Christian Medical & Dental Associations®
Changing Hearts in Healthcare

October 1, 2022

Via Federal eRulemaking Portal

Secretary Xavier Becerra
U.S. Department of Health and Human Services, Office for Civil Rights
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue S.W.
Washington, DC 20201

Re: The Christian Medical & Dental Associations Comment Opposing Proposed Rule Section 1557 Nondiscrimination in Health Programs and Activities
RIN: 0945-AA17, Docket ID: HHS-OS-2022-0012

Dear Secretary Becerra:

The Christian Medical & Dental Associations® (CMDA) founded in 1931 is the largest Christian membership organization comprised of healthcare professionals serving throughout the United States and overseas. We provide programs and services supporting its mission to "change hearts in healthcare." CMDA promotes positions and addresses policies on healthcare issues, and advocates on behalf of its members. We educate our membership on current issues of the day from a federal and state perspective. We coordinate with our network of Christian healthcare professionals for fellowship and professional growth; and we sponsor student ministries in medical and dental schools across the country. Our members provide excellent care for all patients for everything from cancer to the common cold.

Our overseas work is also far-reaching. We conduct short-term medical missions to medically underserved regions of the world and provide healthcare consisting of medical, dental, and surgical teams. In addition, our overseas focus includes our Medical Education International (MEI) program. This short-term mission program provides academic teaching and clinical training upon request from governments, healthcare professional training institutions, and hospitals while building relationships with local colleagues and modeling compassion and care. MEI serves primarily in low- and middle-income countries.

We respectfully submit comments regarding the Notice of Proposed Rulemaking (NPRM) of Section 1557 of the Affordable Care Act.[1] We are in opposition to the extensive revision of the definition of discrimination on the basis of sex, of which the proposed rules states, "Discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of

[1] Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47824 (proposed Aug. 4, 2022).

sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity."

If the proposed regulations are adopted, it will require healthcare professionals not currently protected by a court order to offer on demand controversial and experimental gender transition services such as surgeries, prescribing puberty blockers and cross-sex hormones (including for children), and abortion regardless of one's personally held religious beliefs, and in conflict with the Hippocratic Oath and a professional's own medical judgment. These treatments would be mandated despite a growing body of research and personal testimonies (which the Department neither acknowledges nor addresses) showing that there are significant, often lifelong medical risks that come with gender reassignment therapy. The proposed rule also broadly states that "a provider's view that no gender transition or other gender-affirming care can ever be beneficial for such individuals (or its compliance with a state or local law that reflects a similar judgment) is not a sufficient basis for a judgment that a health service is not clinically appropriate."

As an organization representing thousands of medical professionals, CMDA would counter this premise. Many healthcare professionals—based on their training, expertise, and best medical judgment—view gender transitions as experimental, harmful, irreversible, insufficiently explored by adequate (much less robust) academic medical studies, and conflicting with their conscience freedoms and best medical judgment. The rule also requires insurance to cover these controversial services. As is, this directive is an egregious violation of a healthcare professional's medical judgment and is an example of government overreach that interferes with the doctor/patient relationship. We strongly urge the Department to reconsider moving forward with a regulation that is in stark contradiction to religious liberty, the best available evidence, and rights of conscience, and that infringes on medical judgment—harming medical professionals and patients alike.

Religious Freedom/Rights of Conscience

The Department's intention to override and disregard the medical judgment and religious objections of healthcare professionals is out of alignment with the history of religious freedom in this country and controlling precedent. Furthermore, the Department has failed to justify its position that forcing objecting medical professional to provide services that they believe will harm the patient is the least restrictive means of accomplishing the Department's policy objective.

On August 26, 2022, after the Department published the Section 1557 NPRM, the Fifth Circuit Court of Appeals issued its latest opinion in an ongoing case, *Franciscan Alliance v. Becerra*[2] upholding the district court's decision that the Department's interpretation of Section 1557 violates the Religious Freedom Restoration Act (RFRA).[3] The Fifth Circuit also upheld the district court's decision that Franciscan Alliance and CMDA are entitled to a permanent injunction not just from the Department's 2016 rule, but also from any interpretation of Section

[2] *Franciscan All., Inc. v. Becerra*, 47 F.4th 368 (5th Cir. 2022).
[3] *Franciscan All., Inc. v. Becerra*, 553 F. Supp. 3d 361, 378 (N.D. Tex. 2021), amended, No. 7:16-CV-00108-O, 2021 WL 6774686 (N.D. Tex. Oct. 1, 2021).

