AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

PROTECTING THE RIGHTS OF CONSCIENCE OF HEALTH CARE PROVIDERS AND A PARENT'S RIGHT TO KNOW

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

JULY 11, 2002

Serial No. 107–126

Printed for the use of the Committee on Energy and Commerce

Available via the World Wide Web: http://www.access.gpo.gov/congress/house

U.S. GOVERNMENT PRINTING OFFICE

80–684PS WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

W.J. "BILLY" TAUZIN, Louisiana, *Chairman*

MICHAEL BILIRAKIS, Florida
JOE BARTON, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
PAUL E. GILLMOR, Ohio
JAMES C. GREENWOOD, Pennsylvania
CHRISTOPHER COX, California
NATHAN DEAL, Georgia
RICHARD BURR, North Carolina
ED WHITFIELD, Kentucky
GREG GANSKE, Iowa
CHARLIE NORWOOD, Georgia
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES "CHIP" PICKERING, Mississippi
VITO FOSSELLA, New York
ROY BLUNT, Missouri
TOM DAVIS, Virginia
ED BRYANT, Tennessee
ROBERT L. EHRLICH, Jr., Maryland
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
CHARLES F. BASS, New Hampshire
JOSEPH R. PITTS, Pennsylvania
MARY BONO, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
ERNIE FLETCHER, Kentucky

JOHN D. DINGELL, Michigan
HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RALPH M. HALL, Texas
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
SHERROD BROWN, Ohio
BART GORDON, Tennessee
PETER DEUTSCH, Florida
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
TOM SAWYER, Ohio
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
KAREN McCARTHY, Missouri
TED STRICKLAND, Ohio
DIANA DeGETTE, Colorado
THOMAS M. BARRETT, Wisconsin
BILL LUTHER, Minnesota
LOIS CAPPS, California
MICHAEL F. DOYLE, Pennsylvania
CHRISTOPHER JOHN, Louisiana
JANE HARMAN, California

DAVID V. MARVENTANO, *Staff Director*
JAMES D. BARNETTE, *General Counsel*
REID P.F. STUNTZ, *Minority Staff Director and Chief Counsel*

SUBCOMMITTEE ON HEALTH

MICHAEL BILIRAKIS, Florida, *Chairman*

JOE BARTON, Texas
FRED UPTON, Michigan
JAMES C. GREENWOOD, Pennsylvania
NATHAN DEAL, Georgia
RICHARD BURR, North Carolina
ED WHITFIELD, Kentucky
GREG GANSKE, Iowa
CHARLIE NORWOOD, Georgia
Vice Chairman
BARBARA CUBIN, Wyoming
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
CHARLES "CHIP" PICKERING, Mississippi
ED BRYANT, Tennessee
ROBERT L. EHRLICH, Jr., Maryland
STEVE BUYER, Indiana
JOSEPH R. PITTS, Pennsylvania
W.J. "BILLY" TAUZIN, Louisiana
(Ex Officio)

SHERROD BROWN, Ohio
HENRY A. WAXMAN, California
TED STRICKLAND, Ohio
THOMAS M. BARRETT, Wisconsin
LOIS CAPPS, California
RALPH M. HALL, Texas
EDOLPHUS TOWNS, New York
FRANK PALLONE, Jr., New Jersey
PETER DEUTSCH, Florida
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
ALBERT R. WYNN, Maryland
GENE GREEN, Texas
JOHN D. DINGELL, Michigan,
(Ex Officio)

CONTENTS

	Page
Testimony of:	
Heisler, John A., County Board, McHenry County, Illinois	53
Jenkins, Renee S., on behalf of the American Academy of Pediatrics	48
Vosburgh, Karen	10
Wardle, Lynn, Professor, J. Reuben Clark Law School, Brigham Young University	22
Weiss, Catherine, Director, ACLU Reproductive Freedom Project	13
Wuchner, Addia, Northern Kentucky Independent Health District	43
Material submitted for the record by:	
McHenry County Citizens for Choice, prepared statement of	71

PROTECTING THE RIGHTS OF CONSCIENCE OF HEALTH CARE PROVIDERS AND A PARENT'S RIGHT TO KNOW

THURSDAY, JULY 11, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 3 p.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Burr, Norwood, Pitts, Tauzin (ex officio), Brown, Strickland, Capps, Towns, Deutsch, and Wynn.

Staff present: Patrick Morrisey, deputy staff director; Cheryl Jaeger, majority professional staff; Steven Tilton, health policy coordinator; Eugenia Edwards, legislative clerk; John Ford, minority counsel; and Jessica McNiece, minority staff assistant.

Mr. BILIRAKIS. I call this hearing to order and first would like to thank our witnesses for appearing before the subcommittee today. This subcommittee certainly values your expertise, and we are very grateful for your cooperation and attendance. And as you good people fall in, please, let us try to be orderly.

Today's hearing will touch on two subjects that I know many members of the subcommittee, myself included, feel very strongly about. Because of the vastly divergent views and strong feelings invoked by the issues we will be discussing today, I believe it is important to have a hearing which will afford us the opportunity to listen to different viewpoints. And I think this open dialog and expert testimony will aid all members in making an informed decision about how best to legislate in this area.

Our first panel will discuss an issue that we commonly refer to as the conscience clause. In 1996, the Congress passed, and President Clinton signed into law, provisions that provide protections to health care professionals and a, "health care entity" from being forced to perform abortions if they have moral or religious objections to the procedure. However, court interpretations have called into question whether these sections of law apply to hospitals that object to offering elective abortions.

In 1998, a number of senators attempted to clarify the record by stating that a health care entity was defined to include physicians and other which does not mean that it excludes hospitals. However, this clarification has not been sufficient and it has come to my at-

tention that we need to amend the current statute to ensure that hospitals are covered by the conscience clause. Consequently, I have introduced H.R. 4691, the Abortion Non-Discrimination Act, to guarantee that all health care entities are afforded the important protections provided by the original law, as I believe was intended.

Our second panel will discuss the issue of whether parents have the right to know if their children receive contraceptive devices or drugs from title X family planning clinics. And, again, this is an issue where most of us have had some experience in the raising of our children. And I think it is safe to say that most parents have strong feelings about wanting to know what is going on with their children's health, and as a parent, I certainly can identify with this notion.

Title X regulations specifically prohibit health care providers from informing parents of their child's actions to seek contraceptives. I am interested to hear from our witnesses today whether title X rules allow for appropriate flexibility and deference to the health care professionals that provide care in these clinics. Can a doctor use his or her best judgment about notifying a child's parents about health concerns when providing care to a minor? Question.

Again, I know these are difficult issues, and I look forward to hearing from our witnesses so we can make informed decisions about how best to proceed, and I now recognize my good friend from Ohio, Mr. Brown, for his opening statement. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. This afternoon we will discuss the merits of a proposal to permit health care entities to refuse to comply with Federal, State and local laws pertaining to abortion services. We will discuss parental consent requirement for access to reproductive health services. I want to thank Ms. Weiss for joining us, Dr. Jenkins and the other distinguished panelists.

The majority has labeled the first issue for debate a clarification of existing law. They will argue the legislation clarifies a provision of law known as the Coats Amendment, adopted, as the chairman said, in 1996 omnibus appropriations bill. The Coats Amendment allowed post-graduate physician training programs that chose not to provide or refer for training and abortion procedures to still qualify for Federal funding. This so-called clarification bill would dramatically, dramatically expand this narrow law.

Let me be clear, this is not simply a technical amendment. It is a sweeping expansion to the law that would override Federal and State and local laws. This bill expands this scope of the law beyond graduate medical programs and permits any health care entity, including insurance companies and hospitals and HMOs to refuse to perform, to refuse to provide coverage of, to pay for or refer for abortions.

In the interest of time, I want to mention just one example of how this bill is egregious and irresponsible, putting a political agenda, in my mind, above access to critical and human health care. The Federal Hyde Amendment ensures Medicaid patients access to abortion services in cases of rape, incest or where the pregnancy endangers the woman's life. The chairman's bill would override these standards of care. The bill would give the HMOs the

legal standing to refuse to adhere to the Hyde Amendment. That is a major policy change with tremendous ethical implications.

The chairman's bill also blurs the line between medicine and personal preference. How does this differ from a health care facility or an insurance company denying a critical procedure based on an ethnic bias or a racial bias? And I want to point out that once again the same Members of Congress who claim to be staunch champions of State and local sovereignty, who want to block grant Medicaid to gives States more flexibility, who want to privatize Medicare because it is a "one-size-fits-all," program, who constantly demonize the one-size-fits-all mentality of the Federal Government are now trying to impose a one-size-fits-all refusal clause at the State and the local level. Once you get into the realm of religion and ethics and morals, my conservative colleagues have no problem using the heavy hand of the Federal Government to stifle different perspectives at the State and local level.

Second issue we will discuss this afternoon is parental consent. title X, the only Federal program dedicated exclusively to funding family planning and reproductive health care services has helped to prevent unintended pregnancies, reduce abortions, lower the rate of STDs, including HIV, and improve women's health overall. A study 4 years ago reported that teen pregnancy rates fell 17 percent sine the rate peaked in 1990, and 75 percent of this decline reflects improved contraceptive use among sexually active teens, 25 percent due to reduced sexual activity. That is a very impressive track record that an overwhelming majority of Americans support.

What we are considering today would undermine the inherent value of a title X clinic, confidential access to family planning services, and require teens to get the consent of their parents before receiving contraceptives. While family planning clinics encourage minors to involve their parents in health care decisions, an admiral thing, as Chairman Bilirakis said, Congress cannot and should not write laws that will achieve communication between and adolescent and her or his parents where it simply doesn't exist.

The American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Nurses Association, the American Public Health Association, the American Academy of Family Physicians, among many other respected members of the medical community, all oppose, all those groups that are so involved in this kind of medical care oppose mandatory parental consent or notification requirements for teens receiving services at a title X family planning clinic for obvious reasons, that children and parents, young teens and parents don't always communicate as well as we would like.

This committee should respect the medical community's opinion as well as the success, the success that family planning clinics have achieved in reducing unintended teen pregnancies. Reducing unintended pregnancies is, after all, the key goal, it is a bipartisan goal, it should remain a bipartisan goal. I thank the chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman. The Chair recognizes the chairman of the full committee, Mr. Tauzin, for an opening statement.

Chairman TAUZIN. Thank you, Mr. Chairman. I want to thank you for holding this hearing today. I am pleased the committee is

addressing two important ethical questions that impact health care in our country. Our committee spends a great deal of time exploring ways that we can improve access to health care for America's patients. But an equally important goal has always been that we ensure that ethical guidelines for our health care system are always maintained at the highest possible level. And this is true whether it involves issues pertaining to the rights of conscience of health providers or issues dealing with cloning or stem cells, which this committee wrestled with not too long ago. We still maintain a responsibility to ensure the ethics and morals that are indeed the foundation of much of our society are not trampled upon because of Federal policies. And today we address two of those timely issues.

The first question we ask is should the Federal Government require health care providers to participate in procedures that violate their moral and religious beliefs? In my mind, the answer to that question is a clear no, although admittedly there are some differences of opinion here. Second, is the Federal Government, through some of our health care programs, undermining the critical role that parents play in guaranteeing the well being and the health of their children? That answer requires some analysis. More and more we are learning about instances where parents are currently being shut out of critical health care decisions regarding their children. I believe that is an unacceptable practice.

On the first question, it is important to note that for over 30 years State and Federal Governments have passed conscience clause statutes intended to protect health care providers from being coerced into performing procedures that violate their moral and religiously held beliefs. I supported these laws in the past, and I hope we can all continue to do so in the future. A health care provider should never be forced to abandoned his or her moral values and religious beliefs and be required to perform a particular procedure.

I would like to express my appreciation for the work of Chairman Bilirakis in raising awareness on this important issue. The chairman has offered the Abortion Non-Discrimination Act of this year, H.R. 4691, to clarify the intent of existing law so that it clearly prohibits the discrimination of health care entities who refuse to perform abortions. I strongly support this bill and encourage my colleagues to co-sponsor the bill if they have not already done so.

On the second question we are addressing today, I am frankly very pleased we are beginning to take a closer look at whether or not parents should be denied information about whether a minor that they are legally responsible for is permitted access to contraceptives. And while there are substantial differences of opinion regarding the value and effectiveness of title X programs, current title X regulations do not permit health care providers to use their best judgment or even discuss sensitive health care issues with parents without the express consent of the minor. I think this turns things on its head.

We learned, for example, at our welfare reform hearings last April, that when we were growing up, in the sixties, there were really two sexually transmitted diseases of great concern to be worried about. We were told today there are 25, and they include such diseases affecting young men and women in our society, very often

women, as HPV, herpes and chlamydia. These are viral diseases; they cannot be cured, only managed. And when a title X clinic provides contraceptives and condoms to teens without the parent's consent or notification and there is no evidence that condoms reduce the sexual transmission of many of these infections, the health of these children, in many cases young women of our country, is put at risk without the parents even knowing that is occurring. That doesn't make sense to me.

And when title X clinics allow a child to begin taking a prescription drug or to have access to contraceptives, that encourage a child to make a choice to engage in sexual activities, that put them at risk for diseases that can't be cured, in some cases are non-detectable, they don't even know they have them until they find out they have lost their ability to have children because the disease has destroyed the reproductive capacities. Or they have now incurred a disease that maybe a precursor to cancer because their parents didn't have the chance to tell them maybe this isn't such a good idea for you, maybe you ought to try abstinence, because the parents didn't know because the title X clinic couldn't talk to the parent about these kind of important decisions that parents and children should be making in their lives.

Something has gone terribly wrong. If we only had these two diseases in the 1960's to worry about today, that would be one thing. Think about what young people are facing today, and think about the role that parents are being denied in caring for their own children and worrying about them, helping them make the right decisions. And I think you get a sense of why this is an important hearing today.

So Mr. Bilirakis, I want to thank you for conducting it, and I want to thank the witnesses who are going to come share their thoughts with us today. I hope we learn a little bit today, and maybe we will quell politics with the issue and begin thinking about what really is best for the children of our country. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Chairman, for your statement. The gentlelady from California, Ms. Capps.

Ms. CAPPS. Thank you, Mr. Chairman. And I appreciate your holding this hearing, and I appreciate our expert witnesses for being with us today.

Today, I am speaking and listening, not just as an elected representative but as a mother and a grandmother, a public health nurse and the former director of the Santa Barbara School District Teenage Pregnancy and Parenting Program, a program which provided, and does still provide, child care and development, child development services for school-age parents. I have first-hand real world experience with young men and women struggling with the difficult subject of sex. I have dealt with teenagers trying to cope with the ramifications of bad decisions, and I have worked with young women as they strive to make life-altering decisions. And I have seen the terrible results when we turn our back and deny them help. So today's subjects are of great personal interest to me, and I have significant concerns about them.

First of all, I can tell you from my experience that parental consent requirements for title X services will result in higher teenage

pregnancy rates, period. Like most of my colleagues, I think it is, when at all possible, the best option for a teen considering sexual activity to speak with and consult with his or her parents. Parental involvement in our children's lives is crucial especially for issues like these. And for anyone who works with young people, the interest in bridging that relationship between child and parent is paramount, but not all young people have that option for a variety of reasons. And requiring parental notification and consent will cause many teenagers to avoid seeking help from health clinics. If you have ever sat with someone who is the victim of incest, you will know what this subject means.

These teens have unprotected sex, and they will struggle on their own to deal with the results. Many will seek unsafe abortions or will not get access to critical pre-natal care. No one wants that for our young people. Our best hope is to have a frank conversation with them and help them to understand the gravity of their choices. Parents need to have that role whenever possible. And then, as a last resort, we need to make sure that they have access to all needed services if their families fail them or are not there, literally not there for them.

Our other topic, the so-called conscience clause, is equally difficult. For decades, women have had to fight to get access to the reproductive health services they uniquely need. Programs like title X and Medicaid have risen up around their efforts, and I consider myself to be a religious person. I am very respectful, as respectful as I know how to be, of the deep-seeded beliefs and feelings that many Americans have on the subject of reproductive health. I grant them their right to have positions and feelings that may differ from mine, but I do not accept that anyone should have the authority to compel others to assume these beliefs as well.

Under current law, an individual who has a religious or moral objection to providing a service can refuse to offer it, but the law recognizes certain differences between an individual and an institution. Institutions do not have the same rights, nor should they. Health care facilities exist to provide services. It should be extremely rare when such a facility can deny anyone access to care. Even so, there are only minimal obligations on hospitals and other facilities. Under title X, they only have to tell someone what their choices are and where they can go to receive these services. And under Medicaid, hospitals and clinics will only be obligated to provide an abortion in cases of rape, incest or when the life of the mother is in danger. Enacting broader conscience clause for institutions will result in leaving women without the services that they have a constitutional right to.

So, Mr. Chairman, I think the current law gives sufficient deference to moral objections, and that we need to protect access to critically important reproductive health care. And I yield back the balance of my time.

Mr. BILIRAKIS. The Chair thanks the gentlelady. Mr. Pitts for an opening statement.

Mr. PITTS. Thank you, Mr. Chairman. First, thank you for holding this important hearing today, and thank the witnesses for appearing today.

Both the rights of conscience for health providers and a parent's right to know about prescription drugs for their minor children are a matter of basic ethics in health care. Mr. Chairman, I learned last year of the need for a comprehensive anti-discrimination protection for health care organizations that choose not to provide abortions. Shockingly, some of our fine private hospitals have recently threatened and even forced, compelled to provide abortions, a procedure to which they are opposed to providing.

Currently, Federal law does provide conscience protection for individuals and providers who choose not to perform or refer for abortions. However, recent court cases have demonstrated that this law needs to be clarified to protect hospitals and health care organizations from abortion-related discrimination.

Ms. Vosburgh, a witness before us today, represents Valley Hospital, located in Palmer, Alaska. Valley Hospital is a private, nonsectarian hospital that decided to have a policy against performing abortions. Valley Hospital had a right to have this policy since it, as I said, is a private hospital. Unfortunately, Valley Hospital was ordered to perform abortions against its will.

Mr. Chairman, this is wrong. Abortion is elective surgery, it is not prenatal care, it is not basic health care, as some of our friends would like us to believe. Private hospitals should be able to decide what types of elective surgery they wish to offer. If they don't want to provide abortions, they shouldn't have to. For every one hospital that does not provide abortion, there are scores of hospitals that do provide them. I wonder what other elective surgeries we will begin forcing our hospitals to provide next.

We are not talking about discrimination here, which would be offering a service to some patients and not others. We are talking about a private hospital board making a decision not to offer one type of elective surgery and making that decision apply to everyone who walks in the door, regardless of race, income, whatever.

Mr. Chairman, I am proud to be a co-sponsor of your legislation, the Abortion Non-Discrimination Act. This legislation strengthens existing law by saying that health care providers may not be required to provide abortions. It is common sense, I think it is a technical change. The authors of the 1996 law admit that they intended for hospitals and health care providers to be included in the definition of health care entity. However, unfortunately, the courts have misconstrued this and thus the need for further clarification.

The second issue before us today is even more disturbing. Mr. Chairman, in the State of Pennsylvania, a minor needs written parental or guardian consent to have his or her ears pierced, to get a driver's learning permit, to get married, to receive aspirin in school, to attend a field trip, to get a tattoo, to participate in athletic activity, to be absent from school, to ride a bus other than his own, the list goes on. We do not allow minors to attend R-rated movies, purchase tobacco products, consume alcohol. However, Federal regulations allow a minor to get contraceptives, including injected drugs, like Depo-Provera, and surgical implants, like Norplant, in health care clinics receiving title X funds without parental consent. In fact, it is against the law for medical staff to inform parents that their child is receiving prescription contraceptives.

Mr. Chairman, it is deplorable that while a 14-year-old girl is required to have parental consent to get an aspirin in school or have her ears pierced, she can receive prescription contraceptive drugs and devices without the consent or knowledge of her parents. I am sure you agree with me that parents have a right to know what the government is doing to their children. Further, under current law, in most States, a minor receiving care in a physician's office must receive parental consent before receiving care. However, if that same minor were to enter a title X clinic, she could receive prescription contraceptives without parental consent or notification. Again, it is mandated under Federal regulations.

The testimony we will hear today from Mr. Heisler will show the danger of this regulation. It is unconscionable that our government regulations prevented a 13-year-old parents—girl's parents from knowing that their daughter had been driven to a clinic by her teacher to receive contraceptives and then raped over a period of 18 months this went on. Another example, in 1998, a 16-year-old in Walton County, Georgia, unbeknownst to her parents, went to receive a pelvic exam, an injection of the contraceptive drug, Depo-Provera, in a taxpayer-funded clinic, and as the girl was about to receive the injection she casually mentioned to the nurse that she had a heart murmur. The nurse told the girl she would need a doctor's note, so the clinic would be immune from a malpractice claim, and the family's doctor subsequently notified the mother that the chemical contraception, if it had been administered, there was a great probability that her child would have gone into cardiac arrest and possibly have died because of her heart condition.

These horrific examples could have been prevented if our bill was passed. We don't expect the government to watch over every single teen out there to whom is given birth control. That is a parent's responsibility. However, by keeping them out of the loop, were are, in effect, removing parents from the equation. And so thank you, thank you to all the witnesses for taking time to come and testify. I look forward to hearing their testimony.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Deutsch, for an opening statement.

Mr. DEUTSCH. Thank you, Mr. Chairman. Just listening to opening statements, it is almost as if it is a tale of two cities or a tale of two countries. My good friend and colleague talked about an America which I wish it existed. I wish everyone in America could go to private physicians or go to clinics that are not affected by H.R. 4691, but that is not the case. This type of legislation, in fact, the facts are that it does discriminate. It does discriminate disproportionately of low-income women, people who don't have a choice, people in rural areas. And that would be the effect. I can turn the questions on its head that these are title X funded clinics that they don't have to participate. If they feel so objectionable of the requirements that go along with the funding, then they can choose not to participate; that is their choice.

It is also—I mean, obviously, we have two separate parts of the hearing. It is also interesting, and the chairman well knows this coming from Florida, as I do, that the Florida Supreme Court has actually found a Florida constitutional right of non-notification. And it is interesting. I mean this is not a radical court by any

stretch of the imagination. And it is also—again, I don't know what other States provide State constitutional protection that has been interpreted to provide this. But it is the follow-up of really this whole issue of a tale of two countries.

I don't ever like to personalize statements as a member, but I have a daughter that I hope she never gets pregnant outside of marriage, but if she did, I would hope she would have the relationship with her mom and me to talk to us. But there are many children in America, unfortunately, and we are talking the tens of thousands, who unfortunately don't have those relationships with their parents and situations of abuse, potentially incest, potentially all sorts of other issues that exist. And there is a reason for the distinction that my colleague mentioned between going on a bus without permission and being able to receive contraception or for that matter abortion. There is a very real reason, and the experience of a 16-year-old girl who might be far more experienced than maybe anyone in this room in this area defies the conditions that still exist in America, in many places, under many times and many circumstances.

So I welcome this hearing, I welcome the testimony from different people, and I urge my colleagues who have not seen both sides of America to visit both sides of America. Thank you.

Mr. BILIRAKIS. I thank the gentleman. Mr. Wynn, for an opening statement.

Mr. WYNN. Thank you, Mr. Chairman. I appreciate your calling this hearing on a very, very important issue facing us today. I have very mixed feelings, but I think in listening to the testimony I will be focusing on, and I hope as a committee we focus on the welfare of the child from the standpoint of the child's health. In an era of AIDS and as well as rampant teen pregnancy, it seems to me that young people do have the need to have unfettered access to information about contraception as well as contraceptive devices. Having said that, I also acknowledge that there is a parental role, I just think that that parental role should not come into play once you reach the point of making these crucial decisions.

I also would be interested, however, in hearing from people comment on the question of their interaction of contraceptives with other drugs that the child may be taking and how we can again look at the child's best—protect the child's welfare in those situations where there may be an adverse reaction if full information is not disclosed to the person making the contraceptive information or devices available.

So there are a lot of complex issues before the committee. I also look forward to hearing from the witnesses, but I do believe we have to take the child's physical health, keep that in the forefront of this discussion. Again, I thank you for calling this hearing and look forward to the testimony. Thank you.

Mr. BILIRAKIS. And the Chair thanks the gentleman. And we will go on to the panel now, but before we do I would like to say that Congressman Akin is here at his own time because he has an interest in this subject, and he is more than welcome to be sitting in during our deliberations.

The first panel consists of Ms. Karen Vosburgh, from Palmer Alaska, a very beautiful community, I have been to it; Ms. Cath-

erine Weiss, director of ACLU Reproductive Freedom Project out of New York City; and Professor Lynn Wardle, J. Reuben Clark Law School, Brigham Young University, Provo, Utah.

Welcome. Your submitted testimony is a part of the record, and we would hope you would complement it. We will set the clock at 5 minutes and hopefully we will all do our best to adhere to that time limit. Ms. Vosburgh, please start off. Please, the mike, yes.

STATEMENTS OF KAREN VOSBURGH; CATHERINE WEISS, DIRECTOR, ACLU REPRODUCTIVE FREEDOM PROJECT; AND LYNN WARDLE, PROFESSOR, J. REUBEN CLARK LAW SCHOOL, BRIGHAM YOUNG UNIVERSITY

Ms. VOSBURGH. Good afternoon, Mr. Chairman, and thank you for bringing this up to the forefront. I do thank you for that. And also other members of the committee. Thank you for providing me this opportunity to testify and to express my support for protecting health care providers from forced involvement in abortion.

I serve as a director of the Association Board of Valley Hospital, which is a nonprofit, nonsectarian community-based hospital. This hospital lies in an amazingly beautiful valley, as you said, Mr. Chairman. It is surrounded on three sides by these incredible mountains and beautiful rivers. I mean it is just a very pristine area. It is Palmer, Alaska, and it is located about 50 miles east of Anchorage. There is also another town, Wasilla, that is 10 miles from Palmer. And these two towns and the outlying areas make up a place we call the Valley. There is about 50,000 people there.

It is a place of faith. There are 70 churches in this valley, and we are a very God-based community, and we believe that abortion—we know that abortion is killing a human being.

Valley Hospital is truly a community hospital in that it is governed by the members of the community. Membership in the hospital is open to all residents of our community without regard to citizenship, race, sex or religious preference. The members elect the association board on which I serve. The association board is responsible for raising funds, acquiring land, property and equipment for the hospital and for selecting the members of the hospital's operating board. This board sets the policy of the hospital. And because the members of the operating board are ultimately selected from our community, the board truly represents the community. Among the operating board's current members, for example, are a pastor, a realtor, an attorney, a teacher and a physician.

The community both serves and is served by the hospital. The mission of the hospital is to enhance the health of those we serve, guided by the values of honoring the dignity of all people, representing the interests of the community and providing the highest level of care within the bounds of ethics.

Our small town has an OB/GYN who performs elective abortions. She uses Valley Hospital for her later-term, second trimester elective abortions. For the most part, our community wants abortion to stop at Valley Hospital. So, in the early 1990's, the members elected people to the association board who believe in respect for human life and who hold the philosophy that hospitals are for healing and not for killing. The association board selected the operating board, which passed a resolution reflecting this policy. The resolution

ended abortion at Valley Hospital except in the cases of rape, incest and danger to the life of the mother, which is exactly the same policy that the Federal Government has had in Medicaid and its other health programs for many years. In fact, every year, our operating board continues to update this policy. This is the latest one, and it states that, "A policy has been adopted that elective abortions shall not be performed at Valley Hospital. The exceptions to this policy include documentation by one or more physicians that the fetus has a condition that is incompatible with life, a life-threatening condition exists for the patient or the pregnancy is a result of rape or incest."

