did not define these terms in the relevant statutes.
20 Accordingly, the Rule defines these statutory terms to clarify their scope and to
21 provide adequate enforcement notice to covered entities.
22

1 *Third*, the Rule requires recipients of federal funds to provide assurances
2 and certifications of compliance with the applicable federal conscience
3 requirements. 45 C.F.R. § 88.4. Written assurances and certifications of
4 compliance with the Federal Conscience Statutes must be submitted during the
5 application and reapplication processes associated with receiving federal
6 financial assistance or federal assistance. *Id.* Entities that are already receiving
7 such assistance as of the effective date of the Rule are not required to submit an
8 assurance or certification until they reapply for such assistance, alter the terms of
9 existing assistance, or apply for new lines of federal assistance. *Id.* OCR may
10 require additional assurances and certifications if OCR or HHS has reason to
11 suspect noncompliance with the Federal Conscience Statutes. *Id.*

12 *Fourth*, the Rule establishes enforcement tools to protect conscience
13 rights. 45 C.F.R. § 88.7. OCR will conduct outreach, provide technical
14 assistance, initiate compliance reviews, conduct investigations, and seek
15 voluntary resolutions to more effectively address violations and resolve
16 complaints. *Id.* Where voluntary resolutions are not possible, OCR will
17 supervise and coordinate compliance using existing and longstanding procedures
18 to enforce conditions on grants, contracts, and other funding instruments. *Id.*
19 (citing, *e.g.*, the FAR and 45 C.F.R. Part 75).³ To ensure that recipients of HHS

21 ³ Involuntary remedies—such as the withholding of funds, termination,
22

1 funds comply with their legal obligations, as HHS does with other civil rights
2 laws within its purview, HHS will require certain funding recipients (and sub-
3 recipients) to maintain records and cooperate with OCR’s investigations,
4 reviews, and enforcement actions. *Id.*; NPRM, 83 Fed. Reg. 3881.

5 *Fifth*, the Rule incentivizes, but does not require, recipients and sub-
6 recipients to post a notice summarizing the Federal Conscience Statutes on their
7 website, in employee materials or student handbooks, or in another prominent
8

9 suspension, or debarment—will not occur under the Rule itself, but rather, under
10 HHS’s separate regulations governing grants and contracts. 84 Fed. Reg. 23,222;
11 *see also* 45 C.F.R. 75.374 (addressing HHS’s process when a non-federal entity
12 fails to comply with conditions on a federal award, and requiring that “[u]pon
13 taking any remedy for non-compliance, the HHS awarding agency must provide
14 the non-Federal entity an opportunity to object and provide information and
15 documentation challenging the suspension or termination action, in accordance
16 with written processes and procedures published by the HHS awarding agency”
17 and “must comply with any requirements for hearings, appeals or other
18 administrative proceedings to which the non-Federal entity is entitled under any
19 statute or regulation applicable to the action involved”); 45 C.F.R. part 16
20 (describing the procedures of the Departmental Grant Appeals Board, which
21 reviews certain grants disputes as specified in Appendix A to Part 16).
22

1 location in the workplace. *See* 45 C.F.R. § 88.5.

2 The Rule also includes a severability provision. *See* 45 C.F.R. § 88.10. It
3 states that, if any part of the Rule is held to be invalid or unenforceable, it shall
4 be severable from the remainder of the Rule, which shall remain in full force and
5 effect to the maximum extent permitted by law. *See* 45 C.F.R. § 88.10.

6 **IV. This Litigation**

7 Plaintiff filed suit challenging the Rule and moved for a preliminary
8 injunction. *See* Compl., ECF No. 1; Wash.’s Mot. Prelim. Inj. (PI Mem.), ECF
9 No. 8. Subsequently, the Court granted the parties’ stipulated request to
10 postpone the effective date of the Rule until November 22, 2019, and held
11 Plaintiff’s motion for a preliminary injunction in abeyance. Order, ECF No. 28.
12 The Court then set a briefing schedule for cross-motions for summary judgment.
13 Order, ECF No. 35. Pursuant to the Court’s order, Defendants now move to
14 dismiss or, in the alternative, for summary judgment.⁴

15 **ARGUMENT**

16 **I. Legal Standard**

17 Defendants move to dismiss Plaintiff’s claims in their entirety under Rules
18 12(b)(1) and 12(b)(6) of the Federal Rules of Civil Procedure. Plaintiff bears the
19 burden to show subject matter jurisdiction, and the Court must determine

20 _____
21 ⁴ As this is a record-review case, Defendants do not submit a separate
22 statement of material facts not in dispute. LCivR 56(i).

1 whether it has jurisdiction before addressing the merits. *Steel Co. v. Citizens for*
2 *a Better Env't*, 523 U.S. 83, 94–95, 104 (1998). Under Rule 12(b)(6), a court
3 should grant a motion to dismiss if the complaint does not state “enough facts to
4 state a claim to relief that is plausible on its face.” *Bell Atl. Corp. v. Twombly*,
5 550 U.S. 544, 570 (2007). Although factual allegations are viewed in the light
6 most favorable to the plaintiff, the complaint must show “more than a sheer
7 possibility that a defendant has acted unlawfully”—“[t]hreadbare recitals of the
8 elements of a cause of action, supported by mere conclusory statements, do not
9 suffice.” *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Twombly*, 550
10 U.S. at 570). Furthermore, Plaintiff raises only facial challenges to the Rule,
11 which are “the most difficult challenge[s] to mount successfully.” *United States*
12 *v. Salerno*, 481 U.S. 739, 745 (1987). To prevail, Plaintiff must “establish that
13 no set of circumstances exists under which [the statute] would be valid, or that
14 the statute lacks any plainly legitimate sweep.” *United States of Am. v. Sineneng-*
15 *Smith*, 910 F.3d 461, 470 (9th Cir. 2018) (quoting *United States v. Stevens*, 559
16 U.S. 460, 472 (2010)).

17 In the alternative, Defendants ask that the Court enter summary judgment
18 in their favor. Summary judgment is appropriate if “there is no genuine dispute
19 as to any material fact and the movant is entitled to judgment as a matter of
20 law.” Fed. R. Civ. P. 56(a). For claims brought under the APA, a motion for
21 summary judgment is the appropriate vehicle for summary disposition of the
22 case with one significant caveat: “the district judge sits as an appellate tribunal”

1 to resolve issues at summary judgment. *McCrary v. Gutierrez*, No. C-08-
2 015292, 2010 WL 520762, at *2 (N.D. Cal. Feb. 8, 2010) (quoting *Am.*
3 *Bioscience v. Thompson*, 269 F.3d 1077, 1083 (D.C. Cir. 2001)).

4 Under the APA, an agency’s decision must be upheld unless arbitrary,
5 capricious, an abuse of discretion, or otherwise not in accordance with law. 5
6 U.S.C. § 706(2)(A). Under this deferential standard, the agency’s decision is
7 presumed valid, and the Court considers only whether it “was based on a
8 consideration of the relevant factors and whether there has been a clear error of
9 judgment.” *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416
10 (1971). An agency’s decision may be deemed arbitrary and capricious only in
11 circumstances where the agency “has relied on factors which Congress has not
12 intended it to consider, entirely failed to consider an important aspect of the
13 problem, offered an explanation for its decision that runs counter to the evidence
14 before the agency,” or where its decision “is so implausible that it could not be
15 ascribed to a difference in view or the product of agency expertise.” *Motor*
16 *Vehicle Mfrs. Ass’n, Inc. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 43
17 (1983). The Court may not “substitute its judgment for that of the agency.” *Id.*

18 **II. Plaintiff’s Spending Clause and Establishment Clause Claims Are**
19 **Unripe.**

20 As an initial matter, Plaintiff’s Spending Clause and Establishment Clause
21 claims are not ripe for review, because Plaintiff has identified no specific
22 enforcement action taken against it under the Rule—as indeed, it cannot, given

1 that Defendants have postponed the effective date of the Rule. *See Yahoo!, Inc.*
2 *v. La Ligue Contre La Racisme Et. L'Antisemitise*, 433 F.3d 1199, 1211 (9th Cir.
3 2006). Both claims rely on hypotheses about HHS's enforcement of the Rule
4 that are not yet clearly factually defined. At least two courts have declined to
5 decide similarly premature challenges to the underlying Federal Conscience
6 Statutes on standing and ripeness grounds. *See, e.g., Nat'l Family Planning &*
7 *Reprod. Health Ass'n, Inc. (NFPRHA) v. Gonzales*, 468 F.3d 826, 827 (D.C. Cir.
8 2006); *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at
9 *3 (N.D. Cal. Mar. 18, 2008).

10 In particular, Plaintiff's Spending Clause and Establishment Clause claims
11 are not ripe because they rest on "contingent future events that may not occur as
12 anticipated, or indeed may not occur at all." *Texas v. United States*, 523 U.S.
13 296, 300 (1998) (citation omitted). For example, Plaintiff is concerned that,
14 hypothetically, a person seeking assisted suicide might be stonewalled by a local
15 physician who objects to participating in assisted suicide and delays or refuses to
16 transfer the patient's records to another provider. Compl. ¶ 104. This speculative
17 scenario would require several steps in order to come to fruition. First, a
18 provider would have to object to participating in assisted suicide, and would
19 have to delay or refuse to transfer patient records elsewhere. Next, Washington
20 would have to decide to take action against that provider in violation of the
21 Federal Conscience Statutes. Then, the episode would have to come to the
22 attention of HHS, HHS would have to find Washington's actions to be

1 discriminatory under one of the Federal Conscience Statutes, and HHS would
2 have to take enforcement action under the Rule that would endanger
3 Washington’s funding. Finally, that enforcement action would have to be upheld
4 after exhaustion of all available administrative remedies. *See supra* n.3. The
5 occurrence of any of these steps is far from certain, much less all of them. Thus,
6 judicial resolution of Plaintiff’s Spending Clause and Establishment Clause
7 claims “may turn out to [be] unnecessary.” *Ohio Forestry Ass’n, Inc. v. Sierra*
8 *Club*, 523 U.S. 726, 736 (1998).

9 In addition, this case presents no concrete factual situation in which to
10 evaluate Plaintiff’s Spending Clause and Establishment Clause claims. Courts
11 “should not be forced to decide . . . constitutional questions in a vacuum.” *San*
12 *Diego Cty. Gun Rights Comm. v. Reno*, 98 F.3d 1121, 1132 (9th Cir. 1996)
13 (citation omitted); *cf. W. E. B. DuBois Clubs of Am. v. Clark*, 389 U.S. 309, 311
14 (1967). Because the Rule has never been enforced, and indeed, no funding has
15 ever been withheld under the Federal Conscience Statutes, the contours of any
16 such enforcement action and the scope of funding that may be at risk is
17 unknown. To exercise jurisdiction in advance of any such enforcement action
18 runs the risk of “entangl[ing]” this Court “in an abstract disagreement” over the
19 Rule’s validity before “it [is] clear that [Plaintiff’s conduct is] covered by the
20 [Rule],” and before any decision has been made that “affect[s] [Plaintiff] in any
21 concrete way.” *American-Arab Anti-Discrimination Comm. v. Thornburgh*, 970
22 F.2d 501, 511 (9th Cir. 1991).

1 These claims are also unripe because Plaintiff would suffer no hardship
2 whatsoever as to its Spending Clause and Establishment Clause claims if judicial
3 review were postponed. A party suffers no hardship warranting review unless
4 governmental action “now inflicts significant practical harm upon the interests
5 that the [plaintiff] advances.” *Ohio Forestry Ass’n*, 523 U.S. at 733; *see also*
6 *Nat’l Park Hosp. Ass’n v. U.S. Dep’t of the Interior*, 538 U.S. 803, 810 (2003)
7 (noting that a case is not ripe unless “the impact” of the challenged law is “felt
8 immediately by those subject to it in conducting their day-to-day affairs”
9 (citation omitted)).

10 Plaintiff cannot claim hardship based on the mere existence of the Rule.
11 *Western Oil & Gas Ass’n v. Sonoma Cty.*, 905 F.2d 1287, 1291 (9th Cir. 1990) ;
12 *see also San Diego Gun Rights Comm.*, 98 F.3d at 1132-33 (case not ripe where
13 plaintiffs faced no credible threat of enforcement); *AAMC*, 970 F.2d at 511
14 (same). Here, Plaintiff’s many hypothetical enforcement scenarios (*see, e.g.*,
15 Compl. ¶¶ 4, 81, 100, 103–05) illustrate the difficulty of undertaking a quest to
16 resolve Plaintiff’s imagined Spending and Establishment Clause challenges in
17 the absence of any factual context.

18 Nor is Plaintiff in any immediate danger. The “Hobson’s choice” of which
19 Plaintiff complains—between abandoning state health care policy or losing
20 billions of dollars in federal funds—is not an “immediate” one justifying review
21 of Plaintiff’s premature claims. Should Plaintiff discriminate in a fashion barred
22 by the Federal Conscience Statutes, and should HHS take enforcement action

1 under the Rule, and should Plaintiff decide not to comply through informal
2 means, Plaintiff will then have the opportunity, if necessary, to present its
3 constitutional challenges to the Rule to a court. *AAMC*, 970 F.2d at 511. Because
4 no “irremediable adverse consequences [will] flow from requiring [Plaintiff to
5 bring] a later challenge,” *Toilet Goods Ass’n, Inc. v. Gardner*, 387 U.S. 158, 164
6 (1967), there is no need to decide Plaintiff’s Spending Clause and Establishment
7 Clause claims at this time. *See Lee v. Waters*, 433 F.3d 672, 677 (9th Cir. 2005);
8 *see Poe v. Ullman*, 367 U.S. 497, 503 (1961).

9 As noted above, these considerations have caused two courts to decline—
10 on ripeness and standing grounds—to adjudicate similar challenges to the
11 underlying Federal Conscience Statutes. In *NFPRHA*, 468 F.3d 826, plaintiffs
12 brought Spending Clause and vagueness challenges to the Weldon Amendment.
13 The D.C. Circuit dismissed, holding that plaintiff lacked standing, given that it
14 had not been injured by the Amendment and could not show that it was likely to
15 be. *Id.* Similarly, in *California v. United States*, No. C 05-00328 JSW, 2008 WL
16 744840 (N.D. Cal. Mar. 18, 2008), California challenged the Weldon
17 Amendment on Spending Clause and other grounds. The court dismissed the
18 case for lack of ripeness and standing because “whether California will risk
19 losing federal funds pursuant to the Weldon Amendment if it seeks to enforce [a
20 particular state law provision] is contingent upon a series of future events that
21 may not ever occur.” *Id.* at *5. This Court should likewise dismiss Plaintiff’s
22 Spending Clause and Establishment Clause claims as unripe.

1 **III. Plaintiff’s Claims Lack Merit.**

2 **A. The Challenged Definitions Are Reasonable Exercises of HHS’s**
3 **Statutory Authority.**

4 Plaintiff’s attack on five definitions in the Rule—(1) *assist in the*
5 *performance*, (2) *discriminate or discrimination*, (3) *entity and health care*
6 *entity*, (4) *health service program* and (5) *referral or refer for*—is without merit.
7 As Plaintiff acknowledges, *see*, PI Mem. 23, these claims are governed by
8 *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43
9 (1984). Under this standard, a court first asks “whether Congress has directly
10 spoken to the precise question at issue.” *Id.* at 842. If the answer is yes, the court
11 must give effect to Congress’s intent. If the answer is no—that is, if the statute is
12 ambiguous—“the question for the court is whether the agency’s answer is based
13 on a permissible construction of the statute.” *Id.* at 844. For the reasons set forth
14 below, Plaintiff’s challenge to each definition fails at step one or, in the
15 alternative, at step two of *Chevron*.

16 **1. “Assist in the Performance”**

17 HHS’s definition of “assist in the performance” is entirely consistent with
18 the Church Amendments, 42 U.S.C. § 300a-7(d), the only conscience statute that
19 contains the term. Although the term is used in the Church Amendments, it is
20 not explicitly defined. The Rule defines the term “assist in the performance” as
21 follows:
22

1 to take an action that has a specific, reasonable, and articulable
2 connection to furthering a procedure or a part of a health service
3 program or research activity undertaken by or with another person or
4 entity. This may include counseling, referral, training, or otherwise
5 making arrangements for the procedure or a part of a health service
6 program or research activity, depending on whether aid is provided
7 by such actions.

8 84 Fed. Reg. at 23,263 (to be codified at 45 C.F.R. § 88.2).

9 *I.* Plaintiff’s challenge fails at *Chevron* step one because Congress has
10 directly spoken to the precise question at issue. *Chevron*, 467 U.S. at 842–43.
11 The Court need only open the dictionary, *see Mayo Found. for Med. Educ. &*
12 *Research v. United States*, 562 U.S. 44, 52 (2011) (applying a dictionary
13 definition at step one), which contains the same common-sense definition as the
14 Rule: *Merriam-Webster* defines *assist* as “to give usually supplementary support
15 or aid to,” <https://www.merriam-webster.com/dictionary/assist> (last visited Aug.
16 18, 2019), and *performance* as “the execution of an action,” [https://www.](https://www.merriam-webster.com/dictionary/performance)
17 [merriam-webster.com/dictionary/performance](https://www.merriam-webster.com/dictionary/performance) (last visited Aug. 18, 2019). The
18 Rule’s definition is as close to the dictionary definition of these terms as can be
19 without repeating them verbatim: *assist in the performance* is limited to
20 “specific, reasonable, and articulable” connections between the conscientious
21 objector’s action and the medical procedure. 84 Fed. Reg. at 23,263 (to be
22 codified at 45 C.F.R. § 88.2). “If the connection between an action and a
procedure is irrational, there is no actual connection by which the action
specifically furthers the procedure.” *Id.* at 23,187.

1 2. Even if the Court determines that the term “assist in the performance” is
2 ambiguous, the Court should still uphold HHS’s definition because it is
3 eminently reasonable. “At step two of *Chevron*, [courts] must ‘accept the
4 agency’s construction of the statute’ so long as that reading is reasonable, ‘even
5 if the agency’s reading differs from what the court believes is the best statutory
6 interpretation.’” *Perez-Guzman v. Lynch*, 835 F.3d 1066, 1079 (9th Cir. 2016)
7 (quoting *Nat’l Cable and Telecomms. Ass’n v. Brand-X Internet Servs.*, 545 U.S.
8 967, 980 (2005)).

9 HHS’s definition is reasonable in light of the dictionary definitions of
10 “assist” and “performance” and the Rule’s requirement that “a specific,
11 reasonable, and articulable connection” exist between the conscientious
12 objector’s action and the medical procedure. 84 Fed. Reg. at 23,263 (to be
13 codified at 45 C.F.R. § 88.2); *see also id.* at 23,187 (excluding irrational or
14 excessively attenuated connections). In addition, the Rule furthers the statute’s
15 purpose of protecting individuals and health care entities from discrimination on
16 the basis of their religious or moral convictions by recipients of federal funds;
17 for example, under the Rule, individuals who schedule a patient’s abortion are
18 not outside the scope of the Church Amendments merely because they do not
19 perform the abortion themselves. The Rule recognizes that such individuals too
20 are protected because they provide necessary assistance in the performance of an
21 abortion. *See id.* at 23,188.
22

2. “Discriminate or Discrimination”

1 Plaintiff’s challenge to HHS’s definition of “discriminate or
2 discrimination” is also meritless. The definition, which consists of a three-point
3 list of examples that apply *only to the extent permitted by the Federal*
4 *Conscience Statutes*, is by definition reasonable. Virtually all of the Statutes
5 covered by the Rule employ the term “discriminate” and, as with “assist in the
6 performance,” do not define it. For example, the Coats-Snowe Amendment
7 provides that government recipients of federal funds “may not subject any health
8 care entity to discrimination” on certain bases, such as the “refus[al] to undergo
9 training in the performance of induced abortions.” 42 U.S.C. § 238n(a)(1). But
10 the Coats-Snowe Amendment does not explicitly define “discrimination.”
11 Consistent with the varying types of discrimination that the Federal Conscience
12 Statutes prohibit, the Rule provides a non-exhaustive list of actions that may
13 constitute discrimination. *See* 84 Fed. Reg. at 23,263 (to be codified at 45 C.F.R.
14 § 88.2). This list applies “to the extent permitted by the applicable statute.” *See*
15 *id.* The definition then provides several safe harbors, consisting of actions that, if
16 taken by a regulated entity, would not constitute discrimination. *See id.*

17
18 1. Plaintiff’s challenge to this definition fails at *Chevron* step one. By its
19 terms, the definition does not extend beyond the Statutes to which it applies. *See*
20 45 C.F.R. § 88.2 (defining the term to include actions “as applicable to, and to
21 the extent permitted by, the applicable statute”). Therefore, the definition does
22 not exceed Congress’s intent because it explicitly *cannot* exceed Congress’s

1 intent. Moreover, the common definition of “discrimination” is “to make a
2 difference in treatment or favor on a basis other than individual merit,”
3 *Discriminate*, Merriam-Webster, [https://www.merriam-webster.com/dictionary/](https://www.merriam-webster.com/dictionary/discriminate)
4 discriminate (last visited Aug. 18, 2019), and the Rule merely makes explicit the
5 various manifestations of that broad definition.

6 2. Even if the term is ambiguous, the Court should uphold HHS’s
7 definition at *Chevron* step two. As discussed above, the definition by its terms
8 does not extend beyond the meaning of the Statutes, but rather “must be read in
9 the context of each underlying statute at issue, any other related provisions of the
10 Rule, and the facts and circumstances.” 84 Fed. Reg. at 23,192. To provide
11 guidance on the meaning of discrimination without being under-inclusive, HHS
12 used the word “includes” to establish a non-exhaustive list of examples that
13 could, in the context of the particular underlying Federal Conscience Statute,
14 constitute discrimination. *See id.* at 23,190. And, to ensure that the Rule was not
15 over-inclusive, HHS included three provisions to protect entities that seek to
16 accommodate those with religious or moral objections. *See id.* at 23,263 (to be
17 codified at 45 C.F.R. § 88.2).

18 3. “Entity”

19 Plaintiff’s challenge to “entity,” which it raises in its complaint but not in
20 its preliminary injunction motion, fares no better. The term, in contrast to “health
21 care entity,” discussed *infra*, appears on its own only in the Church
22 Amendments, and that statute does not define the term. The Rule defines it as

1 follows:

2 Entity means a “person” as defined in 1 U.S.C. § 1; the Department;
3 a State, political subdivision of any State, instrumentality of any State
4 or political subdivision thereof; any public agency, public institution,
5 public organization, or other public entity in any State or political
6 subdivision of any State; or, as applicable, a foreign government,
7 foreign nongovernmental organization, or intergovernmental
8 organization (such as the United Nations or its affiliated agencies).

9 84 Fed. Reg. at 23,263.

10 Plaintiff’s challenge to this definition fails at *Chevron* step one. The term
11 “entity” has an exceedingly capacious dictionary definition: “something that has
12 separate and distinct existence and objective or conceptual reality.” *Definition of*
13 *Entity*, Merriam-Webster, <https://www.merriam-webster.com/dictionary/entity>
14 (last visited Aug. 18, 2019). There simply is no way that Congress, in using such
15 a broad term, did not intend to include public agencies, public organizations, and
16 the like. For these reasons, this definition is, at a minimum, a permissible
17 construction of the term “entity.”

