
**Legal Briefing: Conscience Clauses and Conscientious Refusal**

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Readers who learn of cases, statutes, or regulations that they would like to have reported in this column are encouraged to e-mail Thaddeus Pope at tmpope@widener.edu.

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**ABSTRACT**

This issue’s “Legal Briefing” column covers legal developments pertaining to conscience clauses and conscientious refusal. Not only has this topic been the subject of recent articles in this journal, but it has also been the subject of numerous public and professional discussions. Over the past several months, conscientious refusal disputes have had an unusually high profile not only in courthouses, but also in legislative and regulatory halls across the United States.

Healthcare providers’ own moral beliefs have been obstructing and are expected to increasingly obstruct patients’ access to medical services. For example, some providers, on ethical or moral grounds, have denied: (1) sterilization procedures to pregnant patients, (2) pain medications in end-of-life situations, and (3) information about emergency contraception to rape victims. On the other hand, many healthcare providers have been forced to provide medical treatment that is inconsistent with their moral beliefs.

There are two fundamental types of conscientious objection laws. First, there are laws that permit healthcare workers to refuse providing — on ethical, moral, or religious grounds — healthcare services that they might otherwise have a legal or employer-mandated obligation to provide. Second, there are laws directed at forcing healthcare workers to provide services to which they might have ethical, moral, or religious objections. Both types of laws are rarely comprehensive, but instead target: (1) certain types of healthcare providers, (2) specific categories of healthcare services, (3) specific patient circumstances, and (4) certain conditions under which a right or obligation is triggered. For the sake of clarity, I have grouped recent legal developments concerning conscientious refusal into eight categories:

1. Abortion: right to refuse
2. Abortion: duty to provide
3. Contraception: right to refuse
4. Contraception: duty to provide
5. Sterilization: right to refuse
6. Fertility, HIV, vaccines, counseling
7. End-of-life measures: right to refuse
INTRODUCTION

Sometimes healthcare providers, on the basis of a conflict with personal values, beliefs, or moral views, refuse (or want to refuse) to follow a specified course of action that has been requested by a patient or is expected by general practice guidelines. Such refusals are generally legally unproblematic if the provider and patient are not in a treatment relationship. But refusing treatment to a current patient can present several types of legal risk. Often, without specific authorization, such refusal could constitute grounds for professional discipline from a licensing board, grounds for criminal prosecution, or grounds for tortuous abandonment, informed consent liability, or other malpractice liability. Moreover, because such refusals are intentional (as opposed to negligent) acts, they may not be covered by insurance.

Conscientious objection laws provide some protection to some providers who conscientiously object to some procedures under some circumstances. Exactly what grounds for refusal qualify for conscientious objection is often unclear. The scope of much protection extends beyond religion to include ethical and moral beliefs more generally. Sometimes, “given the propensity of the human conscience to define its own boundaries,” the scope of protection is quite broad. Other times, the provider’s grounds may be scrutinized either to assure that they are not hiding self-serving motives or to assure that they are “deeply held” and not based “solely upon considerations of policy, pragmatics, or expediency.”

The equilibrium between providers’ conscience rights and patients’ access rights is typically maintained through the objecting providers’ duty to refer the patient to other providers who do not object. But many physicians report that they do not “consider themselves obligated to disclose information about or refer patients for legal but morally controversial medical procedures.” Moreover, some laws specifically authorize providers to object without attempting referral or transfer. Consequently, it is unclear whether an optimum balance has been struck between the competing goals of providers’ protection and patients’ access.

ABORTION: RIGHT TO REFUSE

Church Amendment

The earliest conscientious refusal laws concerned abortion. In 1973, just weeks after the U.S. Supreme Court announced Roe v. Wade, Congress enacted the Church Amendment, which prohibits courts and government agencies from requiring individuals or facilities to perform abortions or sterilizations if they have moral objections. It also shields individual providers from employers’ discrimination concerning their willingness to perform abortions and sterilizations.

Supreme Court Justice Harry Blackmun, author of Roe, observed that such clauses were “appropriate protection.” Indeed, when the Church Amendment was soon challenged as inconsistent with Roe, the U.S. Court of Appeals for the Ninth Circuit upheld the law, explaining that any constitutional right to privacy is “outweighed by the need to protect the freedom of religion of denominational hospitals.” After all, for some providers, to the degree that they participate in abortion procedures, such participation is moral complicity that violates their core beliefs.

The Church Amendment specifies only one penalty for its violation: a loss of federal funding. Consequently, the Church Amendment can only be enforced by the U.S. Department of Health and Human Services (DHHS). A New York court confirmed this in January 2010. Nurse Catherina Lorena Cenzon-DeCarlo declared that, as a practicing Roman Catholic, she held strong religious beliefs against abortion. But in May 2009, Mt. Sinai forced Cenzon-DeCarlo to participate in the abortion of a 22-week fetus. Otherwise, Mt. Sinai would charge her with “insubordination and patient abandonment.” Indeed, when Cenzon-DeCarlo later complained and pursued internal grievance procedures, Mt. Sinai reduced her shifts. But Cenzon-DeCarlo’s federal lawsuit was quickly dismissed. The U.S. District Court held that even if Mt. Sinai violated the Church Amendment, that law confers no private right of action. In February 2010, Cenzon-DeCarlo filed a notice of appeal to the U.S. Court of Appeals for the Second Circuit.