When the abortionist was told she could no longer perform abortions at Valley Hospital, she was overheard complaining that abortions were a good portion of her income. She sued. The trial judge, Judge Dana Fabe, ruled in her favor, stating that because Valley Hospital received some Federal and State money from Medicaid and Medicare, that it was a quasi-public entity and therefore has to provide abortions. The judge's reasoning was strange, to say the least. How can our receipt of Federal funds be used to forbid us to have the same abortion policy that the Federal Government requires in all its own health facilities?

I believe, however, that this particular Judge Fabe's opinion was colored by her personal views on abortion. In 1993, she made the statement in a newspaper there that, "If a high school student in this State has a fundamental right to choose his or her hairstyle, an Alaskan woman must certainly have a fundamental right to choose whether or not to terminate a pregnancy." That is her reasoning.

Of course, Valley Hospital challenged this decision, and it went before the Alaska Supreme Court. The five-member court is one of a handful of State supreme courts to rule that State funds must be used for elective abortions despite the contrary decision of the State legislature. One member, Justice Bryner—I was there when he said this, and I just about fell on the floor—he said during oral arguments for the State funding issue, he declared that pregnancy is a disease. It was no surprise that this court upheld Judge Fabe's original decision. The Alaska Supreme Court held that Valley Hospital was quasi-public because of its receipt of public monies.

In addition, the court struck down a State law protecting hospitals that refuse to participate in abortions, denying the right of our board to exercise its rights of moral conscience. The court even suggested that it would not respect the religious beliefs of those who decline involvement in abortion, saying, "recognizing such a policy as compelling could violate the Establishment Clause of the First Amendment." And you will find that in Valley Hospital Association v. Mat-Su Coalition for Choice.

In response, the legislature sought to reverse the decision by constitutional amendment, which requires a two-thirds vote of our legislators. Sadly, the amendment failed to garner the two-thirds majority by just one vote, and I am sure many of you understand that here.

Mr. BILIRAKIS. Please summarize, Ms. Vosburgh.

Ms. VOSBURGH. Will do. This court decision potentially places all hospitals in our State in a Catch-22 situation. If you are a non-reli-

gious hospital, you have no First Amendment claim of religious freedom, so you must provide abortions. If you are a religious hospital with a free exercise claim, respect for your right of conscience may be seen as showing favoritism to religion, so you may still have to provide abortions.

I like this quote, this is from Bernard Nathanson who is a former abortionist. He said, "It is clear that permissive abortion is purposeful destruction of what is undeniably human life. It is an impermissible act of deadly violence." For those of us who share this view, that abortion is a form of violence, not a form of health care, being required to provide and support it is a grave injustice.

I ask for myself, my community and for any other hospital or health care provider that does not want to be forced to be involved in killing innocent human life, please pass Congressman Bilirakis' bill, the Abortion Non-Discrimination Act. We, too, have a right to choose—to choose not to be involved in destroying innocent human life. Thank you.

[The prepared statement of Karen Vosburgh follows:]

PREPARED STATEMENT OF KAREN VOSBURGH

Good afternoon, Mr. Chairman and members of the committee. Thank you for providing me this opportunity to testify and express my support for protecting health care providers from forced involvement in abortion.

I serve as a director of the association board of Valley Hospital, a nonprofit nonsectarian community-based hospital. The hospital lies in an amazingly beautifully valley, surrounded on three sides by majestic mountains, with rivers and streams of crystalline blue in Palmer, Alaska. Palmer is located about 50 miles east of Anchorage. There's another town, Wasilla, that's 10 miles from Palmer. These two towns and the outlying areas are known as "the valley."

Valley Hospital is truly a community hospital in that it is governed by the members of the community. Membership in the hospital is open to all residents of our community without regard to citizenship, race, sex or religious preference. The members elect the association board on which I serve. The association board is responsible for raising funds, acquiring land, property and equipment for the hospital and for selecting the members of the hospital's operating board. This board sets the policy of the hospital. And because the members of the operating board are ultimately selected from our community, the board truly represents the community. Among the operating board's current members, for example, are a pastor, a realtor, an attorney, a teacher, and a physician.

The community both serves and is served by the hospital. The mission of the hospital is "to enhance the health of those we serve" guided by the values of honoring the dignity of all people, representing the interests of the community, and providing the highest level of care within the bounds of ethics.

Our small town has an OB/GYN who performs elective abortions. She uses Valley Hospital for her later-term, second trimester abortions. For the most part, our community wants abortion to stop at Valley Hospital. So, in the early 1990's the members elected people to the association board who believe in respect for human life and who hold the philosophy that hospitals are for healing, and not killing. The association board selected the operating board, which passed a resolution reflecting this policy. The resolution ended abortion at Valley Hospital except in the cases of rape, incest and danger to the life of the mother—exactly the same policy the federal government has had in Medicaid and its other health programs for many years.

When the abortionist was told she could no longer perform abortions at Valley Hospital, she was overheard complaining that abortions were a good portion of her income. She sued. The trial judge, Judge Dana Fabe, ruled in her favor, stating that because Valley Hospital received some federal and state money, it was a quasi-public entity, and therefore has to provide abortions. The judge's reasoning was strange, to say the least. How can our receipt of federal funds be used to forbid us to have the same abortion policy that the federal government requires in all its own health facilities? I believe, however, that Judge Fabe's opinion was colored by her personal views on abortion. In 1993 she made the statement that "if a high school student in this state has a fundamental right to choose his or her hairstyle, an Alaskan

woman must certainly have a fundamental right to choose whether or not to terminate a pregnancy."

Of course, Valley Hospital challenged the decision, and it went before the Alaska Supreme Court. This five member court is one of a handful of state supreme courts to rule that state funds must be used for elective abortions despite the contrary decision of the state legislature. One member, Justice Bryner, declared that "pregnancy is a disease" during oral arguments on the funding issue. It was no surprise that the court upheld Judge Fabe's original decision. The Alaska Supreme Court held that Valley Hospital was "quasi-public" because of its receipt of public monies. In addition, the court struck down a state law protecting hospitals that refuse to participate in abortions, denying the right of our board to exercise its rights of moral conscience. The court even suggested that it would not respect the religious beliefs of those who decline involvement in abortion, saying, "recognizing such a policy as 'compelling' could violate the Establishment Clause of the First Amendment." Valley Hospital Ass'n. v. Mat-Su Coalition for Choice, 948 P.2d 963 (Alaska 1997).

In response, the legislature sought to reverse the decision by constitutional amendment, which requires a two-thirds vote of our legislators. Sadly, the amendment failed to garner that two-thirds majority by just one vote.

This court decision potentially places all hospitals in our state in a "Catch-22" situation. If you are a non-religious hospital you have no First Amendment claim of religious freedom, so you must provide abortions. If you are a religious hospital with a "free exercise" claim, respect for your right of conscience may be seen as showing favoritism to religion, so you may still have to provide abortions.

At a time when he was not a member of any religion, former abortionist Bernard Nathanson once said: "It is clear that permissive abortion is purposeful destruction of what is undeniably human life. It is an impermissible act of deadly violence." For those of us who share this view—that abortion is a form of violence, not a form of health care—being required to provide and support it is a grave injustice.

I ask for myself and my community, and for any other hospital or health care provider that does not want to be forced to be involved in killing innocent human life. Please pass Congressman Bilirakis's bill, the Abortion Non-Discrimination Act (H.R. 4691). We, too, have a right to choose—a right to choose not to be involved in destroying life.

Thank you for considering my views.

Mr. BILIRAKIS. Thank you, Ms. Vosburgh.

Ms. Weiss, please proceed. Make sure that mike is on.

STATEMENT OF CATHERINE WEISS

Ms. WEISS. Mr. Chairman and members of the subcommittee, good afternoon and thank you for inviting me to testify today. I am here, as you know, on behalf of the American Civil Liberties Union. Because of its dual long-term commitments to religious liberty and reproductive freedom, the ACLU has a profound interest in the ongoing debate about religious exemptions in the reproductive health context. I am going to begin by telling you about the case that brought the ACLU into this debate, then I will outline the framework we use for analyzing these exemptions. And I will end with a brief discussion of H.R. 4691.

First the story. In 1994, I got a call from a very distraught doctor in Nebraska. He told me that a 19-year-old woman had been admitted through the emergency room of the hospital where he practiced. She had a blood clot in her lung. Tests revealed that she was 10 weeks pregnant. The clotting disorder was a rare complication of the pregnancy. Her treating physicians told her that she had two alternatives. She could stay in the hospital for the remaining 6½ months of her pregnancy, taking medications and undergoing surgery to reduce her risk of death or she could have first trimester abortion. She wanted to go home to her toddler so she decided to have an abortion. Four doctors certified that it was a life-saving procedure for her. On the morning surgery was scheduled, how-

ever, the hospital's lawyer appeared in the operating room brandishing a State law that said that no hospital could be required to permit an abortion on its premises. The procedure was canceled. Ten days of dangerous delay followed. Although moving the patient greatly increased her medical risks, she was ultimately transferred 20 miles by ambulance to the office of her physician. He performed the abortion safely. Although his patient had survived the unconscionable risks to which she had been suggested, the doctor wanted to know whether what the hospital had done was legal. That is one of the questions presented here today.

I move now to the framework the ACLU has developed for analyzing religious exemptions. This framework is meant to balance protection for religious liberty with protection for other critical personal rights. We have identified two main factors. First, would refusal harm the health or other critical personal interests of people who do not share the beliefs that motivate the refusal? The more such burdens fall on third parties, the less acceptable any claimed right to refuse. Second, is the objector sectarian institution engaged in religious practices or is instead an entity, whether religiously affiliated or not, operating in a public, secular setting? The more public and secular the setting, the less acceptable an institution's claimed right to refuse.

H.R. 4691 fails this test. The burdens imposed by the bill would fall primarily on patients of all faiths and no faith seeking health care in public and secular settings. Consider, for example, the hypothetical case of a low-income woman in Washington State who has just been raped. The police take her to a local emergency room in a large, urban catholic hospital. State law in Washington requires hospitals to offer all rape victims emergency contraception so that they can prevent a pregnancy resulting from the assault. The hospital, however, believes that emergency contraception is an abortifacient, so relying on H.R. 4691 the hospital refuses to provide or even inform the patient about emergency contraception. She leaves not knowing that this drug exists.

Three weeks later, the woman's pregnancy test comes back positive. She is devastated and decides to have an abortion. She calls her Medicaid managed care organization. As you know, State and Federal law entitle rape victims to Medicaid coverage for abortion. Relying on H.R. 4691, however, the managed care organization tells the patient that it does not provide abortions and refuses to give her any further information on the subject. She assumes that her abortion isn't covered and starts the race against time of trying to raise the money on her own as the pregnancy advances.

This account provides just one example of how H.R. 4691 could allow hospitals, health plans and other institutions to shirk critical legal obligations to patients, even patients in publicly funded health care programs. But surely health care institutions that employ the general public and serve the general public and even receive public funds should comply with public health laws. The ACLU urges the subcommittee to reject this dangerous bill. Thank you.

[The prepared statement of Catherine Weiss follows:]

PREPARED STATEMENT OF CATHERINE WEISS, DIRECTOR, AMERICAN CIVIL LIBERTIES UNION, REPRODUCTIVE FREEDOM PROJECT

Chairman Bilirakis, Ranking Member Brown, and members of the Subcommittee: My name is Catherine Weiss and I am the Director of the American Civil Liberties Union's Reproductive Freedom Project. I am pleased to testify today on behalf of the ACLU about refusal clauses in the reproductive health context. The ACLU is a nationwide, nonpartisan, nonprofit organization of approximately 300,000 members dedicated to protecting the principles of freedom and equality set forth in the Constitution and in our nation's civil rights laws.

Today, I will explain the practical impact of refusal clauses (sometimes also called religious exemptions or "conscience clauses") that permit entities and individuals to refuse to provide or cover health services to which they object on religious or moral grounds. I will provide a brief overview of federal refusal clauses. And I will offer an analytic framework for evaluating refusal clauses that balances protection for religious liberty with protection for the public health. Finally, I will explain that the public overwhelmingly rejects the principles that underlie overly broad refusal clauses, and I will urge you to oppose H.R. 4691 because it would impose unacceptable burdens on women of all faiths and no faith seeking reproductive health care in public, secular settings.

The ACLU has a long, proud history of vigorously defending religious liberty. In Congress and in the courts, we have supported legislation providing stronger protection for religious exercise—even against neutral, generally applicable laws. For nearly a decade, the ACLU fought to preserve or restore the highest level of constitutional protection for claims of religious exercise. We were founding members of the coalition that supported the Religious Freedom Restoration Act in 1993, and we were instrumental in urging Congress to enact the Religious Land Use and Institutionalized Persons Act of 2000. We have also represented persons challenging burdens on the exercise of their religious beliefs. For example, we have sued to protect the right of Jewish students to wear a Star of David pendant at school; we have sued to defend the right of conservative Christian activists to broadcast on public access television; and we have filed a brief in support of two women who were fired for refusing to work at a Greyhound racetrack on Christmas day. We even offered to back the Rev. Jerry Falwell in his 2001 challenge to Virginia laws restricting ownership of church property.

We have been equally vigilant in our advocacy of reproductive rights. The ACLU fought long and hard to persuade Congress to pass the Freedom of Access to Clinic Entrances Act to protect reproductive health clinics, patients, and professionals from deadly violence. We are currently key supporters of the Equity in Prescription Insurance and Contraceptive Coverage Act to ensure more widespread access to contraception for working women. We have participated in nearly every critical Supreme Court case protecting reproductive freedom, from *Roe v. Wade* to *Planned Parenthood v. Casey* to *Stenberg v. Carhart.* This history makes the ACLU well-positioned to assist the Subcommittee in its consideration of refusal clauses, which, as is illustrated below, can have a dramatic effect on the health of women.

A CASE IN POINT

In the Spring of 1994, a nineteen-year-old Nebraska woman, Sophie Smith,[1] was admitted to the emergency room at a religiously affiliated hospital with a blood clot in her lung. Tests revealed that Smith was approximately ten weeks pregnant, and that the clotting problem resulted from a rare and life-threatening condition exacerbated by the pregnancy. The hospital immediately put Smith on intravenous blood-thinners to eliminate the existing blood clot and to help prevent the formation of more clots that could kill Smith instantly if they lodged in her lungs, heart, or brain.

Smith's doctors told her that she had two alternatives. She could stay in the hospital on intravenous blood-thinners for the remaining six-and-a-half months of her pregnancy. She would also need a procedure in which doctors would insert an umbrella-like device into one of her veins designed to catch blood clots before they reached a vital organ. Or she could have a first-trimester abortion, switch to oral blood thinners, and be released from the hospital. Smith decided to have the abortion. She wanted to go home to care for her two-year-old child.

On the morning Smith was scheduled to have the abortion, the hospital lawyer appeared in the operating room. He announced that the hospital would not permit an abortion on its premises—even though four doctors had certified that an abortion was necessary to save Smith's life. The lawyer was armed with a state refusal law that stated, "No hospital, clinic, institution, or other facility shall be . . . required to

allow the performance of an abortion therein."[2] The procedure was canceled and ten days of dangerous delay followed.

Smith wanted to be transferred to a facility that would perform the abortion, but moving her increased the risk that a blood clot would kill her. Because the blood-thinners she was taking made her prone to excessive bleeding, Smith's doctors felt that she should be treated in a hospital. But the hospital refused to reconsider its decision not to allow the abortion on its premises. Notwithstanding the risks to her health, Smith was ultimately transferred by ambulance to her doctor's office. He performed the abortion and sent her back to the hospital.

Smith was lucky in the end. She survived the risks she faced when this hospital refused to treat her. But the risk itself was unacceptable.

A BRIEF OVERVIEW OF FEDERAL REFUSAL CLAUSES

Refusal clauses pertaining to certain reproductive health services swept the nation in the years following the Supreme Court's 1973 decision legalizing abortion in Roe v. Wade.[3] Congress started the trend that same year when it passed legislation (sponsored by Senator Frank Church and known as the "Church Amendment") in reaction to a 1972 court order that had required a Catholic hospital to allow a sterilization procedure to be performed on its premises.[4] The Church Amendment established that an individual's or entity's receipt of federal funds under certain public health programs is not a basis for requiring recipients with moral or religious objections to perform or assist in sterilization or abortion procedures, or to make facilities or personnel available for the performance of such procedures.[5] The legislation also prohibits certain federally funded institutions from discriminating in employment, or in the extension of staff or other privileges, against any health care professional because the professional refuses to perform or assist in an abortion or sterilization procedure based on a religious or moral objection; because the professional does perform or assist in abortion or sterilization procedures in a separate setting; or because of the professional's religious or moral beliefs concerning these procedures.[6]

In 1996, Congress adopted the Coats Amendment.[7] The amendment prohibits the government from "discriminating" against medical residency programs or other entities that lose accreditation because they fail to provide or require training in abortion services. The amendment was passed after the Accreditation Council for Graduate Medical Education adopted a professional standard requiring residency programs in obstetrics and gynecology to provide abortion training. Under the standard applicable at that time, residency programs or physicians with religious or moral objections could opt out of the required abortion training, although programs remained responsible for insuring that willing residents received abortion training at another institution. The Coats Amendment established that the government could not "discriminate" against a medical residency program solely on the basis of the program's refusal to train new doctors in abortion practice or to refer them elsewhere for such training, even when a residency program lost its accreditation because of its failure to offer training.

In 1997, Congress adopted new statutory requirements for the Medicaid program that, among other things, mandated that states inform patients about how to obtain covered services—including family planning services—that their Medicaid managed care organization did not provide.[8] Congress made clear, however, that the new provisions did not require a Medicaid managed care organization to provide, reimburse, or cover any counseling or referral service to which the organization objects on moral or religious grounds.[9]

In 1998, Congress passed a hard-fought provision that required health plans participating in the Federal Employees Health Benefits Program ("FEHBP")—which provides health insurance for federal employees—to cover prescription contraceptive drugs and devices.[10] Federal employees can generally choose from a wide variety of participating plans. Congress explicitly exempted from the requirement five religiously affiliated health plans that were then FEHBP participants. It also created an exemption for "any existing or future plan, if the plan objects to such coverage on the basis of religious beliefs." (In the years since, no additional plan has requested a religious exemption.) And, in 1999, the House voted against an amendment offered by Representative Chris Smith that would have broadened the exemption to plans that object to contraceptive coverage on the basis of "moral beliefs."

STRIKING THE RIGHT BALANCE

The framework we propose below for analyzing refusal clauses balances protection for the public health in general, reproductive health in particular, patient autonomy, and gender equality with protection for individual religious belief and institutional religious worship. We reject the imposition of religious doctrines on those who do

not share them, especially at the expense of the public health. At the same time, we seek the maximum possible accommodation of an individual's religious or conscientious objections, so long as patients' rights are not compromised as a result. We also seek to insulate pervasively sectarian institutions from having to comply with laws that interfere with their religious practices.

To strike the proper balance, policymakers and advocates must consider each proposed refusal clause carefully, tailoring it to its context. Concrete examples may be clearer than general principles: every rape survivor ought to be offered emergency contraception to protect herself from getting pregnant as a result of the assault, no matter where she is treated; an administrative assistant working at a Catholic university should not have to pay out-of-pocket for birth control pills because her employer believes contraception is a sin; but a church should not have to purchase contraceptive coverage for its ministers and other clerics; and a doctor, nurse, or pharmacist who cannot in good conscience participate in abortions or contraceptive services should be allowed to opt out, so long as the patient is ensured safe, timely, and financially feasible alternative access to treatment. The factors we identify for evaluating refusal clauses should lead to these kinds of fair results.

A FRAMEWORK FOR ANALYZING REFUSAL CLAUSES

Constitutional principles neither *require* nor *forbid* most refusal clauses.[11] Nevertheless, legal principles are useful in constructing a framework for analyzing when an exemption is called for and what it should look like. Based in part on our study of the case law, the ACLU has identified two measures for evaluating refusal clauses. We consider first whether granting an exemption would impose burdens on people who do not share and should not bear the brunt of the objector's religious beliefs. Exemptions that impose little or no burden on others are more acceptable; exemptions that impose substantial burdens are less so. By "burdens," we mean to include obstacles to health care and other critical personal interests, but we do not mean to include the mere exposure of third parties to religious practices or the tax or other financial burdens that may result from permitting certain exemptions. We consider next whether the exemption protects the religious practices of pervasively sectarian institutions or instead protects institutions operating in the public sphere. Exemptions that insulate core religious functions are more acceptable than those that spill over into the secular world.

These measures are not part of any currently accepted legal test. But they reflect concerns that have been an undercurrent in many relevant cases without necessarily determining the outcome of those cases. Although each measure has independent importance, there is some overlap between the two: the imposition of particular religious beliefs on those who do not share them is less likely within a pervasively sectarian institution performing religious functions than in a more secular setting.

Avoiding Burdens on Others

In the reproductive health context, the risk of imposition on those who do not share the objector's beliefs is especially great when an employer, hospital, health plan, pharmacy, or other corporate entity seeks an exemption. The refusal of such institutions to abide by reproductive health mandates directly affects employees, patients, enrollees, and customers of diverse backgrounds and faiths. The law should not permit an institution's religious strictures to interfere with the public's access to reproductive health care.

The courts have repeatedly shown themselves wary of the imposition of an institution's religious beliefs on others. In *Catholic Charities v. Superior Court,*[12] for example, the California Court of Appeal explained at length why the state was justified in adopting a narrow refusal clause that permitted only pervasively sectarian organizations—such as churches, religious orders, and some parochial schools—to refuse to include contraceptive coverage in health plans for their employees. A broader exemption, granting a right to refuse to Catholic Charities and other church-affiliated organizations that employ diverse workforces, would have meant "imposing the employers' religious beliefs on employees who did not share those beliefs." An expansion of the refusal clause would also have "undermine[ed] the anti-discrimination and public welfare goals of the prescription contraceptive coverage statutes."[13]

Another court expressed similar concerns in *St. Agnes Hospital v. Riddick.*[14] There, a board that oversees graduate medical education had withdrawn accreditation from a Catholic hospital's ob/gyn residency program because of several deficiencies, including the hospital's refusal to provide or otherwise allow its medical residents to obtain clinical training in contraception, sterilization, or abortion procedures. The hospital claimed that the withdrawal of its accreditation amounted to religious discrimination. The court rejected this claim, concluding that the state had

more than sufficient reason to insist on comprehensive medical education despite the hospital's religious objection. These reasons included the public's "overwhelmingly compelling interest in . . . competently trained physicians" and the importance of preventing the hospital from "impos[ing] its Catholic philosophy on its residents, many of whom are not Catholic."[15]

The threat of imposition on others is significantly reduced when the law protects individual—as opposed to institutional—decisions about whether to provide certain health services. The federal Church Amendment contains antidiscrimination provisions that shield the conscientious decisions of doctors, nurses, and other practitioners. These provisions serve as a useful model in that they protect both those who refuse to participate in and those who provide abortion or sterilization procedures.[16]

Laws that protect individual religious refusals offer important protections for health care professionals but may compromise the rights of patients unless adequate safeguards are included. There should be limits even to an individual health care provider's right to refuse. For example, whatever their religious or moral scruples, health professionals should give complete and accurate information and make appropriate referrals. Both legal and ethical principles of informed consent require doctors to tell patients about all treatment options, "including those [the doctor] does not provide or favor, so long as they are supported by respectable medical opinion." Doctors who refuse to treat should also "refer the patient to a physician who does offer or favor the alternative treatment."[17] Nor can a health care provider's religious or moral convictions ever justify endangering a patient's safety. Courts have been appropriately intolerant of lapses in medical professionalism, even when they are religiously motivated. For example, a federal appeals court held that a New Jersey hospital was not liable for religious discrimination in firing a labor and delivery nurse who twice refused on religious grounds to scrub for emergency obstetrical procedures. She refused, although in both cases the pregnant women's lives were threatened, and the hospital claimed her refusal in the second case dangerously delayed treatment for a hemorrhaging patient.[18]

Insulating the Religious Functions of Pervasively Sectarian Institutions

The second measure we use to evaluate refusal clauses focuses on the nature of the institution and activity exempted. Churches, temples, mosques, seminaries, and other pervasively sectarian institutions engaged in religious practices ought generally to be free of the requirements of laws repugnant to their beliefs. Among health care institutions, privately funded Christian Science sanatoria may exemplify those that should qualify for a religious exemption. Such sanatoria are staffed by Christian Science healers, and they attend only to those seeking to be healed exclusively through prayer.

When, however, religiously affiliated organizations move into secular pursuits—such as providing medical care or social services to the public or running a business—they should no longer be insulated from secular laws that apply to these secular pursuits. In the public world, they should play by public rules. The vast majority of health care institutions—including those with religious affiliations—serve the general public. They employ a diverse workforce. And they depend on government funds. A recent study found that Medicare and Medicaid accounted for 46% of total revenues to religiously affiliated hospitals in California in 1998, while unrestricted contributions, including charitable donations from church members, accounted for only .0015% (or $15 in every $10,000) of total revenues.[19] These institutions ought to abide by the same standards of care and reproductive health mandates as apply to other health care institutions.

Again, in deciding Free Exercise claims, the courts have recognized the importance of distinguishing the religious from the secular context. In refusing to allow employment discrimination claims by ministers and other clerics against their churches, for example, the courts have concluded that the state should not intrude into matters of church governance and administration because a church's autonomy in these areas is central to its religious mission.[20] The courts have also noted that the employees of churches and comparable religious institutions may be assumed, "based on the religious nature of the employment, [to] agree with or willingly defer their personal choices to the religious tenets espoused by their employer."[21] On the other hand, the courts have acknowledged the appropriateness of preventing entities engaged in secular endeavors from foisting their religious principles on members of the general public.[22]

WHERE THE PUBLIC STANDS

The ACLU recently conducted public opinion research—including focus groups and a nationwide telephone survey—on religious objections to providing reproduc-

tive health services. This qualitative and quantitative research shows that Americans overwhelmingly oppose laws that protect religious objectors at the expense of the patient's rights and the public health.

The public opposes refusal clauses that threaten access to health care.

- 89% oppose "allowing insurance companies to refuse to pay for medical services they object to on religious grounds."
- 88% oppose "allowing pharmacies to refuse to fill prescriptions they object to on religious grounds."
- 86% oppose "allowing employers to refuse to provide their employees with health insurance coverage for medical services the employer objects to on religious grounds."
- 76% oppose "allowing [hospitals] to refuse to provide medical services they object to on religious grounds."

The public's insistence on access reflects its view that *religious refusals jeopardize women's health and lives.* Seven in ten Americans are concerned, for example, that if "religiously affiliated hospitals are allowed to limit access to medical services, the health and lives of many women will be threatened."

The public believes that individuals must be allowed to make health care decisions for themselves. While proponents of refusal clauses often cast the issue as one in which religious liberty is pitted against reproductive rights, the public sees this dichotomy as false.

- 72% agree with the following statement: "Religious liberty is not threatened by requiring hospitals to provide basic medical care. We are not talking about limiting a person's ability to worship, but access to basic health care."

Even when the issue is presented as a choice between the religious interests of institutions and the health care decisions of individuals, however, the public backs the patient.

