

## TAKING CONSCIENCE SERIOUSLY

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## INTRODUCTION

At a Catholic hospital in a large Eastern city, Dr. *S* admits a patient nineteen weeks pregnant and miscarrying. He recommends, and the patient agrees to, the medically indicated treatment—ending the pregnancy. But the hospital ethics committee denies his request because of the institution’s moral objection to abortion: although the fetus has no chance of survival, an ultrasound still detects a fetal heartbeat. The woman becomes septic, with a 106-degree fever and profuse bleeding. Watching the patient “dying before our eyes,” the doctor makes a decision: he performs the abortion. The patient spends another ten days in intensive care and suffers permanent injuries. Horrified, Dr. *S* quits, saying “I just can’t do this. . . . This is not worth it to me.”<sup>1</sup>

This story is not unique. Forty-three percent of doctors have worked in a religiously affiliated institution,<sup>2</sup> many of which restrict treatment, not for medical but for religious reasons. One in five of these doctors reports experiencing conflicts between religious restrictions and what they perceive to be their duties to their patients.<sup>3</sup> Among ob-gyns practicing in religious facilities, the number rises to thirty-seven percent (and a full fifty-two percent of those working in Catholic healthcare institutions).<sup>4</sup>

The phenomenon extends beyond religious facilities. With mergers and changes in corporate affiliation, doctors and nurses increasingly find limitations imposed in their formerly secular work-

<sup>1</sup> Lori R. Freedman et al., *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 *Am. J. Pub. Health* 1774, 1777 (2008).

<sup>2</sup> Debra B. Stulberg et al., *Religious Hospitals and Primary Care Physicians: Conflicts Over Policies for Patient Care*, 25 *J. Gen. Internal Med.* 725, 727 (2010).

<sup>3</sup> *Id.*

<sup>4</sup> Debra B. Stulberg et al., *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient Care Policies*, 73 *Am. J. Obstetrics & Gynecology*, at e1, e4 (2012).

places.<sup>5</sup> And some secular (sometimes even public) institutions also impose moral restrictions on care. Within this array of hospitals, clinics, nursing homes, and practice groups, doctors and nurses may perceive these conflicts, as Dr. *S* seems to, as a matter of conscience, requiring a doctor to do what he perceives to be right despite the consequences for his livelihood.

Yet claims to conscience of medical providers like Dr. *S* are virtually absent from scholarly and legislative debates over conscience in medicine. Lawmakers and scholars focus instead on the archetypal doctor who refuses to participate in contested treatments that his or her institution provides.<sup>6</sup> Legislation in almost every state—known as “conscience clauses”—ensures that employers accommodate refusal and that refusing doctors and nurses face no adverse employment action for violating institutional policies (or professional discipline and liability for contravening acceptable medical standards).<sup>7</sup> Often thought of as limited to the hot-button issue of abortion, many of these clauses cover refusal to deliver

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<sup>5</sup> See generally Judith C. Applebaum & Jill C. Morrison, Hospital Mergers and the Threat to Women’s Reproductive Health Services: Applying the Antitrust Laws, 26 N.Y.U. Rev. L. & Soc. Change 1, 3–14 (2000); Lisa C. Ikemoto, When a Hospital Becomes Catholic, 47 Mercer L. Rev. 1087, 1090–118 (1996).

<sup>6</sup> For representative scholarship, see Dan W. Brock, Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?, 29 Theoretical Med. & Bioethics 187, 190–91 (2008); R. Alta Charo, The Celestial Fire of Conscience—Refusing to Deliver Medical Care, 352 New Eng. J. Med. 2471, 2471–72 (2005); Judith F. Daar, A Clash at the Bedside: Patient Autonomy v. A Physician’s Professional Conscience, 44 Hastings L.J. 1241, 1245–46 (1993); B.M. Dickens & R.J. Cook, The Scope and Limits of Conscientious Objection, 71 Int’l J. Gynecology & Obstetrics 71, 72–76 (2000); Rebecca S. Dresser, Freedom of Conscience, Professional Responsibility, and Access to Abortion, 22 J.L. Med. & Ethics 280, 280–81 (1994); Kent Greenawalt, Objections in Conscience to Medical Procedures: Does Religion Make a Difference?, 2006 U. Ill. L. Rev. 799, 818–25; Sylvia A. Law, Silent No More: Physicians’ Legal and Ethical Obligations to Patients Seeking Abortions, 21 N.Y.U. Rev. L. & Soc. Change 279, 280–82 (1994); Martha Minow, On Being a Religious Professional: The Religious Turn in Professional Ethics, 150 U. Pa. L. Rev. 661, 682–83 (2001); Edmund D. Pellegrino, The Physician’s Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective, 30 Fordham Urb. L.J. 221, 232 (2002).

<sup>7</sup> See, e.g., Ariz. Rev. Stat. Ann. § 36-3205(C) (2009) (“[H]ealth care provider is not subject to criminal or civil liability or professional discipline for . . . [f]ailing to comply with a decision or a direction [at the end of life] that violates the provider’s conscience . . . .”); N.J. Stat. Ann. § 2A:65A-3 (West 2000) (“The refusal to perform, assist in the performance of, or provide abortion services or sterilization procedures shall not constitute grounds for civil or criminal liability, disciplinary action or discriminatory treatment.”).

contraception, sterilization, and fertility care, or to withhold or withdraw life-sustaining procedures.<sup>8</sup> A handful even allow providers to decline to inform patients of treatment options and diagnoses, or to refer patients for care.<sup>9</sup>

At the same time, protection for conscience has been extended to entire hospitals, healthcare systems, clinics, and practice groups.<sup>10</sup> In most states, any facility—whether public or private, secular or religious, non- or for-profit—may assert moral positions against certain treatments and refuse to provide them.<sup>11</sup> Employees, staff, and affiliates of all beliefs and backgrounds must then

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<sup>8</sup> Thaddeus Mason Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusal*, 21 *J. Clinical Ethics* 163, 169 (2010) (noting almost all states allow healthcare providers to refuse end-of-life treatment to which they have conscientious objections); Guttmacher Inst., *State Policies in Brief: Refusing to Provide Health Services* (May 1, 2012), available at [http://www.guttmacher.org/statecenter/spibs/spib\\_RPHS.pdf](http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf) (highlighting such laws regarding abortion in forty-six states, contraception in thirteen states, and sterilization in eighteen states).

<sup>9</sup> See, e.g., 745 Ill. Comp. Stat. 70/4–5 (2010); Miss. Code Ann. § 41-107-5 (2009); Wash. Rev. Code § 48.43.065(2)(a) (2008). The Illinois statute reads,

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 which is contrary to the conscience of such physician or health care personnel.

745 Ill. Comp. Stat. 70/4. Health care is defined as

[A]ny phase of patient care, including but not limited to, testing; diagnosis; prognosis; ancillary research; instructions; family planning, counselling, referrals, or any other advice in connection with the use or procurement of contraceptives and sterilization or abortion procedures; medication; or surgery or other care or treatment rendered by a physician or physicians, nurses, paraprofessionals or health care facility, intended for the physical, emotional, and mental well-being of persons . . . .

*Id.* 70/3.

<sup>10</sup> 42 U.S.C. § 300a-7(b)(2) (2006) (stating that federal funding will not require an entity to provide any personnel or “make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions”); Ariz. Rev. Stat. Ann. § 36-2154(A) (2009) (containing typical language that reads, “[a] hospital is not required to admit any patient for the purpose of performing an abortion”); Cal. Prob. Code § 4734(b) (West 2009) (immunizing institutions refusing to comply with an advance directive contrary to “a policy of the institution that is expressly based on reasons of conscience”); Wyo. Stat. Ann. § 35-22-410 (2011) (immunizing healthcare institutions that decline to comply with an advance directive “contrary to the . . . written policies of the institution”).

<sup>11</sup> A handful, however, limit the reach of institutional conscience clauses to private or religious institutions. See *infra* note 49.

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abide by institutional restrictions even when they conflict with their individual consciences.

Scholars and lawmakers submit that this legislation is essential to preserve conscience. Conscience clauses are understood to be about protecting the consciences of medical providers—especially as they relate to life and death—and are defended on precisely those grounds. But what about Dr. *S* and his conscience? Even as it resolves some conflicts of conscience, does existing legislation create others? If so, how could it better safeguard conscience?

This Article takes the concept of conscience seriously. It accepts as sincere the claims that: (1) a doctor's conscience—especially as it relates to life and death—should be protected; and (2) the goal of this legislation is to protect conscience effectively.<sup>12</sup> Through engagement with the moral philosophical literature, this Article makes two interrelated arguments. First, conscience equally may compel a doctor or nurse to deliver a controversial treatment to a patient in need. But legislation meant to protect conscience, paradoxically, has undermined the consciences of these doctors and nurses. Second, endowing healthcare institutions with conscience via legislation is theoretically and practically problematic. By privileging the institutions' rights to refuse to provide certain treatments, legislation impinges on the rights of individual providers to provide care they feel obligated by conscience to deliver. Yet no theory of institutional conscience arrives at describing a concept akin to human conscience.

By engaging in a fine-grained discussion of conscience, this analysis will add complexity to our understanding of individual conscientious actors and suggest the need to reconsider what basis exists for institutional conscience. It consequently challenges the conventional account of morality in medicine, which limits conscience to those who refuse to deliver controversial treatments. It demonstrates that if we take conscience seriously, we must negotiate equally between competing claims of health providers and the

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<sup>12</sup> Taking this claim seriously for the sake of discussion is not to endorse it, but rather to take it as genuine and not pretextual. It allows us to examine the practical effectiveness of and theoretical justifications for current legislation. Taking conscience seriously also tests (and, ultimately, may help prove) the skeptical view that invocations of conscience are mere pretext for encouraging refusal to provide controversial treatments and limiting constitutional rights.

facilities in which they work—whether they refuse or are willing to provide controversial care. Although the discussion focuses on the treatment of healthcare facilities and medical providers under existing legislation, it has potentially wide-ranging repercussions, as the recent debates over conscience and mandatory contraceptive insurance coverage have shown.<sup>13</sup>

This Article proceeds in three Parts. Part I gives an overview of the legislative and scholarly debates. It shows that existing legislation generates significant asymmetries in the resolution of conflicts between medical providers and the hospitals, clinics, and nursing homes where they practice—which scholarship has not yet challenged. Whereas a doctor who refuses care for reasons of conscience cannot be disciplined and must be accommodated by her workplace, a doctor in an institution that restricts care, like Dr. S, can be fired for following his conscience and providing medical care in violation of institutional policy. In one workplace, institutional conscience yields; in the other, it overrides the individual conscience.

Part II maintains that the favored status of refusing individuals and institutions under state and federal law is theoretically indefensible. First, using the moral philosophical literature from which the concept of conscience derives, it shows that all doctors and nurses have equal claims of conscience, irrespective of whether they refuse or are compelled to perform contested treatments. Second, it argues that despite legislative and scholarly acceptance of institutional conscience, the concept of conscience is a poor theoretical and practical fit for healthcare institutions.

Part III introduces a new framework to negotiate between competing individual and institutional interests and protect conscience more consistently. This Part evaluates and ultimately rejects proposals that would either favor institutional conscience absolutely, privilege individual conscience only, or end conscience protection altogether. In contrast to these absolutist positions, it introduces a more nuanced test—based on the cohesion, message, and size of a healthcare facility—to determine whether institutional interest or

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<sup>13</sup> Katherine Franke & Elizabeth Sepper, *Obama Rule Respects Religious Diversity and Employees' Dignity*, U.S. News & World Rep., Feb. 9, 2012, <http://www.usnews.com/debate-club/should-catholic-and-other-religious-institutions-have-to-cover-birth-control/obama-rule-respects-religious-diversity-and-employees-dignity>.

individual conscience prevails. Differentiating in this way has the potential to achieve a better balance between institutions, individual doctors and nurses, and the patients who depend on them for care.

### I. A BLIND SPOT IN LAW AND LITERATURE

In American society, modern medicine sits uneasily with moral beliefs. With technological advances, doctors now keep patients alive longer, resolve infertility problems for men and women, and extend viability of extremely premature fetuses. The legal regime regulating doctor-patient relationships has also evolved in recent decades. Once willing to endorse medical paternalism, constitutional and common law jurisprudence now embraces patients' rights to informed consent, bodily autonomy, and self-determination. Patients, thus, may refuse treatment, have an abortion, take contraceptives, and insist on natural death.

Although under common law, medical personnel or institutions typically have no duty to provide patients with these services or to accept any person as a patient,<sup>14</sup> legislators have modified the no-duty rule in several ways. Most significantly, in hospital emergency rooms, federal and state statutes require all patients suffering from emergency conditions or in active labor to be stabilized or treated.<sup>15</sup> In many states, statutes create specific obligations to ensure that rape survivors may access emergency contraception.<sup>16</sup> Still others require physicians to offer counseling to terminally ill patients about available palliative care.<sup>17</sup> Institutions participating in Medicare must also meet acceptable standards of practice, disclose all treatment options, and respect patients' rights to give informed consent or refuse treatment.<sup>18</sup> Moreover, having accepted a person

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<sup>14</sup> 61 Am. Jur. 2d Physicians, Surgeons, Etc. § 121 nn.1-3 (2002).

<sup>15</sup> See, e.g., Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006).

<sup>16</sup> Cal. Penal Code § 13823.11(e)(1) (West 2009); 410 Ill. Comp. Stat. 70/2.2 (2011); N.M. Stat. Ann. § 24-10D-3(A) (West 2011); N.Y. Pub. Health Law § 2805-p (McKinney 2012); Ohio Rev. Code Ann. § 2907.29 (LexisNexis 2010); S.C. Code Ann. § 16-3-1350(B) (2003); Wash. Rev. Code § 70.41.350(1)(c) (2011); see also Guttmacher Inst., *supra* note 8.

<sup>17</sup> See, e.g., N.Y. Pub. Health Law § 2997-c(2) (McKinney 2012).

<sup>18</sup> Medicare Condition of Participation: Patient's Rights, 42 C.F.R. § 482.13(b) (2010); Medicare Condition of Participation: Surgical Services, 42 C.F.R. § 482.51

as a patient, providers have an ethical and legal duty to not abandon her, to treat her in accordance with acceptable standards of medical practice, to inform her of treatments and their risks and benefits, and to refer her for services they are not able to provide.<sup>19</sup>

In the face of these changes, some medical providers assert a right to refuse to participate in treatments they object to on the basis of deeply held religious or moral beliefs. Refusal encompasses a large range of care, including: condoms as part of HIV counseling; sterilization; contraception; removal or withholding of respirators, artificial hydration, or nutrition; vaccination; blood transfusions; circumcision; fertility treatments; euthanasia; pain management; stem-cell-derived therapies; and, of course, abortion.

These refusing providers have not gone unnoticed. As Section I.A shows, legislatures across the United States have decided that medical providers' consciences need, and merit, statutory protection from the demands of employers and patients. In so doing, they have overlooked both the doctors and nurses who want to provide controversial care and the significant conflicts generated by the recognition of institutional conscience for refusing institutions. As Section I.B explains, the scholarship similarly has oversimplified the issue. Section I.C then demonstrates conflicts over institutional restrictions may be widespread in practice.

Before we proceed, some definitions are in order. I use "willing provider" to refer to an individual doctor, nurse, or institution that seeks, for moral, religious, or ethical reasons, to participate in delivering a contested treatment that meets acceptable standards of medical practice when a patient requests or requires it. A "refusing provider," by contrast, is an individual doctor, nurse, or institution that declines, for moral, religious, or ethical (rather than medical or

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(2010); Medicare Condition of Participation: Outpatient Services, 42 C.F.R. § 482.54 (2010); Medicare Condition of Participation: Emergency Services, 42 C.F.R. § 482.55 (2010). The Health Care Financing Administration defines "acceptable standards of practice" as those that "rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts." Health Care Fin. Admin., Ctr. for Medicare & Medicaid Servs., Ruling No. 95-1 Part V (Dec. 1995).

<sup>19</sup> 61 Am. Jur. 2d Physicians, Surgeons, Etc. § 121 nn.5-7 (2002); see also Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 Fla. St. U. L. Rev. 779, 804, 822 (2007).



financial) reasons, to participate in delivering contested treatments requested or required by a patient. Whereas refusal frequently may depart from the accepted medical standards or medical ethics, provision of care always complies with them.

Although these definitions track distinctions drawn by legislation, they are necessarily functional. A meaningful distinction between acts and omissions is often lacking in medicine. Moreover, the same individual can be willing in one circumstance and refusing in another, such as a doctor who is willing to dispense contraceptives but declines to perform abortions.

### *A. Asymmetries in Legislation*

Before 1973, conscience in medicine was not an issue that captured public attention. That year, however, the Supreme Court decided *Roe v. Wade*<sup>20</sup> and a district court in Montana enjoined a Catholic hospital from refusing to permit tubal ligations following delivery.<sup>21</sup> In response, the U.S. Congress passed the Church Amendment, which made clear that receipt of federal funds did not require an individual or institution to perform sterilizations or abortions if it “would be contrary to . . . religious beliefs or moral convictions.”<sup>22</sup>

Legislatures across the United States followed, passing legislation—known as conscience clauses—to protect refusing providers from discrimination in hiring, staff privileges, or promotion; professional discipline; civil actions (typically malpractice); and regulatory or criminal sanctions.<sup>23</sup> In almost every state, a doctor may now refuse to comply with a patient’s request to withdraw or withhold life-sustaining treatment.<sup>24</sup> Refusals to provide abortion, con-

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<sup>20</sup> 410 U.S. 113 (1973).

<sup>21</sup> *Taylor v. St. Vincent’s Hosp.*, 369 F. Supp. 948, 951 (D. Mont. 1973).

<sup>22</sup> 42 U.S.C. § 300a-7(b) (1973) (effective October 20, 2000).

<sup>23</sup> See, e.g., Ariz. Rev. Stat. Ann. § 36-3205(C)(1) (2009) (West) (“[H]ealth care provider is not subject to criminal or civil liability or professional discipline for . . . [f]ailing to comply with a decision or a direction [at the end of life] that violates the provider’s conscience . . . .”); N.J. Stat. Ann. § 2A:65A-3 (West 2000) (“The refusal to perform, assist in the performance of, or provide abortion services or sterilization procedures shall not constitute grounds for civil or criminal liability, disciplinary action or discriminatory treatment.”).

<sup>24</sup> See, e.g., Ala. Code § 22-8A-8(b) (2006) (“No nurse, physician, or other health care provider may be required by law or contract in any circumstances to participate

traception, and sterilization are also commonly permitted.<sup>25</sup> Under all but a few conscience clauses, a doctor or nurse may refuse care even in emergency situations.<sup>26</sup> The majority of clauses might be read to authorize discriminatory refusals,<sup>27</sup> as when a provider refuses contraception only to unmarried women.

The stated goal of this legislative activity is to protect medical providers' exercise of conscience. Although in many states legislation simply says that refusal will not be grounds for discipline or liability,<sup>28</sup> in others the statutory text speaks in terms of moral, ethical, or religious grounds or conscientious objection.<sup>29</sup> Bills bear titles like "Health Care Rights of Conscience Act"<sup>30</sup> or "Con-

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in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing."); Tenn. Code Ann. § 32-11-108(a) (2007) (stating that a provider who cannot in good conscience comply with a living will shall inform the patient and assist in transfer but "shall not be subject to civil liability for medical care provided during the interim period until transfer is effectuated"). Federal law expressly allows Medicare providers to refuse to comply with advance directives as permitted under state law. Advance Directives: Requirements for Providers, 42 C.F.R. § 489.102(a)(1)(ii) (2011).

<sup>25</sup> Guttmacher Inst., *supra* note 8 (highlighting laws allowing refusal to provide abortion in forty-six states, contraception in thirteen states, and sterilization in eighteen states).

<sup>26</sup> Only some state conscience clauses contain an emergency exception. See Cal. Health & Safety Code § 123420(d) (West 2006) (containing an exception for emergency for abortion); Fla. Stat. § 765.1105(1)(a) (2010) (containing an exception for emergency); 745 Ill. Comp. Stat. 70/6, 70/9 (2010) (containing exception for any procedure); Iowa Code § 146.1 (2005) (containing an exception for "medical care which has as its primary purpose the treatment of a serious physical condition requiring emergency medical treatment necessary to save the life of a mother"); La. Rev. Stat. Ann. §§ 40:1299.34, 34.5, 35.9 (2008) (containing exception for abortion); Nev. Rev. Stat. § 632.475(3) (2008) (containing exception for abortion); S.C. Code Ann. § 44-41-40 (2002) ("[N]o hospital or clinic shall refuse an emergency admittance" with regard to abortion); Tex. Occ. Code Ann. § 103.004 (West 2012) ("A private hospital or private health care facility is not required to make its facilities available for the performance of an abortion unless a physician determines that the life of the mother is immediately endangered.").

<sup>27</sup> Holly Fernandez Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* 247-48 (2008).

<sup>28</sup> See, e.g., Haw. Rev. Stat. § 453-16(e) (2011); 20 Pa. Consol. Stat. § 5424 (2012).

<sup>29</sup> See Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 *J. Legal Med.* 177, 197-98 (1993) (categorizing abortion-related clauses).