**Coats and Weldon Amendments**

More than two decades after enacting the Church Amendment, Congress enacted additional conscience clause legislation: the Coats Amendment in 1996 and the Weldon Amendment in 2005. These two statutes more broadly prohibit both the government and recipients of government funding from discriminating against providers who refuse to participate in any training or health service on the basis of moral convictions. So, notwithstanding requirements of the Accreditation Council for Graduate Medical Education (ACGME), obstetrics/gynecology residency programs are able to be accredited, even though they might refuse to train in abortion-related services.

**DHHS Regulations**

On 19 December 2008, the DHHS published regulations interpreting and enforcing the Church, Coats, and Weldon Amendments. These regulations prohibit federal funding to health entities that do not accommodate workers who refuse to provide health services or information (including not only abortion, but also virtually any health service) because of objections on moral or religious grounds. The DHHS regulations went into effect on 20 January 2009.

The attack on these regulations was both swift and broad. The attorneys general of seven states filed a lawsuit challenging the constitutionality of the regulations. Legislators introduced bills to repeal the regulations. And even DHHS itself announced its intent to rescind (or at least modify) the regulations and solicited public comments to inform its evaluation. But notwithstanding this three-pronged attack, the regulations are still in force. Indeed, in July 2009, President Obama confirmed that he “still favors a ‘robust’ federal policy protecting health-care workers who have moral objections to performing some procedures.” Later, in his September 2009 address to Congress on healthcare reform legislation, President Obama stated that the “federal conscience laws would remain in place.”

**Patient Protection and Affordable Care Act**

On 23 March 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA). This legislation provides that “qualified health plans” do not need to provide abortion coverage. It further provides that no individual provider or facility may be discriminated against because of a willingness or unwillingness to perform an abortion based on religious or moral beliefs. But the law is carefully qualified in several respects, by: (1) not pre-empting state law, (2) not changing other federal law, (3) not changing Title VII, and (4) not changing EMTALA (the Emergency Medical Treatment and Active Labor Act). So, for example, a conscientiously objecting provider might still be obligated to provide abortion-related services pursuant to legal obligations independent of the PPACA.

**State Law**

Quickly following the 1973 Church Amendment, almost every state enacted its own abortion conscience law. Today, 46 states provide protection to individual providers. Almost as many states provide protection to institutions. But sometimes institutional conscience protection is limited only to private or even only to religious hospitals. Very few states provide conscience clause protection to insurance companies, meaning that employers and payers generally must provide coverage even for those medical services that they oppose.

But over the past two years, many states have been looking to expand abortion conscience protections. For example, two New York bills propose to amend current law so that providers may not only refuse to perform or assist in abortion, but also “refuse to refer a person for such abortion, or refuse to provide information about such abortion.” Similar bills are pending in Illinois, Florida, and North Carolina.
ABORTION: DUTY TO PROVIDE

While laws protecting conscientious objection to abortion are extensive, there are certainly limits to the scope of such protection. There are three notable examples. First, conduct that is only tangentially related to the actual abortion procedure is less likely to be covered by a conscience clause. Second, institutions, especially non-religious institutions, have been afforded less protection. Third, international human rights bodies have been pushing European countries to limit conscientious objection rights to ensure patients’ access to abortion services.

Tangential Services

While healthcare providers need not provide abortion services themselves, there has been some uncertainty over just how far that protection reaches. A number of cases, especially from Illinois, have been brought by healthcare workers who claimed employment discrimination after they were fired for refusing to provide a service “related” to an abortion.46

For example, Faith Moncivaiz, a county health department employee in Illinois, was denied a promotion because she refused to translate information on abortion options into Spanish.47 Stephanie Adamson, an Illinois emergency medical technician, was fired for refusing to drive a woman to an abortion clinic.48 A Mrs. Spellacy, a part-time admissions clerk, was fired because she refused to type up lab and admissions forms for abortion patients.49 And Elaine Tramm, a hospital instruments aide, was fired because she refused to clean the tools that were used to perform an abortion.50 It is doubtful that the employers’ conduct in these four cases constitutes religious discrimination in violation of state or federal laws.

Individual versus Institutional Refusal

Another example of limiting conscientious objection protection involves actions by institutions, as opposed to individual providers. In 2008, the Constitutional Court of Columbia held that conscientious refusal is a right enjoyed by human beings, not by institutions. Five separate healthcare facilities had declined to provide an abortion to a 13-year-old rape victim. The court awarded compensation to the victim, holding that hospitals whose physicians object to undertaking procedures on conscience grounds must have means to accommodate the patient.51 The Constitutional Court also required that individual providers who invoke conscientious objection must be subject to “review.” This is necessary to determine whether the objection is legitimately founded on observance of a recognized religion, as opposed to bias or invidious discrimination.