- 79% believe that it is "more important to respect the personal conscience of individuals making difficult health care decisions" than to "respect the conscience of a religious hospital."
- 69% believe that it is "more important to protect the reproductive freedom of women" than to "protect the religious freedom of religious hospitals."

Moreover, *the public believes that the government's first responsibility is to protect the public health.*

- 72% are more concerned that the government hold "all hospitals—whether religiously affiliated or not—to the same standards" than they are about keeping "the government from forcing religious hospitals to violate their beliefs."
- 83% believe that "if a hospital receives government funds, it should be required to provide basic, legal medical services, regardless of the hospital's religious objections."

Overall, our public opinion research shows that Americans are deeply troubled by the idea that religious interests could come between them and their health care needs.

H.R. 4691—A BROAD AND DANGEROUS REFUSAL CLAUSE

Based on the framework outlined above, the ACLU opposes H.R. 4691, a bill sponsored by Chairman Michael Bilirakis (R-FL), Majority Leader Dick Armey (R-TX), and Representative Joseph Pitts (R-PA). H.R. 4691 would allow a broad range of health care entities to refuse to comply with a wide array of federal, state, and local requirements to provide reproductive health services. As noted above, the United States Constitution does not require any exemption—let alone such a broad exemption—from compliance with public health laws. Moreover, H.R. 4691 fails the test set forth in the ACLU's framework because its burdens would fall primarily on those who do not share the beliefs that motivate the refusal and because it protects institutions engaged in the public and secular provision of health care.

H.R. 4691 would build upon the Coats Amendment, an existing federal refusal clause described above. If enacted, the newly expanded language would provide (amendments in italics):

> The Federal Government, and any State or local government that receives Federal financial assistance, may not subject any health care entity to discrimination on the basis that—
>
> > (1) the entity refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform, *provide coverage of, or pay for induced* abortions, or to provide referrals for such training or such abortions;
>
> . . .
>
> (c) Definitions:

For purposes of this section:

. . .

(2) The term "health care entity" includes an individual physician *or other health professional,* a postgraduate physician training program, a participant in a program of training in the health professions, *a hospital, a provider sponsored organization, a health maintenance organization, a health insurance plan or any other kind of health care facility, organization or plan.*

Practical Effects of the Proposal

The main effect of H.R. 4691 is to prohibit a governmental entity from "discriminating"—that is, treating a health care entity differently—on the basis of the entity's refusal to perform, refer, train, cover, or pay for abortions. But what constitutes "discrimination" would no doubt be the subject of debate and potential litigation.

H.R. 4691 could have the following effects, among others:

- **It would compromise the ability of Title X clients to obtain information critical to their health.** Title X, which provides federal funds for contraceptive services for low-income individuals, requires that grantees provide a referral to a qualified abortion provider upon request as part of non-directive options counseling for pregnant women. H.R. 4691 would prohibit the federal government from enforcing this regulation if it were deemed "discriminatory" to deny Title X grants to providers that refuse to make abortion referrals. The bill could thus undermine federal standards and compromise the health of low-income pregnant women by denying them critical information.
- **It would interfere with the delivery of abortion services to poor women in dire emergencies.** H.R. 4691 would impede a state's ability to comply with the federal Hyde Amendment, which mandates coverage of abortions for women in the Medicaid program in cases of rape, incest, or where the pregnancy endangers a woman's life. Requiring Medicaid managed care organizations that participate in the program to provide such coverage could constitute "discrimination" against those that refuse to provide or refer patients elsewhere for these services.
- **It would interfere with states' ability to enforce their own laws on abortion.** H.R. 4691 could prevent those states that cover medically necessary abortions beyond those mandated by the Hyde Amendment (whether as a result of state constitutional rulings or by virtue of state laws) from effectuating that coverage by contracting only with Medicaid managed care organizations that agree to provide or refer for abortion services. Currently, more than fifteen states require such coverage. H.R. 4691 would interfere with these states' ability to enforce their own laws and constitutional decisions and to manage and ensure delivery of mandated services within their own Medicaid programs.
- **It would disrupt the enforcement of state health care regulations.** H.R. 4691 would thwart the enforcement of state and local laws that require entities certified or licensed by the state to address the full range of health care needs in the communities they serve. A state might be prevented, for example, from denying a "certificate of need" (a state-issued document that is similar to a permit and that is often required before two hospitals can merge) to a newly merged hospital that refused to provide even lifesaving abortions and thus left pregnant women in the community without help in medical emergencies. (Mergers between a religiously affiliated hospital and a secular hospital often raise this issue because some religiously affiliated hospitals insist that the newly merged entity apply religious doctrine in the provision of health services.)
- **It could immunize a health care entity's refusal to provide emergency contraception, even to victims of rape.** Because it does not define the term "abortion," H.R. 4691 could permit health care entities to refuse to provide emergency contraception, even to victims of rape. Although emergency contraception is merely a high dose of ordinary birth control pills and does not interrupt an established pregnancy, some religiously affiliated providers define emergency contraception as an "abortifacient." Health care entities that subscribe to this view could use this bill to attempt to shield themselves from repercussions for refusing to comply with state laws that require hospitals to provide emergency contraception (or referrals for emergency contraception) to rape survivors who present in their emergency rooms.

CONCLUSION

Even interpreting it conservatively, H.R. 4691 is a potentially sweeping federal exemption from current legal and regulatory requirements that govern access to

health services. In fact, it amounts to a broad non-compliance permit for religiously affiliated entities that serve the general public and receive public funds, but nevertheless want exemptions from the general laws that govern other health care entities. The ACLU therefore opposes this dangerous measure and respectfully urges this Subcommittee to reject it.

ENDNOTES

[1] Ms. Smith's name has been changed to protect her identity.
[2] Neb. Rev. Stat. § 28-237.
[3] 410 U.S. 113 (1973).
[4] *See Taylor v. St. Vincent's Hosp.,* 523 F.2d 75, 76 (9th Cir. 1975).
[5] 42 U.S.C. § 300a-7.
[6] *Id.* § 300a-7(c), (d), (e).
[7] 42 U.S.C. § 238n.
[8] 42 U.S.C. § 1396u-2(a)(5)(D).
[9] 42 U.S.C. § 1396u-2(b)(3).
[10] Omnibus Consolidated and Emergency Supplemental Appropriations Act, Pub. L. No. 105-277, § 656, 112 Stat. 2681 (1998).
[11] *Employment Div. v. Smith,* 494 U.S. 872 (1990) (holding that the Free Exercise Clause does not entitle religious objectors to exemptions from neutral, generally applicable laws); *Corp. of the Presiding Bishop v. Amos,* 483 U.S. 327 (1987) (holding that the Establishment Clause does not prohibit an exemption from Title VII of the Civil Rights Act that permits religious organizations to discriminate on the basis of religion in employment decisions.).
[12] 109 Cal. Rptr. 2d 176 (Ct. App.), *petition for review granted,* 31 P.3d 1271 (Cal. 2001).
[13] *Id.* at 183.
[14] 748 F. Supp. 319 (D. Md. 1990).
[15] *Id.* at 330. The Accreditation Council for Graduate Medical Education (ACGME) has since made clear that ob/gyn residency programs must offer clinical training in contraception and sterilization. In addition, the current standards require clinical training in abortion, unless a residency program has a "religious, moral, or legal restriction," in which case the program must nevertheless (1) ensure that residents receive training in how to manage abortion complications; (2) permit residents to receive abortion training elsewhere; and (3) publicize the restriction to all residency applicants. Program Requirements for Residency Education in Obstetrics & Gynecology § V.A.2.d., e. (ACGME, effective Sept. 1999), http://www.acgme.org/req/220pr999.asp. As discussed above, however, the Coats Amendment requires that residency programs be treated as accredited—for licensing, funding, and other governmental purposes—notwithstanding any refusal to offer, refer for, or arrange for abortion training. 42 U.S.C. § 238n.
[16] 42 U.S.C. § 300a-7(c), (d), (e).
[17] President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions: A Report on the Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship 76 (1982); *see also* Principles of Medical Ethics of the American Medical Association, Policy E-8.08 Informed Consent (issued 1981), available at http:// www.ama-assn.org (using policy finder); American College of Obstetricians & Gynecologists Committee Opinion No. 108, Ethical Dimensions of Informed Consent 7-8 (1992).
[18] *Shelton v. Univ. of Med. & Dentistry,* 223 F.3d 220 (3d Cir. 2000).
[19] Lois Uttley & Ronnie Pawelko, MergerWatch Project, Educ. Fund of Family Planning Advocates of N.Y.S., No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States 15 (2002).
[20] *See, e.g., Gellington v. Christian Methodist Episcopal Church,* 203 F.3d 1299 (11th Cir. 2000).
[21] *Catholic Charities,* 109 Cal. Rptr. 2d at 189.
[22] *Riddick,* 748 F. Supp. at 330; *Catholic Charities,* 109 Cal. Rptr. 2d at 189.

Mr. BILIRAKIS. Mr. Wardle, please proceed, sir.

Thank you, Ms. Weiss.

STATEMENT OF LYNN WARDLE

Mr. WARDLE. Thank you. Mr. Chairman and distinguished members of this subcommittee, I am honored to be invited to present testimony today. I have studied and written about abortion for over two decades, and I have seen the transformation of the debate. Initially, advocates of permissive abortion desired to give women the private choice to select abortion. They asserted that they did not intend to force anyone to do anything, but they just sought to repeal laws that prohibited one option available to them that they thought should be available. However, once that goal was achieved by judicial decree, it was not long before they demanded that public funds be available to pay for those abortions and that public hospitals should be forced to perform abortions. Fortunately, although

the ACLU and other organizations instigated and provoked years of litigation to try to force, through interpretation of the Constitution, that public facilities be made available, the Supreme Court rejected those claims.

But they didn't stop there. They have now attempted to enact regulation for accrediting medical schools and teaching hospitals. Where was the ACLU when that conscience debate was fought? Those who claim to stand for the rights of conscience ought to have a record that supports that claim.

When the ACGME regulation was proposed and the battle was fought for the Coats Amendment, Congress had to step forward to pass an amendment to prevent coercion to protect the rights of conscience of medical students and doctors and hospitals. Recently, there has been a series of attempts to compel hospitals and health care groups and other health care organizations to provide abortion services or to give up licenses or be denied the permission to continue to provide medical health services. Also there have been attempts to force health care insurers and private employers to provide abortion coverage and of abortion payment. This isn't free choice, this isn't privacy, this isn't equality, this is bald coercion.

The Supreme Court decisions on abortion funding are very clear, that the Constitution does not require, in spite of the efforts of those who claim to be speaking for choice, to force others to engage in practices that are against their conscience. Let me give you a few examples, incidents that have occurred, just the tip of the iceberg. There was a 1980's study of nurses in America that revealed that 5 percent of those studied, which extrapolated would be 50,000 nurses in America, perceived that their assignment or promotion opportunities had been limited by their moral and religious beliefs about abortion. They identified over 100 incidents in which that had occurred just in the sample. We can give incidents of—these are from the Protection of Conscience web site. Nurses refused employment, forced to resign, workers fired for refusing payment for illegal abortion, worker fired for—hospital aide fired for refusing to clean abortion instruments, K-Mart pharmacist fired for refusing to dispense abortifacient, student pressured to participate in abortion, hospital forces nurses to participate in genetic terminations, more D.C. medics, referring to District of Columbia, say they were forced to have abortions, and now of course Mayor Bloomberg's new policy in New York requiring, mandating all city hospitals to provide abortion training. This is the media mogul who once reportedly told an employee who said she was pregnant, "Kill it, kill it."

Rights of conscience are so fundamental to our country I just want to—the policy decision that is at issue here was made over 30 years ago when the Church Amendment was enacted. It was enacted to protect a hospital with a religious affiliation from having to perform abortions. It passed handily, but it has had to be amended in light of repeated new tactics designed to coerce the denial of and to bar the exercise of rights of conscience.

One of the speakers earlier referred to this as a major expansion, this proposed bill. I would respectfully disagree. This is not a major expansion but it is an effort to close a loophole that is undergoing—seen a major expansion in tactics to circumvent the policy and purpose of the law. When we talk about respect for rights of religion

and religious conscience, we have to put action behind our words. We can't be like Cromwell. Wasn't it Cromwell who said he would respect the religious liberty, but if anyone tried to celebrate the mass, he would burn them at the stake? We see echoes of that in some of the statements by people who are trying to force others to perform abortions against their conscience: "Oh, I respect your right of conscience, but you had better perform an abortion or if not, you will be fired or you will lose your license, you will lose your certificate of authority."

It is ironic that this bill comes at this time before this committee, because I believe this committee has been recently testimony about scandals that resulted when conscience was anesthetized in business practices. And we have seen a call by our President for a revival and renewal of conscience. And yet at the same time, witnesses are asking this committee to not pass a law to protect the rights of conscience in the health care field? I think that it is extremely ironic and would be a tragedy.

Mr. BILIRAKIS. Please summarize, sir.

Mr. WARDLE. I urge this committee to enact the Abortion Non-Discrimination Act. Thank you.

[The prepared statement of Lynn Wardle follows:]

PREPARED STATEMENT OF LYNN D. WARDLE,[1] J. REUBEN CLARK LAW SCHOOL, BRIGHAM YOUNG UNIVERSITY

I. INTRODUCTION

Today a growing number of health care practices, procedures, and medications present serious moral concerns for many health care providers. Recent medical and pharmacological developments increasingly put health care entities at the vortex of some of society's most controversial moral dilemmas. These include issues relating to providing, performing, participating in or facilitating as abortion (both by traditional surgical methods and also by chemical methods such as the "Morning After Pill"), human cloning, embryonic stem cell techniques, genetic engineering including sex preselection, DNA screening for genetic disorders, sterilization, contraception, sex-change, euthanasia, assisted suicide, and capital punishment by lethal injection, to name just a few medically-related practices with profound moral implications. Increasingly there is pressure upon health care providers, both individuals and organizations (such as clinics, hospitals, practice groups, and insurers) to put aside personal moral beliefs in order to facilitate convenient access to new drugs, procedures, and technologies.

In the ordinary course of professional life, without any additional pressures, these dilemmas arise often enough to create crises for tens of thousands of health care entities. However, in addition to these dilemmas there is increasing pressures upon health care participants to facilitate or provide products or services which violate their own consciences. Advocates of particular procedures and programs, particularly major providers of promoters of abortion are systematically singling out health care providers and entities to squeeze and compel them to abandon their moral values as the price to pay to remain in the profession and market.

[1] Professor of Law, J. Reuben Clark Law School. I engaged in scholarly research and writing about these issues for over two decades, and teach a law school Seminar on Biomedical Ethics and Law. *See* Lynn D. Wardle, *The Quandary of Pro-life Free Speech: A Lesson from the Abolitionists,* 62 ALBANY L. REV. 853-966 (1999); Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers,* 14 J. LEGAL MEDICINE 177-230 (1993); Lynn D. Wardle, *A Matter of Conscience: Legal Protection for the Rights of Conscience of Health Care Providers,* 2 CAMBRIDGE Q OF HEALTH CARE ETHICS 529-42 (1993). I express appreciation to my research assistant, William J. Perkins, especially for updating the summary of state laws protecting conscience, and to Maureen Kramlich, for their assistance in providing material that helped in preparing this Statement. Of course, the opinions expressed herein are my own professional opinions and I do not speak for or represent any other person or organization.

II. OVERVIEW OF THE DEVELOPMENT OF THE CRISIS OF CONSCIENCE

I have closely studied abortion law and policy in the United States for thirty years, and have seen the transformation. Initially, advocates of permissive abortion argued that they merely desired to give women the private choice to select abortion. They asserted that they did not intend to force anyone to do anything, but only sought to repeal laws that prohibited one option—abortion—that they believed should be available to pregnant women.

However, after that goal was achieved by judicial decree,[2] it was not long before they demanded that public funds be available, that public hospitals should be forced to provide the service which they considered so desirable. In a series of cases, they repeatedly tried to get the Supreme Court to interpret the Constitution so as to invalidate laws that restricted public funding and provision of abortion in public hospitals.[3] Fortunately, the U.S. Supreme Court turned them down every time. Sadly, a number of state courts have not been so fair, and have accepted these zealots' demands that the state constitutions be interpreted to judicially mandate public funding of abortion.[4]

Then they tried to stop citizens who wished to exercise their right to peacefully assemble in opposition to abortion, and to punish individuals who tried to offer free, peaceful "sidewalk counseling" to pregnant women to advise them about alternatives to abortion. While the Supreme Court has invalidated many (but not all) of such laws and decrees,[5] the effort to suppress pro-life free speech continues, led ironically by the same organizations that championed "the right to choose."[6]

Just a few years ago, they attempted to enact regulations for accrediting medical schools and teaching hospitals to force medical students and young doctors to be trained to perform abortions. Congress had to step forward and pass a law to prevent that coercion and to protect the rights of conscience of medical students, doctors and hospitals.[7]

Recently, there have been a series of attempts to compel hospitals, health care groups, and other hare care organizations to either provide abortion services or to be denied the license, permission or opportunity to engage in the health care service.[8] Also, there have been attempts to mandate that health care insurers and private employers provide coverage and pay for abortion services.

The Supreme Court has declared that the Constitution protects private choice of abortion against state prohibition.[9] The Court has emphasized that it does not compel public assistance, support or facilitation of abortion.[10] The decisions can be read as neutrality decisions—the state must not use its power to *coerce* a decision one way or another regarding childbirth or abortion. The government may prefer, persuade, encourage, and promote one way or the other, but it may not compel.

The private choice to decline to participate in abortion deserves no less protection than the choice to participate in abortion.

Yet zealous abortion activists continue to try to use the powers of government to compel participation in and payment for and coverage of abortion. Specifically, they try to compel hospitals, clinics, provider groups, and health care insurers to provide facilities for, personnel for, and funding for abortion.

---

[2] Roe v. Wade, 410 U.S. 113 (1973).

[3] *See* Maher v. Roe, 432 U.S. 464 (1977); Beal v. Doe, 432 U.S. 438 (1977); Poelker v. Doe, 432 U.S. 519 (1977); Harris v. McRae, 448 U.S. 297 (1980); Williams v. Zbaraz, 448 U.S. 358 (1980); Rust v. Sullivan, 500 U.S. 173 (1991).

[4] *See, e.g.,* Alaska v. Planned Parenthood, 28 P.3d 904 (Alaska 2001); New Mexico Right to Choose/NARAL v. Johnson, 975 P.2d 841 (N.M. 1998); Women of Minn. v. Gomez, 542 N.W.2d 17 (Minn. 1995); Moe v. Sec'y of Admin. & Fin., 417 N.E.2d 387 (Mass. 1981); Comm. to Defend Reprod. Rights v. Myers, 625 P.2d 779 (Cal. 1981).

[5] *See, e.g,* Frisby v. Schultz, 487 U.S. 474 (1988); Bray v. Alexandria Women's Health Clinic, 508 U.S. 263 (1993); National Organization for Women, Inc. v. Scheidler, 510 U.S. 249 (1994); Madsen v. Women's Health Center, Inc., 512 U.S. 753 (1994); Schenck v. Pro-Choice Network of Western New York, 519 U.S. 357 (1997); Hill v. Colorado, 120 S.Ct. 2480 (June 28, 2000).

[6] Lynn D. Wardle, *The Quandary of Pro-life Free Speech: A Lesson from the Abolitionists,* 62 ALBANY L. REV. 853-966 (1999).

[7] 42 U.S.C. § 238n.

[8] *See generally* Valley Hosp. Ass'n v. Mat-su Coalition for Choice, 948 P.2d 963, 965 (Alaska 1997); See also Doe v. Bridgeton Me'l Hosp. Ass'n, 366 A.2d 641 (N.J. 1976).

[9] *See* Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood v. Casey, 505 U.S. 833 (1992); *see also* Maher v. Roe, 432 U.S. 464 (1977); Beal v. Doe, 432 U.S. 438 (1977); Poelker v. Doe, 432 U.S. 519 (1977).

[10] *See supra,* note 6.

III. EXAMPLES OF ABUSES OF RIGHTS OF CONSCIENCE

In repeated cases, pro-abortion extremists are trying (successfully in many cases) to assert the position that a health care entity who will not perform abortions must be denied access to the public market. For instance, currently there is a battle in New Jersey in which pro-abortion zealots are trying to stop the merger of a secular hospital with a religious hospital group because that will result in the hospital not performing abortions.[11] Rather than helping some abortion clinic in the area to expand or operate more actively in the area, the pro-abortion zealots are taking the position that a hospital who does not perform abortion must be disqualified from participating in the health care profession.

In recent years, there have been a number of incidents involving apparent violations of the rights of conscience of health care workers in the United States. Well known is the attempt by the ACGME to require all Ob/Gyn residents in all Ob/Gyn programs be trained to perform abortions.[12] During the 1999 California legislative session, a bill was introduced that would have, among other things, disallowed hospitals that decline to participate in abortion from receiving public financing or state-funded health care contracts.[13] In Connecticut, after abortion rights activists learned that an outpatient surgical center proposed by four hospitals would not perform abortion and sterilizations, they formed a coalition to defeat the proposed center and intervened in Certificate of Need proceedings and the Connecticut Office of Health Care Access refused to issue a certificate.[14] Incidents in which hospital mergers to help struggling hospitals survive have occurred in New Hampshire, Florida, and New York, as well.[15] I cite just a few headlines from the Protection of Conscience website: "Nurse Refused Employment, Forced to Resign" (she refused to participate in abortions); "Worker fired for refusing payment for illegal abortion (refused to sign for welfare payment for abortion); "Hospital Aide Fired for Refusing to Clean Abortion Instruments"; "Kmart Pharmacist Fired for Refusing to Dispense Abortifacient" (other workers had done it for her); "Student pressured to participate in abortion" (in Saskatchewan, Canada, 1999); "Foothills Hospital Now Forces Nurses To Participate In Genetic Terminations" (nurses angry about being forced to participate in abortion of imperfect and late term babies); and "More DC Medics Say They Were Forced to Have Abortions."[16] Michael Bloomberg, the new Mayor of New York, now compels abortion training as an "additional required component to OB/GYN residency programs in all New York City city-owned hospitals. The training is outlined in Michael Bloomberg's Blueprint for Public Health along with a proposal requiring victims of sexual assault to be given emergency contraception when taken to emergency rooms. Previously, only 2 out of the 11 public hospitals include abortion as part of their training. The training will teach OB/GYNs how to perform abortions and provide counseling."[17] News reports say that Bloomberg's plan "allows residents who object to abortion on moral grounds to forego the training."[18] But what pro-abortion politicians consider an appropriate exemption for rights of conscience often turns out to be mere eye wash, narrow, ineffective and cynical. "[T]he media mogul . . . reportedly once told a pregnant employee to "Kill

---

[11] Beth E. Fand, Hospital focus of reproductive rights battle, The Burlington County Times (NJ), July 9, 2002, <http://www.nj.com/news/times/burlington/index.ssf?/base/news-0/102620880525536.xml> (viewed July 9, 2002).

[12] AAPLOG website, <http://www.aaplog.org>.

[13] A.B. 525, 1999-2000 Leg., Reg. Sess. (Ca. 1999).

[14] State of Connecticut Office of Health Care Access Applicants: Roy D. Bebe, M.D., Harford Hospital, John Dempsey Hospital, New Britain General Hospital, Saint Francis Hospital and Medical Center, ASC Network Corporation Docket Number 96-547 ("Establish and Operate a Freestanding Ambulatory Surgery Center in Avon") and Applicant Saint Francis Hospital and Medical Center Docket Number 96-537 ("Establish and Operate a Freestanding Ambulatory Care Center in Avon") letters denying applications dated September 29, 1997, signed by Raymond J. Gorman, Commissioner.

[15] N.H. Att'y. Gen. Rep. on Optima Health, March 10, 1998. City of St. Petersburg v. Bayfront Medical Center, Inc., Bayfront Health System, Inc. and Baycare Health System, Inc. Case No. 8:00-CV-623-27A (M.D. Fla.)—Middle District of Florida Tampa Division Proposed Final Order—approved by City Council on April 10, 2001S. 333, 2001-2002 Reg. Sess. (Ny. 2001) (requiring insurance coverage for "certain women's reproductive health services," by hmos, including abortion); A. 2674, 2001-2002 Reg. Sess. (Ny. 2001) (requires review of changes in hospital mission statement); A. 4397, 2001-2002 Reg. Sess. (Ny. 2001) (public health council to find that "health care needs" will continue to be met after a merger).

[16] Protection of Conscience Project, http://www.consciencelaws.rg/Repression-Conscience.html> (7 Nov. 2001).

[17] Nikki Katz, *Bloomberg Requiring Additional Abortion Training, About Women's Issues* <http://womensissues.about.com/library/weekly/aa011002a.htm> (seen 29 Jan 2002); *NYC Mayor to Mandate Abortion Training for Docs,* Village Voice, Jan. 8, 2002.

[18] *Id.*

it! Kill it!" (The comment, which Bloomberg has denied making, was cited in the legal papers of Sekiko Sakai Garrison, a former Bloomberg News staffer who brought one of three publicized sex-harassment cases against him or his company.)" [19]

These examples reveal only the tip of the iceberg. A landmark empirical study of, *inter alia,* nurses attitudes about and difficulties encountered because of personal objection to abortion and other medical procedures in the 1980s revealed that approximately 5% of the nurses sampled (which extrapolated out would amount to approximately 50,000 nurses in the United States) perceived that their assignment and promotion opportunities may be limited by their moral and religious beliefs about abortion.[20] The nurses in this sample "identified a total of 103 definite cases in which nurses had either been dismissed or had their opportunities limited because of moral beliefs . . . [F]ifty-seven cases were identified in which the nurses beliefs about abortion had cost them opportunities for promotion or sustained employment." [21] Moreover,

> [a]pproximately 7% of Catholic nurses, 4% of Protestant nurses, and 6% of those belonging to 'other' religions indicated they knew at least one other person whose opportunities with hospitals had been limited by personal beliefs . . . Thirty-six nurses [in the national sample] identified a total of 118 of their colleagues who had been limited as a result of their moral and religious beliefs.[22]

IV. EXISTING CONSCIENCE CLAUSE PROTECTION LAWS

These incidents attempt to circumvent existing laws enacted by Congress and 49 states enacted to provide some protection for the rights of conscience of health care workers in at least some situations.[23] The laws, called "conscience clauses" generally are drafted to protect the right of health care professional to refuse to participate in providing a service or procedure to which they have religious or other moral objections. Conscience clauses have been enacted by both federal and state law makers. Sadly, many of these laws are outdate, addressing concerns that are nearly 30 years old, but not address the more recent threats to rights of conscience. Conscience clauses can be traced to a specific judicial decision that provoked a firestorm of controversy. In November 1972 a United States District Court in Billings, Montana issued an injunction forbidding a Catholic hospital to deny the use of its facilities to a physician who wanted to perform a sterilization on a patient there.[24] The suit to enjoin the hospital was brought under 42 U.S.C. § 1983 and 28 U.S.C. § 1343, which provide redress for deprivation of civil rights under color of state law. The district court ruled that the fact that the hospital had received public funds under the federal Hill-Burton Act was alone sufficient to make the hospital a "state actor" for purposes of those civil rights statutes. The next year, in direct response to that ruling, and just months after the Supreme Court's decision in Roe v. Wade,[25] Congress passed the Church Amendment, the original federal conscience clause, 42 U.S.C. § 300a-7, which was designed to prohibit a court or a public official from using receipt of federal grants or assistance under three specific acts,[26] as a basis for requiring any individual or institution to perform or assist in performing abor-

---

[19] *Id.;* Cybercase News Service, Jan. 9, 2002.

