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“Conscience Clauses” or “Unconscionable Clauses”:
Personal Beliefs Versus Professional Responsibilities

Martha S. Swartz, M.S.S., J.D.*

In 2002, a University of Wisconsin student brought a prescription for
Loestrin to pharmacist Neil Noesen, who was working in a local community
pharmacy in Menomonie, Wisconsin. Noesen refused to fill the prescription,
citing his “conscientious objection to participation in refilling a contraceptive
order.” He failed to ask the student whether she had any medical conditions that
might make pregnancy dangerous. He also refused to inform her of any other
local pharmacies that were capable of filling the prescription. When the student,
on her own, located another pharmacy, Noesen refused to transfer the
prescription, claiming that doing so would “induce another to do a morally wrong
or sinful act pursuant to the doctrines of the Roman Catholic Church.” As a
result, the student was unable to take her medication as prescribed and risked
pregnancy.

Pharmacists in a number of other states—including California, Georgia,
Illinois, Louisiana, Massachusetts, New Hampshire, North Carolina, Ohio,
Texas, and Washington—have also refused to fill similar prescriptions. Some
pharmacists will only dispense birth control pills to married women; others

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support.


3. Id. at 5.

4. Id. at 5.

5. Id. at 20. Indeed, the student later became pregnant as the result of one missed dose of her contraceptive medication. Id.

The refusal to provide the pills to anyone, mistakenly believing emergency contraception to be an abortafaciens; still others, like Noesen, “hold prescriptions hostage” so that women are unable to take the prescriptions to other pharmacies.

While much recent publicity has been directed at pharmacists who have refused to fill prescriptions, for many years other health care professionals have been quietly refusing to provide patients with medical care they believe violates their personal beliefs. In 2004, a physician and nurse midwife in rural Pennsylvania, citing their religious beliefs, refused to recommend an abortion to a thirty-two-year-old woman who was nearly twenty weeks pregnant and suffering from an infection of her amniotic fluid—notwithstanding the fact that an abortion was the preferred medical therapy to avoid the spread of the infection. Prioritizing their personal moral objections to abortion over the patient’s health, these professionals ignored the standard that traditionally has guided health care providers in performing their professional responsibilities.

7. Unlike abortion, which terminates a pregnancy, contraception prevents pregnancy by inhibiting fertilization and ovulation.


10. Many other cases have been reported in which health care providers concluded that providing a certain type of care would violate their personal moral codes. See, e.g., 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, 626-27 (2003) (describing a case in which a physician personally paid for a car to transport his patient to another hospital when her own hospital refused to provide a necessary abortion because the woman’s life was not imminently in danger). Other examples include cancer patients who sought information about harvesting an egg or sperm, but faced providers unwilling to talk about the procedure, pregnant patients being denied sterilization at religious hospitals, and providers denying pain medications in end-of-life situations. See, e.g., Baldas, supra note 8; Florence A. Ruderman, Prescription for Injustice, N.Y. TIMES, Sept. 1, 2005, at A23 (describing a pharmacist’s refusal to
Conscience Clauses or Unconscionable Clauses

Consequently, the woman suffered septic shock, was transferred to the hospital’s intensive care unit, and required a total hysterectomy.¹¹

The potential adverse effects on patient care caused by health professionals’ refusals to provide health services, as evidenced by the unwanted pregnancy of the University of Wisconsin student who was unable to obtain her prescription for birth control pills, did not deter the Wisconsin legislature from proposing Assembly and Senate bills to explicitly permit pharmacists to refuse to distribute medication that they believe will cause an abortion—even if that belief is not medically supportable.¹² Nor did concern for the ability of patients to obtain necessary medical care prevent the Wisconsin legislature from passing a new law that would give health care professionals, including pharmacists specifically, broader ability to refuse to participate in a wide variety of medical procedures.¹³

Previously enacted Wisconsin statutes allow health care professionals to opt out of performing abortions and sterilizations. Assembly Bill 207, introduced in March 2005, would have extended those refusal rights not only to participating in procedures that involve embryonic stem cells, but also to withholding or withdrawing nutrition or hydration from individuals who are not terminally ill, such as patients in permanently vegetative states.¹⁴ Governor Jim Doyle vetoed the proposed law, refusing to permit such an expansion of health care professionals’ rights of refusal. In justifying his veto, he announced that the law would “put[] a doctor’s political views ahead of the best interests of patients,” and therefore “ought to be called the ‘unconscionable clause.’”¹⁵

Governor Doyle’s veto, however, runs against the tide of protective legislation enacted over the past thirty-five years that permits health care professionals and institutions to refuse to participate in certain medical procedures. For example, some state laws do not expressly require physicians to

fill pain medication for a terminally ill patient).