International Human Rights

International human rights bodies have expressed increasing concern that some countries’ conscientious objection laws overly restrict women’s access to important healthcare services. For example, in 2008, the European Court of Human Rights condemned Poland and ordered the government to pay 25,000 Euros to a severely myopic woman who was denied a therapeutic abortion and was predictably injured from childbirth.52 A year earlier, in 2007, the parents of a severely disabled child won a judgment from the Polish Supreme Court against a physician who denied them a medically indicated prenatal genetic diagnosis.53

In 1999, the Committee on the Elimination of Discrimination against Women (CEDAW), a United Nations treaty monitoring body, urged, “if health service providers refuse to perform [healthcare] services based on conscientious objection, [then] measures should be introduced to ensure that women are referred to alternative health providers.”54 In 2008, the CEDAW reported to Slovakia that the committee “is deeply concerned about the regulation of the exercise of conscientious objection by health professionals with regard to sexual and reproductive health.” The CEDAW recommended that Slovakia introduce measures to “ensure that women’s access to health and reproductive health is not limited.”55
CONTRACEPTION: RIGHT TO REFUSE

While almost every U.S. state protects conscientious objection with respect to abortion, far fewer protect healthcare providers’ rights to refuse to provide contraception. Still, legislative activity grew significantly in the mid-2000s. This growth was driven largely by the sale of emergency contraception, also known as “Plan B” or the “morning-after pill.” Emergency contraception works up to 72 (although most effectively up to 24) hours after unprotected sex, through stopping ovulation or through decreasing the chances of fertilization. But many providers consider emergency contraception to be an abortifacent because it can also work by preventing an already fertilized egg from implanting into the uterine lining.

Louisiana
In 2005, nurse Toni Lemly informed the hospital administration at St. Tammany Parish Hospital that she objected to administering the morning-after pill because of her religious beliefs. The hospital declined several accommodations suggested by Lemly that might have enabled the facility to continue administering the pill while allowing her to abstain from dispensing it herself. Instead, St. Tammany fired Lemly from her full-time position and reduced her to part-time status, causing a reduction in her pay and the loss of employee benefits. Lemly sued the hospital in 2005. In January 2007, the court denied the hospital’s motion for summary judgment. In 2008, the Louisiana Supreme Court affirmed that order in favor of nurse Lemly.

Missouri
In 2010, a Missouri bill was introduced that would extend conscience protection to pharmacies with respect to those drugs that might be considered abortifacients. “No licensed pharmacy in this state shall be required to perform, assist, recommend, refer to, or participate in any act or service in connection with any drug or device that is an abortifacient, including but not limited to the RU486 drug and emergency contraception such as the Plan B drug.”

New York
New York is considering an even broader bill that would cover even “regular” contraception. “When providing a person with any form of assistance or information about contraception or contraceptive devices (including condoms or other items that are dispensed, discussed or demonstrated as part of any program to prevent the spread of disease) is contrary to the conscience or religious beliefs of any person, he or she may refuse to provide such assistance or information, or refuse to refer a person for such assistance or information.” The bill further provides that “no public or private human services or health care agency, hospital, person, firm, corporation or association shall discriminate against the person so refusing to act.”

Wisconsin
A few state laws (as well as the Missouri and New York bills described above) permit objecting providers to refuse not only participation, but also information and referrals concerning contraception. But the majority of states, like Wisconsin, make the right to conscientiously object conditional on helping the patient get a substitute provider.

These referral/transfer conditions were recently applied and upheld in a series of related actions in Wisconsin. In 2005, the Wisconsin Pharmacy Examining Board disciplined Kmart pharmacist Neil Noesen, a devout Roman Catholic, for refusing either to refill Amanda Renz’s prescription for oral contraceptives or to transfer the prescription to Walmart. In 2008, the Wisconsin Court of Appeals upheld the board’s action, holding that while Noesen had the right to refuse to fill the prescription, he had engaged in “unprofessional conduct” in refusing to transfer the prescription to a different pharmacy. Later, after being fired from a subsequent job, Noesen sued that employer under Title VII. But he lost that case too, because the employer had done all that was required, by offering Noesen reasonable accommodations.

CONTRACEPTION: DUTY TO PROVIDE

While some laws permit conscientious refusal, others mandate providers’ compliance. New Jersey law, for example, bars pharmacies from refusing to fill prescriptions for drugs or medical devices based on employees’ philosophical, moral, or religious objections. Many other states mandate the provision of emergency contraception, especially in cases of sexual assault.

Illinois

On 1 April 2005, then-Illinois Governor Rod Blagojevich filed an “Emergency Rule” that required all pharmacies to dispense contraceptives without delay upon receipt of a valid prescription. Blagojevich explained, “Pharmacists — like everyone else — are free to hold personal religious beliefs, but pharmacies are not free to let those beliefs stand in the way of their obligation to their customers.”