[20] Durham, Wood & Condie, *supra note*____, at 257, 287.

[21] *Id.* at 287.

[22] *Id.* at 258. Again, extrapolated over the entire nursing profession this would represent approximately tens of thousands of nurses who have been the victim of employment discrimination because of their religious or moral beliefs. *Id.* at 258.

[23] There is some inconsistency in the reports on the number of states with some conscience clause protection. Seven years ago, I identified 44 states with such laws and six without any. Americans United for Life, which does very reliable work, that 46 states now have conscience clauses. *See further* Katherine A. White, Note, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights,* 51 Stan. L. Rev. 17031707 n. 18 (1999), citing Rachel Benson Gold, *Special Analysis: Provider 'Conscience' Questions Re-emerge in Wake of Managed Care's Expansion,* in State Reproductive Health Monitor 18 (1997). AUL identifies the four states without any protection of rights of conscience as Alabama, Mississippi, New Hampshire and Vermont. With the aid of a very good research assistant, Brittany Howick, however, I have found that Mississippi and New Hampshire each have a law protecting the rights of conscience in the context of living wills or end of life directives made for a patient by another. Thus, it appeals that all states except Alabama and Vermont have some statutory protection for some rights of conscience of some health care providers in at least some cases.

[24] *See* Taylor v. St. Vincent's Hospital, 369 F.Supp. 948, 950 (D.C.Mont., 1973) (quoting H.R. No. 93-227; 1973 U.S.Code Cong. & Admin.News p. 1553), *aff'd* 523 F.2d 75 (9th Cir. 1975).

[25] 410 U.S. 113 (1973).

[26] The three acts are: The Public Health Service Act, the Community Mental Health Centers Act, and the Developmental Disabilities Services and Facilities Construction Act.

tions or sterilizations, if such would be contrary to religious or moral beliefs.[27] Because of the Supreme Court decision in Roe effectively required all states to legalize nontherapeutic abortion on demand, the conscience clause movement became immediately relevant, and most states enacted conscience clauses to protect the right of at least some health care providers to refuse to perform or participate in abortions.

The Church Amendment is still the main federal protection for the rights of conscience of health care providers. Additionally, Title VII of the Civil Rights Act requires employers generally to accommodate the religious beliefs of their employees that do not cause undue hardship.[28]

Also, in 1997 Congressional "amendments extend[ed] conscience protections to cover Medicaid and Medicare managed care plans, which may now refuse to 'provide, reimburse for, or provide coverage of a counseling or referral service if the . . . organization offering the plan . . . objects to the provision of such service on moral or religious grounds . . .'"[29]

Forty-nine states provide at least some protection for rights of conscience of some health care providers in some circumstances.[30] (Only Vermont has no statutory protection for rights of conscience whatever.) However, only one state, Illinois, has a comprehensive conscience protection law that covers all health care providers, institutions, and payers and applies to all health care services. One other state, Washington, protects the right of conscience to refuse to participate in any health care services and covers all individuals but only religiously-affiliated institutions.

Abortion is the focus of most conscience clauses. Forty-five states allow some health care workers to refuse to participate in abortions. Twenty-five states' conscience clauses cover *only* abortion. Ten states allow health care workers to exercise their right of conscience to not participate in abortion only if working for individuals or private institutions. Two states conscience protection laws cover abortion but apply only when the health care provider is an individual, and one other state has a similar restriction covering sterilization also. Four states cover specifically abortion and contraception. One state covers health care providers regarding abortion, sterilization and artificial insemination, and another covers only abortion, abortifacients, and sterilization. At least three states (California, Mississippi and New Hampshire, and I suspect more but have not done the research) protect a right of health workers to decline to participate in some end-of-life decision implementations in limited circumstances. Two states cover counselors and social workers in some contexts. One state protects the right of pharmacists to not participate in abortion, assisted suicide and euthanasia. Eleven states protect the rights of conscience of medical and nursing students in some situations. Only nine of the sixteen states that mandate health insurance plans to include contraceptive drugs or devices if prescription drugs are covered contain any conscience clause provisions (usually limited to religious employers).

Existing conscience clause laws are inadequate as drafted for at least five major reasons. First, most are very narrow in terms of the practices, procedures or contexts in which they apply—most were drafted with abortion and sterilization in mind and go no further. Second, many of them are very narrow and restrictive, covering only a small group of health care providers, not workers in the health care industry generally. Third, the scope of protection (the discrimination forbidden) is limited. Fourth, the remedies and procedures for vindicating the rights are undeveloped and restricted. Fifth, most of the laws are outdated, having been written before many of the medical developments occurred that have created some of the most difficult moral dilemmas.

V. HOSTILE INTERPRETATIONS

In addition to the deficiencies of drafting, there are problems of interpretation. Judicial interpretation of these statutes has been very grudging, even hostile. In contrast to how civil rights laws in general have been construed during the past thirty years, conscience clauses have received very cold, unsympathetic, unsupportive reception by state and federal judges. Judges have given narrow, hostile interpretation regarding procedures covered, persons covered, protections provided, and have casually circumvented the laws by invoking other laws.

---

[27] 1973 U.S. Code Cong. & Admin. News 1473, 1553.

[28] 42 U.S.C. § 2000.

[29] Katherine A. White, Note, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights,* 51 Stan. L. Rev. 1703, 1708 (1999), citing Balanced Budget Act of 1997, Pub. L. No. 105-33, tit. IV, § 1852(j)(3)(B), 111 Stat. 251, 295.

[30] *Current State Statutes, January 2002,* in Americans United for Life, Health Care Rights of Conscience Act, Model Legislation and Policy Guide, January 2002 (herein "AUL Rights of Conscience Act").

In the limited time available to me, I cannot adequately convey the hostile tenor of most of the cases interpreting conscience clauses. Let me just give you a few selected examples. For example, in *Browhfield v. Daniel Freeman Marina Hospital.*[31] In that case, a rape victim asked an emergency room worker at a Catholic hospital about the availability of the "morning after" pill. The worker declined to give any information because of her religious beliefs. The patient brought suit against the hospital, and the hospital raised the California conscience clause in defense. That statute provided that "no nonprofit hospital or clinic which is organized or operated by a religious corporation . . . or its administrative officers, employees, agents or . . . governing board shall be liable . . . for failure or refusal to perform or to permit the performance of an abortion in such facility or clinic or to provide abortion services."[32]

Thus, the case turned on whether the morning after pill produced abortion. Finding no definition of "abortion" in the statute, the court made no effort to discern legislative intent (specifically, regarding the morning after pill, or generally, regarding protecting conscience rights of health care providers), and made no effort to interpret the statute in light of the policy underlying the statute or to achieve integrity within the structure of the provision, or to determine as a matter of judicial notice whether the morning after pill was understood by the medical community or the Catholic medical community to cause abortion.[33] Instead, citing dicta in another case suggesting that at least one federal court did not consider the morning after pill to be an abortifacient,[34] the California court summarily concluded that the hospital's refusal was not protected because the morning after pill did not cause abortion.[35]

While the conclusion of the court that the morning after pill does not cause abortion in at least some cases is probably inaccurate, the method of statutory construction is even more disturbing. The question the court had was one for which a resort to random dicta in other cases giving unsupported judicial ruminations in the context of interpreting entirely different statutes enacted by a different government is not an intelligent approach to legislative interpretation. The *Brownfield* case is an example of how judges can manipulate the interpretation of a statute to reach the outcome they prefer for personal or ideological reasons. Thus, it illustrates an unfortunate but very real risk for those who try to rely upon the current generation of conscience clauses.

In *Spellacy v. Tri-County Hospital*,[36] Pennsylvania courts held that a part-time admissions clerk who claimed that she was fired by the hospital as a result of her refusal to participate in the admission procedures of abortion patients was not protected by the state's conscience clause because her position was one of mere "ancillary" or "clerical" assistance.[37]

Likewise, in *Erzinger v. Regents of University of California,* the California Appellate court noted: "The proscription only applies when the applicant must participate in acts related to the actual performance of abortions or sterilizations. Indirect or remote connection with abortions or sterilizations are not within the terms of the statute."[38]

The same bias is reflected in the dissenting opinion of two Montana Supreme Court justices in *Swanson v. St. John's Lutheran Hospital.*[39] That case involved a

---

[31] 256 Cal. Rptr. 240 (Cal. App. 2989).

[32] Cal. Health & Safety Code § 25955k. Six years ago, this statute was revised and recodified Cal. Health & Safety Code 123420 (2001) without substantive change.

[33] While the conclusion of the court that the morning after pill does not cause abortion is medically inaccurate (in at least some cases), the method of statutory construction is even more disturbing. The question the court had was one for which a resort to random dicta in other cases giving unsupported judicial ruminations in the context of interpreting entirely different statutes enacted by a different government is not an intelligent approach to legislative interpretation.

[34] *McRae v. Matthews,* 421 F. Supp. 533 (ED. N.Y.1976), *rev'd on other grounds, Harris v. McRae,* 448 U.S. 297 (1980). The court also cited dicta from another case.

[35] *Brownfield,* 256 Cal.Rptr. at 245.

[36] 18 Empl. Prac. Dec. (CCH) ¶8871 (Pa. C.P. De. Cty.), *aff'd,* 395 A.2d 998 (1978).

[37] *Id.* at 5605 (relying on administrative regulations interpreting the conscience clause). Alternatively, the court found that the hospital had met its duty to accommodate because it had offered her four others jobs, all of which she had declined. "There came a time in the *Spellacy* situation when the plaintiff had simply rejected one too many reasonable accommodation offers, and her employer could not be expected to continue generating new ones." Durham, Wood & Condie, *supra* note ___, at 318-319.

[38] Erzinger v. Regents of University of California, 137 Cal. App. 3d 389, 394, 187 Cal. Rptr. 164, 168 (1982). The court held that 42 U.S.C. § 300a-7 did not apply to prevent a university from requiring students to participate in a comprehensive health insurance program which included benefits for persons desiring abortions or sterilizations.

[39] 597 P.2d 702 (1979).

wrongful discharge action brought by a nurse-anesthetist who had worked at a hospital for eight years. She had performed more than two dozen sterilizations, but after participating in one particularly shocking and gruesome abortion, she informed her supervisor that she would not participate in any more sterilizations. The hospital administrator tried to change her mind, referred her to her priest, and called the priest to ask him to counsel her to change her mind. She remained fixed in her decision, and the next day was fired by the hospital administrator. She brought suit under Montana's conscience clause, which protects the rights of individuals to refuse on moral or religious grounds to perform sterilizations, and prohibits employment discrimination based on such refusals. After a harrowing encounter with a hostile Montana trial court, she ultimately prevailed in the Montana Supreme Court.[40] However, two of the Montana Supreme Court justices would have denied her claim on the ground, *inter alia,* that her reasons for refusing to participate in any more sterilizations were *emotional* rather than *moral*.[41]

In *Catholic Charities of Sacramento, Inc. v. Superior Court*,[42] a Catholic charitable organization was held not to qualify for the "religious employer" exemption from a California statute requiring employer to provide prescription contraceptives in benefits package, and was also denied constitutional protection from that requirement which violated basic Roman Catholic doctrine. .

In *Valley Hosp. Ass'n, Inc. v. Mat-Su Coalition for Choice,*[43] the Alaska Supreme Court held that that state's conscience clause was unconstitutional to the extent it applied to allow a private nonprofit hospital that was the sole hospital in the Mat-Su valley to refuse to provide abortions because it was a de facto quasi-public institutions.

In *Larson v. Albany Medical Center,*[44] a New York state appellate court held that employees fired in alleged retaliation for exercising rights protected under the state conscience clause had not no private right of action.

VI. THE HISTORY OF PROTECTION OF CONSCIENCE IN AMERICA

The history of protection of conscience in America is directly relevant to the protection of rights of conscience of health care providers in three ways. First, protection for rights of conscience underlie and historically preceded the First Amendment.[45] In June, 1776, even before the Declaration of Independence, the Virginia Declaration of Rights provided, inter alia, that "all men are equally entitled to the free exercise of religion, according to the dictates of conscience . . ."[46] After centuries of government support for the state church in Virginia, the Baptists led a petition campaign demanding that "every tax upon conscience . . . be abolished."[47] In 1779, Thomas Jefferson introduced his Bill for Establishing Religious Freedom in the Virginia Legislature (House of Burgesses). It declared that "to compel a man to furnish contributions of money for the propagation of opinions which he disbelieves, is sinful and tyrannical." (If Jefferson thought that about merely funding things against ones will, one can imagine what he would say about being compelled to perform acts or services like abortion or the MAP against one's conscience.) Jefferson's Bill did not pass for over six years, but in December, 1785, while Jefferson was Minister to

---

[40] *See infra,* notes ____ through ____ and accompanying text. See also Swanson v. St. Johns Lutheran Hospital, 615 P.2d 882 (Mont. 1980) (affirming award of $11,950.86 to Nurse Swanson, and affirming rejection of her claim for punitive or future damages for lack of evidence).

[41] 597 P.2d at 714. The hospital administrator himself obviously perceived her denial to be based on religious/moral grounds, and treated it as such, contacting the nurse's priest in an effort to have him influence her to drop her objections. The dissenters failed to explain the distinction between "emotional" and "moral" grounds. Are they really mutually exclusive categories? Their bias against conscience clause rights is evident.

By contrast, in a case interpreting a conscience clause that protects the right of physicians from employment discrimination because they *have* performed abortions or sterilizations, a pair of federal courts did not require *any* evidence about the moral or religious basis for a doctor's practice or sterilizations. *See* Watkins v. Mercy Medical Center, 364 F. Supp. 799 (D. Ida. 1973), *aff'd*, 520 F.2d 894 (9th Cir. 1975). There appears to be at least a hint of anti-Catholic, anti-prolife bias in the way the conscience clauses have been interpreted. *See also* In Re Raquena, 517 A.2d 886,891 (N.J. Super. 1986) (lecturing Medical Center that unwillingness to participate in withdrawal of life-support food/hydration systems was not "pro-life", and requiring the hospital to participate in the withdrawal over its and staff's moral objections). *See further infra* notes ____ through ____ and accompanying text.

[42] 109 Cal.Rptr.2d 176 (3d D.Cal.App. 2001).

[43] 948 P.2d 963 (Alaska 1997).

[44] 676 N.Y.S.2d 293 (3d App. Div. 1998).

[45] Joseph L. Hassan, *Freedom of Conscience in Early Virginia: A Precursor to the Religion Clauses of the First Amendment,* Paper submitted for Origins of the Constitution, Apr. 17, 1998.

[46] Kermit Hall, et al, American Legal History: Cases and Materials 70 (1996).

[47] Hassan, *supra,* at 12.

France, James Madison engineered passage of Jefferson's Bill. As finally enacted it declared that "no man shall be . . . molested or burdened in his body or his good, nor shall otherwise suffer on account of his religious opinions or belief . . . and that the same shall in no wise diminish, enlarge or effect their civil capacity." So proud was Jefferson of his role in securing protection for rights of conscience that he asked that his gravestone be inscribed: "Thomas Jefferson, Author of the Declaration of Independence, of the Statute of Virginia for Religious Freedom, and Father of the University of Virginia." [48]

Second, it is critical to understand that in America in the 1770s and 1780s two different views about matters of conscience and religion were competing.[49] One view, with a high and honorable heritage traceable to John Locke's famous essay, *A Letter Concerning Toleration,* viewed accommodation of religious variety and differences to be a matter of utilitarian toleration or accommodation. In some of his early writing, at least, Thomas Jefferson advocated this approach. Respect matters of conscience and religion as simply a matter of *toleration*—sound public policy, good neighborliness and good Polistes. On the other hand, the Virginia Baptists and most famously, James Madison, spoke of matters of conscience and religion not merely as toleration but as fundamental, natural rights. It makes a big difference whether respect for another's moral convictions is given simply as a matter of convenience and tolerance (to be suspended when outweighed by other political considerations, for example, in time of emergency), or whether that is a matter of your neighbor's basic civil rights. Fortunately, the Founders ultimately concluded that protection for conscience was a matter of fundamental right. Early colonial charters and state constitutions spoke of it as a right, and during the frightening emergency of the War of Independence, rather than suspend respect for divergent moral views, many states granted exemptions from conscription to persons with religious scruples against war, such as Quakers and Mennonites. In 1775, the Continental Congress granted a general exemption from military conscription to religious groups. The Virginia Declaration of Rights was initially drafted too guarantee "fullest toleration" of religion; but Madison amended it and when it passed, it protected the rights of religion: "all men are entitled to the full and free exercise of it according to the dictates of conscience." Madison's *Memorial and Remonstrance* expressed the language of rights, not toleration ("The equal right of every citizen to the free exercise of his Religion according to the dictates of conscience is held by the same tenure with all our other rights." [50] Of course, the best example is the protection of conscience as a right is inclusion of the right to free exercise of religion in the First Amendment of the Bill of Rights. (James Madison, of course, was the Father of the Bill of Rights.) Ironically, some courts and most commentators today have slipped into using the language of toleration and accommodation. It is time for us to reassert emphatically the language of rights.

Third, when an effort to revive the religion tax in Virginia was made after the War of Independence, James Madison drafted his famous *Memorial and Remonstrance* declaring that certain things like religious duties "must be left to the conviction and conscience of every man; and it is the right of every man to exercise it as these may dictate." [51] He explained why:

> Before any man can be considered as a member of Civil Society, he must be considered as a subject of the Governor of the Universe: And if a member of a Civil Society, who enters into any subordinate Association, must always do it with reservation of his duty to the general authority; much more must every man who becomes a member of any particular Civil Society, do it with a saving of his allegiance to the Universal Sovereign.[52]

Madison clearly understood that if men are not loyal to themselves, to their conscience, to their God and their moral duty as they see it, it is utterly irrational folly to expect them to be loyal to less compelling moral obligations of legal rules, statutes, judicial orders, or the claims of citizenship and civic virtue, much less professional duties. If you demand that a man betray his conscience, you have eliminated the only moral basis for his fidelity to the rule of law, and have destroyed the foundation for all civic virtue.

Finally, the loss of virtue that results from requiring men to violate and disregard their conscience undermines the basis for self-government. The founders of the American Constitution really believed that virtue in the citizenry was absolutely es-

---

[48] Hassan, *supra,* at 17.

[49] Dawn Hendrickson Steadman, *The Free Exercise Clause and Original Intent: A View Toward Exemptions,* for Origins of the Constitution, Winter Semester 2000.

[50] Steadman, *supra,* at 24.

[51] *Id.*

[52] James Madison, *Memorial and Remonstrance* cited in Hussan at 15.

sential, indispensable for this system of government to function and survive. I have brought just a few quotes from the Founders to make this point.

Thomas Jefferson: "[O]ur rules can have authority over such natural rights only as we have submitted to them. The rights of conscience we never submitted, we could not submit. We are answerable for them to our God."[53]

George Washington: "Tis substantially true, that virtue or morality is a necessary spring of popular government. The rule indeed extends with more or less force to every species of Free Government. Who then is a sincere friend to it, can look with indifference upon attempts to shake the foundation of the fabric?..."[54]

Samuel Adams agreed that "neither the wisest constitution nor the wisest laws will secure the liberty and happiness of a people whose manners are universally corrupt."[55]

James Madison told delegates to Virginia's ratifying convention: "To suppose that any form of government will secure liberty or happiness without any virtue in the people, is a chimerical idea."[56] He also wrote in Federalist No. 57: "The aim of every political Constitution is or ought to be first to obtain for rules men who possess most wisdom to discern, and most virtue to pursue, the common good of society; and in the next place, to take the most effectual precautions for keeping them virtuous whilst they continue to hold their public trust."

John Adams clearly warned: "Out constitution was made only for a moral and religious people. It is wholly inadequate to the government of any other."[57] He also said: "Liberty can no more exist without virtue and independence than the body can live and move without a soul."[58]

Thus, protection of conscience has been crucial to the foundation of this nation.

VII. CONCLUSION

This Energy and Commerce Committee has recently be involved in hearing testimony about enormous scandals caused because businessmen and accountants and other professional have anesthetized their consciences in the pursuit of wealth. The consequences have been seedy, shady, and disastrous for the companies and for the economy of the country.

In this context, it is more than a little ironic to hear abortion zealots plead that Congress must look the other way while they continue to coerce health care professionals and entities to ignore their consciences. The results of not protecting and encouraging the exercise of conscience in the health care profession will be just as disastrous as it has been for Enron and Worldcom and perhaps for Martha Stewart.

Currently pending in Congress is the Abortion Non-Discrimination Act. It is a very small, but very important step in the right direction. It simply protects conscience by requiring modest accommodation for entities that cover and pay for and provide medical services. It merely prohibits use of state power to coerce abandonment of conscience and moral principles. It is a true neutrality provision, guaranteeing each health care participant the right to choose for himself or herself or itself to follow the values and moral precepts they espouse.

I urge this Committee to act promptly to enact the Abortion Non-Discrimination Act and other acts which will address the crisis of conscience and begin to eliminate the intolerance, coercion and discrimination against health care participants who do not believe in participating in the provision of abortion and other morally controversial procedures.

ATTACHMENT

Summary of State Laws Protecting Rights of Conscience—July 8, 2002

Alabama	Code of Ala. § 22-8A-8 (2001) No nurse, physician or healthcare provider is required to withdraw life-sustaining treatment. Health care provider will attempt to transfer patient to other provider.
Alaska	Alaska Stat. § 18.16.010 (b) "Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion under this section."

[53] Thomas Jefferson (1743-1826)

[54] George Washington, Washington's Farewell Address from Saul Padover,The Washington Papers (searched Sept. 9, 1999).

[55] *Id.*

[56] *Id.*

[57] J. Howe, The Changing Political Thought of John Adams 165 (1966).

[58] 10 The Works of John Adams 284.

Summary of State Laws Protecting Rights of Conscience—July 8, 2002—Continued

Arizona	A.R.S. § 36-2151 Hospital, physician or other medical personnel may refuse to perform an abortion for moral or religious reasons.
Arkansas	A.C.A. § 20-16-304, 601 (2001) No person or hospital has to participate in an abortion. Medical personnel may refuse to give contraceptives or information about such things if it is against their religious beliefs.
California	Cal. Health & Safety Code 123420 A physician, nurse or other hospital employee may refuse to participate in an abortion for moral or religious reasons. Admission to a school may not be denied due to applicant's unwillingness to participate in an abortion. Non-profit facility or religious hospitals do not have to perform abortions.
Colorado	C.R.S. 18-6-104 (2001) Hospital does not have to admit a person for the purpose of performing an abortion. A person who is an employee at a hospital does not have to perform an abortion if it is against his morals or religious principles.
	C.R.S. 25-6-102, 207 (2001) No private institution or physician is required to give out contraceptive. A county or city employee may refuse the duty to supply contraceptives.
Connecticut	Conn. Gen. Stat. § 19a-580a (2001) Any physician who does not wish to comply with a living will must transfer the patient.
Delaware	24 Del. Code Ann. 1791 No person is required to participate in an abortion. No hospital has to participate.
Florida	Fla. Stat. § 390.0111 (2001) Hospital and person do not have to participate in abortion if it against moral or religious principles.
	Fla. Stat. § 381.0051 (2001) Physician or other person may refuse to give contraceptives for medical or religious purposes.
Georgia	O.C.G.A. § 16-12-142 (2001) No person or hospital shall be required to perform an abortion when it is against his moral or religious principles.
	O.C.G.A. § 49-7-6 (2001) Any employee can refuse to provide family planning services if it is contrary to his religious beliefs
Hawaii	H.R.S. § 453-16 Nothing in this section shall require any hospital or any person to participate in such abortion nor shall any hospital or any person be liable for such refusal.
Idaho	Idaho Code § 18-612 (2002) No hospital or person shall be required to perform an abortion if it is objected to for moral reasons.
Illinois	745 ILCS 70—Rights of Conscience are protected for all procedures. Sec. 11.2—Health Care Payers are not liable. Sec. 12—Right to recover treble damages, may not be less than $2,500.
Indiana	Ind. Stat. 16-34-1-3 to 5. No hospital shall be required to perform an abortion. No person shall have to do so if it against his moral or religious principles and one cannot be required to participate in an abortion as a condition of training or employment.
Iowa	Iowa Code § 146.1&2 (2002) No person shall be required to perform an abortion if it against his moral or religious convictions. No hospital that is not maintained by public authority must perform an abortion.
Kansas	K.S.A. § 65-443, 444 (2001) No person or hospital is required to perform an abortion. Refusal to do so is not grounds for civil liability against any person.
Kentucky	KRS § 311.800 (2001) No public funds shall be used to perform an abortion. No private hospital or person shall be required to perform an abortion.
Louisiana	La. R.S. 40:1299.31 to .32 (2002) No person in the medical field can be liable for refusing to participate in abortion. No social service worker is liable for refusing to recommend abortions. No hospital shall be required to perform an abortion.
Maine	22 M.R.S. § 1591-2 (2001) no person or hospital is required to perform an abortion. No hospital, firm, or education institution can discriminate for a person's refusal to perform an abortion.
	22 M.R.S. § 1903 (2001) A private institution or physician or their agent may refuse to provide family planning services if it is against their religious or moral beliefs.
Maryland	Md. Health-General Code Ann. § 20-214 No person or hospital has to participate in an abortion, artificial insemination, or sterilization. There is no immunity if a person's referring the patient to a source of pregnancy termination would have prevented death or long lasting injury.
Massachusetts	Mass. Ann. Laws ch. 112, § 12I (2002) Any person who objects to abortion or sterilization will not be required to participate. Such an objection will not be used against a person to keep him out of medical school, social work, etc.
Michigan	MCLS § 333.20181, 20182 (2002) No hospital, teaching institution or person connected with such a facility is required to perform an abortion if objected to on professional, moral, or religious grounds.
Minnesota	Minn. Stat. Ann. 145.414, 145.42 No hospital or person is liable if they refuse to participate in an abortion. No health Plan company will be held liable for not providing abortions.
Mississippi	Miss. Code Ann. § 41-41-215 ''A health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience.''
Missouri	§ 197.032 R.S.Mo.No person or public or private hospital shall be required to treat a person for abortion.
	§ 188.110 R.S. Mo. (2001) No employer can discriminate against employees for their refusal to participate in an abortion.
	§ 188.110 R.S.Mo. (2001) No school can deny admittance for a person's refusal to participate in an abortion

Summary of State Laws Protecting Rights of Conscience—July 8, 2002—Continued

Montana	Mont. Code Anno., § 50-20-111 (2001) No private hospital need provide abortion. All persons have the right to refuse or participate in an abortion. Person can mean individual or corporations.
	Mont. Code Anno. § 50-5-502 to 505 No hospital or medical facility or persons shall have to perform sterilization. Person has the right to injunctive relief or monetary damages. Hospital or medical facility shall not loose any privileges or immunities.
Nebraska	Neb. Rev. Stat. ' 28-337 No hospital in the state, public or private, must perform an abortion, but it must inform the patient of this policy.
Nevada	Nev. Rev. Stat. 632.475—Nurse or somebody providing direct assistance to a patient does not have to assist in an abortion if it is against her morals
New Hampshire	RSA 137-H:6 (2002) A physician who, for conscience sake, cannot comply with a living will shall without delay transfer the patient to another physician.
New Jersey	N.J. Stat. § 2A:65A-1 ''No person shall be required to perform or assist in the performance of an abortion or sterilization.''
	N.J. Stat. § 2A:65A-2 ''No hospital or other health care facility shall be required to provide abortion or sterilization services or procedures.
	N.J. Stat. § 2A:65A-2 No civil liability for those who refuse to perform abortion or sterilization.
New Mexico	N.M. Stat. Ann. § 30-5-2 (2001) No person or hospital has to participate in abortion for moral or religious reasons
	N.M. Stat. Ann. § 24-8-6 (2001) No hospital is required to admit a patient for sterilization if done so on religious grounds.
New York	NY CLS Civ R § 79-i (2002) No person shall be required to perform an abortion if it is against his conscience or religious beliefs.
North Carolina	N.C. Gen. Stat. § 14-45.1 Physician or nurse do not have to perform abortion if it is against their religious principles. A hospital or healthcare institution does not have to offer abortions.
North Dakota	N.D. Cent. Code, § 23-16-14 (2002) NO hospital or person shall be required to perform an abortion.
	N.D. Cent Code 14-02.4-15.1 (1997) Government may not discriminate against health care institute or private agency for refusal to participate in any health care service that is against written religious and moral policies.
Ohio	ORC Ann. 4731.91 (Anderson 2002) No public or private hospital or person has to participate in an abortion.
Oklahoma	63 Okl. St. § 1-741 No Private hospital or person has to participate in an abortion.
Oregon	Or. Rev. Stat. ' 435.485 (2001) No physician must give advice to a patient concerning abortion, but he must advise the patient. No hospital employee is required to participate in an abortion.
	Or. Rev. Stat. § 435.225 (2001) ''Any employee of the Department of Human Services may refuse to accept the duty of offering family planning and birth control services'' if it conflicts with religious principles.
Pennsylvania	18 Pa. C. S. § 3202 (2002) Right of Conscience is protected for all person who desires to not provide an abortion.
	18 Pa. C.S. § 3213. Except for a facility devoted to abortions, no facility is required to perform abortions, and no medical personnel, employee or student is required to participate in an abortion. Civil Liability may reach $5,000.
	43 P.S. § 955.2 (2002) No hospital or person is required to perform an abortion or sterilization. No school can deny admission due to a person's refusal to participate in abortion or sterilization.
Rhode Island	R.I. Gen. Laws § 23-17-11 (2001) No person shall be required to participate in an abortion or sterilization if such are objected to on moral or religious grounds.
South Carolina	S.C. Code Ann. § 44-41-40 (2001) No private institution is required to perform an abortion.
South Dakota	S.D. Codified Laws § 34-23A-12 (2001) No person who refuses to perform an abortion shall be held liable.
Tennessee	Tenn. Code Ann. § 39-15-204, 205 (2001) No hospital or person need provide an abortion.
	Tenn. Code Ann. § 68-34-104 No private institution or physician is required to provide contraceptive procedures or supplies if refusal is based on conscientious or religious objections.
Texas	Tex. Occ. Code § 103.001, 002 (2002) No physician, nurse or employee of a hospital maybe required to participate in an abortion.
	Tex. Occ. Code § 103.003 (2002) A person whose rights are violated may sue the hospital, medical facility or educational institution for an injunction plus affirmative relief, including reinstatement, backpay plus 10%
	Tex. Occ. Code § 103.004 Hospital need not provide abortions.
	Tex. Ins. Code Ann. art. 20A.09(m)—No, HMO, physician, or provider is required to recommend or provide services that violate religious convictions.
Utah	Utah Code Ann. § 76-7-306 (2001) No person shall be required to perform an abortion if it is against his moral or religious beliefs. No private or denominational hospital shall be required to perform abortions.
Virginia	Va. St. § 18.2-75 A hospital, medical facility or physician do not have to perform abortion.

