Consolidated Case Nos. 20-15398, 20-15399, 20-16045, and 20-35044

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

CITY AND COUNTY OF SAN FRANCISCO, ET AL.,
Plaintiffs-Appellees,

v.

ALEX M. AZAR II, ET AL.,
Defendants-Appellants.

Appeal from the United States District Courts for the Northern District of California and the Eastern District of Washington

BRIEF OF *AMICI CURIAE* THE AMERICAN PUBLIC HEALTH ORGANIZATION AND EXPERTS IN PUBLIC HEALTH IN SUPPORT OF PLAINTIFFS-APPELLEES

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rules 26.1 and 29(a)(4)(A) of the Federal Rules of Appellate Procedure, *amici curiae* state that no party to this brief is a publicly-held corporation, issues stock, or has a parent corporation.

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INTEREST OF *AMICI CURIAE*[1]

This *amicus* brief is submitted in support of Appellees. *Amici curiae* are public health experts and clinicians.

The American Public Health Association is an organization of nearly 25,000 public health professionals that champions the health of all people and all communities, strengthens the profession of public health, shares the latest research and information, promotes best practices, and advocates for public health issues and policies grounded in research.

The individual *amici*[2] are leaders in their fields: they include professors at Columbia, Harvard, Johns Hopkins, Georgetown, New York University, Yale, and directors of public health institutes. *Amici* work as, or with front-line public health practitioners, public health researchers, government advisory panels, legislators,

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[1] Pursuant to Federal Rule of Appellate Procedure 29, the parties have consented to the filing of this *amicus* brief; further, undersigned counsel for *amici curiae* certify that: no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money that was intended to fund preparing or submitting this brief; and no person or entity, other than the *amicus curiae*, its members, or its counsel, contributed money intended to fund the preparation or submission of this brief.

[2] A complete listing of the individual *amici curiae* is provided at Appendix A.

global health security teams, and non-profit organizations to protect people from diseases and to advance public health.

Amici are dedicated to ensuring equitable access to a full range of healthcare services for all patients, and believe that it is vitally important for patients to be able to access care that is medically and scientifically sound, and without being compromised by the individual preferences or religious beliefs of those who provide it. *Amici* believe that one's personal convictions cannot and should not be used to deprive a patient of medically sound treatment, information, and services. From that perspective, *amici* submit this brief to provide the Court with additional information about the many public health dangers created by the Department of Health and Human Services' rule, titled *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23, 170 (May 21, 2019) (codified at 45 C.F.R. Part 88).

INTRODUCTION AND SUMMARY OF ARGUMENT

Equitable access to healthcare and patient autonomy, *i.e.*, a patient's innate right to make informed decisions regarding their healthcare, including their reproductive healthcare, and to receive their chosen healthcare treatments and procedures in a timely manner, are cornerstones of public health in this country. Patients rely on medical professionals, who have the expertise and training to

diagnose and treat them. Patients properly expect their healthcare professionals to both provide them with the information they require to make the best decision for their own health and to adequately provide for their treatment. The Department of Health and Human Services' ("HHS") rule, *Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, (the "Rule") stands in direct contrast to these fundamental principles. Adoption of this Rule undermines the core principles of public health and will broadly and negatively impact the public health system.

By allowing individuals to withhold and impede treatment or care based on their personal beliefs, the Rule endangers patients and jeopardizes their ability to obtain appropriate and necessary healthcare. At the same time, application of the Rule will exacerbate the existing disparities in the healthcare system and will disproportionately affect marginalized populations to potentially devastating results. The Rule was appropriately described by the District Court as "arbitrary and capricious" and stated that it "contravene[s] medical ethics" as it is a radical departure from the status quo to the extent that it effectively constitutes new

substantive regulations which are beyond HHS's authority to promulgate. (*See* ER 31–32.)[3]

Recognizing the many ways that the Rule undermines core principles of public health and compromises patient safety and well-being, *amici* urge this Court to affirm the District Court's order.

ARGUMENT

I. THE RULE CONTRAVENES CORE PUBLIC HEALTH PRINCIPLES BECAUSE IT AFFORDS A PROVIDER'S PERSONAL BELIEF ABSOLUTE PRIORITY OVER A PATIENT'S MEDICAL NEEDS.