This Emergency Rule was challenged by individual pharmacists, who were suspended by Walgreens for refusing to comply with the law. The pharmacists alleged that the rule was insufficiently accommodating of their religious beliefs. After a federal court held that the plaintiffs had stated valid claims, the state agreed to enforce the rule only against pharmacies, rather than against individual pharmacists. But that too was challenged. In December 2008, the Illinois Supreme Court held that two pharmacies had stated valid claims under the Illinois Health Care Right of Conscience Act and remanded the case for further proceedings. On remand, in 2009, the trial court issued a temporary restraining order forbidding the state from forcing the plaintiff pharmacies to dispense emergency contraception.

A bill now pending in the Illinois legislature would impose a duty to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration (FDA). If that is not possible, then the bill would require the pharmacy either to return the unfilled prescription or to transmit it to a pharmacy of the patient’s choice.

Washington

In April 2007, the Washington State Board of Pharmacy promulgated rules requiring pharmacies to deliver all lawfully prescribed FDA-approved medications. Under these rules, an individual pharmacist could refuse only if another pharmacist was available to fill the prescription. In July 2007, just before the regulations were to become effective, a pharmacy and several individual pharmacists filed a lawsuit alleging that the regulations violated their constitutional rights.

In November 2007, the U.S. District Court for the Western District of Washington preliminarily enjoined the rules after finding that they likely violated the First Amendment. But in July 2009, the U.S. Court of Appeals for the Ninth Circuit reversed that decision, holding that the district court should have applied a more deferential standard of review. Since the rules were neutral, generally applicable, and did not target religious practices, preferences, or beliefs, the district court should have applied “rational basis” rather than “strict scrutiny” review. In other words, the trial court should not have demanded that the law be justified by a “compelling state interest” and that it be narrowly tailored to achieve that interest. Instead, it should have upheld the law so long as it was “rationally related” to a legitimate government interest. The case is back in the U.S. District Court, and a hearing on the state’s motion for summary judgment is scheduled for 23 April 2010.

Missouri

In Missouri, the proposed Birth Control Protection Act provides that “upon receipt of a valid and lawful prescription or upon a lawful request for contraception approved for over-the-counter use, a licensed pharmacy shall dispense the prescribed drug or device without delay, consistent with the normal time frame for filling any other prescription.” If the prescribed drug or device is not in stock, then the pharmacy must offer the customer the option of (1) “having the pharmacy obtain the contraception under the pharmacy’s standard procedures for expediting ordering of any drug or device not in stock” or (2) locating “another pharmacy of
the customer’s choice or closest pharmacy that has the drug or device in stock and transfer the customer’s prescription to that pharmacy.”79

**Duty to Fill Prescriptions**

Illinois, Missouri, and Washington have not been the only states to enact or to explore enacting laws imposing “duty to provide” obligations on pharmacists and pharmacies.80 For example, an Oklahoma bill requires that pharmacists “shall dispense any prescription contraceptive drug or device.” And, like the Missouri bill, if the drug or device is not in stock, then the pharmacy must either order it or transfer the prescription.81 A New York bill provides that if a product is in stock and a pharmacist employed by a pharmacy refuses, on the basis of a personal belief, to fill a valid prescription for such product, then the pharmacy must either (1) ensure that the prescription is filled by another employed pharmacist or (2) transfer the prescription.82

**Duty to Provide Insurance Coverage**

A majority of states require prescription drug coverage to include contraceptives. But many of these laws include broad conscience clauses. A number of recent state bills mandate the insurance coverage of contraceptives. Typically, these bills provide that if a plan already covers prescription drugs, then it must also cover contraceptives. Such bills are now pending in Illinois,83 North Carolina,84 Oklahoma,85 Pennsylvania,86 and South Dakota.87

**France**

In 1995, two pharmacists in the small French town of Salleboeuf were convicted of violating the Consumer Code for refusing to fill prescriptions for contraceptives. The pharmacists challenged their convictions as inconsistent with their conscience rights under Article 9 of the European Convention of Human Rights. But in 2001, the European Court of Human Rights upheld the convictions, ruling that pharmacists could manifest their religious conviction in ways other than in the “professional sphere” by refusing to fill prescriptions for contraceptives.88 Since then, the court has continued to interpret conscience rights narrowly. For example, in late 2009, the court found no conscientious objection protection for an Armenian Jehovah’s Witness who refused to perform military service.89

**STERILIZATION: RIGHT TO REFUSE**

Just as the federal Church Amendment protects conscientious objection relating to abortion, it also protects conscientious objection relating to sterilization. The Church Amendment prohibits government entities from requiring individuals or entities to perform sterilizations. And it prohibits entities from discriminating against individuals based on their willingness to perform sterilizations. But at the state level, conscience protection for sterilization is far more limited than it is for abortion. Only 16 states allow individual providers to refuse to perform sterilizations. Only 15 states permit institutions to refuse.90