Summary of State Laws Protecting Rights of Conscience—July 8, 2002—Continued

Washington	Wash. Rev. Code Ann. 70.47.160 (2002) No HMO need provide or pay for services that are religiously objectionable.
	Wash. Rev. Code Ann. § 70.122.060 (2002). No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing
West Virginia	W. Va. Code § 16-2F-7 (2001)—No person need participate in and abortion if they refuse for medical reasons or any others.
	W. Va. Code § 16-2B-4 (2001) Any employee of the state may refuse the duty of providing family planning services.
	W. Va. Code § 16-30-12 A health care facility does not need to change it policies that are grounded in sincerely held religious convictions or moral principles.
	A health care provider need not provide service that is contrary to its religious beliefs. (Living Wills etc.)
Wisconsin	Wis. Stat. § 253.09 (2001) No hospital or person is required to participate in abortion or sterilization.
Wyoming	Wyo. Stat. § 35-6-105, 106 (2001) No private hospital or institution or person need provide or participate in abortions. (Also mentions Euthanasia, but appears to be in context of abortion.)
	Wyo. Stat. § 42-5-101 (2001) Any person may refuse the duty of providing family planning or birth control services if done so for religious or personal beliefs.

Mr. BILIRAKIS. Thank you, Mr. Wardle. I felt compelled to introduce the legislation that we are discussing today, because the intent of the legislature has always meant an awful lot to me. And in trying to determine what was intended, I reach to these additional views signed by Senators Bill Frist, McConnell, Gregg, Hutchinson, Coats and DeWine, where they said, "We believe that the term 'health care entity,' "—and I don't know how anyone can, in my opinion, look at it logically and come to the conclusion that a health care entity could exclude a hospital. But we believe that the term, "health care entity," was intended to be read in the straightforward manner of including not only the specific entities mentioned but also those which are routinely seen as health care entities in common usage and other Federal laws, such as a hospital, provider-sponsored entity, health maintenance organization, health plan, et cetera, et cetera. So that is why I felt compelled to do this, because, as Mr. Wardle said, there is a gap there—I am not sure if you used that exact word—and we have got to try to fill that gap.

Ms. Vosburgh——

Ms. VOSBURGH. Yes.

Mr. BILIRAKIS. [continuing] You have indicated that, if I understood you correctly, there is a provider across the street from the hospital——

Ms. VOSBURGH. Yes.

Mr. BILIRAKIS. [continuing] who performs——

Ms. VOSBURGH. Yes, that is abortions.

Mr. BILIRAKIS. [continuing] elective abortions.

Ms. VOSBURGH. Abortionist lamage, yes.

Mr. BILIRAKIS. So if Valley Hospital were afforded conscience protection, then it is likely that women would still have access to elective abortions, correct?

Ms. VOSBURGH. Yes, they would. In fact, she does her first term trimester abortions in her own clinic.

Mr. BILIRAKIS. In her own clinic.

Ms. VOSBURGH. She uses the hospital for second trimester abortions.

Mr. BILIRAKIS. Well, could she perform the second trimester abortions in her own clinic?

Ms. VOSBURGH. No.

Mr. BILIRAKIS. She could not.

Ms. VOSBURGH. No. It is a State law; she has to use the hospital.

Mr. BILIRAKIS. Okay.

Ms. VOSBURGH. But, you know, why should we be forced to——

Mr. BILIRAKIS. How many—I don't know the answer to this, and I guess it is always dangerous to ask a question you don't know the answer to—but how many hospitals are there in the valley?

Ms. VOSBURGH. Just one.

Mr. BILIRAKIS. Just one.

Ms. VOSBURGH. Anchorage is about 50 miles away.

Mr. BILIRAKIS. About 50 miles away. Are there hospitals there where there may not be a problem regarding their conscience in terms of performing abortions?

Ms. VOSBURGH. Providence is a Catholic hospital; it will not allow abortions there either. But there is always a regional—there is the Vets Hospital, so I am not sure if she would do her second trimester abortions there. My suggestion would be to her to build her own facility if she wants to do second trimester abortions.

Mr. BILIRAKIS. Okay. Do you feel then that your experience in Alaska—you obviously feel very strongly about this point, but do you feel that that experience presents a compelling argument for clarifying Congress' original intent in providing Federal conscience protections?

Ms. VOSBURGH. Yes. I believe if this had been in place solidly, that this probably would not have happened.

Mr. BILIRAKIS. Yes. It is just unfortunate. Sometimes you can't see the forest for the trees up here, and you are just so overloaded with so many things on your plate that the intent of the Congress at the time was not played out accurately in terms of what was meant by "health care entity."

Ms. VOSBURGH. One thing I did want to mention is the cases that I brought up here are hard cases—the rape, incest and life of the mother—which are—you know, those are the ones that are tear-wrenching and things. But the fact of the matter is even Planned Parenthood admits that 95 percent and more—some people say only 1 percent—are for life, incest and rape. So 95, 96, 97 percent of all abortions are for nearly birth control purposes. Why should we——

Mr. BILIRAKIS. Well, let us not—yes. I don't disagree with you. Let us not go into that.

Ms. VOSBURGH. All right.

Mr. BILIRAKIS. Mr. Weiss, you mention in your testimony that you oppose extending conscience clause protections to other health care entities because, using your words, "Its burdens fall primarily on those who do not share the beliefs that motivate the refusal." Would you agree that forcing a Catholic hospital, which is based on a faith that finds abortion objectionable, and I think you would agree with that, to perform abortions would also place a burden on that entity based on a belief that this institution does not share if we are talking about placing a burden?

Ms. WEISS. Chairman, it is a matter of balancing the rights involved. The question there is what kind of institution is it? Let us just take for a minute Valley Hospital as against an institution

that I think would be entitled in many cases to exemptions from the public health laws, which would be a privately funded Christian Science Sanitorium. Valley Hospital, just by way of example, was held to be a quasi-public entity by the Alaska Supreme Court for three reasons. First, because it was built on public land, 5 acres donated by the city, with over $10 million in public funds. It operated on very significant public funds. It had been granted a certificate of need by the State through a regulatory process which gave it a health care monopoly in the valley, in return for which it promised to meet the health care needs of the valley. It is the only hospital in the valley in which second trimester procedures can be performed.

Mr. BILIRAKIS. Well, how would you feel about it if it were a Catholic hospital?

Ms. WEISS. Well, then it would depend for me on whether the Catholic hospital met these same kinds of criteria. Is it a hospital that was built with or on public land? Is it operated significantly with public dollars? Does it treat the general public? Does it employ the general public? If so, then I submit it should abide by public health laws. If not, as is the case, for example, with the Christian Science Sanitorium, built with private funds, operated with private funds, it employs Christian scientists, it serves Christian scientists, it heals exclusively through prayer, that kind of pervasively sectarian health care institution ought, in general, to be out from under public health laws that are repugnant to its beliefs, because it is serving a population of believers.

Mr. BILIRAKIS. Thank you, Ms. Weiss. My time has expired. Ms. Capps?

Ms. CAPPS. Thank you very much, Mr. Chairman. And, Ms. Weiss, I will give you a chance to continue. I want to start with the premise that I understand from colleagues who have proposed this legislation that H.R. 4691 is a small technical change in the law and give you an opportunity to agree or disagree and then expand on that.

Ms. WEISS. I think that really it is clear from the comparison of the Coats Amendment with the comparison of the chairman's bill that it is by no means a small technical change in the law. The Coats Amendment defines the term, "health care entity," in this way. The term, "health care entity," includes an individual physician, a post-graduate physician training program or a participant in a program of training in the health professions. The Coats Amendment was passed to address what this body, Congress, viewed as a problem with mandatory—with a professional standard that the Accreditation Council for Graduate Medical Education had issued to require residency programs either to offer or to arrange abortion training for residents.

Just to correct the record here, that professional standard at all times, when it was first promulgated and now, has provided an opt-out for any individual resident or physician who does not want to participate in abortions. It has never, by its terms, forced any doctor who had an objection personally to perform any abortion.

So this body responded to address the problem in residency programs. This new bill, as I think you know, applies not simply to fit individual physicians and residency programs but to hospitals,

health plans, HMOs, insurance companies or any other kind of health care facility, organization or plan. In other words, it applies to everybody. And instead of applying merely to the provision of abortions or referral for abortions or training in those things, it applies also to providing coverage of abortions or paying for them. So it vastly expands the kinds of entities that can have exemptions and the exemptions they can claim. That is why, for example, in the example I gave, a Medicaid managed care organization, an HMO, that participates in the Medicaid Program, could simply refuse to discuss abortion, even abortion that a woman was entitled to under Federal law.

Ms. CAPPS. And at this point, I would appreciate just a brief answer from the other three. I want to really get at the distinction between the conscience clause for an individual provider and what it means to be offering a service. And do you think taxpayer dollars should provide that service, such as a hospital, a clinic or an HMO? And maybe each of you have a chance—I would like to ask if, in your mind, you see no corporate responsibility—you, for example, Ms. Vosburgh, being on the board of a hospital—no corporate responsibility to provide the services that the taxpayers have funded you with?

Ms. VOSBURGH. It is an elective—the abortions that are done there are elective, and, no, I don't see anything. The bill that is trying to be passed here would give a conscience clause out, not only to the doctors and nurses, which are already provided——

Ms. CAPPS. Yes.

Ms. VOSBURGH. [continuing] but for the entities themselves.

Ms. CAPPS. But let us get at, and I will ask, Mr. Wardle, you too to answer here, if there are further distinctions that can be made. Do you believe also that an institution is the same as an individual in terms of the conscience clause? And that we who fund here take very seriously our responsibility to use taxpayer dollars wisely, that when we set out to fund the Medicaid and the various provisions that are authorized under the Constitution of this United States, that an institution has the right to opt-out of that responsibility?

Mr. WARDLE. Well, thank you, Ms. Capps, Representative Capps. I would like to respond in two ways—three ways. First, you have used the term, "corporate responsibility." That is a wonderful term, and it ought to be on our mind, and the purpose of this bill is to protect corporate responsibility, responsibility meaning conscience, ethics, principles. Second, look at the history of the protection, the conscience clause laws in this country. The very first one that was passed was passed by Congress. It was the Church Amendment passed almost exactly 30 years ago, and it was designed to protect the rights of institutions to not have to perform abortions.

And, third, is there a difference between individuals and corporations? Yes, there is, but with respect to protecting rights of conscience, where will you draw the line? Are you going to say you, as an individual, have the right to free speech, but, oh, no, corporations cannot engage in free speech, newspapers, radio companies, television——

Ms. CAPPS. I am going to interrupt just because—Mr. Chairman, may I have 1 extra minute so that Ms. Weiss can also answer this question. I would like to get a survey from all.

Mr. BILIRAKIS. Without objection, but your 27 seconds over already. Without objection, it is——

Ms. CAPPS. Thirty seconds more.

Ms. WEISS. Of course there is a critical difference between institutions and individuals in this matter, and that is because when institutions claim rights of conscience they are very likely to be imposing their religious tenets on people who do not share them. That is to say there are conscientious rights on both—rights of conscience on both sides of the ledger. When an individual patient makes a decision not to have any more children, she is making a decision in which she is standing on moral ground. It is a decision about what is best for her and her family and her children. And that means that she has rights that need to be protected on that side of the ledger.

Ms. CAPPS. Thank you. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentlelady. Mr. Pitts?

Mr. PITTS. Thank you. Ms. Weiss, you mentioned in your testimony about Sophie Smith. Would you, for the record, provide more information to the committee on this case that you mention in your testimony, the blood clot?

Ms. WEISS. Yes, Representative. What information would you like?

Mr. PITTS. Well, just anything you have on it: The name of the hospital that you are talking about.

Ms. WEISS. The hospital was a sectarian hospital in Nebraska, and I have not mentioned its name in testimony because the physician in question, the one who called me, is fearful of violence and does not want to be revealed and continues to practice there. So I have not provided identifying information for that reason.

Mr. PITTS. Okay.

Ms. WEISS. I apologize. That is often a problem in providing identifying details in this field because of the ongoing problem of violence.

Mr. PITTS. In your line of reasoning, as I was seeking to follow it, you seem to say that any entity that takes public money can't have a conscience. A couple of days ago, an article appeared in the Burlington County Times about the purchase of a hospital in Burlington County by Our Lady of Lordes Health Care Services. And the article indicated that the ACLU in New Jersey had been challenging the purchase. The articles says that the ACLU is insisting that our Lady of Lordes, "add a separate building on the Rancocas Hospital campus where women could go for abortions." Is it the position of the ACLU that Catholic hospitals, that our Lady of Lordes, should be required by law to build a separate clinic for abortions upon their property?

Ms. WEISS. Well, that is a very interesting case, Representative Pitts. That is a case in which a Catholic facility is acquiring or merging with a formally secular facility and trying to ensure that the new merged entity lives by the ethical and religious directives for Catholic health care services that govern Catholic facilities,

thereby preventing abortions, sterilization, contraception, fertility treatments, a wide array of reproductive health care.

But the facility that it is buying was itself created by a charitable trust, and in that charitable trust there was—the intent of the donor was expressed to provide a wide array of health services to the low-income community in the relevant city in New Jersey. Now, the question in that case was does the conscience, the moral stance of the original donor to the secular institution have also rights or is it only that the Catholic facility has rights of conscience? And the answer is of course that is not the case. Both facilities were created by charitable trusts, both facilities have consciences, and the question is how do we—can they merge, is there a way that they can affiliate and recognize the conscientious rights of both facilities? That is what is at issue in that case, that is why there is an ongoing debate about how to preserve the intent of the founders of the formally secular facility. That is why you are seeing that in the newspaper, sir.

Mr. PITTS. Thank you. I wish I could continue with you. Maybe we will have a second round, I don't know.

Professor Wardle, do you understand this bill to cover cases of emergency contraception that some providers may see as abortifacient? Does it expand or change the current legal definition of abortion anyway?

Mr. WARDLE. I don't think it changes the current definition of abortion in any way. But let me point out two things here. The critical issue is who decides what my rights of conscience are? Is it going to be for the ACLU to dictate the boundaries of my conscience? And if my definition of what is conscience and what is moral disagrees with them, can they force me to do their will? Can they deny me the opportunity to practice, if I were a doctor, practice medicine; if I were a health care administrator, to administer medicine? The question is who defines conscience? I am pleased to let Ms. Weiss define her own conscience but not to impose that on me. Likewise, if patients want to have medical services that I would not perform as a doctor, let Ms. Weiss direct them in the direction where they can get those services.

You see her definition of abortion is as an entitlement, a definition that has been repudiated at least five times by the United States Supreme Court, but she and the ACLU don't accept it. They believe that abortion is not just a right of private choice but it is an entitlement that has to be facilitated and you have to facilitate it. The distinction between public and private is specious in our economy that is so wholly publicized. The government takes my money then gives it back to me in manner of a student loan. Does that now make me as a student a public actor? Gives it back to me in the form of a license to practice medicine or a certificate of need to perform medical services. Does that make me a public actor? The public/private distinction is a specious distinction.

Mr. PITTS. I see that I am out of time.

Mr. BILIRAKIS. Your time is expired. Would you gentlemen like to have an additional minute?

Mr. PITTS. Yes, sir, Mr. Chairman, if you don't mind.

Mr. BILIRAKIS. Without objection——

Mr. PITTS. I will ask Professor Wardle, based on your research, do you recognize a concerted movement or an effort to require all hospitals to provide abortions? You made some reference to that. I would like you to expand.

Mr. WARDLE. Thank you, Mr. Pitts. Yes, and that is how the issue has changed. I have seen a dramatic change in 30 years. I have studied this for 30 years and written about it for nearly a quarter of a century, and you have seen a dramatic change in the dialog and the expectation from privacy. Just let us be able to choose this. We are not asking to force anybody to do anything. Just let us be able to choose to. Now, you have to facilitate, you have to perform, you have to pay.

Essentially, the position that has been articulated by Ms. Weiss this morning is that no Catholic hospital, and I would say not just Catholic but other religious affiliated hospitals and not just religious affiliated hospitals. We have here a witness from a sectarian hospital that asserted by democratic process a set of principles, right of conscience, forcing them to take a position. The position that is taken today is if you are a hospital that would decline to perform abortions, you cannot expand, you cannot merge, you cannot acquire, you cannot grow unless you are willing to do abortion.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Strickland to inquire.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Wardle, I have a question in regard to your most recent comment that you have observed something over a 20- or 25-year period, and people have gone from just wanting to be able to make the choice to have that as some kind of right that could be imposed upon others. But I am just curious, do you agree with the first part of that? Do you believe that the person should be able to make a personal choice?

Mr. WARDLE. I believe that in some cases that is absolutely right. I think the Supreme Court could have reached the decision it did in Roe v. Wade without the absurd toddering doctrine that it put underneath it. In the case of rape, certainly, in the incest, in the case of life or a health threat.

Mr. STRICKLAND. You know, this really puzzles me because when we talk about the morality of abortion, when we talk about the taking of an innocent human life, then to say in case of rape, in case of incest. It seems to me that there is an inconsistency. If it is an innocent human life, then the child conceived as a result of rape or incest is also an innocent human life. Now, I believe in the right of a woman to choose, but I am just pointing out what I think is a glaring inconsistency among those who make these moral distinctions and still question the validity of a conscience of an individual who may have a different point of view.

Mr. WARDLE. Mr. Representative, I believe the question is, though, and I respect your point of view and the point you make is a very thoughtful and thought-provoking one, but is it for you to tell me what my conscience is or to tell Ms. Vosburgh what her conscience is or to tell Ms. Weiss?

Mr. STRICKLAND. No, it isn't, and that is why—this causes conflict within me, because I think what we are talking about here is an area that for thoughtful people results in internal conflict.

You said something about the mayor of New York. Would you, for my sake, repeat what you said that his comment was when someone was found to be pregnant?

Mr. WARDLE. I am quoting from news reports. "These media mogul reportedly once told a pregnant employee to, 'kill it, kill it.'" I would add, as I do in my written testimony, Bloomberg has denied making the comment, but it was cited in legal papers of Sekiko Sakai Garrison, a former Bloomberg news staffer, who brought one of three publicized sex harassment cases——

Mr. STRICKLAND. Yes, sir.

Mr. WARDLE. [continuing] against him or his company.

Mr. STRICKLAND. I just think it would have been more fair of you to have relayed his denial at the time when you relayed what supposedly was his comment. I don't know Mr. Bloomberg, have no affiliation or any particular sympathy for him, but I think to put out such a statement without also giving us his denial was a little unfair to him.

Mr. WARDLE. Well, I did give it to you in writing, and I just read it to complete the record, sir.

Mr. STRICKLAND. Well, thank you for that. Ms. Vosburgh, this may have been discussed when I wasn't here, and if it is, I apologize. But does your hospital believe that it should perform an abortion under any circumstances?

Ms. VOSBURGH. Yes, rape, incest, life of the mother. It is in the policy that they every year rewrite, which lines up with Federal law too, with title X.

Mr. STRICKLAND. I was just unsure because I was not here.

Ms. VOSBURGH. Yes. And while I am on here, I would like to answer Mrs. Capps. She said since we are a hospital, I am on the board—Okay, sorry.

Mr. STRICKLAND. Yes. I am sorry, we only have 5 minutes. I think Ms. Capps may have—I hope the chairman will give us a second round here.

Mr. BILIRAKIS. I am not contemplating doing that. We have another panel to go yet.

Mr. STRICKLAND. Okay. Well, I am——

Ms. VOSBURGH. I would have been finished by now anyway. Well, the thing is we are elected——

Mr. STRICKLAND. Well, I will respect your right to——

Ms. VOSBURGH. Okay. Well, we are elected. We are elected from the community, from our community. We are elected, and we elect people onto the operating board which make that decision, and the community, the body of the community does not want—they do not want abortions there. Abortions to the majority of the community there, it is an abhorrent thing. It is the taking of human life. Very tiny, yes, but it is human life. That is what fetus means, little one. And it is killing them.

Mr. STRICKLAND. Can I interrupt here?

Ms. VOSBURGH. Yes.

Mr. STRICKLAND. Because are you expressing a religious belief——

Ms. VOSBURGH. No.

Mr. STRICKLAND. [continuing] when you say that or are you expressing a scientific belief? And if it is a scientific belief, then it

is not a matter of conscience, it is a matter of judgment, it seems to me.

Ms. VOSBURGH. It is a matter of humanity. I mean we need to protect all of us.

Mr. STRICKLAND. I do think the Constitution does grant legitimate exceptions for a lot of things based on religious belief. It troubles me that someone could just—some group of individuals could just decide that this is a moral issue devoid of religious theological context and then claim the kind of protections that I think are only available to those who use a religious test for their particular beliefs.

Mr. BILIRAKIS. Without objection, the gentleman is granted an additional minute.

Mr. STRICKLAND. You are very kind.

Mr. BILIRAKIS. Took you by surprise.

Mr. STRICKLAND. You are very kind, Mr. Chairman. I will not accept that gracious invitation. Thank you so much.

Mr. BILIRAKIS. Mr. Akin, did you have maybe a quick question you might raise to this panel? You are not a member of the committee, but I know the other members would not mind if you raised a particular question.

Mr. AKIN. I appreciate the offer.

Mr. BILIRAKIS. All right. Well, we customarily—first of all, thank you. We customarily present questions in writing to the panelists and we will ask you to respond to those in a timely fashion. What is timely? Well, anyhow, 2 or 3 weeks we would hope at the most. So I hope you won't mind receiving those questions and will respond. And we can only thank you. Ms. Weiss came from New York, Mr. Wardle——

Ms. CAPPS. Mr. Chairman?

Mr. BILIRAKIS. [continuing] from Utah and Ms. Vosburgh from Alaska, so you have come quite a long distance, particularly two of you. Yes, ma'am?

Ms. CAPPS. May I suggest that we offer a second round or request that you consider it?

Mr. BILIRAKIS. I would rather not because we have a second panel who is just sitting here, and it is the prerogative of the Chair, as I understand it, and I hope you don't mind, but I would rather not do that. All right. You are excused. Thank you so very much.

Panel II consists of Ms. Addia—is that correct?

Ms. WUCHNER. Addia Wuchner, yes.

Mr. BILIRAKIS. Addia, yes, I am sorry. Ms. Wuchner, Dr. Renee Jenkins, on behalf of the American Academy of Pediatrics, and Mr. John Heisler who is going to be better introduced by I suppose it is his congressman, Mr. Manzullo who has asked—Mr. Manzullo asked for the right to introduce Mr. Heisler. Please proceed, Don.

Mr. MANZULLO. Thank you, Mr. Chairman. I have to introduce—it is my pleasure to introduce my constituent and then I have to run to catch an airplane. Thank you for giving me the opportunity to introduce my constituent, John Heisler. Mr. Heisler is a member of the McHenry County Board. He spent the past several years as the county board's liaison to the Board of Health. Our paths crossed in 1997 when one of the communities in McHenry County,

Crystal Lake, was devastated by the news that a 13-year-old girl had been repeatedly sexually assaulted by her 37-year-old junior high school teacher. The teacher eventually was sentenced to 10 years in prison.

But the following the arrest was even more shocking, the teacher had used the title X Federal Family Planning Program at the McHenry County Health Department to shield his crime, and taxpayers were footing the bill. Tired of using condoms, the teacher brought the young girl to a place where he knew she could get birth control drugs without anybody finding out, the federally funded county health department. The teacher knew that title X rules prohibited clinics from notifying parents when issuing birth control drugs to young girls.

When the girl arrived, a clinic worker injected her with a powerful birth control drug, Depo-Provera, a hormonal drug that possesses severe side effects, including excessive bleeding and bone loss. Eighteen months later into the crime, the little girl broke down, told her parents, she underwent intensive therapy and battled anorexia.