18 **4. “Health Care Entity”**

19 Plaintiff’s challenge to HHS’s definition of “health care entity,” which
20 appears in the Weldon Amendment, the Coats-Snowe Amendment, and the
21 ACA, also fails. The Rule defines “health care entity” in two parts:

22 (1) For purposes of the Coats-Snowe Amendment (42 U.S.C. 238n)
and the subsections of this part implementing that law (§ 88.3(b)), an
individual physician or other health care professional, including a
pharmacist; health care personnel; a participant in a program of

1 training in the health professions; an applicant for training or study
 2 in the health professions; a post-graduate physician training program;
 3 a hospital; a medical laboratory; an entity engaging in biomedical or
 4 behavioral research; a pharmacy; or any other health care provider or
 5 health care facility. As applicable, components of State or local
 governments may be health care entities under the Coats-Snowe
 Amendment; and

6 (2) For purposes of the Weldon Amendment (e.g., Department of
 7 Defense and Labor, Health and Human Services, and Education
 Appropriations Act, 2019, and Continuing Appropriations Act,
 8 2019, Pub. L. 115-245, Div. B., sec. 507(d), 132 Stat. 2981, 3118
 (Sept. 28, 2018)), Patient Protection and Affordable Care Act
 9 section 1553 (42 U.S.C. 18113), and to sections of this part
 implementing those laws (§ 88.3(c) and (e)), an individual
 10 physician or other health care professional, including a pharmacist;
 health care personnel; a participant in a program of training in the
 11 health professions; an applicant for training or study in the health
 professions; a post-graduate physician training program; a hospital;
 12 a medical laboratory; an entity engaging in biomedical or
 behavioral research; a pharmacy; a provider-sponsored
 13 organization; a health maintenance organization; a health insurance
 issuer; a health insurance plan (including group or individual
 14 plans); a plan sponsor or third-party administrator; or any other
 kind of health care organization, facility, or plan. As applicable,
 15 components of State or local governments may be health care
 16 entities under the Weldon Amendment and Patient Protection and
 Affordable Care Act section 1553.

17 84 Fed. Reg. at 23,264 (to be codified at 45 C.F.R. § 88.2).

18 *l.* Beginning with the text, each of these statutes defines the term through
 19 a non-exhaustive list of constituent entities. The Coats-Snowe Amendment
 20 provides that a health care entity “*includes* an individual physician, a
 21 postgraduate physician training program, and a participant in a program of
 22

1 training in the health professions.” 42 U.S.C. § 238n(c)(2) (emphasis added).
2 The Weldon Amendment and the ACA provide that the term “*includes* an
3 individual physician or other health care professional, a hospital, a provider-
4 sponsored organization, a health maintenance organization, a health insurance
5 plan, or any other kind of health care facility, organization, or plan.” 42 U.S.C.
6 § 18113(b) (emphasis added); Pub. L. No. 115-245, § 507(d)(2), 132 Stat. at
7 3118. The term “‘include’ can signal that the list that follows is meant to be
8 illustrative rather than exhaustive.” *Samantar v. Yousuf*, 560 U.S. 305, 317
9 (2010). Furthermore, both statutes contain catch-all phrases: “a participant in a
10 program of training in the health professions” in the Coats-Snowe Amendment,
11 and “other health care professional” and “any other kind of health care facility,
12 organization, or plan” in the Weldon Amendment and ACA. 42 U.S.C.
13 § 238n(c)(2); 42 U.S.C. § 18113(b). Given these features, the statutes plainly
14 contemplate a broader group of health care entities than those explicitly listed.

15 2. Even if the term “health care entity” in the Federal Conscience Statutes
16 were ambiguous, the Rule’s definition is reasonable for the reasons stated above:
17 the statutes explicitly contemplate the inclusion of entities beyond those
18 explicitly listed in the statutes, and Plaintiff has not identified any entity in the
19 Rule’s definition that would not meet the ordinary dictionary definition of
20 “health care entity” or the statutes’ catch-all provisions. Furthermore, the Rule
21 recognizes that the definition of “health care entity” is a flexible one that
22 depends on “the context of the factual and legal issues applicable to the

1 situation.” 84 Fed. Reg. at 23,196. None of the Rule’s definitions apply in all
 2 circumstances. *See id.*

3 5. “Health Service Program”

4 Plaintiff also appears to challenge the definition of “health service
 5 program,” mentioning the Rule’s definition without explaining why it is
 6 unlawful. *See* Compl. ¶ 91. Regardless of this pleading deficiency, the definition
 7 is plainly lawful. The term appears only in the Church Amendments and is not
 8 explicitly defined: “No individual shall be required to perform or assist in the
 9 performance of any part of a *health service program* or research activity funded
 10 in whole or in part under a program administered by the Secretary of Health,
 11 Education and Welfare if his performance or assistance in the performance of
 12 such part of such program or activity would be contrary to his religious beliefs
 13 or moral convictions.” 42 U.S.C. § 300a-7(d) (emphasis added). The Rule states
 14 that a health service program “includes the provision or administration of any
 15 health or health-related services or research activities, health benefits, health or
 16 health-related insurance coverage, health studies, or any other service related to
 17 health or wellness, whether directly; through payments, grants, contracts, or
 18 other instruments; through insurance; or otherwise.” 84 Fed. Reg. at 23,264 (to
 19 be codified at 42 C.F.R. § 88.2).

20 This definition should be upheld at *Chevron* step one. The plain text of the
 21 statute, where the step one inquiry begins and ends, *see Council for Urological*
 22 *Interests v. Burwell*, 790 F.3d 212, 230 (D.C. Cir. 2015), contemplates that the

1 term relates to services or activities “funded in whole or in part under a program
2 administered by the Secretary.” 42 U.S.C. § 300a-7(d). The examples listed in
3 the definition are all such programs. For this reason, the Rule’s definition is also
4 a permissible construction of the Church Amendments at *Chevron* step two.

5 6. “Referral or Refer For”

6 Last, Plaintiff’s challenge to “referral or refer for” is misplaced. As with
7 many of the other definitions in the Rule, “referral or refer for” is not defined in
8 the Weldon Amendment, the Coats-Snowe Amendment, or the ACA, the only
9 statutes in which they appear. The Rule defines “referral or refer for” through a
10 list of activities that qualify as “referral or refer for”: the term

11 includes the provision of information in oral, written, or electronic
12 form (including names, addresses, phone numbers, email or web
13 addresses, directions, instructions, descriptions, or other information
14 resources), where the purpose or reasonably foreseeable outcome of
15 provision of the information is to assist a person in receiving funding
or financing for, training in, obtaining, or performing a particular
health care service, program, activity, or procedure.

16 84 Fed. Reg. at 23,264 (to be codified at 45 C.F.R. § 88.2).

17 1. The Rule’s definition is consistent with Congress’s intent. Although the
18 statutes do not include a definition of “referral or refer for” and the legislative
19 history is silent on the matter, the ordinary dictionary definition of the term
20 indicates Congress’s intent. *See Mayo Found. for Med. Educ. & Research*, 562
21 U.S. at 52. As HHS explained, “The rule’s definition of ‘referral’ or ‘refer for’ . .
22 . . comports with dictionary definitions of the word ‘refer,’ such as the Merriam-

1 Webster’s definition of ‘to send or direct for treatment, aid, information, or
2 decision.’” 84 Fed. Reg. at 23,200 (quoting *Refer*, Merriam-Webster.com,
3 <https://www.merriam-webster.com/dictionary/refer>). The statutes’ structure also
4 makes Congress’s intent clear. The addition of the term “for” following “refer”
5 indicates that Congress did not intend the statutes to be limited to a referral
6 document, but rather to include any referral for abortion (or other health
7 services) in a more general sense. For example, the Coats-Snowe Amendment
8 protects not only a health care entity that declines to refer a patient to an abortion
9 provider, but also a health care entity that declines to refer “for” abortions
10 generally. *See, e.g.*, 42 U.S.C. § 238n(a)(1).

11 2. In the alternative, the Rule’s definition should be upheld at *Chevron*
12 step two. In addition to being consistent with dictionary definitions and the
13 statutes’ structure, the Rule’s definition is faithful to the statutes’ remedial
14 purposes. As HHS explained, defining the term “referral or refer for” more
15 narrowly would exclude forms of coercion that the Federal Conscience Statutes
16 protect against. For example, the Supreme Court recently held that a law
17 requiring health care providers to post notices regarding the availability of state-
18 subsidized abortion likely violated the First Amendment. *See Nat’l Inst. of*
19 *Family & Life Advocates v. Becerra*, 138 S. Ct. 2361, 2378–79 (2018). A
20 narrower definition would not include referrals of this sort, even though they
21 constitute unconstitutional coercion of a health care entity that has a
22 conscientious objection to abortion. The Weldon Amendment, Coats-Snowe

1 Amendments, and the ACA are not this narrow, and HHS acted reasonably when
2 it interpreted the term accordingly.

3 The Rule is reasonable for another reason as well: it uses a non-exhaustive
4 list that “guide[s] the scope of the definition,” recognizing that the terms “take
5 many forms and occur in many contexts.” 84 Fed. Reg. at 23,201. This
6 flexibility means that “the applicability of the rule would turn on the individual
7 facts and circumstances of each case” (*i.e.*, “the relationship between the
8 treatment subject to a referral request and the underlying service or procedure
9 giving rise to the request”). *Id.*

10 **B. Other Provisions of the Rule Are within HHS’s Statutory**
11 **Authority.**

12 Plaintiff’s other statutory authority argument, raised in a handful of
13 perfunctory paragraphs of the complaint and not at all in its motion for a
14 preliminary injunction, *see* Compl. ¶¶ 76–77, 95–96, 113, should be dismissed
15 out of hand. Plaintiff argues that the Federal Conscience Statutes do not permit
16 HHS to impose “financial penalties.” But, as explained *infra*, the Rule does not
17 impose penalties. To the extent that Plaintiff takes issue with the enforcement
18 authority section of the rule, 84 Fed. Reg. at 23,271–72 (to be codified at 45
19 C.F.R. § 88.7), this argument is meritless. As HHS explained, *see* 84 Fed. Reg.
20 at 23,183–86, the enforcement portion of the Rule merely sets forth existing
21 internal HHS processes related to disbursing federal funds: OCR is charged with
22 investigating complaints and seeking voluntary resolutions, and any involuntary

1 remedies occur through coordination between HHS funding components and
2 OCR using preexisting grants and contracts regulation processes. *See* 84 Fed.
3 Reg. at 23,271 (to be codified at 45 C.F.R. § 88.7(i)). And at bottom, it is not the
4 enforcement authority section of the Rule that would cause a loss of federal
5 funds, but the Federal Conscience Statutes themselves, which place conditions
6 on those funds.

7 **C. The Rule Is Consistent with Other Provisions of Law.**

8 Plaintiff also claims that the Rule conflicts with certain provisions within
9 the United States Code. No such conflict exists.

10 **1. Section 1554 of the ACA**

11 Plaintiff claims that the Rule conflicts with Section 1554 of the ACA. *See*
12 Compl. ¶¶ 117–18; PI Mem. at 24–26. That provision states that,
13 “[n]otwithstanding any other provision of this [the Affordable Care] Act, the
14 Secretary of Health and Human Services shall not promulgate any regulation
15 that” (1) “creates any unreasonable barriers to the ability of individuals to obtain
16 appropriate medical care”; (2) “impedes timely access to health care services”;
17 (3) “interferes with communications regarding a full range of treatment options
18 between the patient and the provider”; (4) “restricts the ability of health care
19 providers to provide full disclosure of all relevant information to patients
20 making health care decisions”; (5) “violates the principles of informed consent
21 and the ethical standards of health care professionals”; or (6) “limits the
22

1 availability of health care treatment for the full duration of a patient’s medical
2 needs.” 42 U.S.C. § 18114.

3 Plaintiff’s claim is meritless. All six subjects of Section 1554’s sub-
4 sections involve the *denial* of information or services to patients. The Rule,
5 however, denies nothing. It merely revises the 2011 Rule to ensure knowledge
6 of, compliance with, and enforcement of, the longstanding Federal Conscience
7 Statutes, in order to ensure that individual and institutional health care entities
8 covered by those laws receive proper protection. At bottom, Plaintiff’s objection
9 is not so much to the Rule as to the Federal Conscience Statutes that the Rule
10 implements. Under Plaintiff’s theory, any time a health care entity that receives
11 federal funds exercises its right under the Federal Conscience Statutes to decline
12 to provide a service to which it objects, HHS would violate Section 1554.
13 Plaintiff’s argument, then, is that Congress essentially abrogated the Federal
14 Conscience Statutes through Section 1554. Plaintiff takes this position even as to
15 the Weldon Amendment, which Congress has readopted every year since the
16 ACA’s passage.

17 The Court should reject Plaintiff’s untenable position. First, Section 1554
18 expressly applies “[n]otwithstanding any other provision *of this Act*,” 42 U.S.C.
19 § 18114 (emphasis added)—that is, the ACA. The great majority of the Federal
20 Conscience Statutes that the Rule implements, of course, are not part of the
21 ACA. Nor are the statutes that give the Secretary authority to award funding
22 grants part of the ACA. Had Congress intended Section 1554 to extend beyond

1 the ACA, it could have simply specified that it applies “[n]otwithstanding any
2 other provision of law[.]” 42 U.S.C. § 18032(d)(3)(D)(i). By its own terms,
3 Section 1554 does not apply to the conscience protection provisions outside of
4 the ACA, and therefore does not undermine the Rule’s validity. Another reason
5 that Section 1554 is of no moment is that the Rule does not create, impede,
6 interfere with, restrict, or violate anything. Instead, it simply limits what the
7 government chooses to fund—*i.e.*, providers that do not engage in
8 discrimination.

9 Putting that threshold point aside, Congress went out of its way in the
10 ACA to make clear that nothing in that statute undermines the Federal
11 Conscience Statutes on which the Rule is based. Specifically, Section 1303(c)(2)
12 of the ACA states that

13 Nothing in this Act [*i.e.*, the ACA, including Section 1554] shall be
14 construed to have *any effect* on Federal laws regarding (i) conscience
15 protection; (ii) willingness or refusal to provide abortion; and (iii)
16 discrimination on the basis of the willingness or refusal to provide, pay
for, cover, or refer for abortion or to provide or participate in training to
provide abortion.

17 42 U.S.C. § 18023(c)(2) (emphasis added). This clear expression of
18 congressional intent fatally undercuts Plaintiff’s argument that Section 1554
19 somehow prevents HHS from giving effect to the Federal Conscience Statutes.

20 It is a basic principle of statutory interpretation, moreover, that Congress
21 “does not alter the fundamental details of a regulatory scheme in vague terms or
22 ancillary provisions—it does not, one might say, hide elephants in mouseholes.”

1 | *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001). Plaintiff would
2 | have this Court believe that Congress effectively gutted the Federal Conscience
3 | Statutes, without any meaningful legislative history so indicating, when it passed
4 | Section 1554. That proposition is implausible on its face.⁵

5 | Defendants' interpretation of Section 1554 also comports with common
6 | sense. Section 1554's subsections are open-ended. Nothing in the statute
7 | specifies, for example, what constitutes an "unreasonable barrier[.]" "appropriate
8 | medical care[.]" "all relevant information[.]" or "the ethical standards of health
9 | care professionals[.]" 42 U.S.C. § 18114. And there is nothing in the ACA's
10 | legislative history that sheds light on this provision. Under these circumstances,
11 | it is a substantial question whether Section 1554 claims are reviewable under the
12 | APA at all. *See Citizens to Pres. Overton Park*, 401 U.S. at 410 (explaining that
13 | the APA bars judicial review of agency decision where, among other
14 | circumstances, "statutes are drawn in such broad terms that in a given case there
15 |
16 |
17 |

18 | ⁵ Congress also went on to add *additional* conscience protections in the
19 | ACA. *See, e.g.*, 42 U.S.C. § 18113. The ACA, thus, actually adds to and
20 | underscores the importance of the Federal Conscience Statutes, contrary to
21 | Plaintiff's claim.
22 |

1 is no law to apply” (citation omitted)).⁶ But even if Section 1554 claims are
2 reviewable, it is inconceivable that Congress intended to subject the entire U.S.
3 Code to these general and wholly undefined concepts—and that it did so without
4 leaving any meaningful legislative history.

5 Other principles point in the same direction. “[I]t is a commonplace of
6 statutory construction that the specific governs the general,” *Morales v. Trans*
7 *World Airlines, Inc.*, 504 U.S. 374, 384–85 (1992). “[T]he specific provision is
8 construed as an exception to the general one.” *RadLAX Gateway Hotel, LLC v.*
9 *Amalgamated Bank*, 566 U.S. 639, 645 (2012) (citation omitted). Thus, even if
10 Section 1554 applied to regulations implementing the Federal Conscience
11 Statutes (it does not), and even if Section 1554 and those Statutes were in
12 conflict (they are not), the Federal Conscience Statutes would prevail over
13 Section 1554. Section 1554 is at best a general prohibition of certain types of
14 regulations (very broadly described) and does not speak to conscience objections

15
16 ⁶ Even within the ACA, HHS routinely issues regulations placing criteria
17 and limits on what the government will fund, and on what will be covered in
18 ACA programs. Under Plaintiff’s standardless interpretation of Section 1554, it
19 is far from clear that the government could ever impose *any* limit on *any*
20 parameter of a health program—even if the program’s own statute requires it.
21 Nor is it evident how a court could possibly evaluate challenges brought under
22 Section 1554 if that provision sweeps as broadly as Plaintiff claims.

1 at all. The Federal Conscience Statutes, by contrast, contain specific protections
 2 with respect to specific activities in the context of federally funded health
 3 programs and research activities. Section 1554, therefore, must give way to the
 4 more specific Federal Conscience Statutes and the Rule interpreting them.

5 **2. The ACA’s Preventive Care Coverage Requirement**

6 Plaintiff further claims that the Rule conflicts with the requirement in the
 7 ACA that group health plans and health insurance issuers offering group or
 8 individual health insurance coverage shall provide coverage for, among other
 9 things, certain preventive care. *See* 42 U.S.C. § 300gg-13(a)(4); *see also* PI
 10 Mem. at 27-28. As with Plaintiff’s claim under Section 1554, this argument fails
 11 on its face. Congress was clear that nothing in the ACA should be construed to
 12 have “*any effect*” on federal conscience protection. 42 U.S.C. § 18023(c)(2)
 13 (emphasis added). And Plaintiff utterly fails to explain how the Rule—which
 14 merely implements the Federal Consciences Statutes—runs afoul of the ACA’s
 15 preventive care requirement, despite Congress’s clear direction to the contrary in
 16 the ACA itself.

17 **3. Emergency Medical Treatment and Active Labor Act** 18 **(EMTALA)**

19 Plaintiff also argues that the Rule conflicts with EMTALA, which
 20 requires hospitals with emergency departments to either (1) provide emergency
 21 care “within the staff and facilities available at the hospital,” or (2) transfer the
 22 patient to another medical facility in circumstances permitted by the statute. 42

1 U.S.C. § 1395dd(b)(1)(A). *See* Compl. ¶ 120; PI Mem. at 28–29. There is no
2 conflict, however. As HHS explained in the preamble to the Rule, OCR “intends
3 to read every law passed by Congress in harmony to the fullest extent possible
4 so that there is maximum compliance with the terms of each law.” 84 Fed. Reg.
5 at 23,183. With respect to EMTALA specifically, HHS indicated that it
6 generally agrees with the explanation in the preamble to the 2008 Rule that
7 fulfilling the requirements of EMTALA would *not* conflict with the Federal
8 Conscience Statutes that the Rule interprets. *See id.*

9 Plaintiff points to potential “uncertainty” created by the Rule, with the
10 “possibility” of sanctions for non-compliance. *See* PI Mem. at 29. But in
11 considering Plaintiff’s facial challenge to the Rule, the Court should not assume
12 that some future, hypothetical conflict between EMTALA and the Rule will
13 come to pass. *See Reno v. Flores*, 507 U.S. 292, 309 (1993). HHS has explained
14 that it is “not aware of any instance where a facility required to provide
15 emergency care under EMTALA was unable to do so because its entire staff
16 objected to the service on religious or moral grounds.” 73 Fed. Reg. 78,087. And
17 in any event, HHS has stated that “where EMTALA might apply in a particular
18 case, the Department would apply both EMTALA and the relevant law under
19 this rule harmoniously to the extent possible.” 84 Fed. Reg. 23,188.

20 4. “Non-Directive” Appropriations Rider

21 Plaintiff also argues that the Rule somehow conflicts with HHS
22 appropriations language requiring that all pregnancy counseling be non-

1 directive. Compl. ¶ 121 (citing Pub. L. No. 115-245, 132 Stat. 2981). And
2 Plaintiff seeks to piggyback on this Court’s decision in *Washington v. Azar*, 376
3 F. Supp. 3d 1119 (E.D. Wash. 2019), which concluded that Washington was
4 likely to succeed on its claim that *different* HHS regulations affecting the Title X
5 program were unlawfully “directive.” *Id.* at 1130; *see also* PI Mem. at 29–30.⁷
6 But the non-directive appropriations language is of no moment here. The Rule
7 does not require funding recipients (of Title X grants or otherwise) to engage in
8 pregnancy counseling at all—much less counseling that directs women to any
9 particular outcome with respect to their pregnancy. Instead, the Rule implements

10
11 ⁷ A unanimous motions panel of the Ninth Circuit correctly rejected the
12 Court’s conclusions and stayed the preliminary injunctions entered in the cases
13 Plaintiff cites. Although the Ninth Circuit ordered the defendants’ appeal to be
14 reheard en banc and instructed that the motions panel’s order not be cited as
15 precedential in the Ninth Circuit, *California v. Azar*, No. 19-15974, Order (9th
16 Cir. July 3, 2019), the motions panel’s order constitutes persuasive authority.
17 The Ninth Circuit also expressly indicated that the motions panel’s order has not
18 been vacated. *California v. Azar*, No. 19-15974, Order (9th Cir. July 11, 2019).
19 The *en banc* Ninth Circuit denied the plaintiffs’ motions for an administrative
20 stay of the motions panel’s order, as well as the plaintiffs’ request for a rehearing
21 of that denial by the full Ninth Circuit, and is now in the process of rehearing the
22 question of a stay of the preliminary injunction pending appeal.

1 the Federal Conscience Statutes. Accepting Plaintiff’s argument that the Rule
 2 unlawfully infringes the appropriations rider would require the Court to believe
 3 that—despite Congress’s explicit provisions in the Federal Conscience
 4 Statutes—Congress effectively repealed those protections in an appropriations
 5 rider relating solely to the Tile X program and compelled health care entities to
 6 counsel on all pregnancy options, including abortion, even if they have religious
 7 or moral objections to providing such counseling. That proposition is wholly
 8 implausible and should be rejected. *See Tenn. Valley Auth. v. Hill*, 437 U.S. 153,
 9 190 (1978).

10 **5. Title VII of the Civil Rights Act of 1964**

11 Plaintiff also argues that, because the Rule does not include the same
 12 “undue hardship” exception that Congress included in Title VII, there is a
 13 conflict between that statute and the Rule. Compl. ¶ 122 (citing 42 U.S.C.
 14 § 2000e(j)). Not so. The Rule implements the substantive requirements of the
 15 Federal Conscience Statutes, which, unlike Title VII, contain no such exception.
 16 Indeed, that Congress included an “undue hardship” exception in Title VII but
 17 declined to do so in the Federal Conscience Statutes is strong evidence that
 18 Congress did not intend for such an exception to apply. *Cf., e.g., Franklin Nat’l*
 19 *Bank of Franklin Sq. v. New York*, 347 U.S. 373, 378 (1954) (finding “no
 20 indication that Congress intended to make [an issue] subject to local restrictions,
 21 as it has done by express language in several other instances”). In addition, the
 22 Federal Conscience Statutes apply in more specific contexts than does Title VII,

1 and therefore it is reasonable to infer—given the absence of the “undue
 2 hardship” limitation in the Federal Conscience Statutes—that Congress did not
 3 intend for that limitation to apply to these statutes. *See* 84 Fed. Reg. 23,191; *see*
 4 *also Morales*, 504 U.S. at 384–85 (“[I]t is a commonplace of statutory
 5 construction that the specific governs the general.”).