1557 that would impose similar requirements, including any future regulations promulgated under Section 1557.

As a result, should the Department move forward with finalizing this proposed rule, all current and future members of CMDA are protected from its enforcement in a way that would violate our members' best medical judgment and conscience. Our members are free to exercise their conscience and medical judgment.

Nonetheless, for anyone not protected by a court order, the Department's proposal remains deeply problematic. The Department's stated intent to enforce its mandate against entities with religious objections remains in conflict with the opinions of multiple federal courts. The Department should instead confirm that those with religious objections are exempt.

An additional flaw in the Department's proposal is that it imports the nondiscrimination requirements of Title IX while explicitly refusing to also incorporate the religious exemptions contained in Title IX.[4] In doing so, the Department asks for blind trust that, despite refusing to incorporate time-tested conscience protections, the Department will remain "fully committed to respecting conscience and religious freedom laws when applying this rule."[5]

The Department has earned no such trust from the American people. First, the Department has repeatedly failed to enforce on behalf of medical professionals the dozens of conscience laws passed by Congress. Second, even while it offers false assurances of respect for religious conscience, the Department currently has an NPRM pending at the Office of Information and Regulatory Affairs (OIRA) that would rescind a regulation meant to increase its accountability for enforcing existing federal conscience statutes.[6]

We see the NPRM as violating (at least) the following laws:

***Religious Freedom Restoration Act* of 1993**, 42 U.S.C. 2000bb et seq.

- RFRA enforces the First Amendment's protection of religious freedom from government interference.
- The federal government cannot force a healthcare professional's engagement in activities that substantially burden religious exercise without an exception "of the highest order."
- The "highest order" exception must prove two points:
    1. That there is a "compelling government interest" involved in enforcing this requirement.
    2. That the government cannot accomplish this goal in a manner less burdensome to your religious beliefs.

Section 1557 proposed rule fails both requirements: there is no convincing government interest

[4] 87 Fed. Reg. at 47840.
[5] *Id.* at 47841.
[6] OIRA, Rescission of the Regulation entitled "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," *available at* https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=202204&RIN=0945-AA18 (last visited Oct. 3, 2022).

in enforcing therapy that is neither proven safe nor effective, and there are other far less burdensome means to accomplish the goal of assistance for the sexual minorities in question.

The Church Amendments **to the 1973**, Public Health Service Act, Public Law 93-348, § 214.[7]

- It applies to and prohibits discrimination against or coercion of healthcare professionals and hospitals who object to performing abortions, sterilizations, assisted suicide, and other procedures or services due to religious or moral convictions.
    - The result of using puberty blockers, cross-sex hormones, and surgeries removing healthy body parts ultimately results in sterilization.
- The Church Amendments protect personnel who object to performing or assisting with *any lawful health service* based on a person's religious beliefs or moral convictions.
    - Healthcare professionals are protected from being mandated and coerced into providing services if it goes against their religious beliefs even if the service is legal.

Transgender, medical science and the law

As previously stated under religious freedom/conscience violations, the following laws also protect healthcare professionals from being coerced into providing "gender affirming care". The **proposed Section 1557 rule is contrary to established law and legal precedent.**

- The Church Amendments to the 1973 Public Health Service Act, Public Law 93-348, § 214.[8]
- Religious Freedom Restoration Act of 1993.[9] [10] Beginning at 42 U.S.C. § 2000bb.

This proposed rule also violates ACA Section 1554, 42 U.S. Code § 18114 - Access to Therapies

- Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that:[i]

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
(2) impedes timely access to health care services;
(3) interferes with communications regarding a full range of treatment options between the patient and the provider;
(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care
(5) violates the principles of informed consent and the ethical standards of health care professionals; or
(6) limits the availability of health care treatment for the full duration of a patient's medical needs.

[7] ADF's "A Legal Guide for Healthcare Professionals. 2016. http://tinyurl.com/wtnybnn.
[8] ADF's "A Legal Guide for Healthcare Professionals. 2016. http://tinyurl.com/wtnybnn.
[9] http://tinyurl.com/webhr36.
[10] ADF's "A Legal Guide for Healthcare Professionals." 2016. http://tinyurl.com/wtnybnn.