The whole argument for providing young girls birth control drugs behind their parents' back is cloaked in the double standards, which Mr. Heisler will bring out. But as a result of what happened in McHenry County, we, in 1998, approved my parental notification bill. The Senate never acted on the provision, however, and it died. But we did get legislation that passed, that became law, that title X clinics are not following, and that is that whenever they have reason to believe that a minor is under the age of consent, these title X agencies have the statutory duty to follow local State laws requiring notification to authorities that a child is indeed being raped. That was the two-part prong of the bill that we got passed. It is quite a story that Mr. Heisler has to tell. Again, I appreciate the opportunity to introduce him and I would ask to be excused.

Mr. BILIRAKIS. Thank you.

Mr. AKIN. Thank you.

Mr. BILIRAKIS. The Chair excuses the gentleman.

Ms. Wuchner?

STATEMENTS OF ADDIA WUCHNER, NORTHERN KENTUCKY INDEPENDENT HEALTH DISTRICT; RENEE S. JENKINS, ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS; AND JOHN A. HEISLER, COUNTY BOARD, McHENRY COUNTY, ILLINOIS

Ms. WUCHNER. Thank you. Mr. Chairman and members of the Committee, I appreciate this opportunity to be here today to discuss with you the issue of a parent's right to know, especially as it pertains to medical treatment of minor children without their parents' knowledge or notification.

I am a mother of three, a registered nurse, with a background in women's health. I currently serve on the board of directors for the Northern Kentucky Independent District Health Department and Chair the Community on Human Sexuality Education.

Most parents would be shocked to learn that their teenage daughters may walk into one any of the title X federally funded clinics and obtain free birth control, including injectables such as

Depo-Provera, emergency contraceptives, the morning after pill, without the knowledge or notification of their parents. They would be shocked because, for centuries, all sorts of rights flowing from the parent-child relationship have been acknowledged and protected by law, among them decisions concerning custody, the education and the medical treatment of their children. Yet today, when it comes to sex and the prevention and treatment of pregnancy and the prevention and treatment of sexually transmitted diseases, is seems neither mother nor father are trusted to know what is best.

The Northern Kentucky Board recently passed a motion to gather community input and review title X and Family Planning Services. This review led them to a vote. But the review led to much more. It led to the highlight of the many strings attached to title X which we will discuss today. For example, Section 8.7 states, "Title X projects many not require the written consent of parents or guardians for provisions of services to minors, nor can the project notify parents or guardians before or after a minor has requested and received title X-funded family planning services."

Section 8.6 states, "Title X projects must offer women and minors with a diagnosis of pregnancy, counseling, which is to include pregnancy termination along with information on prenatal care delivery, infant care and foster care."

We found title X policies contradicted our health board's commitment in 2000 to under title V funding to fund a model of character-based abstinence education that included the importance of parental communication. It was apparent to most of us on the board that title X was problematic and would remain so, as it currently exists, because it erodes the parent's right and the parental/child relationship, and it blocks their right to monitor their children's health. It was resolved by the majority of board members that on a local level this may not be the place to deal with this issue of parental notification, but rather it should be addressed at State and at national legislative levels.

Mr. Chairman, committee members, one-third of approximately 5 million women served by the title X programs are U.S. teenagers. In Northern Kentucky, females under the age of 18 represent 24 percent of those came in with parental knowledge, but 75 percent of the young women seen in our clinics are seen without parental notification. The clinics see and treat girls as young as 12 years old. I would like to share with you the day-to-day realities of title X.

Just this year, in one of our Northern Kentucky clinics, a 14-year-old girl came in with her boyfriend's mother. Upon the initial interview, she denied being sexually active, but it was important to her that her boyfriend and his mother like her. The boyfriend's mother wanted the girl to be put on the birth control so that she would not become pregnant when her son had sex with her. Please keep in mind the girl was 14 years old. The adult who brought her into the clinic was not her mother. Following title X guidelines, the 14-year-old's mother could not be notified.

Or what about the 12-year-old who had sex last Thanksgiving holiday and stated she didn't know why she did, she wanted the boy to like her and not get mad. What about her parents? She is only 12 years old. Is putting her on the pill the Government's solu-

tion? Perhaps we can prevent her from becoming pregnant, but she will also need to use a condom, and that will only prevent some of the sexually transmitted diseases that she will be exposed to. She is 12 and routinely forgets her homework assignments. A 14-year-old girl, recently seen in a local emergency room with a sexually transmitted infection, gave a medical history of already having five different sexual partners.

Title X specifies that a minor must be treated as an adult when seeking family planning services, yet these are really children at risk, children in engaging in adult behaviors. These high-risk behaviors do not need the cloak of government-funded clinics providing a pill to replace behavioral interventions but rather a true model of health would provide interventions when necessary that assists parents in building a bridge rather than a wedge in the parental and child relationship.

It is in the context of the parent/child relationship that the norms and values of the family are transmitted. A minor cannot legally sign a document or a contract. The school nurse cannot give her an aspirin. She cannot have her ears pierced at the mall without her parents' okay. Yet title X allows this minor to decide and receive family planning services and medications without her parents' knowledge. This means that your daughter, your granddaughters or any minor female can be put on hormonal medications or given an emergency birth control without notification of her parents or guardians, those most knowledgeable of her health and family health history.

Mr. BILIRAKIS. Please summarize.

Ms. WUCHNER. It is irresponsible to move in this direction. Mr. Chairman and members of the committee, a common sense wisdom and sound medical practice would agree that parents have the right to monitor their child's health care and well being. As Government and as a Nation, we must support the first building blocks of our society, the family, by restoring a parent's right to know and monitor their child's health and their well being. Thank you.

[The prepared statement of Addia Wuchner follows:]

PREPARED STATEMENT OF ADDIA WUCHNER, BOARD OF DIRECTORS, NORTHERN KENTUCKY INDEPENDENT HEALTH DISTRICT

Mr. Chairman and Members of the Committee: I appreciate the opportunity to be here today to discuss the issues of a "parent's right to know", especially where it pertains to medications or medical treatment and care, in this case, adolescent reproductive health and the distribution of hormonal birth control agents and devices to minors without parental knowledge or notification.

I am a registered nurse with a background in women's health. I currently serve on the Board of Directors of the Northern Kentucky Independent District Health Department and Chair the Human Sexual Education Committee. I was appointed to the Board and serve as the designee of Judge Executive Gary Moore of Boone County, Kentucky. The Health District provides services for a four county region.

Most parents would be shocked to learn that their teenage daughter may walk into lkone of these federally funded clinics and obtain free contraceptives, including injectables such as Depo-Provera, and emergency contraceptives (the morning after pill) without their knowledge or notification.

They would be shocked because, for centuries, all sorts of rights flowing from the parent-child relationship have been acknowledged and protected by law, among them decisions concerning custody, education and medical care. Yet today, when it comes to sex, the prevention and "treatment" of pregnancy, and the prevention and treatment of sexually transmitted diseases, the federal government tells us that neither Mother nor Father knows best.

The rights of parents to address and provide for their children's medical care has been undermined by controversial guidelines transforming parent's right to know into a privacy issue.

Children need two decades, more or less, of love, education, training, discipline and experience to be able to function independently of parents and make sound decisions concerning their lives. Throughout this formative period, parents have the right and duty to guide their children well. This last proposition should hardly be controversial. Ask any mother and father who've had to provide a school nurse with written permission just to see that their child gets a midday dose of Tylenol®.

Background on Recent Title X Federal Funding Issues and Northern Kentucky Independent District Health Department:

Earlier this year the Board passed a motion to gather community input and review the policies of Title X funded Family Planning Services and the medical and scientific information available on all FDA approved contraceptives and birth control methods currently provided under the Family Planning Services.

A public caucus was held on the issues of the "Impact of Title X" on May 9, 2002, and on June 19, 2002 the Board met to vote on whether we would continue to accept or reject the Federal Title X funding of Family Planning Services.

As the issues were manipulated under the microscope of the press, political, religious, ethical and moral debates, and at great length, they became emotionally charged with accusations that some Board members do not care about poor women. The actual facts of why the Board was taking a look at Title X funded Family Planning and the birth control medications and devices that are dispensed through the program became, at times, publicly clouded. Our responsibility to the Northern Kentucky community impelled us to ask several questions: What is Title X's impact on health of women and adolescent females? What are the ramifications of Title X funding? What benefits could be attained by discontinuing the status quo and promoting women's health, absent of Title X?

While researching the medical and scientific information on birth control methods and devices, our Title X review also highlighted the many "strings" attached to accepting Title X funding from the federal government. These requirements (strings) are laid out in the Program Guidelines for Project Grants for Family Planning Services set forth by the United States Department of Health and Human Services, Office of Public Health and Population Control.

The Program guide begins by defining the wording of the document and just what is meant when the words "must" and "may" are used. Section 1.1 Definitions states, "Throughout this document the word "must" indicates mandatory program policy".

For example:

- Title X projects *may* not require the written consent of parents or guardians for provision of services to minors. Nor can the project notify parents or guardians before or after a minor has requested or received Title X funded family planning services. (reference Section 8.7 Program Guidelines for Project Grants for Family Planning Services)
- Title X projects *must* offer women and minors with a pregnancy diagnosis, counseling which is to include *pregnancy termination* along with information on prenatal care and delivery, infant care, foster care . . . (Reference Section 8.6 Program Guidelines for Project Grants for Family Planning Services)

BOARD ACTIONS.

Title X Blocks parents' right and responsibility to monitor their children's health

In 2000, the Northern Kentucky Independent District Health Board took a fresh look at the efficacy and coherence of its adolescent sexuality programs and chose to support Character Based Abstinence Education. The Board was farsighted in recognizing both the power of an abstinence focus and that the 20th-century model of contraceptive education was ineffective. However, Title X remains a product of its times, and its requirement to provide contraceptive services to adolescents without parental notification contradicted our Health Board's year 2000 stated intention to focus on character based abstinence education, including parental communication.

The fact is that Title X blocks parents' rights and responsibilities to monitor their children's health. When minors seek contraceptive information, they must be informed about all birth control methods, treated for medical conditions and sexually transmitted infections and have medication prescribed and dispensed to them with out their parents' knowledge or consent. This became an issue that greatly disturbed Board Members and the community.

Board members researched, studied, pondered, and sought public input. We found ourselves constrained by the fact that you could not reject part of Title X and still

receive funding for services. We were bound to the structure and guidelines set forth by the Programs Guidelines of the Project. On June 19, the twenty-seven members present at the Board meeting voted 14 to 13, with the Chair casting a tie breaking vote, to reject a motion that would have discontinued the Department's acceptance of close to $220,000 in Title X and related funding.

Two issues/concerns were prevalent in discussions with Board members. First, there was concern that if we rejected the funding there would not be another service in place at this time to adequately provide family planning services to low income women. Second, and of most concern to the majority of the Board members, was the treatment of children and adolescents without parental knowledge.

The Judge Executive, Steve Pendery from Campbell County, resolved that the local level may not be the place to deal with the issue of parental notification but, rather, it should be addressed at a State and National Legislative level. While Judge Pendery felt he needed to vote to retain the Title X funding for practical reasons, in the press the next morning Judge Pendery concluded that the Board is not as divided as it seems; "We're a lot closer on this issue than the vote makes it sound."

I voted with the support of my Judge Executive, Gary Moore, to discontinue the Health Department's collaboration with Title X funding and to look for other sources of funding to support a model of Family Planning Services not restricted by the constraints of Title X. On June 20, Judge Pendery's designee sent a letter to Board members requesting that we move forward with letters to all legislators in Kentucky asking for their help in changing the Title X requirements regarding girls under the age of 18 receiving birth control without their parents' knowledge.

It was apparent to most of us on the Board working on this issue that Title X would remain problematic as it currently exists because it erodes parental rights and the parent-child relationship.

Title X and Parent's Right to Know

Mr. Chairman and Members, I know you are well aware that Title X of the Public Health Service Act was established as a federal program in 1970. For many years it has offered low-income women certain "reproductive health" services, including family planning as well as "non-directive" pregnancy counseling and referrals on all "options," including termination of pregnancy.

One-third of the approximately five million women served by the program are teenagers. Unmarried teens may qualify for free services regardless of their parents' income, knowledge of or consent to care. Currently, a teenager may walk into any Title X clinic and receive free prescription contraceptives, including injectables, i.e., Depo-Provera, or emergency contraceptives (the morning after pill) without her parents' knowledge or consent. Congressmen, one of these young girls may easily be your daughter or granddaughter.

To date, our Northern Kentucky clinics' statistics show that of the clients seen and treated this year, looking at numbers for females under the age of 18, only 24% came in with parental knowledge or consent. Approximately 75% of the young women seen in our clinics are seen without parental notification. The clinics have seen and treated girls as young as 12 years old.

Example Case:

Just this year, in one of our Northern Kentucky clinics, a 14-year-old girl came in with her boyfriend's mother. Upon initial interview, she denied being sexually active at that time, but it was important to her that her boyfriend and his mother like her. The boyfriend's mother wanted the girl put on some form of birth control so she would not become pregnant when her son had sex with her. Please keep in mind the girl was 14 years old. The adult who brought her in to the clinic was not her mother. The 14-year-olds' mother was not notified. This is the reality of the strings attached to Title X.

Under the auspices of Title X, providers of women's and adolescent health services have fallen into disaster control mode, leaving proactive mediation and behavioral interventions on the back burner. We abet unhealthy practices by offering birth control to sexually active teens, especially young women who are the population at the greatest risk for Human Papillomavirus (HPV) and other STDs. These behaviors of young people need parental awareness, so that they may support and give guidance and dialog that respects the norms and values of the family. A true health model would then provide intervention when necessary that assists parents in parenting, building a bridge rather than a wedge in the parent-child relationship. These high risk behaviors do not need the cloak of government funded clinics providing a "pill" to replace behavior interventions, rather the situation calls for more support for parental communication.

Title X specifies that a minor must be treated as an adult when seeking family planning services, yet these are really children engaging in adult behaviors.

The issue remains that a minor cannot legally sign a contract; the school nurse cannot give her an aspirin; she cannot have her ears pierced in the mall without her parent's OK; yet Title X allows a minor to decide and receive family planning services and FDA approved methods of birth control without a parent's knowledge. Title X is anti-parental rights.

CONCLUSION

Title X means your daughter, your granddaughter, or any minor female, can be put on hormonal medications or be given an emergency contraceptive (morning after pill), without those most knowledgeable—her parents or guardians—of her health and family health history being able to advise her regarding known risk factors that, in combination with contraindications or adverse effects, could lead to serious future health complications. While the clinician must ask her if she knows her own medical and family medical history (mandatory), it is irresponsible and dangerous to assume that a 13 or 15-year old would have a complete knowledge of such information. Most children are unaware of their family risk factors. It is also unethical for a medical professional to treat a patient and prescribe or dispense medication without a completed personal and family medical history.

Overall, lack of parental notification in the Title X program are affronts to parents' rightful role as the primary educators of their children. Government agencies and counselors cannot replace and should not interfere with the rights and responsibilities of parents, particularly in sensitive matters dealing with human sexuality. Government should protect the role of loving and supportive parents, yet make it possible to terminate the rights of parents who abuse the trust and privilege of being a parent.

Parents must be trusted to monitor their minor children's health and to protect them from the consequences of promiscuous behavior.

Mr. Chairman and Members of the Committee, common sense, wisdom, and sound medical practice would agree that parents have the right to monitor and care for the health and welfare of their children. I implore you to take the necessary steps to reverse the erosion of parental rights and lift the blanket of confidentiality currently mandated under Title X. This completes my prepared statement. Thank you again for this opportunity to testify on the issue of a Parent's Right to Know. I would be happy to respond to any questions you may have at this time.

Mr. BILIRAKIS. Thank you very much.

Dr. Jenkins?

STATEMENT OF RENEE S. JENKINS

Ms. JENKINS. Good afternoon, Mr. Chairman, members of the committee. I am Dr. Renee Jenkins—is this on? Okay. Start again. Good afternoon. Mr. Chairman, members of the committee. I am Dr. Renee Jenkins here in Washington who has taken care of adolescents for more than 20 years. I am also professor and Chair of the Department of Pediatrics and Child Health at Howard University College of Medicine. I am speaking today on behalf of the American Academy of Pediatrics. My statement also is endorsed and supported by the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians and the Society for Adolescent Medicine.

Most importantly, I too am a parent who shares the same worries about my daughter's health as other parents. My testimony today will cover three key points: One, the importance of parental involvement; two, the importance of confidentiality and access to health care; and, three, concerns about H.R. 4783, the States and Parental Rights Improvement Act of 2002.

Under parental involvement, as clinicians we firmly believe that parents should be involved in and responsible for assuring medical care for our children. Family communication about health care decisions is the desired goal and the health care professions are able

to assist in this effort. We strongly encourage and hope that adolescents communicate with and involve their parents and other trusts adults in important health care decisions. These health care decisions include issues of substance abuse, mental health and reproductive health.

Providing confidential health care services does not preclude working toward the goal of family communication and involvement of parents, as is sometimes inferred. To the contrary, research has shown that adolescents often voluntarily share information with their parents. Clinical experience confirms that this often occurs after they consult privately with their health care provider. My role as a pediatrician is to support, encourage, strengthen and enhance parental communication and involvement in adolescent decisions without compromising the ethics and integrity of my relationship with adolescent patients.

While there may be circumstances when it is necessary and appropriate for the health care provider to inform parents or guardians of certain health problems facing a minor, for example, when there is a risk of imminent harm, there is a critical need to ensure that an adolescent's health information is protected. Concern about confidentiality is one of the primary reasons that young people delay seeking health care, including health care for sensitive health issues. While parental involvement is both very desirable and should be encouraged, it may not be feasible.

Legislated mandatory parental consent or notification will certainly reduce the likelihood that young people will seek timely treatment for sensitive health issues. Adolescents will rarely admit to the use of the alcohol and drugs in front of their parent. The confidential interview gives them an opportunity to speak to a professional that can help them early and detect underlying depression when it is present and avoid the risk of suicide, for example, and other negative outcomes. When young people have symptoms of sexually transmitted diseases, they often delay going for treatment so long that complications that would normally be avoided occur, sometimes requiring hospitalization.

Having access to confidential care also provides an access point for adolescents to receive other health care services. These include things like cholesterol screening, immunizations, blood pressure monitoring or pelvic exams, services that are critical to the adolescent's health but could be overlooked if the adolescent had not visited a doctor. Ensuring the confidentiality in the delivery of health care services provides a necessary gateway that allows adolescents to simply get in the door so that we as health care professionals can help guide them in appropriate directions that includes parental involvement. Without confidentiality, early care and treatment is too often preempted.

Concerns about H.R. 4783, for reasons outlined in greater detail in our testimony, we oppose this legislation. We believe that this legislation will undermine the Federal guarantee of confidentiality for health care services under the title X program and other child and adolescent health programs. H.R. 4783 would create barriers to health care, especially for low-income young people who need to obtain affordable prescription drugs, including prescriptive contraceptives through federally supported health clinics. The barrier

would also impact health care services outside the scope of reproductive health.

In conclusion, as a physician, a teacher and most of all as a parent who is concerned about the quality and safety of health care for my daughter as well as for the quality and safety of health care for all adolescents in this country, I urge you to reject attempts to restrict adolescents' access to confidential health care services, including prescription drugs or devices. Mr. Chairman, thank you for the opportunity to testify before this committee today, and I will be happy when the time comes to take any questions. Thank you.

[The prepared statement of Renee S. Jenkins follows:]

PREPARED STATEMENT OF RENEE JENKINS, PROFESSOR AND CHAIR, DEPARTMENT OF PEDIATRICS AND CHILD HEALTH, HOWARD UNIVERSITY COLLEGE OF MEDICINE ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS

Good afternoon. Mr. Chairman, members of the Committee, I am Dr. Renee Jenkins, a practicing pediatrician who has taken care of adolescents for more than 20 years. I am also professor and chairman, Department of Pediatrics and Child Health, at Howard University College of Medicine. I am speaking today on behalf of the American Academy of Pediatrics (AAP), an organization representing 57,000 pediatricians throughout the nation. In addition, my comments are endorsed and supported by the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians and the Society for Adolescent Medicine.

Each of the organizations supportive of this testimony is fully committed to the health and well-being of adolescents. Specifically, the American College of Obstetricians and Gynecologists is an organization representing 44,000 obstetricians-gynecologists dedicated to health for women of all ages; the American Academy of Family Physicians is one of the largest national medical organizations, representing more than 93,500 family physicians, family practice residents and medical students; and the Society for Adolescent Medicine includes more than 1,400 physicians, nurses, psychologists, social workers, nutritionists and others involved in service delivery, teaching or research on the health and welfare of adolescents. *In total, we represent more than 196,000 medical professionals.*

It is from these perspectives, and perhaps most importantly as a parent, that I am here today to express our views concerning the issue of parental consent or notification for minors seeking health care services, including prescription drugs or devices. My comments today will also address H.R. 4783, the "State's and Parental Rights Improvement Act of 2002," which we believe would undermine confidential health care services for adolescents. I would like to thank the Committee for this opportunity to present this statement as Congress continues to debate this issue of significance to adolescent health care.

OVERVIEW

The American Academy of Pediatrics and the endorsing organizations firmly believe that parents should be involved in and responsible for assuring medical care for our children. Moreover, we would agree that as parents we ordinarily act in the best interests of our children and that minors benefit from our advice and the emotional support we provide as parents. We strongly encourage and hope that adolescents communicate with and involve their parents and/or other trusted adults in important health care decisions affecting their lives. These discussions include such issues as substance abuse, mental health and pregnancy and pregnancy termination. We know and research confirms that most adolescents do so voluntarily. This is predicated not by laws but on the quality of their relationships. By its very nature family communication is a family responsibility. Adolescents who live in warm, loving, caring environments, who feel supported by their parents, will in most instances communicate with their parents in a crisis including the disclosure of a pregnancy or other urgent health concerns. However, even adolescents reared in the best of household environments will at times be unwilling to make full disclosure of their behaviors because they do not wish to disappoint and hurt loving and caring parents.

Family communication about health care decisions is the desired goal, and health care professionals are able to assist in this effort. Allowing confidentiality of care for adolescents does not preclude the involvement of parents, as it is sometimes presumed. To the contrary, research has shown that adolescents often voluntarily share

information with their parents and clinical experience confirms that this often occurs after they consult privately with their health care provider.

Ensuring confidential care is about striking an important balance among parents, providers and the adolescent patient. While there may be circumstances when it is necessary and appropriate for the health care provider to inform parents or guardians of certain health problems facing a minor (e.g., life-threatening emergency) there is a critical need to ensure that an adolescent's health information is protected. Providing confidential care does not preclude working toward the goal of family communication.

Pediatricians, parents and policy makers know well the number of adolescents that are beginning to use illicit drugs, alcohol and become sexually active. What may start as experimentation with friends often leads to long term dependencies, accidents, injuries, sexually transmitted disease and a myriad of other physical and behavioral issues. In the infrequent cases where communication between adolescents and their parents can not be facilitated, many of these negative outcomes can be avoided if the adolescent has access to confidential health care.

My role as a pediatrician is to support, encourage, strengthen and enhance parental communication and involvement in adolescent decisions without compromising the ethics and integrity of my relationship with adolescent patients. Health professionals have an obligation to provide the best possible care to respond to the needs of their adolescent patients. This care should, at a minimum, include mental health, substance abuse, and services for other psychosocial problems including therapy, crisis management, day treatment, and residential care; comprehensive reproductive health services, such as sexuality education, counseling, mental health assessment; diagnosis and treatment regarding pubertal development; access to the full range of family planning services; pregnancy-related care; prenatal and delivery care; diagnosis and treatment of sexually transmitted diseases and referrals for other health and social services.

We understand that pending legislation, the "State's and Parental Rights Improvement Act of 2002" (H.R. 4783), is, in part, the basis for this discussion today. This legislation would allow states to require parental consent or notification for the purpose of dispensing prescription drugs or devices to minors under federal health care programs, such as the Title X Family Planning program and the Title V Maternal and Child Health Block Grant.

For reasons outlined below, we believe that this legislation would undermine the federal guarantee of confidentiality for health care services under the Title X program and other child and adolescent health programs, and is *inconsistent* with the policies of the endorsing organizations. In addition, this legislation could have a chilling effect on state programs that may opt to follow the federal recommendation.

The stated intent of those who support mandatory parental consent or notification legislation, of the type that H.R. 4783 would allow states to adopt, is that it enhances family communication as well as parental involvement and responsibility. However, the evidence does not support that these laws have that desired effect. To the contrary, there is evidence that these laws may have an adverse impact on some families and that it increases the risk of medical and psychological harm to adolescents. According to the AAP, "[i]nvoluntary parental notification can precipitate a family crisis characterized by severe parental anger and rejection of the minor and her partner. One third of minors who do not inform parents already have experienced family violence and fear it will recur. Research on abusive and dysfunctional families shows that violence is at its worse during a family member's pregnancy and during the adolescence of the family's children." It is for these and other reasons that the American Academy of Pediatrics and other organizations represented today oppose H.R. 4783 and any other legislation that will undermine federal guarantees of confidentiality for adolescents receiving health care services.

Since the involvement of a concerned adult can contribute to the health and success of an adolescent, policies in health care settings should encourage and facilitate communication between a minor and her parent(s), when appropriate. However, concerns about confidentiality, as well as economic considerations, can be significant barriers to healthcare for some adolescents. For example, the potential health risks to adolescents if they are unable to obtain reproductive health services are so compelling that legal barriers and deference to parental involvement should not stand in the way of needed health care for patients who request confidentiality.

CONFIDENTIALITY OF CARE

I would like to turn my attention to the issue of confidentiality—whether adolescents can access health care services, including prescription drugs and devices, without parental consent. The American Academy of Pediatrics and other medical orga-

nizations that I am representing today firmly believe that young people must have access to confidential health care services. Every one of our states' laws also provides confidential access to some services for young people, whether for sexually transmitted diseases (STDs), drug addiction or reproductive health care. Concern about confidentiality is one of the primary reasons young people delay seeking health services for sensitive issues, whether for substance use, an unintended pregnancy or for other reasons. While parental involvement is very desirable, and should be encouraged, it may not always be feasible and it should *not* be legislated. Young people must be able to receive accurate diagnosis and appropriate treatment expeditiously and confidentially.

Let me share a few general examples that underscore the importance of confidentiality of care:

- *Reproductive health:* Chlamydia is the number one bacterial sexually transmitted disease (STD) in the United States today. Every state allows a minor to give his or her consent for STD services. However, if a young woman comes into the clinic to receive a confidential consultation because she suspects she has chlamydia, or some other STD, it is critical that she not only receive the diagnosis in confidence but also the treatment to address the medical issue. Untreated, this type of problem can lead to serious consequences, including pelvic inflammatory disease or hospitalization.
- *Eating disorder:* Given the societal pressures and images portraying the glamour of being thin, young adolescent women face a range of eating disorders, including bulimia and anorexia nervosa. In the case of bulimia, it may be difficult for a parent to detect this illness and a child may not be forthcoming with a parent for fear of disappointing them. Having access to confidential health care services may be one of the few avenues that an adolescent is able to pursue to address his/her needs.
- *Mental Health:* Unfortunately, as we all know, mental health issues continue to be associated with a stigma, as well as often linked with substance abuse. For adolescents this stigma can be even more amplified for many reasons. However, we find that a teen may see a physician in confidence for a short period of time to address the feelings of fear or depression or drug use and then, through these consultations, build confidence in being able to talk a parent. Some teens are surprised to learn that their parents are very supportive and will not punish them for their behaviors or illness. Having a buffer of confidentiality is critical to facilitating a positive outcome.

