Congress of the United States

Washington, DC 20510

December 5, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Secretary Kennedy and Administrator Oz,

On November 25, HHS-CMS published its final rule[1] involving graduate medical education (GME) accreditation which is set to take effect on January 1, 2026. Significantly, the rule had this to say in response to conscience protections for medical residents[2]:

> *"Many commenters that supported the proposal also recommended that CMS expand the policy to explicitly prohibit the use of accreditation standards that violate Federal healthcare conscience laws, including the Church Amendments[3], the Coats-Snowe Amendment[4], certain provisions of the Affordable Care Act[5], and the Weldon Amendment. These statutory provisions generally prohibit discrimination against recipients of certain Federal funding who refuse to perform abortions or provide other services in violation of their moral or religious convictions. ... Other commenters stated that the existing regulations at §§ 413.75(b) and 412.105(f)(1)(i)(D), which recognize approved programs that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion, should be expanded to include other services, such as in vitro fertilization, surrogacy, certain forms of family planning, sterilization, sex-rejecting procedures, assisted suicide, euthanasia, medical aid in dying, voluntary stopping of eating and drinking, and inducing death for organ harvesting.* ***In response to comments recommending further expansion of the proposed policy, we may take these comments into consideration for future rulemaking.***"

We are writing to request that the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) issue a rule addressing a significant issue that is leading to the violation of conscience rights of resident physicians in training across the country. Currently, in order for a graduate medical education (GME) program to be fully accredited by the Accreditation Council for Graduate Medical Education (ACGME), they must provide training in induced abortion as standard training to all [obstetrics

[1] https://www.federalregister.gov/documents/2025/11/25/2025-20907/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

[2] See section XXI. Graduate Medical Education Accreditation beginning at page 54025.

[3] 42 U.S.C. 300a-7.

[4] 42 U.S.C. 238n.

[5] Pub. L. 111-148.

and gynecology] residents.[6] ACGME is the only accrediting body for GME [obstetrics and gynecology] programs in the US and thus there is no other option for training programs or residents.

This requirement also forces faith-based hospitals who have moral and religious objections to induced abortion to provide this training as well as pay faculty to perform these procedures. While ACGME claims to be in compliance with well-established conscience protections by offering residents the option to "opt out" of this training, this requires first year residents – the most vulnerable in the hierarchy of medical training – to publicly state to their fellow residents as well as their superiors, who will determine the course of their career, that they don't want to do something they are being told is standard training.

This not only sets up an extremely coercive environment where many residents feel they need to "go along to get along" but we have also heard of several instances where residents who opt out are given increased workloads as a result (one example is attached). Medical students are aware of this environment, and as a result many students with either religious or moral opposition to induced abortion are deciding to avoid the specialty of Obstetrics and Gynecology so that they will not have to face this situation.[7]

Prior to 2018 (and since the early 1990s), any OB/GYN resident who desired training in induced abortion was able to receive it by opting in. This allowed those who desired to perform induced abortions in their practice to receive abortion training while not forcing those who did not to participate. At the end of 2018, the ACGME changed their accreditation requirement to now require all OB/GYN residency programs to incorporate induced abortion training as a standard part of the curriculum that would be automatically required of all residents unless they decided to opt out. Also troubling, this shift has made training in induced abortion now considered the standard.

The idea that induced abortion is a standard part of OB/GYN practice is inaccurate, given that 76-93% of practicing OB/GYN physicians do not perform induced abortions.[8] This is not for lack of training. **Every obstetrician-gynecologist is trained in the medical and surgical methods used to evacuate the uterus, and it is the same procedure whether it is being performed on a dead unborn baby as a result of a miscarriage, or on a live unborn baby in the case of induced abortion. Prior to 2018, all OB/GYN residents were already required to be trained in miscarriage management (including D&C and D&E procedures), the treatment of ectopic pregnancy, and the treatment of life-threatening conditions in**

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[6] The CDC defines induced abortion as "an intervention performed by a licensed clinician (for instance, a physician, nurse-midwife, nurse practitioner, physician assistant) within the limits of state regulations, that is intended to terminate a suspected or known ongoing intrauterine pregnancy and that does not result in a live birth." Their definition goes on to say that this definition "excludes management of intrauterine fetal death, early pregnancy failure/loss, ectopic pregnancy, or retained products of conception."

[7] Christian Medical Association survey (2019), available at: https://app.box.com/shared/static/lcw6k7syfgtio27zlegnor7q33g42bzf.pdf.