<sup>30</sup> H. 609, 2006 Leg., Reg. Sess. (Ala. 2006); S. 1141, 85th Gen. Assemb., Reg. Sess. (Ark. 2005); H. 4741, 93d Leg., 1st Reg. Sess. (Mich. 2005); H. 1539, 93d Gen. Assemb., 2d Reg. Sess. (Mo. 2006); Assemb. Bill 2016, 212th Leg., Reg. Sess. (N.J. 2006); H. 6793, 2006 Gen. Assemb., Jan. Sess. (R.I. 2006); H. 1184, 81st Leg., 2006 Sess. (S.D. 2006); S. 1016, 79th Leg., Reg. Sess. (Tex. 2005); H. 183, 68th Biennial Sess. (Vt. 2005); S. 41, 77th Leg., 2d Sess. (W. Va. 2006).

science clause”<sup>31</sup> and emphasize “the rights of all individuals to pursue their religious beliefs and to follow the dictates of their own consciences.”<sup>32</sup>

Under these clauses’ anti-discrimination provisions, employers may not discriminate against doctors and nurses who decline to provide certain treatments when making hiring, promotion, or firing decisions.<sup>33</sup> Under the Federal Title VII standard, an employer must offer a reasonable accommodation, unless doing so will result in an undue hardship.<sup>34</sup> Although an undue hardship has been defined as anything more than a de minimis burden,<sup>35</sup> the case law suggests that healthcare facilities often go to great lengths to accommodate their employees, perhaps in part to comply with more onerous state conscience clauses.<sup>36</sup> A number of state clauses do

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<sup>31</sup> See, e.g., Va. Code Ann. § 18.2-75 (2009).

<sup>32</sup> Ga. Code Ann. § 49-7-9 (2009).

<sup>33</sup> See, e.g., 42 U.S.C. §§ 300a-7(c), (e) (2006); see also *Nead v. Bd. of Trs. of E. Ill. Univ.*, No. 05-2137, 2006 WL 1582454, at \*4–5 (C.D. Ill. June 6, 2006) (finding sufficient to state a Title VII claim allegations that employee had not been promoted because of her opposition to emergency contraception). Statutory damages (and sometimes criminal sanctions) are occasionally specified. See, e.g., Cal. Health & Safety Code § 123420 (West 2006) (making violation a misdemeanor); 745 Ill. Comp. Stat. 30/1(c) (2010) (stating violation results in “civil damages equal to 3 times the amount of proved damages”); Nev. Rev. Stat. § 632.475 (2008) (authorizing criminal penalty); N.Y. Civ. Rights Law § 79-i (McKinney 2009) (authorizing criminal penalty); Ohio Rev. Code Ann. § 4731.91 (LexisNexis 2006) (authorizing civil damages).

<sup>34</sup> *Ansonia Bd. of Educ. v. Philbrook*, 479 U.S. 60, 68–69 (1986). The Church Amendment does not create a private right of action, although a violation thereof can result in loss of federal funding. *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695, 699 (2d Cir. 2010). Courts have interpreted Title VII to permit religious discrimination claims founded on refusal to participate in contested treatments. *Nead*, 2006 WL 1582454, at \*5.

<sup>35</sup> This standard is met by costs like additional staffing or lost business. *Trans World Airlines v. Hardison*, 432 U.S. 63, 84 (1977).

<sup>36</sup> See *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 226–28 (3d Cir. 2000) (finding for hospital that repeatedly offered to transfer labor and delivery nurse to other positions); *Grant v. Fairview Hosp. & Healthcare Servs.*, No. Civ. 02-4232JNEJGL, 2004 WL 326694, at \*1, \*5 (D. Minn. Feb. 18, 2004) (granting hospital’s motion to dismiss where it offered to allow ultrasound technician to opt-out of examining women contemplating abortion); *Tramm v. Porter Mem’l Hosp.*, 128 F.R.D. 666, 667–68 (N.D. Ind. 1989) (issuing summary judgment in favor of surgical aide in public hospital who refused to clean instruments used in abortions); *Kenny v. Ambulatory Ctr. of Miami*, 400 So. 2d 1262, 1266–67 (Fla. Dist. Ct. App. 1981) (finding in favor of nurse who objected to gynecological procedures and was employed in an operating room where sixteen percent of procedures were gynecological because employer should have accommodated her by rearranging schedules); *Swanson v. St. John’s Lu-*

not incorporate any limitations on the employer's duty to accommodate.<sup>37</sup> They also, with few exceptions, appear to apply to clinics that provide abortions.<sup>38</sup> The broadest clauses seem "absolute—even up to the point of shielding workers from performing the essential functions of their jobs."<sup>39</sup>

Generally, anti-discrimination provisions extend to the refusing provider alone. Only in the exceptional case does legislation acknowledge the *willing* individual provider. Most notably, the Church Amendment prohibits discrimination against "any physician or other health care personnel . . . because he performed or assisted in the performance of a lawful sterilization procedure or abortion . . . or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions."<sup>40</sup> Two states follow this approach.<sup>41</sup> These provisions, however, only prohibit discrimination based on prior or off-site performance of either proce-

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theran Hosp., 597 P.2d 702, 709, 711 (Mont. 1979) (finding for a nurse-anesthetist despite the fact that employer could only procure a substitute from fifty-five or ninety-mile distances when her full-time schedule did not conflict); *Larson v. Albany Med. Ctr.*, 676 N.Y.S.2d 293, 294, 296 (N.Y. App. Div. 1998) (finding for nurses who objected to participating in an abortion); see also Thaddeus Mason Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusal*, 21 J. Clinical Ethics 163, 166 (2010) (reporting a 2005 Louisiana case denying summary judgment to a hospital in 2007 that fired a nurse who refused to administer emergency contraception).

<sup>37</sup> James A. Sonne, *Firing Thoreau: Conscience and At-Will Employment*, 9 U. Pa. J. Lab. & Emp. L. 235, 242 (2007).

<sup>38</sup> Three states include a narrow exception. Cal. Health & Safety Code § 123420(a) (West 2006) (exempting employer when "person would be assigned in the normal course of business of any hospital, facility, or clinic to work in those parts of the hospital, facility, or clinic where abortion patients are cared for"); Ky. Rev. Stat. Ann. § 311.800(5)(c) (LexisNexis 2011) (excluding facility "operated exclusively for the purposes of performing abortions or sterilizations"); 18 Pa. Consol. Stat. § 3213(f)(1) (2000) (exempting "facility devoted exclusively to the performance of abortions").

<sup>39</sup> Sonne, *supra* note 37, at 284; see also *Swanson*, 597 P.2d at 709–10 (determining that the right to refuse is unqualified and does not require weighing interests of the employer).

<sup>40</sup> 42 U.S.C. § 300a-7(c) (2006).

<sup>41</sup> Ky. Rev. Stat. Ann. §§ 311.800(5)(b)–(c) (LexisNexis 2011) (prohibiting discrimination against individuals "on account of the willingness or refusal . . . to perform or participate in abortion or sterilization" or "any statement or other manifestation of attitude by such person with respect to abortion or sterilization"); Mich. Comp. Laws § 333.20184 (2008) (prohibiting discrimination against "an individual . . . [who] previously participated in, or expressed a willingness to participate in, a termination of pregnancy").

dures. They do not require refusing institutions to accommodate willing providers.

A handful of other state conscience clauses recognize the willing provider more comprehensively. Alabama is unusual in providing that “[n]o person may be discriminated against in employment or professional privileges because of the person’s *participation* or refusal to participate in the withholding or withdrawal of life-sustaining treatment.”<sup>42</sup> Oregon’s Death with Dignity Act protects the ability of willing providers in refusing institutions to provide assisted suicide off site, deliver information, and refer patients, but allows institutions to prohibit their dispensing the drugs on site.<sup>43</sup> Broad state conscience clauses, which safeguard a physician from performing any form of medical service contrary to conscience, might also be read to include willing providers.<sup>44</sup>

As a general rule, however, lawmakers have exacerbated conflicts between institutions and willing providers by creating institutional conscience for refusing healthcare entities.<sup>45</sup> The Church Amendment, for instance, states that federal funding will not require an entity to provide any personnel or “make its facilities available for the performance of any sterilization procedure or abortion if the performance of such procedure or abortion in such facilities is prohibited by the entity on the basis of religious beliefs or moral convictions.”<sup>46</sup> Another common version immunizes

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<sup>42</sup> Ala. Code § 22-8A-8(b) (2006) (emphasis added). Regarding end-of-life care, state clauses shield providers who follow advance directives from liability, but generally do not resolve the conflict between these providers and institutions that limit ability to carry out patients’ wishes. South Dakota seems to protect both perspectives as well, stating that a person “who performs . . . an abortion” may not face repercussions from the institution. S.D. Codified Laws § 34-23A-13 (2011).

<sup>43</sup> Or. Rev. Stat. § 127.885 (2003).

<sup>44</sup> For example, Washington’s statute reads:

No individual health care provider, religiously sponsored health carrier, or health care facility may be required by law or contract in any circumstances to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion. No person may be discriminated against in employment or professional privileges because of such objection.

Wash. Rev. Code § 48.43.065(2)(a) (2008).

<sup>45</sup> With regard to abortion and end-of-life care, almost all states allow institutional refusal. See Natalie Langlois, Note, Life-Sustaining Treatment Law: A Model for Balancing a Woman’s Reproductive Rights with a Pharmacist’s Conscientious Objection, 47 B.C. L. Rev. 815, 838–39 (2006); Guttmacher Inst., *supra* note 8.

<sup>46</sup> 42 U.S.C. § 300a-7(b)(2)(A) (2006).

healthcare institutions that decline to comply with an advance directive because it “is contrary to . . . the written policies of the institution”<sup>47</sup> or to “a policy of the institution that is expressly based on reasons of conscience.”<sup>48</sup>

Only when an institution refuses to deliver legal, necessary care does the law recognize a concept of “institutional conscience.” Under most provisions, an entire hospital, healthcare system, clinic, or practice group may refuse contested treatments. The legislation typically does not differentiate between religious and secular, public and private, and for-profit and not-for-profit institutions.<sup>49</sup> In several jurisdictions, broad conscience clauses allow *any* corporation or entity associated with healthcare—including insurance companies—to decline to participate in, refer for, or give information about *any healthcare service* for reasons of conscience.<sup>50</sup> Employees and medical staff of all faiths, beliefs, and backgrounds must then abide by the institutional policy of refusal.

For both willing and refusing nurses and doctors, then, the primary point of conflict is not with the law, but with the policies of entities with which they are associated. As a result, cases involving refusing individual providers have most commonly arisen in the anti-discrimination context (rather than tort or disciplinary actions). The following exhibits the asymmetries in the ways conflicts are resolved under existing legislation:

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<sup>47</sup> Wyo. Stat. Ann. § 35-22-410(a)(v) (2011).

<sup>48</sup> Cal. Prob. Code § 4734(b) (West 2009).

<sup>49</sup> A handful, however, limit the reach of institutional conscience clauses to private institutions, see Ark. Code Ann. § 20-16-304 (2006); Me. Rev. Stat. tit. 22, § 1903(4) (2004); Tenn. Code Ann. § 68-34-104(5) (2011), or religious institutions, see Cal. Health & Safety Code § 123420(c) (West 2006); N.J. Stat. Ann. § 26:2H-65(b) (West 2007).

<sup>50</sup> 745 Ill. Comp. Stat. 70/4 (2010); Miss. Code Ann. § 41-107-5(3) (2009); Wash. Rev. Code § 48.43.065(2)(a) (2008). Since 2004, over a dozen states have considered similar legislation. Harrington, *supra* note 19, at 784–87.

Amendments to federal law also broaden the range of services, protecting any individual from being required “to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services”—that is Medicare and Medicaid—if participation would violate “his religious beliefs and or moral convictions.” 42 U.S.C. § 300a-7(d) (2006).

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	<u>Refusing Institution</u>	<u>Willing Institution</u>
<u>Refusing Individual Provider</u>	No conflict	Individual wins
<u>Willing Individual Provider</u>	Institution wins	No conflict

### *B. Gaps in the Scholarship*

Like lawmakers, legal scholars have both neglected the conscience of the willing provider and failed to scrutinize the concept of institutional conscience. They instead have operated under the assumption that legislation in this area effectively protects provider conscience but may (or must) be tempered to ensure patient access. Their focus, therefore, has been on the seemingly most significant issue: the appropriate balance between the patient's access to healthcare and the refusing provider's conscience. Although constitutional values of free exercise, autonomy, privacy, self-determination, and equality underlie these discussions, the literature has engaged, as does this Article, in legislative analysis because constitutional doctrine provides few answers to the controversy over conscience.<sup>51</sup>

The refusing provider has been at the center of scholarly proposals. The interests of refusing doctors and nurses are set against the demands of their employers.<sup>52</sup> Generally applicable laws (or ethical rules) are understood to create a dilemma for the refuser, with debate over whether exemptions for refusal can be justified as

<sup>51</sup> It is generally agreed that the First Amendment neither prohibits nor requires exemptions for medical providers with moral or religious objections to generally applicable laws. *Employment Division v. Smith*, 494 U.S. 872, 879 (1990) (holding that the right of free exercise does not relieve an individual of the obligation to comply with a "valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)" (quoting *United States v. Lee*, 455 U.S. 252, 263 n.3 (1982) (Stevens, J., concurring in judgment))); see also Harrington, *supra* note 19, at 789–91 (discussing free exercise issues in healthcare conscience debate). Nor do equal protection arguments, based on women's need for reproductive care, prove effective. See, e.g., *Poelker v. Doe*, 432 U.S. 519, 521 (1977) (holding that state may favor childbirth over abortion). Moreover, because of the state action requirement in U.S. constitutional law, constitutional doctrine cannot resolve the problems of conscience faced by providers in private institutions.

<sup>52</sup> See generally Bruce G. Davis, *Defining the Employment Rights of Medical Personnel Within the Parameters of Personal Conscience*, 1986 *Det. C.L. Rev.* 847; Sonne, *supra* note 37, at 236.

a matter of medical ethics.<sup>53</sup> The vast majority of literature pits the refuser's moral convictions against the patient's (and community's) access to healthcare.<sup>54</sup>

By and large, willing doctors and nurses have been absent from the legal literature, their moral convictions presumed to coincide perfectly with their employer's. Although the potential for conflict between these individuals and refusing institutions occasionally has been noted in passing,<sup>55</sup> only recently have a few scholars begun to consider the willing provider. Bernard Dickens and Rebecca Cook have described doctors' "conscientious commitment" to provide

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<sup>53</sup> See, e.g., Robert Baker, *Conscience and the Unconscionable*, 23 *Bioethics* ii, iii–iv (2009) (concluding that refusal to refer to or to provide a service when no alternatives are available is unprofessional conduct); Robert F. Card, *Conscientious Objection and Emergency Contraception*, 7 *Am. J. Bioethics*, 8, 9 (2007) (arguing that professionals have an ethical obligation to dispense emergency contraception); Bernard M. Dickens, *Ethical Misconduct by Abuse of Conscientious Objection Laws*, 25 *Med. Law* 513, 517–19 (2006) (noting some conscience clauses allow unethical conduct).

<sup>54</sup> See generally Lynch, *supra* note 27; William W. Bassett, *Private Religious Hospitals: Limitations upon Autonomous Moral Choices in Reproductive Medicine*, 17 *J. Contemp. Health L. & Pol'y* 455 (2001); Kathleen M. Boozang, *Deciding the Fate of Religious Hospitals in the Emerging Health Care Market*, 31 *Hous. L. Rev.* 1429 (1995); Brock, *supra* note 6; Julie D. Cantor, *Conscientious Objection Gone Awry—Restoring Selfless Professionalism in Medicine*, 360 *New. Eng. J. Med.* 1484, 1485 (2009); Charo, *supra* note 6; Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 *Or. L. Rev.* 625 (2003); Elena N. Cohen, *Disclosing Religious Restrictions in Health Care: Balancing Individual and Institutional Preferences*, 1 *Gender Med.* 8, 8 (2004); Daar, *supra* note 6; Dickens & Cook, *supra* note 6; Dresser, *supra* note 6; Greenawalt, *supra* note 6; Harrington, *supra* note 19; Ikemoto, *supra* note 5; Minow, *supra* note 6; Julian Savulescu, *Conscientious Objection in Medicine*, 332 *Brit. Med. J.* 294, 294 (2006); Carson Strong, *Conscientious Objection the Morning After*, 7 *Am. J. Bioethics* 32, 32 (2007); Martha S. Swartz, "Conscience Clauses" or "Unconscionable Clauses": Personal Beliefs Versus Professional Responsibilities, 6 *Yale J. Health Pol'y L. & Ethics* 269, 282–83 (2006); Katherine A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights*, 51 *Stan. L. Rev.* 1703 (1999); Robin Fretwell Wilson, *Essay: The Limits of Conscience: Moral Clashes Over Deeply Divisive Healthcare Procedures*, 34 *Am. J. L. & Med.* 41 (2008).

<sup>55</sup> See, e.g., Cohen, *supra* note 54 ("[I]t is also undeniable that when health care institutions . . . impose ethical and religious restrictions, they limit the options of patients and practitioners alike."); Pellegrino, *supra* note 6, at 236 (acknowledging that Catholic directives apply to all who practice in a Catholic institution, irrespective of their personal beliefs); Susan J. Stabile, *When Conscience Clashes with State Law & Policy: Catholic Institutions*, 46 *J. Cath. Legal Stud.* 137, 147 (2007) (recognizing "the fact that a Catholic institution serves or employs non-Catholics means that the Church's position is in some way being extended to non-Catholics").



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abortion or contraception in historical and comparative perspective.<sup>56</sup> Several others have argued that Title VII and the Church Amendment should be enforced to protect doctors who advocate for abortion rights or perform abortions off-site.<sup>57</sup> None of these accounts, however, has identified the asymmetries in legislation or the theoretical bases for protecting the willing provider's conscience.

Moreover, the scholarship has overlooked theoretical problems with institutional conscience. Although a few legal scholars admit some discomfort with institutional conscience,<sup>58</sup> they have not scrutinized the concept. The fundamental tension between institutional and individual conscience has remained unexamined.

This Article aims to fill these gaps. This approach does not intend to minimize the importance of access to healthcare that has been thoroughly and convincingly analyzed elsewhere,<sup>59</sup> but rather to challenge the calculus that views conscience as conflicting with patient care. Contested treatments involve the consciences of a number of actors—including doctors, nurses, institutions, and patients.<sup>60</sup> The interests of the provider and patient need not always be in opposition. Indeed, considering the willing provider, who by definition seeks to carry out patients' wishes and best interests, should only bolster patients' access to care.

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<sup>56</sup> Bernard M. Dickens & Rebecca J. Cook, *Conscientious Commitment to Women's Health*, 113 *Int'l J. Gynecology & Obstetrics* 163, 164 (2011).

<sup>57</sup> Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 *Yale J.L. & Feminism* 135, 154 (2003); Steph Sterling & Jessica L. Waters, *Beyond Religious Refusals: The Case for Protecting Health Care Workers' Provision of Abortion Care*, 34 *Harv. J.L. & Gender* 463, 495 (2011).

<sup>58</sup> See Greenawalt, *supra* note 6, at 824 (noting that "[t]he issue is harder with respect to institutions" and "it is somewhat difficult to say what gives a collective entity an objection in conscience").

<sup>59</sup> See *supra* note 6. Patients' interests are central to any legislative proposal and will be considered in Part III.

<sup>60</sup> The issue of patient conscience is largely beyond the scope of this Article, but for helpful analysis, see Kathleen M. Boozang, *Divining a Patient's Religious Beliefs in Treatment Termination Decision-Making*, 15 *Temp. Pol. & Civ. Rts. L. Rev.* 345 (2006); April L. Cherry, *The Free Exercise Rights of Pregnant Women Who Refuse Medical Treatment*, 69 *Tenn. L. Rev.* 563 (2002).

*C. The Pressing Conflict Between Refusing Institutions and Willing Individuals*

Neglect of the willing provider in law and scholarship is not simply a theoretical problem. The reach of refusing institutions means a number of providers encounter restrictions that conflict in meaningful ways with professional standards. Available empirical and anecdotal evidence suggests that doctors and nurses clash with refusing institutions over limitations on care.

Restrictions at refusing institutions affect a large percentage of medical providers. In one recent empirical study, forty-three percent of physicians reported having practiced in a religiously affiliated institution during their careers, a large number of which had institutional policies of refusal.<sup>61</sup> As one might expect, policies most commonly limit abortion, contraception, sterilization, and end-of-life care. However, many healthcare institutions that assert an objection to legal, medically necessary care are not affiliated with any religion.<sup>62</sup> For instance, Vanguard, a for-profit, nonsectarian investor group, operates several formerly religious hospitals with refusal

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<sup>61</sup> Stulberg et al., *supra* note 2. One thousand general internal medicine, family medicine, or general practice physicians were surveyed as to whether they had worked in a religiously affiliated hospital or practice, whether they had experienced conflict with the institution over religiously based patient care policies, and how they believed physicians should respond to such conflicts. *Id.* at 726.

<sup>62</sup> According to the American Medical Association, medically necessary care is [h]ealth care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.

Eugene Ogrod, Report of the Council on Medical Service 13-I-99: Definition of "Medical Necessity," *Am. Med. Ass'n* (1999), <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-medical-service/reports-topic/medicare-medicaid.page>.

policies.<sup>63</sup> Similarly public hospitals may (or are required to) prohibit abortions or other controversial procedures in most states.<sup>64</sup>

Within these facilities, medical providers may face conflicts between professional best practice and institutional refusals. One in five family physicians, general internists, and general practitioners reports having experienced conflict with the religious institution where they worked “regarding [the institution’s] religiously based policies for patient care.”<sup>65</sup> As one would expect, the rates of conflict are even higher in facilities with wide-ranging restrictions, and in certain specialties (such as obstetrics and gynecology).<sup>66</sup> A nationally representative study of obstetrician–gynecologists found that thirty-seven percent of those who practice in a religiously affiliated institution have faced conflicts over religion-based policies for patient care.<sup>67</sup> Over half of ob-gyns who work in Catholic institutions reported such conflicts.<sup>68</sup>

Among refusing institutions, Catholic healthcare is distinguished by its size and the extent of its restrictions. The nation’s largest nonprofit medical provider, Catholic healthcare is a major market

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<sup>63</sup> Ill. Health Facilities and Servs. Review Bd., Application for Permit 10-014, West Suburban Med. Ctr., Oak Park, Ill., at 991, Mar. 18, 2010, available at <http://www.hfsrb.illinois.gov/Apps/2010-03-18%2010-014%20CON%202010-03-18%2010-014%20APPLICATION.pdf> (claiming to “successfully operate[] faith-based hospitals in San Antonio, Texas and Worcester, Massachusetts while maintaining the values and mission of the founders of these facilities”).