**END-OF-LIFE MEASURES: RIGHT TO REFUSE**

While the bulk of legal activity on conscientious objection still concerns reproduction, there have been important recent legal developments concerning conscientious objection to end-of-life measures. Attention has been fueled, in no small part, by the November 2009 directive of the U.S. Conference of Catholic Bishops. The directive states that Roman Catholic health facilities have “an obligation to provide patients with . . . medically assisted nutrition and hydration” even when they are in “chronic and presumably irreversible conditions.”91
State Healthcare Decisions Acts

Every state has a healthcare decisions act providing standards both for advance directives and for surrogate decision making. Almost every one of these statutes includes a provision that allows healthcare providers to refuse end-of-life treatment to which they have conscientious objections. For example, 10 states have healthcare decisions statutes modeled on the Uniform Healthcare Decisions Act. These statutes specify that a “healthcare provider may decline to comply with an individual instruction or healthcare decision for reasons of conscience.” And they give providers civil, criminal, and disciplinary immunity for exercising such a refusal.

Typically, the right to refuse is conditional, such that a patient’s right outweighs a provider’s conscience protection unless or until a patient can be transferred. This is a significant limitation in the context of medical futility disputes. Indeed, it is the same limitation imposed on providers’ rights to refuse life-sustaining treatment for professional reasons. The right to refuse (on either conscience or professional grounds) can often be implemented only through transferring a patient. Unless the transfer can be accomplished, there is effectively no right to refuse treatment.

Patient Self-Determination Act

Recognizing the widespread implementation of conscientious objection in state law, the federal Patient Self-Determination Act states, “Nothing in this section shall be construed to prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive.”

Patient Protection and Affordable Care Act

The healthcare reform legislation enacted in March 2010 provides that healthcare workers may not be discriminated against because of their refusal to provide assisted suicide, euthanasia, or mercy killing. The law defines these three interventions as excluding pain treatment and withholding or withdrawing medical interventions, including artificial nutrition and hydration.

New York

On 16 March 2010, New York Governor David Patterson signed the Family Health Care Decisions Act (FHCDA). The FHCDA effects broad changes to New York law on treatment decisions for incapacitated hospital and nursing home patients. The FHCDA provides that “nothing in this Article shall be construed to require . . . a healthcare provider to honor a health care decision made pursuant to this Article if (A) the decision is contrary to the individual’s sincerely held religious beliefs or  sincerely  held  moral  convictions; and (B) the . . . provider [informs the decision maker and the hospital and] cooperate[s] in facilitating such transfer.”

A separate and still-pending New York bill provides, “when providing a person with any form of assistance or information relating to life-sustaining medical treatment is contrary to the conscience or religious beliefs of any person, he or she may refuse to provide such assistance or information, or refuse to refer a person for such assistance or information.” Furthermore, “no public or private human services or health care agency, hospital, person, firm, corporation or association shall discriminate against the person so refusing to act.”

Washington and Oregon

Oregon’s well-known Death with Dignity Act provides that no provider has any duty to participate in physician-assisted suicide. The physician’s only obligation is to transfer the patient’s records to a new provider. When the Washington State Death with Dignity Act came into force last year, it closely copied the language in Oregon’s conscience clause.
Wisconsin
Most conscientious objection rights require the objecting provider to at least inform the patient about the objectionable treatment and arrange a transfer or referral. But some states have been moving toward authorizing more categorical rights to refuse.106 For example, in 2003, both chambers of the Wisconsin Legislature passed a bill that would allow providers to ignore a patient’s do-not-resuscitate (DNR) order and advance directive to forgo the use of a feeding tube.107 But in 2004, Governor Jim Doyle vetoed the bill because it did not require providers to give a referral or even inform the patient that a certain treatment option might exist.108 In 2005, the legislature passed very similar legislation.109 The governor again vetoed it for substantially similar reasons. In 2006, the legislature was unable to override the veto.

New Mexico
Sometimes providers claim a conscience right when they actually have non-conscience-based reasons for refusing treatment. In the early 2000s, the New Mexico Orthopedic Surgery Center had patients sign a consent form acknowledging that the center would not honor their advance directive. The center claimed that this was for reasons of conscience. But it produced no policy or mission statement substantiating any such a commitment. In February 2006, the center dropped its waiver policy in settlement of a lawsuit filed by the American Civil Liberties Union on behalf of Harold Folley.110

United Kingdom
The General Medical Council (GMC) is the regulatory agency that licenses and registers physicians in the U.K. In May 2010, the GMC published Treatment and Care towards the End of Life: Good Practice in Decision Making. This “Guidance,” which takes effect on 1 July 2010, requires that providers with conscientious objections comply with decisions to continue or stop treatment until a transfer has been arranged.111

FERTILITY, HIV, VACCINES, COUNSELING
In contrast to abortion, contraception, and end-of-life measures, there have been substantially fewer legal developments concerning conscientious objection to other medical interventions.112 For example, general obligations to provide sexually transmitted disease (STD) and HIV (human immunodeficiency virus) counseling typically include no conscience exception.113 But there is concern that providers may increasingly refuse to provide other healthcare services. For example, some may not recommend chicken pox or rubella vaccinations because they were originally produced using fetal tissue cultures.114 Animal rights supporters may refuse to provide xenotransplantation.115 Some providers may refuse to provide terminal sedation.116 Others may refuse to perform male circumcision.117 A few may refuse to provide genetic screening because of the risk of abortion. Some may decline to fill a prescription for an AIDS (acquired immunodeficiency syndrome) drug, claiming that the patient has practiced an “immoral” life-style.118 And others may refuse to provide therapies that were developed with embryonic stem cells.119