6 **D. The Rule Is Neither Arbitrary Nor Capricious.**

7 Agency action must be upheld in the face of an APA claim if the agency
 8 “examines the relevant data and articulates a satisfactory explanation for its
 9 action[,] including a rational connection between the facts found and the choice
 10 made.” *Motor Vehicle Mfrs. Ass’n, of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*,
 11 463 U.S. 29, 43 (1983) (citation omitted); *Gill v. U.S. Dep’t of Justice*, 913 F.3d
 12 1179, 1187 (9th Cir. 2019). Under this deferential standard of review, “a court is
 13 not to substitute its judgment for that of the agency . . . and should uphold a
 14 decision of less than ideal clarity if the agency’s path may reasonably be
 15 discerned.” *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 513–14 (2009)
 16 (citations omitted). The Rule easily satisfies this deferential review.

17 Plaintiff makes several general arguments in support of its claim that the
 18 Rule is “arbitrary” and “capricious.” None is persuasive, and none can overcome
 19 the presumption of validity to which the agency rulemaking is entitled.

20 **1. HHS Adequately Explained Why it Changed Course.**

21 The Rule undeniably revises HHS’s approach to enforcing the Federal
 22 Conscience Statutes. But HHS is permitted to “consider varying interpretations

1 and the wisdom of its policy on a continuing basis, for example, in response to
2 changed factual circumstances, or a change in administrations.” *Nat’l Cable &*
3 *Telecomm. Ass’n v. Brand-X Internet Servs.*, 545 U.S. 967, 981 (2005) (internal
4 citation omitted). As the Supreme Court has explained, there is no heightened
5 standard when an agency changes its policy so long as the agency shows that “the
6 new policy is permissible under the statute, that there are good reasons for it, and
7 that the agency believes it to be better, which the conscious change of course
8 adequately indicates.” *Fox Television*, 556 U.S. at 515. HHS has met that standard
9 here.

10 Contrary to Plaintiff’s claim, Compl. ¶ 125, HHS did acknowledge that it
11 was changing its policy in promulgating the Rule, including its policy with respect
12 to assurance and certification requirements. Further, it provided a “cogent
13 rationale” and an “evidentiary basis” for doing so. *See* Compl. ¶ 125. As HHS
14 explained in the preamble to the Rule, it determined that the preexisting regulatory
15 structure was insufficient to protect the statutory rights and liberty interests of
16 health care entities. *See* 84 Fed. Reg. at 23,228. HHS reasonably judged that the
17 2011 Rule lacked adequate measures to enforce the Federal Conscience Statutes
18 and promoted confusion, not clarity, about the scope of those statutory
19 protections. The 2011 Rule related to just three of the many Federal Conscience
20 Statutes and did not provide adequate incentives for covered entities to “institute
21 proactive measures to protect conscience, prohibit coercion, and promote
22 nondiscrimination.” *Id.* at 23,228. Moreover, the 2011 Rule failed to provide

1 sufficient information concerning the scope of the various Federal Conscience
2 Statutes, especially regarding their interaction with state laws, including state laws
3 adopted since the promulgation of the 2011 Rule. *Id.*; *see also* NPRM, 83 Fed.
4 Reg. at 3889. HHS also relied, in part, on complaints it received of alleged
5 violations of the Federal Conscience Statutes. *See* NPRM, 83 Fed. Reg. at 3886;
6 84 Fed. Reg. at 23,229. The increase in complaints is, of course just “one of the
7 many metrics used to demonstrate the importance of this rule.” *Id.* The increase
8 in complaints was both real and significant. Many of these complaints allege
9 violations of religious and conscience-based beliefs in the medical setting, and
10 while a large subset of them complain of conduct that is outside the scope of the
11 Federal Conscience Statutes and the Rule,⁸ some do implicate the relevant
12 statutes, *see, e.g.*, Admin. Record (AR) 544188–207 (Ex. A); 544516 (Ex. B);
13 544612–23 (Ex. C). Further, the complaints overall illustrate the need for HHS to
14 clarify the scope and effect of the Federal Conscience Statutes.

15 2. HHS’s Definitions Were the Product of Reasoned 16 Decisionmaking.

17 As discussed above, HHS crafted each definition in the Rule in a reasonable
18 exercise of its statutory authority. The defined terms are also neither arbitrary nor

19
20 ⁸ For example, many complaints were from patients and/or parents who
21 criticized the vaccination policies at schools and medical offices, *see, e.g.*, AR
22 542458 (Ex. D).

1 capricious. Plaintiff claims that the definitions of “assist in the performance,”
2 “discrimination,” “health care entity,” and “referral” “create an unworkable
3 situation . . . by dramatically expanding the universe of protected personas and
4 prohibited conduct.” PI Mem. at 32; *see also* Compl ¶¶ 80–93. In support of this
5 argument, Plaintiff offers various uncertainties and hypothetical examples of
6 potential outcomes of the Rule. *See* PI Mem. at 32–33; Compl. ¶¶ 80–93. But
7 again, Plaintiff’s rule challenge is facial, and the fact that it can “point to a
8 hypothetical case in which the rule might lead to an arbitrary result does not render
9 the rule ‘arbitrary or capricious.’” *Am. Hosp. Ass’n v. NLRB*, 499 U.S. 606, 619
10 (1991).

11 HHS weighed comments that argued that the proposed definitions did not
12 go far enough and others complaining that the definitions were overbroad, and
13 provided thoughtful, detailed explanations for why each of the challenged
14 definitions correctly interpreted the relevant statutes. *See generally* 84 Fed. Reg.
15 23,186–203; *e.g., id.* at 23,194 (declining to explicitly incorporate “social workers
16 and schools of social work” into the definition of “health care entity” because “[i]t
17 is unclear in many circumstances [whether] such entities deliver health care”); *id.*
18 at 23,191 (explaining that HHS would not incorporate into the rule the “undue
19 hardship” exception for reasonable accommodations under Title VII because
20 Congress did not adopt such an exception in the Federal Conscience Statutes). The
21 agency also modified each challenged definition in response to the comments it
22 received, including narrowing and clarifying each definition in significant

1 respects. *See id.* at 23,181–203; *e.g., id.* at 23,186–89 (reviewing several
2 categories of comments asserting that the proposed definition of “assist in the
3 performance of” was overbroad, agreeing in part, and narrowing the definition
4 from “to participate in any activity” with an “articulable connection[,]” to “to take
5 an action that has a specific, reasonable, and articulable connection,” among other
6 changes and clarifications). HHS thus satisfied its APA obligations.

7 **3. HHS Reasonably Weighed the Rule’s Costs and Benefits.**

8 In addition to HHS’s purpose of improving knowledge about and
9 enforcement of the Federal Conscience Statutes, HHS identified four primary
10 benefits of the Rule in its cost-benefit analysis: (1) increasing the number of health
11 care providers; (2) improving the doctor-patient relationship; (3) eliminating the
12 harm from requiring health care entities to violate their consciences; and (4)
13 reducing unlawful discrimination in the health care industry and promoting
14 personal freedom. 84 Fed. Reg. at 23,246. To the extent that HHS relied on a
15 limited 2009 poll to reach this conclusion, the agency did not act unreasonably in
16 considering it. *See San Luis & Delta-Mendota Water Auth. v. Locke*, 776 F.3d
17 971, 995 (9th Cir. 2014) (Even “if the only available data is “‘weak,’ and thus not
18 dispositive,” an agency’s reliance on such data “does not render the agency’s
19 determination ‘arbitrary and capricious’” (citation omitted)). HHS’s policy
20 determination relied on its own analysis, the comments it received in response to
21 the NPRM, anecdotal evidence, and, yes, the 2009 poll. 84 Fed. Reg. at 23,247.
22 There was nothing unreasonable, arbitrary, or capricious in HHS considering the

1 | poll among other non-empirical evidence. *See Fox Television*, 556 U.S. at 521
2 | (“[E]ven in the absence of evidence, the agency’s predictive judgment (which
3 | merits deference) makes entire sense. To predict that complete immunity for
4 | fleeting expletives, ardently desired by broadcasters, will lead to a substantial
5 | increase in fleeting expletives seems to us an exercise in logic rather than
6 | clairvoyance.”).

7 | Moreover, HHS scarcely assigned controlling weight to either the 2009
8 | survey or the ramifications of that survey: HHS ultimately concluded that it lacked
9 | sufficient data to quantify the theoretical effect but that the available data was
10 | adequate “to conclude that the rule will increase, or at least not decrease, access
11 | to health care providers and services.” 84 Fed. Reg. at 23,247; *The Lands Council*
12 | *v. McNair*, 537 F.3d 981, 993 (9th Cir. 2008) (“[W]e are to conduct a “particularly
13 | deferential review” of an “agency’s predictive judgments about areas that are
14 | within the agency’s field of discretion and expertise” (citation omitted)).

15 | HHS also considered other potential benefits of the Rule for health care
16 | entities, such as the reduction in “harm that providers suffer when they are forced
17 | to violate their consciences.” 84 Fed. Reg. 23,246 (citing, among other sources,
18 | Kevin Theriot & Ken Connelly, *Free to Do No Harm: Conscience Protections for*
19 | *Healthcare Professionals*, 49 Ariz. Stat. L.J. 549, 565 (2017)).

20 | Whether the Rule would increase or decrease the number of providers is a
21 | difficult policy assessment that should be left to the entity with responsibility for
22 | making those assessments—HHS. Indeed, “[w]hether [the Court] would have

1 done what the agency did is immaterial,” so long as the agency engages in an
2 appropriate decisionmaking process. *Mingo Logan Coal Co. v. EPA*, 829 F.3d
3 710, 718 (D.C. Cir. 2016). The court asks only whether the decision “was based
4 on a consideration of the relevant factors and whether there has been a clear error
5 of judgment.” *Citizens to Preserve Overton Park*, 401 U.S. at 416. Here, HHS
6 assessed the available evidence and reasonably concluded that the Rule would
7 “increase, or at least not decrease,” the number of providers. 84 Fed. Reg. at
8 23,247.

9 Plaintiff separately argues that HHS inadequately considered the effect of
10 the Rule on healthcare access, PI Mem. at 34–35; *see also* Compl. ¶ 126. But HHS
11 received no data that would “enable[] a reliable quantification of the effect of the
12 rule on access to providers and to care,” 84 Fed. Reg. at 23,250. Absent reliable
13 data from which to quantify the effects, HHS was scarcely arbitrary in relying on
14 the data it did have—and that data indicated that, if anything, the Rule would
15 increase the number of available providers, which can reasonably be predicted to
16 improve patient care. *See id.* at 23,180; *see also Fox Television*, 556 U.S. at 521.

17 Furthermore, HHS explicitly sought comments on “whether this final rule
18 would result in unjustified limitations on access to health care.” 84 Fed. Reg. at
19 23,250; NPRM, 83 Fed. Reg. at 3900 (request for comment). Ultimately, and as
20 HHS explained, the majority of the comments it received in response to that
21 request focused on preexisting discrimination in health care and did not attempt
22 to answer the question of how the Rule itself would affect access to health care.

1 84 Fed. Reg. at 23,250. HHS studied academic literature relating to preexisting
2 statutes, but found “insufficient evidence to conclude that conscience protections
3 have negative effects on access to health care.” *See id.* at 23,251 & n.345. HHS
4 also considered a report with anecdotal data on discrimination against LGBT
5 patients in states with religious freedom laws. 84. Fed. Reg. at 23,252. But, as
6 HHS explained, that report contained only anecdotal accounts—thus making it
7 unfit for extrapolation—and made no attempt to establish a causal mechanism
8 between religious freedom laws and the discrimination it reported. *Id.*

9 Many of these questions—the precise effect of the Rule on patient care, the
10 effort that will be required to comply with a new policy—are difficult to answer.
11 Plaintiff’s view seems to be that an agency cannot take an action until it has
12 commissioned or executed studies on every potential repercussion of that action.
13 While that might be a technocrat’s dream, it is not what the APA requires. Instead,
14 the APA commits these decisions to the agency’s expertise. “Whether [the Court]
15 would have done what the agency did is immaterial[,]” so long as the agency
16 engages in an appropriate decisionmaking process. *Mingo Logan Coal Co.*, 829
17 F.3d at 718. Where, as here, HHS assessed the available evidence on a subject,
18 and reached a reasonable conclusion, this Court should not accept Plaintiff’s
19 invitation to second-guess the agency’s policy conclusions.

20 **E. The Rule Does Not Violate the Separation of Powers.**

21 Plaintiff asserts that the Rule violates the separation of powers because an
22 agency cannot “refuse to disburse money appropriated by Congress.” Compl.

1 ¶ 137; *see also* Compl. ¶¶ 135-38. But the Rule is not such a refusal—rather the
 2 Rule *complies* with congressional dictates. *See, e.g.*, Pub. L. No. 115-245, Div.
 3 B, § 507(d)(1), 132 Stat. at 3118 (Weldon Amendment, providing that “[n]one
 4 of the funds made available in this Act may be made available to [a recipient
 5 that] subjects any institutional or individual health care entity to discrimination
 6 on the basis that the health care entity does not provide, pay for, provide
 7 coverage of, or refer for abortions.”). As explained above, the Rule does not
 8 change the substantive law. 84 Fed. Reg. at 23,256. Agencies commonly enact
 9 such regulations implementing Congress’s funding conditions. *See, e.g.*, Final
 10 Rule, 68 Fed. Reg. 51,334-01 (a regulation by twenty-two agencies
 11 implementing Title VI, the Rehabilitation Act, and the Age Discrimination Act).

12 **F. The Rule Complies with the Spending Clause.**

13 Plaintiff alleges that the Rule violates the Spending Clause. Compl.
 14 ¶¶ 128-34. More specifically, Plaintiff alleges that the Rule is ambiguous, that
 15 the Rule is coercive, and that the Rule’s requirements are insufficiently related to
 16 the purpose of the Federal Conscience Statutes. All of these contentions are
 17 wrong.

18 As an initial matter, although Plaintiff purports to object to the *Rule*, its
 19 true objection is to the Federal Conscience Statutes, which originated the
 20 conditions on the government’s offer of funds. The Rule does not alter the
 21 Statutes’ substantive conscience requirements. *See* 84 Fed. Reg. 23,256. Nor can
 22 Plaintiff show that the Rule deviates from the Statutes in an unconstitutional

1 way, because many of its arguments—for example, that the amount of funding at
2 stake is coercively large—apply equally to the Rule *and* the Statutes. In other
3 instances, the Rule is clearly *less* susceptible to attack than the statutes—for
4 example, Plaintiff argues that the conditions on federal grants are ambiguous,
5 but the Rule provides greater clarity than the conscience statutes themselves.

6 Furthermore, Plaintiff’s specific objections under the Spending Clause fail
7 on their merits. Congress’s Article I authority to “set the terms on which it
8 disburses federal money to the States” is “broad,” and these conditions fall
9 within that authority. *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548
10 U.S. 291, 296 (2006); *see also, e.g., South Dakota v. Dole*, 483 U.S. 203, 206
11 (1987) (noting that Congress has “repeatedly employed the [spending] power to
12 further broad policy objectives by conditioning receipt of federal moneys upon
13 compliance by the recipient with federal statutory and administrative directives.”
14 (citations omitted)).

15 ***Coercion*** - A conditional offer of federal funds will be found to be unduly
16 coercive only in the unusual case—“[i]n the typical case we look to the States to
17 defend their prerogatives by adopting ‘the simple expedient of not yielding’ to
18 federal blandishments.” *NFIB v. Sebelius*, 567 U.S. 519, 579 (2012) (Roberts,
19 C.J.) (quoting *Massachusetts v. Mellon*, 262 U. S. 447, 482 (1923)). Comparing
20 this case to *NFIB* shows that no unconstitutional coercion has occurred. In *NFIB*,
21 the Supreme Court concluded that an ACA provision that conditioned all
22 Medicaid funds on a state’s agreement to expand its Medicaid program violated

1 the Spending Clause by “transform[ing]” Medicaid into a new program. 567
2 U.S. at 583. The Federal Conscience Statutes and the Rule are quite different.

3 First, unlike in *NFIB*, where states were provided with a binary choice—
4 either expand their Medicaid programs, or lose all of their Medicaid funding—it
5 is far from clear that noncompliance with the Federal Conscience Statutes and
6 the Rule would impact *all* of the funding sources identified by Plaintiff. HHS
7 has a variety of enforcement options when the conditions for its grants are not
8 met, and the Rule clarifies that HHS will always begin by trying to resolve a
9 potential violation through informal means. 84 Fed. Reg. at 23, 271 (“If an
10 investigation or compliance review indicates a failure to comply with Federal
11 conscience and antidiscrimination laws or this part, OCR will so inform the
12 relevant parties and *the matter will be resolved by informal means whenever*
13 *possible.*” (emphasis added)); *see also supra* note 3 (discussing HHS’s
14 enforcement procedures). Far from the “gun to the head” at issue in *NFIB*, 567
15 U.S. at 581, this series of informal enforcement proceedings is not unduly
16 coercive. Plaintiff’s apocalyptic (and hypothetical) scenarios of complete
17 funding loss—scenarios that have not remotely come to pass in the decades that
18 many of the Federal Conscience Statutes have been in effect—are of no help.
19 Plaintiff cannot succeed on its facial challenge by identifying a handful of
20 implausible and speculative circumstances in which the operation of the Federal
21 Conscience Statutes and the Rule *might* have a coercive effect; instead, it must
22 show that the Rule has *no* constitutional applications. *United States v. Sineneng-*

1 | *Smith*, 910 F.3d 461, 470 (9th Cir. 2018). And, the further factual context that
2 | would be available if such a scenario did occur would be helpful to the Court in
3 | evaluating Plaintiff’s Spending Clause claims, thus highlighting the lack of
4 | ripeness at this time.

5 | Second, unlike in *NFIB*, Plaintiff cannot plead surprise because the
6 | Federal Conscience Statutes and their conditions have existed for decades. *See*,
7 | *e.g.*, 42 U.S.C. § 300a-7 (first Church Amendments enacted in 1973); 42 U.S.C.
8 | § 238n (Coats-Snowe Amendment, enacted in 1996). The ACA provisions at
9 | issue in *NFIB* required the states to adopt an entirely new Medicaid expansion.
10 | *Cf. NFIB*, 567 U.S. at 584 (Roberts, C.J.) (criticizing the Medicaid expansion as
11 | an attempt to “enlist[] the States in a new health care program” and “surpris[e]
12 | participating States with postacceptance or ‘retroactive’ conditions” (citation
13 | omitted)). If anything, the Rule should be an improvement from Plaintiff’s
14 | perspective because the Rule provides additional clarity, transparency, notice,
15 | and insight into HHS’s enforcement processes.

16 | Plaintiff suggests that “the expanded scope” of the Rule, PI Mem. at 41,
17 | motivates its challenge, but this argument is a retread of Plaintiff’s statutory
18 | authority claim (which, for the reasons described above, fails), and in any event
19 | there is no Spending Clause barrier to clarifying the terms on which an entity
20 | may receive federal funding. *Cf. NFIB*, 567 U.S. at 582–83 (holding that the
21 | Medicaid statute authorized Congress to modify its terms without creating
22 |

1 Spending Clause problems, so long as the modifications did not rise to the level
2 of creating a new program).

3 ***Ambiguity*** - Plaintiff makes no attempt to argue that the terms of the
4 *Federal Conscience Statutes* are ambiguous, likely because each clearly
5 provides unambiguous notice to funding recipients of the Statutes' anti-
6 discrimination provisions. The Rule—which adds additional clarification and
7 interpretation on top of that are already provided in the statutes—is necessarily
8 clearer and less ambiguous than the statutes. Both are more than adequate to
9 pass the ambiguity analysis, which focuses on whether or not potential recipients
10 are aware that the federal government has placed conditions on federal funds,
11 rather than on whether every detail of such conditions has been set forth. *See,*
12 *e.g., Mayweathers v. Newland*, 314 F.3d 1062, 1067 (9th Cir. 2002)
13 (“[C]onditions may be ‘largely indeterminate,’ so long as the statute ‘provid[es]
14 clear notice to the States that they, by accepting funds under the Act, would
15 indeed be obligated to comply with the conditions.’ Congress is not required to
16 list every factual instance in which a state will fail to comply with a
17 condition. . . . Congress must, however, make the existence of the condition
18 itself . . . explicitly obvious.” (quoting *Pennhurst State Sch. & Hosp. v.*
19 *Halderman*, 451 U.S. 1, 24–25 (1981))).

20 ***Nexus*** - Plaintiff’s allegation that the Rule is not adequately related to the
21 purpose of the targeted funding, Compl. ¶ 133, fails because it is the Federal
22 Conscience Statutes—not the Rule—that establish the linkage between

1 conscience protections and federal funding. Further, the governmental purpose
2 of the statutes is to ensure that federal funds do not subsidize discrimination
3 against individual and institutional health care entities on the basis of their
4 moral, religious, or other beliefs about certain care (or coverage), in service of
5 the government’s interests in protecting the free exercise of religion and in
6 encouraging and overseeing a robust health care system. *See Mayweathers*, 314
7 F.3d at 1066–67 (upholding the Religious Land Use and Institutionalized
8 Persons Act (RLUIPA) against a Spending Clause challenge because “by
9 fostering non-discrimination, RLUIPA follows a long tradition of federal
10 legislation designed to guard against unfair bias and infringement on
11 fundamental freedoms”). Plaintiff objects that the funding for its “labor and
12 educational programs,” PI Mem. at 43, might also be at risk, but offers no
13 evidence to support this claim. The Rule applies only to funds administered,
14 conducted, or funded by HHS. Plaintiff should not succeed on its *facial*
15 challenge on the speculative theory that the Rule would somehow affect funds
16 provided other departments.

17 **G. The Rule Comports with the Establishment Clause.**

18 Plaintiff argues that the Rule violates the Establishment Clause, Compl.
19 ¶¶ 139-42, but under its theory, it would be the *preexisting* Federal Conscience
20 Statutes that violate the Establishment Clause by creating supposed “favoritism
21 toward religious beliefs.” Yet Plaintiff does not challenge the Federal
22 Conscience Statutes themselves and even endorses several of them. *See, e.g., PI*

1 | *Mem.* at 4. And as explained above, the Rule does not change the substantive
2 | law that Congress established in the Federal Conscience Statutes. *See* 84 Fed.
3 | Reg. 23,256.