<sup>64</sup> See, e.g., Ariz. Rev. Stat. Ann. § 15-1630 (2009) (prohibiting abortions in state hospitals unless “necessary to save the life of the woman”). The Supreme Court has upheld prohibitions on the use of public facilities for abortions, provided there is an exception for therapeutic abortions. *Webster v. Reprod. Health Servs.*, 492 U.S. 490, 507–11 (1989) (rejecting due process challenge); *Poelker v. Doe*, 432 U.S. 519, 520–21 (1977) (per curiam) (rejecting equal protection argument).

<sup>65</sup> Stulberg et al., *supra* note 2, at 726–27. There are few empirical studies of the tension between physicians and refusing institutions.

<sup>66</sup> Lois Uttley & Ronnie Pawelko, *No Strings Attached: Public Funding of Religiously-Sponsored Hospitals in the United States* 26 (2002), available at [http://www.mergerwatch.org/storage/pdf-files/bp\\_no\\_strings.pdf](http://www.mergerwatch.org/storage/pdf-files/bp_no_strings.pdf) (describing an ob-gyn who, due to religious restrictions, was refused permission to admit a woman whose membranes ruptured at fourteen weeks to a hospital that recently merged with a Catholic hospital); Freedman et al., *supra* note 1, at 1774 (reporting a qualitative study showing ob-gyns’ struggle against institutional policies that delay or deny urgent surgical abortion to patients).

<sup>67</sup> Stulberg et al., *supra* note 4, at 10–11.

<sup>68</sup> *Id.*

player.<sup>69</sup> At any time, over half a million full-time employees—14.3% of full-time hospital employees—work at Catholic hospitals. This number does not include the many physicians who have admitting privileges at these hospitals or the employees of the numerous Catholic nursing homes, long-term care facilities, and clinics.

In these institutions, medical providers are required to follow the Ethical and Religious Directives for Catholic Health Care Services (“ERDs”) as a condition of employment or admitting privileges.<sup>70</sup> At over forty pages long, the ERDs cover many topics that do not affect medical care. A number, however, contradict accepted professional ethical imperatives that require doctors and nurses to place patient welfare above self-interest, respect patient autonomy, guarantee continuity of care, and ensure patients receive adequate information.<sup>71</sup>

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<sup>69</sup> Catholic healthcare has more than 1400 long-term and other health facilities and 600 hospitals. Catholic Health Ass’n of the United States, *A Passionate Voice for Compassionate Care* 9, available at <http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=9370> (last visited Oct. 13, 2012). It also includes sixty-one multi-institution health systems. Catholic Health Ass’n of the United States, *Catholic Health Care in the United States* 2, Jan. 2010, available at <http://www.chausa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=7830>; see also Joe Carlson, *Seeking Catholic Cohesion: CHA Report Stresses Cooperation over Consolidation*, *ModernHealthcare.com*, Aug. 16, 2010, <http://www.modernhealthcare.com/article/20100816/MAGAZINE/100819940> (“Today the three largest not-for-profit hospital owners in the country are all Catholic . . .”).

<sup>70</sup> United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 3–4 (5th ed. 2009), available at <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf> [hereinafter ERDs]. Sometimes restrictions on providers extend outside the Catholic facility. For instance, an ob-gyn was placed under review by his Catholic employer for performing abortions at Planned Parenthood. Sterling & Waters, *supra* note 57, at 471.

<sup>71</sup> See, e.g., Am. Med. Ass’n, *Opinion. 8.08 – Informed Consent* (2006), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion808.page> (“Physicians should sensitively and respectfully disclose all relevant medical information to patients.”); Am. Med. Ass’n, *Opinion. 10.01 – Fundamental Elements of the Patient-Physician Relationship §§ (1)–(2)* (1993), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page> (“The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.”); Am. Med. Ass’n, *Principles of Medical Ethics*, at VIII (2001), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page> (“A physician shall, while caring for a patient, regard responsibility to the patient

The tension is most acute in reproductive care. Artificial reproductive technology, nontherapeutic abortion, contraception, condoms, and sterilization are not permitted.<sup>72</sup> Research and therapy using treatments derived from fetal tissue or embryonic stem cells are also disallowed.<sup>73</sup>

The directives limit the information doctors may provide to “morally legitimate alternatives,”<sup>74</sup> with wide-ranging repercussions for physician practice and patient care. Catholic clinics have refused to instruct HIV-positive patients as to the importance of condoms and of cleaning needles used for intravenous drugs to prevent transmission.<sup>75</sup> Participants in trials of drugs that may cause fetal anomalies have merely been instructed not to become pregnant, instead of receiving contraception.<sup>76</sup> Discussing prenatal testing is prohibited if it might result in the woman’s decision to abort a fetus (as when testing shows a nonviable fetus or severe anomalies).<sup>77</sup> Counseling a rape victim about emergency contraception is also often restricted.<sup>78</sup> By contrast, medical ethics absolutely prohibit withholding medical information from patients without their knowledge or consent.<sup>79</sup>

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as paramount.”); Am. Nurses Ass’n, Code of Ethics for Nurses §§ 1.1, 1.4 (2001), available at <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf> (“Patients have the moral and legal right . . . to be given accurate, complete and understandable information . . .”).

<sup>72</sup> ERDs, supra note 70, at 25 ¶¶ 38–41, 26 ¶ 45, 27 ¶¶ 48, 52, 53.

<sup>73</sup> Id. at 33 ¶ 66.

<sup>74</sup> Id. at 20 ¶ 27. “The free and informed health care decision of the person or the person’s surrogate is to be followed so long as it does not contradict Catholic principles.” Id. at 20 ¶ 28.

<sup>75</sup> Mireya Navarro, Ethics of Giving AIDS Advice Troubles Catholic Hospitals, N.Y. Times, Jan. 3, 1993, at A1.

<sup>76</sup> Martien A.M. Pijnenburg et al., Catholic Healthcare Organizations and the Articulation of Their Identity, 20 HEC Forum 75, 80 (2008).

<sup>77</sup> ERDs, supra note 70, at 27 ¶ 50.

<sup>78</sup> Teresa Harrison, Availability of Emergency Contraception: A Survey of Hospital Emergency Department Staff, 46 Annals of Emergency Med. 105 (2005) (finding that fifty-five percent of all Catholic hospitals refuse to dispense EC under any circumstance); NARAL Pro-Choice Mass., Press Release, Access to Emergency Contraception in MA Hospitals Declines, Dec. 2008, available at <http://www.prochoicemass.org/media/echosp2008.shtml> (reporting that despite legal requirements only fifty-six percent of Massachusetts Catholic hospitals offer rape victims emergency contraception).

<sup>79</sup> Am. Med. Ass’n, Opinion. 8.082 – Withholding Information from Patients (2006), available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8082.page>.

End-of-life care is the other principal area of conflict. Even where a patient has an advance directive or is competent to make a decision about the use or withdrawal of artificial life support, a provider is forbidden from honoring her wishes if they are contrary to Catholic teaching.<sup>80</sup> With regard to artificial nutrition and hydration, the ERDs impose “an obligation to provide patients with food and water,” even when they are in “chronic and presumably irreversible conditions” and are likely to require feeding indefinitely.<sup>81</sup> Although palliative care is encouraged, terminal sedation is disallowed.<sup>82</sup>

Sometimes ambiguity in the directives constrains providers’ ability to treat and counsel patients. For instance, the ERDs accept that a rape victim “should be able to defend herself against a potential conception,” seemingly limiting the dispensing of emergency contraception to instances where conception can be disproved (despite the absence of any such medical test).<sup>83</sup> Uncertainty about the moral status of an ectopic pregnancy, which involves a pregnancy outside the uterus that cannot come to term, may result in delays, unnecessary tests, or surgical methods that render the woman infertile, instead of immediate use of a less-intrusive medical procedure.<sup>84</sup> Even in emergencies, the permissi-

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<sup>80</sup> ERDs, *supra* note 70, at 19 ¶ 24. The directives provide that “[t]he free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.” *Id.* at 31 ¶ 59.

<sup>81</sup> *Id.* at 31 ¶ 58.

<sup>82</sup> Terminal sedation uses sedatives to make the patient unaware and unconscious in order to relieve extreme suffering while disease takes its course and eventually leads to death. The ERDs call for keeping patients as free of pain as possible, but stipulate that a patient “should not be deprived of consciousness without a compelling reason” and “[p]atients experiencing suffering that cannot be alleviated should be helped to appreciate the Christian understanding of redemptive suffering.” *Id.* at 32 ¶ 61. These restrictions do not align with physicians’ views regarding end-of-life care. See Farr A. Curlin et al., *To Die, To Sleep: US Physicians’ Religious and Other Objections to Physician-Assisted Suicide, Terminal Sedation, and Withdrawal of Life Support*, 25 *Am. J. Hospice & Palliative Med.* 112, 115 (2008) (survey finding only eighteen percent of physicians object to terminal sedation and five percent object to withdrawal of artificial life support).

<sup>83</sup> ERDs, *supra* note 70, at 21–22 ¶ 36.

<sup>84</sup> *Id.* ¶ 48, at 27 (“In case of extrauterine pregnancy, no intervention is morally licit which constitutes a direct abortion.”). For instances in which this restriction negatively affected patient care, see Nat’l Health Law Program, *Health Care Refusals: Undermining Quality Care for Women* 15, 40, 57 (2010), available at

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bility of abortions necessary for a woman's health or life is inconsistently interpreted across facilities.<sup>85</sup>

Surprisingly, doctors and nurses encounter these restrictions even outside of official or clearly identifiable Catholic facilities.<sup>86</sup> As a result of hundreds of mergers between religious and nonreligious facilities since the 1990s, healthcare systems with names like "Optima" and institutions with names like "Daniel Freeman Marina Hospital" came to impose religious doctrine.<sup>87</sup> Recent sales further confuse the issue, as secular, for-profit investor groups continue to require compliance with the ERDs in formerly Catholic facilities.<sup>88</sup> Outside of the hospital context, cooperative arrangements and leases with Catholic health systems mean there is often

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[http://www.healthlaw.org/images/stories/Health\\_Care\\_Refusals\\_Undermining\\_Quality\\_Care\\_for\\_Women.pdf](http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf) (discussing conscience clauses and restrictions on the use of emergency contraception and prohibitions against the use of certain treatments for ectopic pregnancies), and Angel M. Foster et al., *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study*, 21 *Women's Health Issues* 104, 106 (2011) (discussing interviews with practitioners in Catholic hospitals who have dealt with the challenges of managing ectopic pregnancies under the directives). A recent survey found that although there is much confusion over the status of ectopic pregnancy in Catholic moral teachings, a low percentage of ob-gyns in Catholic institutions (5.5%) report that institutional policies limit the options they have for treating ectopic pregnancy (the study did not include emergency department or family physicians who also manage ectopic pregnancy and did not establish physicians' level of awareness of religious policies for care). Stulberg et al., *supra* note 4, at 11.

<sup>85</sup> Freedman et al., *supra* note 1 (reporting physicians' agonizing over treatment for miscarriage under these restrictions).

<sup>86</sup> See Lawrence E. Singer, *Does Mission Matter?*, 6 *Hous. J. Health L. & Pol'y* 347, 353-57 (2006) (explaining criteria, including a religious order's sponsorship, that make healthcare facilities Catholic).

<sup>87</sup> *Health System Bans Abortions in Facilities*, *Med. Ethics Advisor*, Apr. 1, 1998, <http://www.highbeam.com/doc/1G1-206673157.html> (reporting that, following the merger of Catholic Medical Center and Elliot Hospital into Optima Healthcare, abortion was prohibited at both facilities); see also *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240 (Cal. Ct. App. 1989) (considering claim by rape victim against Catholic hospital for denying emergency contraception and counseling).

<sup>88</sup> In these cases, it is difficult for potential patients or employees to know that the hospital imposes religious limitations. For instance, after the sale of West Suburban Hospital in Chicago, for-profit Vanguard agreed to keep the ERDs in place but took all religious language off the website. Telephone Interview with Leah Bartelt, Staff Counsel, American Civil Liberties Union of Illinois Reproductive Rights Project (Oct. 20, 2010).

compliance with the ERDs at non-Catholic physician groups, nursing homes, and ancillary care organizations.<sup>89</sup>

With changes in corporate affiliation and ownership, providers find limitations imposed at their formerly secular workplaces. They must then choose between accepting limits on care and finding alternative employment. For instance, after the clinic where he was a psychiatrist merged with a Catholic hospital, one doctor lost his admitting privileges because he refused to agree to the ERDs on the ground that they interfered with his patients' rights.<sup>90</sup> If the entity resulting from the merger becomes the largest medical employer in the area,<sup>91</sup> the choice for providers becomes starker—accept restrictions or leave town.

As a result, medical providers have been at the forefront of protests against mergers or joint operations with refusing health facilities. For example, hospital staff have resisted acquisitions by Catholic health systems in order to avoid religious limits on end-of-life care.<sup>92</sup> Medical staff similarly have sought to enjoin policies limiting abortions or sterilizations imposed by the boards of nonprofit community hospitals.<sup>93</sup>

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<sup>89</sup> For instance, in Lane County, Oregon, where the Catholic health system already controls seventy percent of hospital services, several major physician groups have also affiliated with the system and agreed to comply with religious restrictions. Ikemoto, *supra* note 5, at 1102 n.84.

<sup>90</sup> Uttley & Pawelko, *supra* note 66, at 32.

<sup>91</sup> See, e.g., John C. Grossmeier, *Adopting and Implementing a Policy Governance Model*, 52 *J. Healthcare Mgmt.* 343, 344 (2007) (discussing merger of Catholic and non-Catholic hospitals into community's largest employer and six counties' sole community provider).

<sup>92</sup> Harris Meyer, *Catholic Directive May Thwart End-Of-Life Wishes: Bishops Cite 'Obligation' for Using Feeding Tubes at Religious Facilities*, *Kaiser Health News*, Feb. 27, 2010, <http://www.kaiserhealthnews.org/Stories/2010/February/24/Catholic-directive-may-thwart-end-of-life-wishes.aspx> (discussing end-of-life care restrictions in Catholic health systems); see also Debran Rowland, *The Boundaries of Her Body: The Troubling History of Women's Rights in America* 290 (2004) (noting reports that, during mergers, Catholic partners sometimes assured secular facilities that abortions for life-threatening conditions would be allowed, only to later delay or deny them); Navarro, *supra* note 75 (reporting that HIV counselors at Catholic clinic protested decision to ban distribution of educational materials).

<sup>93</sup> See, e.g., *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963 (Alaska 1997) (seeking injunction against hospital policy prohibiting elective abortions); *Doe v. Bridgeton Hosp. Ass'n*, 366 A.2d 641, 642–43 (N.J. 1976) (noting plaintiffs requested that hospital be compelled to provide first-trimester elective abortions).



Increasingly, providers will be caught between moral restrictions and medical ethics. First, hospitals—both willing and refusing—are purchasing or affiliating with physicians’ practices, in part because of incentives in healthcare reform.<sup>94</sup> Second, the Catholic Church in particular appears to be adopting more restrictive interpretations of doctrine.<sup>95</sup> In contrast to previous versions, current ERDs require hydration and nutrition at the end of life and categorize sterilization as a moral wrong on par with murder.<sup>96</sup> U.S. bishops have begun to crack down on any departure from the directives.<sup>97</sup> Physicians once able to discretely perform prohibited counseling and procedures thus may experience increasing tension between their professional conscience and institutional restrictions.

## II. PROBLEMATIZING LEGISLATION’S INCONSISTENT DEFENSE OF CONSCIENCE

Consider two hypothetical physicians. The first, Dr. Abbott, refuses to administer contraception, but works at a hospital committed to delivering all necessary care to patients. By contrast, the second, Dr. Baker, feels a moral imperative to ensure his patients have autonomy over their reproductive lives, but his employer has moral policies against contraceptives. Under the approach taken by

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<sup>94</sup> Reed Abelson, *Catholic Gains in Health Care Include Strings*, N.Y. Times, Feb. 21, 2012, at A1.

<sup>95</sup> Leigh Page, *Abortion Showdown Again Puts Catholic Hospitals at Odds With Church; More Catholic Healthcare West Hospitals May be Targeted*, Becker’s Hosp. Rev., Dec. 23, 2010, available at <http://www.beckershospitalreview.com/hospital-financial-and-business-news/abortion-showdown-again-puts-catholic-hospitals-at-odds-with-church-more-catholic-healthcare-west-hospitals-may-be-targeted.html>.

<sup>96</sup> Rachel Benson Gold, *Hierarchy Crackdown Clouds Future of Sterilization, EC Provision at Catholic Hospitals*, 5 Guttmacher Inst. Rep. Pub. Pol’y 11, 12 (2002), available at <http://www.guttmacher.org/pubs/tgr/05/2/gr050211.pdf> (noting that the revised directives designate sterilization as “intrinsically immoral,” calling into question at least forty Catholic facilities’ arrangements allowing sterilization).

<sup>97</sup> Editorial, *A Matter of Life or Death*, N.Y. Times, Dec. 23, 2010, at A32 (noting that St. Joseph’s Hospital in Phoenix was stripped of its Catholic status after it performed an abortion to save a woman’s life and refused to agree to the bishop’s demand never to perform a life-saving abortion again); Joe Carlson, *Catholic Hospitals Under Scrutiny: Observers Question if Facilities Are Performing Birth-Control Procedures*, ModernHealthcare.com, Mar. 15, 2010, available at <http://www.modernhealthcare.com/article/20100315/MAGAZINE/100319992> (reporting that the ninety-two-year Catholic sponsorship of one of Oregon’s largest hospitals ended over sterilizations).

most legislation, Dr. Abbott can refuse to prescribe emergency contraception to a rape victim in violation of her institution's policy—without consequence. Dr. Baker, however, can be fired for prescribing emergency contraception to a rape victim—even if he acts in good conscience—because he has violated the institutional policy of refusal.

This Part argues that these asymmetries render current legislation fundamentally and conceptually incoherent. It takes seriously the claim of medical providers to act on conscience. It uses relevant philosophical literature theorizing conscience to outline a basic understanding of what we mean by conscience, and why as a society we care about protecting it. Based on this literature, it introduces two interconnected arguments. First, willing providers equally may claim to act on conscience. The strongest arguments about the nature of conscience cannot justify their disparate treatment under current legislation. Second, no theory of institutional conscience arrives at describing a concept akin to human conscience. Instead, institutional conscience might be said to reflect the value of moral association. Under any conception of institutional conscience, however, the disparate treatment of refusing and willing institutions cannot be justified.

#### *A. The Meaning and Value of Conscience*

The concept of conscience was first developed in the moral philosophical literature, and it is this literature that can most helpfully inform the identification of claims of conscience. This Section does not comprehensively describe philosophical theories of conscience or the disagreements among them. Rather, it seeks to draw out commonalities across traditions going back to medieval philosophy.<sup>98</sup>

Although philosophers do not agree on a single definition, conscience broadly refers to “human knowledge of right and wrong, and thus . . . our moral consciousness, process of moral decision

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<sup>98</sup> Douglas C. Langston, *Conscience and Other Virtues: From Bonaventure to MacIntyre 2* (2001) (noting these constitute the most direct “source for our present understanding of conscience”).

making, and settled moral judgments or decisions.”<sup>99</sup> It implies consciousness of first principles like “life is inviolable” or “do no harm.”<sup>100</sup> It is not a mechanical application of rules or principles, but a comprehensive evaluation of the circumstances of an action, based on the totality of one’s intellectual and moral personhood.<sup>101</sup> Conscience represents a process by which a person identifies moral principles, assesses context, and decides whether to do or omit a particular act.<sup>102</sup>

Conscience thus compels action, or the withholding of action.<sup>103</sup> In Catholic and other moral traditions, these judgments of conscience must be obeyed, or the individual will have acted immorally.<sup>104</sup> Although individuals will disagree over fundamental ques-

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<sup>99</sup> Darlene Fozard Weaver, *Conscience: Rightly Formed and Otherwise*, 132 *Commonweal* 10, 11 (2005). Definitions of conscience at the time of the Founding reflect its philosophical basis. See, e.g., Michael W. McConnell, *The Origins and Historical Understanding of Free Exercise of Religion*, 103 *Harv. L. Rev.* 1409, 1493 (1990) (compiling definitions such as Noah Webster’s “natural knowledge, or the faculty that decides on the right or wrong of actions in regard to one’s self,” James Buchanan’s “testimony of one’s own mind,” and Samuel Johnson’s “knowledge or faculty by which we judge of the goodness or wickedness of ourselves”).

<sup>100</sup> Langston, *supra* note 98, at 7 (explaining that the term conscience derives from *conscientia* which has a double meaning of consciousness, meaning awareness, and conscience, connected to the knowledge of what a person should do).

<sup>101</sup> *Id.* at 99–100, 106 (explaining that conscience is connected to moral reasoning, emotional reactions of guilt, and a tendency to strive to do good); Daniel P. Sulmasy, *What Is Conscience and Why Is Respect for It So Important?*, 29 *Theoretical Med. & Bioethics* 135, 138 (2008) (noting that conscience “unifies the cognitive, conative, and emotional aspects of the moral life by a commitment to integrity or moral wholeness”).

<sup>102</sup> Douglas Langston, *Medieval Theories of Conscience*, *Stanford Encyclopedia of Phil.*, July 7, 2011, <http://plato.stanford.edu/entries/conscience-medieval/> (noting the medieval view “regard[ed] human beings as capable of knowing in general what ought to be done and applying this knowledge through conscience to particular decisions about action”).

