



Office of the General Counsel

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EO 12866 Meeting on the Proposed Rule “Safeguarding the Rights of Conscience as Protected by Federal Statutes,” RIN 0945-AA18

I. Introduction

Thank you for the opportunity to meet with you and offer our comments on the U.S. Department of Health and Human Services’ (the “Department”) proposed rule “Safeguarding the Rights of Conscience as Protected by Federal Statutes,” 88 Fed. Reg. 820 (Jan. 5, 2023). The Catholic Church cares deeply about the protection of the right of conscience in health care. Pope Francis has repeatedly affirmed the fundamental importance of this right.

The Church’s emphasis on the primacy of conscience exists in harmony with its longstanding ministry to the sick and its support for health care for all people.

Catholics have been called to care for the sick since the earliest days of our faith. Here in America, the Ursuline nuns ran the Royal Hospital in New Orleans before our country declared its independence from Britain.¹ Today, with hundreds of hospitals and health care facilities affiliated with the Catholic Church, Catholic entities taken together are the largest nonprofit health care provider in this country.² We do this work in fulfillment of the direct command of Jesus Christ and in imitation of his divine ministry here on Earth.

We serve all in need, without regard to race, religion, sex, or any other characteristic, because we believe that health care is a basic human right. As the USCCB’s predecessor organization, the National Conference of Catholic Bishops, stated in 1993, “This right flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God.”³ The same core beliefs about human dignity and the wisdom of God’s design that motivate Catholics to care for the sick also shape our convictions about preborn children, sexual conduct, and the immutable nature of the human person – convictions that are now often at issue in the current health care context. These commitments are inseparable.

Because health care ineluctably raises questions of religious significance – of life and death, and what it means to be healthy and to flourish – the protection of conscience and

¹ John E. Salvaggio, *New Orleans’ Charity Hospital: A Story of Physicians, Politics, and Poverty* 8 (1992).

² Catholic Health Ass’n, *Catholic Health Care in the United States*, at 1 (Mar. 2021), www.chausa.org/about/about/facts-statistics.

³ <https://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/health-care-comprehensive-care.pdf>.

religious freedom in health care is particularly important. This is true not only of health care providers, but of health care consumers as well. A health care industry devoid of any sensitivity to, or understanding of, the religious beliefs of its patients would not well serve our religiously diverse citizenry.

This rulemaking is just one of many recent proposals and policies that have raised concern among the bishops about the protection of religious liberty and conscience rights. So our comments submitted on this rule, and our comments here today, are of a piece with a broader effort by the bishops to remind the administration of the need to honor these God-given and historically affirmed rights.

II. What is conscience?

The concept of “conscience” is familiar to everyone, but what does the Church mean when it talks about conscience? Why does the Church care so much about it?

The Catechism defines conscience as “a judgment of reason by which the human person recognizes the moral quality of a concrete act...”⁴ Pope Paul VI wrote that “Deep within his conscience man discovers a law which he has not laid upon himself but which he must obey... Man has in his heart a law inscribed by God.”⁵

The Church teaches that we are obligated to follow our consciences. Accordingly, says the Catechism, “Man has the right to act in conscience and in freedom so as personally to make moral decisions. ‘He must not be forced to act contrary to his conscience.’”⁶

The Church also teaches that Catholics have a duty to develop or form their consciences in the light of the Word of God. This is a lifelong task to which we are continually called. A person can be morally culpable for an act performed in accordance with the judgment of an ill-formed conscience. One way that a conscience can become ill-formed is when the habit of doing the wrong thing desensitizes our conscience to its wrongness.

In other words, conscience is not moral truth itself. Conscience is human discernment, at once both fallible and binding, of a divine moral truth. It is a capacity for moral decision-making that we are morally obligated to cultivate and refine.

When we feel the pang of conscience after doing wrong, it can help lead us toward sincere contrition, forgiveness, and ultimately, therefore, salvation.

So when the Church advocates for the protection of rights of conscience, we are not asking that each person’s whim operate as an exception to the law. Conscience is a weightier matter than doing what feels right in the moment. It is a function and a responsibility at the heart of what it means to be a human and a child of God.

⁴ Catechism of the Catholic Church 1778.

⁵ Pope Paul VI, *Gaudium et spes* 16.

⁶ Catechism of the Catholic Church 1782.

In this light, it makes sense that our law has long protected rights of conscience, and why many of the conscience statutes invoke the concept of conscience via language protecting not only religious beliefs but also moral convictions.