Fertility Treatments
In San Diego, physicians refused to provide Guadalupe Benitez with certain fertility treatments. Their moral and religious opposition derived not (as in the case of most conscientious objection) from the nature of the procedure itself. They had no problem with providing fertility treatments. Instead, the providers’ objections were patient-specific. They did not want to provide the treatments to Benitez because she was a single woman and a lesbian.120

In 2008, the California Supreme Court held that the physicians’ First Amendment rights to free speech and free exercise of religion did not exempt them from complying with the state’s civil rights act. The court held that California’s Unruh Civil Rights Act121 furthered a compelling interest in ensuring full and equal
access to medical treatment irrespective of sexual orientation, and that there were no less-restrictive means to achieve that goal. In late 2009, the parties settled the lawsuit for an undisclosed sum.  

Counseling

In March 2010, the U.S. District Court in Detroit denied a motion for summary judgment by Eastern Michigan University (EMU) in a lawsuit brought by a former graduate counseling student, Julea Ward. In 2009, EMU dismissed Ward from its counseling program for expressing her Christian beliefs opposing homosexual conduct. Ward alleged that, in violation of her First Amendment rights, EMU officials retaliated against her for expressing her religious beliefs.

COMPREHENSIVE LAWS: RIGHT TO REFUSE

Most conscientious refusal laws are limited to specific types of providers and to specific types of procedures. But some are broad enough to cover many or all types of services. Mississippi’s Health Care Rights of Conscience Act, for example, covers “any phase of patient medical care, treatment or procedure,” including referral and counseling. Furthermore, the act applies to all types of health service providers, as well as to payers and institutions. Other states have been developing similar legislation.

Idaho

In March 2010, Idaho enacted a new law that extends conscience protection to any healthcare worker refusing, on moral grounds, to “counsel, advise, perform, dispense, assist in or refer” someone for a healthcare service. “Healthcare service” is broadly defined as including “abortion, dispensation of an abortifacient drug, human embryonic stem cell research, treatment regimens utilizing human embryonic stem cells, human embryo cloning or end of life treatment and care.” Moreover, the healthcare worker is not professionally obligated to help the individual find another provider, except in life-threatening situations.

Louisiana

In 2009, the Louisiana legislature enacted a measure designed to protect all types of healthcare workers to refuse services based on their religious beliefs or moral convictions. Covered services include “abortion, dispensation of abortifacient drugs, human embryonic stem cell research, human embryo cloning, euthanasia, or physician-assisted suicide.” But healthcare facilities must have sufficient staff to provide patient care in the event that an employee declines to participate in any healthcare service that violates his or her conscience.

Oklahoma

In April 2010, Oklahoma enacted its Freedom of Conscience Act. This statute permits any provider or facility to refuse to “perform, practice, engage in, assist in, recommend, counsel in favor of, make referrals for, prescribe, dispense, or administer drugs or devices or otherwise promote or encourage” certain healthcare services. Those services include (1) abortion, (2) procedures related to destruction of an in vitro human embryo, (3) procedures on a fetus in an artificial womb that is not related to the beneficial treatment of the fetus, (4) procedures involving fetal tissue or organs that come from a source other than a stillbirth or miscarriage, and (5) procedures that cause the death of an individual by assisted suicide, euthanasia, or mercy killing.

Washington

A Washington bill proposes similarly broad conscience protection. “No physician or health care personnel . . . shall be civilly or criminally liable . . . by reason of his or her refusal to perform, assist, counsel, suggest, recommend, refer, or participate in any way in any particular form of health care service that is contrary to the conscience of such physician or health care personnel.”
Europe

The European Parliament has recommended that its member states ensure that conscientiously objecting providers refer patients to non-objecting providers. In the other branch of the European Union legislature, the Council of Europe, some members moved that member states develop oversight frameworks for conscientious objection, to ensure that women are referred to equivalent practitioners in a timely manner. The Committee on Equal Opportunities for Women and Men held an “exchange of views” in October and November 2009. It plans to consider the report in June 2010.

CONCLUSION

Several U.S. states (and many nations) are taking dramatically different approaches to conscience clauses and conscientious objection. Some jurisdictions mandate the participation of healthcare providers. Several impose a categorical duty to provide treatment. Some mandate participation only when no other provider is available. In contrast, other jurisdictions authorize conscientious objection, usually so long as the provider makes a transfer or referral. But some jurisdictions categorically authorize refusal with no strings attached. Moreover, all of the above laws not only vary materially, but also are in a state of flux.