4 | Indeed, for all of the same reasons that the Federal Conscience Statutes
5 | are in harmony with the Establishment Clause, the Rule is too. *See, e.g., Kong v.*
6 | *Scully*, 341 F.3d 1132 (9th Cir. 2003), *opinion amended on denial of reh’g*, 357
7 | F.3d 895 (9th Cir. 2004) (upholding several of the Federal Conscience Statutes
8 | against an Establishment Clause challenge); *Chrisman v. Sisters of St. Joseph of*
9 | *Peace*, 506 F.2d 308, 311 (9th Cir. 1974) (upholding a provision of the Church
10 | Amendments—Pub. L. No. 93-45, 87 Stat. 95 § 401—against an Establishment
11 | Clause challenge because Congress was seeking to “preserve the government’s
12 | neutrality in the face of religious differences” rather than to “affirmatively
13 | prefer[] one religion over another.”). “[T]here is ample room for accommodation
14 | of religion under the Establishment Clause.” *Corp. of Presiding Bishop of*
15 | *Church v. Amos*, 483 U.S. 327, 338 (1987). The Rule serves the legitimate
16 | secular purpose of alleviating potential burdens of conscience on individual and
17 | institutional health care entities, just as the Federal Conscience Statutes do.
18 | Additionally, the Rule neither promotes nor subsidizes any religious message or
19 | belief; rather, it explains the enforcement processes for existing federal statutes.
20 | Finally, the Rule, like many of the Federal Conscience Statutes, is generally
21 | neutral between various religions and between religion and non-religion. *Cf.*,
22 | *e.g.*, 42 U.S.C. § 238n (Coats-Snowe Amendment, the applicability of which

1 does not turn on a religious belief); Pub. L. No. 115-245, Div. B., § 507(d)
 2 (Weldon Amendment, the applicability of which does not turn on religious
 3 belief); 42 U.S.C. § 300a-7 (Church Amendments, which equally protect health
 4 care providers from discrimination based on religious beliefs or moral
 5 convictions).⁹

6 ***Burden on third parties*** - Plaintiff's argument that the Rule impermissibly
 7 burdens third parties, PI Mem. at 44-45, fails because the Establishment Clause
 8 does not bar religious accommodations that could have an adverse effect on
 9 others. For example, in *Corporation of the Presiding Bishop of the Church of*
 10 *Jesus Christ of Latter-day Saints v. Amos*, 483 U.S. 327 (1987), the Supreme
 11 Court held that Title VII's religious exemption to the prohibition against
 12 religious discrimination in employment was consistent with the Establishment
 13 Clause even though it allowed an employer to terminate the plaintiff's
 14 employment. While the plaintiff was "[u]ndoubtedly" adversely affected, "it was
 15 the Church[,] . . . not the Government" that caused that effect. 483 U.S. at 337
 16 n.15. Similarly, in *Doe v. Bolton*, the Supreme Court characterized a state statute
 17 that allowed hospitals, physicians, and other employees to refrain from

18 _____
 19 ⁹ Plaintiff unpersuasively refers to a "strict scrutiny" test, PI Mem. at 44
 20 (citing *Larson v. Valente*, 456 U.S. 228 (1982)), which applies only to
 21 *denominational* preferences. *Larson*, 456 U.S. at 246. But the Rule contains no
 22 sectarian preference.

1 participating in abortions as “appropriate protection [for] the individual and []
2 the denominational hospital.” 410 U.S. 179, 197–98 (1973).

3 Here, the Federal Conscience Statutes (and, therefore, the Rule) do not
4 directly burden anyone; instead, they simply encourage entities not to
5 discriminate. If any adverse effects occur, they thus result from the conscience
6 decisions of health care entities, not the government. *See Amos*, 483 U.S. at 337
7 n.15 (noting that plaintiff “was not legally obligated” to take the steps necessary
8 to save his job, and that his discharge “was not required by statute”). Finally, to
9 the extent it is appropriate to consider the burdens on third parties in the
10 Establishment Clause context and determine if they “override other significant
11 interests,” *Cutter v. Wilkinson*, 544 U.S. 709, 720, 722 (2005), Congress has
12 already struck this balance by conditioning federal health care funds on
13 compliance with the Federal Conscience Statutes.

14 ***Coercion*** - Plaintiff’s argument that the Rule coerces religious exercise,
15 PI Mem. at 45-46, is nonsensical. The Rule (and the Federal Conscience
16 Statutes) protects health care entities (and others) in determining whether to
17 participate in providing (or covering) certain care. The Federal Conscience
18 Statutes and the Rule do not “dictate” to anyone, PI Mem. at 45; rather they offer
19 conditioned federal funds for recipients to accept or not. If Plaintiff wishes to
20 engage in the discrimination prohibited by the Federal Conscience Statutes, then
21 it is free to decline HHS funds and make its own unfettered decisions.
22

1 **H. Any Relief Should Be Limited.**

2 **1. Any Relief Should Be Limited To Plaintiff.**

3 For the reasons discussed above, the Court should dismiss this case or, in
4 the alternative, grant summary judgment to Defendants and deny Plaintiff’s
5 forthcoming motion for summary judgment. But even if the Court were to
6 disagree, in accordance with the Court’s constitutionally prescribed role, any
7 relief should be limited to redressing the injuries of the parties before this Court.
8 *See Gill v. Whitford*, 138 S. Ct. 1916, 1921, 1933–34 (2018). Equitable
9 principles likewise require that any relief “be no more burdensome to the
10 defendant than necessary to provide complete relief to the plaintiffs.” *Madsen v.*
11 *Women’s Health Ctr., Inc.*, 512 U.S. 753, 765 (1994) (citation omitted).

12 Here, Plaintiff fails to show that nationwide relief is necessary to redress
13 its alleged injuries. To start, Plaintiff’s choice to bring a facial constitutional
14 challenge does not justify nationwide relief. *See City & Cty. of San Francisco v.*
15 *Trump*, 897 F.3d 1225, 1244–45 (9th Cir. 2018) (vacating nationwide scope of
16 injunction in facial constitutional challenge to executive order). Nor does
17 Plaintiff’s decision to bring APA claims necessitate a nationwide remedy. *See,*
18 *e.g., California v. Azar*, 911 F.3d 558, 582–84 (9th Cir. 2018) (vacating
19 nationwide scope of injunction in facial challenge under the APA). A court
20 “do[es] not lightly assume that Congress has intended to depart from established
21 principles” regarding equitable discretion, *Weinberger v. Romero-Barcelo*, 456
22 U.S. 305, 313 (1982), and the APA’s general instruction that unlawful agency

1 action “shall” be “set aside,” 5 U.S.C. § 706(2), is insufficient to mandate such a
2 departure. The Supreme Court therefore has confirmed that, even in an APA
3 case, “equitable defenses may be interposed.” *Abbott Labs. v. Gardner*, 387 U.S.
4 136, 155 (1967). Accordingly, the Court should construe the “set aside”
5 language in Section 706(2) as applying only to the named Plaintiff, especially
6 given that no federal court had issued a nationwide injunction before Congress’s
7 enactment of the APA in 1946, nor would do so for more than fifteen years
8 thereafter, *Trump v. Hawaii*, 138 S. Ct. 2392, 2426 (2018) (Thomas, J.,
9 concurring).

10 Nationwide relief would be particularly harmful here given that three
11 other district courts in California, New York, and Maryland are currently
12 considering similar challenges. If the government prevails in all three other
13 jurisdictions, nationwide relief here would render those victories meaningless as
14 a practical matter. It would also preclude appellate courts from testing Plaintiff’s
15 factual assertions against the Rule’s operation in other jurisdictions.

16 **2. Any Relief Should Be Limited To Specific Provisions.**

17 Similarly, should the Court decide to set aside or enjoin any portion of the
18 Rule, the Court should allow the remainder to go into effect. In determining
19 whether severance is appropriate, courts look to both the agency’s intent and
20 whether the regulation can function sensibly without the excised provision(s).
21 *MD/DC/DE Broadcasters Ass’n v. FCC*, 236 F.3d 13, 22 (D.C. Cir. 2001).

22 Here, the intent of the agency is clear: Section 88.10 of the Rule provides

1 that, if a provision of the Rule is held to be invalid or unenforceable, “such
2 provision shall be severable,” and “[a] severed provision shall not affect the
3 remainder of this part.” 84 Fed. Reg. at 23,272; *see also id.* at 23,226. Nor is
4 there any functional reason why the entire Rule must fall if the Court agrees with
5 Plaintiff’s attacks on particular provisions. The Rule implements a variety of
6 statutory provisions protecting conscience, but Plaintiff has not alleged harms
7 stemming from compliance with the Rule with respect to each and every one of
8 those statutes. Moreover, the various definitions in Section 88.2 that Plaintiff
9 challenges can operate independently of one another, as can the other provisions
10 in the Rule. And there is certainly no logical basis for setting aside or enjoining
11 the entire Rule if the Court agrees with only some of Plaintiff’s challenges.

12 **3. Any Relief Should Not Affect Ongoing Investigations**
13 **Based on the 2011 Rule or the Federal Conscience Statutes.**

14 Finally, if the Court does set aside the Rule or enter an injunction, the
15 Court should make clear that this relief does not prevent HHS from continuing
16 to investigate violations of, and to enforce, federal conscience and anti-
17 discrimination laws under the prior 2011 Rule or the Federal Conscience
18 Statutes themselves. Such investigations are independent of the Rule that is the
19 subject of this lawsuit, and require the investment of significant resources, and
20 therefore HHS should not be prevented from continuing to pursue them, or from
21 acting under its existing statutory or regulatory enforcement authority, even if
22 the Court were to otherwise set aside or enjoin the Rule.

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CONCLUSION

For the reasons stated above, Defendants respectfully ask that the Court dismiss this case or, in the alternative, enter judgment in Defendants’ favor.

Dated: August 19, 2019

Respectfully submitted,

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Assistant Attorney General

JOSEPH H. HARRINGTON
United States Attorney

JAMES M. BURNHAM
Deputy Assistant Attorney General

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Counsel for Defendants

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CERTIFICATE OF SERVICE

I hereby certify that on August 19, 2019, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification to all counsel of record.

/s/ Rebecca Kopplin
REBECCA KOPPLIN
Trial Attorney
U.S. Department of Justice

EXHIBIT A



**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)
CIVIL RIGHTS DISCRIMINATION COMPLAINT**

Form Approved: OMB No. 0990-0269.
See OMB Statement on Reverse.



YOUR FIRST NAME [REDACTED]		YOUR LAST NAME [REDACTED]	
HOME / CELL PHONE (Please include area code) [REDACTED]		WORK PHONE (Please include area code) [REDACTED]	
STREET ADDRESS [REDACTED]		CITY [REDACTED]	
STATE [REDACTED]	ZIP [REDACTED]	E-MAIL ADDRESS (If available) [REDACTED]	

Are you filing this complaint for someone else? Yes No
If Yes, whose civil rights do you believe were violated?

FIRST NAME [REDACTED]	LAST NAME [REDACTED]
--------------------------	-------------------------

I believe that I have been (or someone else has been) discriminated against on the basis of:

- Race / Color / National Origin
 Age
 Religion / Conscience
 Sex
 Disability
 Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?

PERSON/AGENCY/ORGANIZATION
Washington State Department of Corrections

STREET ADDRESS <u>7345 Linderson Way SW</u>		CITY <u>Tumwater</u>
STATE <u>Washington</u>	ZIP <u>98501</u>	PHONE (Please include area code) <u>(360) 725-8213</u>

When do you believe that the discrimination occurred?

LIST DATE(S)
10/02/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

No reasonable accommodation provided for my religious objection to prescribing hormones to men wanting to transition into women. When other providers offered to prescribe hormones to these patients under my care they were told by DOC leadership that they could not see my patients and no accommodation has been provided. Attached is a more detailed account as well as emails from my Facility Medical director, Chief medical officer, and the health care authority.

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE [REDACTED]	DATE (mm/dd/yyyy) <u>03/06/2018</u>
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Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: www.hhs.gov/ocr/civilrights/complaints/index.html. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

- Braille
 Large Print
 Cassette tape
 Computer diskette
 Electronic mail
 TDD
 Sign language interpreter (specify language): _____
 Foreign language interpreter (specify language): _____ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME		LAST NAME	
HOME PHONE (Please include area code)		WORK PHONE (Please include area code)	
STREET ADDRESS		CITY	
STATE	ZIP	E-MAIL ADDRESS (If available)	

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

EEOC, DOC internal discrimination complaint	
DATE(S) FILED	CASE NUMBER(S) (if known)
02/06/2018, 11/16/2017	null, null

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one) RACE (select one or more)
 Hispanic or Latino
 American Indian or Alaska Native
 Asian
 Native Hawaiian or Other Pacific Islander
 Not Hispanic or Latino
 Black or African American
 White
 Other (specify): _____
 PRIMARY LANGUAGE SPOKEN (if other than English) _____

How did you learn about the Office for Civil Rights?

- HHS Website/Internet Search
 Family/Friend/Associate
 Religious/Community Org
 Lawyer/Legal Org
 Phone Directory
 Employer
 Fed/State/Local Gov
 Healthcare Provider/Health Plan
 Conference/OCR Brochure
 Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

**U.S. Department of Health and Human
 Services
 Office for Civil Rights
 Centralized Case Management Operations
 200 Independence Ave., S.W.
 Suite 515F, HHH Building
 Washington, D.C. 20201
 Customer Response Center: (800) 368-1019
 Fax: (202) 619-3818
 TDD: (800) 537-7697
 Email: ocrmail@hhs.gov**

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**



COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.



- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.
- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

CONSENT: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

CONSENT DENIED: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: _____ Date: 03/06/2018

*Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

Name (Please print): _____

Address: _____

Telephone Number: _____



NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

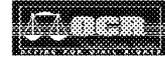
The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:

- (i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 *et seq.*), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
- (ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
- (iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
- (iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 *et seq.*) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS “designated agency” authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
- (v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.



OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

- (i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
- (ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
- (iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
- (iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".



PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.



CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed \$100.00.

If you have any questions about this complaint and consent package, Please contact OCR at <http://www.hhs.gov/ocr/office/about/contactus/index.html>

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

- April 2017 - Offender Approved by gender dysphoria Care Review Committee (CRC) for hormone therapy. My religious conviction will not allow me to prescribe hormones for this indication. [REDACTED] provided a reasonable accommodation at that time by taking over the management of this element of the patient's healthcare request.
- September 28th forwarded KITE from NEW offender requesting renewal of hormones for GD to [REDACTED]
- September 29th 2017 - Annual DOC health care provider meeting. Three hours of education on Gender dysphoria (GD).
- October 2nd - Noticed KITE response from [REDACTED] to offender saying "follow up with PCP." [REDACTED] volunteered to manage this issue for the patient.
- October 4th - Medical provider meeting: [REDACTED] read a series of scenarios asking the providers about religious ethics in the medical field. She gave an example of a Muslim working as a hospitalist who morally objected to hospice care because he viewed it as similar to euthanasia. She gave another example of a Jehovah's Witness working in an ER who morally objected to blood transfusions. (Both of these scenarios are extreme situations that would never happen. You would never encounter a hospitalist who wouldn't be ok with hospice and you would never find an ER provider who was not ok with blood transfusions.) In both of these scenarios she emphasized the "undue hardship" that would be placed on the conscientious objector's colleagues. These were directed at me in front of my colleagues.
- October 9th - Had in person conversation with [REDACTED] regarding treatment of GD. She stated that it would be the expectation of the provider on site to prescribe hormones and if I decided to stay working for the DOC than I would be expected to prescribe. I expressed that it is not an option for me to prescribe for this due to my conscience and religious beliefs. I expanded that other providers have already offered to do this. (See email chain started on October 9th titled "conversation with [REDACTED]")
- October 12th - Email from [REDACTED] forwarding an email to [REDACTED] and myself stating "forwarding to his primary care providers." [REDACTED] replied to the email.
- October 18th - Forwarded KITE from offender regarding GD to [REDACTED] and [REDACTED]. Phone call with [REDACTED] (CMO) (@10:44 on state phone) and [REDACTED] (@13:02pm on work phone [REDACTED]) Told them individually that this is a personal religious conviction that causes me to not be able to prescribe hormones for this indication but that I have found ways to mitigate this through other providers. Both of them stated that if I were to stay with the department I would be expected to prescribe this medication. If they were to allow this then it would be a slippery slope for anyone with religious convictions to not follow department policy.
- October 24th - Email from [REDACTED] to [REDACTED] stating "this is [REDACTED] patient and he needs to see the patient."
- October 26th around 1500 - [REDACTED] called [REDACTED] and ordered her not to prescribe any hormone therapy for inmates at IMU and to call her if I asked her to do so. Email from [REDACTED] with a KITE to the offender stating "Per [REDACTED], [REDACTED] is your provider while you are in the IMU"...
- October 31st - Received call from [REDACTED] who told me that [REDACTED] called her and told her she was "forbidden" from seeing my patients.
- December 11th - Email from [REDACTED] stating that the department cannot accommodate to my religious conviction.

-January 4th – Phone call from internal discrimination stating that there will not be an investigation as this is clearly under the rules of discrimination for Washington State.
March 6th – Received call from [REDACTED] (Program Manager - Diversity & Recruitment) and he states that [REDACTED] did not believe that my accommodation was reasonable. He did not really address my questions as to why beyond referencing policy 100.500 as their rationale. That in some way I was being discriminatory. Did not feel like they addressed the fact that they are refusing to let me refer patients based on a religious belief.

I have never been discriminatory to any patient. In fact, I saw this particular patient regarding other medical issues. I told him that his hormone management would be managed by [REDACTED] and [REDACTED]. He was fine with this. I am unable to prescribe or order laboratory tests for this indication because of my conscience and religious objections and it is getting to the point where I am feeling discriminated against for my beliefs. Telling all the other providers that they cannot see any of my patients is discriminatory because this has not been done to any other providers and the reason is because of my religious belief. I am providing access to care and there are willing prescribers to manage this low acuity issue in a small subset of inmates and clearly does not pose undue hardship on anyone. There had been reasonable accommodation for this in the past but is now being taken away. I feel like [REDACTED] and DOC health services leadership is placing undue burden on me and is being irresponsible by knowing what I have said yet continuing to pass the issue to me as if I am going to change my mind on my deeply held convictions. Attempting to force my hand is creating a hostile work environment for me.

[REDACTED]

From: [REDACTED]
Sent: Monday, December 11, 2017 4:51 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: RE: Conscientious objection.

Hi [REDACTED]

My apologies. [REDACTED] and I have been playing "phone tag" due to our busy schedules.

After consultation with DOC Leadership, it will continue to be an expectation that you provide all health care to your patient panel. Passing patient care to another clinician due to personal beliefs is not something that the Department cannot support.

While I do respect your personal beliefs, this is something that we cannot accommodate.

[REDACTED]

From: [REDACTED]
Sent: Friday, December 08, 2017 2:03 PM
To: [REDACTED]
Subject: Conscientious objection.

[REDACTED]

I wanted to hear from you what your understanding is of my consciences objection to prescribing hormone therapy for transgender individuals. I know that [REDACTED] was supposed to reach out to you but I have not heard back yet. Is it still leadership's stance that if I stay employed with the DOC I will be expected to prescribe hormones for this indication and that no reasonable accommodation will be provided?

Thanks,

[REDACTED]

[REDACTED]

Monroe Correction Complex

Phone: [REDACTED]

[REDACTED]

From: [REDACTED]
Sent: Thursday, October 26, 2017 8:26 AM
To: [REDACTED]; Jacob A. (DOC)
Cc: [REDACTED]
Subject: RE: [REDACTED]

Hello,

I want to remind us all that every medical practitioner is expected to uphold the mission of the DOC and provide care to their patients as consistent with Department policies. No one practitioner is allowed to pick and choose those conditions within appropriate scope of practice that they will and will not treat. It is the responsibility of each provider to fully manage each patient's medical needs within their capabilities, escalating or referring care to specialists as appropriate. Intentionally failing or refusing to fully manage each patient's medical needs impedes the care of the patient and may lead to corrective or disciplinary action. Please note that referrals to other providers to manage these patients creates extra work burden for one's colleagues and can create a sense that the patient is being treated differently than others.

[REDACTED]

Chief Medical Officer
Health Services Division
Department of Corrections
Tumwater, WA 98504-1123

From: [REDACTED]
Sent: Wednesday, October 25, 2017 12:24 PM
To: [REDACTED]
Cc: [REDACTED]
K. [REDACTED]
Subject: RE: [REDACTED]

As discussed, you've received training on how to manage these patients, and it is expected of the midlevel providers to provide their direct care. It is not appropriate to wash your hands of this issue, which is what you are seeking to do by sending all these kites to me.

From: [REDACTED]
Sent: Wednesday, October 25, 2017 12:21 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: [REDACTED]

[REDACTED]

From: [REDACTED]
Sent: Tuesday, October 10, 2017 7:42 PM
To: [REDACTED]
Subject: [REDACTED]

I will be at MCC again this week both Wednesday 10/11 and Thursday 10/12. I will attempt to stop by and see you then.

[REDACTED] Union Representative
Teamsters Local Union No. 117

[REDACTED]

We build unity and power for all working people to improve lives and lift up our communities. This is our Union.

Teamsters Local Union No. 117 Confidentiality Statement

This message and any attached files might contain confidential information protected by federal and state law. The information is intended only for the use of the individual(s) or entities originally named as addressees. The improper disclosure of such information may be subject to civil or criminal penalties. If this message reached you in error, please contact the sender and destroy this message. Disclosing, copying, forwarding, or distributing the information by unauthorized individuals or entities is strictly prohibited by law.

-----Original Message-----

From: [REDACTED]
Sent: Tuesday, October 10, 2017 8:28 AM
To: [REDACTED]
Subject: FW: Conversation with [REDACTED]

[REDACTED]

I am not sure what your role is but I am seeking some legal counsel as I am a teamsters member. Below is a conversation that has started surrounding the gender dysphoria issue in our state. I am a medical provider at Monroe Correctional Complex. I am a blue badge employee and have been for 2 years. The issue is this: I am ethically opposed to prescribing hormone therapy to men for the purpose of "treating" their gender dysphoria but it is the DOCs mission to do this. I am essential being told that I will need to prescribe these medications or find another Job. Do you have any suggestions on a route I should take

[REDACTED]

I included you because you are my union representative. Feel free to stop by the IMU to discuss further

-----Original Message-----

From: [REDACTED]
Sent: Tuesday, October 10, 2017 8:04 AM
To: [REDACTED]
Cc: [REDACTED]
Subject: Re: Conversation with [REDACTED]

Hi [REDACTED]

That's not quite what I said, but if it's what you took away from that conversation, please let me clarify.

You are not being asked to leave. What I said was that as an employee acting on behalf of the state, you are expected to carry out the mission of DOC, which includes providing hormone treatment for gender dysphoria. If you are unwilling to do this, then you need to examine whether DOC is the right place for you.

But as long as you continue in your role as a medical provider for DOC, you will be expected to provide this care.

Your personal beliefs do not enter into the issue, though I do recognize that your decision will be determined by them. And no one is happy that you may choose to leave.

However, if you determine that you cannot support DOC's mission in this regard, we will support you in seeking other employment, and provide an excellent recommendation.

I hope this clarifies things.

Thanks,

[REDACTED]

Sent from my iPhone

> On Oct 9, 2017, at 9:25 PM, [REDACTED]

>

> I had a conversation with [REDACTED] today and I wanted to make sure that I am understanding what you all decided.

>

> Essentially, it is now part of the DOCs mission to treat transgender individuals with hormone therapy and this therapy will be issued by the provider onsite once approved by the gender dysphasia CRC. And if i, the prescriber, cannot align myself with this mission due to my strong conviction that this is harmful to my patients in a medical, social, biblical, and biologic way, I will be asked to find a job elsewhere.

>

> Is this accurate?

>

> Anyone feel free to answer.

>

> Sent from my iPhone

The Washington Department of Corrections is increasing the security level for email messages containing confidential or restricted data. A new Secure Email Portal is being implemented. Outbound email messages from DOC staff that contain confidential or restricted data will be routed to the portal. A notification of the secured message will be delivered to the recipient.

Click on the following web link for more information. <http://doc.wa.gov/information/secure-email.htm>

[REDACTED]

From: [REDACTED]
Sent: Thursday, October 19, 2017 12:04 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: RE: Conversation with [REDACTED]

Sorry- this was stuck in my outbox from yesterday.