Most adolescents will seek medical care with their parent or parents' knowledge. Making services contingent on **mandatory** parental involvement (either parental consent or notification) however, may drastically affect adolescent decision-making. Mandatory parental consent or notification reduces the likelihood that young people will seek timely treatment for sensitive health issues. In a regional survey of suburban adolescents, only 45 percent said they would seek medical care for sexually transmitted diseases, drug abuse or birth control if they were forced to notify their parents.

A teen struggling with concerns over his or her substance use, emotional well-being or sexual health may be reluctant to share these concerns with a parent for fear of embarrassment, disapproval, or possible violence. A parent or relative may even be the cause or focus of the teen's emotional or physical problems. The guarantee of confidentiality and the adolescent' s awareness of this guarantee are both essential in helping adolescents to seek health care.

For these reasons, physicians strongly support adolescents' ability to access confidential health care. A national survey conducted by the American Medical Association (AMA) found that physicians favor confidentiality for adolescents. A regional survey of pediatricians showed strong backing of confidential health services for adolescents. Of the physicians surveyed, 75 percent favored confidential treatment for adolescents. Pediatricians describe confidentiality as "essential" in ensuring that patients share necessary and factual information with their health care provider. This is especially important if we are to reduce the incidence of adolescent suicide and other mental health concerns, substance abuse, sexually transmitted diseases, unintended pregnancies and other preventable risky behaviors.

Many influential health care organizations support the provision of confidential health services for adolescents; here is what they say:

The American Academy of Pediatrics. "A general policy guaranteeing confidentiality for the teenager, except in life-threatening situations, should be clearly stated to the parent and the adolescent at the initiation of the professional relationship, either verbally or in writing."

American College of Obstetricians and Gynecologists. "Parents and adolescents should be informed, both separately and together, that they each have a pri-

vate and privileged relationship with the provider. Additionally, they should be informed of any restrictions on the confidential nature of that relationship."

The American Academy of Family Physicians. "The American Academy of Family Physicians supports the appropriateness of parental involvement in medical decision-making for adolescents, especially when they are engaging in precarious or adult behaviors. Whenever possible, family physicians make an effort to facilitate parental contact to help bridge any communication challenges that may arise between parent and child."

The Society for Adolescent Medicine. "The most practical reason for clinicians to grant confidentiality to adolescent patients is to facilitate accurate diagnosis and appropriate treatment . . . If an assurance of confidentiality is not extended, this may create an obstacle to care since that adolescent may withhold information, delay entry into care, or refuse care."

The American Medical Association. "The AMA reaffirms that confidential care for adolescents is critical to improving their health. The AMA encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When in the opinion of the physician parental involvement would not be beneficial, parental consent or notification should not be a barrier to care."

American College of Physicians-American Society of Internal Medicine. "Physicians should be knowledgeable about state laws governing the rights of adolescent patients to confidentiality and the adolescent's legal right to consent to treatment. The physician must not release information without the patient's consent unless required by the law or if there is a duty to warn another."

The American Public Health Association. APHA "urges that . . . confidential health services (be) tailored to the needs of adolescents, including sexually active adolescents, adolescents considering sexual intercourse, and those seeking information, counseling, or services related to preventing, continuing or terminating a pregnancy."

CONCLUSION

In conclusion, as a physician, a teacher, and most of all, as a parent, who is concerned about the quality and safety of health care for my daughter as well as for the quality and safety of health care for all adolescents in this country, I urge you to reject attempts to restrict adolescents' access to confidential health care services, including prescription drugs or devices.

Thank-you. I would be happy to answer any questions you may have.

Mr. BILIRAKIS. Thank you very much, Dr. Jenkins.

Mr. Heisler.

STATEMENT OF JOHN A. HEISLER

Mr. HEISLER. Mr. Chairman and members of the committee, I want to thank you for the opportunity to come before you and explain why McHenry County, Illinois refuses to take Federal funding that requires us to provide contraceptive services to minor without parental notification.

Our county was forced to deal with an issue of parental notification when we found out that a 12-year-old junior high student was getting chemical contraceptive shots because her 37-year-old teacher was raping her. The McHenry County Board of Health administers a $4 million budget and generally—should I continue?

Mr. BILIRAKIS. Yes, please continue. That is a message to us regarding what is happening on the floor.

Mr. HEISLER. The Department of Health has three divisions: Animal Control, Environmental and Nursing. About 75 percent of the revenues of the health department are derived from grants. In the past, grants were sought out and applied for by senior staff within the department. Grant applications are formally submitted to State and Federal Government over the signature of the health department administrator. Since my county's rejection of the title X grant, all new grant applications and all grant renewals in excess

of $50,000 are submitted to the county board for approval prior to being submitted to the grantor.

The McHenry County Board of Health was created by resolution of the county board, not by referendum. While State statute in Illinois does extend a great deal of authority to the board of health, the ultimate authority comes from the county board who approves its budget and appoints its members.

The title X debate in McHenry County began in January 1997 when it was learned that a 12- or 13-year-old school girl had been driven to the county health department clinic on several occasions by her 37-year-old Crystal Lake Middle School teacher who had been having sexual relations with her for some 18 months to receive injections of the contraceptive drug, Depo-Provera. Unfortunately, Federal title X regulations prevented her parents from being informed.

Her teacher, William Saturday, pleaded guilty to criminal sexual assault charges in September 1997 and was sentenced to 10 years in prison. According to public record, Mr. Saturday was released in February of this year after serving less than half of his sentence. He is currently on parole and living in McHenry County as a registered sex offender.

This teacher could not take or send a 12-year-old girl to his school nurse. He could not take her to a private doctor or physician. He could only take her to a title X program facility where no parental consent was allowed. The title X grant aided him in his crime. In Illinois we protect our children under various State statutes. A minor cannot buy a pack of cigarettes, a drink or even get a tattoo in Illinois because of the potential danger. Furthermore, the school code of the State of Illinois prohibits the administration of any drug or medical attention without parental consent. It is shocking to think that a Federal grant program can circumvent our State code.

As a member of the board of health, the Health Department Oversight Committee and the county board, I began to inquire about the no-parental notification clause of title X. I was not made apparent of the executive review and the executive review of the grant. Hearing no acceptable answers, I asked the health department administrator to check with the Federal Government, and he was told that there would be no exceptions and further that we had to accept the title X grant with the no-parental notification provision or reject it in its entirety. I would like to repeat that. The Federal agency that administers title X essentially gave the parents in McHenry County two options: Take the title X money and be kept in the dark about your kids or reject the money. Ultimately McHenry County did, in fact, reject title X funding.

At the regular county board meeting of October 1997, I made the motion to remove the approximately $47,800 in title X funds from the county budget. In addition, as finance chairman, I restored the gynecological services to poor adult women to the budget from local tax dollars. The message was sent back to Washington, "We cannot be bought. We will not accept your money if it affects our children. We feel it is the parents' right to determine if any child needs medical services. A child in McHenry County cannot be given even an aspirin from the school nurse without parental consent. The board

of health in McHenry County will not circumvent the basic rights of parents by accepting Federal title X funds."

McHenry County has not applied for title X funds since this time. We do not provide contraceptive services to minors without parental consent. We have allocated tax dollars for pre-natal care and all other related gynecological services to that segment of our population that cannot afford medical services or insurance. As with all of our nursing services, we target recipients who do not qualify for Medicaid or have sufficient income to afford medical insurance.

The debate over the title X grant in McHenry County was stifled by a gag order due to the lawsuits brought against the county by the girl's parents. Elected officials, board members and employees were asked not to discuss the issue as it might have had a detrimental effect on the defense of the county's position.

Mr. BILIRAKIS. Please summarize, Mr. Heisler.

Mr. HEISLER. I have lived in Crystal Lake all my life. My entire family still lives in Crystal Lake, and I think I represent the values of the majority in McHenry County. Unlike other political issues, there was no room for compromise with the Federal title X funds. I believe, at least in this instance, the moral majority did prevail. If the Federal Government continues to mandate that we keep parents in the dark, we will be happy to provide for our own without help from title X funding. Thank you.

[The prepared statement of John A. Heisler follows:]

PREPARED STATEMENT OF JOHN A. HEISLER

Mr. Chairman and Members of the Committee, I want to thank you for the opportunity to come before you and explain why McHenry County, Illinois refuses to take federal funding that requires us to provide contraceptive services to minors without parental notification. Our County was forced to deal with the issue of parental notification when we found out that a 12-year-old junior high school student was getting chemical contraceptive shots because her 37-year-old teacher was raping her.

Background:

McHenry County is about 50 miles northwest of Chicago, Illinois. Population is approximately 280,000. McHenry County is the fastest growing county in the State of Illinois.

The County Board is a 24-member board, made up of four elected representatives from each of the six districts within the County.

I have been a member of the County Board since August 1994. I am a member of the Public Health Committee, the Valley Hi Nursing Home Committee and Chairman of the County's Finance Committee. McHenry County has an annual budget of about $130 million and has approximately 1,200 employees including a sheriff's department of 300 officers.

Throughout the County, we have several organizations that are supported by the County budget. These organizations have their own Boards whose members are appointed by the County Board, and each has a "Liaison" member from the County Board with voting privileges. These "Liaison" members are on these Boards to give some fiscal guidance and to promote the general philosophy of the full County Board.

In the fall of 1994, I was appointed Liaison Member of the McHenry County's Board of Health. The McHenry County Board of Health had eight members (now nine) consisting of two physicians, a dentist, a civil engineer, a nurse, two citizens from the County and the County Board Liaison.

The McHenry County Board of Health administers a $4 million budget and generally sets the policies and standards of conduct for a staff of 100. The Department of Health has three divisions: animal control, environmental, and nursing. About 75% of the revenues of the Health Department are derived from grants. In the past, grants were sought out and applied for by senior staff within the Department. Grant applications are formally submitted to the State or Federal Government over the

signature of the Health Department Administrator. Since the County's rejection of the Title X grant, all new grant applications, and all grant renewals in excess of $50,000 are submitted to the County Board for approval prior to being submitted to the grantor.

The McHenry County Board of Health was created by Resolution of the County Board, not by referendum. While State Statute does extend a great deal of authority to the Board of Health, the ultimate authority comes from the County Board who approves its budget and appoints its members.

Title X:

The Title X debate in McHenry County began in January 1997, when it was learned that a 12-year-old grade school girl had been driven to the County Health Department Clinic on several occasions by a 37-year-old Crystal Lake Middle School teacher who had been having sexual relations with her for 18 months, to receive injections of the contraceptive drug Depo-Provera.© Unfortunately, federal Title X regulations prevented her parents from being informed.

Her teacher, William Saturday, pleaded guilty to criminal sexual assault charges in September 1997, and was sentenced to 10 years in prison. According to public records, William Saturday was released in February of this year—after serving less than half of his sentence—and he is currently on parole and living in McHenry County as a registered sex offender.

This teacher could not take or send the 12-year-old girl to the school nurse. He could not take her to a private doctor or physician. He could only take her to a Title X program facility where no parental consent was allowed. The Title X grant aided him in his crime.

In Illinois we protect our children under various state statutes. A minor cannot by law buy a cigarette, a drink, or even get a tattoo in Illinois because of the potential danger.

Furthermore, the school code of the state of Illinois prohibits the administration of any drug or medical attention without parental consent. It is shocking to think that a federal grant program can circumvent our state code.

As a member of the Board of Health, the Health Department Oversight Committee (Public Health Committee) and the County Board, I began to inquire as to why the "no-parental notification clause" of Title X was not made apparent in the executive review of the grant. Hearing no acceptable answer, I asked the County Health Department Administrator to check with the Federal Government, and he was told that there would be no exceptions and further that we had to accept the Title X grant with the "no-parental notification" provision, or reject it in its entirety.

I'd like to repeat that: The federal agency that administers Title X essentially gave the parents in McHenry County two options: 1) take Title X money and be kept in the dark about your kids or 2) reject the money.

Ultimately, McHenry County did, in fact, reject Title X funding. At the regular County Board meeting of October 1997, I made the motion to remove the approximately $47,800 in Title X funds from the County's Budget. In addition, as Finance Chairman, I restored all gynecological services to poor adult women to the budget from local tax dollars. The message sent back to Washington was: We can't be bought. We will not accept your money if it affects our children. We feel it is the parents' right to determine if any child needs medical services. A child in McHenry County cannot be given even an aspirin from the school nurse without parental consent. The Board of Health in McHenry County will not circumvent the basic rights of parents by accepting federal Title X funds.

McHenry County has not applied for Title X funds since this time. We do not provide contraceptive services to minors without parental consent. We have allocated tax dollars for pre-natal care and all other related gynecological services to that segment of our population that cannot afford medical services or insurance. As with all of our nursing services, we target recipients who do not qualify for Medicaid or have sufficient income to afford medical insurance.

The Debate:

The debate over the Title X grant in McHenry County was stifled by a gag order due to the lawsuits brought against the County by the girl's parents. Elected officials, Board Members, and employees were asked not to discuss the issue as it might have had a detrimental effect on the defense of the County's position. The vocal minority in the community was not under any such restriction. As a result, the public debate was very one sided. Proponents of Title X organized into a group called "Friends of Public Health" and attacked me at home, at work, at church and at Board meetings. Under the gag order, I was not permitted to reply or respond.

I have lived in Crystal Lake all my life. My entire family still lives in Crystal Lake, and I think I represent the values of the majority in McHenry County. Unlike other political issues, there was no room for compromise with the federal Title X funds. I believe, at least in this instance, the moral majority did prevail.

If the federal government continues to mandate that we keep parents in the dark, we will be happy to provide for our own without help from Title X funding.

Thank you.

Mr. BILIRAKIS. Thank you, Mr. Heisler. Ms. Wuchner, last April, this subcommittee had a hearing on abstinence education. I was pleased to read in your testimony that Northern Kentucky Independent District Health Board stated an intention to focus on what we call character-based abstinence education, including parental communication. So I wonder if you can take maybe a couple minutes, give us an update on the status of such education in Northern Kentucky and what do you think of it? In other words, your opinion, how would you grade it?

Ms. WUCHNER. That change came about last year because of research into title V funding, just like we were doing this year in title X. And it revealed that some of the programs that we were currently providing for the schools did not meet the wise guidelines that Congress set forth in title V funding. And so we had a set up a screening tool to screen programs that would meet the guidelines and be appropriate for the values and the conditions of our community. One of the things I want to add is that when a public opinion poll was taken in Northern Kentucky by the press, it was three to one in favor of abstinence education. This is the voice of parents in our community. That led to then a lot of hard work to discover programs that would meet the factors in the screening tool, meet the guidelines, and we began doing that and chose a particular program that would now be available for this coming school year.

I would like to say that for quite some time the health department was not the most popular place to come for your ex education for your schools. There were public schools that used the programs but many that didn't. We just had a meeting and the report was that we need to add some staff. We may have more people than we ever anticipated, more schools signing up for programs this fall that support character-based abstinence education and a continuum and also the parents' communication and parents have been put into the program. So thank you.

Mr. BILIRAKIS. Thank you. Thank you very much. And the Chair now yields the balance of his time to Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman. Mr. Chairman, I would like to submit for the record a letter to you from the Honorable Steven Ogden, a State Representative from Texas who wrote a parental consent law that was invalidated by the title X regulations.

Mr. BILIRAKIS. Without objection, that will be the case.

[The letter referred to follows:]

July 11, 2002

The Honorable MICHAEL BILIRAKIS
Chair, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

DEAR CHAIRMAN BILIRAKIS: Over the past several sessions of the Texas Legislature, I have attempted to strengthen state law and practice to ensure parents and guardians are involved in their children's health care decisions.

Currently, Title X of the Public Health Services Act and Title XIX of the Social Security Act hamper my state's desire to preserve the traditional role of parents in raising their children.

In the state's appropriations bill for FY 2000-2001, I included a rider directing the Texas Department of Health (TDH) to distribute funds for medical, dental, psychological or surgical treatment provided to a minor *only if* consent to treatment were obtained according to Texas law (Chapter 32 of the Family Code). The rider was permitted to be waived if federal funds would be lost.

In an exchange of letters between TDH and the regional office of the U.S. Department of Health and Human Services in 1999, it was determined that Texas would lose federal funds if the rider were implemented. Nevertheless, I included a similar rider in the FY 2002-2003 appropriations bill.

I seek your assistance in amending current federal law and regulations to permit Texas to accept federal funds under Title X and Title XIX without having to ignore its sovereign laws.

Sincerely,

STEPHEN E. OGDEN

Attachments
cc: The Honorable Joe Barton
Mr. Ed Perez, Texas Office of State and Federal Relations

Mr. PITTS. Thank you. Ms. Wuchner, if a doctor in your State's title X program decided that it was in the best of a girl, both physically and emotionally, to notify her parents that their daughter was receiving chemical contraception shots, was depressed, was sick with a venereal disease, what penalty would be levied against the title X clinic? Would your program lose Federal funding?

Ms. WUCHNER. I think it is the perception of the clinicians that they would lose the funding. Now, there has always been discussion to this point, but at this point no one ever exercises that right if there is a right to do that because of the fear of losing the funding of the program. When the board grappled with this decision on title X funding this year, it was the consensus that it was problematic, that clinicians could not make that decision, that they were bound by the structure of title X funding to provide services to minors without parent notification.

Mr. PITTS. Thank you. Dr. Jenkins, does the American Academy of Pediatrics support any laws requiring parental notification or parental consent before prescribing medications or performing surgeries?

Ms. JENKINS. Let me say that the American Academy of Pediatrics recognizes the right for adolescents to receive confidential care and the acknowledgment that under State statutes are what governs most of us in terms of what we can do in a practice situation. Again, the concept here seems to be prohibiting physicians from notifying parents, and I don't think that is the stand that most of us are engaged in at all. I think most of us in fact involve parents when we can with adolescents once they come and present issues of a sensitive nature, including issues related to reproductive health. And so this particular stand that we would support laws

that prohibit physicians I don't think our interpretation of the laws are that physicians are prohibited from giving parents—engaging parents in the health care with their adolescents. I think the picture is that it is not in the adolescent's best interest to think that they will come in the office, they will see you, they will present an issue to you and then you will call their out of the context of their engagement in that visit. And I think those are the kinds of situations that in many of the bills about this communication is what people are trying to protect against. And that is the fear that you, out of the context of the relationship within the care, that you would then pick up the phone or do something else to notify a parent and not really work with the young person to help them share this information.

Mr. PITTS. Well, Dr. Jenkins, if I may interrupt, and my time has expired, does the academy support any laws requiring parental notification or parental consent? I mean you have indicated——

Ms. JENKINS. You mean any laws related to what? To——

Mr. PITTS. Before prescribing medications or performing surgeries?

Ms. JENKINS. I don't performing surgeries is part of that. I think the academy does not support laws that require parental consent for contraceptive care, for example, that require parental consent. But I think part of what your question was expands pretty far beyond that limitation.

Mr. PITTS. Well, I am not sure——

Mr. BILIRAKIS. The title X regs say that they must not be disclosed, that receiving services must be held confidential and must not be disclosed. That is what it says.

Ms. JENKINS. But when they are saying, "must not," are they saying under what kind of provision that that occurs? It seems to me that if in some of the pictures that have been—kind of cases that have been discussed here, that it does not preclude the physician from counseling the adolescent about involving their parents, okay?

Mr. BILIRAKIS. That is correct.

Ms. JENKINS. What it does is it says don't pick up the phone and call somebody. It seems to me that would be my interpretation under that situation. It does not say that you cannot work with the adolescent and engage them in a situation in which they would involve their parents.

Mr. BILIRAKIS. My time has long expired. Mrs. Capps.

Ms. CAPPS. Thank you. I will allow you, Dr. Jenkins, in a moment to return to this. But, first, Mr. Heisler, you gave an eloquent testimony to the case study, if you will, of your country and your involvement in it. And your reason for being here is because you say that you did not want to accept, as a county, Federal money when it had all the strings attached to it that it did. And you have refused title X funding which implements mandatory parental notification laws for your health care facilities within your jurisdiction there. But I wonder if you have noticed that two statistics have changed in that time. Apparently 25 percent more teenage births have occurred in your county and that the rate of chlamydia for people 20 years and younger has doubled whereas the surrounding counties these numbers have continued to go down.

Dr. Jenkins, I want to thank you for being here on behalf of the academy. The American Academy of Pediatrics has been really on the forefront of engaging, I believe, our families to become stronger, because it is through this kind of communication skill that you help to instill in adolescents that gives them the confidence to talk with their parents in sensitive areas that sometimes teenagers are shy or hesitant to do. I am thinking of my own experience as a mother and also working with teen parents to watch and bring my own kids into their pediatrician as kids and sat in the office with them, and then at a certain point to have the child be able to walk into the doctor's office alone and the kind of increased confidence that gave my own children to begin to formulate the questions that they could deal with directly with you and that I had the confidence of trusting you and your profession.

You are kind of here today representing all of these people within clinics and settings around the country who work with teenagers, not the easiest group necessarily to work with, particularly in the area of sexuality and especially perhaps in this country where we have many conflicting standards that impede upon a young person's mind and also recognizing, as the academy does, the variety of family, that there is not a word "family" that is uniform in this country today that you presume upon that as you see a patient come into see you within the context of their home life, which can be very, very varied. And so I want—I would like you to use this time to further get at for us what this confidential relationship is, why is it so scary to some of us, and how can we come to see it as something that can be positive and assist our young as they make very important and life-changing decisions?

Ms. JENKINS. Right. First of all, let me say it sounds like you had a wonderful pediatrician.

Ms. CAPPS. Yes, I did.

Ms. JENKINS. Okay.

Ms. CAPPS. I felt very fortunate to—more than one, actually, over the life long.

Ms. JENKINS. Is that right? Okay. Well, I think what you have painted as a parent is that developmental context, and that is just so important. I think very often when people deal with their teenagers evolving through adolescence and into adulthood, they don't understand that it is a process and that in that process there has to be a bit of letting go, a pulling back over time. And so what helps the adolescent really manage themselves more effectively as older adolescents and young adults is having the opportunity to work with their primary care giver around these issues or to go to other health professions and express these issues. So I think our role is to really work with them to do that. And I think many of us also do this outside of even our own practices. I work with a project in the District now that works with fifth graders and their parents around some of these issues, trying to improve parental communication but also help the young people be supported by their families and work with families about how to support young people through their adolescence. So, certainly, pediatricians are in their training programs taught these types of skills and practice them and believe in them very firmly.

Ms. CAPPS. Could we focus again for the remaining time on title X and the rare, I would hope rare, times when teenagers present themselves to you, to our clinics in the various communities without, with an absence, with a dysfunctional family, if you will, or a non-existent family, an incestuous family, whatever the—and it is not that rare. How then does the pediatrician respond?

Ms. JENKINS. I think the pediatrician very often will look for other adult support individuals. I think sometimes there is not support within the family, and we have talked about situations in which external people are engaged in some sexual abuse with adolescents, but the incest is not uncommon and situations in which someone in the household is having an inappropriate relationship with the child is not uncommon. And so many agencies also have a relationship in which they are able to get help for these young people in addition to just providing family planning services. I think sort of the sense that we have this isolated sort of take this pill, take this shot is really not the way people operate, and I think that we understand the context in which some of this occurs, and we do seek intervention for these young people, and we certainly report incidents according to State and local statutes.

Ms. CAPPS. Thank you very much.

Mr. BILIRAKIS. Thank you. Mr. Pitts for his own time.

Mr. PITTS. Thank you, Mr. Chairman. Mr. Heisler, your testimony was quite compelling. You said that the parents of the young girl who was raped sued the county. What happened in that lawsuit? Do you know if anyone besides the perpetrator was held liable for keeping the parents in the dark after this awful victimization had gone on for 18 months? And also you said the Title X Office said essentially, "Keep the parents in the dark or don't take the title X money?" Did you ever hear from the office again when you made national news for rejecting title X money? Did anyone from the Title X Office call and say, "Hey, let us work something out"?

Mr. HEISLER. Thank you, Congressman. Frankly, with regard to the suit that the parents brought against the county, I do know that the county was dismissed out of the suit. I believe the principal at the grade school where this teacher taught was dismissed out of the suit. Beyond that I don't know what happened with it. Now, with respect to any further contact from the Title X people, we have had none.

Mr. PITTS. Do you think that other concerned citizens should ask their counties to follow your lead in breaking away or do you think the Federal agency that runs title X should reexamine the regulations that they have?

Mr. HEISLER. Oh, absolutely. I mean I might respond to that by saying I don't know the reason why Congresswoman Capps made that comment to me regarding the increase in teen pregnancy in McHenry County, but I can tell her that we have had a 100 percent decrease in teachers raping kids in McHenry County. It doesn't happen anymore. Parents know about it.

Mr. PITTS. Thank you. Dr. Jenkins, studies have reported that children are reaching puberty at very early ages, even as early as 9 years old. In your professional opinion, should a title X clinic be handing our or injecting a 9-year-old girl with prescription contra-

ceptive drugs? Do you think a 9-year-old should be making medical decisions without her parents' input?

Ms. JENKINS. I know you don't think I am going to say yes. First of all, I think when people talk about the studies you are talking about with puberty, they mean appearance of breast buds, which is the onset of puberty. They do not mean, for example, full reproductive maturity. So I think we should be clear about we are talking about when we read those studies about early puberal maturation.

It is my opinion that most responsible health professionals recognize that adolescents of a certain chronologic age who have behaviors that perhaps are in the adult range do not necessarily have decisionmaking skills that are in that range, and take the appropriate stances in terms of intervention of some sort, either to try to understand what is the context of that relationship and to seek intervention for a young person.

For example, I work in the inner city here in the District, and the anecdotal evidence is that approximately mid-teens is a time when you get adolescents who are reporting sometimes certain sexual behaviors. But when you have young people who are below those ages who come to you with any evidence and very often they are not reporting it, it is what you find on examination that suggests, for example, that something is occurring, that you take the appropriate intervention. And most often that is to engage a social service individual into investigating what the situation is for that young person. But I don't think——

Mr. PITTS. But you are aware that the title X regs say that services without regard to age, you know, religion, race, color, national origin, age have to be provided.

Ms. JENKINS. If services are provided, I don't think it probably says specifically that you have to inject or give someone a contraceptive if you think that is inappropriate for what has happened to that young person.

Mr. PITTS. Well, suppose a 12-year-old girl walks into the title X clinic, don't you think someone should be calling the authorities or her parents? Isn't having sexual relations with a 12-year-old statutory rape, as we heard in this case, 12-, 13-year-old? But do you agree that to comply with Federal law, title X clinics should be reporting the fact that these minors are coming in for contraception?

Ms. JENKINS. I think, as far as I am aware, that the reporting of statutory rape is determined by the jurisdiction, and in the District, for example, there are guidelines around the age for reporting statutory rape and also child abuse. As far as I am aware, those statutes do not necessarily say that the first step is to call a parent up for notification. The first step is to engage the appropriate authorities.

Mr. PITTS. Would you limit the number of times per month, for instance, that a minor girl could get drugs? For instance, there is no limit now for a teenager going in for the "morning after" pill.

Mr. BILIRAKIS. Just a very brief answer to that, please, if you can.

Ms. JENKINS. I think that is a question sort of taken out of context, and so I——

Mr. BILIRAKIS. Do you want an answer to your question. The doctor seems to feel it is taken out of context.

Mr. PITTS. Go ahead. You may proceed.

Mr. BILIRAKIS. Go ahead.

