The New US “Conscience and Religious Freedom Division”: Imposing Religious Beliefs on Others

The core mission of the United States Department of Health and Human Services (DHHS) is “to enhance and protect the health and well-being of all Americans.” The Trump administration recently announced the creation of the Conscience and Religious Freedom Division (CRFD) of the DHHS Office for Civil Rights to accept complaints by health care providers who feel that they have had to participate in medical procedures counter to their religious values. The CRFD directly contradicts the DHHS mission as well as standards of medical ethics.

JEOPARDIZING CARE

The proposed CRFD rules[1] outline a wide-ranging plan that allows members of the health care workforce to avoid providing any health-related services, programs, research activities, or insurance coverage that conflict with their religious beliefs. The rules apply to all health care professionals, ranging from doctors and nurses to front desk staff and insurance administrators. Hospitals or clinics that do not allow their care providers to refuse patients for religious reasons face repercussions that could include a loss of federal funding.

Under the proposed CRFD rules, health care providers are encouraged to prioritize their religious beliefs above the welfare of their patients. The 95% of Americans who report having sex before marriage[2] may risk their health care provider denying them care or contraceptive counseling if they disclose their sexual behavior. In the midst of an opioid epidemic, the 25 million Americans who report using illicit drugs[3] risk being turned away from care if they disclose their drug use. With some providers, the 52% of Americans who drink alcohol[3] may risk being turned away as well.

DISCOURAGING DISCLOSURES

The proposed CRFD rules would make each provider an unknown, unwritten law unto her- or himself. Patients could reasonably be concerned about disclosing stigmatized characteristics or behaviors to any provider, given that the information might be entered into electronic medical records that other providers would see. The rules would permit doctors to refuse to continue their visit with a man whose medical record references an extramarital affair or with an adolescent whose record indicates that she is a lesbian.

LGBT PATIENTS

The rules could pose a particular danger of broad discrimination affecting lesbian, gay, bisexual, and transgender (LGBT) patients, especially given that Office for Civil Rights chief Roger Severino has argued that health care providers should be able to refuse to provide transition-related care to transgender patients.[4]

Turning away or stigmatizing LGBT patients will cause substantial harm to a population that already experiences large disparities. In 2015, 33% of transgender patients reported mistreatment in medical care and 23% reported delaying care owing to fear of mistreatment,[5] figures that would increase if the CRFD sanctions discrimination. Stigma, including that which the CRFD could allow on the part of health care providers, is also linked to high suicidality among LGBT individuals, particularly youths.[6]

Perhaps most chillingly, the CRFD rules contain no protections to ensure life-saving care for patients if they present in an emergency. This means that doctors can, according to the rules as currently written, refuse life-saving care if they deem a patient’s characteristics or behaviors to somehow run counter to their “conscience.” This is in direct contravention of not only centuries of medical practice but also the American Medical Association’s Code of Medical Ethics. The first section of the code,[7] the modern-day equivalent of the Hippocratic Oath, is devoted to patient–provider relationships. According to the code, patient–physician trust “gives rise to physicians’ ethical responsibility to place patients’ welfare above the physician’s own self-interest or obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.”[7]

IMPOSING BELIEFS ON OTHERS

In the spirit of prioritizing patient welfare above all, it is a proud tradition in American medicine to provide care to everyone, regardless of who they are or what they have done. The Tsarnaev brothers received medical care at a Boston hospital after detonating bombs at the Boston Marathon. Surviving school shooters are treated for their wounds. And doctors today regularly treat people who carry out any number of heinous acts. That is as it should be; health

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This editorial was accepted April 14, 2018.

doi: 10.2105/AJPH.2018.304488

care as a right is a cornerstone of our shared humanity.

The proposed CRFD rules turn providers' prioritization of patient welfare on its head, creating a scenario in which providers are encouraged not only to prioritize their own religious beliefs over the welfare of their patients but to impose their beliefs on others, potentially to the harm of patient welfare.

PROTECTING PATIENTS FROM HARM

Ironically, the DHHS Office for Civil Rights was created explicitly to counter the harmful effects of discrimination on patient health. The CRFD will serve as a pernicious Trojan horse, allowing harm to be wrought on patients within the very office that was created to protect patients from harm.

The cornerstone of health care is a trusting relationship between patients and providers. Patients routinely disclose to providers intimate thoughts and behaviors that they may not even disclose to their spouses or parents. Discussions of sexual behavior, substance use, mental health issues, and other stigmatized subjects are critical for health promotion.

For decades, the DHHS has promoted the health and well-being of all Americans. The CRFD should not harm health by disrupting the trusting relationships Americans have with health care providers or by endorsing discrimination. Newly confirmed DHHS secretary Alex Azar should not proceed with the CRFD, and health care providers and public health practitioners should discourage the DHHS from proceeding with the division. If the CRFD is implemented, legal challenges should be brought against health care providers who discriminate on the basis of gender identity, sexual orientation, race, ethnicity, or religion. Finally, regardless of CRFD policies, the principles of medical ethics do not sanction turning away or treating patients differently according to their characteristics or behaviors; health care providers should continue to observe standards of medical ethics and serve all patients to the best of their ability. AJPH

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Both authors originated the editorial. J. Raifman drafted the editorial, and S. Galea revised it.

ACKNOWLEDGMENTS

Julia Raifman was funded by National Institute of Mental Health grant R25MH083620.

Note. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

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Health Challenges and Opportunities for an Aging China

If there is an issue of concern to all nations of the world in the past, present, and future, it is population aging. The most populous nation in the world, China also has the largest elderly population. There were 143.9 million elderly adults (aged 65 years or older) living in China at the end of 2015, accounting for 10.5% of the total population.[1] China's older population is larger than the sum of the elderly populations of European nations.

China is also one of the nations where population aging is taking place most rapidly. In 2000, the percentage of the population aged 65 years or older in China reached 7%, and, according to estimates, it will take only 26 years to double this percentage to 14%.[2] By contrast, the same rise required 115 years in France and 85 years in Sweden.[2] The old-age dependency ratio in China has reached 14.3%, indicating substantial social and family burdens. The significant numbers of older adults, as well as their health, living conditions, social security status, and support networks, are matters of great concern to the government and to families.

At the same time as this demographic transition, China has been undergoing rapid social, economic, and institutional changes. Since the Chinese economic reform of the late 1970s and 1980s, advances in medicine and technology have helped lead to an increase in the life expectancy of the Chinese population (from 67.8 years in 1981 to 76.3 years in 2015).[1] Moreover, the age-standardized death rate among older adults decreased from 45.8 per 1000 population in 2005 to 31.2 per 1000 in 2015.[1]

However, the main causes of death among older adults have not changed significantly. As shown in Figure 1, noncommunicable diseases—such as diseases of the circulation system, diseases of the respiratory system, and neoplasms—and injuries, poisonings, and consequences of external causes are still

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This editorial was accepted March 25, 2018.
doi: 10.2105/AJPH.2018.304444