The NPRM refers to "gender affirming care" numerous times. "Gender affirming care" is not a medical term, and the Department has failed to define the term and to support its definition with unbiased medical evidence.

"Gender affirming care" or using experimental and unproven interventions (surgeries/hormones) on at-risk youth who may be gender dysphoric or may have underlying mental health issues is a dangerous undertaking. G(T)AHC is not the standard of care, does not reduce suicide and (GAHC) is lifelong. Furthermore, chemical sterilization and surgery on a healthy body part is not healthcare.[11] [12] [13]

In regard to "gender affirming care", often the assertion or justification for performing these procedures is to reduce suicidality, including with children. In an article written by renown expert, Dr. Andre Van Mol these sexual orientation change efforts (SOCE) are based on a flawed study. An excerpt from the article says "A response letter led by Christopher Rosik (including Paul Sullins, Walter Schumm and me) was also published in the *American Journal of Public Health*.[2] Three main study flaws were noted. First, the authors lumped adverse childhood events as a total sum, including SOCE as one. Second, they should have considered whether those seeking SOCE did so due to already being more distressed. With no pre-SOCE control for existing suicidality, it was speculative for Blosnich to suggest SOCE caused harm. And third, the Generations study sampled only LGBT-identified individuals—therefore excluding sexual minorities who benefitted from SOCE, thus no longer identifying as LGBT—and used "a single-item measure of SOCE" which was "fraught with validity concerns."

Other experts/organizations raise caution about unilaterally adopting "gender affirming care" as a medical standard of care. One such organization is the Society for Evidence Based Gender Medicine (SEGM). This organization earlier this year (April 2022) published a piece called "Fact-Checking the HHS". The article states "The HHS accurately describes "gender-affirming care" as a series of interventions that are "*aligning the outward, physical traits with their gender identity*" through a cascade of progressively irreversible interventions starting with social transition, proceeding to endocrine interventions (puberty blockers and cross sex hormones) and culminating in surgery. Unfortunately, a number of the claims made in the document range from overreaching to highly misleading. They go on to say "This incomplete representation of the relevant issues is likely to mislead the public to believe that this is the best and only alternative,

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[11] James M. Cantor (2019): Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy, Journal of Sex & Marital Therapy,
[12] DOI:10.1080/0092623X.2019.1698481
de Vries, A. L., and P. T. Cohen-Kettenis. 2012. Clinical management of gender dysphoria in children and adolescents: The Dutch approach. Journal of Homosexuality 59(3): 301–320.
[13] Michael Laidlaw, Michelle Cretella & Kevin Donovan (2019) The Right to Best Care for Children Does Not Include the Right to Medical Transition, The American Journal of Bioethics, 19:2, 75-77, DOI: 10.1080/15265161.2018.1557288

particularly when no other alternatives are mentioned. The public is also likely to erroneously assume that the risks of affirmative care are low. Patients and families are not capable of providing valid informed consent when the information they receive is inaccurate and incomplete".

Another organization with great concerns with the current trend in the United States of some unquestioningly providing "gender affirming care" is Rethink Identity Medicine Ethics. In a recently released resource, The Facts About "Gender Affirming Care" (GAC) for Children and Adolescents, it refutes the claim of the "safety" and "medical necessity" of GAC. There is an assumption that "GAC is proven "safe" and leads to better mental health outcomes for children and adolescents who identify as transgender or who are diagnosed with gender dysphoria. In fact, an excerpt of the publication, states "Several recent European systematic reviews of evidence on GAC came to similar conclusions. Public health authorities in the UK, Finland, and Sweden all concluded that there is insufficient evidence to support the claim that either puberty blockers or cross-sex hormones provide mental health benefits for gender dysphoric children and adolescents. The Swedish health authority, for example, came to the stark conclusion that "the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases."

In claim #4 on the World Professional Association for Transgender Health (WPATH) The WPATH (World Professional Association for Transgender Health) "Standards of Care Volume 8" 2(SOC), clearly states that the "standards" are merely "flexible clinical guidelines" for "promoting optimal healthcare and guiding the treatment of people experiencing gender dysphoria." In addition, the SOC specifically sets an expectation that "individual health professionals and programs may modify" the suggested protocols. "As such, the WPATH SOC cannot be viewed or used as authoritative medical standards of care. They are merely practice suggestions".

