Re: American Academy of Nursing Response to HHS Request for Information: Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding; due on or before 11/24/17.

The request for information (RFI) entitled “Removing Barriers for Religious and Faith-Based Organizations to Participate in HHS Programs and Receive Public Funding” indicates that the Department of Health and Human Services (HHS) is considering expanding religious exemptions in HHS programs and activities. The American Academy of Nursing is pleased to have the opportunity to comment in response to the RFI. We are concerned that rather than discussing the needs of the patients and individuals served by HHS’ programs, the RFI is exclusively focused on soliciting information regarding presumed regulatory and programmatic barriers to the inclusion of more faith-based organizations in HHS programs. Faith-based organizations do not face barriers to participation in HHS programs, and allowing additional accommodations will make it harder for women and LGBTQ people to access the services they need. Our comments consist of eight major points, delineated below.¹

1. Evidence-based standards of care directs patient care, regardless of religion or faith. Focus should be on patients and their choices and autonomy in health care.

Every nurse’s primary commitment is to the patient. In addition to providing competent, professional and high quality care, there is also an emphasis on providing patient education and support. The nursing profession holds sacred the patient’s right of autonomy, to make informed decisions to direct his or her care, as well as the crucial role that nurses play in supporting the patient. Patient education and advocacy are essential elements of the nursing process. Thus, it is the patients’ decisions, regardless of faith, that should guide healthcare providers’ care of patients, as articulated in the American Nurses Association (ANA) Code of Ethics. It fully supports the rights of patients to determine their own care:

“Respect for human dignity requires the recognition of specific patient rights, in particular, the right to self-determination. Patients have the moral and legal right to determine what will be done with and to their own person; to be given accurate, complete, and understandable information in a manner that facilitates an informed decision; and to be assisted with weighing the benefits, burdens, and available options in their treatment, including the choice of no treatment. They also have the right to accept, refuse, or terminate treatment without deceit, undue influence, duress, coercion, or prejudice, and to be given necessary support throughout the decision-making and treatment process. Such support includes the opportunity to make decisions with family and significant others and to obtain advice from expert, knowledgeable nurses, and other health professionals. Nurses have an obligation to be familiar with and to understand the moral and legal rights of patients. Nurses preserve, protect, and support those

¹ Prepared for the Academy by members Ellen Olshansky and Kaye Bender (AAN Board members) and Diana Taylor (Co-Chair, Women’s Health Expert Panel), 11/22/2017.
rights by assessing the patient’s understanding of the information presented and explaining the implications of all potential decisions.

... The limitation of individual rights must always be considered a serious departure from the standard of care, justified only when there are no less-restrictive means available to preserve the rights of others, meet the demands of law, and protect the public’s health.  

In addition, we endorse the rights of patients to make their own choices about reproductive health, and to receive complete information to assist them in making those choices, as outlined in ANA’s position statement on reproductive health:

“...the health care client has the right to privacy and the right to make decisions about personal health care based on full information and without coercion. It is the obligation of the health care provider to share with the client all relevant information about health choices that are legal and to support that client regardless of the decision the client makes. Abortion is a reproductive alternative that is legal and that the health care provider can objectively discuss when counseling clients.”

For nurses who have concerns about the provision of reproductive healthcare services, existing laws and ethical guidelines protect the rights of health care providers to follow their moral and religious convictions.

“Conscience-based refusals to participate exclude personal preference, prejudice, bias, convenience, or arbitrariness. Acts of conscientious objection may be acts of moral courage and may not insulate nurses from formal or informal consequences. Nurses who decide not to participate on the grounds of conscientious objection must communicate this decision in a timely and appropriate manner. Such refusal should be made known as soon as possible, in advance and in time for alternate arrangements to be made for patient care.