In short, conscientious objection is still an unsettled area of bioethics. And it remains very active as the U.S. Congress, U.S. state legislatures, agencies, courts, professional associations, and the broader society struggle to strike the best balance between providers’ rights and patients’ rights. No solution will totally satisfy everyone. But while burdens on a patient’s access and a provider’s conscience cannot be eliminated, they can and should be mitigated, to the extent possible.

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NOTES


4. The focus of this article is on the conscience rights of healthcare providers. Outside its scope are new issues concerning the conscience rights of patients, such as the right to refuse vaccinations or the right to


5. Most laws protect “negative claims of conscience,” in that they authorize healthcare providers to refuse to provide a service that might otherwise be required. Conscience clause laws rarely protect “positive claims of conscience,” in that they do not authorize providers to provide services that would otherwise be prohibited. M.R. Wicclair, “Negative and Positive Claims of Conscience,” Cambridge Quarterly of Healthcare Ethics 18 (2009): 14. But this distinction can be ambiguous due to problems of individuation. For example, a Roman Catholic facility might refuse to withdraw a feeding tube. But that refusal could also be characterized as the affirmative provision of treatment.


7. This is the definition used by the U.S. Equal Employment Opportunity Commission (EEOC). 29 C.F.R. § 1605.1 (“the Commission will define religious practices to include moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views.”).


11. Joint Commission, 2010 Comprehensive Accreditation Manual for Hospitals: the Official Handbook (Oak Ridge, Ill.: Joint Commission, 2010), § HR-01.01.01; B.M. Dickens, “Conscientious Objection and Professionalism,” Expert Reviews in Obstetrics and Gynecology 4, no. 2 (2009): 97. Dickens contrasts the International Covenant on Civil and Political Rights Article 18(1), that grants the “freedom of thought, conscience and religion,” with Article 18(3) that subjects such freedom “to such limitations as . . . are necessary to protect public safety . . . or the fundamental rights and freedoms of others.” B.M. Dickens, “Legal Protection and Limits of Conscientious Objection: When Conscientious Objection Is Unethical,” Medicine and Law 28 (2009): 337. Unless a conscience clause permits, physicians typically have a duty not only to refer but also to provide informed consent. For example, an objecting provider may be obligated to disclose the risks from not having an abortion. Thomas v. Abdul-Malak, No. 02-1374 (W.D. Pa. 29 July 2004).


13. Other federal laws also provide for conscientious objection. Title VII of the Civil Rights Act of 1964 requires employers to make reasonable accommodations available for the religious practices of an employee unless doing so would create an undue burden in the workplace. 42 U.S.C. § 2000e-2. For example, it was sufficient that a hospital offered an emergency room nurse (objecting to emergency obstetrical procedures) a position in the neonatal intensive care unit, even if it was not a position that she wanted. Shelton v. University of Medicine, 223 F.3d 220 (3d Cir. 2000). It was sufficient that a hospital allowed a staff pharmacist to trade some, but not all, requested shifts because the hospital demonstrated that further accommodation would create an “undue hardship.” Brener v. Diagnostic Center Hospital, 671 F.2d 141 (5th Cir. 1982). In contrast, a Florida pharmacy failed to establish that accommodations for an Orthodox Jewish pharmacist would constitute an undue hardship. Hellinger v. Eckerd Corp., 67 F. Supp. 2d 1359 (S.D. Fla. 1999). Similarly, a
Southern California jury awarded Michelle Diaz $50,000 after she was fired from a public health clinic for refusing to dispense emergency contraception. *Diaz v. County of Riverside Health Services*, No. 5:00-CV-00-936-VAP-SGL (C.D. Cal., 24 May 2002).


15. 42 U.S.C. 300a-7.


17. The bill’s sponsor, Senator Frank Church (Idaho-D), was reacting not only to *Roe* but also to a federal court decision ordering a Roman Catholic facility to permit the use of its facilities to perform sterilizations. *Taylor v. St. Vincent’s Hosp.*, 369 F. Supp. 948 (D. Mont. 1973), aff’d 523 F.2d 75 (9th Cir. 1975).


19. Notwithstanding the judgment of the U.S. District Court, Cenzon De-Carlo may still pursue other remedies that she is afforded under state law or under other federal statutes.

20. The Coats Amendment is also known as section 245 of the Public Health Services Act, 42 U.S.C. § 238n. It prohibits discrimination against individuals and entities that “refuse[] to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions.”


22. The Weldon Amendment survived at least two court challenges. *Lockyer v. United States*, No. C-05-00328-JSW (N.D. Cal. 18 March 2008); *National Family Planning & Reproductive Health Ass’n v. Gonzales*, No. 04-CV-02148, 391 F. Supp. 2d 200 (D.D.C. 2005), aff’d 373 U.S. App. 346 (D.C. Cir. 2006). Other federal legislation: (1) protects state and federal corrections employees from participating in capital punishment, 18 U.S.C. § 3597(b); (2) prohibits requiring a Medicaid managed-care plan or a Medicare Choice plan to provide counseling or referral services if the organization objects on moral or religious grounds, 42 U.S.C. § 1396u-2, 42 U.S.C. § 1395w-22(j)(3)(B); and (3) prohibits requiring providers in the Federal Employees Health Benefit Plan from discussing treatment options inconsistent with their ethical, moral, or religious beliefs, 48 C.F.R. § 1609.7001(c)(7).