¹¹. Abdul-Malek, No. 02-1374.

¹². A.B. 285, 97th Leg., Reg. Sess. (Wis. 2005); S.B. 155, 97th Leg., Reg. Sess. (Wis. 2005). These bills—neither of which were scheduled for a vote—would also permit pharmacists to refuse to dispense a drug if “the pharmacist believes that the drug . . . would be used for the purpose of . . . [c]ausing the death of any person,” but only “if the pharmacist consults with the practitioner who prescribed the drug . . . before the pharmacist makes the refusal”; no such condition is attached to the refusal to dispense medication that the pharmacist believes “would be used for the purpose of . . . [c]ausing an abortion.” Wis. A.B. 285; Wis. S.B. 155; see also H.B. 1383, 104th Gen. Assemb., Reg. Sess. (Tenn. 2005); S.B. 76, 104th Gen. Assemb., Reg. Sess. (Tenn. 2005) (permitting pharmacists to refuse to dispense any medicines that violate their moral principles).


¹⁴. Id. at § 31(b)(7).

participate in abortions, even when abortion is necessary to save the woman’s life and even if no other physician is available. Several states permit pharmacists to refuse to fill prescriptions for contraceptives if doing so would conflict with the pharmacist’s personal or moral beliefs. Some states permit nurses to refuse to participate in terminating the life support of a terminally ill patient, regardless of the patient’s and patient’s family’s wishes, if the nurse believes that participating in such procedures would violate her religious beliefs. In fact, in some states, any kind of health care provider may refuse to provide any kind of health service based on her personal beliefs.

Emergency contraception has been a particularly controversial subject for state legislatures and governors. The controversy surrounds whether the pill

17. See, e.g., ARK. CODE ANN. § 20-16-304(5) (West 2005) (“religious or conscientious objection”); FLA. STAT. ANN. § 381.0051(6) (West 2005) (“religious reasons”); ME. REV. STAT. ANN. tit. 22, § 1903(4) (2005) (“religious or conscientious objection”); TENN. CODE ANN. § 68-34-104(5) (2005) (“religious or conscientious objection”); W. VA. CODE ANN. § 16-2B-4 (West 2006) (“personal religious beliefs”); WYO. STAT. ANN. § 42-5-101(d) (2005) (“personal or religious beliefs”); cf. GA. CODE ANN. § 49-7-6 (2005) (permitting refusal due to “personal religious beliefs,” but authorizing agency directors “to reassign the duties of any such employees in order to carry out this chapter effectively”); OR. REV. STAT. ANN. § 435.225 (West 2003) (permitting refusal if a procedure is contrary to employee’s “personal or religious beliefs,” but requiring that employee to “notify the immediate supervisor in writing of such refusal in order that arrangements may be made for eligible persons to obtain such information and services from another employee”).
18. See, e.g., ALASKA STAT. § 13.52.060(e) (2005); 20 PA. CONS. STAT. ANN. § 5409(b) (West 2005); W. VA. CODE ANN. § 16-30-12(b) (West 2006).
20. State legislatures in Alaska, California, Hawaii, Maine, New Hampshire, New Mexico, and Washington have all passed bills requiring hospital emergency rooms to make emergency contraception available to rape survivors and to allow pharmacists to dispense emergency contraception through a collaborative agreement with a physician. NARAL Pro-Choice Massachusetts, Emergency Contraception Bill (Sept. 15, 2005), http://www.prochoicemass.org/s10issues/200309292.shtml. In Massachusetts, the state legislature overrode Governor Mitt Romney’s veto of a bill requiring all hospitals to dispense emergency contraception to rape victims. Although the state public health commissioner originally interpreted the law not to apply to private hospitals, Massachusetts To Exempt Private Hospitals from Emergency Contraception Laws, NEWS TARGET, Dec. 18, 2005, http://www.newstarget.com/z015976.html, Governor Romney’s administration eventually overturned that interpretation. On February 15, 2006, the New York Times reported that the Massachusetts state pharmacy board ruled that Wal-Mart pharmacies were required under state law to stock and dispense emergency contraception. Katie Zezima, Massachusetts: Contraceptives Must Be Stocked, N.Y.TIMES, Feb. 15, 2006, at A20; see also
should be available in hospital emergency rooms for administration to rape victims. As a practical matter, emergency contraception, or the “morning-after pill,” must be dispensed to women within seventy-two hours of unprotected sexual intercourse in order to prevent a pregnancy. Some state legislatures have passed laws that specifically permit hospitals or pharmacists that hold religious or moral objections to refuse to dispense the medication, while others have enacted laws requiring all hospitals, including religious hospitals, to dispense the drug. The relationships between state legislatures and state governors are being severely tested as governors veto these bills, some on the basis that the State should not interfere with the physician-patient relationship and others on the basis that the State should not interfere with the rights of religious hospitals.

