Law and the Public's Health

THE ELUSIVE QUEST FOR BALANCE: THE 2008 HHS REGULATION PROHIBITING DISCRIMINATION AGAINST HEALTH-CARE WORKERS BASED ON RELIGIOUS BELIEFS

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On December 19, 2008, the U.S. Department of Health and Human Services (HHS) published a final regulation barring discrimination against health-care providers based on their religious or moral beliefs. The rule, which overlaps with previous civil rights regulations on the same subject, raises numerous complex legal, policy, and practical questions. The proposed rule generated more than 200,000 comments, legislation to bar the regulation was introduced in both the House[1] and Senate,[2] and on January 15, seven Attorneys General filed suit to enjoin the regulation's implementation.[3] On February 27, 2009, the Obama Administration indicated its intention to rescind the regulation.[4] (At the time this article was finalized, no official notice had been published.) As of March 2009, the rule's fate remains unclear, although the issues it raises are enduring.

This installment of *Law and the Public's Health* examines the nondiscrimination regulation and assesses its implications for policy and practice, as well as for efforts to strike a balance between patients' and health-care workers' rights.

BACKGROUND

The origins of the regulation lie in an opinion issued in late 2007 by the American College of Obstetricians and Gynecologists (ACOG) Ethics Committee. The opinion concluded that physicians with religious or moral objections to certain procedures should refer patients to other providers where possible, but also noted that in emergency circumstances, physicians might have a professional and ethical obligation to furnish necessary care, even if objectionable.[5] In response, then HHS Secretary Michael Leavitt drafted a letter to the American Board of Obstetrics and Gynecology (ABOG), the certification body for obstetricians/gynecologists (OB/GYNs), noting his concern that ACOG and ABOG policies "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."[6]

ABOG assured the Secretary that a provider's position on abortion was not considered in its certification procedures.[7] Nevertheless, HHS issued a proposed antidiscrimination rule to protect physicians; citing no actual instance of discrimination, HHS identified a potential for adverse action by ABOG and the problem of religious intolerance.[8] The regulation extended beyond OB/GYN care; ABOG continued to deny the risk.

THE REGULATION

Following preliminary publication on August 21, 2008, a revised regulation was released on August 26, 2008, with a 30-day comment period.[9] A final rule was published on December 19, 2008,[10] and took effect on January 18, 2009, although a key portion of the rule related to certification of compliance did not take effect on that date.

The final rule virtually repeats the proposed rule, applying to health-care providers (hospitals, physicians' offices, clinics, and health departments) who receive federal funds (other than Medicare Part B only or Medicaid only in the case of physicians). Covered providers must certify that they will not discriminate against individuals or entities who refuse to perform tasks "reasonably" believed to "constitute" or "contribute to" a "morally or religiously objectionable" health-care service.[10] Certification, if it becomes effective, would be a condition of participation in any federal program (e.g., Medicare, Medicaid, or State Children's Health Insurance Program; National Institutes of Health research grants; or Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, or Health Resources and Services Administration program grants). Noncompliance amounts to a violation that can trigger both civil and criminal penalties, as well as exclusion from federal programs.[11] Surprisingly, while HHS estimated that the regulation will affect 571,947 health-care entities, it also assumed that their costs would rise by only $43.6 million annually.

Opposing comments filed by health-care organizations, representatives of state and local governments,

and the Attorneys General of 13 states concluded that the regulation was vague, unnecessary, and unworkable. Most interesting, perhaps, were comments submitted by the Equal Employment Opportunity Commission (EEOC), which had not been consulted in development of the regulation (in apparent violation of an Executive Order requiring interagency coordination).[12] The EEOC noted that the regulation was inconsistent with longstanding policy in the area of Title VII of the Civil Rights Act of 1964,[13] which prohibits discrimination on the basis of race, sex, national origin, or religion, and is contrary to recently released guidance on religious discrimination. The EEOC commented that the rule "is unnecessary for protection of employees and applicants, is potentially confusing to the regulated community, and will impose a burden on covered employers, particularly small employers."[14]

Statutory basis and reach

The rule purports to implement three federal laws: the Church Amendments[15] (named after its sponsor), Section 245 of the Public Health Service Act (PHS Act),[16] and the Weldon Amendment.[17]

The Church Amendments. Enacted following *Roe v. Wade,* the legislation prevents discrimination by recipients of certain federal funds in the case of health-care professionals who refuse to provide abortions. The central provision of the legislation bars covered entities from requiring individuals to "perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by [HHS]" if such performance or assistance "would be contrary to his religious beliefs or moral convictions."

Section 245 of the PHS Act. Section 245 of the PHS Act prohibits the federal government, and any state or local governments receiving federal funding, from discriminating against any health-care entity based on that entity's refusal to provide abortion-related services or training.

Weldon Amendment. The Weldon Amendment prohibits the allocation of certain funds to a federal agency or program or state or local government that discriminates against any health-care entity (including individuals and insurers) based on a refusal to "provide, pay for, provide coverage of, or refer for abortions."