Also, of note in WPATH's new guidelines version 8, page 9, Gender Dysphoria it states that "While Gender Dysphoria (GD) is still considered a mental health condition in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5-TR) of the American Psychiatric Association, gender incongruence is no longer seen as pathological or a mental disorder in the world health community. Gender Incongruence is recognized as a condition in the International Classification of Diseases and Related Health Problems, 11th Version of the World Health Organization (ICD-11). Because of historical and current stigma, TGD people can experience distress or dysphoria that may be addressed with various gender-affirming treatment options". This statement is highly problematic and ambiguous. There is no clear definition or goal in dealing with the psychological issue of gender dysphoria.

CMDA expresses concern that standards dictated by WPATH, a non-medical group widely relied on in the rule, is setting "standards of care". We would encourage the department to not rely upon activist groups with a clear ideological agenda in place.

Finally, the Department has failed to give a cost estimate to insurance companies, healthcare professionals, facilities, and businesses of mandating these services. The Department has ignored the enormous negative impact on society at large if this rule is promulgated.

Conclusion

Healthcare professionals with religious or moral objections often face discrimination. It is common that medical students or other health care professionals face discrimination for declining to participate in procedures to which they have moral or religious objections. If professionals feel coerced in the workplace, it will likely deter people of faith from entering the medical profession if they are fearful that their ability to practice medicine according to their conscience is not protected.

If this NPRM proceeds as proposed, healthcare professionals of faith will not be assured protections to practice medicine conscientiously, as they may feel may coerced to perform procedures or prescribe medications that violate their deeply held religious beliefs and moral convictions. This will result in decreased access to healthcare professionals, services, and facilities for patients in low-income and rural areas. A very real risk of worsening the maternal health crisis due to declining access to care if healthcare professionals are forced out of medicine if their ability to practice conscientious medicine is not upheld.

Another potential result if this NPRM proceeds is a significant decrease in access to healthcare for the poor and medically underserved populations. In the survey commissioned by CMDA three in five (62%) of those surveyed are "currently involved in **serving poor and medically-underserved populations**, either domestically or overseas. "Nearly **three in five** (58%) are "involved in **serving patients on a volunteer or pro-bono basis** in the past 3 years."

Sincerely,
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Appendix A

Basis for Conscience Freedom

America's founding documents confirm the biblical assertion of freedom of conscience, asserting conscience as a fundamental human right.

a. "We hold these Truths to be self-evident, that all Men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the Pursuit of Happiness -- That to secure these Rights, Governments are instituted among Men, deriving their just Powers from the Consent of the Governed, that whenever any Form of Government becomes destructive of these Ends, it is the Right of the People to alter or to abolish it, and to institute new Government, laying its Foundation on such Principles, and organizing its Powers in such Form, as to them shall seem most likely to affect their Safety and Happiness.
b. "Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances." -- Amendment 1, U.S. Constitution

Appendix B

CMDA Members 2019 Survey

The Christian Medical & Dental Associations (CMDA), the nation's largest faith-based association of health professionals, released findings of a national survey showing that conscience-protecting laws and regulations help protect patient access to healthcare while addressing rampant discrimination against faith-based health professionals.

The survey, a nationwide poll of faith-based health professionals, conducted by Heart and Mind Strategies, LLC, found that 91 percent said they would have to "stop practicing medicine altogether than be forced to violate my conscience." That finding holds significant implications for millions of patients, especially the poor and those in underserved regions who depend upon faith-based health facilities and professionals for their care.

The survey of faith-based health professionals also found that virtually all care for patients "regardless of sexual orientation, gender identification, or family makeup, with sensitivity and compassion, even when I cannot validate their choices." The finding puts the lie to the charge that somehow conscience protections will result in whole classes of patients being denied care.

"Faith-based health professionals actually seek out and serve marginalized patients to provide compassionate care," explained CMDA CEO Emeritus Dr. David Stevens. "All we ask as we serve is that the government not intrude into the physician-patient relationship by dictating that we must do controversial procedures and prescriptions that counter our best medical judgment or religious beliefs."

Appendix C

Key Findings of 2019 Survey

In 2019, the Christian Medical and Dental Associations (CMDA) conducted a survey of its 19,000 members throughout the country on several issues including rights of conscience. The following are some of the key findings.