Ms. JENKINS. Okay. My answer would be I would need to—I would have to know more about a case situation than to say arbitrarily, "You can only come here three times." I think we clearly have to understand in some of the instances what we are talking about these young people getting contraception. The alternative in not getting contraception is pregnancy, and many of the issues are certainly not resolved by a young person becoming pregnant in a situation like that or being faced with the alternative we heard about earlier, which is an abortion.

So I think when we are giving contraceptive services, we generally are talking about a young person, for the most instances, who is not at the ages that you are talking about but who is an older young person. As the high school studies show, that 50 percent or more of young people have had some sort of sexual encounter, and so you are really not doing—giving a drug or not giving a drug based on there being no alternative or no other risk that presents itself.

So I think when you manage young people you look at what the risks are for the total situation in terms of what is being done. And very often for the young people that come to title X the alternative is, "Well, if I can't get contraception, I am not going to have sex anymore." That generally is not what the interpretation is. And very often these young people end up in a situation where they either acquire an STD or they become pregnant unintentionally. So I think we are working in a battleground situation that is not as cut and dry as you want to present it in the situation, let me tell you. They are very complicated, and very often you make decisions in the context of the total picture for the young person, but you appropriately engage agencies when it presents to you a situation that requires that.

Mr. BILIRAKIS. Thank you, Doctor. Mr. Strickland.

Mr. STRICKLAND. Thank you. I am sitting here thinking of a school librarian in my district that was called to the gymnasium of one of my local schools. The girl was sick, the coach said, "See what you can find out." They went into this broom closet. The librarian said to this young girl, "Could you be pregnant?" She said, "Oh, no, I have never done it." And then she started screaming, "It is coming out," and this librarian said, "I pulled down her blue jeans and a baby was born in that broom closet." That is the situation that we face. Then the girl started saying, "My mother will kill me. My mother will kill me." I wish every family in this country was an Ozzy and Harriet kind of family. It is not.

Now, I just want to make something clear. Title X requires that providers comply with State laws on reporting incest, rape and molestation. Is that not true? Can someone answer that?

Ms. JENKINS. Yes.

Mr. STRICKLAND. So what are we talking about? If a 12-year-old comes into your clinic and is pregnant, that child has been molested, the report is made to the authorities, is it not?

Ms. JENKINS. Should be, yes.

Mr. STRICKLAND. Absolutely. I think we ought to clear that up, because I think there has been an implication here that these clinics cover up crime, and I don't think there is any evidence that that is in fact the case.

Dr. Jenkins, just for the record, I want to make sure that from your point of view this is the bottom line. In your professional opinion, H.R. 4783, the Brady Consental Parent Bill, do you believe that bill, if passed in its present form, would be bad for the health of children?

Ms. JENKINS. Yes, I do. I think it would be bad for the health of adolescents who need or who will not be able to access care and prescriptions that would be relevant to their care, yes.

Mr. STRICKLAND. Okay. And a question to Ms.—and if I am mispronouncing the name, I apologize—is it Wuchner?

Ms. WUCHNER. That is correct. Thank you.

Mr. STRICKLAND. Ms. Wuchner, do you believe that women who use birth control pills are committing abortion or abortions result from the use of birth control pills?

Ms. WUCHNER. Well, first of all, the question is irrelevant, because we are talking about minor children and medications given to minor children.

Mr. STRICKLAND. But I would like to know your opinion about an adult woman who uses a birth control pill. Do you believe——

Ms. WUCHNER. Do I believe she is committing an abortion?

Mr. STRICKLAND. Yes.

Ms. WUCHNER. No. I think the pill operates by three mechanisms and that is scientific fact. Do I believe she is committing an abortion? No, at this point. Do you understand what I mean by that? The pill has three mechanisms of action, which is listed in the PDR. One is to prevent ovulation, the other is to affect the viscosity of the mucous and the other would prevent egg implantation which is a fertilized embryo if that should occur from implanting. It would render the lining unacceptable to that. But we are talking about minor children and prescriptions being given to minor children and treatment being given to minor children without their parents' knowledge, parents who are entrusted to care for these children by just the human nature——

Mr. STRICKLAND. I understand.

Ms. WUCHNER. [continuing] puts children in the care of their parent.

Mr. STRICKLAND. And I am sympathetic. I think in nearly all cases certainly parents ought to be involved. What would you say to those circumstances, and they occur and the occur much more frequently than most of us would like to admit, where there is a father, an uncle, some other relative, do you believe there should at least some provision for not involving the parents when a child may have been subjected to an abusive situation within the home itself?

Ms. WUCHNER. The law at that point provides a provision, and that is the requirement that that would be reportable. That is a reportable case to the authorities. It takes it out now of the context of parental consent and now puts it into a legal or an illegal situation that has occurred with a minor child.

Mr. STRICKLAND. But isn't it——

Ms. WUCHNER. You see what I am saying, that is separate.

Mr. STRICKLAND. But isn't——

Ms. WUCHNER. And that is not calling the parents to report them if they are the perpetrators of the child. Whoever perpetrates the child that needs to be reported. That is problematic. We are talking about medical care and treatment of minors, and that is different. We are not talking about an abusive situation. It could be an abusive situation, which means that it is reportable.

Mr. STRICKLAND. When a young child is being sexually involved, that is an abusive situation.

Ms. WUCHNER. That is correct. When she is being sexually abused by someone in the family, the authorities are reported and an investigation ensues which would mean parental notification. And if that parent is violating or a member of that family or community is violating that child, then the legal action and the appropriate action is going to take place whether—there is going to be natural notification.

Mr. STRICKLAND. Could I just follow up very quickly?

Mr. BILIRAKIS. Very quickly.

Mr. STRICKLAND. Would you be satisfied if the law required under circumstances that are difficult like this that the authorities be notified rather than the parents?

Ms. WUCHNER. The law does require under the circumstances that authorities be notified.

Mr. STRICKLAND. But are the parents also required to be involved under those circumstances, as the law is written?

Ms. WUCHNER. Now, we are talking about circumstances, and we are talking about general medical care that does not involve parents. Under the law, the authorities are notified and parents would immediately become involved because what would take place is the authorities would then go to begin an investigation. See that is a separate issue. We are talking about a child that has been now violated in some range. So that means that there would have been authority notified, and then what happens is it is not the clinician who is treating the child that has notified the parents, because, again, as Mr. Pitts mentioned, adolescents must be assured of their confidentiality, and the musts that are mentioned or the guidelines in title X, those musts are mandatory. You can't breach from those. So the only way around that must is to go to the legal authorities and report it. The clinicians' hands are tied.

Mr. STRICKLAND. My time is up. Thank you.

Mr. BILIRAKIS. Mr. Towns, to inquire.

Mr. TOWNS. Thank you very much, Mr. Chairman. Let me begin, Mr. Heisler, by making sure that I understood you. You said that the majority—are you saying the majority of the health care professionals support your position or are you saying the majority of the people in McHenry County support your position?

Mr. HEISLER. No, I said the majority of the people in McHenry County.

Mr. TOWNS. Well, is it true then that before McHenry County Health Board was able to successfully reject title X funding, they first voted not to reject title X funds? Is that true? Yes or no.

Mr. HEISLER. The board itself, the health board itself, we had several votes. It came down to a 4 to 4 at the health department——

Mr. TOWNS. Four to 4 is not a majority.

Mr. HEISLER. No, I know. The health board did not initially reject title X. The county board rejected the title X funding. The county board appoints the health board and approves their budget.

Mr. TOWNS. Let me make certain I understand. There is a representative by the name of Cal Skinner who changed the numbers on the board in order to break a tie, and then you went out shopping for someone who committed themselves, and indicated the fact that they would vote to reject the funds. You had to campaign to get somebody to do that.

Mr. HEISLER. No, that is not right.

Mr. TOWNS. After you got that person to do that——

Mr. HEISLER. Not at all.

Mr. TOWNS. [continuing] then you ended up having a 5 to 4 vote. Now, how do you arrive at this great majority that you keep talking about here?

Mr. HEISLER. You are misinformed, Congressman. That is not at all what happened. The change in the number of members in the board of health, which is a subboard of the county board, went from five to four, eight to nine, so we could have that 5 to 4 well after this whole title X thing was over with. We didn't want to have that happen again.

Mr. TOWNS. If it was 4 to 4, how did you get that? I mean somewhere in here I am losing a step.

Mr. HEISLER. Well, let me explain it. The board of health——

Mr. TOWNS. Four to 4 is a tie.

Mr. HEISLER. Four to 4 it fails, you are right. Four to 4 it fails. The board of health did not reject it. The county board removed the funding, removed the title X funding. The county board funds the board of health activities.

Mr. TOWNS. Well, let me ask you this then, isn't it true that the majority of the health care professionals in McHenry County spoke out adamantly in favor of continuing title X funding?

Mr. HEISLER. I wouldn't say that that is true at all.

Mr. TOWNS. Well, I have a letter from 23 doctors and nurses in McHenry County, as well as a number of organizations, such as the Illinois Caucus of Adolescence Health, who disagree with your opinion on this issue. Isn't it also true that only one physician came out in support of ending title X funding?

Mr. HEISLER. You seem to have the statistics there, sir. I don't know who that one physician might be. I can tell you——

Mr. TOWNS. I don't want to meet him either. I don't want to meet him. Go ahead.

Mr. HEISLER. I can only tell you what happened. And what happened, McHenry County appoints the board of health. The county board appoints the board of health. The county board created the board of health. The board of health, through some decision that it might make that perhaps adverse to the philosophy of the elected officials of McHenry County, can in fact dissolve the board of health. The ultimate authority at McHenry County relative to

these title X grants comes with the elected officials of the county board. We rejected it 15 to 6.

Mr. TOWNS. Let me say this: Is it safe to say that you do not represent the values of the majority of the medical profession in McHenry County? Is it safe to say that?

Mr. HEISLER. You can say that. I am not a medical professional, I didn't take a poll of the medical profession of McHenry County. I speak for the people. I am an elected official of McHenry County. I speak for 250,000 people that live there. I have lived in McHenry County for 58 years.

Mr. TOWNS. You didn't take a poll of the people either.

Mr. HEISLER. Let me explain that. My grandfather started a shoe store 100 years ago on the corner of Crystal Lake, Illinois, and there is more people that walk into that shoe store and tell me about their philosophy of life than walk into your home office I will bet you because we know what is going on. My brother is on the county board. We know how the people feel in McHenry County about this issue. That is why it failed.

Mr. TOWNS. I seriously doubt that, because I come from a county that represents 2.5 million people, so I seriously doubt that.

Mr. HEISLER. Well——

Mr. BILIRAKIS. The gentleman's time has expired. Now, is this something you want to continue on for another few seconds?

Mr. TOWNS. Well, no more than the fact that I think that his testimony is very misleading. He indicated that the majority of the people, and it would seem to me he had taken a poll of the people of McHenry County. I mean and then all of a sudden he is talking about somebody walking in a shoe store.

Mr. BILIRAKIS. Well, I am not going to speak on behalf of Mr. Heisler, but he is an elected official just as we are. We are representing the people, and I think what his point is that he represents the people in that area, and if he wasn't representing them adequately as far as this issue or any other issues are concerned, he would no longer be an elected official when his elections take place.

Mr. TOWNS. Well, maybe the next election will take care of that.

Mr. BILIRAKIS. So anyhow, the time is expired. Mr. Akin, would you like a couple of minutes to inquire? You have been very patient, you have sat here throughout this entire thing. You obviously have an interest in it.

Mr. AKIN. Yes. Thank you, Mr. Chairman. I appreciate that opportunity. I did have a question or two. I just wanted to clarify a couple things.

Mr. BILIRAKIS. All right. Let us do it. Let us do it.

Mr. AKINN. Thank you. I guess any of the three of you might be able to answer this, but, Dr. Jenkins, perhaps maybe you could. Let me just give you a hypothetical because there has been a little bit of confusion about exactly, at least from listening to testimony, where we are in this. Let us say that you are in a title X clinic, a child comes into you, let us just assume it is a minor child. And the child says, basically, "I want some contraceptive shots" or whatever it is, and they are a minor. And they say, "My mom and dad would shoot me if they knew I were here. But I know that I can come here and trust you, and so therefore I want this—I am

a minor and I want this medication." Can you, according to the law, call that child's parents and tell them what is going on? I am not talking about what you want to do, I am just saying legally could you do that the way the law is set up now?

Ms. JENKINS. Under title X?

Mr. AKIN. Yes.

Ms. JENKINS. What has been discussed here is that apparently to pick up the phone and call the parent at that point would be not allowed under title X.

Mr. AKIN. So it would be illegal for you to do that.

Ms. JENKINS. As far as I understand title X. I don't know if you are trying to set me up.

Mr. AKIN. No. I am just trying to get the facts as to how this works. I am not trying to get you thrown in jail.

Ms. JENKINS. Okay. I don't have it in front of me, but based on what we have talked about, that is what the guidelines say, okay?

Mr. AKIN. Ms. Wuchner, is that your understanding that that would be——

Ms. WUCHNER. Yes, Mr. Akin, that is correct.

Mr. AKIN. So it would be illegal for people——

Ms. WUCHNER. I am looking at the regs, exactly. It would be illegal——

Mr. AKIN. Okay. So they could not do that.

Ms. WUCHNER. It would be in violation of the guidelines that are mandated in title X, yes.

Mr. AKIN. Okay. Now, Dr. Jenkins, you have mentioned that you deal with a lot of different kinds of situations, and some of them are just kind of dicey; they are not the sort of things that are—I understand that. But also there are some families that are functional out there. What this law says to me is that de facto we are giving the minor the right to choose their parents, effectively, in this situation. And they are saying as a minor, "Well, you know, my parents, I don't really want to accept what they are saying is right and wrong or what they think I should be doing, and so I am going to end run their authority and come to you." Does it make you feel uncomfortable when the parents know nothing about it, let alone consent to it, that in a sense you usurp their role as an agent of the State in cases where maybe there is a very functional family?

Ms. JENKINS. My experience has been that a lot of times young people overestimate the reaction of their parents, okay? And what in my position I very often do is to try to work with them around getting a better communication with their parents about it. I don't just say, "Okay, you don't want to tell your parents. Okay. There is no discussion about that." Because I have found that over time when there is a functional family that most parents would rather their kids get some help and not be at risk for adverse and negative outcomes. One of my very first experiences of health——

Mr. AKIN. Well, I think you answered my question, and actually it seems like a very common sense answer, what you said. You know, what you are saying is is that you try to work with the particular situation, try and bring some reconciliation and maybe steer the child back toward their parents. I mean I think that is a real common sense answer.

I guess the concern I have is the way the law is set up right now. What you are telling me is that you are prohibited from having the alternative of talking to the parent at all in this situation.

Ms. JENKINS. I don't think that is true. I think what it says——

Mr. AKIN. Unless the kid acquiesces.

Ms. JENKINS. Yes.

Mr. AKIN. So in every one of these situations we are basically giving the government the de facto right to usurp or to take over the role of parents without the parents' knowledge or consent when the child is a minor. That is the way it is set up now. I think most of us believe that, yes, if you can, you work with the parents, but it seems like the law is actually contrary to that situation, and it seems like to me you talk about making decisions, the first natural line of defense for the child is the parents. And who is making the decisions? Doesn't it seem logical to at least give the parents a chance to be parents? I understand there are dysfunctional families, I understand there are parents who don't want to make the decisions, don't care about their children. But there are some who do.

Mr. BILIRAKIS. Well, the gentleman's time has expired. Ms. Capps, for 30 seconds to finish this up.

Ms. CAPPS. I was going to ask my colleague to yield and just to give Dr. Jenkins an opportunity. You are assuming that it is a mechanical situation where a child comes in, demands a prescription and it is automatically written. And I don't think that is the kind of relationship that I heard Dr. Jenkins talking about. The optimum relationship is one where you have known this adolescent over years, if possible. Now, that is not always that way, but there certainly isn't anything in this law, as I understand it, that requires that the State usurps the role of the parent. It does give one protection really for abnormal, abusive relationships in which a child is a victim. And there is no adult other than this provider who is a professional, who should be trusted to both report and also work with. Now, that is why I think it is difficult to answer the question because it is not one that I would assume that you find yourself in.

Mr. BILIRAKIS. Well, the gentlelady's time is long expired. Ms. Wuchner, as long as everybody is taking liberties——

Ms. WUCHNER. Yes, sir.

Mr. BILIRAKIS. [continuing] do you feel that there should be more flexibility in title X? I mean, you know, we have discussed all of these problems, and we know that there are all sorts of different and often very difficult situations, and I think it is very easy to put ourselves in the shoes of Dr. Jenkins and some of the patients that she sees. But from the standpoint of flexibility, do you have a comment, very briefly? I don't want to—you know, we have been at this for 2½ hours now.

Ms. WUCHNER. Okay. Basically, I think there has been a lot of confusion. It is not the long-term relationship that happens in a public health clinic, it is short term. Usually the patient, there are two visits, and clinicians would love to encourage young people to notify their parents, but that doesn't take place, and I told you in 75 percent of the times it doesn't.

Mr. BILIRAKIS. And they can't do that without the approval of the child; is that right?

Ms. WUCHNER. Without the approval of the child. It is the mandates of title X, they are restricted by that. So there is not an opportunity to bring that child and that parent together in dialog without the permission—even when the clinician know it is in the best interest of that child and they are fearful.

Mr. BILIRAKIS. Even if Dr. Jenkins, who seems to——

Ms. WUCHNER. In a title X clinic.

Mr. BILIRAKIS. [continuing] I mean not seems to, who cares about children, if Dr. Jenkins feels that she should do it in certain instances, unless she gets the approval of the child, she can't do it.

Ms. WUCHNER. I am a nurse and I have worked with doctors for many years as a nurse, and we use nurses in our clinics because that is what required by the State. And there is not one clinician that wants to come there that day and give bad care, but the law ties the hands of the clinician, it ties the hands of the board. We could not make our decision, and this is the point that we came to where it was an agreement almost on the majority of the board that title X was problematic in this area.

Mr. BILIRAKIS. All right.

Ms. WUCHNER. I hope I answered your question.

Mr. BILIRAKIS. You did, you did. All right, listen. The record remains open obviously for opening statements on the part of the members of the committee, and also remains open regarding the opportunity to submit questions to you three good people where hopefully you will respond to those in a timely fashion. You know, we appreciate it very much. We can just go on and on and on. This is a very significant topic, obviously. Yes, ma'am?

Ms. CAPPS. May I just make one question to you, Mr. Chairman.

Mr. BILIRAKIS. Lois, very quickly.

Ms. CAPPS. Twenty-five States have laws guaranteeing access to contraception to minors, and 50 States for STD treatment. So this law, if it is enacted by Congress, will usurp a lot of States' rights; am I correct?

Mr. BILIRAKIS. You are telling me, don't ask me. Well, I don't know what the future of this legislation is, but obviously it would have an opportunity for debate in all of these technical points, and the answer to your question would all come out. But these good people are here to help us make those decisions.

Ms. CAPPS. And I just—since Ms. Wuchner has worked in a lot of these clinics, doctors don't have to prescribe. I mean the question that came from my colleague very to the point of saying that the minor comes in and you can't notify the parent. But you also don't have to prescribe.

Ms. WUCHNER. First of all, I will just clarify, I have never worked in the clinic. My area is women's health, but I am on the board of the directors of the health department.

Ms. CAPPS. Well, I guess it would be Dr. Jenkins. I mean you don't automatically write a prescription for a 12-year-old.

Ms. JENKINS. No. There are lots of reasons why you wouldn't do that.

Ms. CAPPS. Where you would not do that, it would not be in the child's best interest.

Ms. JENKINS. Right.
Mr. BILIRAKIS. Okay. All right.
Ms. CAPPS. I promise not to ask anymore.
Mr. BILIRAKIS. The hearing is over. Thank you very much.
[Whereupon, at 5:35 p.m., the subcommittee was adjourned.]
[Additional material submitted for the record follows:]

PREPARED STATEMENT OF MCHENRY COUNTY CITIZENS FOR CHOICE

McHenry County Citizens for Choice (MCCC) is a local non-partisan grassroots organization dedicated to education about women's reproductive rights. We represent the full spectrum of McHenry County voters. Our activists include a cross section of moderate Republicans and concerned Democrats who are also members of such diverse groups as the League of Women Voters, The Women's Leadership Council, The American Association of University Women, and The Religious Coalition for Reproductive Choice. Supporters also belong to professional groups such as the American Academy of Pediatrics, the American Medical Association, and the American Association of Public Health.

MCCC represents thousands of citizens in McHenry County who have been diametrically opposed to the past and present attempts of Congressman Donald Manzullo (R-16) to deny minors confidential access to the Title X program through the imposition of federal parental consent restrictions.

In McHenry County, during the 1997-1998 period under discussion, there were hundreds of post cards and letters sent to the county board in support of Title X funding. In addition, more than twenty local medical doctors, including pediatricians, signed a common letter of support. None of these documents were ever publicly or privately acknowledged. Other medical professionals, public health administrators, advocates for adolescent health and private citizens wrote letters to the editor of the local paper and came forward at regularly scheduled meetings of the Board of Health and the full County Board to speak in favor of retaining Title X funds and it is noteworthy that the two medical doctors on the Board of Health supported Title X. Congressman Manzullo has continually failed to address the concerns of his constituency regarding this matter in his attempts to make this a national issue.

The major travesty however, was the way in which opponents of Title X repeatedly attempted to link a local criminal case involving predatory sexual abuse with the teen confidentiality requirement in Title X. That action confused the issue and distracted local elected officials whose concern should have been focused on the public health issue under their jurisdiction.

The case in question began in 1997 and involved a multimillion-dollar lawsuit alleging sexual abuse of a minor, which was brought against a teacher, his employer—Crystal Lake School District 47, and the County Health Department. In a subsequent civil suit against the local Church of Jesus Christ of Latter Day Saints, the girl divulged that the teacher, who was also a youth minister at the church, originally befriended her during a church outing to Six Flags Great America. According to court records the abuse began in the spring of 1995. Nine months later the abuser took the girl to the Health Department where she told nurses and a doctor that she needed birth control. The records indicate that she had been sexually active for nine months before her visit to the Health Department.

Nevertheless, Congressman Manzullo misrepresented the true situation when he was quoted in an interview with the local newspaper, "It simply brings into focus what happens when a 14-year-old receives birth control shots from a health department without the knowledge or consent of the parents."

To complicate matters, the law suit brought by the parents of the victim against the County Health Department and the school district effectively curtailed any public discussion at the county level. At one point the County Board was also involved peripherally in the legal entanglement. It provided a large window of opportunity for only one side of the issue to be aired since the litigation forced the Health Department professionals, the Board of Health and eventually the County Board, to remain silent under direction of their attorneys. The hundreds of cards, letters, and petitions signed and submitted by ministers, teachers, healthcare workers and local residents received no response or public recognition.

The local newspaper filled its pages for months with articles about the "sex scandal." It repeatedly cited the use of Title X services, thereby craftily relaying a subliminal message about the evils of contraceptive availability. There were two other cases of sexual misconduct with minors involving teachers in McHenry County during this same period; one teacher convicted in 1997 and another facing charges that

same year. However, apparently because contraception was not an issue, both received only a perfunctory reference in the last paragraph of a front page article on this case.

Was there really a concern for the well-being of a teen victim or was it an opportunity to take the focus away from Title X as a public health issue and replace it with personal religious ideology shrouded in the cloak of "parental control?" "Parental control" has long been a wedge issue for ultra-conservatives and to engender fear is an effective tool when in reality your position has no substance. Religious political manipulation can have tragic consequences in the lives of real people especially when it is substituted for sound professional consideration on issues of public health.

Teenage sex is a serious issue with two aspects: (1) moral, and (2) public health. The morality of the issue must be handled by the teenagers, their parents, and their clergy or other professionals they wish to involve. The public health side is appropriately handled by the civic agencies such as the Health Department which is charged with maintaining the health and safety of the citizenry. It is yet another example of the importance of keeping issues properly categorized. It was when the Health Department abandoned its civic mission and became an arbiter of morality due to extreme political pressure that the issue became so muddled that everyone sustained a loss; the teens, the community, the taxpayers and the integrity of our local government.

The ideal concept of parents communicating and guiding their adolescents through the difficult years to adulthood is one on which we can all agree. The problem is, we are not in an ideal world. We are in a world of advertising which sells products by promising better sexual opportunities. A world where there are less than ideal homes, where little or no information is given, where parenting skills are lacking and in some where real abuse exists.

The confidentiality of Title X is no threat to parental involvement. Parents can and should talk to their children and educate them on these issues every day of their lives. With accurate information, open communication and the opportunity to discuss good and bad choices along with consequences and responsibilities . . . many of society's problems could be solved.

The concept of parental involvement is right. But laws are not the answer. More realistically, in our community, as in many, we need to build the societal infrastructure to ensure reasonable success for our teen population in navigating the difficult adolescent years. By that we mean comprehensive sexuality education and parenting classes for both parents and teens, a coordinated community effort sponsored by hospitals, schools, churches, local agencies and the media.

What happened in McHenry County was not about parent's *rights*. It was about closing access to information, professional counseling and reproductive care. It was about changing the focus from all the positive elements of Title X and furthering a child rearing philosophy based on withholding contraceptive information. It was about punishing teens who have disobeyed their parent's by forcing them to bear the consequences of an unwanted pregnancy or sexually transmitted disease to teach them a lesson. It was also about some parents, unsure of their own ability to communicate effectively with their teens, trying to block out any source of information that might be available in the community. Something like burning books.

If there was any doubt that right-wing politics and personal religiosity had a stranglehold on this issue from the beginning, it should be noted that it was the wife of the chairman of the health board who raised the level of rhetoric against Title X (with the backing of a local right-wing state representative). This person organized a demonstration outside the county building before a health board meeting where the only non-print medium represented was a religious television station.

Locking the door of Health Departments by requiring parental consent will not keep teens from having sex. We know that 85% (Planned Parenthood) are already sexually active for nearly a year before they access those services. When they do, it is because they fear they may be pregnant.

If contraceptive availability is not why teens have sex then what is? Many teens find solace in sexual relationships when love, attention and self esteem are missing in their lives. They want someone who will love them unconditionally and not leave. We fail to acknowledge that teenagers have sex for the same reasons adults do. We lose credibility when we deny that our children are sexual beings. But they must be made aware that having sex carries with it all sorts of responsibilities. They must feel a responsibility for the physical and emotional well-being of the other person and be prepared for all the possibilities and decisions that being sexually active may present to them such as disease and unintended pregnancy. For those reasons and others, it is both desirable and rational to be abstinent until physically, emotionally and financially able to enter a committed long term relationship.

The professionals at health clinics can address the emotional and physical needs of their patients in a straightforward non-judgmental way. They can encourage better parent/teen communication to seek solutions for the reasons the teen feels the need for a sexual relationship. It can be the intervention that prevents that teen from becoming another abortion statistic or entering the welfare rolls as a single parent. This type of counsel is, in fact, required under the provisions of Title X.

The issue should not be viewed as a matter of parental rights or a political battle to be won. It is simply the most compassionate and financially effective way of addressing real and pressing problems of preventative health care in our community. People of good will recognize that while everyone is free to guide their own children, we cannot close the door to a healthful and productive life to teens who, for whatever reason, are not receiving that guidance. A caring community should not abandon teens who are most at risk, those who are already disadvantaged by all the conditions associated with poverty, and dysfunctional or broken families. Those teens must also have access to good counseling and education from professionals they trust, who can help them learn how to make responsible decisions in their lives.