IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, *et al.* Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, *in his official capacity as Secretary of the United States Department of Health and Human Services*; and UNITED STATES OF AMERICA, Defendants.	No. 1:19-cv-04676-PAE (rel. 1:19-cv-05433-PAE; 1:19-cv-05435-PAE) **DEFENDANTS' CONSOLIDATED MOTION TO DISMISS OR, IN THE ALTERNATIVE, MOTION FOR SUMMARY JUDGMENT**
PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary, United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; and OFFICE FOR CIVIL RIGHTS, United States Department of Health and Human Services, Defendants.	No. 1:19-cv-05433-PAE (rel. 1:19-cv-0476-PAE; 1:19-cv-05435-PAE)

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; and PUBLIC HEALTH SOLUTIONS, Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services; OFFICE FOR CIVIL RIGHTS of the U.S. Department of Health and Human Services, Defendants.	)	No. 1:19-cv-05435-PAE (rel. 1:19-cv-0476-PAE; 1:19-cv-05433-PAE)

Pursuant to Rule 12(b)(1), Rule 12(b)(6), and Rule 56 of the Federal Rules of Civil Procedure, and this Court's July 16, 2019 Order, Defendants move to dismiss Plaintiffs' complaints in these related cases or, in the alternative, move for summary judgment. Although Defendants do not believe it is necessary for the Court to rule on Plaintiffs' pending motions for a preliminary injunction, Defendants also oppose those motions.

Included with this motion are Defendants' memorandum of law, the portions of the administrative record cited therein (excluding citations to the Federal Register), and a proposed order. Because this case arises under the Administrative Procdure Act (APA), Defendants have not included a Rule 56.1 Statement of Undisputed Material Facts. *See Glara Fashion, Inc. v. Holder*, No. 11 Civ. 889(PAE), 2012 WL 352309, at *1 n.1 (S.D.N.Y. Feb. 3, 2012) ("Because this case arises under the APA, the Court's decision is based on the administrative record.

Accordingly, no Rule 56.1 Statement was required to be submitted by the parties." (citations omitted)).

Dated: August 14, 2019

Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

JAMES M. BURNHAM
Deputy Assistant Attorney General

CHRISTOPHER A. BATES
Senior Counsel to the Assistant Attorney General

MICHELLE R. BENNETT
Assistant Branch Director

/s/ Bradley P. Humphreys
BRADLEY P. HUMPHREYS
(D.C. Bar No. 988057)
Trial Attorney, U.S. Department of Justice
Civil Division, Federal Programs Branch
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Counsel for Defendants

Exhibit 1

Form Approved: OMB No. 0945-0002
Expiration Date: 04/30/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

Civil Rights Discrimination Complaint

YOUR FIRST NAME	YOUR LAST NAME
[redacted]	N/A
HOME PHONE (*Please include area code*)	WORK PHONE (*Please include area code*)
	[redacted]
STREET ADDRESS	CITY
[redacted]	
STATE	ZIP / 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	LAST NAME
American Association of ProLife Ob-Gyn	

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 ag

PERSON / AGENCY / ORGANIZATION [redacted]

STREET ADDRESS	
409 12th Street SW	Washington
STATE	ZIP / PHONE (*Please include area code*)
D.C.	20024 (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*)

☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE (*select one or more*)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ 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.**

HHS-700 (10/17) (BACK)

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: 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[redacted]

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.

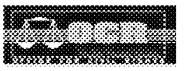
CAN I SEE MY OCR FILE?

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

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

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[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

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.

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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."

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,

[redacted]

Counsel, Thomas More Society

[redacted]

Enclosures

EXHIBIT ONE

ACOG COMMITTEE OPINION

Number 385, November 2007 *Reaffirmed 2016*

Committee on Ethics

PDF Format

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

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 nondiscriminatory. 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.

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 preovulatory 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.

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" (1). 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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EXHIBIT TWO

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February 6, 2008

AAPLOG RESPONSE TO THE ACOG ETHICS COMMITTEE OPINION #385, TITLED "THE LIMITS OFCONSCIENTIOUS 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

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[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 Obsetricia 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.

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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

[redacted]D.
Board President
American College of Obstetricians and Gynecologists
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Washington, D.C. 20090-6920
February 28, 2008

Dear[redacted]:

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,

[redacted]
President, Catholic Medical Association

[redacted]
Executive Director, Catholic Medical Association

cc.:

[redacted]
Chair, ACOG Committee on Ethics

[redacted]
c/o ACOG Ethics Committee

[redacted]
c/o ACOG Ethics Committee

EXHIBIT FOUR

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

Joint Letter of Protest

Christian Medical Association *et al*

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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."