1. *Faith-based health professionals need conscience protections to ensure their continued medical practice*. Of those surveyed **91% would stop practicing medicine without conscience protections**.
2. *Conscience-driven health professionals care for all patients*. **97% care for all patients regardless of agreement with patients' choices, including sexual orientation, gender identification, etc.**
3. *Religious health professionals face rampant and increasing discrimination, please see a few examples:* **76% Responded in the affirmative to the question** "Over the course of your professional experience, has the number of medical professionals being pressured to compromise their moral, ethical, or religious beliefs in their practice increased, decreased, or stayed the same?" (Q250)

   60% Common "that doctors, medical students or other healthcare professionals face discrimination for declining to participate in activities or provide medical procedures to which they have moral or religious objections."(Q210)

   36% "Experience pressure from or discrimination by faculty or administrators based on your moral, ethical, or religious beliefs. (Q255)

As a part of the 2019 Survey of faith-based health professionals, the following are Policy findings in reference to Conscience regulation:

Q225 "Conscience protection for medical professionals who decline to participate in healthcare procedures, like abortion, assisted suicide and transgender procedures and prescriptions, to which they object on moral or religious grounds. 97% necessary

Q230 "If this new conscience protection regulation is eliminated, which of the following effects do you feel it could have on the medical profession?"
Fewer doctors practicing medicine. 70%
Decreased access to healthcare providers, services, facilities for patients in low-income areas. 60%
Decreased access to healthcare providers, services, facilities for patients in rural areas. 60%

Q235 "If conscience protection for medical professionals was eliminated. This means professionals who decline to participate in healthcare procedures, like abortion, assisted suicide and gender reassignment surgery, to which they object on moral or religious grounds are forced to participate in these procedures or face legal action." 56% would limit their practice.

The protections afforded for healthcare professionals of rights of conscience as the current rule stands. We are surprised and somewhat puzzled that the U.S. Department of Health and Human Services would attempt to rescind the protections currently afforded to healthcare professionals of faith. The potential recission of this rule seems to counter The First Amendment which sought

to protect religious belief and practice from heavy-handed intervention by allowing people to follow their conscience and their organizations to follow their religious and ethical values. Polling of our membership supports that this rule is an absolute necessity and ensures that medical professionals are not coerced by government to violate their deeply held religious convictions. Enforcing conscience protections safeguards patient access to healthcare--by stemming a potential forced exodus from medicine by faith-based and pro-life professionals and organizations. Our survey of faith-based health professionals from August 2019 provides hard data that documents this point.

Appendix D

CMDA Member Healthcare Conscience Testimonies

The following anecdotes are personal testimonies from members of CMDA. These personal stories demonstrate the challenges that faith-based medical professionals face every day serving on the front lines. Without the assurance of conscience protections in place, these challenges will only increase and will undoubtedly drive many healthcare professionals out of medicine completely.

I am writing as a Physician Assistant who wants rights of conscience protected for all healthcare providers in the United States. I have been a PA since 2013 and have worked in four different settings: Internal Medicine, Obstetrics and Gynecology, Pulmonary, and now Oncology. PAs are known for being able to transition into various fields of healthcare and in my roles in each of these diverse areas, right of conscience is pivotal.

First, while working in outpatient internal medicine setting, I had a transgender patient ask me to prescribe him hormones to transition to the female gender. With his multiple psychological comorbidities, I recommended he start with intensive psychological treatment prior to even considering hormonal therapy. I used my right of conscience, and my patient respected my decision.

In women's health, I refused to place IUDs (intrauterine devices) because my conscience compels me that these devices could be abortifacients. My employer respected my beliefs. I also refused to refer any patients to abortion services and both my employer and patients understood my convictions.

It doesn't matter in what setting you practice medicine. Ethics always come into play, and I cherish the ability to practice medicine as my deep-held beliefs and the original Hippocratic oath urges, "First do no harm." I want to continue to practice medicine this way.

M.S. PA-C (Georgia)

As an intern, the opportunity to get into the operating room was a great privilege, as most of our time was spent in labor and delivery or the clinic. I was the only intern who declined to perform elective abortions, and I made it clear that it was because of my Christian convictions. One of my fellow interns was frequently given the privilege of scrubbing in on surgical cases. I questioned my chief resident as to why I wasn't being given that opportunity and she replied that she was "working hard doing the abortions" and had earned this privilege whereas I had "refused" to do this work and hence did not "get the perk".