...Nurses are obliged to provide for patient safety, to avoid patient abandonment, and to withdraw only when assured that nursing care is available to the patient. When the integrity of nurses is compromised by patterns of institutional behavior or professional practice, thereby eroding the ethical environment and resulting in moral distress, nurses have an obligation to express their concern or conscientious objection individually or collectively to the appropriate authority or committee.”


2. Faith-based organizations do not face obstacles to participation in HHS programs. There currently exist regulations that protect healthcare providers for refusing to care for certain patients based religious beliefs. There is no need for additional regulations.

The RFI asks respondents to identify barriers to participation in HHS programs for faith-based organizations, but these organizations do not face obstacles to participation in HHS funded programs and activities. The Academy respects the historical role that faith-based organizations have played, and continue to play, in providing an array of important services to people and communities in need of
health care, education, social services, and other charitable services in the United States. Indeed, a number of safety-net health care providers across the nation work closely with faith-based organizations to serve the diverse and wide-ranging health, social, and economic needs of the beneficiaries they serve, and some providers involved in HHS-funded programs are themselves faith-based organizations.

The long and extensive partnership between faith-based organizations and HHS, as noted by the RFI, shows they are not facing barriers to participating. Moreover, there already exists a number of federal laws and programs that accommodate religious organizations, and a number of federal laws, including the so-called Church Amendments, Coats Amendment, and Weldon Amendment, grant religious exemptions from treating a woman seeking an abortion. Many of these religious exemptions and accommodations already threaten the health and well-being of women across the country.

What some faith-based providers have identified as barriers are nondiscrimination principles and programs, which are conditions that apply equally to all HHS contractors and grantees—religious or secular. For example, some religiously affiliated health care organizations have registered objections to fully complying with the Affordable Care Act’s broad-based prohibition on sex discrimination in health programs or activities. In addition, the United States Conference of Catholic Bishops (USCCB) has asked to contract with the federal government but not abide by the employment protections other federal contractors must follow. Specifically, the USCCB demanded broad exceptions in order to discriminate against employees because of their gender identity or sexual orientation. But nondiscrimination laws and program conditions are not barriers or discrimination based on religion. They are fundamental legal requirements from which there can be no accommodation.

3. The focus in women’s health care should be on preventing discrimination against nurses and other health care providers who DO choose to work with certain patients (e.g., assisted fertility, end of life, contraception, abortion)

As stated in number 1 above, nurses provide care for patients regardless of their religious beliefs or those of their employers or others in the health care system. There must also be protections for those health care providers who feel an obligation to care for all patients regardless of whether or not that patient’s choice is the same. The health care provider would make. Respect for conscience requires accommodation of both objection to participation in services and commitment to their delivery. Conscientious commitment may call for courage when treatment is provided that contradicts non-medical directives such as those by religious institutions and officers. Healthcare providers’ professional ethics require mutual tolerance and accommodation, however, and resistance to forces of intolerance. Institutions that would apply punitive sanctions against those whose exercising of their rights to conscience the institutions disapprove weaken the justification for protection of the exercise of conscience they require or approve.

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4. Faith-based organizations are not excluded from eligibility for HHS funding.

The RFI asks whether and how faith-based groups are excluded from HHS funding, but we do not believe that they are. Rather, faith-based organizations already benefit from unique partnership opportunities with the federal government. As mentioned in the RFI, Presidents George W. Bush and Barack Obama issued executive orders that direct federal agencies to ensure “equal protection under the laws for faith-based and community organizations” and to “strengthen the capacity of faith-based organizations to deliver services effectively to those in need.” These and other executive orders and regulations already promote federal partnerships with religiously affiliated organizations, and “ensure[ ] faith-based community groups and organizations are as equally eligible as secular groups to compete for federal funding to provide social services to the public.”