Professional healthcare is of critical importance not only to the functioning of individual patients, but also local communities, and the nation at large.[4] Healthcare policy and the laws that codify it should, as a matter of foundational principle, aim to foster the highest possible level of health at each of those levels, *i.e.*, individual, local communities, and national.[5]

Public health policy is commonly grounded in an ethical framework prioritizing fundamental human rights: the right to health, the right to equal

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[3] "ER" refers to the Ninth Circuit Excerpts of Record, Dkt. 17. "SER" refers to the Ninth Circuit Supplemental Excerpts of Record, Dkt. 46.

[4] *See* Lawrence O. Gostin & Lindsay F. Wiley, *Public Health Law: Power, Duty, Restraint* 7-8 (3d ed. 2016) (hereinafter "*Public Health*").

[5] *Id.* at 4.

treatment, and the right to autonomy regarding medical decisions.[6] Based on that ethical framework, when a patient's medical needs conflict with a provider's objections to certain healthcare procedures or treatment, the nature of the provider's position of trust and power over the patient and the provider's duty to minimize health harms and promote the health of the patient, obligates the provider and the organization(s) providing healthcare to the patient to prioritize the patient's needs over those objections. *See* APHA, Universal Access to Contraception, Policy No. 20153 (Nov. 3, 2015) (hereinafter "APHA Universal Access Statement"), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/12/17/09/14/universal-access-to-contraception ("Conscientious objection to the provision of essential information and contraceptive services or, in cases of failure, safe abortion services cannot compromise the rights of individuals to information, services, and effective referrals."). These principles of prioritizing patient health and well-being are core to both medical ethics and the field of public health. For example, the American

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[6] *See* Wendy K. Mariner *et al*., *Public Health Law* 16 (3d ed. 2019); Am. Pub. Health Ass'n, *Public Health Code of Ethics* 5 (2019) (hereinafter "APHA Public Health Code of Ethics") ("Public health practitioners and organizations have an ethical responsibility to prevent, minimize, and mitigate health harms and to promote and protect public safety, health, and well-being."), https://www.apha.org/-/media/files/pdf/membergroups/ethics/code_of_ethics.

Medical Association's Code of Medical Ethics ("AMA Code") provides that a physician is ethically *required* to use sound medical judgment, holding the best interests of the patient as paramount.[7]

The Rule, however, fundamentally departs from and undermines this public health ethical framework and instead, absolutely prioritizes the objections of individual providers. (*See* 45 C.F.R § 88.) By permitting any individual who works at a healthcare facility to elevate their personal beliefs above the health needs of the patient, the Rule disregards the most core principles of public health. In a total defiance of established standards, the Rule allows any healthcare employee, volunteer or subcontractor to deny or impede patient care, even in emergency circumstances in which a referral is not possible or could negatively

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[7] AMA Code, Opinion 1.1.1, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf; *see also* AMA Code, Opinion 1.1.3, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf ("[P]atients' rights" includes "respect, dignity," and the right "to make decisions about [their care] . . . and to have those decisions respected."). "The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest." AMA Code, Opinion 1.1.1, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf.

affect the patient's well-being.[8] In fact, the Rule is drawn so broadly that the term "workforce" includes wide-ranging non-medical staff who can obstruct patient access to care or information. *See* 45 C.F.R. § 88.2. Moreover, in the inevitable event of a conflict between an individual's objection and a patient's medical treatment or procedure, the Rule provides that it is *merely optional* for the patient to be referred to another provider. 45 C.F.R. § 88.3. As a result of these overly broad and poorly defined criteria, the Rule emboldens not only doctors, nurses, and emergency medical technicians, but virtually every single person who works at a healthcare facility to refuse to provide information, treatment, and/or help to those who need it without notifying the patient. In doing so, the Rule destroys the paramount commitment of public health to prioritize access to healthcare and patient well-being.

The Rule stands in direct opposition to accepted public health principles, absolutely prioritizes the caregiver's personal beliefs above the health and safety of the patient, and as such, the District Court correctly characterized the Rule as transformative and vacated the Rule.

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[8] *See* 84 Fed. Reg. 23, 170, 23,263 (May 21, 2019) (making no exception in §§ 88.1-88.2 for emergency situations).