Some may challenge the appropriateness of state-licensed hospitals refusing to provide emergency contraception to rape victims. Others may question the professionalism of the pharmacist who refused to dispense birth control pills and the physician and nurse who refused to provide the medical treatment necessary to preserve their patient’s reproductive capacity. Nevertheless, since the early 1970s, the U.S. Congress and most state legislatures have widely accepted the ability of health care professionals and institutions to refuse to perform their

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22. See, e.g., H.B. 2541, 47th Leg., 1st Reg. Sess. (Ariz. 2005) (permitting pharmacists to refuse to provide emergency contraception if doing so conflicts with their moral or religious beliefs). The bill was vetoed by Governor Napolitano on April 5, 2005. Napolitano, supra note 20; cf. A.B. 21, 2005-2006 Leg., Reg. Sess. (Cal. 2005) (requiring pharmacies to find ways to fill prescriptions when an individual pharmacist refuses to provide medication on moral or religious grounds).

23. See, e.g., H.B. 05-1042, 65th Leg., 1st Reg. Sess. (Colo. 2005) (requiring hospitals to tell rape victims about the availability of emergency contraception). Governor Bill Owens vetoed the bill. Owens, supra note 20. At the federal level, Senator Lautenberg (D-NJ), Representatives Carolyn Malone (D-NY), and Debbie Wasserman-Schultz (D-FL) recently introduced the Access to Legal Pharmaceuticals Act, H.R. 1652, 109th Cong. (2005), that would allow individual pharmacists to refuse to fill a prescription, but only if another pharmacist at the same pharmacy would fill it.


25. See, e.g., Owens, supra note 20.
professional responsibilities because of their personal moral or religious beliefs. On the federal level, Congress passed the Hyde-Weldon Amendment in 2004, which requires federal funds to be disbursed only to federal agencies that honor so-called conscience clauses; as a condition of federal funding, agencies must allow the institutions, insurers, health care facilities, and individual health care providers that they fund to refuse to provide, pay for, provide coverage for, or refer for abortions. Unlike the majority of conscience clauses that have proliferated in the past thirty years, the Hyde-Weldon Amendment is so broadly drafted that it does not limit a health care provider's objection to personal belief or conscience. Rather, any reason for refusal will suffice. The Amendment even permits health care providers to refuse to provide, pay for, or even refer patients for abortions when the abortion is necessary to save the life of the mother.

As overreaching as the Hyde-Weldon Amendment is, it is merely the latest in a series of federal and state laws that allow health care providers, institutions, and insurers to refuse to provide medical care to patients. Various professional associations also have incorporated provisions into their official Codes of Ethics that allow their members to decline to perform particular procedures or provide certain services on the basis of their personal beliefs. Until 2005, the Joint

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29. See, e.g., AM. MED. ASS’N, H-295.896, CONSCIENCE CLAUSE: FINAL REPORT, available at