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

> 3. "Physiciansâ€¦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 â€¦ practice in proximity to individuals who do not share their viewsâ€¦"

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,

[redacted]

[redacted]

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

EXHIBIT FIVE

Congress of the United States
Washington, DC 20515

March 14, 2008

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

Dear [redacted],

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)

Trent Franks (AZ-2)

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

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

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

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

James L. Oberstar (MN-8)

Joseph R. Pitts (PA-16)

Christopher H. Smith (NJ-4)

W. Todd Akin (MO-2)

Mike Ferguson (NJ-7)

Scott Garrett (NJ-5)

J. Gresham Barrett (SC-3)

Barbara Cubin (WY)

Jeff Fortenberry (NE-1)

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.

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:

[redacted]

The American College of Obstetricians and Gynecologists

EXHIBIT SEVEN

ABO+G

American Board of Obstetrics + Gynecology

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,

[redacted]

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.

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS (OCR)

CIVIL RIGHTS DISCRIMINATION COMPLAINT

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

Are you filing this complaint for someone else? ☐ Yes ☒ No

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

FIRST NAME	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 (or someone else)?

PERSON/AGENCY/ORGANIZATION

Washington State Department of Corrections

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

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	DATE *(mm/dd/yyyy)*
[redacted]	03/06/2018

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 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)

☐ Hispanic or Latino

☒ Not Hispanic or Latino

RACE (select one or more)

☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☒ White ☐ Other (specify): _____

PRIMARY LANGUAGE SPOKEN (if other then 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.**

HHS-699 (7/09) (BACK)

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:

[X] **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: [redacted] 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): [redacted]

Address: [redacted]

Telephone Number: [redacted]

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 rational. 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]
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 pat6ients. 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]

Hey [redacted]
FYI
Thanks,

[redacted]

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

This is [redacted]atient 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.

[redacted]

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.

ACLJ
American Center for Law & Justice

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:

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

Complaint filed on behalf of:

[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) 549-5252 (Facsimile)

could not participate in such procedures as a matter of religious belief. Her employer deliberately misled [redacted] about the nature of the procedure, and then, after [redacted] 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, [redacted] 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 [redacted] 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 [redacted] and other nurses, were only formally informed of the change in October of 2017. Thus, it is highly possible that other staff and, perhaps, [redacted] 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 [redacted] and others will attest, have a history of demeaning, belittling, and failing to respect the views of conscientious objectors.

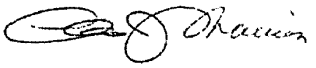
The Church Amendment protects the conscience rights of individuals and entities that object to performing or assisting in the performance of abortion or sterilization procedures if doing so would be contrary to the provider's religious beliefs or moral convictions, and prohibits discrimination in employment 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 [redacted] (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:

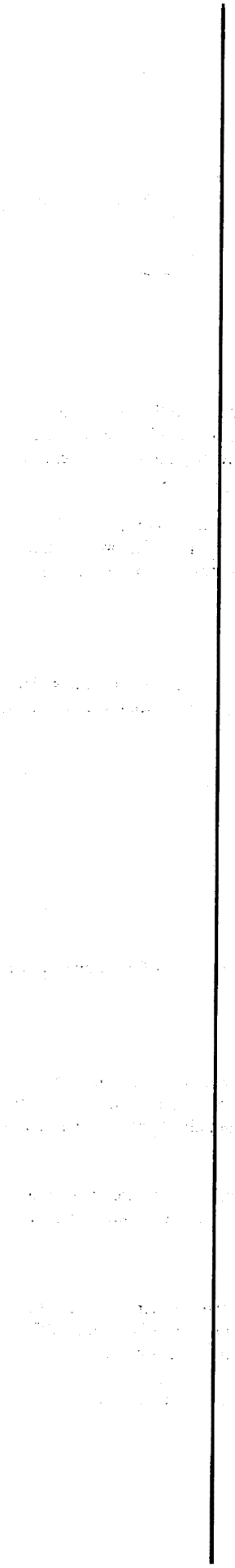
I. When the need to provide care or treatment of a patient is in conflict with an employee's cultural values, ethics or religious beliefs, the employee may request to be reassigned to other duties and not participate in the specific type of care or treatment. In the event a conflict of care arises, care 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.