A. The Rule Is Contrary To Widely-Accepted International Public Health Principles That Prioritize Patient Care.

Promoting health and minimizing health harms are cornerstones of medical ethics and public health, and prioritizing patient health and autonomy is not fundamentally inconsistent with respect for an individual's exercise of their personal religious or moral beliefs--a view that is widely shared by international public health authorities.[9] For example, global health organizations recognize fundamental standards that permit healthcare providers to act on their objections to reproductive healthcare procedures *where a patient is able to be referred to another safe, readily accessible abortion provider*. *See, e.g.,* World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems, 96 (2012), https://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf?sequence=1 ("[h]ealth-care professionals who claim conscientious objection must refer the woman to another willing and trained provider in the same, or another easily accessible health-care facility, in

[9] *See* Julia Raifman & Sandro Galea, *The New US "Conscience and Religious Freedom Division": Imposing Religious Beliefs on Others,* 108 Am. J. Pub. Health 889, 890 (2018) ("[T]he principles of medical ethics do not sanction turning away or treating patients differently according to their characteristics or behaviors; health care providers should continue to observe standards of medical ethics and serve all patients to the best of their ability.").

accordance with national law");[10] Int'l Planned Parenthood Fed'n, *IMAP Statement on Conscientious Objection: Refusal of Care and Professional Conduct of Reproductive Health Services in the Context of Legal Restrictions* 4 (2016) (hereinafter "IMAP Statement")[11] ("WHO recognizes conscientious objection as a barrier to lawful abortion services which impedes women from accessing the services for which they are eligible and contributes to unsafe abortion."). Similarly, the international guidance does not disregard a patient's need for medical treatment in circumstances of an emergency, further providing that, "[w]here referral is not possible, *the healthcare professional who objects must provide safe abortion to save the woman's life and to prevent damage to her health*." World Health Organization, Safe Abortion: Technical and Policy Guidance for Health Systems, 96 (emphasis added); *see also* APHA Universal Access Statement, ("Conscientious objection to the provision of essential information and contraceptive services or, in cases of failure, safe abortion services

[10] *See also id*. at 86, 94 (recognizing that "allowing conscientious objection without referrals on the part of health-care providers and facilities" "contribute[s] to unsafe abortion" and can create a "chilling effect").

[11] https://www.ippf.org/sites/default/files/2017-01/IMAP%20Statement%20on%20conscientious%20objection.pdf.

cannot compromise the rights of individuals to information, services, and effective referrals").[12]

Unlike the Rule, which gives healthcare employees an unfettered ability to deny care based on their personal beliefs, international public health guidelines seek to balance the competing priorities of the needs of the patient (which are paramount in medical ethics) and the individual religious or moral objections of care providers, ensuring that the latter may be accommodated so long as they do not negatively impact the former. *See id*; *see also*, Comm. on Econ., Soc., and Cultural Rts., *General Comment No. 22 on the Right to Sexual and Reproductive Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, ¶ 43, U.N. Doc. E/C.12/GC/22 (May 2, 2016), https://www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health ("Where health care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not

[12] *See also*, Comm. on the Elimination of Discrimination Against Women, Rep. on the Work of Its Twentieth and Twenty-First Sessions, U.N. Doc. A/54/38/Rev.1, chap. I, at 4, ¶ 11 (1999), https://www.un.org/womenwatch/daw/cedaw/reports/21report.pdf (recommending in General Recommendation No. 24 that "if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.").

inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and the performance of services in urgent or emergency situations.").

Thus, these widely-recognized public health principles demonstrate that in order to create a healthcare system that properly prioritizes patient autonomy, safeguards must be in place to ensure that even if a provider objects to a patient's treatment option, the patient is able to receive proper care without undue delay. Yet, the Rule seeks to upend the status quo and undermine the core principles of public health by actively protecting individual caregivers who withhold contraceptive or abortion care and/or who withhold information and referrals on moral or religious grounds.[13]

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[13] Hum. Rts. Council, Rep. of the Working Group on the Issue of Discrimination Against Women in Law and in Practice on Its Mission to the United States of America, ¶¶ 71, 95(i), U.N. Doc. A/HRC/32/44/Add.2 (2016) https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/172/75/PDF/G1617275.pdf?OpenElement (recognizing that "[r]efusal to provide sexual and reproductive health services [in the United States] on the grounds of religious freedom should not be permitted where such refusal would effectively deny women immediate access to the highest attainable standard of reproductive health care and affect the implementation of rights to which they are entitled under both international human rights standards and domestic law.").