274
Commission on the Accreditation of Healthcare Organizations required hospitals to adopt policies allowing staff members to refuse to participate in certain types of health care. Some hospitals have entered into agreements with their staffs acknowledging staff members’ rights to refuse to participate in certain types of

http://www.ama-assn.org (search “H-295.896”; then follow “Policy Finder - American Medical Association: H-295.896”) (last visited March 10, 2006) (requiring medical schools to have “mechanisms in place that permit students to be excused from activities that violate the students’ religious or ethical beliefs”); Lois Snyder & Cathy Leffler (for the Ethics and Human Rights Comm., Am. College of Physicians), Ethics Manual, Fifth Edition, 142 ANNALS OF INTERNAL MED. 560, 564, 571 (2005) (stating that physicians who object to abortion, sterilization, contraception, or other reproductive services are “not obligated to recommend, perform, or prescribe them,” although they are obligated to “transfer care as along as the health of the patient is not compromised,” but at the same time recognizing that “[t]he physician’s first and primary duty is to the patient” and “[t]he physician’s professional role is to make recommendations on the basis of their medical merit and to pursue options that comport with the patient’s unique background and preferences”); cf. AM. NURSES ASS’N, CODE OF ETHICS FOR NURSES WITH INTERPRETIVE STATEMENTS Provision 5.4 (2001), available at http://www.nursingworld.org/ethics/code/protected_nwcoe303.htm (“Where a particular treatment, intervention, activity, or practice is morally objectionable to the nurse, whether intrinsically so or because it is inappropriate for the specific patient, or where it may jeopardize both patients and nursing practice, the nurse is justified in refusing to participate on moral grounds. Such grounds exclude personal preference, prejudice, convenience, or arbitrariness. Conscientious objection may not insulate the nurse against formal or informal penalty.”). Additionally, the American Pharmacists Association has addressed the refusal rights of its members. The Code of Ethics for Pharmacists affirms that “[a] pharmacist places concern for the well-being of the patient at the center of professional practice.” AM. PHARM. ASS’N, CODE OF ETHICS FOR PHARMACISTS (1994), http://www.apha.org (follow “Pharmacy Practice” hyperlink; then follow “Code of Ethics” hyperlink under “Pharmacy Practice Resources”). However, in reaction to the legalization of physician assisted suicide in Oregon, the American Pharmacists Association adopted an additional policy stating: “APhA recognizes the individual pharmacist’s right to exercise conscientious refusal and supports the establishment of systems to ensure [the] patient’s access to legally prescribed therapy without compromising the pharmacist’s right of conscientious refusal.” Freedom of Conscience for Small Pharmacies: Hearing Before the H. Small Business Comm., 109th Cong. (2005) (statement of Linda Garrelts MacLean, Clinical Assistant Professor of Pharmacotherapy, Washington State University on behalf of the American Pharmacists Association), available at http://wwwc.house.gov/smbiz/hearings/databaseDrivenHearingsSystem/displayTestimony.asp?hear ingIdDateFormat=050725&testimonyId=380.

30. JOINT COMM’N FOR THE ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK, at CK-30 (2005) (modifying this standard from one in which the refusal rights of health care workers are emphasized to one which focuses on the needs of patients, suggesting a possible change in focus). This standard previously stated: “The hospital addresses a staff member’s request not to participate in any aspect of patient care.” Id. In 2005, this standard was modified to read: “The hospital follows ethical behavior in its care, treatment, and services and business practices.” Id. at RI-8.

275
Yale Journal of Health Policy, Law, and Ethics, Vol. 6 [2006], Iss. 2, Art. 2


32. E.g., Taylor v. St. Vincent’s Hosp., 369 F. Supp. 948 (D. Mont. 1973) (involving a Catholic hospital that refused to allow a patient to undergo a sterilization procedure at the time she was having a Caesarian section), aff’d, 523 F.2d 75 (9th Cir. 1975).

33. E.g., Valley Hosp. Ass’n v. Mat-su Coal. for Choice, 948 P.2d 963 (Alaska 1997) (involving a hospital that refused to allow elective abortions to be performed at its facility).

34. E.g., Bartling v. Glendale Adventist Med. Ctr., 209 Cal. Rptr. 220 (Ct. App. 1984) (involving a hospital that refused to disconnect a mechanical respirator at the patient’s request); In re Jobes, 529 A.2d 434 (N.J. 1987) (involving a nursing home that refused to remove a feeding tube from a patient in a vegetative state at the request of her husband); see discussion infra Part III.