[8] Desai S, Jones RK, Castle K. Estimating abortion provision and abortion referrals among United States obstetrician-gynecologists in private practice. Contraception. 2018 Apr;97(4):297-302. doi: 10.1016/j.contraception.2017.11.004. Epub 2017 Nov 21. PMID: 29174883; PMCID: PMC5942890.
Stulberg DB, Dude AM, Dahlquist I, Curlin FA. Abortion provision among practicing obstetrician-gynecologists. Obstet Gynecol. 2011 Sep;118(3):609-614. doi: 10.1097/AOG.0b013e31822ad973. PMID: 21860290; PMCID: PMC3170127.
Grossman D, Grindlay K, Altshuler AL, Schulkin J. Induced Abortion Provision Among a National Sample of Obstetrician-Gynecologists. Obstet Gynecol. 2019 Mar;133(3):477-483. doi: 10.1097/AOG.0000000000003110. PMID: 30741798.

pregnancy (including ending the pregnancy when needed to save a woman's life. The change to opt-out did not provide any additional essential training to medical residents – the only thing it did was set up an environment which coerces residents to participate in procedures that intentionally end the lives of fetal human beings. By returning training in induced abortion to an opt-in system, OB/GYN residents will still receive all the training they need to fully care for women, and training in induced abortion will still be available for those who wish to receive it.

The Coats-Snowe Amendment, enacted in 1996, generally prohibits discrimination against a health care entity for refusing to engage in certain abortion related training activities. The opt-out requirement is a clear violation of the conscience protections provided by the Coats-Snowe Amendment.[9] Returning training in induced abortion to an opt-in option for medical trainees would still allow for anyone who desired this training to easily access it but would prevent any physician who does not from being coerced into participating. Not only is this what our conscience laws are meant to prevent, but it would also increase the number of medical students willing to go into the specialty of OB/GYN – a critical need at a time when maternity healthcare deserts exist across the country. This would improve access to care for millions of American women.

Because the current opt-out induced abortion training requirement is a clear violation of existing federal law, HHS and CMS should issue a rule to require any graduate medical education program to provide induced abortion as an opt-in only option in order to receive their federal GME funding and in order to receive CMS reimbursements. We urge you to expeditiously act in this matter.

Sincerely,

Gregory F. Murphy, M.D.
Member of Congress

James Lankford
United States Senator

Steve Daines
United States Senator

Cindy Hyde-Smith
United States Senator

Ashley Moody
United States Senator

Ted Budd
United States Senator

Ted Cruz
United States Senator

Jim Banks
U.S. Senator

[9] Opinion No. KP-0395, Office of Attorney General of Texas Ken Paxton from December 13, 2021.

Michael Cloud
Member of Congress

Sheri Biggs
Member of Congress

Julie Fedorchak
Member of Congress

Robert F. Onder, Jr.
Member of Congress

John Joyce, M.D.
Member of Congress

Mary E. Miller
Member of Congress

Christopher H. Smith
Member of Congress

Barry Loudermilk
Member of Congress

Ben Cline
Member of Congress

Claudia Tenney
Member of Congress

Andy Biggs
Member of Congress

APPENDIX:

Testimony of Ashley M.S. Womack, MD

May 11, 2021

My name is Dr. Ashley Womack. I am a native Texan and an Obstetrician Gynecologist currently completing a Minimally Invasive Gynecologic Surgery Fellowship in Arizona. I write today to share my experience attempting to opt-out of abortion training during my Obstetrics and Gynecology (ObGyn) residency training at the University of Texas at Austin.

I began my residency in June of 2015 and remember learning that the Accreditation Council for Graduate Medical Education (ACGME) had changed abortion training for ObGyn residents from an "opt-in" to an "opt-out" policy. I felt nervous and anxiously anticipated the family planning rotation that would be automatically built into my schedule as a second-year resident. To be clear at the outset, I held and still hold the utmost respect for my attending physicians and resident colleagues. To this day, I look to them for advice and mentorship both personally and professionally. This context makes my story about opt-out abortion training that much more difficult.

As a Catholic physician I believe in the dignity of every life, which includes both the mother and the unborn child. Under no circumstance would an abortion be morally acceptable. The "opt-out" abortion training created for me a serious and unnecessary professional dilemma. What kinds of things would they expect me to do? How would I opt out? What would my attending physicians and colleagues think of me when I opt out? Would they think of me as a slacker, dishonest, problematic, or just confusing?

As the time for my rotation approached, I heard stories of other residents who had tried to opt-out before me. One resident simply did not show up for duties because she did not think anyone would listen. Another resident had to meet with our program director and felt so pressured to go to Planned Parenthood that she eventually went despite her objection. She planned to apply for fellowship and her application heavily depended on good letters of recommendation from the physicians who were requiring her attendance at Planned Parenthood. Her future depended on their approval.

Knowing the testimonies of those prior residents, I thought that NOT going to Planned Parenthood would not be an option, so I went. I thought that I could learn without formally participating in morally and professionally objectionable practices. I quickly realized that this would not be the experience.

I object to abortion because it is the direct killing of a life within a mother. The life of the baby is constantly recognized in our specialty as we do "confirmation of pregnancy" ultrasounds for our patients

in the early first trimester and celebrate with these mothers as they see and hear their child for the first time. We know it is a life. The mother knows it is a life.