In doing so, the Rule renders the objections of the caregiver superior to a patient's health and decisions over their own body. This is a balance that disregards international health standards and improperly places patients at risk.

II. THE RULE WOULD EXACERBATE DEEPLY-ROOTED HEALTH INEQUITIES.

A foundational principle of public health is the promotion of health equity and reduction of health disparities. *See* APHA, *Health Equity* ("Creating health equity is a guiding priority and core value" of public health.")[14] *See also*, APHA Public Health Code of Ethics, *supra* note 6 (promoting health equity and ensuring that public health steps "do not exacerbate health inequities" are "core values") ; *see also* Gostin & Wiley, *Public Health*, *supra* note 4, at 18 ("Social justice is viewed as so central to the mission of public health that it has been described as the field's core value . . . . Social justice captures the twin moral impulses that animate public health: to advance human well-being by improving health and to do so particularly by focusing on the needs of the most disadvantaged."). In violation of this well-established public health standard, the Rule is poised to have a grossly disproportionate impact on the most vulnerable populations within American

[14] *Health Equity*, AM. PUB. HEALTH ASS'N, https://www.apha.org/topics-and-issues/health-equity.

society. Specifically, the Rule would intensify health disparities affecting low-income people, people of color, immigrants, people with disabilities, people in rural communities, and LGBTQ+ people.[15] As health experts have observed, "decreased access to health services brought about by conscientious objection has a disproportionate impact on those living in precarious or unstable economic circumstances, or at otherwise heightened risk, and aggravates inequities in health status."[16]

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[15] Members of the LGBTQ+ community face an array of barriers to adequate healthcare that are exacerbated by the Rule; issues unique to that community are covered at more length in other amicus briefs. *See Amici Curiae* Brief of Scholars of the LGBT Population in Support of Appellees and Affirmance filed contemporaneously.

[16] WENDY CHAVKIN *ET AL.*, CONSCIENTIOUS OBJECTION AND REFUSAL TO PROVIDE REPRODUCTIVE HEALTHCARE: A WHITE PAPER EXAMINING PREVALENCE, HEALTH CONSEQUENCES, AND POLICY RESPONSES 7-8 (2013), https://globaldoctorsforchoice.org/wp-content/uploads/GDC_White-paper-on-CO-in-reproductive-health_ENG.pdf (investigating how conscientious objection can further limit already limited services, especially in resource scare regions); *see also* LOUIS UTTLEY *ET AL.*, ACLU & MERGER WATCH PROJECT, MISCARRIAGE OF MEDICINE, THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO REPRODUCTIVE HEALTH CARE 14-15 (2013) (hereinafter "ACLU Miscarriage of Medicine"), https://www.aclu.org/sites/default/files/field_document/growth-of-catholic-hospitals-2013.pdf (cataloging the increasing prevalence of Catholic hospitals in the U.S., leading to more regions in the U.S. where a Catholic hospital is the only available community hospital).

Low-Income People. Due to a lack of resources, such as access to health insurance, low-income individuals are disproportionately likely to rely on federally-funded healthcare services and to utilize emergency rooms for treatment that would otherwise be provided by a primary care physician, and as a result, these persons have less choice and control in who provides them medical information and treatment.[17] The Rule would further reduce the medical information and treatment available to such low-income people, as it would enable the emergency room provider to not only withhold care, but also information and necessary referrals to other providers, and such patients are significantly less likely to have the resources to independently seek further care or receive medical information beyond that provided in the emergency room. *Id.*

People of Color. The Rule would also aggravate health inequities for people of color, who already have suffered from historical discrimination which far too often manifests as a provider's disregard for their autonomy, as the Rule would further embolden a provider's ability to undermine a patient of color's autonomy

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[17] *See* NAT'L WOMEN'S L. CTR., MIND THE GAP: LOW-INCOME WOMEN IN DIRE NEED OF HEALTH INSURANCE (2014) https://www.nwlc.org/sites/default/files/pdfs/nwlcmindthegapmedicaidreportfinal_20140122.pdf.

with regards to their reproductive healthcare.[18] Moreover, people of color are more likely to receive care in Catholic-affiliated hospitals, meaning that they are more likely to be impacted by the Rule, which would result in the further restriction of medical information and treatment available to people of color. *See* Kira Shepherd *et al.*, *Bearing Faith: The Limits of Catholic Health Care for Women of Color* (2018).[19] This is especially troubling in the context of the historical experiences people of color have had in seeking reproductive medical care, which include brutal violations of informed consent and reproductive autonomy, such as forced