28. DHHS, ‘Proposed Rule: Rescission of the Regulation Entitled ‘Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of


33. H.R. 3590 § 1303(a)(3). An Executive Order issued at the same time as the passage of H.R. 3590 states: “Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. 300a-7, and the Weldon Amendment, section 508(d)(1) of Public Law 111-8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.” Executive Order No. 13535, “Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act,” 75 Fed. Reg. 15,599 (24 March 2010).

34. H.R. 3590 § 1303(b)(1).

35. H.R. 3590 § 1303(b)(2).

36. H.R. 3590 § 1303(b)(3).

37. H.R. 3590 § 1303(c).


40. Every state that provides a conscience refusal right to an individual provider also provides such a right to an institution, except Connecticut, New York, and Rhode Island. Guttmacher Institute, ibid. Traditionally, private secular hospitals have seldom been accorded institutional conscience rights. Doe v. Bridgeton Hospital Association, 366 A.2d 641 (N.J. 1976); Valley Hospital Association v. Mat-Su Coalition for Choice, 948 P.2d 963 (Alaska 1997).

41. 305 Ill. Comp. Stat.§5/5-16.3(a); N.D. Cent. Code § 14-02.4-15.1; Tex. Ins. Code § 20A.09(m); Wash. Rev. Code § 48.43.065(2)(a).


45. N.C. H.B. 432 (2009) (Hilton) (extending protection from physicians to other healthcare providers); N.C. H.B. 432 (2009) (Hilton) (covering pharmacists and relating to the prescription of drugs that result in abortion which could include Plan B).

46. An extreme example of pushing the boundaries of conscience protection is a lawsuit in which students complained that their student fees were being used to subsidize abortion. Erzinger v. Regents of the
University of California, 187 Cal. Rptr. 164 (Cal. App. 1982).

47. Moncivaiz v. DeKalb County Health Dept., No. 03-CV 50226, 2004 WL 539994 (N.D. Ill., 21 April 2004). The parties stipulated to dismiss after the trial court granted the defendants’ motion to dismiss most of the claims. The county agreed to pay $40,000 without admitting to liability. “Woman Settles Discrimination Case against County Health Department,” AP Alert, 27 May 2004.


50. Tramm v. Porte Memorial Hosp., No. H-87-355 (N.D. Ind., 22 December 1989). While the court held that Tramm’s duties fell outside the scope of the abortion conscience clause, it also held that she proved the ambulance company subjected her to an adverse employment action on the basis of her religious beliefs.


52. Tysiac v. Poland, No. 5410/03, ECHR 2007-IV.


58. Emergency contraception is available without a prescription. But, like cigarettes, contraceptives are held behind the counter due to age restrictions. Emergency contraception is distinct from mifepristone (also known as mifepristone or RU-486), which is used to end an early pregnancy. Mifepristone is supplied directly to physicians and not to pharmacies. FDA, “Mifepristone Questions and Answers,” 24 February 2010, http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111328.htm, accessed 17 April 2010.


60. Lemly v. St. Tammany Parish Hospital District No. 1, 8 So. 3d 588 (La. 2009).

64. Noesen v. Wisconsin Department of Regulation and Licensing, Pharmacy Examining Board, 751 N.W.2d 385 (Wis. App. 2008).
73. 745 Ill. Comp. Stat. 70/1 et seq.
78. Stormans, Inc. v. Selecky, 586 F.3d 1109 (9th Cir. 2009).
80. In 2008, California Assembly Member Nava introduced a bill that would require pharmacists to fill all legal prescriptions regardless of moral objections. Cal. A.B. 67 (2008) (Nava). While the bill is still pending, it has been amended to now address an unrelated issue.
90. Guttmacher, see note 39 above.
94. E.g., 16 Del. Code § 2508(e).
95. E.g., 16 Del. Code § 2510(a)(5).
99. 42 U.S.C. § 1396a(w)(3); 42 C.F.R. § 489.102(c)(2).
102. N.Y. Pub. Health Law § 2994N. A hospital can also make conscientious objections if it has a “formally adopted policy” based on religious beliefs or moral convictions “central to the facility’s operating principles.”
105. Rev. Code Wash. § 70.245.190(d).
112. Many of these other interventions would be covered by the “comprehensive laws” discussed below.
120. Benitez v. North Coast Women’s Care Medical Group, 44 Cal. 4th 1145 (2008).
123. Ward v. Board of Control of Eastern Michigan University, No. 09-CV-11237, 2010 WL 1141605 (E.D. Mich., 24 March 2010). In a similar earlier case with a private employer, the court found that accommodating the counselor’s aversion to certain topics was not required because it would constitute an undue burden. Bruff v. Northern Mississippi Health Services, 244 F.3d 495 (5th Cir. 2001).