CATHOLIC MEDICAL ASSOCIATION

CELEBRATING 90 YEARS 1932-2022

RE: RIN: 0945-AA17 [Docket ID: HHS-OS-2022-0012]
Nondiscrimination in Health Programs and Activities, HHS Proposed Rule on Section 1557 of the Affordable Care Act

To Whom It May Concern:

The Catholic Medical Association (CMA) was established ninety years ago. Since then, there have been many occasions of frustration with governmental intrusion and obstruction in the provision of the best possible care to our patients. However, none of those episodes were as worrisome, drastic, and damaging as the impact of the NPRM Rule 1557. If these policies are finalized, it will be the most destructive blow to the American health care system in our organization's existence, and likely ever.

In the field of medicine, our commitment is to care for every individual requesting our help for their illnesses and injuries. It is an error of logic to equate "care" with psychophysical "comfort". Many patients "feel" that something is medically wrong with them and seek a medical remedy. We are committed and expected to do something *for* them. Requiring us to provide "gender-affirming care", is demanding we do something *to* them. With that logic, are we expected to provide bariatric surgery for normal weight persons who have poor body image? Are we to provide diet suppression medication for anorexic patients? The concept of an individual's "ideal body", whether related to sex or not, is personal, emotional, and highly individual. Why should their "need for comfort" supersede the health care professional's discomfort with

providing the perceived care needed. This demand is a blatant disregard for our principles and commitment, as well as for our patients' best interests.

Implementation of this rule will open a Pandora's box that will never be closed. The complications related to gender surgery are frequent and often devastating. Will Federal funds be committed to the clear and massive need for lifelong postoperative care? For those individuals who elect to detransition, will coverage be mandated for the extensive interventions and counseling required? Will the American taxpayer be expected to pay for cosmetic surgeries to masculinize or feminize these patients? Has HHS evaluated the intermediate and long-term costs of these and many other factors, or simply allowed ideology to overcome common sense and thorough consideration?

The HHS Office of Population Affairs "Gender-Affirming Care and Young People" publication is a short-sighted and close-minded discussion of a complex problem. It lacks any information regarding the widespread literature that cautions against these interventions, choosing to only cite references with an alarming absence of scientific rigor. The studies and papers cited are all considered "low quality/low certainty" in the medical community. In short, the area of "gender care" has absolutely no established standards of care that are evidence-based. The most disturbing statement is found in the introduction to the document: "*For transgender and nonbinary children and adolescents, early gender-affirming care is crucial to overall health and well-being*…" There is no data whatsoever to support this statement. Further, this indicates a complete disregard for the European experience and reports, including their uniform retreat from these interventions as a result of proven harm over the years. Suicidal ideation, suicide attempts, and completed suicides do *not* decrease as a result of these methods. There is a glaring

absence of information in the document regarding the benefits of counseling and expectant observation in gender dysphoric children. When more than eighty per cent of these children will desist with simple measures and go on to lead normal lives, why would demonstrably harmful measures be promoted? Even with adult transitions, the experience of our colleagues in the United Kingdom, Finland, and Sweden have documented the lack of evidence for benefits with mental health outcomes.

HHS refers to various organizations to support these policies. This is particularly true with WPATH, as well as the American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatry (AACAP). HHS fails to note that these organizations' statements are opinion-based, and not evidence-based. Even in WPATH's oft-referenced "Standards of Care Volume 7", gender-focused interventions are described as "flexible clinical guidelines". In essence and fact, WPATH is offering suggestions, not science. HHS is mistaken if it believes that the damages resulting from these policies can be hidden by or attributed to these medical groups. The public will readily recognize the callous disregard for science by HHS.

At the practical level, implementation of the proposed rule will devastate the availability and quality of health care in America. Physicians and others who object to these methods, whether on the basis of conscience or religion or professional judgment, will leave their professions. Potential physicians and others will alter their career plans and enter non-medical fields that respect their principles and beliefs. This erosion of workers will lead to closures of clinics, followed by hospitals. The greatest impact will be on the poor and minority communities, where the need is most dire. Is HHS willing to mandate care for less than one per

cent of Americans and eliminate care for the large population that depends on it?

The large majority of the surgical procedures involved in gender-based intervention are significant and non-standardized. Does HHS understand the processes that preparation for major surgery requires? A surgeon will not agree to operate, nor will an anesthesiologist agree to participate in the surgery, unless the patient is medically cleared by their primary care provider and/or another specialist. If the individual's medical status is deemed too high risk for surgery, will the non-surgeon be accused of discrimination and punished? Further, given the clear record of significant risks and potential complications with these surgeries, will HHS subsidize the additional liability coverage premiums that surgeons will predictably have to pay? Has HHS projected these costs related to the extra interventions needed as a result of complications, malpractice claims, and the loss of health care professionals willing to provide these ill-advised procedures?

Within the text of the Rule 1557 NPRM, HHS states that it is "…*fully committed to respecting conscience and religious freedom laws*…" Given HHS' history with such issues, its credibility is exceptionally thin. If that statement were true, why are the Little Sisters of the Poor still a target? Why does HHS support hospitals that force conscientiously objecting nurses to participate in abortions? Why are adoption agencies founded on Christian principles without protection from HHS? Truly, actions speak louder than words, and HHS' words ring hollow in this NPRM.

It is disappointing that HHS plans to ignore its own mission, which states that the agency is intent on "…*fostering sound, sustained advances in the sciences*…" The policies proposed are bereft of any

scientific basis in fact. Rather, HHS seems focused on ideology and political interests. Our CMA members did not enter the medical field as a result of our ideology or political views. We do not need to be monitored for possible discrimination. Our commitment is to take care of the person in front of us, without regard for their circumstances. We readily accept the need to have difficult discussions with our patients, and as a result of an open patient-physician relationship, they will know that we have their best interests in mind. Equating identity terminology with biology and science is a grave error. Forcing us to provide interventions that we know are wrong and harmful violates our conscience, disrespects our extensive education, and most profoundly, worsens our patients' lives. If this rule is finalized, is HHS prepared to provide funds for those patients and families who demand reparations for the harms done to them? Harms that resulted from requirements imposed by non-medical government bureaucracy. It is a mistake to propose these policies. It would be a monumental error and lack of thoughtful foresight to implement them. The harm done by them will be seen for generations to come.

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