<sup>103</sup> Thomas Aquinas, *Summa Theologica* 678, pt. I, Question 79, art. 13 (Fathers of the English Dominican Province trans., 1920), available at <http://www.newadvent.org/summa/1079.htm> (“[C]onscience may be resolved into *cum alio scientia*, i.e., knowledge applied to an individual case. But the application of knowledge to something is done by some act. Wherefore from this explanation of the name it is clear that conscience is an act.”); Charles E. Curran, *Conscience in the Light of the Catholic Moral Tradition*, in *Conscience: Readings in Moral Theology* No. 14, at 3, 3 (Charles E. Curran ed., 2004) (“Conscience is generally understood as the judgment about the morality of an act to be done or omitted or already done or omitted by the person.”).

<sup>104</sup> Vatican II, *Dignitatis Humanae* ¶ 3 (1965), available at <http://www.consciencelaws.org/issues-ethical/ethical045.html> (“He is bound to follow this conscience faithfully in all his activity so that he may come to God, who is his last end. Therefore he must not be

tions of right and wrong, each experiences conscience in determining the morality of his or her own actions.

Acting according to conscience has real importance less because it is about being (morally or politically) right than because it is central to being a whole person. Both theory and experience indicate that conscience is closely related to one's moral integrity or sense of self. As Dan Brock argues, conscientious judgments "define who, at least morally speaking, the individual is, what she stands for, what is the central moral core of her character."<sup>105</sup> Prospectively, a person often associates the pangs of conscience with a sense that "the loss of integrity or wholeness" would ensue from acting contrary to one's moral judgment.<sup>106</sup> Retrospectively, failure to follow one's conscience generates regret and guilt.<sup>107</sup>

This concern for the individual's moral integrity has been at the heart of the debates over conscience in medicine. Some have suggested that requiring a physician to violate her conscience would create "a psychological schism that violates the integrity of the person as a unity of body, soul, and psyche."<sup>108</sup> Others have asserted that doctors who object to certain treatments should eschew rele-

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forced to act contrary to his conscience."); see also 1 Hannah Arendt, *The Life of the Mind* 186 (1978) (arguing for the importance of being consistent with oneself, which Socrates epitomizes); Michael G. Baylor, *Action and Person: Conscience in Late Scholasticism and the Young Luther* 254 (1977) (noting that "Luther continued to assert the principle that it is always wrong to act against conscience"); Langston, *supra* note 98, at 27 (noting that medieval philosopher Bonaventure indicates that it is wrong to act against conscience); Thomas E. Hill Jr., *Four Conceptions of Conscience*, in *Integrity and Conscience* 13, 17 (Ian Shapiro & Robert Adams eds., 1998) ("Kant's moral theory holds that each of us must, in the end, treat our own (final) moral judgments as authoritative, even though they are fallible.").

<sup>105</sup> Brock, *supra* note 6, at 189.

<sup>106</sup> James F. Childress, *Conscience and Conscientious Actions in the Context of MCOs*, 7 *Kennedy Inst. of Ethics J.* 403, 404 (1997); see Arendt, *supra* note 104, at 189 (conceptualizing conscience as an inner dialogue that seeks harmony and to act morally); Baylor, *supra* note 104, at 210 (deeming Luther's major contribution to understanding conscience to be judging not only the value of particular actions but also the whole person).

<sup>107</sup> Curran, *supra* note 103, at 18.

<sup>108</sup> Pellegrino, *supra* note 6, at 240; see also Mark R. Wicclair, *Conscientious Objection in Medicine*, 14 *Bioethics* 205, 213 (2000) (arguing that a conscientious objector "is asserting the stronger claim that his or her moral integrity is at stake").

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vant specializations in order to avoid “deep divisions within the self.”<sup>109</sup>

Legal and philosophical defenses of freedom of conscience thus tend to be based on the value of living in accordance with conscience, independent of its content.<sup>110</sup> As a number of scholars have argued, an individual’s moral integrity offers the most compelling moral basis for respecting her conscience.<sup>111</sup> In a liberal pluralistic society, the objective truth or falsity of an individual’s moral commitments cannot form the justification for determining when to accommodate conscience. Instead, “the moral weight of [an individual’s] conscience-based objection can be grounded in the value of moral integrity and self-respect as well as the significant harm associated with self-betrayal and loss of self-respect.”<sup>112</sup>

Even natural law or objectivist accounts of conscience, which purport to determine the truth of moral claims, support freedom of conscience based on moral integrity. According to these traditions, although conscience acts as God’s representative within each indi-

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<sup>109</sup> Jeffrey Blustein & Alan R. Fleischman, *The Pro-Life Maternal-Fetal Medicine Physician: A Problem of Integrity*, 25 *Hastings Ctr. Rep.* 22, 22 (1995).

<sup>110</sup> Martha C. Nussbaum, *Liberty of Conscience: In Defense of America’s Tradition of Religious Equality* 52 (2008) (explaining that Roger Williams, Stoic natural law doctrines, and many Christian sects in the American colonies viewed conscience as something “infinitely precious” possessed equally by all); Martin Benjamin, *Conscience*, in 1 *The Encyclopedia of Bioethics* 513, 514 (Stephen G. Post ed., 3d ed. 2004) (arguing that the consequences to oneself, rather than the objective moral quality of an act, is the central concern of conscience); Christopher L. Eisgruber & Lawrence G. Sager, *The Vulnerability of Conscience: The Constitutional Basis for Protecting Religious Conduct*, 61 *U. Chi. L. Rev.* 1245, 1268 (1994) (“[T]his pull toward rectitude becomes a central, dominating feature of a person’s motivation and self-identity.”); Immanuel Kant, *The Metaphysical Elements of Ethics*, in *The Critique of Pure Reason, the Critique of Practical Reason, and Other Ethical Treatises, The Critique of Judgement* 363, 375 (Encyclopedia Britannica 1952) (1780) (noting that “when a man is conscious of having acted according to his conscience, then, as far as regards guilt or innocence, nothing more can be required of him, only he is bound to enlighten his *understanding* as to what is duty or not”).

<sup>111</sup> See, e.g., Brock, *supra* note 6, at 189; Yossi Nehushtan, *Secular and Religious Conscientious Exemptions: Between Tolerance and Equality*, in *Law and Religion in Theoretical and Historical Context* 243, 245 (Peter Cane et al. eds., 2008) (describing accommodation of a person’s conscience as “always reflect[ing] respect for his autonomy and personhood”); Steven D. Smith, *What Does Religion Have to Do with Freedom of Conscience?*, 76 *U. Colo. L. Rev.* 911, 935 (2005) (asserting that the most plausible rationale for respecting conscience is that it is central to personhood).

<sup>112</sup> *Wicclair*, *supra* note 108, at 214.

vidual and demands obedience as a duty to the divine,<sup>113</sup> it is not infallible. A person may mistake the facts, reason poorly, or adopt the wrong fundamental moral commitments, thereby acting conscientiously but performing an act deemed objectively wrong.<sup>114</sup> In such cases, the natural law tradition suggests she must still act according to her conscience.<sup>115</sup> Respect for an individual's subjective striving to do good—not the objective correctness of her moral convictions—thus forms a justification for protecting her freedom of conscience.<sup>116</sup>

This account requires treating equal claims of conscience alike, regardless of whether we judge them to be morally wrong (within, of course, the limits necessary to a well-ordered society).<sup>117</sup> As Mar-

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<sup>113</sup> Vatican II, *supra* note 104 (“It is through his conscience that man sees and recognizes the demands of the divine law.”); see also Weaver, *supra* note 99, at 12 (“For Aquinas, in apprehending and applying moral principles, human beings participate in the divine law.”).

<sup>114</sup> Sulmasy, *supra* note 101, at 140; see also Curran, *supra* note 103, at 4 (noting that “Catholic tradition gives some primacy to the subjective aspect of conscience over the objective”).

<sup>115</sup> See Thomas Aquinas, *On Conscience: Disputed Question on Truth 17*, in *Thomas Aquinas: Selected Writings 217, 233* (Ralph McInerny ed. & trans., 1998) (“That conscience binds means that when one does not follow it he incurs sin.”); Catechism of the Catholic Church, pt. 3, art. 6, ch. I, ¶ 1778 (1993), available at [http://www.vatican.va/archive/ENG0015/\\_P5Z.HTM](http://www.vatican.va/archive/ENG0015/_P5Z.HTM) (quoting Cardinal John Henry Newman for the proposition that “[c]onscience is the aboriginal Vicar of Christ”); Richard P. McBrien, *Catholicism 973* (1994) (“If . . . after appropriate study, reflection, and prayer, a person is convinced that his or her conscience is correct, in spite of a conflict with the moral teachings of the Church, the person not only may but *must* follow the dictates of conscience rather than the teachings of the Church.”); Brian V. Johnstone, *Conscience and Error*, in *Conscience: Readings in Moral Theology No. 14*, at 163, 166 (Charles E. Curran ed., 2004) (arguing that this teaching on “erroneous conscience was widely accepted by moral theologians in the 19th century and into the present”).

<sup>116</sup> Johnstone, *supra* note 115, at 171 (“Contemporary moral theologians have taught us to look not only at the conformity of acts to the ontological order, but to the goodness (or badness) of persons, which is interpreted in terms of right striving, or ‘striving out of love for the right.’”); Vatican II, *Constitution on the Church in the Modern World* ¶ 17 (1965), *reprinted in* *Conscience: Readings in Moral Theology No. 14*, at 65, 66 (stating that humans’ “dignity . . . requires them to act out of conscious and free choice, as moved and drawn in a personal way from within, and not by their own blind impulses or by external constraint”); Weaver, *supra* note 99, at 12 (noting that Vatican II clarified that “coercing the conscience of another or acting against one’s own conscience violates the person”).

<sup>117</sup> Nussbaum, *supra* note 110, at 2; John Rawls, *A Theory of Justice* 181 (1999); Nehushtan, *supra* note 111, at 263 (noting that the justification for equal toleration of

tha Nussbaum has argued, conscience as “the core of our humanity” serves to render all human beings equal and, as a result, claims of conscience deserve equal respect.<sup>118</sup> In a pluralistic society, individuals recognize the value of maintaining their own moral integrity, and “this gives them in turn a reason to value and respect the moral integrity of others.”<sup>119</sup>

Recognizing the equality of human conscience does not, it should be noted, require exemptions from legislation for all (or any) acts of conscience. A well-ordered society might demand that all persons follow the law or face repercussions, irrespective of individual conscience. The value of conscience could also be outweighed by other considerations, such as the disvalue to the patient or society of protecting conscience. When, however, a particular issue, such as participation in abortion, is deemed sufficiently weighty to allow conscience to trump legal or employment demands, fairness requires extending exemptions equally. Focusing on the content of a conviction rather than the integrity of the individual simply amounts to legislating a particular moral perspective, rather than dedication to freedom of conscience.<sup>120</sup>

Although one might argue that conscience clauses should in fact be considered morals legislation, there is value to understanding the effect of this legislation on the operation of conscience. Other scholarly accounts have presumed existing legislation effectively protects conscience, while potentially threatening patient access to care.<sup>121</sup> This Article shows that, to the contrary, legislation meant to safeguard conscience undercuts it. Legislators genuinely committed to conscience should be troubled by this revelation, even if some of their colleagues have the suppression of contested treatments as their true objective.

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conscience lies in the fact that even though not all claims are judged equally valid, each person has autonomy and dignity).

<sup>118</sup> Nussbaum, *supra* note 110, at 79.

<sup>119</sup> Brock, *supra* note 6, at 189; see also Sulmasy, *supra* note 101, at 145 (“People of conscience owe each other, first and foremost, respect for their consciences.”).

<sup>120</sup> See Nadia N. Sawicki, *The Hollow Promise of Freedom of Conscience*, 33 *Cardozo L. Rev.* 1389, 1448 (2012) (arguing that adopting a “content-based view” of conscience means abandoning the premise that freedom of conscience is a fundamental principle).

<sup>121</sup> See *supra* note 6.

*B. The Willing Provider's Conscience*

As the Supreme Court recognized in *Roe v. Wade*, certain medical decisions—like abortion—inspire “deep and seemingly absolute convictions” among physicians.<sup>122</sup> In these contested areas, one cannot expect unanimity of conviction. This Part argues that just as some nurses and doctors judge contraception, fertility treatments, or palliative care to be morally wrong, so too do others hold deep and seemingly absolute convictions in favor of these treatments. In concrete situations, these providers may judge their participation to be morally required and perform these procedures in good conscience.

Of course, for many providers the decision whether to participate in controversial treatments has little to do with conscience and does not implicate the concern for moral integrity that justifies legislative protection. Even with regard to abortion, most physicians do not refuse as a matter of conscience.<sup>123</sup> Instead, factors like risks to physical safety, inconvenience, controversy, low professional esteem, lack of community support, gaps in medical education, and continuing paternalism contribute to their decisions.<sup>124</sup> At the end of life as well, physicians may overtreat patients due to (mis)perceptions of possible liability.<sup>125</sup> By the same token, some providers may deliver controversial treatments, not out of conscience, but to boost income or reduce malpractice risk.<sup>126</sup>

That said, each provider comes into practice with a set of religious, moral, and ethical convictions—all three of which may in-

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<sup>122</sup> 410 U.S. 113, 116 (1973).

<sup>123</sup> J.M. Westfall et al., *Abortion Attitudes and Practices of Family and General Practice Physicians*, 33 *J. Fam. Prac.* 47, 50 (1991) (finding that only eight percent of U.S. physicians believe abortion is always wrong).

<sup>124</sup> See Carole Joffe, *Dispatches from the Abortion Wars: The Costs of Fanaticism to Doctors, Patients, and the Rest of Us* 17–18 (2009); Dresser, *supra* note 6, at 282, 284.

<sup>125</sup> Stephen Wear et al., *Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment*, 19 *J. Med. & Phil.* 147, 153 (1994) (“Many physicians . . . seem to believe that an active withdrawal involves significantly more *legal* jeopardy than a passive withholding . . .”).

<sup>126</sup> Sonia Mateu Suter, *The Routinization of Prenatal Testing*, 28 *Am. J.L. & Med.* 233, 251–54 (2002) (discussing ways in which the threat of liability contributed to the routinization of prenatal testing); U.S. “Baby Business” (Infertility Services) Worth \$4 Billion, *PRWeb*, Aug. 17, 2009, <http://www.prweb.com/releases/2009/08/prweb2750574.htm> (reporting market research showing the average fertility clinic takes in \$3.2 million in revenue).



form conscience. Medical training, of course, can be expected to guide most actions in the day-to-day routine of a physician. But, from time to time, situations will arise in which a doctor will have to make moral judgments of right and wrong. Sometimes, the dictates of conscience and the requirements of the employer will collide.

Religious beliefs, which statutes and philosophical traditions recognize as a basis for acts of conscience, may be of as fundamental significance to a willing provider as they are to a refuser. For instance, for a religious nurse who determines life is inviolable, conscience might lead him to give condoms to his HIV-positive patients to preserve the lives of others. Religious individuals may see these judgments as a matter not only of individual integrity, but also of personal salvation. As Justice Stevens said in his *Cruzan v. Director, Missouri Department of Health* dissent, in the universe of end-of-life care, “not much may be said with confidence . . . unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.”<sup>127</sup> Some intensive care unit nurses, for instance, invoke religious beliefs in favor of withholding care and indicate that God would not want patients to suffer the way they do.<sup>128</sup> Sometimes, however, religiosity correlates strongly to opposition to a particular procedure, as with assisted suicide.<sup>129</sup>

Religion, however, has no monopoly on conscience, as statutory regimes typically recognize.<sup>130</sup> For instance, abortion-related conscience clauses identify as bases for refusal: “moral or religious

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<sup>127</sup> 497 U.S. 261, 343 (1990) (Stevens, J., dissenting).

<sup>128</sup> David A. Asch et al., *The Limits of Suffering: Critical Care Nurses' Views of Hospital Care at the End of Life*, 45 *Soc. Sci. & Med.* 1661, 1665 (1997); see, e.g., *John F. Kennedy Mem'l Hosp. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984) (describing view of medical technology as “a means of prolonging the dying process rather than a means of continuing life”).

<sup>129</sup> See, e.g., Curlin et al., *supra* note 82, at 112 (finding that high intrinsic religiosity was related to objection to physician-assisted suicide).

<sup>130</sup> The debate among First Amendment scholars as to whether the Constitution's protection of free exercise of religion encompasses freedom of conscience indicates that religion and conscience are not synonymous. Nussbaum, *supra* note 110, at 102 (“[I]t has been a perpetual problem whether conscientious commitments that do not take a religious form receive any protection under the Free Exercise Clause.”); McConnell, *supra* note 99, at 1494–95 (suggesting that the omission of “conscience” from the Constitution might have been a decision to protect a subset of conscience).

grounds”; “ethical, moral, or religious grounds”; “religious or conscientious objections” or “conscience or religious belief”; or “conscientious objections” alone.<sup>131</sup> In other areas, even statutes that appear to limit exercise of conscience to religious claims have been interpreted to protect conscientious beliefs derived from ethical, moral, or religious principles.<sup>132</sup> In the absence of a statute, courts also have occasionally recognized medical ethics as a basis for conscientious refusal at the end of life.<sup>133</sup> Medical providers may conscientiously evaluate the morality of every situation in light of these professional norms and act accordingly.

The sincerity of many willing providers’ beliefs—whether religious, moral, or ethical—is manifest in the heavy burdens they endure in order to follow their consciences. In the context of abortion, providers face threats to their lives and families, targeted and expensive regulations, and professional and community stigma. Many risk their livelihoods. Within facilities that restrict reproductive or end-of-life care, some doctors have lost admitting privileges or been forced to resign.<sup>134</sup> Some subvert institutional protocol to save their patients’ lives.<sup>135</sup> Others reportedly meet patients in the parking lot to dispense emergency contraception,<sup>136</sup> or indicate false

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<sup>131</sup> Wardle, *supra* note 29 (categorizing abortion-related clauses).

<sup>132</sup> For conscientious objection to the draft, the Supreme Court interpreted “religious” to include “moral, ethical, or religious beliefs about what is right and wrong” that are “held with the strength of traditional religious convictions.” *Welsh v. United States*, 398 U.S. 333, 339–40 (1970). Also, the Equal Employment Opportunity Commission (“EEOC”) has adopted this construction of discrimination based on religion for the purpose of Title VII. EEOC Compliance Manual 12-IA1, at 7 (2008), available at <http://www.eeoc.gov/policy/docs/religion.pdf> (“Religious beliefs include theistic beliefs as well as non-theistic ‘moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views.’”).

<sup>133</sup> *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 639 (Mass. 1986) (noting a policy of refusing to withhold a feeding tube based on principles “recognized and accepted within a significant segment of the medical profession and the hospital community”).

<sup>134</sup> As early as 1973, a urologist lost staff privileges at a Catholic hospital, where he had practiced for six years, for refusing to discontinue vasectomies. *Watkins v. Mercy Med. Ctr.*, 364 F. Supp. 799, 800 (D. Idaho 1973). More recently, a Catholic hospital in Illinois asked a doctor who performed abortions outside the facility to step down as chief of the Obstetrics-Gynecology Department. *Eisenstadt*, *supra* note 57, at 136.

<sup>135</sup> *Foster et al.*, *supra* note 84 (reporting doctors’ providing medicine to resolve ectopic pregnancies and offering referrals and information surreptitiously); *Freedman et al.*, *supra* note 1.

<sup>136</sup> *Eisenstadt*, *supra* note 57, at 141.

diagnoses in patient charts in order to perform sterilizations.<sup>137</sup> In facilities that restrict provision of information or referrals for prohibited care (as Catholic institutions do), reports suggest doctors routinely violate policy.<sup>138</sup>

Two objections—one practical, one theoretical—might be made to recognizing the conscience of the willing provider.<sup>139</sup> The first is that a doctor or nurse who wants to provide prohibited services should simply work elsewhere.<sup>140</sup> This argument, however, is equally valid (or invalid) for refusing providers, who could equally seek out a refusing employer. Moreover, there are a number of reasons why doctors and nurses may be unable to change employment or affiliation. First, they may be under multi-year contracts at the time the conflict arises.<sup>141</sup> With regard to residencies, in particular, if the institution later imposes restrictions, the resident will be required to stay on for the remainder of the contract. Second, in many areas of the country, a limited number of hospitals exist. By necessity, a provider practicing in the area may be affiliated with a particular hospital.<sup>142</sup> Third, consolidation of healthcare means fewer choices for providers. Many managed care organizations enter

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<sup>137</sup> Nat'l Health Law Program, *supra* note 84, at 18.

<sup>138</sup> Stulberg et al., *supra* note 2; see also Eisenstadt, *supra* note 57, at 140–41 (following the purchase of hospital by Catholic health system, one physician insisted that “I will give a patient all of her medical options and allow her to make her own decision”); Women’s Law Ctr., *Below the Radar: Health Care Providers’ Religious Refusals Can Endanger Pregnant Women’s Lives and Health* 8, Jan. 2011, available at <http://www.nwlc.org/sites/default/files/pdfs/nwlcbelowtheradar2011.pdf> (“Dr. Y, practicing in a Catholic-affiliated hospital in California, said she often takes patients aside and reviews all of their treatment options . . . She reported that other physicians at the hospital offer referrals and information ‘under the radar’ as well.”).

<sup>139</sup> Relatedly, one might argue that willing and refusing institutions face different burdens in accommodating diverging individual conscience such that we might recognize the willing provider’s conscience but not accommodate it. For a rebuttal of this argument, see notes 196–206 and accompanying text.

<sup>140</sup> Stabile, *supra* note 55; see also Richard T. De George, *The Moral Responsibility of the Hospital*, 7 *J. Med. & Phil.* 87, 98 (1982) (arguing that if providers in a refusing hospital “think it is immoral not to perform abortions in certain cases, and they feel morally impelled to perform them in those cases, then they should not accept employment in such hospitals”).