I remember my first day on rotation at Planned Parenthood and having anxiety as I walked through the heavily secured door. How will I decline to perform certain tasks? What will they think of me? Will it be awkward and uncomfortable? What will I end up doing if I am not doing abortions?

At Planned Parenthood, I sat and listened as "counselors" talked to women about the "kind of abortion that would be best" for them. I did not hear any counselor discuss the option of parenting or adoption.

For any procedure in medicine, we are taught to counsel our patients on the risks, benefits, and ALTERNATIVES of any procedure in order to have fully informed consent. These women were and are being denied full counseling and education. I remember feeling uncomfortable with this egregious shortcoming.

Next, I helped with ultrasounds. I remember feeling hopeful that I could do ultrasounds since this would just be another way for women to be educated in order to have full informed consent regarding an abortion procedure. As I performed the ultrasound, though, my attending physician asked the woman to look away from the screen and put noise-canceling headphones on with music as we played the heartbeat (for ½ a second). Again, hiding information from these patients was no true counsel or care, and it pressured me as a resident to betray the trust these women had in me as a physician.

I could not stand the idea of being in a place where physicians were helping women kill their unborn children, and in a way that lacked education, empowerment, and informed consent. I did not want to be associated with any aspect of this procedure – the planning of it, the procedure itself, or the recovery. My presence went against everything I stood and trained for as a physician – to defend life, to heal life, and to celebrate life.

With that, I emailed my program director and let her know that I needed to continue to "opt-out" of my family planning experience at Planned Parenthood and did not want to go to the facility any longer. She requested an in-person meeting where she printed the ACGME requirements of an "opt-out" abortion training. At the risk of her disapproval, I let her know that I must opt-out of going altogether. She let me know that this was not an option and if I persist in my request not to go, then I must meet with the Chair of the Department.

This was an intimidating thought. I was still a junior (2nd year) resident, and I had to meet with the Chair of the whole ObGyn department? Luckily, I had a wonderful faculty mentor who agreed to accompany me so as to help my nerves and serve as a witness. When I met with the Chair, she again outlined the requirements dictated by the ACGME for abortion training. I reviewed the list with her and let her know all the other clinic sites and experiences where I could meet the requirements. After about a thirty minute conversation, she then said that if I could propose my own curriculum for the 5-week rotation, she would consider it.

So, in a weekend amid the rigors of a resident call schedule, I scrapped together a plan. Fortunately, I knew doctors at a local clinic who were more than willing to take me on and participate in a new resident experience wherein I could deepen my training without compromising my ethics. I emailed this curriculum to the Chair before Monday so as to avoid another week at Planned Parenthood.

When my next day assigned to Planned Parenthood arrived, I still had not heard back from the Chair with approval. My attending physician at Planned Parenthood (who was also my program director) emailed me

and said that since we had not heard approval from the Chair, then she would see me tomorrow at 7am at Planned Parenthood. Respectfully, I responded and said I would not be there. I would continue to opt-out, and I would be at the alternative clinic unless she directed me otherwise.

There is a clear hierarchy in medicine. The attending physician is the leader of the medical team followed by the fellow, resident, and then medical student. The thought of a resident, especially a 2nd year resident, defying an attending's request would be absurd. But I felt so strong in my convictions that I knew I had no other choice but to continue the course. Would there be retribution? Would I be disciplined? Did I jeopardize my future career by losing their approval? Would I forever have a social stigma that would affect my day-to-day work life? Again, these are my colleagues, attending physicians, mentors, and friends.

Luckily, with support from community members, attending physicians, and mentors, my situation was ultimately resolved in a positive manner. Two years later, we now have a new and model curriculum for residents seeking an alternative to abortion training, and I still share a mutual respect with my attending physicians from residency. However, this success was not without prolonged struggle, uncertainty, and several one-on-one meetings and escalations. None of this was sought for but rather imposed by the opt-out policy.

A resident should not have to sift through several layers of authority in order to follow his or her conscience. We have the right to hold our own beliefs and should not be coerced into straying from reasonable objections. If an OBGYN resident desires training in abortive procedures, the current policy requires they have that option. But an opt-out policy which makes abortion training the de-facto approach to women's health care is coercive and avoidable.

Elective abortion training is NOT essential to training an excellent ObGyn physician, and it should not be the default expectation that all trainees will perform them or even want to perform abortions. Opt-out policies place residents in an insecure and morally compromised situation that is completely avoidable. We need to empower trainees by offering the freedom to choose, in good conscience, and this can only be accomplished with an opt-in policy. Give residents who object to abortion an alternative track that respects their conscience and promotes an inclusive work environment. This is the reasonable and responsible approach which respects the range of beliefs within our polarized ObGyn specialty.

Thank you for your time.

Sincerely,

Ashley Womack

Ashley M.S. Womack, MD