36. Baldas, supra note 8, at 17.


38. See, e.g., William W. Bassett, Private Religious Hospitals: Limitations upon Autonomous

276
who argue against the expansion of refusal clauses generally do not question the right of individual health care professionals to refuse to participate in care to which they object on the basis of their personal consciences.\textsuperscript{39} Rather, those commentators endorse the autonomous right of individual health care professionals to refuse to provide care based on their religious or moral beliefs. At least one commentator has suggested that the physician’s right to assert her personal autonomy in the form of her personal conscience—quite aside from professional ethics—is at least as important as the patient’s autonomous right to choose her medical treatment.\textsuperscript{40}

This Article argues that, while health care professionals should be encouraged to refuse to participate in treatment that violates the generally accepted professional standards of practice applicable to their professions, the monopolistic state-granted licenses that medical professionals receive should preclude these professionals from injecting their personal beliefs into their professional practices. Such a distinction must be made between professional integrity based on prevailing medical ethics and personal morality in order not only to protect patient access to medical care, but also to implement health care professionals’ fiduciary obligations to their patients. The provision of medically indicated health care should be the health care professional’s primary responsibility, subordinating personal religious or moral beliefs to the needs of patients.\textsuperscript{41} Recognizing this principle will reinforce patient trust in health care

\textsuperscript{39} See, e.g., Bassett, supra note 38, at 456 (arguing that while the refusal rights of individual health care professionals should be secured, health care institutions should be able to refuse only if patients can choose their providers freely).

\textsuperscript{40} Edmund D. Pellegrino, Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship, 10 J. CONTEMP. HEALTH L. & POL’Y 47, 58 (1994) (“The physician-patient relationship is a moral equation with reciprocal rights and obligations. Today, that equation is becoming unbalanced as patient autonomy is elevated to the status of a trumping principle, morally as well as legally. For some, this even implies or includes overriding the physician’s values, his discretionary latitude in clinical decisions, and in some cases, even his rights of conscience.”).

\textsuperscript{41} In arguing against the acceptance of physician-assisted suicide, the Supreme Court has acknowledged that “[t]he patient’s trust in the doctor’s whole-hearted devotion to his best interests
professionals and the integrity of the health care system.

The expected standard of care for health professionals should be to place patients' interests above their own. The patient's autonomous expression of her interests should set the course for medical decision-making, guided by the health care professional's advice. The professional's advice should derive from both clinical evidence and professional ethics. The personal religious or moral beliefs of the health care professional should not play a role in this process.

The wave of legislatively enacted refusal clauses condoning the practice of refusing to participate in the delivery of health care should be abated. Professional schools should teach, institutional policies should encourage, and professional codes of ethics should confirm that health care professionals are professionally obligated to provide patients with requested care—so long as it is not medically contra-indicated, prohibited from the standpoint of professional ethics, or illegal. Disfavoring medical professionals from injecting their personal moral judgments into their clinical decision-making will reinforce the health care professional's fiduciary duty to her patients and bolster the trust placed in her by her patients who should be able to assume that the professional's primary interest is in promoting their health.

This approach does not mean that there is no room for medical professionals to raise issues of personal conscience in refusing to provide medically indicated care, but it does mean that circumstances in which conscientious objection based on personal beliefs is considered acceptable should be rare. To ensure the rarity of their invocation, health care professionals should be admonished that conscientious objections based on personal beliefs, as opposed to professional ethics, will entail consequences. Most severely, where conscientious objection adversely impacts a patient's health, the professional might be subject to reprimand, transfer, or termination. The Nurses Code of Ethics recognizes this possibility when it states: "[c]onscious objection may not insulate the nurse against formal or informal penalty." When a professional represents herself as a

will be hard to sustain [if physician-assisted suicide is permitted]." Washington v. Glucksberg, 521 U.S. 702, 731 (1997) (Assisted Suicide in the United States: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary, 104th Cong. 355-56 (1996) (statement of Dr. Leon R. Kass)). A similar argument can be put forth against the physician who, in refusing to provide treatment based upon her personal moral code, places her own personal interests ahead of those of the patient, thus violating the patient's trust in the physician's devotion to her best interests.

42. See, e.g., Wis. ADMIN. CODE § Phar 10.03(2) (West 2006) (defining "unprofessional conduct" as "[e]n glaring in any pharmacy practice which constitutes a danger to the health, welfare, or safety of patient or public, including but not limited to, practicing in a manner which substantially departs from the standard of care ordinarily exercised by a pharmacist which harmed or could have harmed a patient . . .") (emphasis added).