<sup>141</sup> This is likely when, as has been reported, refusing employers tell doctors that there will be no interference in their treatment of patients despite contracts with religious restrictions. Physicians for Reprod. Choice and Health, *Mergers and You: The Physicians’ Guide to Religious Hospital Mergers* 4–5 (2001).

<sup>142</sup> Many Catholic hospitals function as “sole community providers,” providing the only hospital care in the community. Ikemoto, *supra* note 5, at 1102–03.

into exclusive contracts with hospitals or require doctors to secure admitting privileges at a particular hospital (irrespective of moral limitations).<sup>143</sup> Omitting Catholic healthcare alone, to say nothing of all other refusing institutions, would mean giving up association with four of the ten largest health systems.<sup>144</sup>

The second objection claims that a moral distinction exists between being compelled to perform and being compelled to refrain from an action.<sup>145</sup> As the argument goes, legislators should be most concerned that doctors not be forced to perform procedures that violate their deepest convictions. Compelling doctors to refrain from treatments they are called to do by conscience, by contrast, may be tolerated.

However, the distinction between acts and omissions is insufficient to explain moral responsibility in the medical field, even if the theory were generally to hold.<sup>146</sup> A doctor who omits to perform CPR at a patient's request has committed no wrong. A doctor, however, who unilaterally omits to deliver CPR to a patient will be considered morally (and legally) responsible. Moreover, whether medical treatments involve acts or omissions is often difficult to discern. An oft-cited example involves stopping a respirator at a patient's request: "Does the physician omit continuing the treatment or act to disconnect it?"<sup>147</sup> Withholding or removing artificial

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<sup>143</sup> Bassett, *supra* note 54, at 458–59, 469–71.

<sup>144</sup> Stulberg et al., *supra* note 4, at 73.

<sup>145</sup> Sulmasy, *supra* note 101, at 147 (“[S]ubstantially greater moral justification should be required to compel someone to perform an action in the name of tolerance than should be required to compel someone to refrain from an action in the name of tolerance.”).

<sup>146</sup> For a general critique, see Frances Howard-Snyder, *Doing vs. Allowing Harm*, *Stanford Encyclopedia of Philosophy*, Dec. 20, 2007, <http://plato.stanford.edu/entries/doing-allowing/> (discussing philosophical theories that distinguish doing from allowing harm and concluding that “there is no decisive reason to say that any of these distinctions is morally significant” and these intuitions lie in “other morally significant distinctions (distinctions concerning intentions, difficulty or ease of avoiding the harm, etc.)”); see also *Archie v. City of Racine*, 847 F.2d 1211, 1213 (7th Cir. 1988) (en banc) (“[I]t is possible to restate most actions as corresponding inactions with the same effect, and to show that inaction may have the same effects as a forbidden action.”).

<sup>147</sup> President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* 66 (1983).

nutrition similarly may be described as either *omitting* feeding or *actively* starving a patient.<sup>148</sup>

Moral responsibility here is instead a function of the duties of medical providers. Role-specific obligations of beneficence and nonmaleficence explicitly recognize that providers stand in a special relationship to patients and may harm them through their omissions.<sup>149</sup> Consequently, a nurse who does not counsel a young woman planning to undergo chemotherapy about options to preserve future fertility is equally morally responsible, whether she is considered to actively do harm or simply allow harm.

Because of these duties, medical providers themselves may not distinguish between being compelled to refrain and being compelled to perform treatments. For instance, literature on nursing defines moral distress with reference to being required to refrain, that is, as “aris[ing] when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.”<sup>150</sup> As Mark Wicclair argues, “[o]ne’s moral integrity can be damaged by either performing an action that is contrary to one’s core ethical beliefs or by failing to perform an action that is required by those beliefs.”<sup>151</sup> Take, for example, the case of a pregnant woman who is miscarrying with no chance of fetal viability and will die if left untreated. A refusing doctor might claim that he cannot be forced to perform an abortion and must wait for the fetal heartbeat to stop. A willing provider, by contrast, might claim that he cannot be compelled to let the woman suffer and risk death. Both providers agree on the sanctity of life, and the effects

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<sup>148</sup> See *Quill v. Vacco*, 80 F.3d 716, 729 (2d Cir. 1996), rev’d, 521 U.S. 793 (1997) (rejecting act-omission distinction between assisting suicide and withholding treatment).

<sup>149</sup> John Coggon, *On Acts, Omissions and Responsibility*, 34 *J. Med. Ethics* 576, 577 (2008).

<sup>150</sup> Andrew Jameton, *Nursing Practice: The Ethical Issues* 6 (1984). Empirical studies of moral distress commonly document end-of-life treatments that could be described as either actions or omissions (including overtreating a patient, keeping hopelessly ill people attached to respirators, and inadequately medicating pain). Mary C. Corley et al., *Nurse Moral Distress and Ethical Work Environment*, 12 *Nursing Ethics* 381, 382 (2005); Ellen H. Elpern et al., *Moral Distress of Staff Nurses in a Medical Intensive Care Unit*, 14 *Am. J. Critical Care* 523, 526 (2005).

<sup>151</sup> Mark R. Wicclair, *Negative and Positive Claims of Conscience*, 18 *Cambridge Q. Healthcare Ethics* 14, 16 (2009).

on conscience are the same, irrespective of the act-omission status of the conscientious belief.<sup>152</sup>

Even if we were to set aside the flaws in the act-omission theory, it still fails to explain the law's asymmetrical treatment of the willing and refusing provider. Existing legislation does *not* draw any such fundamental distinction between acts and omissions, as end-of-life care makes plain. Consider a terminally ill patient who has indicated he wishes not to receive life support. In this situation, a supposedly refusing provider would seek to "act," to impose life-sustaining treatment. The willing provider, by contrast, believes honoring the patient's decision is morally required and seeks to "omit" life support.<sup>153</sup> In this case, the usual roles are reversed. The *refusing* provider would be required by institutional policy to *refrain* from delivering treatment she believes is required; and the *willing* provider would be compelled to *perform* a procedure she believes is prohibited.<sup>154</sup>

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<sup>152</sup> As this example shows, any distinction between a morally prohibited act and a morally permitted act does not make the call of conscience any less absolute or sincere for a willing provider. With regard to abortion, prohibition and permissiveness are likely the appropriate characterization; certainly, no doctor believes he must provide all abortions, whereas a doctor might believe that she may not provide any abortion. However, providers may experience an equally absolute commitment to deliver information and referral about abortion, to provide abortions for one's own patients instead of abandoning them, or to perform abortions in emergencies or situations of hardship to the patient. And commitment to delivering other procedures may manifest as equally absolute for the willing provider (that is, as a moral prohibition on withholding emergency contraception from women or denying patients their wishes for end-of-life care).

<sup>153</sup> It should be noted that nurses and physicians report violating their consciences in much greater percentages in overtreating patients. Allan S. Brett, Problems in Caring for Critically and Terminally Ill Patients: Perspectives of Physicians and Nurses, 14 HEC Forum 132, 140 (2002) (fifty-five percent of providers compared to twelve percent); Mildred Z. Solomon et al., Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments, 83 Am. J. Pub. Health 14, 16 (1993) (four times as many concerned about overtreatment than undertreatment); Mildred Z. Solomon et al., New and Lingering Controversies in Pediatric End-of-Life Care, 116 Pediatrics 872, 877 (2005) (finding physicians were ten times as worried and nurses more than twenty times as worried about overtreatment than undertreatment).

<sup>154</sup> This argument also holds true for withdrawal of life support. See, e.g., Gray v. Romeo, 697 F. Supp. 580, 588 n.4 (D.R.I. 1988) ("No analytical difference exists between withholding and withdrawing medical treatment."); Bartling v. Superior Court, 209 Cal. Rptr. 220, 226 n.8 (Cal. App. Dep't Super. Ct. 1984) (describing order to allow defendant to exercise his right to remove a respirator as "restrain[ing] staff and hospital] from interfering with" patient's decision).

Accordingly, the distinction between being compelled to refrain from an act and being forced to perform an act seems not to justify the baselines drawn by current statutes. That this distinction may be legally irrelevant can be seen in constitutional free exercise jurisprudence, which does not differentiate between laws that require individuals to do acts they believe morally or religiously prohibited (working on the Sabbath<sup>155</sup>) and laws that require individuals to refrain from what they believe is required (engaging in ritual animal sacrifice<sup>156</sup>).

As we have seen, legislative frameworks do not acknowledge willing providers' consciences. Instead, they exacerbate conflicts by recognizing institutional conscience for refusing health facilities. The next Section examines whether permitting institutional policies to trump individual conscience only in refusing institutions is theoretically defensible.

### *C. The Curious Case of Institutional Conscience*

Understanding how individual conscience works is relatively straightforward; we can identify the bearers of conscience, the manner in which it is expressed, and (generally speaking) its bases. Institutional conscience poses greater difficulties for legal and moral argumentation. Corporations are creatures of law without the capacity to feel, reason, or act without mediating agents.<sup>157</sup> Although healthcare businesses are typically designed for “moral ends . . . such as rendering charitable service, relieving suffering, . . . curing the sick, or saving life,”<sup>158</sup> most focus primarily on generating revenue in order to survive (or profit). They lack distinctly human characteristics—such as the capacities to discern right from wrong, to be conscious of specific circumstances in mak-

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In fact, many disagreements over morality in medicine regard differing treatment plans, rather than actions and omissions. Such disagreements arise with regard to restrictions on ectopic pregnancies (calling for a surgical versus a medical method), emergency contraception, and palliative care.

<sup>155</sup> *Frazer v. Ill. Dep't of Emp. Sec.*, 489 U.S. 829, 832 (1989).

<sup>156</sup> *Church of the Lukumi Babalu Aye v. City of Hialeah*, 508 U.S. 520, 531 (1993).

<sup>157</sup> Corporations do not enjoy all of the rights of natural persons, and courts have struggled to distinguish protections for corporations. See, e.g., *FCC v. AT&T*, 131 S. Ct. 1177 (2011) (holding that corporations do not have a right of personal privacy for purposes of the Freedom of Information Act).

<sup>158</sup> Wardle, *supra* note 29, at 185.

ing moral judgments, and to comport one's acts to context—that seem to be required to exercise conscience. Indeed, various secular and theological traditions share the position that conscience is intimately connected to human nature.<sup>159</sup>

This Section explores the theoretical underpinnings and weaknesses of institutional conscience. First, it argues that despite legislative and scholarly acceptance, the concept of conscience is a poor fit for healthcare facilities. Second, it contends that the most compelling theoretical argument—which suggests that the societal value captured by “institutional conscience” is allowing moral association in healthcare—is belied by the reality of modern medicine. Third, the theoretical justifications for protecting institutional interests do not support extant legislation's privileging of refusing institutions.

### *1. Conscience as a Theoretically Poor Fit for Corporations*

Although the academy has generally overlooked institutional conscience, a handful of scholars writing in the Catholic tradition have suggested that it merits respect on an equal basis with individual conscience.<sup>160</sup> They present two possible conceptions of institutional conscience. Neither, however, arrives at postulating the equivalent of human conscience.

The first view of institutional conscience (the “mission-operation” theory) maintains that a healthcare corporation has moral agency, and its mission statement and operational structure

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<sup>159</sup> Immanuel Kant, *The Metaphysics of Morals* 189 (Mary Gregor ed., 1996) (1797) (“Every human being has a conscience.”); Smith, *supra* note 111 (arguing that conscience is “central to human personhood”); Weaver, *supra* note 99, at 11–12 (“Conscience is a capacity for moral knowledge that belongs to human nature.”).

<sup>160</sup> See generally Thomas A. Nairn, *Institutional Conscience Revisited: Catholic Institutions and Christian Ethics*, *New Theology Rev.*, May 2001, at 39; Edmund D. Pellegrino, *The Ethics of Collective Judgments in Medicine and Health Care*, 7 *J. Med. & Phil.* 3 (1982); Sulmasy, *supra* note 101; Kevin W. Wildes, *Institutional Identity, Integrity, and Conscience*, 7 *Kennedy Inst. Ethics J.* 413, 416–17 (1997). Contra George J. Annas, *At Law: Transferring the Ethical Hot Potato*, 17 *Hastings Center Rep.* 20, 21 (1987) (“Hospitals are corporations that have no natural personhood, and hence are incapable of having either ‘moral’ or ‘ethical objections’ to actions.”). Although developing a theoretical argument for or against corporate conscience is outside the scope of this Article, it merits further consideration by philosophers and legal scholars alike.



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represent its conscience.<sup>161</sup> This approach situates moral agency in the fact that healthcare facilities have an identity larger than their constituent parts and an ability to carry out acts and affect individual lives.<sup>162</sup> Beth Israel Hospital remains Beth Israel Hospital, even when a shift changes or its administrators are replaced; as such, it can be held legally (and perhaps morally) responsible for its actions.<sup>163</sup> The overarching moral identity or conscience of the institution is then expressed through its mission statement and ongoing processes (such as budgeting, strategic planning, and continuing education).<sup>164</sup> Under this mission-operation theory, by harmonizing its decisions with the mission statement, an institution makes moral judgments and strives to maintain its integrity like a human being.<sup>165</sup>

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<sup>161</sup> This theory is related to debates among business ethics scholars over the moral responsibility (or agency) of corporations. See, e.g., Rogene A. Buchholz & Sandra B. Rosenthal, *Integrating Ethics All the Way Through: The Issue of Moral Agency Reconsidered*, 66 *J. Bus. Ethics* 233, 234–35 (2006) (summarizing debates); Geoff Moore, *Corporate Moral Agency: Review and Implications*, 21 *J. Bus. Ethics* 329, 331–32 (1999) (same). It is important to note, however, that business ethics discussions treat corporate social responsibility and the propriety of integrating ethics into business. They thus focus largely on whether corporations can be held morally responsible (rather than on whether corporations are morally entitled to legislative exemptions).

<sup>162</sup> Proponents of corporate moral responsibility also define moral agency in terms of corporate decisionmaking structures. Buchholz & Rosenthal, *supra* note 161, at 237 (“While the corporation is certainly not a moral person, it may, however, be a moral agent, as corporations do act through a some kind of a decisionmaking procedure and these decisions have impacts on people.”); Peter A. French, *Collective Responsibility and the Practice of Medicine*, 7 *J. Med. & Phil.* 65, 69 (1982) (noting the importance of intentionality and decisionmaking structures to corporate moral agency); Kenneth E. Goodpaster & John B. Mathews, Jr., *Can a Corporation Have a Conscience?*, *Harv. Bus. Rev.*, Jan.–Feb. 1982, at 132, 134–35 (defining moral agency to require rationality and awareness of effect of one’s decisions on others); Michael D. Smith, *The Virtuous Organization*, 7 *J. Med. & Phil.* 35, 37–38 (1982) (focusing on capability of deciding and acting). The corporation’s decisions acquire a moral character in that they affect human beings. See, e.g., Richard T. De George, *The Moral Responsibility of the Hospital*, 7 *J. Med. & Phil.* 87, 87 (1982) (defining moral agency as established when hospitals act rationally, choose between alternatives, and affect human beings).

<sup>163</sup> French, *supra* note 162, at 74–75.

<sup>164</sup> Wildes, *supra* note 160; see also Pellegrino, *supra* note 6, at 235 (“The ethical ‘code’ or commitment of a specific institution is now customarily expressed in its mission statement. This is in a way the ‘conscience’ of the institution.”).

<sup>165</sup> Ana Smith Iltis, *Institutional Integrity in Roman Catholic Health Care Institutions*, 7 *Christian Bioethics* 95, 98–102 (2001); Kevin W. Wildes, *Institutional Integrity: Approval, Toleration and Holy War or “Always True to You in My Fashion,”* 16 *J. Med. & Phil.* 211, 214–15 (1991).

While few conscience clauses define institutional conscience, several do adopt this approach. For a healthcare entity to have a recognized “conscience,” the reason for refusal must be referenced in its ethical policies<sup>166</sup> or “existing or proposed religious, moral or ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations or other relevant documents.”<sup>167</sup> Even in the absence of legislation, hospitals have asserted this position in litigation. In *Brophy v. New England Sinai Hospital*, for instance, the court credited the importance of a hospital’s ethical policies and described requiring feeding tube removal as an “unnecessary intrusion upon the hospital’s ethical integrity.”<sup>168</sup>

This mission-operation theory emphasizes the value of allowing an institution to create and maintain institution-wide norms that give it a distinct identity. The theory further appreciates that institutions may provide a mechanism for reinforcement of individual norms. For instance, a weak-willed provider of a particular religious moral viewpoint might seek out an institution with that religion’s policies in order to bind himself to the mast.<sup>169</sup>

This theory, however, falls far short of establishing conscience. First, it ignores the dependence of the institution on individual human beings. Because the institution lacks consciousness and agency, individuals must necessarily interpret and apply any rules or principles to specific situations (potentially exercising individual conscience). Adoption of the mission statement, strategic planning, and budgeting takes place through the action of individuals. Second, the mission-operation theory is too rigid and formalistic to establish corporate conscience as analogous to individual con-

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<sup>166</sup> Ky. Rev. Stat. Ann. § 311.800 (LexisNexis 2011); see also N.J. Stat. Ann. § 26:2H-65 (West 2007) (noting institutional “policies and practices”); N.M. Stat. Ann. § 24-7A-7 (West 2011) (noting a “policy of the health-care institution that is expressly based on reasons of conscience”).

<sup>167</sup> Miss. Code Ann. § 41-107-3(h) (2009); see also 745 Ill. Comp. Stat. 70/11 (2010) (“[A]s documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other governing documents . . .”).

<sup>168</sup> 497 N.E.2d 626, 639 (Mass. 1986); see also *Delio v. Westchester Cnty. Med. Ctr.*, 516 N.Y.S.2d 677, 693 (N.Y. App. Div. 1987).

<sup>169</sup> Thanks to Professor Anthony O’Rourke for this point.

science.<sup>170</sup> Moral judgment is more nuanced than the application of rules without reference to context.<sup>171</sup>

Finally, this approach suggests institutional norms can be determinative in every situation. Mission statements, however, are typically abstract and aspirational. As we know, people often agree on broad principles but do not apply them contextually in the same way. For instance, in *Cruzan v. Missouri Department of Public Health*,<sup>172</sup> American Catholic bishops took opposing views on whether, under the circumstances, withdrawing artificial nutrition from a patient in a persistent vegetative state was a moral option.<sup>173</sup> Even when more detailed rules are in place, disagreements will occur over their meaning. For example, in one widely reported incident in Phoenix, Arizona, a Catholic hospital's ethics committee determined that a life-saving abortion was morally required and the bishop subsequently disagreed.<sup>174</sup>

Whereas the first approach considers the mission to reflect conscience, the second approach to institutional conscience (which will be referred to as the "moral-collective" theory) contends that although a corporation cannot be said to have a conscience as humans do, it nonetheless represents a means by which individuals come together to express their collective moral judgments.<sup>175</sup> Indi-

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<sup>170</sup> Many business ethics and philosophy scholars who argue in favor of corporate moral agency indicate that moral personhood, inherent to human beings, must be distinguished from the limited moral agency of a corporation. Peter A. French, *Corporate Ethics* 10 (1995) (admitting his initial use of the term "person" may have confused the issue); Rita C. Manning, *Corporate Responsibility and Corporate Personhood*, 3 *J. Bus. Ethics* 77, 77 (1984) (arguing that the concept of personhood is beyond what we can attribute to corporations); David T. Ozar, *Do Corporations Have Moral Rights?*, 4 *J. Bus. Ethics* 277, 279–80 (1985) (arguing corporations lack moral rights).

<sup>171</sup> See supra notes 99–104 and accompanying text.

<sup>172</sup> 497 U.S. 261 (1990).

<sup>173</sup> Sandra Johnson, *The Catholic Bishops, the Law, and Nutrition and Hydration: An Historical Footnote*, 19 *Annals Health L.* 97, 99–100 (2010).

<sup>174</sup> Daniel Burke, *Phoenix Controversy Highlights Rift Between Catholic Hospitals and Church Leadership*, *Huffington Post*, Dec. 23, 2010, [http://www.huffingtonpost.com/2010/12/23/abortion-debate-opens-rif\\_n\\_800494.html](http://www.huffingtonpost.com/2010/12/23/abortion-debate-opens-rif_n_800494.html).

<sup>175</sup> Robert K. Vischer, *Conscience and the Common Good: Reclaiming the Space Between Person and State* 179 (2009) ("[T]he corporation serves as a venue and vehicle for the sharing of conscience-driven claims."). This tracks another perspective in the corporate moral responsibility debate. See, e.g., M.G. Velazquez, *Why Corporations Are Not Morally Responsible for Anything They Do*, in *Contemporary Issues in Business Ethics* 114, 114–15 (J.R. Des Jardins & J.J. McCall eds., 1983) (arguing that

viduals, as the argument goes, recognize that their moral convictions can be best furthered through group action, and so they form partnerships, limited liability companies, and corporate structures accordingly. Organizations then “become vehicles for individuals to realize their own values and identities.”<sup>176</sup> Proponents of this view argue that legislation should protect institutional conscience in order to respect “the conscience and morality of the individuals whose will and purposes the entities were created to effectuate.”<sup>177</sup>

By its own admission, the moral-collective theory fails to describe institutional conscience *per se*. First, it ascribes conscience to a group of people, not an institution. The institution itself does not have a conscience, but rather functions as a means by which various individuals express their moral convictions. Second, the theory does not describe conscience as such. By focusing on the collective, it neglects that conscience regards not simply shared moral values or religious affiliation, but rather how each individual presents herself to the world. It assumes that individuals who agree on universal rules can perfectly predict their individual moral judgments in advance for every possible situation. But, as we know, principles like “life is inviolable” are often insufficiently determinate to dictate agreement on particular situations. Indeed, even affiliation with the same religion has been shown not to significantly reduce conflicts between physicians and religious health facilities over patient care.<sup>178</sup>

Despite its theoretical flaws, the moral-collective theory may usefully describe the value society means to capture through the shorthand of “institutional conscience.” Legislative recognition of institutional conscience might then serve to ensure individuals can live out their conception of the good life in community with others,

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organizational goals are goals for at least some participating individuals and that individuals should be held accountable).