Later in my residency, I was the chief of the obstetrical service and was thus responsible for the care and management of all the obstetrical patients on the clinic service. We had a patient at the time whose baby was diagnosed with Down syndrome, and the mother had decided to abort. Since she was so far along, she was to have labor induced and was to be managed on the obstetrical floor. I spoke with my attending physician and told her that I could not, in good conscience, participate in this patient's care because of my Christian values. I explained that I had made arrangements with another resident who was willing to oversee this patient's care in my stead. The attending proceeded to reprimand me loudly in front of my team of residents,

interns and medical students. She accused me of abandoning my patient, of shirking my responsibilities, and being insensitive to my patient. Not once did she acknowledge that I had a legitimate right to take such a stand. During private practice, I have not experienced such blatant examples of religious discrimination but have certainly felt 'snubbed' or dismissed for my faith.

In general, there has not been a collegiate atmosphere of mutual respect for differing stances. Practicing medicine under the covering of right of conscience invokes the use of moral and ethical standards such as those found in the Bible and the Hippocratic Oath.

We are medical PROFESSIONALS, not providers, because we profess to certain standards that provide the basis for a covenantal relationship with patients designed to protect them from harm and to seek their highest good. One of the first things medical students learn is Primum non Nocera, or "first do no harm." The essence of the doctor-patient relationship is based on the sacred trust that your doctor will always act in your best interest. Within the safety of this covenant, patients have the confidence and security of knowing that this physician will consistently make decisions that are their best interests and not based upon expediency, money, or other unethical pursuit. Similarly, physicians are not vending machines, and the doctor-patient relationship is not a business transaction.

Right of Conscience is not just the right to refuse to perform services that are morally objectionable, but also the right to do what is best for the patient. For example: a physician declines to perform abortion based upon the truth that human life is precious, that it is God-given and based upon the knowledge that abortion brings harm to the woman - physically, psychologically, and spiritually, as well as sure death to the baby. These convictions are not based upon feelings, but on deeply held values that form the basis for how life is lived and therefore medicine is practiced.
MD, FACOG (Maryland)

I am a palliative care physician in Knoxville, Tennessee. I have the opportunity to walk with patients and families through some of the most difficult experiences of their lives and at times, very complex and difficult ethical situations. I maintain a strong faith and it serves as my inspiration to serve others as they face life threatening illness and death.

If I were to be compelled to violate my conscience and beliefs, I would rather walk away from this field or find a different way to serve without violating my conscience and beliefs. I welcome and strongly support legislation helping protect my beliefs and right of conscience. Such legislation also protects my patients from losing a well-trained and compassionate physician when there are so very few of us in the field of palliative care.
AMD (Tennessee)

I am a Family Medicine physician currently living in Columbia, South Carolina. My husband and I are originally from Oklahoma. While living in Tulsa I worked for a university as the campus physician. They hired me without asking my stance on contraceptive management, "emergency contraception", or referrals for abortion. I was fairly young and had only worked with a Christian group, so I did not even think to ask about that.

They pressured me multiple times to sign a standing order for the morning after pill and even brought a counsel of University Administration to try to pressure me into it. I was threatened that I'd lose my job if I did not sign for it. I stood my ground and did not end up losing my job, but it was incredibly stressful. I had gone to medical school and residency, 7 years of training, and the university administration thought they should be able to dictate how I practice medicine.

If physicians are not able to practice in a way that is in line with their conscience, fewer people are going to go to medical school, and more doctors are going to retire early. In a world where we already have a shortage of doctors, the access to care will further decrease. Personally, I refuse to work in any setting where I am required to be involved in ending a life in any form or fashion.
M.D. (South Carolina)

As a physician, I have witnessed the erosion of my profession over the last 30 years. We have become technicians instead of caring professionals. We are now part of the greater mob of "health care providers" with cash registers in our consultation rooms (the electronic medical record). Now the final blow is to rob us of our conscience in our care for the patient because our thoughts and practice do not conform to the collective. It began with algorithms that come from on high that say that a particular drug, X-ray study or procedure are "not medically necessary" and this is communicated to us by a computer generated form or worse, someone wearing a headset and reading the rules out of a notebook while sitting thousands of miles away.

