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The “Conscience” Rule: How Will It Affect Patients’ Access to Health Services?

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increases resting energy expenditure and fat burning right after exercise, countering metabolic downregulation.

"Different types of exercise promote different metabolic responses," said Paulo Gentil, PhD, the study's senior author and a professor at the Federal University of Goiás in Brazil. "In this regard, high-intensity exercise might be particularly interesting for fat loss, not because of the calories spent while you exercise but because it makes your body burn more fat after you exercise."

The Design

Gentil's team conducted a meta-analysis of 36 clinical trials comparing HIIT and SIT—the 2 most common types of interval training—with moderate-intensity continuous training for fat loss. The studies evaluated changes in total body fat percentage and/or total absolute fat mass. They included 1012 children through older adults, spanning a range of baseline physical activity and ranging from underweight to obese.

What We've Learned

- All of the exercise approaches significantly reduced total body fat percentage and total absolute fat mass.

- None of the approaches outperformed the others in terms of reducing total body fat percentage.
- But interval training was more effective for decreasing total absolute fat mass. On average, the SIT and HIIT protocols reduced total absolute fat mass by 6.2% and 6%, respectively, compared with 3.4% for moderate-intensity continuous training.
- The interval training workouts were also shorter. The SIT, HIIT, and moderate-intensity routines in studies evaluating total absolute fat mass lasted on average 23 minutes, 25 minutes, and 41 minutes, respectively.

The Caveats

- The biggest reductions in total absolute fat mass occurred when interval training workouts were supervised, which likely increases adherence.
- The study designs differed widely, and many of them didn't instruct participants to stick to their normal diet, both of which could make the findings less reliable.

How Intense Is Intense?

The terms "high intensity" and "sprint" are relative. Keeping this in mind can

encourage exercising and help to avoid injuries. "Interval training can be performed by almost everyone; we just have to know how to adapt it," Gentil told *JAMA*. "If you have knee problems and are not able to run, you can cycle or even swim. If you have heart disease, you can work at a controlled intensity. For a healthy young person, a sprint could involve running at high velocities, while for a frail elder, slow walking might be enough."

Gentil's bottom line: "Interval training seems to be a time-efficient approach for promoting fat loss." ■

What Is Interval Training?

- Interval training is an intermittent period of physical effort interspersed by recovery periods.
- High intensity interval training requires "near-maximal" efforts performed at or above 80% of maximal heart rate or the equivalent of maximal oxygen consumption.
- Sprint interval training requires "all-out" efforts performed at or above peak oxygen consumption.

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The JAMA Forum

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Lawrence O. Gostin, JD

On May 2, 2019, the US Department of Health and Human Services (HHS) and Office of Civil Rights (OCR) released a [final rule](#) that heightens the rights of hospitals and health workers to refuse to participate in patients' medical care based on religious or moral grounds. The rule covers [OCR's authority](#) to investigate and enforce violations of 25 federal "conscience protection" laws. Tied to the US Constitution's spending power, the rule applies to state and local governments, as well as public and private health care professionals and entities if they receive federal funds such as Medicare or Medicaid. The rule applies to a range of important [health services](#) such as abortions, sterilizations, assisted sui-

cide, and advance directives—extending to sex reassignment and HIV treatment.

History and Purpose

In December 2008, OCR finalized a [rule](#) to enforce the [Church, Coates-Snow, and Weldon amendments](#)—all designed to protect health workers and entities who object to assisting in abortion or sterilization for religious or moral reasons. In 2011, the Obama administration [substantially rescinded](#) the rule but maintained OCR's authority to conduct investigations of alleged violations of conscience protection laws.

On May 4, 2017, President Trump signed an Executive Order, [Promoting Free Speech and Religious Liberty](#). Shortly thereafter, he

created the [Office of Conscience and Religious Freedom](#) within HHS to "more vigorously and effectively enforce existing laws protecting the rights of conscience and religious freedom."

The Conscience Rule

The final rule significantly expands OCR's authority to enforce [federal conscience protection laws](#). The earlier rule covered only 3 conscience statutes, while this final rule extends to 25.