<sup>176</sup> Suzanne Davis & Paul Lansing, *When Two Fundamental Rights Collide at the Pharmacy: The Struggle to Balance the Consumer's Right to Access Contraception and the Pharmacist's Right of Conscience*, 12 *DePaul J. Health Care L.* 67, 100 (2009); see also Steven H. Miles et al., *Conflicts Between Patients' Wishes to Forgo Treatment and the Policies of Health Care Facilities*, 321 *New Eng. J. Med.* 48, 49 (1989) (arguing that the courts should not compel institutions to violate moral standards held by individuals within the institution).

<sup>177</sup> Wardle, *supra* note 29, at 186.

<sup>178</sup> Stulberg et al., *supra* note 2, at 728.

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disassociate themselves from acts or individuals of whom they disapprove, and agree on institutional norms that reinforce their own convictions.

## *2. Mismatch Between Theory and the Reality of Modern Healthcare*

The modern healthcare system, which is characterized by corporate consolidation and moral pluralism, does not reflect a theoretical vision that values individuals associating with one another based on shared convictions. The notion that an institutional position represents the collective morality, which is central to the moral-collective theory, swiftly falls apart as organizations become larger and less cohesive.

The moral-collective theory does, however, have the advantage of accurately describing some subset of healthcare businesses. For instance, an individual doctor may seek to hire a nurse committed to treat patients according to his moral vision for the practice; in this most straightforward case, the individual and institutional conscience are one and the same. At a step removed, a group of family members who hold moral convictions in common might seek to exclude from the practice those who disagree. Another step down the road, several doctors might partner based on their religious ideals. Within these tight-knit groups of individuals, the moral-collective theory prioritizes the collective over the dissenting individual. The underlying concern is preventing one individual from defeating the ability of the whole to live out its shared vision of a moral life.

Large and less-cohesive entities, however, do not represent associations based on moral convictions. Corporations, as conglomerate entities, exist indefinitely and independently of changes in their founders or the individuals who act as administrators or employees.<sup>179</sup> Those associated with them come together for reasons other than shared moral positions. Hospitals, for instance, encompass hundreds, if not thousands, of employees and affiliates. Working conditions, pay, and convenience, among other things, likely figure into decisions to work within a particular hospital. One cannot assume the individuals are all united in their moral convictions and that institutional policy reflects each of them. Indeed, as one recent nationally representative survey of ob-gyns concluded, physicians

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<sup>179</sup> French, *supra* note 162, at 72–75.

“working in religious hospitals are themselves religiously diverse,” and those identifying as Roman Catholic are no more likely to work in a Catholic hospital.<sup>180</sup>

Recognizing institutional conscience for large healthcare institutions departs radically from a theory based on collective moral convictions. In a pluralistic society and healthcare system, allowing certain individuals to live out their moral beliefs through these institutions comes at the cost of imposing those individuals’ moral beliefs on others (be they patients or colleagues). Within hospitals, each board member, administrator, medical staff member, and employee may vie for institutional decisions that reflect his or her ethical, moral, or religious views.<sup>181</sup> Allowing any one of these groups to represent the “conscience” of the institution raises thorny questions about whose moral convictions count.

One of two broad categories of persons could be the relevant group. The first includes nurses and doctors who deliver care.<sup>182</sup> The second encompasses those responsible for founding and running the corporate structure: the trustees, the administrator(s), the founders, or the shareholders.<sup>183</sup> Actors outside the facility, such as the healthcare system or corporate owner, might also be considered. For religious hospitals, the religious organization or order with which they are affiliated could be added.

Privileging founders and administrators makes practical sense with regard to big-picture business decisions about facility-wide priorities, percentage of charitable care, and staffing policies. However, it is much less clear why the moral beliefs of administrators (or founders) are the relevant consideration in the care of individual patients. The remoteness of administrators from patient care should caution against allowing their moral values to override the

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<sup>180</sup> Stulberg et al., *supra* note 4, at 10.

<sup>181</sup> Boozang, *supra* note 54, at 1505.

<sup>182</sup> At least one court has expressed the view that the medical staff should be included in making ethical decisions. In *re Requena*, 517 A.2d 886, 892 (N.J. Super. Ct. Ch. Div. 1986) (“A process for making specific ethical decisions which does not even take into account the views of the treating physicians directly involved with the individual patient whose care is under consideration is even more seriously flawed.”).

<sup>183</sup> Pellegrino, *supra* note 160, at 4 (arguing that a hospital board of trustees “ratifies and implements these policies through its administrators and they share responsibility for the moral quality of hospital decisions”).

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conscientious judgments of individual doctors and nurses in particular situations.

Furthermore, hospitals are not characterized by the hierarchical structure that dominates most employing institutions. Traditionally (and still today in some states), the corporate practice of medicine doctrine barred any institutional control of medical decisions. Instead, “hospital boards are expected to, and do, simply ‘rubber stamp’ medical staff recommendations.”<sup>184</sup> The division in authority between administration and medicine is reflected in licensure laws and private accreditation laws and in health insurance which pays hospitals separately from physicians.<sup>185</sup>

For-profit and public institutions also present particular difficulties for a vision of institutional conscience as a moral collective. Within for-profit businesses, even though moral convictions might come into play, the profit motive (in some cases, an obligation to maximize shareholder wealth) must drive decisionmaking.<sup>186</sup> With regard to public facilities, one might expect commitment to provide all legal, medically necessary treatment to be the public conscience.<sup>187</sup> But, because institutional conscience is undefined in law and theory, administrators of public hospitals may insist on refusal. In *Conservatorship of Morrison v. Abramovice*, for instance, the director of a public hospital asserted personal moral grounds against removing the patient’s feeding tube.<sup>188</sup>

In sum, at a certain juncture, “institutional conscience” no longer recognizes coming together based on shared values. It becomes merely a way to impose moral convictions on others and thwart the individual exercise of conscience. At that point, it protects societal interests neither in conscience nor in moral association.

### *3. No Theoretical Support for Favoring Refusing Institutions*

Even if we were to accept the theoretical justifications for protecting institutional conscience, the distinction that legislation

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<sup>184</sup> Health Care Law and Ethics 1265 (Mark A. Hall et al. eds., 2007).

<sup>185</sup> Id. at 17–18.

<sup>186</sup> Colin P. Marks, Jiminy Cricket for the Corporation: Understanding the Corporate “Conscience,” 42 Val. U. L. Rev. 1129, 1148 (2008).

<sup>187</sup> Wardle, *supra* note 29, at 186 n.47.

<sup>188</sup> 253 Cal. Rptr. 530, 531 (Cal. Ct. App. 1988).

draws between refusing and willing institutions cannot be supported. To the extent existing legislation seeks to promote either mission adherence or moral collectives, it misses the mark. No principle explains why a refusing employer may impose its moral norms on staff, but a willing institution must accommodate individual providers' refusing consciences with which it disagrees.<sup>189</sup>

Under the mission-operation theory, expression of corporate identity through institutional norms does not distinguish refusing institutions. All hospitals assert the delivery of healthcare as their central moral imperative; few specify restrictions on care as a matter of mission. Within both willing and refusing hospitals, ethics committees or administrators further define their approach to healthcare delivery through bylaws, guidelines, and institutional norms.<sup>190</sup> Through these processes, willing as much as refusing institutions maintain a particular identity.

Similarly, under the moral-collective theory, if institutions have a conscience by virtue of the individuals who make it up, it would seem reasonable to expect all similar institutions to have consciences sufficient to trump countervailing individual claims. Yet conscience legislation protects only the right of individuals to unite in their opposition to providing particular controversial treatments.

Take one example of a willing provider that meets both the mission-operation and moral-collective theories of institutional conscience. Planned Parenthood of New York City expresses its mission and core values in what look to be moral terms: "every individual deserves equal access to the entire range of quality, science-based sexual and reproductive health care services," and "every woman deserves to be treated as a morally capable decision maker entitled to make her own sexual and reproductive deci-

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<sup>189</sup> The dichotomy is clear in a common statutory text, which states that "[a] hospital is not required to admit any patient for the purpose of performing an abortion" and that "any employee of a hospital, doctor, clinic or other medical or surgical facility in which an abortion has been authorized . . . is not required to facilitate or participate" in an abortion. Ariz. Rev. Stat. Ann. § 36-2154(A) (2011). Recall that most conscience clauses disallow willing institutions from taking refusal into consideration in hiring, firing, and promotion.

<sup>190</sup> Clark, *supra* note 54, at 634–35 (noting that in Catholic hospitals, restrictions typically appear in these documents).



sions.”<sup>191</sup> The doctors, nurses, and administrators within the institution share these core values and join together to provide medical care in accordance with its norms. Yet its institutional conscience goes unrecognized by law.

Contrary to what one might think, religion does not dictate the difference.<sup>192</sup> Although Catholic healthcare is the paradigmatic case of the refusing institution, many faiths regard tending to the sick as part of their mission. Several limit nontherapeutic abortions or end-of-life care,<sup>193</sup> but others express no such restrictions. The mission statements and affiliations with religious organizations of healthcare facilities willing to provide some array of controversial procedures are often indistinguishable from those of Catholic institutions.<sup>194</sup> Yet conscience clauses assume these religious hospitals, nursing homes, and clinics do not qualify for institutional conscience. The legislation provides no guarantee they can fire or decline to hire employees or associates who disagree with their religious convictions in favor of care.<sup>195</sup>

What is more, almost all conscience clauses recognize institutional conscience for refusing *secular* institutions. Individual employers or practice groups qualify as having conscience, irrespective of their relationship to any formal religious teachings or structures. One study of nursing homes in New York City, for ex-

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<sup>191</sup> Planned Parenthood, Mission and Values of Planned Parenthood of New York City, <http://www.plannedparenthood.org/nyc/mission-values-14915.htm> (last visited June 5, 2012).

<sup>192</sup> Some legislation is limited to sectarian providers, but still distinguishes between refusing and willing facilities. Given meaningful disagreements within the same faith, it is difficult to imagine religions explaining the distinction drawn by legislation. Elliott N. Dorf, *End-of-Life: Jewish Perspective*, 366 *Lancet* 862, 863 (2005) (discussing conflicting positions within Judaism over end-of-life care).

<sup>193</sup> Cohen, *supra* note 54, at 8.

<sup>194</sup> Compare Episcopal Health Services, <http://www.ehs.org/> (last visited June 5, 2012) (noting commitment to quality healthcare and patient safety “overseen by the Bishop of Long Island and guided by the teachings and traditions of the Episcopal Church”), with St. Francis Care, [http://www.stfranciscare.org/About\\_Us/Our\\_Mission\\_and\\_Core\\_Values.aspx](http://www.stfranciscare.org/About_Us/Our_Mission_and_Core_Values.aspx) (last visited June 5, 2012) (noting commitment “to health and healing through excellence, compassionate care and reverence for the spirituality of each person” under the authority of the Catholic Archdiocese of Hartford, Connecticut).

<sup>195</sup> It is not clear whether 42 U.S.C. § 2000e-1 (2006), which allows religious organizations to give employment preference to members of their own religion, provides recourse against the enforcement of conscience clauses for facilities that qualify as religious organizations.

ample, found thirty-five of the fifty-four nursing homes that claimed conscientious objection to withholding or withdrawing life-sustaining treatment lacked any official religious affiliation.<sup>196</sup>

Ironically, in most jurisdictions, the same facility—religious or not—may alternate between refusing and willing. For example, a clinic that only refuses to provide nontherapeutic abortions typically will have to accommodate a doctor who will not participate in therapeutic abortions, sterilizations, or contraceptive care. The plain language of the broadest clauses seems to suggest that an individual provider could become a Christian Scientist, insist on prescribing prayer to all patients, and be owed accommodation, whether he works in a refusing or willing, religious or secular institution.<sup>197</sup> In essence, the clauses create a trump card for the most refusing refuser.

One might argue that privileging refusing institutions is nonetheless justified because they would suffer greater harm if individuals perform treatments to which they object. According to this argument, accommodation of a willing doctor would degrade norms that the institution carefully developed and fostered, even to the point of destroying its identity as a refusing institution. Under this account, the refusing institution experiences an ontological harm, analogous to the integrity of the individual. Accommodation also in effect requires the institution to subsidize financially an individual with whom it disagrees, making operating rooms, support staff, and instruments available.

This argument, however, does not consider that a willing facility suffers the same type of harm. Its dedication to delivering all necessary care or honoring patient autonomy is damaged by the refuser who does neither. Like a refusing institution, a willing facility

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<sup>196</sup> Cynthia K. Hosay, Compliance with Patients' End-of-Life Wishes by Nursing Homes in New York City with Conscience Policies, 44 *Omega: J. Death & Dying* 57, 69 (2002).

<sup>197</sup> Mississippi's conscience clause, a version of which has been proposed in more than fifteen states, protects "any individual who may be asked to participate in any way in a health-care service" from discrimination for declining to participate in a health care service, defined as "any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health-care providers or health-care institutions." Miss. Code Ann. §§ 41-107-3, 41-107-5 (2009).

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must subsidize an opposing viewpoint, in this case the refusal of care to patients who need it. Accommodation of the refusing provider imposes more significant financial burdens, such as alternate (or duplicate) staffing.

The distinction also falls apart when we consider other types of institutions. An individual or small group practice that refuses to inform patients about contraceptives may experience harm (in the form of forced association) if required to retain an associate who, in good conscience, delivers this information. Any harm, however, will be no greater than that suffered by the provider committed to reproductive freedom who must accommodate a colleague who refuses to deliver contraceptive information.

One might plausibly claim, however, that within some subset of institutions, a willing facility more easily can adapt to the presence of dissenting individuals while accomplishing its institutional goals. According to this argument, a willing hospital can both maintain its identity and redistribute staff to ensure no medical provider participates in any treatment to which he or she conscientiously objects. In practice, hospitals generally seem able to reasonably accommodate some number of refusing staff under the Title VII undue hardship standard.<sup>198</sup> By contrast, a hospital that has a policy prohibiting sterilization cannot allow a sterilization to be performed without suffering harm.

Although at the margins it may be easier for a willing hospital to accommodate refusal while providing care, the distinction does not hold up as a general principle. First, refusing hospitals similarly can distance themselves from individual providers or procedures. Courts have recognized this by sometimes ordering refusing hospitals to allow doctors without objections or from outside the facility to remove feeding tubes in compliance with patients' wishes.<sup>199</sup> Faced with hospital mergers and state laws requiring provision of emergency contraception, refusing healthcare systems also have often worked out compromises, allowing the establishment of sepa-

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<sup>198</sup> For a selection of Title VII and other cases, see *supra* note 36.

<sup>199</sup> See, e.g., *Elbaum by Elbaum v. Grace Plaza of Great Neck*, 544 N.Y.S.2d 840, 848 (App. Div. 1989).

rate facilities to provide prohibited care or the entry of outsiders to deliver information and treatment.<sup>200</sup>

Second, many moral disagreements are about proper treatment, rather than absolute prohibition. For instance, when a woman presents with an ectopic pregnancy, a Catholic hospital may require a doctor to run unnecessary tests (such as an ultrasound for a fetal heartbeat) and perform a surgical procedure that leaves her infertile.<sup>201</sup> In a willing hospital, the doctor would be obliged to act immediately and would use nonsurgical methotrexate, if medically indicated. The same analysis holds true with regard to managing miscarriages and providing emergency contraception to rape victims. The harm suffered in each institution is the failure of a dissenting staff person to follow institutional procedure, resulting in a treatment viewed as wrong by the institution.

As the analysis suggests, the evaluation of harm cannot take place without taking the patient into consideration. Refusal risks harm to patients in ways that conscientious commitment does not. In *Shelton v. University of Medicine and Dentistry of New Jersey*, for example, a Pentecostal nurse on the labor and delivery staff refused to assist in an emergency cesarean-section of an eighteen-weeks-pregnant woman “standing in a pool of blood,” causing a thirty-minute delay of emergency surgery.<sup>202</sup> The willing institution, of course, has a duty to mitigate the harm and, under the Title VII undue hardship standard, may reasonably be able to accommodate some number of refusers.<sup>203</sup> Nonetheless, the presence of any refuser risks delays, the traumatizing of patients, and bodily harm.<sup>204</sup> The absolute accommodation required by some state conscience clauses may lead to greater risk of patient injury. Pennsylvania law seems to acknowledge this, allowing facilities that provide abortion

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<sup>200</sup> Merger Watch, Working with the Community: Hospital Merger Compromises that Protect Patients 2–3, Dec. 2005, [http://www.mergerwatch.org/storage/pdf-files/ch\\_compromises.pdf](http://www.mergerwatch.org/storage/pdf-files/ch_compromises.pdf) (documenting an array of compromises adopted to ensure continuity of services); see also Lynch, *supra* note 27, at 107 (observing that “distance to the objectionable act is morally relevant”).

<sup>201</sup> Foster, *supra* note 84, at 106 (reporting one doctor believed that her hospital’s policies actually resulted in several cases of tubal rupture).

<sup>202</sup> 223 F.3d 220, 223 (3d Cir. 2000).

<sup>203</sup> See *supra* notes 34–36 and accompanying text.

<sup>204</sup> Jill Morrison & Micole Allekotte, Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious or Ethical Reasons, 9 *Ave Maria L. Rev.* 141, 160–61 (2010).

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or sterilization to apply for an exemption from anti-discrimination provisions when too many staff members refuse to participate in the procedures.<sup>205</sup>

At an extreme, a willing institution forced to accommodate refusing providers loses not only its identity as offering all necessary care, but its very identity as a healthcare facility. The central moral imperative of caring for patients cedes to the facilitation of moral expression.<sup>206</sup> By contrast, even if forced to perform sterilizations, the refusing hospital retains its substantive character; it remains a hospital.

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Ignoring the willing provider and privileging the refusing institution are opposite sides of the same coin. Each alone generates asymmetries in the treatment of willing and refusing individuals and of willing and refusing institutions. Each lacks a strong theoretical foundation to justify the disparate treatment of refusing and willing providers.

The next Part introduces a new way to balance the inherent tension between legislative protection of institutional conscience and societal respect for individual conscience.

### III. A BETTER BALANCE BETWEEN INDIVIDUAL CONSCIENCE AND INSTITUTIONAL NORMS

The problem of morality in medicine is anything but straightforward. Difficult issues of provider conscience and patient autonomy challenge both scholars and lawmakers. Community access to care, medical ethics, free exercise of religion, and discrimination against women all come into the analysis. By bringing the willing provider into the discussion, this Article has added further complications. It has unearthed a tension that inheres in the individual-institution relationship and likely precludes a solution that treats individual and institutional conscience as equal to one another.

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<sup>205</sup> 16 Pa. Code § 51.51 (2000).

<sup>206</sup> Smith, *supra* note 162, at 37–41 (arguing that a hospital's morally significant idiosyncratic goal (the goal without which it could no longer be understood to exist) is the provision of healthcare).

Nonetheless, legislators must seek to draw lines between claims of conscience in a coherent and impartial way. That is not to say that legislation should exempt all conscientious positions. Nor that it must accommodate any act of conscience at all. Rather, given the equal moral integrity of each individual, to the extent we exempt conscience for particular procedures or against countervailing institutional claims we should do so equally. Any solution should be evaluated according to its effects on conscience and also—fundamentally—on patients’ rights and access to medical care.

With that in mind, this Part introduces a new framework—based on the cohesion, message, and size of a healthcare facility—to help decide whether institutional interest or individual conscience wins out. Section III.A begins by considering and ultimately rejecting as unworkable the absolutist alternatives proposed by other scholars. Section III.B develops an approach that differentiates between small, cohesive institutions and large, pluralistic entities. It argues that this rule has the potential to better balance conscience, moral association, and patient care.

### *A. Evaluating the Absolutist Alternatives*

Three alternatives have been proposed to address the problem of morality in medicine. The first prioritizes institutional conscience, stripping away protection for individual doctors and nurses. The second takes the opposite approach and favors individual conscience over institutional policies. The third refrains from enacting conscience legislation at all and, instead, requires institutions and individuals to exercise their consciences within the boundaries of medical ethics, generally applicable law, and competent medical practice. Unfortunately, as this Section shows, each falls short—indicating the need for a new approach.

#### *1. An Institutional Trump Card*

This first proposal would allow the institutional position to trump individual claims of conscience in all instances. It envisions a “moral marketplace” in which there are a wide variety of medical

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institutions and strong moral convictions.<sup>207</sup> Employees and consumers then vote with their feet (and their dollars), embracing or rejecting a business's moral norms.<sup>208</sup>

In essence, this model acts as a broad institutional conscience clause and shifts our societal priorities from the protection of conscience to respect for institutional norms. Healthcare facilities of any size (from individual practices to large hospitals) could dictate positions on care, information, or referral for any moral reason and hire and fire associates based on their adherence to corporate policy. Within this model, "the exercise of employees' own consciences is fettered by the boundaries of institutional conscience,"<sup>209</sup> and corporations can exclude "certain segments of society in order to construct a chosen identity."<sup>210</sup>

Under ideal conditions, this moral marketplace might have some traction. Each person would work to maximize adherence to his or her moral convictions, and the market would present unlimited options for medical care. A patient would accurately anticipate future medical needs and select a physician, fully informed of limitations on care. Employees would be able to find employers that share their moral positions, and perfectly predict their moral judgments when faced with different medical situations. Although moral positions at the margins might be unable to secure a sufficient market share to survive, the state could either intervene or tolerate a small number of people being underserved.<sup>211</sup>

In actuality, the obstacles to this approach are virtually insurmountable. First, it presumes that patients and employees want to choose medical providers or employers based on moral conviction; and, for that matter, that doctors and nurses recognize or are eager to disclose their most deeply held beliefs to patients, associates, and employers. Such moral matching would radically shake up our

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<sup>207</sup> See generally Vischer, *supra* note 175; Thomas W. Dunfee, *The Marketplace of Morality: First Steps Toward a Theory of Moral Choice*, 8 *Bus. Ethics Q.* 127 (1998).