From: [REDACTED]
Sent: Thursday, October 19, 2017 12:03 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: RE: Conversation with [REDACTED]

[REDACTED]
Good speaking with you today. I understand your position and I hope I have been able to clearly articulate the importance of DOC practitioners adhering to the Department policy in treating patients. As we discussed, the next step is for you to speak with [REDACTED]. I copy both of them as well as their assistants here.
best,
[REDACTED]

From: [REDACTED]
Sent: Monday, October 16, 2017 10:40 PM
To: [REDACTED]
Subject: Re: Conversation with [REDACTED]

[REDACTED] I initially told you that tomorrow might work for me but I actually will not be in tomorrow. I should be in on Wednesday however if you want to talk. Let me know. We could also just do a phone call sometime
Thanks,
[REDACTED]

Sent from my iPhone

On Oct 11, 2017, at 10:44 AM, [REDACTED] wrote:

Hi [REDACTED]
[REDACTED] is out of the office so I will respond.
Thank you for reaching out and sharing your understanding of the conversation you had with [REDACTED] regarding the treatment of Gender Dysphoria within the Department of Corrections. It is true that it is DOC policy to provide medically appropriate treatment to individuals with Gender Dysphoria as approved by the Gender Dysphoria Care Review Committee. This includes hormonal treatment according to guidelines consistent with community practice.
I am happy to meet and discuss your concerns with you. I could come out to Monroe next week on a mutually agreeable date.
best,

[REDACTED]
Chief Medical Officer
Health Services, Department of Corrections

From: [REDACTED]
Sent: Monday, October 09, 2017 9:25 PM
To: [REDACTED]
(DOC)
Subject: Conversation with [REDACTED]

I had a conversation with [REDACTED] today and I wanted to make sure that I am understanding what you all decided.

Essentially, it is now part of the DOCs mission to treat transgender individuals with hormone therapy and this therapy will be issued by the provider onsite once approved by the gender dysphasia CRC. And if i, the prescriber, cannot align myself with this mission due to my strong conviction that this is harmful to my patients in a medical, social, biblical, and biologic way, I will be asked to find a job elsewhere.

Is this accurate?

Anyone feel free to answer.

Sent from my iPhone

I understand. I will manage these patient by continuing to refer them to either you or one of the other providers in a timely manner just like is done with the hepatitis C patients.

From: [REDACTED]
Sent: Wednesday, October 25, 2017 12:03 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: RE: [REDACTED]

[REDACTED]

As you've been told separately by me, [REDACTED] you are expected to manage patients' transgender issues while they reside on your unit, as is expected of all providers.

Thanks,

[REDACTED]

Facility Medical Director, MCC

[REDACTED]

From: [REDACTED]
Sent: Wednesday, October 25, 2017 9:50 AM
To: [REDACTED]
Cc: [REDACTED]
Subject: RE: [REDACTED]

I did see the patient in regard to his Ensure request and ear pain. I told him that [REDACTED] would be managing his transgender issue. He had no issue with another provider seeing him for this. He was quite frustrated that he only received 2 responses from the 12 kites he has sent. Please see this patient at your convenience.

Thanks,

[REDACTED]

From: [REDACTED]
Sent: Wednesday, October 25, 2017 8:30 AM
To: [REDACTED]
Subject: FW: [REDACTED]

He [REDACTED]

FYI

Thanks,

[REDACTED]

From: [REDACTED]
Sent: Tuesday, October 24, 2017 4:10 PM
To: [REDACTED]
Subject: RE: [REDACTED]

This is [REDACTED] patient and he needs to see the patient.

From: [REDACTED]
Sent: Tuesday, October 24, 2017 3:00 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: FW: [REDACTED]

Hi [REDACTED]
Would you like me to see [REDACTED] in the IMU or would you like to?
Thanks,
[REDACTED]

From: [REDACTED]
Sent: Tuesday, October 24, 2017 11:32 AM
To: [REDACTED]
Subject: RE: [REDACTED]

Not sure. I asked this morning but they don't know. Could be for a few more weeks.

From: [REDACTED]
Sent: Tuesday, October 24, 2017 11:32 AM
To: [REDACTED]
Subject: RE: [REDACTED]

Any idea on how long she will be in the IMU?

From: [REDACTED]
Sent: Tuesday, October 24, 2017 11:19 AM
To: [REDACTED]
Subject: [REDACTED]

[REDACTED]
Is wanting some follow up regarding his hormones. He is not happy that his testosterone is so high. Ill defer to you.



No reasonable accommodation provided for my religious objection to prescribing hormones to men wanting to transition into women. When other providers offered to prescribe hormones to these patients under my care they were told by DOC leadership that they could not see my patients and no accommodation has been provided. Attached is a more detailed account as well as emails from my Facility Medical director, Chief medical officer, and the health care authority.

EXHIBIT B



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)
Civil Rights Discrimination Complaint



YOUR FIRST NAME [REDACTED]		YOUR LAST NAME N/A	
HOME PHONE (Please include area code)		WORK PHONE (Please include area code) [REDACTED]	
STREET ADDRESS [REDACTED]			CITY [REDACTED]
STATE [REDACTED]	ZIP [REDACTED]	E-MAIL ADDRESS (if available) [REDACTED]	

Are you filing this complaint for someone else? Yes No

If Yes, whose civil rights do you believe were violated?

FIRST NAME American Association of ProLife Ob-Gyn	LAST NAME
--	-----------

I believe that I have been (or someone else has been) discriminated against on the basis of:

- Race / Color / National Origin
 Age
 Religion / Conscience
 Sex
 Disability
 Other (specify):

Who or what agency or organization do you believe discriminated against you?
PERSON / AGENCY / ORGANIZATION
[REDACTED]

STREET ADDRESS 409 12th Street SW		Washington
STATE D.C.	ZIP 20024	PHONE (Please include area code) (202) 638-5277

When do you believe that the occurred?

LIST DATE(S)
Starting November 2007 to present

Describe briefly what happened. How and why do you believe you have been discriminated against? Please be as specific as possible.
(Attach additional pages as needed)

Please see letter attached stating specifics

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE _____ DATE 3/23/2018

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: www.hhs.gov/ocr/civilrights/complaints/index.html. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form).

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for OCR to communicate with you about this complaint? (Check all that apply)

- Braille Large Print Cassette tape Computer diskette Electronic mail TDD
- Sign language interpreter (specify language): _____
- Foreign language interpreter (specify language): _____ Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME		LAST NAME	
HOME PHONE (Please include area code)		WORK PHONE (Please include area code)	
STREET ADDRESS		CITY	
STATE	ZIP	E-MAIL ADDRESS (if available)	

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON / AGENCY / ORGANIZATION / COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (if known)
---------------	---------------------------

To help us better serve the public; please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one) RACE (select one or more)

Hispanic or Latino American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander

Not Hispanic or Latino Black or African American White Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other than English):

How did you learn about the Office for Civil Rights?

- HHS Website /Internet Search Family / Friend /Associate Religious /Community Org Lawyer /Legal Org Phone Directory Employer
- Fed /State/Local Gov Healthcare Provider /Health Plan Conference /OCR Brochure Other(specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

U.S. Department of Health and Human Services
 Office for Civil Rights
 Centralized Case Management Operations
 200 Independence Ave., S.W.
 Suite 515F, HHH Building
 Washington, D.C. 20201
 Customer Response Center: (800) 368-1019
 Fax: (202) 619-3818
 TDD: (800) 537-7697
 Email: ocrmail@hhs.gov

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail this complaint form to this address.**



COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights and Protecting Personal Information in Complaint Investigations for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.
- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.

Complaint Consent Form

Page 1 of 2



- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

CONSENT: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

CONSENT DENIED: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature:

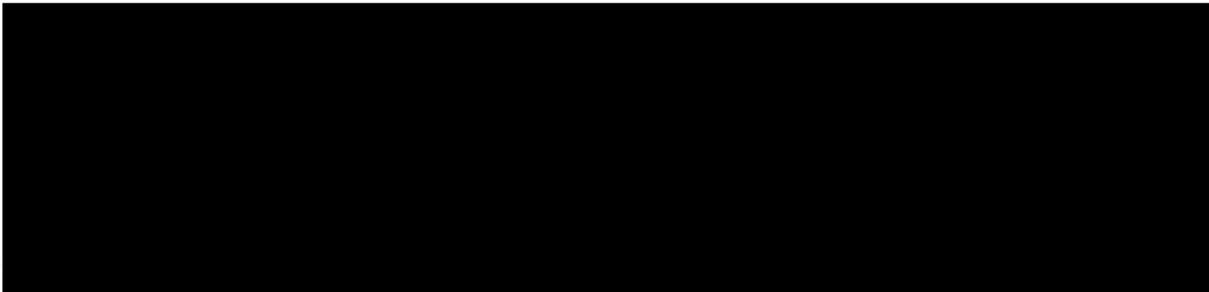
Date: 3/23/2018

**Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.*

Name (Pl

Address:

Telephon





NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

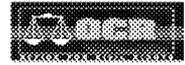
The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:

- (i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 *et seq.*), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
- (ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
- (iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
- (iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 *et seq.*) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS “designated agency” authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
- (v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.



OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

- (i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
- (ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
- (iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
- (iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

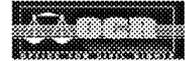
Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".



PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.



CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed \$100.00.

If you have any questions about this complaint and consent package, Please contact OCR at <http://www.hhs.gov/ocr/office/about/contactus/index.html>

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

THOMAS MORE SOCIETY

A National Public Interest Law Firm

March 23, 2018

Via US Mail & email: ocrmail@hhs.gov

U.S. Department of Health and Human Services
Office of Civil Rights
Centralized Case Management Operations
200 Independence Ave., S.W.
Suite 515F, HHH Building
Washington, D.C. 20201

Re: Violations of Conscience Rights of Physicians

Dear members of the Office of Civil Rights for the Department:

We write on behalf of our client, American Association of Pro-Life Obstetricians and Gynecologists ("AAPLOG") and its Executive Director, [REDACTED] M.D., seeking the assistance of the Office of Civil Rights to investigate ongoing efforts by the American College of Obstetricians and Gynecologists ("ACOG") and its lobbying sister organization American Congress of Obstetrics and Gynecology ("The Congress") to stifle and countermand conscience rights of pro-life physicians to decline to perform, participate in, or assist in the performance of abortion practices because of their conscience and/or religious opposition to such practices.

AAPLOG is a nonprofit professional medical organization consisting of approximately 4,000 obstetrician-gynecologist members and associates practicing medicine in the United States and in several foreign countries. Its mission is to encourage the practice of medicine consistent with scientific truth and the Hippocratic oath, both of which it views as orienting medicine, as a healing art, toward the well-being and flourishing of all human life. ACOG is another membership organization of obstetricians and gynecologists. It purports to represent 58,000 physicians and partners. The Congress, ACOG's sister organization, a 501(c)(4) organization under the Internal Revenue Code, exists "to promote policy positions" of ACOG, in other words, to lobby. All members of ACOG are automatically members of The Congress regardless of the desire of the member to abstain from the Congress's pro-abortion lobbying.

In November 2007 ACOG issued Ethics Statement #385. **Exhibit One.** ACOG in this statement declares to be "unethical" any physician refusing to perform or refer for elective abortions. This statement was promptly and vigorously called into

19 S. LaSalle | Suite 603 | Chicago, IL 60603 || P: 312.782.1680 | F: 312.782.1887
501 Scoular | 2027 Dodge | Omaha, NE 68102 || P: 402-346-5010 | F: 402 345 8853
www.thomasmoresociety.org

"Injustice anywhere is a threat to justice everywhere." – Rev. Dr. Martin Luther King

HHS, Office of Civil Rights
March 23, 2018
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question by AAPLOG, other medical associations, and speakers before the President's Council on Bioethics. See, e.g., **Exhibit Two** (AAPLOG Response of Feb. 6, 2008); **Exhibit Three** (Letter from Catholic Medical Association, February 28, 2008); **Exhibit Four** (Joint Letter of Protest by various medical organizations, Dec. 7, 2007); **Exhibit Five** (Letter by 16 Members of Congress, March 14, 2008). These and other objectors requested that ACOG retract the Ethics Statement #385 as being unsupported and discriminatory. At the same time, the Department of Health and Human Services ("HHS") sent a letter to the American Board of Obstetrics and Gynecology ("ABOG"), which is the certifying body for obstetricians and gynecologists in the U.S., objecting to the ACOG policy and questioning its influence on ob-gyn certification procedures. See **Exhibit Six** (March 14, 2008 Letter to [REDACTED], M.D., Executive Director ABOG). ABOG responded with a letter protesting its innocence. See **Exhibit Seven** (March 19, 2008 Letter of [REDACTED], M.D. to [REDACTED], Secretary HHS). ACOG itself responded to the criticism by promising its members to revisit Ethics Statement #385, see **Exhibit Eight** (Letter to [REDACTED] March 26, 2008), but it never changed the policy, instead reconfirming it, most recently in 2016.¹

ABOG's letter (Exhibit Seven) as a disclaimer carries no legal weight, since it is not an affirmative policy statement of ABOG itself. It thus gives no assurance to a pro-life ob-gyn against accusation of unethical conduct under Ethics Statement #385 upon a conscience-based refusal to perform or refer for abortion. What is needed is an affirmative statement from ABOG declaring that a conscience-based refusal to perform or refer for abortion does *not* constitute an ethical violation. But that has not been forthcoming. Without it an ob-gyn remains vulnerable to the possibility that his or her conscience-based refusal to participate in abortion could be considered unethical, prompting a loss of board certification, loss of employment, and other professional and personal adverse consequences. In that respect, the threat posed by Ethics Statement #385 is neither imaginary nor inflated. Under ABOG's current rules, an accusation of unethical professional behavior can lead to rescission of board certification, loss of licensure, and loss of hospital privileges.² Indeed, the very existence of Ethics Statement #385 is a

¹ See <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine> (last visited, March 21, 2018).

² See 2018 Bulletin for the Certifying Examination in Obstetrics and Gynecology, accessible at <https://www.abog.org/bulletins/2018%20Certifying%20Examination%20in%20Obstetrics%20and%20Gynecology.pdf> (last visited March 21, 2018). The Bulletin states, at p.7: "If a candidate is involved in an investigation by a health care organization regarding practice

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sword of Damocles hanging over Hippocratic oath physicians, and exerts a continuing chilling effect on their conscientious performance of ob-gyn services.

This ongoing state of affairs -- in which a licensed and board certified obstetrician-gynecologist can potentially be denied certification solely on the basis of refusal to perform or refer for abortions -- is also undesirable and counterproductive from the standpoint of public policy. As is well known, the United States suffers from a critical shortage of physicians, particularly in rural and other underserved areas of the country. To qualify and certify a single ob-gyn takes eight years of training, including four years of medical school and four years in an approved ob-gyn residency program. Qualified, dedicated ob-gyns provide desperately needed obstetric and gynecological services throughout the United States, including in rural and underserved areas of our country where their professional services often constitute the primary care for women of reproductive age. To deny certification to a fully trained ob-gyn solely because of ideological disagreement with a conscience-based objection to perform or refer for abortion would disserve all women who depend on such physicians, and exacerbate the already critical shortage of health care professionals in rural and other underserved communities, which desperately require such services. This makes no sense as sound public policy.

The 4,000 members of AAPLOG and countless other physicians consider ACOG Ethics Statement #385 to pose an intentional and systematic threat to the right of Hippocratic physicians in this country to follow, on the basis of conscience, time-honored Hippocratic principles of medicine. The very existence of this policy violates the conscience rights of all AAPLOG members, whom Dr. Harrison represents as Executive Director of AAPLOG, and the conscience rights of all pro-life physicians in this country.

For these reasons, AAPLOG hereby petitions the OCR for an investigation into:

1. The systematic and continued violation of conscience rights of Hippocratic physicians authorized by ACOG's adoption and continued advancement of Ethics Statement #385.

activities or for ethical or moral issues, the individual will not be scheduled for examination, and a decision to approve or disapprove the application will be deferred until either the candidate has been cleared or until ABOG has received sufficient information to make a final decision." See also, at p. 8: "This means that each such medical license must not be restricted, suspended, on probation, revoked, nor include conditions of practice. The terms 'restricted' and 'conditions' include any and all limitations, terms or requirements imposed on a physician's license regardless of whether they deal directly with patient care."

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2. The relationship between ABOG with ACOG, an abortion advocacy organization, and the use by ABOG of ACOG Ethics Statement #385 as a criteria for board certification.

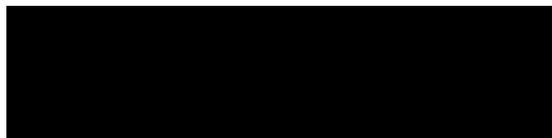
3. The unlawful use by covered entities of ABOG board certification or ACOG Ethics Statement #385 to intimidate and discriminate against individuals in violation of federal laws protecting conscience rights.

We respectfully request your office, after investigating these issues, to take appropriate action to prevent -- both now and for the future -- ACOG's political views favoring abortion, and its policy statements arising from those views, from interfering with, curtailing, or punishing the rights of conscience of pro-life physicians and service providers. In this regard, we respectfully request that HHS issue regulations that: (1) Require covered entities to provide a clear statement that covered entities cannot discriminate against individuals or healthcare entities because they refuse to perform, refer for, or train to perform, elective abortions; and (2) Require covered entities to post notices informing all healthcare providers of their conscience rights as well as that government offices individuals or healthcare entities can contact to request assistance in the event their rights are violated.

AAPLOG believes that HHS should take these and other steps necessary to prevent ABOG and ACOG from the current cat-and-mouse strategy that is being used to intimidate and harass pro-life physicians and service providers in a manner wholly inconsistent with the letter and spirit of the federal laws protecting conscience.

Thank you for considering this complaint. Please contact the undersigned in the event additional information is needed to bring your investigation to conclusion.

Respectfully,



Counsel, Thomas More Society



Enclosures

EXHIBIT ONE

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ACOG COMMITTEE OPINION

Number 385, November 2007

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Committee on Ethics

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The Limits of Conscientious Refusal in Reproductive Medicine

ABSTRACT: Health care providers occasionally may find that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience—particularly in the field of reproductive medicine. Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities. Conscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled. All health care providers must provide accurate and unbiased information so that patients can make informed decisions. Where conscience implores physicians to deviate from standard practices, they must provide potential patients with accurate and prior notice of their personal moral commitments. Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that patients request. In resource-poor areas, access to safe and legal reproductive services should be maintained. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care.

Physicians and other providers may not always agree with the decisions patients make about their own health and health care. Such differences are expected—and, indeed, underlie the American model of informed consent and respect for patient autonomy. Occasionally, however, providers anticipate that providing indicated, even standard, care would present for them a personal moral problem—a conflict of conscience. In such cases, some providers claim a right to refuse to provide certain services, refuse to refer patients to another provider for these services, or even decline to inform patients of their existing options (1).

Conscientious refusals have been particularly widespread in the arena of reproductive medicine, in which there are deep divisions regarding the moral acceptability of pregnancy termination and contraception. In Texas, for example, a pharmacist rejected a rape victim's prescription for emergency contraception, arguing that dispensing the medication was a "violation of morals" (2). In Virginia, a 42-year-old mother of two was refused a prescription for emergency contraception, became pregnant, and ultimately underwent an abortion she tried to prevent by requesting emergency contraception (3). In California, a physician refused to perform intrauterine insemination for a lesbian couple, prompted by religious beliefs and disapproval of lesbians having children (4). In Nebraska, a 19-year-old woman with a life-threatening pulmonary embolism at 10 weeks of gestation was refused a first-trimester pregnancy termination when admitted to a religiously affiliated hospital and was ultimately transferred by ambulance to another facility to undergo the procedure (5). At the heart of each of these examples of refusal is a claim of conscience—a claim that to provide certain services would compromise the moral integrity of a provider or institution.

In this opinion, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics considers the issues raised by conscientious refusals in reproductive medicine and outlines a framework for defining the ethically appropriate limits of conscientious refusal in reproductive health contexts. The committee begins by offering a definition of conscience and describing what might constitute an authentic claim of conscience. Next, it discusses the limits of conscientious refusals, describing how claims of conscience should be weighed in the context of other values critical to the ethical provision of health care. It then outlines options for public policy regarding conscientious refusals in reproductive medicine. Finally, the committee proposes a series of recommendations that maximize accommodation of an individual's religious or moral beliefs while avoiding imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive health care that all women deserve.

Defining Conscience

In this effort to reconcile the sometimes competing demands of religious or moral freedom and reproductive rights, it is important to characterize what is meant by conscience. Conscience has been defined as the private, constant, ethically

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attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction (6). An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity. Thus, what is taken seriously and is the specific focus of this document is not simply a broad claim to provider autonomy (7), but rather the particular claim to a provider's right to protect his or her moral integrity—to uphold the "soundness, reliability, wholeness and integration of [one's] moral character" (8).

Personal conscience, so conceived, is not merely a source of potential conflict. Rather, it has a critical and useful place in the practice of medicine. In many cases, it can foster thoughtful, effective, and humane care. Ethical decision making in medicine often touches on individuals' deepest identity-conferring beliefs about the nature and meaning of creating and sustaining life (9). Yet, conscience also may conflict with professional and ethical standards and result in inefficiency, adverse outcomes, violation of patients' rights, and erosion of trust if, for example, one's conscience limits the information or care provided to a patient. Finding a balance between respect for conscience and other important values is critical to the ethical practice of medicine.

In some circumstances, respect for conscience must be weighed against respect for particular social values. Challenges to a health care professional's integrity may occur when a practitioner feels that actions required by an external authority violate the goals of medicine and his or her fiduciary obligations to the patient. Established clinical norms may come into conflict with guidelines imposed by law, regulation, or public policy. For example, policies that mandate physician reporting of undocumented patients to immigration authorities conflict with norms such as privacy and confidentiality and the primary principle of nonmaleficence that govern the provider-patient relationship (10). Such challenges to integrity can result in considerable moral distress for providers and are best met through organized advocacy on the part of professional organizations (11, 12). When threats to patient well-being and the health care professional's integrity are at issue, some individual providers find a conscience-based refusal to comply with policies and acceptance of any associated professional and personal consequences to be the only morally tenable course of action (10).

Claims of conscience are not always genuine. They may mask distaste for certain procedures, discriminatory attitudes, or other self-interested motives (13). Providers who decide not to perform abortions primarily because they find the procedure unpleasant or because they fear criticism from those in society who advocate against it do not have a genuine claim of conscience. Nor do providers who refuse to provide care for individuals because of fear of disease transmission to themselves or other patients. Positions that are merely self-protective do not constitute the basis for a genuine claim of conscience. Furthermore, the logic of conscience, as a form of self-reflection on and judgment about whether one's own acts are obligatory or prohibited, means that it would be odd or absurd to say "I would have a guilty conscience if she did 'x.'" Although some have raised concerns about complicity in the context of referral to another provider for requested medical care, the logic of conscience entails that to act in accordance with conscience, the provider need not rebuke other providers or obstruct them from performing an act (8). Finally, referral to another provider need not be conceptualized as a repudiation or compromise of one's own values, but instead can be seen as an acknowledgment of both the widespread and thoughtful disagreement among physicians and society at large and the moral sincerity of others with whom one disagrees (14).

The authenticity of conscience can be assessed through inquiry into 1) the extent to which the underlying values asserted constitute a core component of a provider's identity, 2) the depth of the provider's reflection on the issue at hand, and 3) the likelihood that the provider will experience guilt, shame, or loss of self-respect by performing the act in question (9). It is the genuine claim of conscience that is considered next, in the context of the values that guide ethical health care.

Defining Limits for Conscientious Refusal

Even when appeals to conscience are genuine, when a provider's moral integrity is truly at stake, there are clearly limits to the degree to which appeals to conscience may justifiably guide decision making. Although respect for conscience is a value, it is only a *prima facie* value, which means it can and should be overridden in the interest of other moral obligations that outweigh it in a given circumstance. Professional ethics requires that health be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and non-discriminatory. By virtue of entering the profession of medicine, physicians accept a set of moral values—and duties—that are central to medical practice (15). Thus, with professional privileges come professional responsibilities to patients, which must precede a provider's personal interests (16). When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of conscientious refusal. In the following sections, four criteria are highlighted as important in determining appropriate limits for conscientious refusal in reproductive health contexts.

1. Potential for Imposition

The first important consideration in defining limits for conscientious refusal is the degree to which a refusal constitutes an imposition on patients who do not share the objector's beliefs. One of the guiding principles in the practice of medicine is respect for patient autonomy, a principle that holds that persons should be free to choose and act without controlling constraints imposed by others. To respect a patient's autonomy is to respect her capacities and perspectives, including her right to hold certain views, make certain choices, and take certain actions based on personal values and beliefs (17). Respect involves acknowledging decision-making rights and acting in a way that enables patients to make choices for themselves. Respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing.