The existing executive orders considered the questions raised by the RFI. Thus, the Academy urges HHS to not create any new “accommodation” in order to ensure any potential grantee or contractor will adhere to any and all program requirements. Moreover, HHS must ensure that any HHS-funded or contracted organization provides programs or services that comport with unbiased, evidence-based standards of care. Religious beliefs should never determine a HHS program beneficiary’s access to services, and nobody should ever fear that an HHS grantee or contractor will turn them away due to religious or moral beliefs.

5. Standards already exist, developed by the American Nurses Association (ANA), for nurses to work with faith-based organizations

Nursing has a long history of working with faith-based organizations to improve and provide population health care. As evidenced by the joint ANA/Faith Community Nursing (FCN) Standards and Scope of Practice, there are existing guidelines for nurses to provide evidence-based care. The real barriers for nurses to meet these standards are in healthcare facilities where there are restrictive religious directives or in private specialty clinics that do not provide comprehensive or evidence-based care.

The HHS proposed regulations appear to be in violation of both the FCN specialty standards as well as the foundational nursing practice standards. The proposals encourage religious employers (e.g., religiously affiliated hospitals and health professional programs) to discriminate in ways that go far beyond the exemptions in current federal law, affording broad exemptions for federal grantees and contractors. These religious exemptions would be in violation of nursing ethical codes and standards of care and could allow these hospitals and clinics to hire or fire anyone who didn’t follow all of their religious teachings. And it would all be paid for by public funds.

6. Continued partnership with faith-based organizations must ensure women and LGBTQ people can access nondiscriminatory care.

The RFI asks about the proper role for faith-based organizations to participate in HHS programs. Faith-based organizations do have a long and important history of partnering with HHS to deliver vital health and social service programs. Yet some faith-based organizations also have a history of using HHS funds to discriminate and withhold needed services. LGBTQ individuals have been denied care or

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13 NAT'L WOMEN'S LAW CTR., HEALTH CARE REFUSALS HARM PATIENTS: THE THREAT TO REPRODUCTIVE HEALTH CARE (May 2014), http://www.nwlc.org/sites/default/files/pdfs/refusals_harm_patients_repro_factsheet_5-30-14.pdf. See also AMERICAN
been subject to disparaging provider behavior because of their sexual orientation or gender identity, and women have been refused services at religiously affiliated hospitals when seeking contraceptive services, sterilization or abortion care.14

Women, LGBTQ individuals, and people of color—those most in need of care due to health and health care disparities—are most affected by religious refusals. Refusals undermine the ability for individuals from these groups to access comprehensive and unbiased health care, including sexual and reproductive health information and services. Efforts by faith-based organizations or providers to limit the information and access to services that patients are entitled to receive, even when the organization may not provide those services itself, are incompatible with true consumer choice and individual decision making.

Thus, we strongly urge HHS to reinforce existing policies and practices that rightly prioritize the needs of the individuals and communities receiving HHS programs and services, including reproductive health care services. The proper role of faith-based organizations that administer health care services, social services, research, or other HHS activities is to engage in medically accurate, evidence-based, non-discriminatory, and unbiased activities. Any new or continued government collaboration with faith-based organizations should not include the sanctioning of discriminatory practices that fail to serve certain populations or deny particular services, including reproductive health care such as contraception, maternity care, sterilization, and abortion.

7. HHS should focus on the promotion of the health of the public and the assurance that program beneficiaries have access to all the services they need.

The focus of HHS’ RFI regarding faith-based organizations is both flawed and misplaced. The RFI misses the mark in two important ways. First, the RFI ignores the reality that many faith-based organizations have objections to essential health services that are the foundation of longstanding, critical HHS programs. In the arena of health care, and particularly family planning and sexual health, HHS-funded programs cannot achieve their fundamental objectives if the program contractors or grantees refuse to provide essential services, such as contraception, or discriminate against patient populations, including women and LGBTQ people.

Second, the RFI fails to consider the needs of program beneficiaries and the entities currently participating in already overburdened and underfunded HHS programs. HHS should be working to eliminate existing discrimination in HHS programs and activities, including refusals to provide reproductive health care or to serve certain populations. In addition, HHS must examine how to improve patient access to the essential health care services funded through HHS programs, which would include examining the barriers current health care providers face in meeting the needs of their patients through these programs.