43. AM. NURSES ASS'N, supra note 29, at Provision 5.4.
provider of certain services, she has a responsibility to provide that care without reference to her personal beliefs. This is especially true for medical professionals who, by virtue of their state-granted licenses, hold a monopoly on the type of care they provide.

This Article reviews the history of "conscience" or "refusal" clauses in federal and state laws, as well as their treatment by various courts. Part I highlights the expansion of refusal clauses and the distinctions various clauses make in their coverage. Part II reviews the case law involving both institutions and individuals who have refused to provide care. While both federal and state legislatures are increasingly sympathetic to the passage of broad refusal clauses, courts have been somewhat less lenient in their interpretation of these and related laws. Part III discusses the concurrent and at times opposing movement toward enhanced patient autonomy. In the context of medical decision-making, courts have generally not condoned health care professionals’ prerogatives to advance their values over their patient’s desires. Part IV elaborates on some of the compromises that have been proposed to address potential conflicts between patients’ exercise of their decision-making autonomy and their access to health care, on the one hand, and the health care provider’s personal beliefs, on the other. Part V finds none of these so-called compromises satisfactory. It suggests that the proliferation of these clauses undermines patient autonomy, threatens patient access to care, and subverts patients’ trust in their health care professionals. Rather than being guided by their personal moral judgments, health care professionals should be guided by those ethics that comprise the standard of care of their professions. Part VI argues against the wholesale acceptance of conscience or refusal clauses, positing that the medical needs of the patient should eclipse the personal morality of the treating health care professional. The opportunity for conscientious objection on the basis of the health care professional’s personal morals should be discouraged. Due to the monopolistic nature of health care professionals’ state-granted licenses, these professionals should be obligated to provide requested medical care that is not medically contraindicated, is not outside generally accepted medical or professional ethics, and is not illegal.

I. EXPANSION OF REFUSAL CLAUSES

Refusal clauses first began to proliferate at the state and federal levels following the Supreme Court’s decision in Roe v. Wade. Initially, such clauses granted the rights of health care providers to refuse to participate in abortion and sterilization. However, over the past thirty-five years, refusal clauses have

44. 410 U.S. 113 (1973).
expanded to cover a broader range of entities and types of procedures. While early refusal clauses applied only to direct providers of care and health care institutions,45 more recent clauses often extend to indirect providers of care, including payers.46 Recent refusal clauses extend far beyond abortion and sterilization to include, in some cases, all types of health services.47

The Church Amendment, enacted in 1973, was the first federally mandated conscience clause.48 The Amendment prohibited a court or public official from using certain federal funds49 to require any individual or institution to perform or assist in performing abortions or sterilization procedures, if doing so would violate the individual's or institution's religious or moral beliefs.50 It also prohibited certain federally funded institutions from discriminating in admission for internships and residencies against any health care professional on the basis of her refusal to participate in an abortion or sterilization procedure contrary to her religious or moral beliefs.51 Finally, it extended protection of the health care professional's right to refuse beyond abortion and sterilization to all health services funded through the Department of Health and Human Services (DHHS), specifying that no individuals participating in programs and research activities funded through DHHS “shall be required to perform or assist in the performance of any part of a health service program . . . if his performance or assistance in the performance of such part of such programs . . . would be contrary to his religious beliefs or moral convictions.”52

45. See, e.g., OR. REV. STAT. ANN. § 435.485 (West 2005) (effective 1969) ("No physician is required to give advice with respect to or participate in any termination of a pregnancy if the refusal to do so is based on an election not to give such advice or to participate in such terminations and the physician so advises the patient.").

46. E.g., MISS. CODE ANN. § 41-107-9 (West 2004) ("A health care payer has the right to decline to pay, and no health care payer shall be required to pay for or arrange for the payment of a health care service that violates its conscience."); see also ARK. CODE. ANN. §§ 20-16-304(4)-(5) (West 2005) (extending the right of refusal explicitly to pharmacists who object to providing contraceptives).

47. See, e.g., 745 ILL. COMP. STAT. ANN. 70/1 (West 2005); MISS. CODE ANN. § 41-107-3 (West 2004). The state of Washington was ahead of this trend; it enacted a similarly broad statute in 1995. WASH. REV. CODE ANN. § 70.47.160 (West 2006) (effective 1995).