It is not uncommon for conscientious refusals to result in imposition of religious or moral beliefs on a patient who may not share these beliefs, which may undermine respect for patient autonomy. Women's informed requests for contraception or sterilization, for example, are an important expression of autonomous choice regarding reproductive decision making. Refusals to dispense contraception may constitute a failure to respect women's capacity to decide for themselves whether and under what circumstances to become pregnant.

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Similar issues arise when patients are unable to obtain medication that has been prescribed by a physician. Although pharmacist conduct is beyond the scope of this document, refusals by other professionals can have an important impact on a physician's efforts to provide appropriate reproductive health care. Providing complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion, is fundamental to respect for patient autonomy and forms the basis of informed decision making in reproductive medicine. Providers refusing to provide such information on the grounds of moral or religious objection fail in their fundamental duty to enable patients to make decisions for themselves. When the potential for imposition and breach of autonomy is high due either to controlling constraints on medication or procedures or to the provider's withholding of information critical to reproductive decision making, conscientious refusal cannot be justified.

2. Effect on Patient Health

A second important consideration in evaluating conscientious refusal is the impact such a refusal might have on well-being as the patient perceives it—in particular, the potential for harm. For the purpose of this discussion, harm refers to significant bodily harm, such as pain, disability, or death or a patient's conception of well-being. Those who choose the profession of medicine (like those who choose the profession of law or who are trustees) are bound by special fiduciary duties, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest (16). Although conscientious refusals stem in part from the commitment to "first, do no harm," their result can be just the opposite. For example, religiously based refusals to perform tubal sterilization at the time of cesarean delivery can place a woman in harm's way—either by putting her at risk for an undesired or unsafe pregnancy or by necessitating an additional, separate sterilization procedure with its attendant and additional risks.

Some experts have argued that in the context of pregnancy, a moral obligation to promote fetal well-being also should justifiably guide care. But even though views about the moral status of the fetus and the obligations that status confers differ widely, support of such moral pluralism does not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients. Indeed, in the vast majority of cases, the interests of the pregnant woman and fetus converge. For situations in which their interests diverge, the pregnant woman's autonomous decisions should be respected (18). Furthermore, in situations "in which maternal competence for medical decision making is impaired, health care providers should act in the best interests of the woman first and her fetus second" (19).

3. Scientific Integrity

The third criterion for evaluating authentic conscientious refusal is the scientific integrity of the facts supporting the objector's claim. Core to the practice of medicine is a commitment to science and evidence-based practice. Patients rightly expect care guided by best evidence as well as information based on rigorous science. When conscientious refusals reflect a misunderstanding or mistrust of science, limits to conscientious refusal should be defined, in part, by the strength or weakness of the science on which refusals are based. In other words, claims of conscientious refusal should be considered invalid when the rationale for a refusal contradicts the body of scientific evidence.

The broad debate about refusals to dispense emergency contraception, for example, has been complicated by misinformation and a prevalent belief that emergency contraception acts primarily by preventing implantation (20). However, a large body of published evidence supports a different primary mechanism of action, namely the prevention of fertilization. A review of the literature indicates that Plan B can interfere with sperm migration and that progestin-only use of Plan B suppresses the luteinizing hormone surge, which prevents ovulation or leads to the release of ova that are resistant to fertilization. Studies do not support a major postfertilization mechanism of action (21). Although even a slight possibility of postfertilization events may be relevant to some women's decisions about whether to use contraception, provider refusals to dispense emergency contraception based on unsupported beliefs about its primary mechanism of action should not be justified.

In the context of the morally difficult and highly contentious debate about pregnancy termination, scientific integrity is one of several important considerations. For example, some have argued against providing access to abortion based on claims that induced abortion is associated with an increase in breast cancer risk; however, a 2003 U.S. National Cancer Institute panel concluded that there is well-established epidemiologic evidence that induced abortion and breast cancer are not associated (22). Refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women.

Scientific integrity is particularly important at the level of public policy, where unsound appeals to science may have masked an agenda based on religious beliefs. Delays in granting over-the-counter status for emergency contraception are one such example. Critics of the U.S. Food and Drug Administration's delay cited deep flaws in the science and evidence used to justify the delay, flaws these critics argued were indicative of unspoken and misplaced value judgments (23). Thus, the scientific integrity of a claim of refusal is an important metric in determining the acceptability of conscience-based practices or policies.

4. Potential for Discrimination

Finally, conscientious refusals should be evaluated on the basis of their potential for discrimination. Justice is a complex and important concept that requires medical professionals and policy makers to treat individuals fairly and to provide medical services in a nondiscriminatory manner. One conception of justice, sometimes referred to as the distributive paradigm, calls for fair allocation of society's benefits and burdens. Persons intending conscientious refusal should consider the degree to which they create or reinforce an unfair distribution of the benefits of reproductive technology. For instance, refusal to dispense contraception may place a disproportionate burden on disenfranchised women in resource-poor areas. Whereas a single, affluent professional might experience such a refusal as inconvenient and seek out another physician, a young mother of three depending on public transportation might find such a refusal to be an insurmountable barrier to medication because other options are not realistically available to her. She thus may experience loss of control of her reproductive fate and quality of life for herself and her children. Refusals that unduly burden the most vulnerable of society violate the core commitment to justice in the distribution of health resources.

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Another conception of justice is concerned with matters of oppression as well as distribution (24). Thus, the impact of conscientious refusals on oppression of certain groups of people should guide limits for claims of conscience as well. Consider, for instance, refusals to provide infertility services to same-sex couples. It is likely that such couples would be able to obtain infertility services from another provider and would not have their health jeopardized, *per se*. Nevertheless, allowing physicians to discriminate on the basis of sexual orientation would constitute a deeper insult, namely reinforcing the scientifically unfounded idea that fitness to parent is based on sexual orientation, and, thus, reinforcing the oppressed status of same-sex couples. The concept of oppression raises the implications of all conscientious refusals for gender justice in general. Legitimizing refusals in reproductive contexts may reinforce the tendency to value women primarily with regard to their capacity for reproduction while ignoring their interests and rights as people more generally. As the place of conscience in reproductive medicine is considered, the impact of permissive policies toward conscientious refusals on the status of women must be considered seriously as well.

Some might say that it is not the job of a physician to "fix" social inequities. However, it is the responsibility, whenever possible, of physicians as advocates for patients' needs and rights not to create or reinforce racial or socioeconomic inequalities in society. Thus, refusals that create or reinforce such inequalities should raise significant caution.

Institutional and Organizational Responsibilities

Given these limits, individual practitioners may face difficult decisions about adherence to conscience in the context of professional responsibilities. Some have offered, however, that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences" (5). Rather, institutions and professional organizations should work to create and maintain organizational structures that ensure nondiscriminatory access to all professional services and minimize the need for individual practitioners to act in opposition to their deeply held beliefs. This requires at the very least that systems be in place for counseling and referral, particularly in resource-poor areas where conscientious refusals have significant potential to limit patient choice, and that individuals and institutions "act affirmatively to protect patients from unexpected and disruptive denials of service" (13). Individuals and institutions should support staffing that does not place practitioners or facilities in situations in which the harms and thus conflicts from conscientious refusals are likely to arise. For example, those who feel it improper to prescribe emergency contraception should not staff sites, such as emergency rooms, in which such requests are likely to arise, and prompt disposition of emergency contraception is required and often integral to professional practice. Similarly, institutions that uphold doctrinal objections should not position themselves as primary providers of emergency care for victims of sexual assault; when such patients do present for care, they should be given prophylaxis. Institutions should work toward structures that reduce the impact on patients of professionals' refusals to provide standard reproductive services.

Recommendations

Respect for conscience is one of many values important to the ethical practice of reproductive medicine. Given this framework for analysis, the ACOG Committee on Ethics proposes the following recommendations, which it believes maximize respect for health care professionals' consciences without compromising the health and well-being of the women they serve.

1. In the provision of reproductive services, the patient's well-being must be paramount. Any conscientious refusal that conflicts with a patient's well-being should be accommodated only if the primary duty to the patient can be fulfilled.
2. Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care. They must disclose scientifically accurate and professionally accepted characterizations of reproductive health services.
3. Where conscience implores physicians to deviate from standard practices, including abortion, sterilization, and provision of contraceptives, they must provide potential patients with accurate and prior notice of their personal moral commitments. In the process of providing prior notice, physicians should not use their professional authority to argue or advocate these positions.
4. Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.
5. In an emergency in which referral is not possible or might negatively affect a patient's physical or mental health, providers have an obligation to provide medically indicated and requested care regardless of the provider's personal moral objections.
6. In resource-poor areas, access to safe and legal reproductive services should be maintained. Conscientious refusals that undermine access should raise significant caution. Providers with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place so that patients have access to the service that the physician does not wish to provide. Rights to withdraw from caring for an individual should not be a pretext for interfering with patients' rights to health care services.
7. Lawmakers should advance policies that balance protection of providers' consciences with the critical goal of ensuring timely, effective, evidence-based, and safe access to all women seeking reproductive services.

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The limits of conscientious refusal in reproductive medicine. ACOG Committee Opinion No. 385. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2007;110:1203-8.

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American College of Obstetricians and Gynecologists

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EXHIBIT TWO

**AAPLOG - AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS &
GYNECOLOGISTS**
EXECUTIVE OFFICE: AAPLOG 339 River Ave, Holland, MI 49423 Website:
www.aaplog.org
Telephone: (616) 546-2639 E-Mail: prolifeob@aol.com
February 6, 2008

**AAPLOG RESPONSE TO THE ACOG ETHICS COMMITTEE OPINION #385,
TITLED "THE LIMITS OF CONSCIENTIOUS REFUSAL IN REPRODUCTIVE
MEDICINE"**

The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG), one of the largest Special Interest Groups of the American College of Obstetricians and Gynecologists (ACOG), strongly objects to the November 2007 release of ACOG Committee Opinion, Number 385, titled "The Limits of Conscientious Refusal in Reproductive Medicine."

We find it unethical and unacceptable that a small committee of ACOG members would pretend to provide the moral compass for 49,000 other members on one of the most ethically controversial issues in our society and within our medical specialty—and that without ever consulting the full membership.

ACOG Committee Opinion #385 is in opposition to 2500 years of accepted Hippocratic ethical medical tradition. Legal elective abortion made a unique arrival in the late 1960s in the United States as part of a legal-societal initiative, rather than as the culmination of a scientific process in biomedicine. The acceptance of elective abortion in American medical practice was contrary to the historic ethical position of Western medicine with regard to abortion.

Therefore it is of great concern that this committee opinion repeatedly describes elective abortion, and other controversial reproductive medical procedures and services as "standard." The term "standard," as used in the document, is never defined. Ideally, a care "standard" would involve a balanced and thorough consideration of the existing medical literature for the effect on the patient's health and well being, both in the short term and in the long term. There is scant evidence regarding the outcomes of elective abortion, other than its decided effectiveness at ending a pregnancy. In general, the long term safety of abortion, and its "benefit" for women, has been either assumed, or accepted on the basis of inadequate follow-up studies.

On the contrary, there are poor reproductive and other health outcomes associated with elective abortion in methodologically sound scientific studies. The data from nations with extensive computer based health registries, where linkage with subsequent health outcomes is a practical reality, show that elective

abortion has significant adverse association with subsequent preterm birth,¹ depression,² suicide,³ placenta previa,⁴ and breast cancer.⁵ (“Although it remains uncertain whether elective abortion increases subsequent breast cancer, it is clear that a decision to abort and delay pregnancy culminates in a loss of protection with the net effect being an increased risk.”)⁴

While there may be conflicting data with regard to these issues, ACOG documents have summarily denied the significance of any literature demonstrating an association. We are aware of no current ACOG educational materials providing balance to this extreme position.

In this regard, we also find the Opinion statement, “Health care providers must impart accurate and unbiased information so that patients can make informed decisions about their health care,” to be at odds with the actual practice of informed consent in elective abortion. The College has allowed the development of a procedure (elective abortion) in its specialty area for which record keeping is inadequate and meaningful tracking of complications is virtually impossible. There is a relative absence of data collected on abortion and subsequent health status in the United States. ACOG has colluded in this state of affairs by not insisting on adequate record keeping and reporting for this procedure. Since accurate risk and complication rates are unavailable, it is vacuous to make reference to “accurate and unbiased information” for making “informed” decisions.

Further, in most instances, the abortion practitioner is not responsible to care for “complications” of his or her work, and often may not even be aware that a complication has occurred. Rather, the emergency room physician, or the obstetrician/gynecologist on call for the emergency department, inherits untoward fallout of abortion. Therefore the physician performing the procedure cannot even accurately reference his or her own experience with regard to complications in informed consent conversations. This is the only instance in American medicine where the operating physician is not the primary physician responsible for the initial oversight of complications of their surgical procedure. Perhaps the ACOG

¹ National Academy of Science's Institute of Medicine report " Preterm Birth: Causes, Consequences, and Prevention." July 2006, Appendix, page 518-19; Calhoun, B, Rooney, B; “Induced Abortion and Risk of Later Premature Birth,” Journal of American Physicians and Surgeons, Volt 8, #2, 2003.

² David M. Fergusson, et al; “Abortion In Young Women And Subsequent Mental Health,” J. of Child Psychology and Psychiatry, Vol 47:1 2006.

³ Gissler, M, et.al., “Pregnancy associated deaths in Finland 1987-1994, Acta Obstetrica et Gynecologica Scandinavica 76:651-657, 1997.

⁴ Thorp, et al, “Long Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence,” OB GYN Survey, Vol 58, No. 1, 2002.

⁵ MacMahon, et al, Bull. “Age at First Birth and Breast Cancer Risk”, WHO 43:209-221, 1970; Trichopolous D, Hsieh C, MacMahon B, Lin T, et al, Age at any Birth and Breast Cancer Risk, International J Cancer, 31:701-704, 1983.

Committee on Ethics should address the strange ethics of this “prevailing standard” of reproductive health service.

Dr. Allan Sawyer, who is an AAPLOG member and current Chairman of the ACOG Committee on Coding and Nomenclature, as well as chairman of a hospital ethics committee, has stated in a prior letter to ACOG, “It is a foundational principle of ethics that autonomy must be balanced by the other principles of ethics. Any one principle of ethics cannot trump all of the others, otherwise there is distortion of truth and the dominant principle ends up skewing the analysis. The end result often is anything but ethical. ACOG’s Committee Opinion #385 is an excellent example of the collapse of ethical decision-making when patient autonomy is allowed to dominate over every other principle of ethics. This is not so much an ethics committee opinion as it is a document that promotes the right-to-abortion-on-demand stance of ACOG.”⁶ Dr. Sawyer’s comments accurately reflect AAPLOG’s position on this issue.

The idea that physicians are obligated to provide or refer for elective abortion services simply on the basis of “patient request” is antithetical to the practice of modern medicine. It is to make patient autonomy rule over physician conscience. It is to make the physician the corner vendor. A more balanced approach would be to accept that where opinions vary, the patient is free to seek a second opinion, but not to impose her will on the attending physician.

The Ethics Committee directive that those who oppose elective abortion on conscience grounds should locate their practice in proximity to an abortionist for patient convenience is patently absurd. Quite apart from our conscience convictions, this is a completely unrealistic idea. Conformity with this recommendation would result in large swathes of the United States being without any obstetric or gynecologic care (the large majority of abortion clinics are located in the inner city).

The Committee Opinion informs us that conscience based refusals should be evaluated on the basis of their potential for discrimination. For years a glaring example of systematic discrimination has been implicitly accepted within the current provision of abortion services nationwide. Year after year, African-American women have their unborn children aborted at a per capita rate three times that of Caucasian women. There has never been a protest from ACOG against this extreme disproportion in the actual distribution of abortion services. What would the Ethics Committee advise to rectify this inequity? Should the abortion rate be increased for Caucasian women, or should the abortion rate be decreased for African-American women, in order to meet the standards of justice and equitable distribution of reproductive health services?

⁶ Used with Dr. Sawyer’s permission

Finally, it seems that the Ethics Committee does not understand the strength and depth of a conscience conviction against the elective, deliberate taking of an unborn human life. This is not a negotiable issue for those who hold this conviction. The United States Supreme Court allowed elective abortion to be a legal right. The U.S. Supreme Court is not an infallible moral guide for a person's conscience, as evidenced by a previous similar egregious ruling.⁷

For these reasons, we, the AAPLOG board of directors, find this Committee Opinion to be neither scientifically nor ethically sound. We strongly urge that Committee Opinion #385 be rescinded at the earliest opportunity.

Sincerely,

Joseph L. DeCook, MD, FACOG, Vice-President, AAPLOG, for the Executive Committee and the Board of AAPLOG

⁷ We reference the infamous Dred Scott vs Sanford case of 1857, in which the Supreme Court of the United States found, by a 7-2 majority, that no person of African descent could claim U.S. Citizenship. (Africans, according to the Court, were "beings of an inferior order, and altogether unfit to associate with the white race,... so far inferior that they had no rights which the white man was bound to respect.") Since slaves had no claim to citizenship, they could not bring suit in court. We find the status of the unborn under Roe to be strikingly similar to the plight of the African slaves under Dred Scott: Both are human beings, but neither had/has basic human rights: neither had/has the legal right to appeal to the courts for justice or protection when they were/are victims of inhumane treatment or purposeful killing.

EXHIBIT THREE

██████████ D.
Board President
American College of Obstetricians and Gynecologists
409 12th St., S.W.
Washington, D.C. 20090-6920
February 28, 2008

Dear ██████████:

On November 7, 2007, the American College of Obstetricians and Gynecologists (ACOG) Committee on Ethics released an Opinion, “The Limits of Conscientious Refusal in Reproductive Medicine” (the “Opinion”), which attempts to resolve the issue of ethically appropriate limits of conscientious judgments in reproductive medicine. This is an issue that demands serious attention and sustained dialogue. Unfortunately, however, the Opinion not only fails to provide helpful guidance, but is so flawed that it threatens the reputation of ACOG itself. The Catholic Medical Association urges ACOG to rescind this opinion immediately.

The Committee on Ethics’ Opinion exhibits three fatal flaws: (1) it is woefully inadequate in basic ethical theory and analysis; (2) the “considerations” advanced to limit conscientious judgments are so vague and contentious that they cannot meaningfully function as ethical or professional guidelines; and (3) the solutions proposed are unjust, unworkable, and harmful to the profession of medicine. We elaborate on these points briefly below.

1. Flaws in Ethical Analysis. The Opinion contains a seriously flawed and gratuitously condescending approach to conscience. The Opinion describes conscience in limited, negative, emotional terms, emphasizing such terms as “private,” “sanction,” “sentiment,” and emotions such as self-hatred. At best, the Opinion notes, “Personal conscience, so conceived, is not merely a source of potential conflict.” In fact, however, while conscience is a personal, subjective judgment, it is not merely “private” or relativistic. Conscientious judgments provide guidance both for good actions that should be done and unethical actions that should be refused. It is true that conscientious judgments are at times accompanied by emotion, particularly in conflict cases. Still, conscience is not a matter of feeling, as the Opinion suggests, but a judgment about moral truth.

In addition to providing an inadequate description of the nature and role of conscience, the Opinion fails to do justice to the ethical issue of cooperation in evil raised by providing referrals for abortion and, indeed, dismisses concerns about complicity in gravely immoral actions.

This disregard for the harm caused by complicity in moral evil is particularly hard to understand given the painful lessons the medical profession learned from physicians' silent tolerance of, or complicity in, the crimes against humanity in Nazi Germany. Here in the United States, in the infamous Tuskegee Syphilis Study, U.S. Public Health Service physicians denied treatment to patients with syphilis so they could study the late stages of the disease. Moreover, physicians participated or acquiesced in involuntary sterilizations under color of law in more than 30 more states between 1907 and the early 1970s. All agree now that these practices were unethical and a violation of patients' rights and that physicians were wrong to cooperate, even tacitly, or to remain silent, even when they were not direct participants.

The Opinion mentions, but fails to describe, what it means by the "set of moral values – and duties – that are central to medical practice." Since the Opinion goes on to list four "criteria" that ostensibly trump physicians' ethical convictions, it appears that these are the moral values and duties the Ethics Committee has in mind. Inexplicably missing in this section of the Opinion is any mention of respect for human life, which *has* been recognized by most physicians across centuries and cultures as a fundamental value and duty that *is* central to the practice of medicine.

Finally, the Opinion attempts, in several ways, to legitimize a moral duty to provide any requested "reproductive service." The Opinion appeals to terminology such as "standard care," "standard reproductive services," and "standard practices" without ever defining who or what has established these standards. The Opinion attempts to conflate the duty to provide treatment in an emergency with a new obligation – to provide "medically indicated and requested care" where failure to do so "might" negatively affect a patient's "mental health." This so-called obligation is unnecessary and completely unfounded. Our position is that elective abortion is not healthcare, nor does it qualify as an emergency. In a true emergency, where a pregnant woman's life is in danger, physicians can and should strive to save the lives of the mother and her unborn child.

2. Considerations Limiting Conscientious Refusal. The "considerations" that the Opinion claims limit conscientious judgments are so vague and contentious that they cannot meaningfully function as ethical guidelines. For example, the Opinion cites the "degree of imposition" as a criterion for overriding the ethical and professional judgment of physicians. It is

not clear at all what kinds or degrees of “imposition” will trump ethical judgment, much less why they should. In appealing to the criterion of “effect on patient health,” the Opinion unfairly assumes that all requested reproductive interventions (including abortion or egg harvesting) are in fact good for the patient’s health. Moreover, it unfairly implies that physicians with ethical objections to such practices are not motivated precisely by concern for the patient’s short and long term health. In appealing to the category of scientific integrity, the Opinion overstates the certainty that current science can provide about the mechanism of drugs (such as those used in Plan B). And it fails to recognize that the real “possibility of postfertilization events” inherent in the use of such drugs *is* a valid matter for a professional’s clinical and ethical judgment. Finally, in appealing to “matters of oppression,” the Opinion injects a dubious political criterion into the heart of medical decision-making.

3. Solutions Proposed. The Opinion proposes solutions that are unjust, unworkable, and harmful to the profession of medicine. The Opinion unfairly dictates that only physicians who oppose a specific set of medical “services” should be required to provide patients with “prior notice of their personal moral commitments.” We think that *all* physicians should be ready to explain, whenever appropriate, their ethical convictions with regard to medical practice and care. To suggest that providers with pro-life ethical convictions “practice in proximity to individuals who do not share their views” is unworkable.

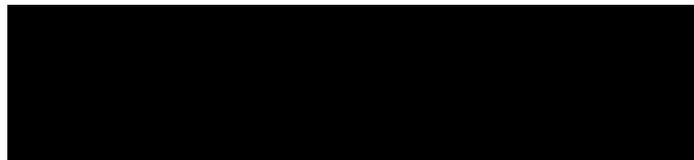
The solutions proposed in the Opinion are not only unjust and unworkable, but harmful to the profession of medicine. First, by negatively and narrowly defining conscience and by suggesting that judgments of conscience are best left to “organized advocacy” groups, the Opinion tacitly discourages physicians from thinking and acting in accordance with their judgment of what is ethical or unethical. The demand that physicians provide “professionally accepted characterizations of reproductive health services” shows distrust of professionals and of the quality of the medical profession as a whole. Second, in appealing to the vague criterion of past discrimination allegedly suffered by some people, the Opinion allows values and considerations extraneous to the practice and profession of medicine to dictate treatment modalities.