The new rule broadly [defines](#) federal conscience laws. Covered entities and protected activities are equally broad, including those performing services, paying for services (private and employer-based insurance),

counseling, or even referring to other physicians. Health workers cannot be required to train for certain services to which they object. The rule extends to any employee of a covered entity, such as hospital receptionists and cleaners. Patients also may object to health services, including children's mental health services. Although the rule doesn't expressly govern childhood vaccinations, physicians, nurses, and patients could potentially claim a conscience exemption.

Importantly, the final rule implements stringent enforcement tools, including complaints investigations, compliance reviews, and referrals to the Department of Justice. Covered entities must submit compliance assurances to HHS, keep compliance records, and cooperate with enforcement, and they cannot discriminate against complainants. The rule incentivizes but doesn't require entities to post notices of conscience rights.

Legal and Public Health Implications

The final rule widens the avenue for denying access to services, even **constitutionally protected** services like abortion, to women; to persons who are gay, lesbian, bisexual, or transgender; and to others. Under the **Church amendments**, individuals cannot be required to "assist in the performance" of health services that offend their religious or moral beliefs. The rule broadly defines that phrase to include any action with an "articulable connection" to the service to which the provider objects, such as counseling or medical referrals. In that way, the rule not only allows health workers to deny services, but also to limit information on where patients could receive the service. Health care professionals and entities cannot be required to inform patients of available funding or contact information. The rule's expansive definition of covered entities could, for example, extend to a pharmacist filling a prescription for contraceptives, a receptionist scheduling an appointment for sexually transmitted disease treatment, or an ambulance driver transporting a woman for an emergency abortion.

The HHS rule does not take access to care into consideration, which will primarily affect **rural and underserved communities**. Forty-six states already have laws or policies **allowing health care entities to refuse to provide abortion services**, which means that women who are poor, disabled, or otherwise disadvantaged will find it hard to access reproductive health services. Underfunded and understaffed community health centers in predominantly rural areas do not have the resources to hire additional staff to cover services when their health workers opt out on religious or moral grounds. This could perpetuate and increase existing health disparities.



The final rule also has vital public health implications, allowing parents to object, on religious or moral grounds, to their children receiving certain health services relating to **suicide prevention**, hearing loss **screenings** for newborns, **child abuse** prevention and treatment, and **pediatric vaccines**. Amidst a **US measles outbreak**, the rule could **reinforce dangerous misconceptions about vaccine safety and effectiveness**, placing religious beliefs above the health of children. Parents could object to vaccines for their children, while nurses could decline to administer potentially life-saving vaccines. Conceivably, a first responder might refuse to carry or administer naloxone to rapidly reverse opioid overdose, citing an objection to encouraging drug abuse.

Finally, the rule could reinforce stigma or legitimize **discrimination** against women; gay, lesbian, bisexual, or transgender individuals; persons living with HIV/AIDS; or individuals victimized by sex trafficking.

The rule, for example, could result in reducing access to HIV/AIDS prevention services such as preexposure prophylaxis, counseling, and condoms; reproductive health and family planning; end-of-life care, including in states that have legalized physician-assisted dying; or treatment for gender dysphoria. Even if a vulnerable patient is not blocked from needed services, it could discourage treatment-seeking behavior and cause stigma. Discrimination conflicts with other **civil rights protections** at state and federal levels, and can dissuade entire classes of persons from seeking needed medical care.

The new rule takes effect 60 days after its May 2 release. Major questions remain on how the rule will be enforced. For example, how will it affect **Emergency Medical Treatment and Labor Act** requirements for emergency medical care? How will it align with antidiscrimination provisions under the Affordable Care Act? San Francisco recently launched a **lawsuit** against HHS alleging the rule will impair access to care.

Ethically, health care workers and organizations have the right to their sincerely held religious and conscientious beliefs. Patients also have rights to be treated fairly, especially when it comes to their health and well-being. The lingering question is whether that delicate balance has now tipped against vulnerable patients who deserve equal access to essential medical services. ■

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