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[18] *See* In Our Own Voice: National Black Women's Reproductive Justice Agenda, Comment on Proposed Rule, https://www.regulations.gov/document?D=HHS-OCR-2018-0002-65976; U.S. Nat'l Acads. of Scis., Eng'g, and Med., *Communities in Action: Pathways to Health Equity 2* (Alina Baciu *et al*. eds., 2017), https://www.ncbi.nlm.nih.gov/books/NBK425848/pdf/Bookshelf_NBK425848.pdf ("Health inequities are in large part a result of poverty, structural racism, and discrimination."); John F. Dovidio & Susan T. Fiske, *Under the Radar: How Unexamined Biases in Decision-Making Processes in Clinical Interactions Can Contribute to Health Care Disparities*, 102 Am. J. Pub. Health 945, 945 (2012), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2011.300601 ("[R]acial/ethnic minorities receive poorer quality health care than do Whites in the United States," and "have more health problems" due to, among other things "access to health care," "bias among health care providers," and resultant "mistrust").

[19] https://lawrightsreligion.law.columbia.edu/sites/default/files/content/BearingFaith.pdf.

childbearing, sterilization and medical experimentation.[20] Additionally, the Rule is also particularly problematic for people of color as they are more likely to live in healthcare shortage areas, and women of color suffer staggeringly high rates of maternal mortality and morbidity.[21] People of color continue to face structural barriers and bias and discrimination in medical encounters and to receive lower quality care. Accordingly, the Rule would not only perpetuate the horrifying undermining of the autonomy of people of color, but it would also further erode access to medical care for people of color in the context of reproductive health.

Immigrants and Foreign Born Patients. Immigrants are also likely to be negatively impacted by the Rule, as they are already disproportionately less likely

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[20] DEIRDRE COOPER OWENS, MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGIN OF AMERICAN GYNECOLOGY 11 (2017); LISA CACARI-STONE & MAGDALENA AVILA, *RETHINKING RESEARCH ETHICS FOR LATINOS: THE POLICY PARADOX OF HEALTH REFORM AND THE ROLE OF SOCIAL JUSTICE*, 22 J. ETHICS & BEHAV. 445, 449 (2012).

[21] *See, e.g.*, In Our Own Voice: National Black Women's Reproductive Justice Agenda, Comment on Proposed Rule, https://www.regulations.gov/document?D=HHS-OCR-2018-0002-65976; Roni Caryn Rabin, *Huge Racial Disparities Found in Deaths Linked to Pregnancy*, N.Y. Times, May 7, 2019, https://www.nytimes.com/2019/05/07/health/pregnancy-deaths-.html; and Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. Times, April 11, 2018, https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html

to have health insurance or to seek treatment for their reproductive health. *See* Athena Tapales *et al*., Guttmacher Inst., *The Sexual and Reproductive Health of Foreign-Born Women in the United States*, 98 Contraception 47 (2018). And when faced with an objecting caregiver, immigrants are less likely to be able to independently find an alternative provider or to obtain healthcare information outside of the information provided by the objecting caregiver. As such, the Rule will operate to significantly limit immigrants' ability to locate healthcare providers who can (or will) provide their requested treatment, even in an emergency. Further, approximately 49% of foreign-born individuals living in America are not proficient English speakers. *See* Nat'l Immigration Law Ctr., Comment on Proposed Rule.[22] The Rule would further exacerbate structural barriers and the difficulty of navigating the healthcare system by allowing providers to withhold information about alternative treatment options and/or providers, which likely prevents such patients from ever learning about, let alone receiving, such alternative treatment options. *See id.*

Patients in Underserved and Rural Locations. Every state has medically underserved areas, and in many of these areas, Catholic-affiliated hospitals are the

[22] https://beta.regulations.gov/comment/HHS-OCR-2018-0002-71248

only providers for short-term, acute care. *See* Lori R. Freedman *et al.*, *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, AM. J . PUB. HEALTH (2008).[23] In these circumstances, patients will likely encounter conscientious objectors and face obstacles to obtaining the care they need by operation of the Rule. *See id.*; Shepherd, *supra*. Transportation to another provider in these medically underserved areas may be an insurmountable barrier, not only for lower-income patients, but also for patients with disabilities, and patients living in rural areas, who may not be able to find another provider within a reasonable distance.[24] Moreover, access to healthcare is worsening in rural areas, as hospitals and OB-GYN centers have been and are continuing to close, heightening the difficulty of finding alternative reproductive care providers, and these closures have disproportionately affected rural people of color, rural people with disabilities, and the rural unemployed.[25]

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[23] https://www.ncbi.nlrn.nih.gov/prnc/articles/PMC2636458/.