Please restore the humanity of medicine by insisting that our rights and conscience freedoms need to remain intact while we care for our patients. Do you really want your physician so compartmentalized that they are disconnected from their hearts while listening yours?
M.D. (Colorado)

I am a hospital medicine doctor practicing in Columbus, Ohio. I am very concerned about rights of conscience protections for my medical practice. I enjoy my job as a hospitalist, providing care for a diverse range of patients from across Ohio. I am concerned that I am protected against providing medications that would actively speed death in patients with poor prognosis. It is important to me that in terminal situation that I not be forced to be a party to assisted suicide. I am also concerned that I should not be coerced to prescribe abortifacient drugs that may harm a fetus if the primary purpose is not the immediate preservation of the mother's health and life.

Finally, in the case of those patients who take hormonal treatments for the purpose of gender transition, my conscience will not allow me to participate in further assisting their desires to change gender identification with the assistance of chemical means. I believe I can best care for my patients if my rights in these reservations are respected.
M.D-American Board of Internal Medicine Certified Practicing Hospital Medicine (Ohio)

As a practicing family physician for over 28 years, I am witnessing a slow erosion of freedom pertaining to physician's right of conscience in our country. Shifts in our culture have promulgated this:
a.) Doctors are seen less as professionals and more as "providers" ready to meet "customers'" needs.

b.) There has been a move from small, independent practices to large, employed groups which are part of a "Health System" that subjects professionals, for better or worse, to that culture's mandates and expectations.
c.) We live in a postmodern world where truth and "common sense" are increasingly unrecognized by communities. Individual opinions, at times, can be granted the weight of experts.
d.) We live in a divisive culture focused more upon obtaining and keeping power than upon respecting and considering valid minority dissent.
e.) We are losing the ideology of sacrificing for the common good.
f.) We no longer view right and wrong, as a society, as an inherent mandate from God Almighty, but rather as being determined by the individual.

Considering these cultural shifts, well-intentioned, compassionate medical professionals, many who are people of faith who seek to practice within the bounds of their own conscience, will be at risk of being penalized. When a physician declines to be a "team player" in a decision because it has the potential to cause harm to an individual, family, or even the community at large, that doctor may be labeled with "weaponized words" and shown the door. Will physicians one day lose their jobs for acting in good faith, or lose their medical licenses because they disagree with a plan of care demanded by the patient or health system? Without some type of conscience protection, physicians will be at risk of being crushed into the mold of political correctness at the expense of their conscience and integrity.

Physicians must have the freedom to do what they feel is truly best for the patient while maintaining their own conscience before our Creator. This type of freedom has been an American virtue throughout our country's history and is now in jeopardy. Sometimes saying "no" to a patient's request is the most compassionate option for a patient. If we truly value integrity in the practice of medicine, it is vital to protect medical professionals' rights of conscience. By doing so, our world is not degraded, but rather enriched.
MD FAAFP (West Virginia)

I can say that as a medical instructor, the majority of our students are clearly hoping that they will graduate and find a job within a world where they can work according to their conscience. I just completed testing 47 students on how they would provide patient education regarding various genetic issues, including inherited cancer syndromes, genetic testing for diseases in the pediatric population, assisting couples with questions regarding in vitro fertilization and genetic screening options, how genetic tests are utilized in the U.S. and globally, etc. This test was partially written and partially oral. In both the written and oral sections students brought up ethical issues they were struggling with. (This is a state university!) Some students specifically asked, "If I feel that this is wrong, will I be able to tell the patient that I cannot support it and refer them to someone else? Do I have the right to say "I cannot provide that service for you?"

This was a genuine concern for these students and at least 90% stated they were personally concerned about CRISPER and genetic manipulation, several stated that they were concerned about the disappearance of Down Syndrome, 100% stated that they were concerned about loss of diversity and the errancy of assuming you can "make things turn out ok" with genetic selection.

Several students linked things to WWII selectivity's and to China and their male/female selection, etc., even though these things were not a part of my instruction to them regarding medical genetics. They are watching and concerned!

When I asked the students, "Do you want the provider who is caring for you to have a conscience or to be willing to work with a conscience?", 100% responded that for their personal care, they want a provider who practices with their conscience because they believe that that provider would be more likely to truly have their best interests in mind. If the provider does not practice with a conscience, they will not care if the patient is receiving the highest quality of care or not, instead they will likely do the easiest thing--the path of least resistance.
[Professor at a Kansas State University]