Third, the Opinion invites lawmakers to enforce compliance with these vague and contentious notions. This would run counter to AMA Code of Ethics Opinion E-10.05: “[I]t may be ethically permissible for physicians to decline a potential patient when . . . [a] specific treatment sought by an individual is incompatible with the physician’s personal, religious, or moral beliefs.” Moreover, this expressly contradicts ACOG’s own Statement of Policy on Abortion: “The intervention of legislative bodies into medical decision making is inappropriate, ill-advised and dangerous.”

Such legislation could not help but undermine the freedom and integrity of the profession of medicine and invite additional litigation and legislation that have nothing to do with promoting the health of women. Indeed, ACOG should be aware that legislation attempting to enforce this Opinion would violate constitutional and statutory protections of physicians' freedom of religion and conscience rights at federal and state levels. Finally, driving out physicians who respect the value of every human life – born and unborn – from the profession of obstetrics and gynecology would harm the profession and the health of many women and children.

There is a great deal of work to be done in assisting members of ACOG to practice medicine conscientiously, and to educate patients on what this means and why it is important. We stand ready to assist in this task. However, to be valid, any effort will have to be based on sound ethical analysis, undertaken in a spirit of dialogue, with respect for diversity in beliefs. The Committee on Ethics Opinion No. 385 falls significantly short in all these respects. Therefore, it should be rescinded immediately.

Respectfully,



President, Catholic Medical Association



Executive Director, Catholic Medical Association

cc.:



Chair, ACOG Committee on Ethics



c/o ACOG Ethics Committee



c/o ACOG Ethics Committee

EXHIBIT FOUR

3/22/2018

ACOG Committee on Ethics Opinion No. 385: Christian Medical Association et al Joint Letter of Protest

 Project Logo **Protection of Conscience Project**
www.consciencelaws.org
Service, not Servitude

Joint Letter of Protest

Christian Medical Association *et al*

Reproduced with permission

December 7, 2007

American College of Obstetricians and Gynecology
Douglas W. Laube, MD, President
PO Box 96920
Washington, D.C. 20090-6920

Dear [REDACTED]:

The undersigned individuals and organizations urge the repudiation and withdrawal of the recently published position statement of The Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG), "The Limits of Conscientious Refusal in Reproductive Medicine."

The ACOG statement suggests a profound misunderstanding of the nature and exercise of conscience, an underlying bias against persons of faith and an apparent attempt to disenfranchise physicians who oppose ACOG's political activism on abortion.

The paper indicates that ACOG views the exercise of conscience and faith not so much as a cornerstone right in a democracy or as a historic hallmark of medicine, but rather as an inconvenient obstacle to abortion access.

A few excerpts from ACOG's paper illustrate these concerns:

1. "An appeal to conscience would express a sentiment such as 'If I were to do 'x,' I could not live with myself / I would hate myself, I wouldn't be able to sleep at night.'"

By caricaturing conscience as a pitifully self-centered, subjective feeling, ACOG denigrates the objective sources of conviction. Physicians of faith base decisions of conscience not on personal whims and feelings but on the objective teachings of Scripture--the same Scriptures that have provided the foundation for the laws of much of civilization. A physician's conscience may also be informed by time-honored ethical standards such as the Hippocratic Oath, which for centuries provided a foundation for medical ethics until abortion advocacy censored its teachings.

2. Physicians may not exercise their right of conscience if that might "constitute an imposition of religious or moral beliefs on patients."

SHARES

3/22/2018

ACOG Committee on Ethics Opinion No. 385: Christian Medical Association et al Joint Letter of Protest

is tantamount to "imposing religious or moral beliefs on patients."

3. "Physicians have the duty to refer patients in a timely manner to other providers if they do not feel they can in conscience provide the standard reproductive service that patients request."

This assertion contradicts a basic corollary of conscience. The same life-honoring, objective principles--"Thou shalt not kill," and "first, do no harm"--that persuade many conscientious physicians not to perform abortions also persuade them not to recommend someone else to do the deed.

4. "All healthcare providers must provide accurate and unbiased information so that patients can make informed decisions."

Normally no one would question this principle, but in this case, context is everything. Since ACOG has gone to court to fight laws requiring abortion doctors to offer informed consent information to patients on the risks and alternatives to abortion,¹ clearly ACOG intends to selectively apply this requirement only to pro-life physicians to force them to offer abortion as an option.

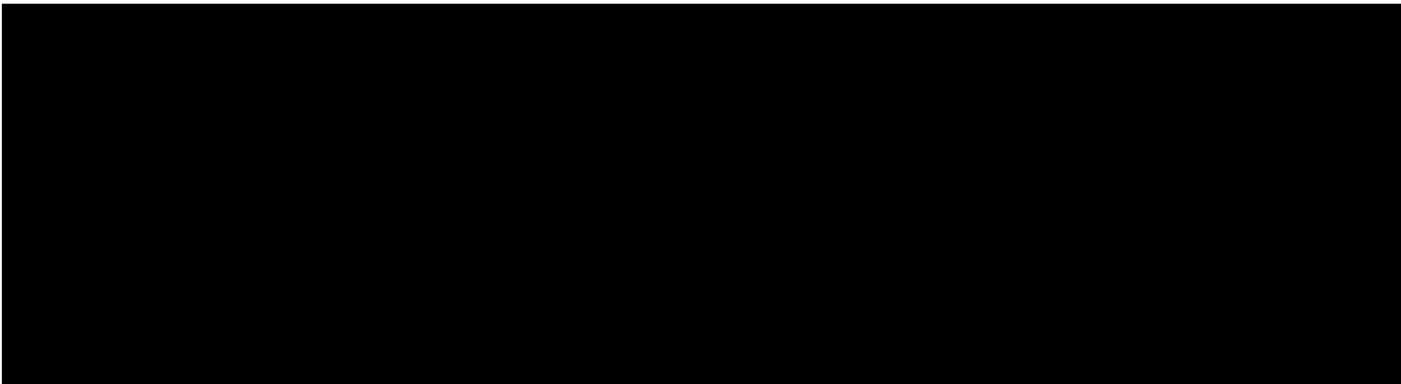
5. "Providers with moral or religious objections should practice in proximity to individuals who do not share their views"

It is incredible that ACOG would actually require a pro-life physician to relocate his or her practice to be close to an abortion facility. Besides the fact that this drastic requirement is selectively invoked only against pro-life doctors, it would also have the negative practical impact of removing desperately needed doctors from underserved areas.

ACOG's misguided and uninformed public statement on conscience limits is bound to have the effect, whether unintended or actually intended, of discouraging persons of faith from practicing or choosing obstetrics and gynecology as a profession. At a time when many communities are already suffering the loss of obstetricians and gynecologists forced out of their practices for economic reasons, it seems especially unwise to send such a message of ideological intolerance and religious discrimination.

ACOG's aggressive political advocacy for abortion has significantly impaired its ability to speak for all physicians and to judge matters of medical ethics without bias. We urge ACOG to reconsider and withdraw this statement as a step toward remedying that lamentable loss of respectability and credibility.

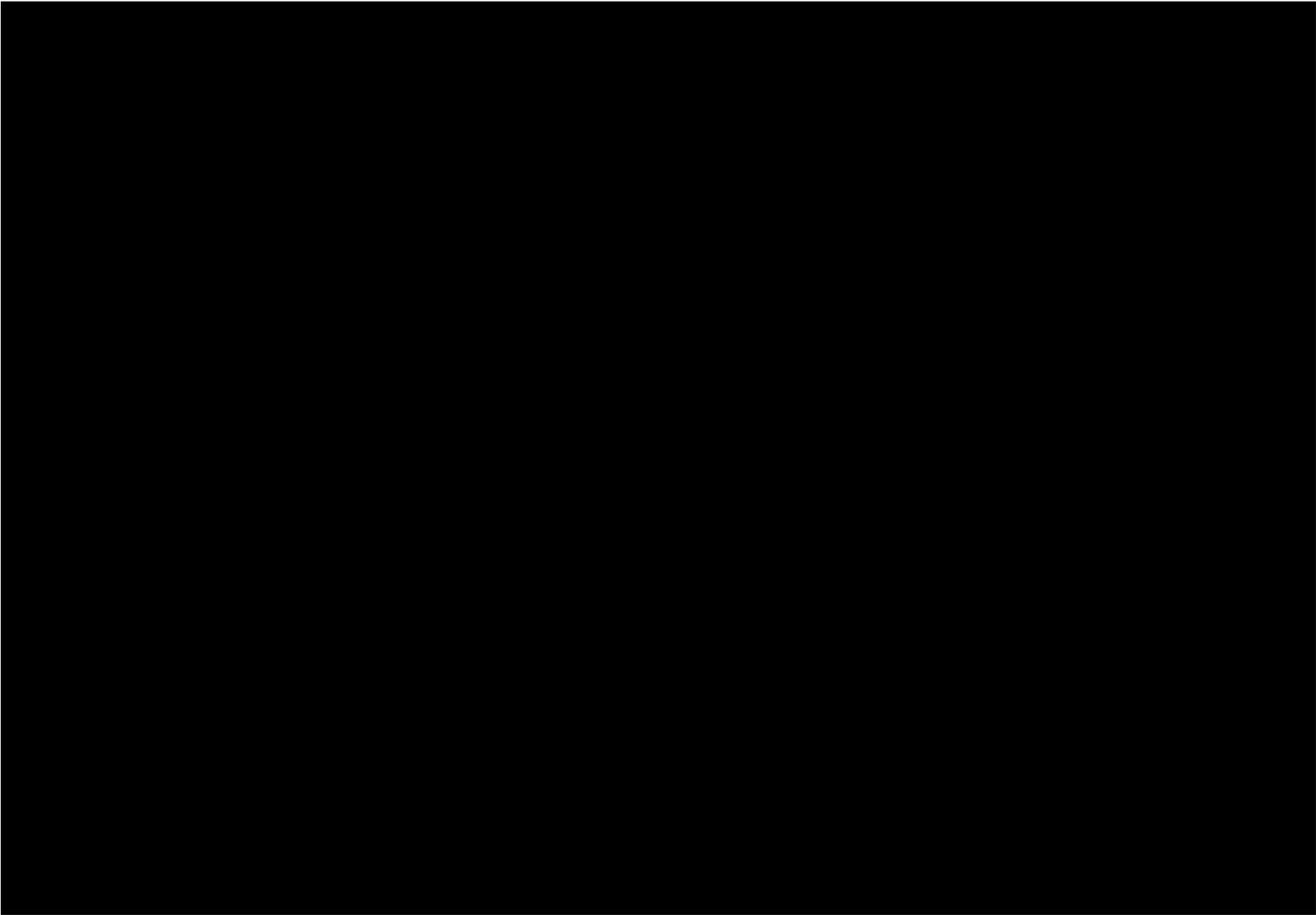
Sincerely,



SHARES

3/22/2018

ACOG Committee on Ethics Opinion No. 385: Christian Medical Association et al Joint Letter of Protest



Notes

1. American College of Obstetricians v. Thornburgh, 737 F.2d 283, 297-98 (3d Cir.1984).

cc: ACOG Executive Board Affairs
ACOG Government Relations
ACOG Clinical Practice

SHARES

EXHIBIT FIVE

Congress of the United States
Washington, DC 20515

March 14, 2008

██████████ MD, MS, President
The American College of Obstetricians and Gynecology
409 12th Street, SW
Washington, DC 20090-6920

Dear ██████████

We are deeply concerned to learn of The American College of Obstetricians and Gynecology (ACOG) Committee Opinion #385 which could destroy the rights of conscience for pro-life obstetricians and gynecologists across our nation. Conforming to this guideline would force pro-life OB-GYNs to violate their moral and ethical beliefs regarding controversial issues like abortion. Furthermore, when paired with newly revised certification policies of the American Board of Obstetrics and Gynecology that condition board certification on compliance with ACOG ethics guidelines, we are concerned that the views represented in Opinion #385 can be used to force valuable pro-life OB-GYNs out of the practice of medicine for exercising their rights of conscience. *If used as a basis for decertifying physicians, these physicians would most likely lose hospital privileges and effectively be put out of business, denying the physician's right to practice his or her profession. Moreover, pro-life women would lose the right to choose OB-GYNs who share their moral convictions.*

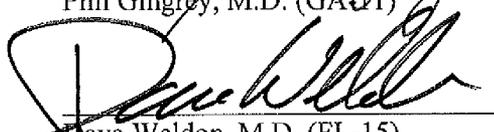
As you know, Opinion #385 entitled "The Limits of Conscientious Refusal in Reproductive Medicine," contains seven recommendations that we believe jeopardize the rights of conscience of OB/GYNs. This report calls on OB-GYNs to disregard their moral, ethical or religious objections to abortion and instructs them to perform or refer for abortion. Opinion #385 also obligates the protection of the liberty interests of the pregnant women over the life and health of the unborn child, regardless of what the provider believes is in the best interests of both patients. This is a worrisome departure from professional standards set by state legislatures and other professional medical organizations such as the American Medical Association (AMA). The AMA House of Delegates policy on abortion states: "Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles." Currently, nearly all states recognize the right of physicians to refuse to provide abortions.

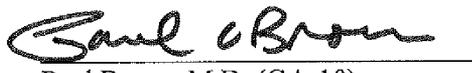
We are aware that member physicians and civil rights organizations have requested for clarification on Opinion #385. We, as Members of the House of Representative are asking the same and want assurance that OB-GYNs will not face severe consequences, including decertification, for refusing to perform or refer for an abortion on grounds of conscience. In light of these concerns, we request a clear explanation of whether Opinion #385 represents the official position of ACOG and what outcomes were intended by those who crafted Opinion #385. Furthermore, as the largest American association of OBGYNs, we ask that you provide further clarification by

explaining the general intent, import and force of ACOG Ethics Opinions as applied under ABOG's 2008 MOC Bulletin. Finally, please clarify the impact of ACOG Ethics Committee reports on board certification and ACOG membership. We request the courtesy of your response to these concerns by March 29th, 2008.

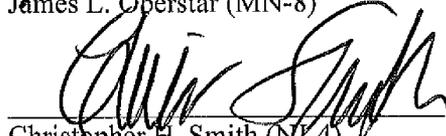
Sincerely,


Phil Gingrey, M.D. (GA-11)


Dave Weldon, M.D. (FL-15)

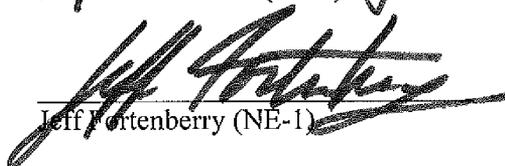

Paul Broun, M.D. (GA-10)


James L. Oberstar (MN-8)


Christopher H. Smith (NJ-4)

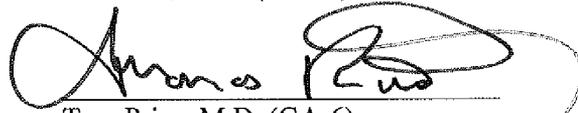

Mike Ferguson (NJ-7)

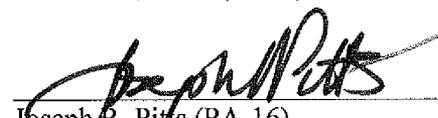

J. Gresham Barrett (SC-3)


Jeff Fortenberry (NE-1)


Trent Franks (AZ-2)


Ron Paul, M.D. (TX-14)

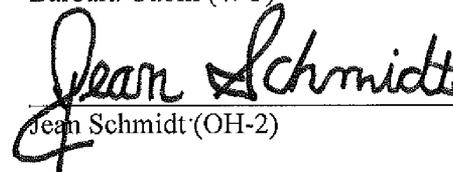

Tom Price, M.D. (GA-6)


Joseph R. Pitts (PA-16)


W. Todd Akin (MO-2)


Scott Garrett (NJ-5)


Barbara Cubin (WY)


Jean Schmidt (OH-2)

Cc: Anne D. Lyerly, MD, Chair of Ethics Committee
The American College of Obstetricians and Gynecology

Lucia DiVenere, Director of the Department of Government Affairs
American College of Obstetricians and Gynecologists

EXHIBIT SIX



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 14 2008

[REDACTED]
Executive Director
The American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204

Dear [REDACTED]:

I am writing to express my strong concern over recent actions that undermine the conscience and other individual rights of health care providers. Specifically, I bring to your attention the potential interaction of the American Board of Obstetrics and Gynecology's (ABOG) Bulletin for 2008 Maintenance of Certification (Bulletin) with a recent report (Opinion Number 385) issued by the American College of Obstetricians and Gynecologists (ACOG) Ethics Committee on November 7, 2007 entitled "The Limits of Conscience Refusal in Reproductive Medicine".

The ACOG Ethics Committee report recommends that in the context of providing abortions, "Physicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive service that patients request." It appears that the interaction of the ABOG Bulletin with the ACOG ethics report would force physicians to violate their conscience by referring patients for abortions or taking other objectionable actions, or risk losing their board certification.

As you know, Congress has protected the rights of physicians and other health care professionals by passing two non-discrimination laws and annually renewing an appropriations rider that protect the rights, including conscience rights, of health care professionals in programs or facilities conducted or supported by federal funds. (See 42 U.S.C. § 238n, 42 U.S.C. § 300a-7, and the Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, 121 Stat. 1844, § 508). Additionally, threats to withhold or revoke board certification can cause serious economic harm to good practitioners.

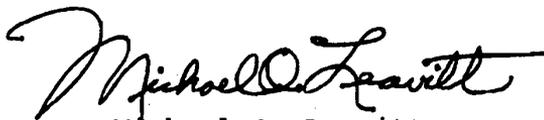
Page 2 - Norman F. Gant, M.D.

I am concerned that the actions taken by ACOG and ABOG could result in the denial or revocation of Board certification of a physician who -- but for his or her refusal, for example, to refer a patient for an abortion -- would be certified. These actions, in turn, could result in certain HHS-funded State and local governments, institutions, or other entities that require Board certification taking action against the physician based just on the Board's denial or revocation of certification. In particular, I am concerned that such actions by these entities would violate federal laws against discrimination.

In the hope that compliance of entities with the obligations that accompany certain federal funds will not be jeopardized, it would be helpful if you could clarify that ABOG will not rely on the ACOG Ethics Committee Report, "The Limits of Conscience Refusal in Reproductive Medicine" when making determinations of whether to grant or revoke board certifications.

Thank you very much for your assistance in this matter.

Sincerely,



Michael O. Leavitt

cc:


The American College of Obstetricians and Gynecologists

EXHIBIT SEVEN



*** RECEIVED ***
Mar 26 2008 11:04:39 WS# 20
OSNUM: 032620081005
OFFICE OF THE SECRETARY
CORRESPONDENCE
American Board of Obstetrics + Gynecology

Frank W. Ling, M.D.
Germantown, TN
President

Philip J. DiSaia, M.D.
Orange CA
Chairman

Larry J. Copeland, M.D.
Columbus, OH
Vice President

Nanette F. Santoro, M.D.
Bronx, NY
Treasurer

Directors:

Bruce R. Carr, M.D.
Dallas, TX

Sandra A. Carson, M.D.
Providence, RI

Mary C. Ciotti, M.D.
Sacramento, CA

James E. Ferguson, II, M.D.
Lexington, KY

Wesley C. Fowler, Jr., M.D.
Chapel Hill, NC

David M. Gershenson, M.D.
Houston, TX

Diane M. Hartmann, M.D.
Rochester, NY

Roy T. Nakayama, M.D.
Honolulu, HI

Valerie M. Parisi, M.D., MPH
Detroit, MI

Susan M. Ramin, M.D.
Houston, TX

Stephen C. Rubin, M.D.
Philadelphia, PA

Robert S. Schenken, M.D.
San Antonio, TX

Russell R. Snyder, M.D.
Galveston, TX

Michael L. Socol, M.D.
Chicago, IL

Ralph K. Tamura, M.D.
Chicago, IL

George D. Wendel, Jr., M.D.
Dallas, TX

First in Women's Health

Norman F. Gant, M.D.
Executive Director

Alvin L. Brekken, M.D.
Assistant to the Executive Director

Larry C. Gilstrap, III, M.D.
Director of Evaluation

The Vineyard Centre
2915 Vine Street
Dallas, TX 75204
Phone (214) 871-1619
Fax (214) 871-1943

March 19, 2008

Michael O. Leavitt
Secretary
The US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Leavitt:

I am responding to your letter addressed to me asking about the American Board of Obstetrics and Gynecology's stand with respect to a physician's choice "to violate their conscience by referring patients for abortions or taking other objectionable actions, or risk losing their board certification." I can only say that I do not know where you came up with any suggestion, much less documentation, that the American Board of Obstetrics and Gynecology has ever asked anyone to violate their own ethical or moral standards.

Please be assured that the American Board of Obstetrics and Gynecology has taken no stand, pro or con, against individual physicians who choose to or choose not to perform abortions or to refer patients to abortion providers. Moreover, such an issue is not a consideration in the applications or in the examinations administered by the American Board of Obstetrics and Gynecology in any of its certification or in its Maintenance of Certification requirements or examinations.

Best Wishes,



Executive Director

NFG/kd

EXHIBIT EIGHT



March 26, 2008

Dear Fellows:

Thank you for your comments on Committee Opinion #385, "The Limits of Conscientious Refusal in Reproductive Medicine." The Committee on Ethics is grateful for the thoughtful and considered input of Fellows regarding this document. We received many letters reflecting the importance of this issue to Fellows, as well as a breadth of opinion regarding the role of conscience in professional life.

The Committee on Ethics met on March 17-18, 2008, and discussed the correspondence received since the Opinion's publication. The letters and a summary of the concerns raised were carefully reviewed. Also the Executive Committee of ACOG's Executive Board met and discussed the Opinion and the response to the Opinion on March 24, 2008.

We want to be clear the Opinion does not compel any Fellow to perform any procedure which he or she finds to be in conflict with his or her conscience and affirms the importance of conscience in shaping ethical professional conduct. For example, while this is not a document focused on abortion, ACOG recognizes that support for or opposition to abortion is a matter of profound moral conviction, and ACOG respects the need and responsibility of its members to determine their individual positions on this issue based on their personal values and beliefs. We want to assure members with a diversity of views on this issue that they have a place in our organization.

Ethics Committee Opinions provide guidance regarding ethical issues. This Committee Opinion is not part of the "Code of Professional Ethics of the American College of Obstetricians and Gynecologists." This Committee Opinion was not intended to be used as a rule of ethical conduct which could be used to affect an individual's initial or continuing Fellowship in ACOG. Similarly, it is not cited in the American Board of Obstetrics and Gynecology's "Bulletin for 2008" and "Bulletin for 2008 Maintenance of Certification," and an obstetrician-gynecologist's board certification is not determined or jeopardized by his or her adherence to this Opinion.

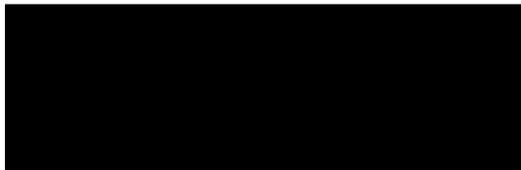
March 26, 2008

Page 2

Conscience has an important role in the ethical practice of medicine. While this Opinion attempted to provide guidance for balancing the critical role of conscience with a woman's right to access reproductive medicine, the Executive Committee has noted the uncertain and mixed interpretation of this Opinion. Thus, the Executive Committee has instructed the Committee on Ethics to hold a special meeting as soon as possible to reevaluate ACOG Committee Opinion #385.

Thank you again for your thoughtful comments.