[24] Lisa I. Iezzoni *et al.*, *Rural Residents with Disabilities Confront Substantial Barriers to Obtaining Primary Care*, 41 Health Services Rsch. 1258 (2006); *see also* Lawrence Gostin, *The "Conscience" Rule: How Will It Affect Patients' Access to Health Services?*, JAMA Health Forum (May 15, 2019), https://jamanetwork.com/channels/health-forum/fullarticle/2759640.

[25] *See* Ctr. for Medicare & Medicaid Servs., *Improving Access to Internal Health Care in Rural Communities* 1 (2019), https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-

Persons with Disabilities. People with disabilities already face significant hurdles in obtaining healthcare services, in the form of inaccessible medical offices and equipment, and providers who do not understand or address the needs of persons with disabilities, and the Rule stands to make such barriers even worse. *See* Janice C. Probst *et al.*, Person and Place: *The Compounding Effects of Race/Ethnicity and Rurality on Health*, AM. J . PUB. HEALTH (2011).[26] And even more egregious, the Rule would allow any person tangentially connected to the provision of healthcare services to impose their personal belief on a patient with disabilities, which could result in ordinary or life-saving care being denied because of the provider's personal belief about the person's abilities and quality of life. *See* The Disability Coalition, Comment on Proposed Rule.[27]

Maternal-Health-Care-in-Rural-Communities.pdf ("Since January 2010, more than 100 rural hospitals have closed, with a disproportionate share occurring in the South. . . . Between 2004 and 2014, 179 rural counties lost or closed their hospital obstetric services. Consequentially, fewer than 50% of rural women have access to perinatal services within a 30-mile drive from their home and more than 10% of rural women drive 100 miles or more for these services. These conditions affect access to care before, during, and after pregnancy and are more pronounced in the Black and Hispanic communities, and disproportionately affects low-income women.").

[26] http://ajph.aphapublications.org/doi/fu1V10.2105/AJPH.94.10.1695.

[27] https://beta.regulations.gov/comment/HHS-OCR-2018-0002-66494 ("Many people with disabilities receive home and community-based services (HCBS), including residential and day services, from religiously-affiliated providers. . . .

The Rule will force all of these patients in need of healthcare services to overcome even more barriers simply to obtain healthcare treatment. Many individuals face multiple, overlapping barriers to care. Further, the denial of healthcare can be experienced as stigma and discourage patients from further seeking services. Faced with these additional challenges, it is likely that these marginalized populations will likely not receive their chosen treatment, and/or simply receive substandard care, or forgo pursuing medical care entirely. *See Discrimination in America: Experiences and Views of American Women*, NPR & HARVARD T.H. CHAN SCH. OF PUB. HEALTH (Dec. 2017)[28]; *The State of*

Many people with disabilities live or spend much of their day in provider-controlled settings where they often receive supports and services. They may rely on a case manager to coordinate necessary services, a transportation provider to get them to community appointments, or a personal care attendant to help them take medications and manage their daily activities. Under this broad new proposed language, any of these providers could believe they are entitled to object to providing a service covered under the regulation and not even tell the individual where they could obtain that service, how to find an alternative provider, or even whether the service is available to them. . . . Finally, due to limited provider networks in some areas and to the important role that case managers and personal care attendants play in coordinating care, it may be more difficult for people with disabilities and older adults to find an alternate providers who can help them.")

[28] https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2017/12/NPR-RWJF-HSPH-Discrimination-Women-Final-Report.pdf.

Black Women & Reproductive Justice, IN OUR OWN VOICE (2017)[29]; Haynes *et al.*, *Contraceptive Use at Last Intercourse Among Reproductive-Aged Women with Disabilities: An Analysis of Population-Based Data from Seven States*, CONTRACEPTION (2017).[30]

III. THE RULE THREATENS FAR REACHING HARM FOR NUMEROUS HEALTHCARE SERVICES.

The Rule represents a dramatic and dangerous departure from the status quo. It is poorly drafted and unworkably vague creating uncertainty that will have dangerous consequences for patients and the healthcare system at large.