But while all three laws address abortion (its provision, abortion training, or abortion coverage), the rule appears to extend well beyond the terms of the legislation to reach being required to perform or assist in the performance of any "procedure" that is found "objectionable" by the individual, as defined by the individual. Furthermore, the phrase "assist in the performance" is defined as participating in any activity "with a reasonable connection to a procedure, health service or health service program, or research activity," involving individuals who are members of the "workforce" of a "Department-funded entity," with the concept of activity reaching "counseling, referral, training, and other arrangements for the procedure, health service, or research activity." Furthermore, the evidence that would be necessary to make the belief "reasonable" is not defined. The term "workforce" is defined as "employees, volunteers, trainees, contractors, and other persons whose conduct, in the performance of work for a Department-funded entity, is under the control or authority of such entity. . . ."[10]

The rule clarifies the reach of the covered activities, noting that "an employee whose task it is to clean the instruments used in a particular procedure would also be considered to assist in the performance of the particular procedure;"[9] this scope remained in both the proposed and final regulation. Thus, any person who may be considered to be an employee of or contractor to any covered health-care professional or entity can refuse to perform a job function that in the view of the individual is "reasonably" connected to an objectionable procedure. The rule encompasses virtually all phases of health care.

Rather than enforcing the law through an individual complaint process, the rule reaches entities broadly by requiring prospective certification of nondiscrimination; the term "discriminate" is not defined, despite the breadth of the enforcement system, which includes penalties and sanctions for noncompliance. The rule provides variable certification requirements based on the type of entity and federal funding received. Certain providers are specifically exempted from the certification requirement, such as those whose only federal funding is through Medicare Parts B or C or through a state Medicaid program. Thus, the regulation aims most directly at hospitals and other Medicare Part A providers, as well as major research institutions. These institutions frequently are involved in many types of care that conceivably could trigger objections such as care for people with end-stage acquired immunodeficiency syndrome, or palliative-only care for infants with irreversible medical conditions such as anencephaly, or children or adults at the end of life.

IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

In requiring certification of nondiscrimination by thousands of covered entities, the rule both extends

the reach of health-care activities whose performance is subject to the scope of the rule, while at the same time providing covered entities with no guidepost regarding what is meant by "discrimination." It is conceivable under the rule that a health worker who must honor a "do not resuscitate" order sought by a dying patient can claim discrimination if barred from furnishing aggressive treatment. Because the rule lacks a definition of discrimination, health-care providers are left without direction regarding how to balance their professional ethics as well as their conflicting duties under law, particularly those related to patient privacy and autonomy. Whether requiring health-care workers to adhere to the professional standard of care or honor patients' health-care instructions amounts to discrimination remains an open question under the rule, exposing covered entities to significant potential legal liability, while potentially diminishing health-care safety and quality.

Beyond the conflicts it creates, the new regulation appears to contravene other laws, most notably Title VII of the 1964 Civil Rights Act. As with other civil rights laws, Title VII balances the rights of employees and employers by prohibiting discrimination based on religious or moral convictions, but requiring employers to make only reasonable accommodation and allowing employers to refuse accommodation when it would be an undue hardship or impose a substantial cost on the business.[18] The HHS rule contains no such balance.

The law also may create conflicts with other laws. The Emergency Medical Treatment and Labor Act (EMTALA) requires all Medicare-participating hospitals to provide screening, stabilization, and/or an appropriate transfer for emergency patients.[19] In one case cited by ACOG in its ethics opinion, a 19-year-old Nebraska woman with a life-threatening pulmonary embolism was refused a first-trimester abortion by a religiously affiliated hospital. If a similar case were to arise, would the HHS regulation permit the provider to refuse screening and stabilization care, which might entail a rapid abortion, in violation of EMTALA?

In its scope, the rule appears to move well beyond abortion, reaching services that are unrelated to abortion but potentially controversial to certain workers, such as emergency contraception or information for rape victims. The law would appear to supersede state laws barring pharmacists from refusing to fill contraceptive prescriptions,[20] such as New Jersey's law, which requires pharmacies to "properly fill lawful prescriptions . . . without undue delay, despite any [employee] conflicts due to sincerely held moral, philosophical, or religious beliefs."[21] Many also have laws requiring the provision of emergency contraception or information about emergency contraception to rape victims.[22] Furthermore, because what constitutes discrimination is unclear, whether federal law would preempt state law in such a situation remains unclear. Would covered pharmacies be discriminating if they hired an additional pharmacist to fill prescriptions that the first pharmacist will not fill, because the second hire is effectively forcing the first pharmacist to work in an environment in which objectionable prescriptions are being dispensed? Could the pharmacy ensure that the second pharmacist would be willing to dispense those prescriptions?

Finally, of course, if the federal rule reduces care below professionally accepted standards, nothing in the rule bars liability for medical negligence under state law, which may not be preempted.[23] Put another way, the fact that a health-care entity is permitting a worker to refuse to aid in a morally objectionable activity offers no defense against legal liability for injuries caused by substandard care, particularly where the concept of discrimination has never even been defined.

Whether the rule will be completely rescinded or modified remains to be seen. Importantly, the EEOC has developed a comprehensive approach to balancing worker and patient rights, and one that can guide health-care professionals and the health-care system as a whole as the fate of the 2008 nondiscrimination rule is resolved.

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