Sincerely yours,



President

EXHIBIT C



May 9, 2018

RECEIVED
MAY 11 2018
HHS/OCR HQ

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

Attn: Conscience and Religious Freedom Division

Re: **Complaint for Discrimination in Violation of 42 U.S.C. § 300a-7(c)(1)**
("Church Amendment")

Contact attorney for complainant:

Complaint filed on behalf of:

Francis J. Manion, Esq.
Geoffrey R. Surtees, Esq.
American Center for Law and Justice
6375 New Hope Rd.
P.O. Box 60
New Hope, KY 40052
502-549-7020
fmanion@aclj.org

[REDACTED]

*Person/Agency/Organization
committing discrimination:*

The University of Vermont Medical
Center
111 Colchester Avenue
Burlington, Vermont 05401
802-847-0000

Date and nature of discriminatory acts:

In 2017, the complainant, [REDACTED] RN, was coerced by her employer, University of Vermont Medical Center, Inc. ("UVMMC") into participating in an abortion. Ms [REDACTED] a Catholic, had previously informed her employer that she

*
6375 New Hope Road
New Hope, Kentucky 40052
(502) 549-7020
(502) 549-5232 (Fax/voice)



could not participate in such procedures as a matter of religious belief. Her employer deliberately misled ██████ about the nature of the procedure, and then, after ██████ confirmed that she was, in fact, being assigned to an abortion, refused her request that other equally qualified and available personnel take her place. Fearing a charge of patient abandonment which could bring with it loss of employment and revocation of her nursing license, ██████ participated in the procedure under duress. She suffered immediate emotional distress, attempted to suppress the event psychologically, and has been haunted by nightmares ever since. In addition, her employer has created a hostile environment targeting ██████ and other employees who conscientiously object to participating in abortion procedures.

The coerced-participation event described above appears to have been related to a change in UVMMC policy regarding the hospital's performance of abortions. Under the leadership, since 2013, of a hospital board President with decades-long experience in senior leadership of Planned Parenthood facilities in Vermont, Portland, Oregon, and New York City, UVMMC reversed a longstanding policy which limited abortions in its facilities to those considered "medically necessary." While the policy appears to have been changed *sub silentio* at some point even before 2017, hospital staff, including ██████ and other nurses, were only formally informed of the change in October of 2017. Thus, it is highly possible that other staff and, perhaps, ██████ herself, have been deceived into participating in other abortion procedures which were misleadingly labeled as "miscarriages" or "medically necessary" but which were, in fact, purely elective abortions.

In addition, following public controversy which arose after the formal disclosure to staff of the hospital's new policy in the Fall of 2017, UVMMC, in February 2018, adopted a revised "Conflict of Care" policy. (Copy attached hereto). This policy is sharply inconsistent with existing federal conscience laws and inappropriately continues to leave the conscience rights of hospital employees to the virtually unbridled discretion of supervisors who, as ██████ and others will attest, have a history of demeaning, belittling, and failing to respect the views of conscientious objectors.

The Church Amendment protects the conscience rights of individuals and entities that object to performing or assisting in the performance of abortion or sterilization procedures if doing so would be contrary to the provider's religious beliefs or moral convictions, and prohibits discrimination in employment of "any physician or other health care personnel . . . because of his religious beliefs or moral convictions respecting sterilization procedures or abortions." 42 U.S.C. §300a-7 *et seq.*

It is clear that ██████ (and perhaps others employed at UVMMC) has suffered and continues to suffer discrimination and violations of her conscience rights under federal law. We urge your office to immediately initiate an



investigation of these charges and order appropriate remedial and corrective actions as soon as possible.

Our investigation has disclosed identities and contact information of individuals in addition to our client who have information pertinent to this matter. That information, to the extent said individuals have already spoken publicly about it or authorize us to disclose it, will be provided upon request.

Respectfully submitted,



Francis J. Manion
Senior Counsel
American Center for Law & Justice

Date: May 9, 2018



Documents Status: **Approved**

IDENT	HR-F-09
Type of Document	Policy
Applicability Type	Corporate
Title of Owner	Dir Human Resources
Title of Approving Official	VP Human Resources
Date Effective	2/5/2018
Date of Next Review	2/5/2021

THE
University of Vermont
 MEDICAL CENTER

TITLE: Conflict of Care: Staff Conscientious Objection

PURPOSE: UVM Medical Center respects workforce diversity and the cultural values, ethics and religious beliefs of our staff. In situations where a conflict may exist between the employee's cultural values, ethics, and religious beliefs and their participation in any aspect of patient care, UVMMC supports a process by which an employee may request to be excused from performing specific duties.

Patients and their families' perspectives and choices are valued and honored in all phases of care. Accordingly, all patients are entitled to comprehensive, quality care, without regard to their diagnosis, race, color, sex, sexual orientation, gender identity or expression, ancestry, place of birth, HIV status, national origin, religion, marital status, age, language, socioeconomic status, physical or mental disability, protected veteran status.

UVMMC encourages open dialogue between the employee and their leader.

POLICY STATEMENT: Employees may request to be excused from participating in a type of care/treatment in situations where that care/treatment conflicts with the employee's cultural values, ethics, or religious beliefs. Procedures/treatments which may present conflict may include but are *not limited* to the following:

- Blood and blood component administration
- Elective termination of pregnancy
- Initiation and cessation of life support
- DNR/Life support issues for critically ill/terminally ill populations
- Assisting with the harvesting of human organs
- Sterilization procedures
- Reproductive technologies

Alternative staffing arrangements will be considered, and if appropriate, arranged. At no time will staff be allowed to act in a manner that negatively impacts the patient's care or treatment.

PROCEDURE:

- I. When the need to provide care or treatment of a patient is in conflict with an employee's cultural values, ethics or religious beliefs, the employee may request to be reassigned to other duties and not participate in the specific type of care or treatment. In the event a conflict of care arises, care of the patient will be maintained until alternate staffing arrangements can be provided.
- II. UVMMC supports open dialogue between the employee and their leader when a conflict exists for the employee. We recognize that not all conflicts can be predicted. When possible we encourage employees to proactively raise concerns about potential conflicts in order to minimize impact to patient care.
- III. During the hiring process, the hiring manager shall discuss the typical scope of practice and service within the department in which the candidate has applied to work. Employees are expected to perform all the duties of their positions as set forth in their job descriptions, given to them at the time of hire or whenever revised.
- IV. All new employees are informed about this Conflict of Care policy during new employee orientation.

Printed on: 4/12/2018 11:00 AM By: [REDACTED]

DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document, possibly a letter or a report, with several lines of text per paragraph. The content is mostly obscured by noise and low contrast.]

Documents Status: **Approved**

- V. The direct Supervisor/designee shall be responsible for administering and monitoring a process to accommodate an employee's cultural values, ethics, and religious beliefs regarding treatment of patients.
- a) An employee who desires to be reassigned from a specific type of care or treatment shall submit the request in writing to the Supervisor/designee. Written request may be received on the form provided in this policy OR via an email addressed to the Supervisor/designee containing the details as requested/outlined on the form.
 - b) The written request will be acknowledged by the Supervisor/designee and maintained in the appropriate unit resource binder for scheduling purposes within the unit. The Supervisor/designee will assign staff as necessary for appropriate patient coverage. The written request will be placed in the employee's electronic personnel file by the Supervisor/designee.
 - c) Any conflict which may occur in an emergent situation for which staff may not have previously submitted a written request, may be brought to the Supervisor/designee. Alternative coverage may be sought at the discretion of the Supervisor/designee. The written request shall be submitted by the employee directly following the event and the request will be placed in the employee's electronic personnel file by the Supervisor/designee.
 - d) Any employee who is excused from an aspect of care will be re-assigned to other responsibilities.
 - e) In any scenario where circumstances prevent arrangements for alternate coverage, the staff member will be expected to provide the assigned care to ensure patient care is not negatively impacted.
 - f) Refusal to perform assigned job functions will be addressed in accordance with established corrective action procedures by the supervisor, in consultation with leadership and/or Human Resources.
- VI. All employees have access to the Ethics Consultation through UVMHC's Director of Clinical Ethics and can request input on ethical issues by contacting Provider Access Services (847-2700), ask who the ethics consultant on call is and should then contact that consultant by phone or in person.
- VII. An employee experiencing ongoing conflict of care issues should seek a transfer to a department or position where conflict of care issues are less likely to occur.

MONITORING PLAN: N/A

DEFINITIONS: N/A

RELATED POLICIES: Code of Conduct B1N; Clinical Ethics Consultations ETH15; Compliance & Privacy Plan B31

REFERENCES: 2017, Hospital Accreditation Standards, The Joint Commission LD.04.02

REVIEWERS: [REDACTED]

OWNER: [REDACTED], Dir Human Resources

APPROVING OFFICIAL: [REDACTED] Human Resources

Printed on: 4/12/2018 11:00 AM By: [REDACTED]

DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.

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[Faint, illegible text on the right side of the page, possibly bleed-through from the reverse side.]

Documents Status: **Approved**

Conflict of Care Disclosure Form

To be completed by the employee making the request: *Make a copy of this form for your records and then give this form to your leader.*

Your Name: _____ (Please Print)

Your Signature: _____ Date: _____

Please identify the clinical circumstances where you experience personal conflict. Please provide specific details regarding which procedure/treatment you are requesting to be excused from.

Please briefly provide your reasons for requesting removal from the patient's care team.

Received by: _____ (Please Print)

Leader Signature

Date Received

Printed on: 4/12/2018 11:00 AM By: [REDACTED]

DISCLAIMER: Only the online policy is considered official. Please compare with on-line document for accuracy.

[The text in this section is extremely faint and illegible due to the quality of the scan. It appears to be a multi-paragraph document.]

EXHIBIT D



**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE FOR CIVIL RIGHTS (OCR)
CIVIL RIGHTS DISCRIMINATION COMPLAINT**

Form Approved, OMB No. 0990-0289
See OMB Statement on Reverse.



YOUR FIRST NAME [REDACTED]		YOUR LAST NAME [REDACTED]	
HOME PHONE (Please include area code) [REDACTED]		WORK PHONE (Please include area code) [REDACTED]	
STREET ADDRESS [REDACTED]		CITY [REDACTED]	
STATE [REDACTED]	ZIP 77379	[REDACTED]	
FIRST NAME [REDACTED]		LAST NAME [REDACTED]	

If Yes, whose civil rights do you believe were violated?
 Yes No

I believe that I have been (or someone else has been) discriminated against on the basis of:

Race / Color / National Origin
 Age
 Religion / Conscience
 Sex
 Disability
 Other (specify): _____

Who or what agency or organization do you believe discriminated against you (or someone else)?
 PERSON/AGENCY/ORGANIZATION

Champions pediatric

STREET ADDRESS 10607 Kwykendahl		CITY Spring
STATE Texas	ZIP 77379	PHONE (Please include area code)

When do you believe that the discrimination occurred?
 LIST DATE(S)

09/11/2017, 10/29/2017

Describe briefly what happened. How and why do you believe that you have been discriminated against? Please be as specific as possible.
 (Attach additional pages as needed)

At my daughters 2 mo checkup when I declined vaccination, I was told she could no longer be a patient there. This also happened the following month at my other child's 18 mo old checkup. My daughter had a severe reaction to a vaccine she received there prior, and has an autoimmune issue so they are fully aware of why she cannot be vaccinated any further. I even obtained a medical exemption stating she cannot receive further vaccines on top of already having a conscience exemption. We were kicked out and told by [REDACTED] the office manager they are a "vaccine only clinic"

Please sign and date this complaint. You do not need to sign if submitting this form by email because submission by email represents your signature.

SIGNATURE [REDACTED]	DATE (mm/dd/yyyy) 01/26/2019
-------------------------	---------------------------------

Filing a complaint with OCR is voluntary. However, without the information requested above, OCR may be unable to proceed with your complaint. We collect this information under authority of Sections 1553 and 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Church Amendments, the Coats-Snowe Amendment, the Weldon Amendment, and other civil rights statutes. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible discrimination, for internal systems operations, or for routine uses, which include disclosure of information outside the Department of Health and Human Services (HHS) for purposes associated with civil rights compliance and as permitted by law. It is illegal for a recipient of Federal financial assistance from HHS to intimidate, threaten, coerce, or discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under Federal civil rights laws. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information. To submit an electronic complaint, go to OCR's web site at: www.hhs.gov/ocr/civilrights/complaints/index.html. To submit a complaint using alternative methods, see reverse page (page 2 of the complaint form)

The remaining information on this form is optional. Failure to answer these voluntary questions will not affect OCR's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint? (Check all that apply)

- Braille
 Large Print
 Cassette tape
 Computer diskette
 Electronic mail
 TDD
 Sign language interpreter (specify language): _____
 Foreign language interpreter (specify language): _____
 Other: _____

If we cannot reach you directly, is there someone we can contact to help us reach you?

FIRST NAME		LAST NAME	
HOME PHONE (Please include area code)		WORK PHONE (Please include area code)	
STREET ADDRESS			CITY
STATE	ZIP	E-MAIL ADDRESS (If available)	

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed)

PERSON/AGENCY/ORGANIZATION/ COURT NAME(S)

DATE(S) FILED	CASE NUMBER(S) (If known)
---------------	---------------------------

To help us better serve the public, please provide the following information for the person you believe was discriminated against (you or the person on whose behalf you are filing).

ETHNICITY (select one) RACE (select one or more)
 Hispanic or Latino
 American Indian or Alaska Native
 Asian
 Native Hawaiian or Other Pacific Islander
 Not Hispanic or Latino
 Black or African American
 White
 Other (specify): _____
 PRIMARY LANGUAGE SPOKEN (if other than English) _____

How did you learn about the Office for Civil Rights?

- HHS Website/Internet Search
 Family/Friend/Associate
 Religious/Community Org
 Lawyer/Legal Org
 Phone Directory
 Employer
 Fed/State/Local Gov
 Healthcare Provider/Health Plan
 Conference/OCR Brochure
 Other (specify): _____

To submit a complaint, please type or print, sign, and return completed complaint form package (including consent form) to the OCR Headquarters address below.

**U.S. Department of Health and Human
 Services
 Office for Civil Rights
 Centralized Case Management Operations
 200 Independence Ave., S.W.
 Suite 515F, HHH Building
 Washington, D.C. 20201
 Customer Response Center: (800) 368-1019
 Fax: (202) 619-3818
 TDD: (800) 537-7697
 Email: ocrmail@hhs.gov**

Burden Statement

Public reporting burden for the collection of information on this complaint form is estimated to average 45 minutes per response, including the time for reviewing instructions, gathering the data needed and entering and reviewing the information on the completed complaint form. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HHS/OS Reports Clearance Officer, Office of Information Resources Management, 200 Independence Ave. S.W., Room 531H, Washington, D.C. 20201. **Please do not mail complaint form to this address.**



COMPLAINANT CONSENT FORM

The Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) has the authority to collect and receive material and information about you, including personnel and medical records, which are relevant to its investigation of your complaint.

To investigate your complaint, OCR may need to reveal your identity or identifying information about you to persons at the entity or agency under investigation or to other persons, agencies, or entities.

The Privacy Act of 1974 protects certain federal records that contain personally identifiable information about you and, with your consent, allows OCR to use your name or other personal information, if necessary, to investigate your complaint.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

Additionally, OCR may disclose information, including medical records and other personal information, which it has gathered during the course of its investigation in order to comply with a request under the Freedom of Information Act (FOIA) and may refer your complaint to another appropriate agency.

Under FOIA, OCR may be required to release information regarding the investigation of your complaint; however, we will make every effort, as permitted by law, to protect information that identifies individuals or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

Please read and review the documents entitled, *Notice to Complainants and Other Individuals Asked to Supply Information to the Office for Civil Rights* and *Protecting Personal Information in Complaint Investigations* for further information regarding how OCR may obtain, use, and disclose your information while investigating your complaint.

In order to expedite the investigation of your complaint if it is accepted by OCR, please read, sign, and return one copy of this consent form to OCR with your complaint. Please make one copy for your records.

- As a complainant, I understand that in the course of the investigation of my complaint it may become necessary for OCR to reveal my identity or identifying information about me to persons at the entity or agency under investigation or to other persons, agencies, or entities.



- I am also aware of the obligations of OCR to honor requests under the Freedom of Information Act (FOIA). I understand that it may be necessary for OCR to disclose information, including personally identifying information, which it has gathered as part of its investigation of my complaint.
- In addition, I understand that as a complainant I am covered by the Department of Health and Human Services' (HHS) regulations which protect any individual from being intimidated, threatened, coerced, retaliated against, or discriminated against because he/she has made a complaint, testified, assisted, or participated in any manner in any mediation, investigation, hearing, proceeding, or other part of HHS' investigation, conciliation, or enforcement process.

After reading the above information, please check ONLY ONE of the following boxes:

CONSENT: I have read, understand, and agree to the above and give permission to OCR to reveal my identity or identifying information about me in my case file to persons at the entity or agency under investigation or to other relevant persons, agencies, or entities during any part of HHS' investigation, conciliation, or enforcement process.

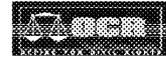
CONSENT DENIED: I have read and I understand the above and do not give permission to OCR to reveal my identity or identifying information about me. I understand that this denial of consent is likely to impede the investigation of my complaint and may result in closure of the investigation.

Signature: _____ Date: 01/20/2018
*Please sign and date _____ to sign if submitting this form by email because submission by email represents your signature.

Name (Please print): _____

Address: _____

Telephone Number: _____



NOTICE TO COMPLAINANTS AND OTHER INDIVIDUALS ASKED TO SUPPLY INFORMATION TO THE OFFICE FOR CIVIL RIGHTS

Privacy Act

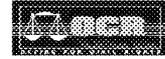
The Privacy Act of 1974 (5 U.S.C. § 552a) requires OCR to notify individuals whom it asks to supply information that:

— OCR is authorized to solicit information under:

- (i) Federal laws barring discrimination by recipients of Federal financial assistance on grounds of race, color, national origin, disability, age, sex, religion, and conscience under programs and activities receiving Federal financial assistance from the U.S. Department of Health and Human Services (HHS), including, but not limited to, Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 *et seq.*), Sections 794 and 855 of the Public Health Service Act (42 U.S.C. §§ 295m and 296g), Section 1553 of the Affordable Care Act (42 U.S.C. § 18113), the Church Amendments (42 U.S.C. § 300a-7), the Coats-Snowe Amendment (42 U.S.C. § 238n) and the Weldon Amendment (*e.g.*, Consolidated Appropriations Act of 2017, Pub. L. 115-31, Div. H, Tit. V, § 507);
- (ii) Titles VI and XVI of the Public Health Service Act (42 U.S.C. §§ 291 *et seq.* and 300s *et seq.*) and 42 C.F.R. Part 124, Subpart G (Community Service obligations of Hill- Burton facilities);
- (iii) 45 C.F.R. Part 85, as it implements Section 504 of the Rehabilitation Act in programs conducted by HHS; and
- (iv) Title II of the Americans with Disabilities Act (42 U.S.C. § 12131 *et seq.*) and Department of Justice regulations at 28 C.F.R. Part 35, which give HHS “designated agency” authority to investigate and resolve disability discrimination complaints against certain public entities, defined as health and service agencies of state and local governments, regardless of whether they receive federal financial assistance.
- (v) The Standards for the Privacy of Individually Identifiable Health Information (The Privacy Rule) at 45 C.F.R. Part 160 and Subparts A and E of Part 164, which enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (42 U.S.C. § 1320d-2).

OCR will request information for the purpose of determining and securing compliance with the Federal laws listed above. Disclosure of this requested information to OCR by individuals who are not recipients of Federal financial assistance is voluntary; however, even individuals who voluntarily disclose information are subject to prosecution and penalties under 18 U.S.C. § 1001 for making false statements.

Additionally, although disclosure is voluntary for individuals who are not recipients of Federal financial assistance, failure to provide OCR with requested information may preclude OCR from making a compliance determination or enforcing the laws above.



OCR has the authority to disclose personal information collected during an investigation without the individual's consent for the following routine uses:

- (i) to make disclosures to OCR contractors who are required to maintain Privacy Act safeguards with respect to such records;
- (ii) for disclosure to a congressional office from the record of an individual in response to an inquiry made at the request of the individual;
- (iii) to make disclosures to the Department of Justice to permit effective defense of litigation; and
- (iv) to make disclosures to the appropriate agency in the event that records maintained by OCR to carry out its functions indicate a violation or potential violation of law.

Under 5 U.S.C. § 552a(k)(2) and the HHS Privacy Act regulations at 45 C.F.R. § 5b.11 OCR complaint records have been exempted as investigatory material compiled for law enforcement purposes from certain Privacy Act access, amendment, correction and notification requirements.

Freedom of Information Act

A complainant, the recipient or any member of the public may request release of OCR records under the Freedom of Information Act (5 U.S.C. § 552) (FOIA) and HHS regulations at 45 C.F.R. Part 5.

Fraud and False Statements

Federal law, at 18 U.S.C. §1001, authorizes prosecution and penalties of fine or imprisonment for conviction of "whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry".



PROTECTING PERSONAL INFORMATION IN COMPLAINT INVESTIGATIONS

To investigate your complaint, the Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) will collect information from different sources. Depending on the type of complaint, we may need to get copies of your medical records, or other information that is personal to you. This Fact Sheet explains how OCR protects your personal information that is part of your case file.

HOW DOES OCR PROTECT MY PERSONAL INFORMATION?

OCR is required by law to protect your personal information. The Privacy Act of 1974 protects Federal records about an individual containing personally identifiable information, including, but not limited to, the individual's medical history, education, financial transactions, and criminal or employment history that contains an individual's name or other identifying information.

Because of the Privacy Act, OCR will use your name or other personal information with a signed consent and only when it is necessary to complete the investigation of your complaint or to enforce civil rights laws or when it is otherwise permitted by law.

Consent is voluntary, and it is not always needed in order to investigate your complaint; however, failure to give consent is likely to impede the investigation of your complaint and may result in the closure of your case.

CAN I SEE MY OCR FILE?

Under the Freedom of Information Act (FOIA), you can request a copy of your case file once your case has been closed; however, OCR can withhold information from you in order to protect the identities of witnesses and other sources of information.

CAN OCR GIVE MY FILE TO ANY ONE ELSE?

If a complaint indicates a violation or a potential violation of law, OCR can refer the complaint to another appropriate agency without your permission.

If you file a complaint with OCR, and we decide we cannot help you, we may refer your complaint to another agency such as the Department of Justice.



CAN ANYONE ELSE SEE THE INFORMATION IN MY FILE?

Access to OCR's files and records is controlled by the Freedom of Information Act (FOIA). Under FOIA, OCR may be required to release information about this case upon public request. In the event that OCR receives such a request, we will make every effort, as permitted by law, to protect information that identifies individuals, or that, if released, could constitute a clearly unwarranted invasion of personal privacy.

If OCR receives protected health information about you in connection with a HIPAA Privacy Rule investigation or compliance review, we will only share this information with individuals outside of HHS if necessary for our compliance efforts or if we are required to do so by another law.

DOES IT COST ANYTHING FOR ME (OR SOMEONE ELSE) TO OBTAIN A COPY OF MY FILE?

In most cases, the first two hours spent searching for document(s) you request under the Freedom of Information Act and the first 100 pages are free. Additional search time or copying time may result in a cost for which you will be responsible. If you wish to limit the search time and number of pages to a maximum of two hours and 100 pages; please specify this in your request. You may also set a specific cost limit, for example, cost not to exceed \$100.00.

If you have any questions about this complaint and consent package, Please contact OCR at <http://www.hhs.gov/ocr/office/about/contactus/index.html>

OR

Contact the Customer Response Center at (800) 368-1019

(see contact information on page 2 of the Complaint Form)

PROPOSED ORDER

The Court, having considered Defendants' motion to dismiss or, in the alternative, motion for summary judgment, Plaintiffs' oppositions, and the entire record herein, orders as follows:

IT IS HEREBY ORDERED that Defendants' motion is **GRANTED**, and [Plaintiffs' complaints are dismissed with prejudice / summary judgment is entered in Defendants' favor]. **IT IS SO ORDERED.**

Dated: _____

THE HONORABLE STANLEY A. BASTIAN
UNITED STATES DISTRICT JUDGE