<sup>208</sup> Robert K. Vischer, *Conscience in Context: Pharmacist Rights and the Eroding Moral Marketplace*, 17 *Stan. L. & Pol'y Rev.* 83, 86, 93 (2006).

<sup>209</sup> Vischer, *supra* note 175, at 195.

<sup>210</sup> Vischer, *supra* note 208, at 115 (limiting only if exclusion would deprive an individual of "a key path by which to access political participation or economic opportunity").

<sup>211</sup> *Id.* at 112–13.

current system of healthcare organization.<sup>212</sup> Second, it runs counter to intuitions that individual claims of conscience are morally superior to those of institutional structures. Even scholars defending broad conscience protections generally take the position that, as a first principle, “society should be more concerned for the conscientious objections of individuals than of facilities, which lack a moral being and consequently cannot suffer metaphysical consequences for their choices.”<sup>213</sup>

In our pluralistic society, this is often the way the law approaches issues of conviction, for example allowing individuals, but rarely institutions, to discriminate.<sup>214</sup> In end-of-life care cases, courts also tend to give greater weight to individual conscience. They are more likely to order medical facilities, which can bring in outside providers, to accede to patients’ wishes, than to demand the same from individual providers.<sup>215</sup> Americans tend to agree with this approach: in a poll of American women, seventy-nine percent opposed legislation allowing hospitals to refuse to deliver treatments for religious or moral reasons.<sup>216</sup>

Third, this approach cannot account for market failures. Any market theory must deal with the unequal distribution of resources across society. When purchasing decisions constitute the primary means of imposing and expressing moral convictions, that the

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<sup>212</sup> Stulberg et al., *supra* note 4, at 10 (concluding that ob-gyns associated with religiously affiliated facilities are themselves religiously diverse and that Catholic ob-gyns are no more likely to practice in Catholic institutions than other ob-gyns).

<sup>213</sup> Wilson, *supra* note 54, at 61; see also Lynch, *supra* note 27, at 107 (contending “it is better for an institution like a hospital or pharmacy to have to violate its conscience”).

<sup>214</sup> See Michael A. Rie, *Defining the Limits of Institutional Moral Agency in Health Care: A Response to Kevin Wildes*, 16 *J. Med. & Phil.* 221, 223 (1991).

<sup>215</sup> See, e.g., *Gray v. Romeo*, 697 F. Supp. 580, 591 (D.R.I. 1988) (requiring hospital to accede to the patient’s refusal of feeding tube if the patient could not be “promptly transferred to a health care facility that will respect her wishes”); *In re Jobes*, 529 A.2d 434, 450 (N.J. 1987) (requiring nursing home to remove feeding tube despite moral objections); *Grace Plaza of Great Neck v. Elbaum*, 588 N.Y.S.2d 853, 858–59 (App. Div. 1992) (refusing to force an individual to render treatment contrary to his conscience, but ordering the institution to arrange transfer or permit a willing doctor to treat patient). But see *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 298–99 (App. Dep’t Super. Ct. 1986) (requiring medical staff to remove feeding tube in accordance with patient’s wishes).

<sup>216</sup> Nancy Belden et al., *Reproductive Health and Access to Services: A National Survey of Women 15* (2000), available at <http://www.catholicsforchoice.org/topics/healthcare/documents/2000religionreproductivehealthandaccesstoservices.pdf>.



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wealthy will have a disproportionate say seems unfair. In some areas, wealthy consumers opposed to a particular procedure, even if in the minority, may have sufficient market power to block access for those who seek it.<sup>217</sup>

Healthcare in particular is not a well-functioning market. High barriers to entry limit the number of market competitors. Doctors and nurses benefit from years of training, state investment in education, and stringent licensing regimes.<sup>218</sup> These barriers to entry (and the presence of monopolies or duopolies in numerous markets) are only more extreme with regard to institutions, especially hospitals.<sup>219</sup> Although in some communities an adequate number of individual providers could exist for moral matching, in any market only a small number of hospitals are economically feasible. Moral views will inevitably outnumber hospitals.<sup>220</sup>

Patients also have imperfect knowledge of institutional moral positions and medical options, inhibiting rational choice. For instance, although some elderly people seek out nursing homes affiliated with their faith,<sup>221</sup> they and their families are often ignorant of institutional restrictions on care.<sup>222</sup> Devout Catholics express surprise and apprehension upon learning that Catholic facilities

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<sup>217</sup> Vischer, *supra* note 208, at 112–13.

<sup>218</sup> *Id.* at 114.

<sup>219</sup> To enter the market in most states, hospitals must secure a certificate of need through a process that aims to expand access to healthcare and minimize unnecessary spending. Pamela C. Smith & Dana A. Forgione, *The Development of Certificate of Need Legislation*, 36 *J. Health Care Fin.* 35, 37 (2009); see also Laura Ungar & Patrick Howington, *University Hospital Merger Stirs End-of-Life Care Fears*, *Courier-Journal*, Jul. 23, 2011, <http://www.courier-journal.com/article/20110723/BUSINESS/307240044/University-Hospital-merger-stirs-end-life-care-fears> (reporting that Catholic healthcare takeover of three hospitals, including a public hospital, would mean that indigent patients who can only receive care in the public hospital would have no access to unrestricted care).

<sup>220</sup> Ikemoto, *supra* note 5, at 1102–03 (“Of the forty-six Catholic sole community providers, only two are located in counties where Catholics constitute a majority of the population.”).

<sup>221</sup> Miles et al., *supra* note 176.

<sup>222</sup> See, e.g., *Gray v. Romeo*, 697 F. Supp. 580, 590–91 (D.R.I. 1988) (noting that nursing home did not notify patient’s family of its policy of refusal to remove feeding tubes until they requested removal); *In re Jobes*, 529 A.2d 434, 450 (N.J. 1987) (same). Patients and their families often do not realize that withdrawal of treatment is an option, even when they are simply awaiting death. Wear et al., *supra* note 125, at 151.

might not follow their advance directives.<sup>223</sup> Of women polled about what services are prohibited in Catholic hospitals, a plurality (forty-five percent) thought Catholic hospitals would provide all reproductive healthcare services; another twenty-three percent said they did not know whether they could access all services.<sup>224</sup> Reports indicate that even doctors sometimes do not associate limitations on care with moral restrictions.<sup>225</sup>

Moreover, limitations on patient choice are pervasive, largely as a result of healthcare financing. Managed care organizations, for example, typically require members to seek treatment from designated institutions or doctors; they may further oblige all doctors to be affiliated with a specific institution, limiting diversity of moral views.<sup>226</sup> One study found that forty-two percent of Americans with employer-sponsored insurance had no choice of plan.<sup>227</sup> Individuals covered by Medicaid, in particular, find a limited number of providers willing to accept them as patients. In some states, they are automatically enrolled in religiously affiliated managed care plans.<sup>228</sup> Choices are also constrained in emergencies because an ambulance will transport patients to the closest hospital regardless of correspondence between moral views.

Finally, the moral marketplace approach risks resegregating medical practice. A return to the parochialism that once characterized American medicine would force patients to “regard with suspicion professionals who do not share their particular religion,

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<sup>223</sup> See, e.g., Judith Graham, *Directive Says Food and Water Must Be Given to Patients in Persistent Vegetative State*, *Chi. Trib.*, Feb. 9, 2010, [http://articles.chicagotribune.com/2010-02-09/news/1002080254\\_1\\_vegetative-state-bishops-church-teachings](http://articles.chicagotribune.com/2010-02-09/news/1002080254_1_vegetative-state-bishops-church-teachings) (reporting reactions of several devout Catholics).

<sup>224</sup> Belden et al., *supra* note 216, at 13.

<sup>225</sup> Angel M. Foster et al., *Ibis Reproductive Health, Assessing Hospital Policies & Practices Regarding Ectopic Pregnancy & Miscarriage Management* 19 (2010), available at <http://www.ibisreproductivehealth.org/news/documents/Summaryofqualitativestudy.pdf> (reporting doctors' failure to link unavailability of the preferred treatment for ectopic pregnancies to religious policies).

<sup>226</sup> Bassett, *supra* note 54, at 458–59 (“The issue of hospital provider choice is central to the balance of patient rights and organizational imperatives where religiously affiliated hospitals enter into participatory contractual arrangements with general service HMOs as medical service providers.”).

<sup>227</sup> Alain C. Enthoven & Sara J. Singer, *Unrealistic Expectations Born of Defective Institutions*, 24 *J. Health Pol. Pol’y & L.* 931, 934 (1999).

<sup>228</sup> Morrison & Allekotte, *supra* note 204, at 157.

race, ethnicity, gender, politics, life style, or sexual orientation.”<sup>229</sup> This would negate one of modern medicine’s biggest moral achievements, the commitment to a pluralistic system in which providers offer their services on equal terms to all patients.<sup>230</sup>

## *2. An End to Institutional Conscience*

One could take the opposite approach and limit conscience protection to individual providers. Legislation then would prohibit institutions from refusing treatment for moral or religious reasons. Doctors and nurses would be free to follow their consciences, with each institution acting as “the facilitator of all consciences.”<sup>231</sup>

Taking this tack would make clear the primacy of individual conscience and better ensure patient care. It would resolve the tension between refusing institutions and the doctors and nurses who work there that has been the subject of much of this Article. It also would ensure institutions—of all sizes—meet accepted medical standards, such that patients could expect to receive diagnoses, referrals, and treatments they need in any relevant facility.

This approach has the additional virtue of manageability. Institutions can better bear the administrative costs of increasing patient access and managing staff with different moral views. Indeed, the law demands just that from willing institutions. As Pennsylvania recognizes by statute, with an obligation to accommodate refusing providers it becomes “imperative that the institutions obtain the services of responsible physicians and other necessary personnel whose personal views on abortion do not prohibit them from providing or participating in abortions or sterilizations.”<sup>232</sup> In the context of pharmacists’ objections to filling prescriptions for contraception as well, models exist for placing the burden of patient access on the institution.<sup>233</sup> For example, a California regulation re-

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<sup>229</sup> Baker, *supra* note 53, at iii.

<sup>230</sup> *Id.* at ii.

<sup>231</sup> Lynch, *supra* note 27, at 101.

<sup>232</sup> 16 Pa. Code § 51.51(a) (2000).

<sup>233</sup> Lynch, *supra* note 27, at 101 (noting the “relative success in other instances of moral conflict where there are readily available institutions on which to place the burden of ensuring patient access”).

quires pharmacies to accept and fill prescriptions, but allows accommodation of individual pharmacists' objections.<sup>234</sup>

Nonetheless, categorical denial of institutional conscience may undervalue moral associations. Lynn Wardle, for example, argues that "to deny protection to health care institutions contradicts the central purpose of conscience clauses, which is to protect the moral sensibilities and deeply-held beliefs of the individuals who make up the institution."<sup>235</sup> This proposal effectively prevents those facilities that actually bring together people based on shared convictions from forming associations and excluding dissenters. These smaller, tight-knit entities would face real hardships if required to accommodate individual conscience absolutely or to hire additional staff to deliver services to which its existing staff object.<sup>236</sup>

Ending institutional conscience also creates the possibility that some facilities will retreat from medical care. Refusing religious facilities, in particular, would face three choices: remove limitations on care, close, or become secular. Because this proposal would apply to all healthcare facilities of any size, it would defeat the ability of individuals to unite, even in small practices based on religious or moral beliefs. Religious individuals with private practices, for example, might go out of business in order to avoid joining with those with whom they disagree. Nursing homes that provide religiously restricted care largely to co-adherents might be barred from continuing to do so. As a whole, the American public might have fewer options and less nonprofit care.<sup>237</sup>

### *3. Getting Out of the Conscience Clause Game*

Finally, one could do away with legal protection for conscience altogether. Medical providers choose to enter into a profession, accept its ethics, and enjoy a state-sanctioned monopoly, which comes with specific obligations to the public. According to this argument, legal and ethical requirements consequently should apply to these professionals irrespective of their religious or moral be-

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<sup>234</sup> Cal. Bus. & Prof. Code § 733(b)(3) (West 2010).

<sup>235</sup> Wardle, *supra* note 29, at 186.

<sup>236</sup> For this reason, some legislation exempts small employers. Wilson, *supra* note 54, at 61–62 (arguing in favor of exceptions for small pharmacies because of the difficulty of staffing around moral objections).

<sup>237</sup> Bassett, *supra* note 54, at 536; Pellegrino, *supra* note 6, at 238.

liefs. All hospitals, clinics, and individual providers should live up to acceptable standards of medical practice. Patients should receive healthcare and information in a uniform way across institutions and practitioners.

This proposal takes two forms: the first reverts to the ethical compromise of referral and information; the second, less moderate form requires providers to perform all procedures associated with their specialties. According to the first approach, medical ethical rules already strike a reasonable balance between individual conscience and patient care. Providers may refuse to participate in treatments for moral reasons, but must inform patients of treatment options and refer for care.<sup>238</sup> They also may not abandon a patient already under their care, in an emergency or otherwise.<sup>239</sup> Failure to live up to these rules should risk tort liability, professional discipline, or termination of employment or admitting privileges.<sup>240</sup> Similarly, each facility should be required to abide by statutory regimes for emergency care, ensuring even contested procedures are delivered in emergencies. Facilities receiving Medicare should also comply with conditions on participation requiring them to disclose all treatment options and meet acceptable standards of practice.<sup>241</sup>

Nonetheless, this approach does not resolve the question of what happens when individual conscience and institutional norms diverge (within the bounds of the ethical compromise). It also leaves some uncertainty about patient access to medical care. In remote areas, patients may be unable to reach an institution or individual willing to provide care, even when they do receive referrals and information. Legal, necessary care could become unavailable.

A more aggressive approach would avoid this problem by abandoning the ethical compromise and requiring each physician to provide the services associated with his or her specialty.<sup>242</sup> An ob-

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<sup>238</sup> Law, *supra* note 6, at 303–06.

<sup>239</sup> See *supra* notes 18–19 and accompanying text.

<sup>240</sup> See, e.g., *Thomas v. Abdul-Malak*, No. 02-CV-1374 (W.D. Pa. July 29, 2004) (holding physician liable for failure to ensure informed consent by not disclosing dangerous situation to pregnant woman).

<sup>241</sup> For Medicare conditions of participation, see *supra* note 18.

<sup>242</sup> Blustein & Fleischman, *supra* note 109, at 25; Cantor, *supra* note 54. Some commentators argue that a doctor unwilling to provide medical services is unsuited to the profession. See Rosamund Rhodes, *The Professional Responsibilities of Medicine*, *in*

gyn, for example, would not be able to opt out of sterilizations, abortions, or contraceptive services. Individual providers could then adapt by choosing specialties that involve no treatments to which they object. Arguably this approach would extend to health-care institutions, requiring each to provide the care one would expect from the particular type of facility, increasing patient access to healthcare. Community health centers would prescribe contraception; nursing homes would honor patients' wishes about care.

Paradoxically, if put into practice, this proposal might reduce patient access to medical services at least in the short term. The pressure to specialize could aggravate the shortage of primary care physicians.<sup>243</sup> Older nurses and doctors might retire rather than switch specialties or provide treatments to which they object.<sup>244</sup> Given the rapid pace of medical advances, providers with no objections to current procedures might face future demands with which they could not in good conscience comply. Conscience, moreover, is not static, and communities could lose experienced providers if no means exist to accommodate changed beliefs.

Furthermore, both variations of this solution fail to solve the individual-institution conflict. In the absence of legislative involvement, these discussions would devolve to the professional and accrediting bodies. Because these groups are separate and fragmented, coordinating one approach to deal with conflicts would be extremely difficult. Instead, one could expect hospital organizations to assert standards that protect the interests of hospitals, physicians' groups to pursue their self-interest, and so on. Physicians, nurses, and institutions would still experience tensions over the morality of particular practices, but no process would be in place to resolve them.

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The Blackwell Guide to Medical Ethics 71, 84–85 (Rosamond Rhodes et al. eds., 2007); see also Savulescu, *supra* note 54. The practical effect of this view would be similar to requiring performance of specialty-specific procedures.

<sup>243</sup> American Academy of Family Physicians, *More Residency Slots Needed to Curb Worsening Physician Shortages* 1 (2010), available at <http://www.aafp.org/online/en/home/publications/news/news-now/professional-issues/201020aamcwrkfrcupdt.html> (predicting shortage of 45,000 primary care physicians within a decade).

<sup>244</sup> In 2010, nearly half of practicing physicians were fifty-five or older. Alan Portner, *Half of U.S. Docs Reach Age 65 by 2020*, D.C. Pub. Pol'y Examiner, Mar. 8, 2010, at 2, available at <http://www.examiner.com/public-policy-in-washington-dc/half-of-u-s-docs-reach-age-65-by-2020-less-doctors-more-patients-projected>.

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Ultimately, however, this approach is not viable. Freedom of conscience is, and will likely remain, an important value in American society. Any workable solution cannot reject it out of hand.

*B. A Framework for Identifying Moral Associations and Protecting Patients*

In contrast to absolutist positions, this Section proposes a more nuanced approach to determining whether institutional interest or individual conscience wins out. First, it sets forth a framework that considers the size of the institution, how cohesive it is, and whether it is focused around expressing a message on the relevant issue to decide whether an institution embodies an interest in moral association that supersedes the interest in individual conscience. Although this framework has some limitations, it provides a theoretically coherent rule that treats willing and refusing providers and their institutions alike. Second, this Section recommends that conscience legislation be limited to nondiscrimination, resolving the individual-institution conflict while leaving in place legal and ethical standards that protect patients. Together, these reforms would improve the balance between conscience, moral association, and patient care.

*1. Cohesion, Size, and Message Central to Moral Associations*

To identify whether a particular healthcare institution reflects the value of moral association, the proposed framework looks to three connected factors: cohesion, size, and message. Each factor is rooted in the strongest theoretical arguments in favor of institutional conscience. Together, they indicate the strength of the associational interest, that is, whether providers, patients, and administrators are closely united or have only attenuated attachments to one another. They also demonstrate the importance of morality to the association, considering whether a commitment to a moral viewpoint is central and shared. Although this multi-variable test is more complex than a bright-line rule such as size alone, it has a

solid foundation in our legal system, tracking some of the criteria related to freedom of association.<sup>245</sup>

The first factor, cohesion, helps answer the question: are people affiliated with the institution actually associating with one another based on moral values? This may be reflected in the selectivity of “membership” in the institution and the importance of moral factors to selection of staff, co-workers, and partners. In cohesive institutions, one could expect to see administrators, medical providers, and patients sharing similar values and conflicting seldom, if at all, over significant moral issues.

The second factor, size, is closely related to cohesion. As we have seen, small practice groups and individual employers are more likely to have strong interests in moral associations, whereas large institutions are typically pluralistic by nature. Differentiating based on size mirrors federal and state anti-discrimination laws,<sup>246</sup> which recognize that smaller businesses may reflect more intimate relationships and experience greater burdens if required to accommodate employees and to litigate employment claims.<sup>247</sup> By contrast, large entities can manage staff in a way that delivers comprehensive care while respecting individual exercise of conscience for both willing and refusing providers.

The final factor, message, refers to the visibility and centrality of the moral position to the institution. For most healthcare enterprises, the principal message of the institution is simply the provi-

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<sup>245</sup> *Roberts v. U.S. Jaycees*, 468 U.S. 609, 620 (1984) (“[F]actors that may be relevant include size, purpose, policies, selectivity, congeniality, and other characteristics that in a particular case may be pertinent.”). That is not to say that some healthcare facilities have constitutionally protected interests in freedom of expressive association. Indeed, although the Supreme Court’s jurisprudence in this area is murky, the Court has distinguished commercial activity, like provision of healthcare, from expressive association. *Id.* (noting that “a large business enterprise . . . seems remote from the concerns giving rise to this constitutional protection”).

<sup>246</sup> 29 U.S.C. § 630(b) (2009) (twenty employees); *id.* § 2611(4)(A)(i) (fifty employees); 42 U.S.C. § 2000e(b) (2000) (fifteen employees); *id.* § 12111(5)(A) (2009) (same); see also Jarod S. Gonzalez, *State Antidiscrimination Statutes and Implied Preemption of Common Law Torts: Valuing the Common Law*, 59 S.C. L. Rev. 115, 119 n.18 (2007) (listing state anti-discrimination acts with numerical thresholds).

<sup>247</sup> See *Gottling v. P.R. Inc.*, 61 P.3d 989, 995 (Utah 2002) (“Congress included the small business exception in Title VII to protect the intimate relationships associated with small employers . . .”); Howard M. Wasserman, *Jurisdiction and Merits*, 83 Wash. L. Rev. 643, 690 (2005) (noting concern for “businesses less able to bear the costs of compliance with new federal obligations”).



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sion of medical care. Others, however, may clearly convey a message in a way that is pivotal to their mission. For example, an Orthodox Jewish nursing home may hold itself out as catering to the end-of-life care of Orthodox elderly in accordance with their religious tenets and within a community of co-adherents. An AIDS hospice devoted to gay rights similarly may make clear the moral mission of the institution, drawing patients and practitioners who share its perspective. The message of the institution is represented as fundamental to the work and clearly communicated to prospective patients, employees, and the public at large.

Distinguishing between institutions based on their cohesion, size, and messaging has the advantage of a strong theoretical foundation. It equally protects the ability of a reproductive rights clinic to exclude employees who refuse to deliver contraceptives and of a natural family planning clinic to reject employees who disagree with its methods.<sup>248</sup> It acknowledges that demanding accommodation of countervailing employee conscience is especially likely to impinge on associational interests of these smaller, cohesive, and dedicated groups. In the most extreme case, such as the solo abortion provider who hires a nurse who then refuses to participate in abortions, accommodation disallows any possibility of moral association.