The Academy urges HHS to prioritize the needs of the beneficiaries of HHS programs and the health care providers that already serve them at the forefront of any consideration of achieving HHS’ “mission of improving Americans’ health and well-being.”

8. Accommodations that cause third party harm are unlawful.

The RFI asks respondents to identify changes to HHS regulations, guidance, or other documents to “ensure faith-based organizations receive accommodation.” But, the RFI fails to ask respondents to identify the impact accommodations would have on program beneficiaries. Before creating any accommodations, HHS must consider the impact on third parties of any accommodation and may not grant an accommodation if it harms third parties.

Any accommodation that results in third party harm is unlawful. The First Amendment forbids the government from creating religious accommodations to generally applicable laws when the accommodation would have a detrimental effect on third parties. In *Hobby Lobby*, the Supreme Court made clear this same principle applies when developing an accommodation pursuant to the Religious Freedom Restoration Act (RFRA), finding that the impact on third parties must be “precisely zero.”

Final Statements:

The American Academy of Nursing urges HHS to remain religiously and morally neutral in its funding and activities to ensure that individuals do not feel proselytized by providers or receive access to a limited scope of services due the moral or religious nature of the organization.

In addition, the Academy does not agree with HHS’ statement that implies that HHS may give priority in funding opportunities to faith-based organizations over other entities. The Academy strongly urges the HHS Departments to ensure that the definition of “religious organization” is narrow and limited. The definition should delineate the factors that are to be met, so that religious organizations and their employees will know whether or not they will be subject to the accommodation. HHS should not extend the accommodation to for-profit organizations, religious health insurance issuers, or third party administrators. The religious employer exemption should not be expanded beyond the current federal definitions.

Public health programs and policies must be based on research, evidence, and medical and health-related facts, and must be responsive to individual patient and consumer needs and wishes. In order to fulfill the person-centered strategy laid out by HHS, consumers require medically accurate, evidence-based, unbiased comprehensive health care services so that they can use their own decision making capacity to choose health care services that are consistent with their individual morality and circumstances.

The Academy raises concerns that HHS is inserting concepts that run contrary to medical and health-related evidence and standards of care, and reflect one particular religious point of view.

- The Academy supports HHS’ affirmation of the importance of consumer choice and empowerment, but note that consumer choice and empowerment must be driven by fully informed, patient-centered decision making.

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17 *Hobby Lobby, 134 S. Ct. at 2760; see also id. at 2781–82.*
• Efforts are opposed to limit the provision of health information, including but not limited to when it concerns the full range of contraceptive options including sterilization, abortion, and LGBTQ-inclusive sexual health information.

• While the Academy appreciates HHS' desire to strengthen and expand the healthcare workforce, federal law provides ample protections and religious exemptions, such as the Church Amendments, for health care entities and individuals who object to providing certain services based on their religious beliefs. HHS proposed regulations cite no evidence that further protections are needed and we note that additional provisions to shield these providers from delivering evidence-based, quality medical and health-related services that meet the standard of care would be unnecessary and restrictive. All healthcare provision should be guided by clear, robust and consistent standards that are monitored and updated to reflect the best evidence and recommendations available.

• The Academy strongly urges the HHS to ensure that the definition of “religious organization” is narrow and limited. The definition should delineate the factors that are to be met, so that religious organizations and their employees will know whether or not they will be subject to the accommodation. HHS should not extend the accommodation to for-profit organizations, religious health insurance issuers, or third party administrators. The religious employer exemption should not be expanded beyond the current federal definitions.

The American Academy of Nursing is appreciative of the opportunity to comment on the RFI.

Sincerely,

[Signature]

Cheryl Sullivan
Chief Executive Officer