III. Conscience rights are good for health care workers and their patients

We are encouraged that the proposed rule acknowledges the benefits of protecting conscience rights, when it says, in reference to religious or moral objections to providing or referring for abortions or assisted suicide, that “[r]especting such objections honors liberty and human dignity. It also redounds to the benefit of the medical profession.”⁷ This echoes conclusions reached in the 2019 Rule’s analysis of its estimated benefits, conclusions that we endorse.⁸

The 2019 Rule’s estimation of benefits also anticipated that the 2019 Rule would not just benefit the medical profession, but also patients. For brevity, we will mention only a few of the ways that robust conscience protections for health care workers would benefit patients, but would encourage you to consult the full analysis in the 2019 Rule.

First, the threat of being forced to violate one’s conscience exerts downward pressure on the number of people working in health care, as both a barrier to entry and an incentive to exit. Polling of health care workers of faith supports this.⁹ Lessening or removing that threat therefore ought to increase the number of health care workers. Under a regime of strong conscience protections, a community that otherwise has no OB-GYN or an insufficient number of OB-GYNs may gain an OB-GYN who, for religious reasons, will not provide or refer for abortions. That community is in the same position either way with regard to access to abortion, but has gained greater and needed access to the life-affirming care that an OB-GYN can provide.

Second, many patients want health care providers who share their values. Again, polling supports this. For instance, a survey conducted by a former Chair of Bioethics of the National Institutes of Health Clinical Center found that “nearly one-fifth of [cancer] patients surveyed ‘thought they would change physicians if their physician told them he or she ‘had provided euthanasia [sic] or assisted suicide’ for other patients.’”¹⁰

⁷ 88 Fed. Reg. at 826.

⁸ See 84 Fed. Reg. 23170 at 23246-54 (May 21, 2019) (the “2019 Rule”).

⁹ <https://www.usccb.org/about/pro-life-activities/upload/USCCB-Key-Takeaways-handout-final.pdf>.

¹⁰ Bowman & Schandavel, citing Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 *Lancet* 1805, 1808 (1996); see also Christian Medical Association & Freedom2Care summary of polls conducted April, 2009 and May, 2011, available at https://docs.wixstatic.com/ugd/809e70_7ddb46110dde46cb961ef3a678d7e41c.pdf (“88% of American adults surveyed said it is either ‘very’ or ‘somewhat’ important to them that they share a similar set of morals as their doctors, nurses, and other healthcare providers”).

More broadly though, in terms of the quality of care delivered by medical professionals and institutions that approach health care through the lens of faith, the proof is in the pudding. One study found that nonprofit religiously affiliated hospitals “save more lives, release patients from the hospital sooner, and have better overall patient satisfaction ratings.”¹¹ Religious hospitals “demonstrated significantly better results than for-profit and government hospitals on inpatient and 30-day mortality, patient safety, length of stay, and patient satisfaction.”¹²

Recent polling conducted on behalf of the USCCB found broad public support for the protection of conscience in health care.¹³

In one survey question, respondents were asked to agree with one of two statements: 1) “Refusing to perform a gender transition procedure is always discrimination against the patient requesting it,” and 2) “If a doctor would prescribe a transgender patient antibiotics for strep throat but would not perform a gender transition procedure for him, that’s not discrimination. It’s an objection to the procedure, not the patient.” Seventy percent of respondents agreed with the second statement.

Sixty-four percent of respondents opposed the government forcing individuals to perform gender transition procedures against their religious beliefs, and 55% opposed the government forcing religious organizations to perform them against their beliefs. Meanwhile, 60% of respondents agreed that if a doctor has a religious belief that life begins at conception, the government should not pressure or penalize the doctor to perform abortions.

IV. The impact of the proposed rule

A. What does the rule mean in the first place?

The proposed rule does not define the terms of the statutes it implements, presumably out of a desire to avoid litigation over the substance of those definitions, and to account for court rulings holding that the 2019 Rule’s definitions exceeded the Department’s statutory authority. Without those definitions, the scope of conscience rights that the proposed rule would protect is unclear. The preamble to the proposed rule offers only hints about how the Department will interpret the subject statutes in the course of enforcement. So it is difficult to estimate the degree to which the proposed rule will generate the benefits associated with the protection of conscience rights. For instance, if the Department interprets the statutory protections to be effectively capped by Title VII’s current standard, the benefits of the final rule will be less than if the Department applied the plain meaning of the statutes. We note, however, that if the Department takes the position that Title VII sets the ceiling for conscience protections, that ceiling has been

¹¹ David Foster et al., Hospital Performance Differences by Ownership 1 (June 2013), <http://docplayer.net/13886677-Hospital-performance-differences-by-ownership.html>.

¹² *Id.* at 2.