Considering these three factors makes clear that the theory of moral association is a poor fit for large, pluralistic healthcare facilities. Hospitals are the classic example of pluralism in medicine, bringing together employees and affiliates of all moral convictions. They offer services to the entire community and patients come to them to receive the full array of treatment, not to indicate their adherence to moral positions. They are large, in terms of the number of both patients served and staff affiliated with them. The primary message hospitals send is that they are open to and can be relied on by the public for medical care. Patients are rarely aware that religious restrictions may be imposed on treatments.<sup>249</sup> Indeed, the very structure of the hospital undermines its ability to maintain cohesion and messaging. Both law and practice have institutionalized a structure that preserves the independence of the medical staff

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<sup>248</sup> Vischer, *supra* note 175, at 177.

<sup>249</sup> See *supra* notes 221–25 and accompanying text.

from administrators in making medical decisions.”<sup>250</sup> As George Annas says, “hospitals don’t practice medicine, physicians do.”<sup>251</sup>

In sum, under this framework, small, cohesive institutions with clear messages would receive protection of the interest in moral association. At the other extreme, large business entities like hospitals, which are pluralistic by their nature, would be excluded from legislative protection. For other types of institutions—such as nursing homes, hospices, clinics, or ambulatory surgery centers—decisions about including or excluding them would turn on whether they are sufficiently cohesive and devoted to a message so as to supersede the interest in individual conscience.

Although this framework does not perfectly maximize liberty, it may generate the best balance. An individual could join in a cohesive practice group to express shared moral convictions and bar others, while finding his individual conscience accommodated in a hospital setting. In return, he would accept limitations on his freedom. Within the hospital, he must associate with people espousing a variety of positions; in his small group of like-minded providers, he may face expulsion if his conscience calls for violating the institutional norms.

Public policy concerns also support excluding large, pluralistic entities from legislative protection. Hospitals are central to patient care in two ways that set them apart from smaller institutions. First, they deal with emergencies, in which patients’ interests are at their apex.<sup>252</sup> More acute hardships befall a patient whose care is denied or delayed in emergencies, such as rape, ectopic pregnancies, or health-threatening conditions during pregnancy. Greater suffering ensues when patients’ wishes are ignored, as when life-sustaining measures are applied in violation of advance directives. Although some commentators suggest transferring patients, transfer only leads to delays and increases risks for the patient.

Second, in many parts of the country, an alternative hospital is not easily accessible. A refusing hospital may enjoy a de facto monopoly. For example, in 1990, the only hospital in Alaska to allow abortions changed its policy, rendering abortion inaccessible for

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<sup>250</sup> Mark Hall et al., *Health Care Law and Ethics* 155 (3d ed. 2011).

<sup>251</sup> Annas, *supra* note 160.

<sup>252</sup> Although not all hospitals have emergency rooms, this point applies to most community hospitals.

women who needed an abortion in the second trimester because, for instance, they had a medical condition like diabetes, which makes carrying a pregnancy to term dangerous.<sup>253</sup>

Although notice might mitigate some patient harm caused by refusal,<sup>254</sup> the differential impact of disclosure suggests an additional reason to distinguish hospitals (and possibly other institutions) from small, cohesive private practice groups. In a hospital, it seems implausible to expect patients to take action based on disclosure posted on the hospital wall. Even if notices are distributed as part of the intake process, patients and their families are unlikely to register their import.<sup>255</sup> By contrast, notice might be an important tool for individual doctors or practice groups. For instance, disclosure at the point of first contact (before the patient schedules an appointment or comes to the office) could inform a patient's choice.

Courts have sometimes acknowledged these key differences. In *Doe v. Bridgeton Hospital Ass'n*, for example, New Jersey's supreme court determined that the state's conscience clause could not extend to private, nonsectarian hospitals because the hospitals were quasi-public institutions with obligations to serve the public.<sup>256</sup> Alaska's conscience clause was similarly construed to prohibit a nonsectarian hospital from restricting the availability of abortions.<sup>257</sup> Reasons for treating private, nonprofit hospitals as quasi-

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<sup>253</sup> *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 965 (Alaska 1997) (only excepting fetal conditions "incompatible with life," life-threatening conditions, rape, or incest).

<sup>254</sup> Some conscience clauses require notice to be posted. See, e.g., Cal. Health & Safety Code § 123420(c) (West 2006). A number of end-of-life conscience clauses require that restrictive policies be "timely communicated to the patient or to a person then authorized to make health care decisions," although they do not define "timely" and assume the person will already be a patient. See, e.g., Alaska Stat. § 13.52.060(e) (2009).

<sup>255</sup> Anna Maria Cugliari & Tracy E. Miller, *Moral and Religious Objections by Hospitals to Withholding and Withdrawing Life-Sustaining Treatment*, 19 J. Community Health 87 (1994) (finding that in 1994, only ten percent of hospitals that objected on grounds of conscience to withdrawing or withholding life-sustaining treatment stated objection in writing); Hosay, *supra* note 196, at 71–72 (indicating that the experience of consumer advocacy groups suggests patients' families given notice of nursing home restrictions in lengthy admissions agreements do not read or understand them).

<sup>256</sup> 366 A.2d 641, 645–47 (N.J. 1976).

<sup>257</sup> *Valley Hosp. Ass'n*, 948 P.2d at 970–72. Neither case decided the issue of whether a sectarian institution raised different considerations.

public (such as tax exemption, state regulation, and public funding), however, do not apply to group or individual practices in the same way.<sup>258</sup>

What would this proposal mean in practice for institutions? As an initial matter, hospitals would be excluded from conscience protection. They would be required to abide by statutory regimes for emergency care, ensuring even contested procedures are delivered. Hospitals receiving Medicare would be expected to disclose all treatment options and meet acceptable standards of practice, as the conditions of Medicare participation demand. The onus would be on the institution to manage the administrative costs of ensuring patient access and scheduling staff with different moral views.

This proposal would not require all large, pluralistic institutions to provide all care. Currently, healthcare facilities may pick and choose the treatments they provide. As one court has suggested, “non-ethical reasons, such as lack of personnel or facilities or of specialization in non-obstetrical and non-surgical fields” can justify an institution’s denying certain services.<sup>259</sup> Patients do not expect to receive, for example, HIV treatments at an orthopedic hospital. Standard, if controversial, procedures could, however, be expected in facilities that provide general medical services, have equipment, expertise, and staff, and permit similar procedures, when “it is the sound medical judgment of the physician with the concurrence of his patient that that particular facility has certain advantages and is where the procedure should be performed.”<sup>260</sup>

By ensuring that, irrespective of the objections of individual providers, the larger institution meets acceptable medical standards, the proposal similarly would minimize conflicts between patients and providers. At least in emergencies, patients could expect to receive the treatment they need in any emergency room.<sup>261</sup> For instance, all hospitals—though not every provider—might be re-

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<sup>258</sup> Law and the American Health Care System 40 (Sara Rosenbaum et al. eds., 2012); see also *Payton v. Weaver*, 182 Cal. Rptr. 225, 230 (Cal. Ct. App. 1982) (stating, “where such a hospital contains a unique, or scarce, medical resource needed to preserve life, it is arguably in the nature of a ‘public service enterprise’”).

<sup>259</sup> *Wolfe v. Schroering*, 541 F.2d 523, 527 n.6 (6th Cir. 1976) (holding that application of conscience clause to public hospitals would be unconstitutional).

<sup>260</sup> *Roe v. Ariz. Bd. of Regents*, 549 P.2d 150, 158 (Ariz. 1976) (Gordon, J., dissenting) (arguing that public hospitals should not be covered by conscience clause).

<sup>261</sup> See supra notes 15–19 and accompanying text.

quired to deliver emergency contraception to rape victims. The frequent end-of-life conflicts would be mitigated as well, because no institution that failed to qualify as a moral association could refuse to honor a patient's wishes for moral or religious reasons. Numerous court cases attest to the trauma experienced by a patient and his or her family when an institution objects to feeding tube removal, forcing them to seek out another institution and a transfer from a place where the patient is already comfortable.<sup>262</sup> Rejecting institutional refusal for pluralistic facilities would reduce the burden on the dying and their families, since a willing physician in the same facility could take over care. It also would better safeguard refusing doctors and nurses who sometimes receive court orders to remove feeding tubes when another facility cannot be found or transfer would harm the patient.

Despite its advantages, this proposal has several limitations. First, it does not solve the problem of patient access in areas underserved by individual doctors. In the most difficult cases, a particular service might become unavailable in a particular community because the sole specialist (or a number of specialists) refuses to provide it. In such instances, several scholars suggest requiring an objector to render necessary care if no substitute provider can be found, creating incentives for the individual refuser to work in proximity to willing providers and for the state to mitigate the problem.<sup>263</sup> States similarly might consider a licensing scheme that requires a certain number of willing providers per refusing providers in a given area. Additionally or alternatively, states might offer inducements to bring willing providers to underserved areas.

Second, requiring hospitals and similar institutions to accommodate all consciences might discourage some religious organizations from establishing them, despite opportunities for creative compromises.<sup>264</sup> Consequently, some scholars recommend that con-

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<sup>262</sup> See Daar, *supra* note 6, at 1269–74 (discussing cases and effects on families).

<sup>263</sup> Lynch, *supra* note 27, at 79; Baker, *supra* note 53, at iii.

<sup>264</sup> This solution would likely face free exercise challenges. However, following *Employment Division v. Smith*, 494 U.S. 872 (1990), a generally applicable law like this is likely to survive constitutional scrutiny. Even in states with higher standards or Religious Freedom Restoration Acts, which implement the pre-*Smith* constitutional standard, regulation of this type could overcome a constitutional challenge. See, e.g., *Catholic Charities of Sacramento v. Superior Court*, 32 Cal. 4th 527 (Cal. 2004) (scrutinizing contraceptive coverage legislation under both the *Smith* and the compelling

science clauses be limited to institutions affiliated with a religious organization, regardless of their size or category.<sup>265</sup> Several courts have also suggested sectarian hospitals might be unique.<sup>266</sup> From a patient access perspective, this approach is undeniably superior to the status quo. Public, for-profit, and nonsectarian institutions would have an obligation to deliver all treatments within their abilities. At those institutions, moral and religious viewpoints of administrators would not be imposed on individual patients, nurses, and doctors.

Nevertheless, this fix would not alleviate the burdens placed on patients and willing doctors and nurses. Concerns about patient access, notice, and emergency care apply equally to religious hospitals. Almost one-third of the approximately six hundred Catholic hospitals are in rural areas.<sup>267</sup> Some enjoy “a practical, but not state-enforced, monopoly in obstetrical services.”<sup>268</sup> Yet patients are rarely aware that religious restrictions may be imposed on treatments.<sup>269</sup> Even if we assume that religion might serve to differentiate nursing homes or clinics, allowing hospitals—regardless of their affiliation—to deny care tips the balance too far against patient interests and individual conscience.

Moreover, defenses of exemptions for religious hospitals seem rooted in the past, evoking an anachronistic Catholic hospital where nuns serve as sponsors, administrators, and providers of

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interest test); *Catholic Charities of the Diocese of Albany v. Serio*, 808 N.Y.S.2d 447 (N.Y. App. Div. 2006) (holding mandatory contraceptive coverage passed New York Constitution’s intermediate balancing standard). *St. Agnes Hospital of Baltimore v. Riddick*, 748 F. Supp. 319 (D. Md. 1990), is instructive. There, prior to *Smith*, the district court found that Catholic hospitals were not entitled to an exemption from requirements that residents receive experience in contraception, abortions, and sterilizations imposed by the accreditation body for obstetrics-gynecology programs. The Court considered “ensuring that these procedures are performed by competently trained physicians” to be “an overwhelmingly compelling interest” and found that there was no less restrictive method to implement nationwide physician training. *Id.* at 330.

<sup>265</sup> Boozang, *supra* note 54, at 1505–08; Greenawalt, *supra* note 6, at 824–25; Harrington, *supra* note 19, at 799.

<sup>266</sup> *Valley Hosp. Ass’n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 965 (Alaska 1997); *Bridgeton Hosp. Ass’n*, 366 A.2d at 645–47.

<sup>267</sup> Singer, *supra* note 86, at 376–77.

<sup>268</sup> *Ham v. Holy Rosary Hosp.*, 529 P.2d 361, 365 (Mont. 1974) (internal quotation marks and citation omitted).

<sup>269</sup> See *supra* note 221–25 and accompanying text.

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medical care and Church monies provide financing.<sup>270</sup> Modern Catholic hospitals bear little resemblance to this model of religious association. Religious orders have little to no patient interaction and sponsor “systems in markets in which they no longer have—or never did have—an active presence.”<sup>271</sup> Funding comes from public and private insurance payments; charitable donations are negligible (in one representative state, amounting to .0015%).<sup>272</sup> This means, in effect, that such a hospital can give up its Catholic affiliation without a meaningful change in operations.

History also suggests that refusing hospitals might find ways to continue to deliver care in accordance with religious tradition. For instance, in states that have mandated emergency contraception for rape victims or condoms as part of HIV counseling, Catholic facilities have agreed to compromises: either directly delivering the services, allowing independent counselors to do so, or advising and referring to another facility (in the case of condoms).<sup>273</sup> Similarly, mergers of Catholic and secular facilities have sometimes resulted in creative solutions designed simultaneously to assure continuity in patient care and to avoid the Catholic facility’s material cooperation in acts deemed wrong. For instance, agreements have allowed legally separate entities to operate clinics onsite or nearby in order to maintain provision of sterilizations, in vitro fertilization, abortion, and contraception.<sup>274</sup>

Ultimately, a legislative framework based on institutional category, distinguished by cohesion, size, and message, would promote pluralism in medicine. Smaller facilities with cohesive staff and clear moral positions could represent an array of moral or religious approaches to medicine. Large, pluralistic institutions, though providing the same baseline level of care, could distinguish themselves in other ways as well. A hospital might have the kindest nursing staff, adopt a team-based approach to patient care, or remunerate its employees especially well.

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<sup>270</sup> J. Stuart Showalter & John L. Miles, *Restructuring Health Care Organizations While Retaining Recognition as a Catholic Institution*, 32 *St. Louis U. L.J.* 1111, 1116–21 (1988) (documenting changes in Catholic healthcare).

<sup>271</sup> Singer, *supra* note 86, at 348.

<sup>272</sup> Uttley & Pawelko, *supra* note 66, at 13, 15.

<sup>273</sup> Boozang, *supra* note 54, at 1511.

<sup>274</sup> *Id.* at 1513–14 (noting mergers that used separate corporate structuring); *Merger Watch*, *supra* note 200 (providing examples of creative compromises).

## *2. Restoring the Obligation to Do No Harm*

This proposed framework, especially when combined with creative accommodations of religious hospitals, offers a manageable and coherent approach to the particular problem of the individual-institution conflict. Focusing on this inherent tension between individuals and institutions is most pressing, because it cannot be satisfactorily addressed through professional standard setting. The asymmetries in treatment of the individual-institution conflict demand legislative resolution.

Currently, however, most legislation extends beyond the tensions between providers and institutions. In addition to creating rights against discrimination for refusing providers, it immunizes refusing providers from civil and criminal liability and assures they cannot face professional discipline for their refusal to treat patients. In effect, conscience legislation foresees and authorizes refusing providers' harming patients. Harming patients carries no repercussions for refusers.

Immunity from liability also oversteps the legislative purpose of protecting providers' moral integrity. Institutional arrangements and opportunities for exit and patient selection should enable a provider to safeguard his or her conscience without doing harm. Immunity, by contrast, gives a refuser license to trample the patient's moral and bodily integrity. It accepts a right to harm others, an exceptionally strange result given the profession's duty of non-maleficence.

The proposal here would instead limit legislative involvement to nondiscrimination, resolving the institution-individual conflict in favor of individuals in large institutions. If a provider were to harm a person, however, he could face liability.

Removing immunity provisions from conscience legislation has benefits for both institutions and the medical profession as whole. Under an antidiscrimination regime, hospitals and other pluralistic, noncohesive institutions will not be assuming the risk of liability by having refusing physicians on staff or employing refusing nurses. They will not have to constantly and closely monitor refusing providers as the immunity provisions might encourage them to do. More significantly, trust in the medical profession is best fostered through a legal regime where patients are confident that a doctor



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who does not share their moral views will ensure no harm comes to them.

Moral associations and exercise of conscience would not be deterred under this approach, but refusing providers would have strong incentives to conduct early and effective notice, provide all information, and deliver referrals. As many scholars have argued, duties to refer and inform impose minimal burdens and should be required of all doctors.<sup>275</sup> These obligations are necessary to address the information disparities in the doctor-patient relationship and to acknowledge the impossibility of a patient anticipating all future needs at the beginning of the treatment relationship. This solution has particular appeal when we consider the new generation of conscience clauses that tolerate any doctor or entity denying patients information, referrals, or counseling for any procedure for reasons so broad that the risk of anarchy looms large. It has the benefit of guaranteeing that patients receive information and referrals. It also seems to protect conscientious objectors, the vast majority of whom accept that they have professional ethical obligations to refer for and counsel about procedures they find morally objectionable.<sup>276</sup>

#### CONCLUSION

Correcting the asymmetry that characterizes conscience clauses matters, most immediately, for willing doctors, nurses, and institutions. Nonetheless, it has potentially broad implications. Invoking conscience in order to refuse to perform employment obligations is rapidly spreading beyond medicine—to pharmacists,<sup>277</sup> ambulance

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<sup>275</sup> Am. Acad. of Pediatrics Comm. on Bioethics, Physician Refusal to Provide Information or Treatment on the Basis of Claims of Conscience, 124 *Pediatrics* 1689, 1691 (2009); Dan W. Brock, Conscientious Refusal by Physicians and Pharmacists: Who Is Obligated to Do What, and Why?, 29 *Theories Med. & Bioethics* 187, 194 (2008); Thomas May & Mark P. Aulisio, Personal Morality and Professional Obligations: Rights of Conscience and Informed Consent, 52 *Persp. Biology & Med.*, 30, 35 (2009).

<sup>276</sup> Ryan E. Lawrence & Farr A. Curlin, Physicians' Beliefs About Conscience in Medicine: A National Survey, 84 *Acad. Med.* 1276, 1278 (2009).

<sup>277</sup> See, e.g., Laura A. Davidson et al., Religion and Conscientious Objection: A Survey of Pharmacists' Willingness to Dispense Medications, 71 *Soc. Sci. & Med.* 161 (2010) (discussing spread of invocations of conscience by pharmacists).

drivers,<sup>278</sup> supermarket cashiers,<sup>279</sup> and lawyers.<sup>280</sup> Even further afield, some suggest exemptions from anti-discrimination norms for business owners who object to same-sex marriage.<sup>281</sup> Conscience legislation—modeled on medical conscience clauses, which this analysis has shown to be deeply flawed—has been proposed and sometimes passed in these ever-wider areas.<sup>282</sup>

Future legislative efforts and scholarly thinking should strive to take conscience seriously. No longer should employees or staff within a refusing institution be presumed to share its moral positions. Instead, potential conflicts between institutional interests and individual conscience should be explored and justified. Similarly, courts should consider the equality of individual conscience in interpreting current statutes, especially those broad medical conscience clauses that plausibly can be read to allow willing providers to exercise conscience in face of countervailing policies.

Of course, a skeptic might suggest that legislators are not genuinely committed to conscience, but instead use “conscience” as pretext for opposition to controversial procedures. If so, one could expect legislators to remain unmoved by this account and to experience no need to remedy the asymmetries in current legislation. Although such an outcome would be disappointing to those who value conscience, it would, at least, have the benefit of encouraging frank discussions in academia and society at large about

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<sup>278</sup> *Adamson v. Superior Ambulance Serv.*, No. 04C 3247 (N.D. Ill. May 7, 2004); see also Steven Kreytak, *Bus Driver Says Religious Views Led to Firing: Man Refused to Take Clients to Planned Parenthood Clinic*, *Austin-Am. Statesman*, Jul. 16, 2010, <http://www.statesman.com/news/local/bus-driver-says-religious-views-led-to-firing-807732.html>.

<sup>279</sup> Chris Serres & Matt McKinney, *Target Is Transferring Cashiers Who Avoid Pork*, *Star Trib. (Minneapolis, MN)*, Mar. 17, 2007, at 1A.

<sup>280</sup> Teresa Stanton Collett, *Professional Versus Moral Duty: Accepting Appointments in Unjust Civil Cases*, 32 *Wake Forest L. Rev.* 635, 640–48 (1997).

<sup>281</sup> Thomas C. Berg, *What Same-Sex-Marriage and Religious-Liberty Claims Have in Common*, 5 *Nw. J.L. & Soc. Pol'y* 206, 207 (2010); Robin Fretwell Wilson, *Same-Sex Marriage and Religious Liberty: Life After Prop 8*, 14 *Nexus* 101, 110 (2009).

<sup>282</sup> See, e.g., *Wash. Rev. Code* § 48.43.065(2) (2011) (exempting HMOs with moral or religious policies); *Conn. S. Tr.*, S. 899, Apr. 22, 2009 (statement of Sen. McLachlan) (arguing that healthcare conscience clauses should provide a model for same-sex marriage legislation); Joanna K. Sax, *Access to Prescription Drugs: A Normative Economic Approach to Pharmacist Conscience Clause Legislation*, 63 *Me. L. Rev.* 89 (2010) (describing spread of state conscience legislation to pharmacists). I plan to examine the extension of these arguments to same-sex marriage in a future article.

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the interests that these laws serve. No longer could proponents of one-sided conscience clauses appeal to respect for conscience when their concerns lie elsewhere. Indeed, if all that remains to justify these laws is opposition to particular procedures, the societal interest in access to healthcare should prevail in legislative deliberations, scholarly debates, and judicial proceedings. In any event, clarity about both individual conscience and the tendency of existing legislation to undermine it can only be helpful to future discussions.

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