As detailed in prior sections, the Rule is vastly overbroad, and threatens to embolden numerous employees of a healthcare provider (including doctors, nurses, administrators, receptionists, custodial staff, etc.) to deny or obstruct a patient from receiving medical care that they object to, regardless of whether that employee has any medical training or knowledge. (45 C.F.R. § 88.2.) In fact, as the District Court observed, the Rule allows employees to block the patient's access to healthcare treatment and information. (ER p. 35.) *See also* State Att'ys Gen.,

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29 http://blackrj.org/wp-content/uploads/2017/06/FINAL-InOurVoices_Report_final.pdf.56 RM.

30 https://www.ncbi.nlm.nih.gov/pubmed/29253580.

Comment on Proposed Rule, https://beta.regulations.gov/comment/HHS-OCR-2018-0002-70188 ("[t]he addition of laboratories is unrelated to the procedures targeted by any of the referenced statutes, and their inclusion could lead to the refusal of all manner of routine testing, including pregnancy testing"); Nat'l Women's L.Ctr., Comment on Proposed Rule, https://beta.regulations.gov/comment/HHS-OCR-2018-0002-71248 ("a volunteer at a hospital could claim a right to refuse to deliver medicine to a patient's room or even deliver meals to a patient who is recovering from a surgery to which the volunteer objects").[31] By opening the door to countless employees, volunteers, and subcontractors of an institution who might seek to raise an objection and obstruct a medical procedure or prevent treatment, the Rule creates an unethical danger to patients. For example, under the Rule, a patient seeking an abortion could conceivably be impeded at every step of the process of seeking care—by a receptionist who refuses to book an appointment, by a treating nurse or physician

[31] See also Ctr. for Reprod. Rts., Comment Letter on Proposed Rule; Delegations of Authority (Mar. 27, 2018), https://beta.regulations.gov/comment/HHS-OCR-2018-0002-71830 ("For example, the proposed rule could allow entities to refuse to provide information about any other entity that might refer for an abortion, or to withhold pertinent medical information about a woman's pregnancy if the provider fears that the woman may choose to seek out an abortion or sterilization provider. It could also allow providers to not inform patients that they are withholding medical information.").

who refuses to provide certain care (or even to provide information about such care), and/or by an office worker who will not provide a referral or list of alternative providers who will render the requisite medical care, resulting in undue delay potentially affecting the availability, risk, and cost of the procedure for that patient. Thus, under the Rule, persons with a remote connection to healthcare would be able to personally disrupt the provision of care to a patient under any circumstances, merely by asserting a moral objection to a given procedure.[32]

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[32] The Rule's definitions of additional terms are also extremely problematic: For example, the Rule's definition of "referral" allows for an unprecedented number of objections, with dramatic implications for patients. A referral "includes the provision of information in oral, written, or electronic form (including names, addresses, phone numbers, email or web addresses, directions, instructions, descriptions, or other information resources), where the purpose or reasonably foreseeable outcome of provision of the information is to assist a person in receiving funding or financing for, training in, obtaining, or performing a particular healthcare service, program, activity, or procedure." (45 C.F.R. § 88.2.) This would even encompass a list of accredited clinics or practitioners in any given area. As a result, numerous persons beyond the treating physician might assert objections that could remove any reference (whether online or printed) to facilities performing potentially certain services, such as abortion.

In addition, the Rule's definition of "assist in the performance," in combination with other provisions, embolden persons to interpose an objection (whether on religious or other grounds) to "any part" of a "healthcare program." (45 C.F.R. § 88.2; *see* Rule Sections 88.3(a)(v), 88.3(a(2)(vi).) This suggests that manifold activities that take place in hospitals or are related to health and wellness are at risk, which would incentivize hospitals to scrub their entire organization of any potentially controversial healthcare services.