¹³ <https://www.usccb.org/american-voters-support-tolerance-and-freedom-live-your-beliefs>

raised since the proposed rule was published, via the Supreme Court’s decision in *Groff v. DeJoy*, 600 U.S. 447 (2023).

We observed in our comments on the Department’s proposed rule on Section 1557 of the Affordable Care Act that it was impossible to know how severely that proposed rule would threaten conscience rights, because the Department did not explain what sort of protections it believes the conscience statutes provide.¹⁴ Vice versa here – it is impossible to know how much is at stake in this rulemaking when the Department has not yet announced, for example, whether it will take the position that refusal to perform abortions is a form of sex discrimination prohibited under Section 1557. (In our comments on the proposed Section 1557 regulations, we explain why, in our view, it is not.)

B. The impact of the rule as written versus what the Department could have written

The proposed rule’s Regulatory Impact Analysis asks for comments on the impact of various policy options – first, simply rescinding the 2019 Rule; second, adopting the proposed rule; and third, adopting the proposed rule with a modification that makes it mandatory for covered entities to post the notice of rights (which is voluntary under the proposed rule as drafted).

The question of the impact of rescinding the 2019 Rule seems largely academic, since it remains under vacatur. And we will discuss the impact and effectiveness of the notice, whether voluntary or mandatory, below. But another way to assess the impact of this rule is to compare it to the rule that HHS could have written while still avoiding concerns about exceeding its statutory authority.

Assuming for the sake of argument that the Department truly does lack statutory authority to define the terms of the Weldon, Church, and Coats-Snowe Amendments, it still has explicit statutory authority to engage in substantive rulemaking on fourteen different statutory conscience protections. These include significant protections under the ACA regarding assisted suicide and abortion. Two court rulings that vacated the 2019 Rule acknowledged the Department’s authority on those statutes. So the Department could have written a rule that exercised that authority in full, including definitions of the terms used in those statutes, and reaped at least some of the benefits that the 2019 Rule would have achieved for health care workers and their patients.

¹⁴ https://www.usccb.org/sites/default/files/about/general-counsel/rulemaking/upload/2022.comments.1557.regulations.final_.pdf.

C. The notice of rights

One substantial difference in impact among the policy options would be in the awareness that the rule would generate of the existence of federal health care conscience statutes and the protections they provide. Making notice mandatory would do the most for this objective.

Regardless of whether such notice is voluntary or mandatory, the proposed rule's model text will make it hard for covered entities to draft accurate notices and – critically – will often fail to meaningfully inform protected individuals of their rights.

The model text provides a placeholder that covered entities can fill in with a list of the conscience statutes that apply to them. However, the rule text itself, by deleting Section 88.3 of the 2019 Rule, offers no information to covered entities about what statutes apply to them. Each federal health care conscience statute imposes different compliance obligations and applies to a different stream of funds. Therefore, unlike with notices for Title VI, Title IX, or Section 504, covered entities cannot know what their obligations are simply by virtue of their receipt of any federal financial assistance from the Department. This was a problem that Section 88.3 of the 2019 Rule sought to address by providing an exhaustive and detailed description of who is covered by each statute implemented by the rule. The Department's proposal provides only an incomplete summary of who is covered by which statute, and only does so in the preamble, which will be more difficult than the rule text for covered entities to find when researching what their obligations are.

The text also provides no description at all of what the federal health care conscience statutes require. While it is true that a broad description of all those statutes' requirements may not be accurate as applied to a particular covered entity, total omission of any such information will make the notice nearly useless to any protected individual reading it. For example, using the model text, a health care worker may see a notice in the breakroom that says "ACME Biomedical Research Corp complies with applicable Federal health care provider conscience protection statutes, including paragraph (c)(2) of the Church Amendments. If you believe that ACME has violated any of these provisions, you can file a complaint..." and so on. The average health care worker will have no idea what paragraph (c)(2) of the Church Amendments is or what it means for their rights.

Instead, the notice should include a description of the general nature of the conscience statutes, with an acknowledgment that they "may" apply to a covered entity (which avoids the problem of an inaccurate guarantee of applicability), such as that provided in the 2019 Rule's model text.¹⁵ Alternatively, the Department could provide suggested summary blurbs for each statute, which covered entities can use to describe the requirements of the statutes they are subject to.

¹⁵ "You may have the right under Federal law to decline to perform, assist in the performance of, refer for, undergo, or pay for certain health care-related treatments, research, or services (such as abortion or assisted suicide, among others) that violate your conscience, religious beliefs, or moral convictions." 84 Fed. Reg. at 23272.

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In conclusion, we respectfully urge the Department to adopt a final rule that affords both health care workers and patients the benefits of robust protection of the right of conscience. Thank you for the opportunity to comment.