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 UVMMC'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

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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 _____

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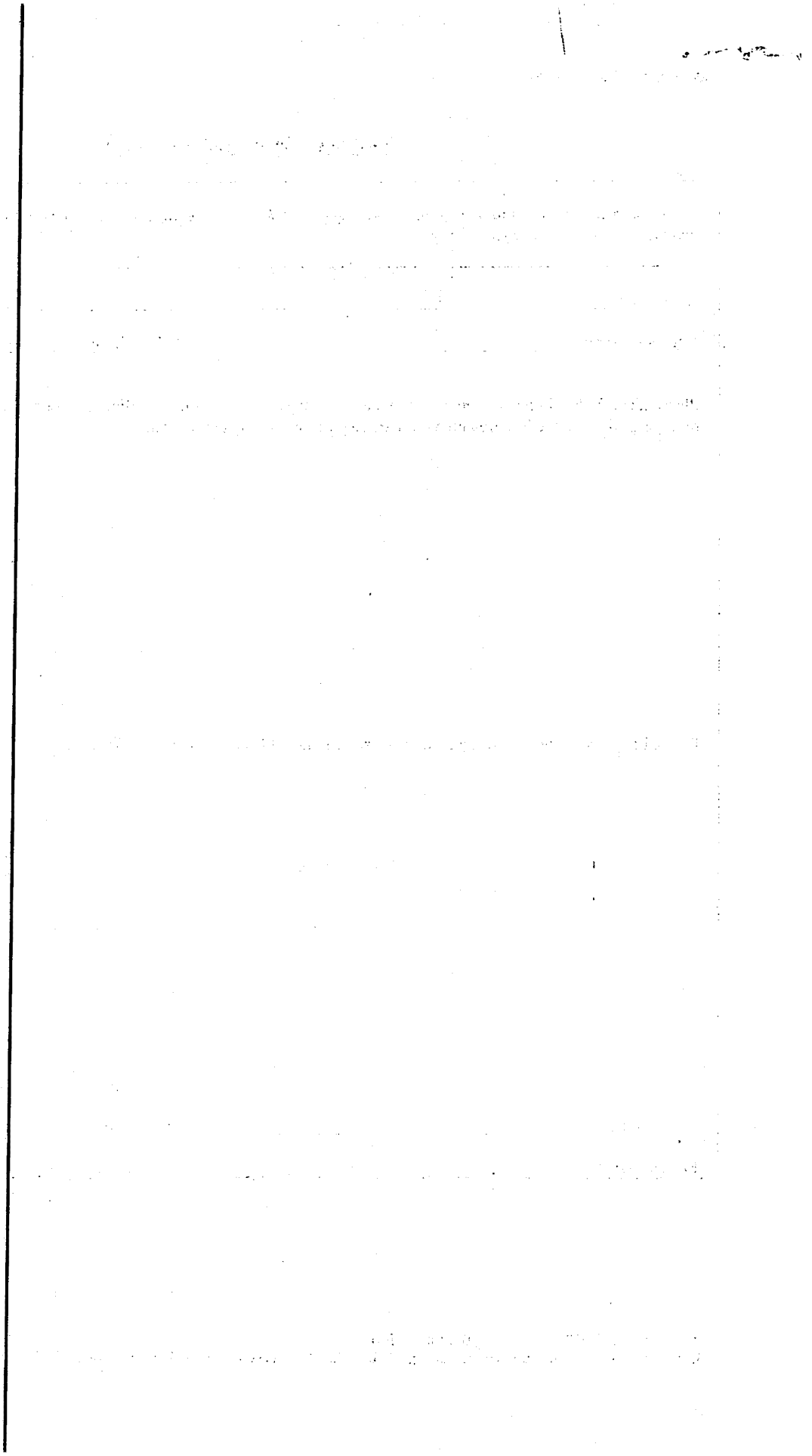

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

STATE OF NEW YORK, *et al.* Plaintiffs, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ALEX M. AZAR II, *in his official capacity as Secretary of the United States Department of Health and Human Services*; and UNITED STATES OF AMERICA, Defendants.	No. 1:19-cv-04676-PAE (rel. 1:19-cv-05433-PAE; 1:19-cv-05435-PAE) **[PROPOSED] ORDER**
PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; and PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND, INC., Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary, United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director, Office for Civil Rights, United States Department of Health and Human Services; and OFFICE FOR CIVIL RIGHTS, United States Department of Health and Human Services, Defendants.	No. 1:19-cv-05433-PAE (rel. 1:19-cv-0476-PAE; 1:19-cv-05435-PAE)

NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION; and PUBLIC HEALTH SOLUTIONS, Plaintiffs, v. ALEX M. AZAR II, in his official capacity as Secretary of the U.S. Department of Health and Human Services; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROGER SEVERINO, in his official capacity as Director of the Office for Civil Rights of the U.S. Department of Health and Human Services; OFFICE FOR CIVIL RIGHTS of the U.S. Department of Health and Human Services, Defendants.	)	No. 1:19-cv-05435-PAE (rel. 1:19-cv-0476-PAE; 1:19-cv-05433-PAE)

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 FURTHER ORDERED that Plaintiffs' motions for a preliminary injunction are DENIED.

IT IS SO ORDERED.

Dated: _____

_____
Hon. Paul A. Engelmayer
United States District Judge