Further, a patient cannot even count on the objector to take "any additional action" after withholding diagnosis, treatment, or information, to inform them that they have been denied service. 45 C.F.R. § 88.3. This leaves patients ignorant that they have been denied information about treatment options. A patient's access to medical care should not be conditioned on the patient's knowledge of all available treatment options, but the Rule does just that by placing the onus on the patient to know the full extent of their options or else be denied such medical care. Thus, the Rule undermines a patient's fundamental right to be informed about their healthcare and available medical options. *See* AMA Code, Opinion 2.1.1, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/code-of-medical-ethics-chapter-1.pdf ("Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care.").[33]

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[33] The American Academy of Pediatrics similarly explains: "Informed consent should be seen as an essential part of health care practice…[T]he goals of the informed consent process (protecting and promoting health-related interests and incorporating the patient and/or the family in health care decision-making) . . . are grounded by the same ethical principles of beneficence, justice, and respect for autonomy." Am. Acad. of Pediatrics, Comm. on Bioethics, *Informed Consent in Decision-Making in Pediatric Practice*, PEDIATRICS, AUG. 2016, at 2 (2016), https://pediatrics.aappublications.org/content/pediatrics/138/2/e20161484.full.pdf.

The Rule's broad and vague language threatens the provision of manifold forms of healthcare services. While the effects on reproductive healthcare are readily apparent, numerous other forms of care will be similarly compromised: sterilization, end of life care, and medical interventions for people experiencing substance use disorders are just a few more examples. The Rule's ambiguities will mean that it jeopardizes medical procedures linked to stem cell research, blood transfusions, medical treatments with porcine ingredients (*e.g.*, insulin), HIV, HPV, and other STI prevention and treatment, infertility treatment, and a broad range of LGBTQ+ healthcare. 45 C.F.R. § 88.3.

The Rule's enforcement mechanisms, which include withdrawing or even clawing back funding for violations of the Rule, combined with the Rule's broad and vague definitions and other provisions, threaten to significantly disrupt and harm public health. A single violation could cost a State or provider *all* of its HHS funding, including Medicare and Medicaid funding; and losing this funding could cut essential healthcare programs and close hospitals. In fact, the government's Ninth Circuit brief explains that HHS can impose a "recipient-wide" termination of funds (Br. at p. 36.) This means that the countless public health objectives that state governments serve using HHS funds could be terminated. These draconian penalties for even minor violations of the Rule threaten to cost state and local

governments *billions* of dollars in funding, resulting in significantly reduced public health programs and more hospital closures, all of which drastically and negatively affect public health, and the impact of the Rule would be even worse during the current pandemic. COVID-19 has already exacerbated health disparities and it has vividly demonstrated how important and challenging it can be for those who are marginalized to navigate and access healthcare, and the Rule threatens to make access even worse during these desperate and trying times.

Finally, the Rule would reduce trust in healthcare providers. This further erosion of trust is especially dangerous for communities of color, who have had that trust violated in the past. (*See* Sec. II*, supra*.) The loss of trust will deter even more people from seeking healthcare services, and can cause collateral public health consequences, including hampering efforts to address public health crises. Gostin & Wiley, *Public Health*, *supra* note 4, at 307 ("[p]ublic health depends on the community's trust"); *see also* Raifman and Galea, *supra* note 9 ("The cornerstone of health care is a trusting relationship between patients and providers."); Gostin, *supra* note 23 ("Even if a vulnerable patient is not blocked from needed services, it could discourage treatment-seeking behavior and cause stigma."). The spread of COVID-19 and disparities in underserved and minority populations have placed a spotlight on longstanding health inequalities. It has also

highlighted why trust in healthcare is essential to public health; without public confidence in the advice and treatment of healthcare providers, the consequences can be dire, affecting individuals, communities, and the entire nation.[34] The Rule will aggravate these inequalities and undermine the objectives of the public health system. The Rule is a step in the wrong direction and will negatively impact the segments of the populations in most urgent need of support.

CONCLUSION

For all the foregoing reasons, *amici curiae*, the American Public Health Association and experts in public health, urge this Court to uphold the District Court's Order.

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Respectfully submitted,

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[34] Marianne Udow-Phillips & Paula M Lantz, *Trust in Public Health Is Essential Amid the COVID-19 Pandemic*, 15 J. Hosp. Med. 431-33 (2020).

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CERTIFICATE OF SERVICE

The undersigned, an attorney representing *Amicus Curiae* the American Public Health Organization and Experts in Public Health certifies that on October 20, 2020, the foregoing document was electronically filed with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the counsel of record.

/s/ *Leah R. Bruno*

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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Signature */s/ Leah R. Bruno* **Date** October 20, 2020

APPENDIX A

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