50. 42 U.S.C. § 300a-7(b).

51. 42 U.S.C. § 300a-7(e).

52. 42 U.S.C. § 300a-7(d).
Enacted in response both to Roe, which effectively required all states to permit non-therapeutic abortions, and to Taylor v. St. Vincent’s Hospital, in which a Catholic hospital was compelled to perform a tubal ligation in violation of Catholic directives, the Church Amendment set the course for subsequent legislation at both the state and federal levels. Although some states had refusal statutes in place that addressed “therapeutic abortions” before Roe was decided, there was a flurry of legislative activity after Roe, with state legislatures creating rights of refusal for both health care professionals and institutions to permit them not to participate in now-legalized abortions. Some statutes were limited to abortion, but others included rights of refusal for both abortion and sterilization procedures. While most permitted both health care institutions and individuals to refuse to participate in abortions, some gave

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53. 369 F. Supp. 948 (D. Mont. 1973), aff’d, 523 F.2d 75 (9th Cir. 1975). The plaintiffs sued the hospital under 42 U.S.C. § 1983 and 28 U.S.C. § 1343, claiming that the hospital, due to its receipt of Hill Burton funds (i.e., funds provided for hospital construction under Title VI of the Public Health Service Act, 42 U.S.C. § 291 (2000)), had acted under the color of state law when it deprived them of their right to have tubal ligation surgery at the hospital. The district court initially ruled that the hospital’s receipt of federal funds was sufficient to make the hospital a state actor for the purpose of the suit. However, the district court dissolved the injunction following Congress’s adoption of the Church Amendment, which “[b]y its plain language... prohibits any court from finding that a hospital which receives Hill-Burton funds is acting under color of state law.” Taylor, 369 F. Supp. at 950.

54. “Therapeutic abortions” were abortions that were considered medically necessary to preserve the health or life of the pregnant woman. Hospitals often established boards to determine whether an abortion was “therapeutic.”

55. E.g., OR. REV. STAT. ANN. § 435.485 (West 2003) (enacted 1969) (“(1) No physician is required to give advice with respect to or participate in any termination of a pregnancy if the refusal to do so is based on an election not to give such advice or to participate in such terminations and the physician advises the patient.... (2) No hospital employee or member of the hospital medical staff is required to participate in any termination of a pregnancy if the employee or staff member notifies the hospital of the election not to participate in such terminations.”); N.M. STAT. ANN. § 30-5-2 (West 2005) (enacted 1969) (stating that hospitals are not required to admit patients “for the purposes of performing an abortion” nor is a “person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital... who objects to the justified medical termination on moral or religious grounds” required to participate in the procedure).


57. E.g., MICH. COMP. LAWS ANN. § 333.20182 (West 2006); NEV. REV. STAT. ANN. § 632.475 (West 2005).

special protection to "private or denominational" institutions.\textsuperscript{59}

In 1981, Congress again addressed the issue of the right to refuse to participate in certain types of medical care, expanding that right to cover health insurers. As part of its appropriations bill for the District of Columbia, Congress specified that any legislation regarding contraceptive coverage by health insurance plans must contain a "conscience clause" that "provides exceptions for religious beliefs and moral convictions."\textsuperscript{60}

As the number of state refusal clauses in the area of reproductive services continued to increase after 1973, the right of health care providers to refuse to participate in other types of services began to appear after 1976. In that year, the New Jersey Supreme Court decided the case of \textit{In Re Quinlan}, in which the parents of Karen Quinlan, a young woman in a persistent vegetative state, petitioned the court to authorize the removal of the respirator upon which she appeared to depend to breathe.\textsuperscript{61} In response to public pressure triggered by this well-publicized case, state legislatures began passing "Natural Death Acts," which permitted people to prepare living wills through which they could provide medical direction to their care providers in the event that they were not able to express their wishes at the relevant time. Since 1976, all states have enacted some form of advance directive legislation, whether in the form of living wills, durable powers of attorney, or health care proxies,\textsuperscript{62} virtually all of these statutes contain clauses that permit health care professionals to disregard a patient's or

\begin{footnotes}
\item[59] IND. CODE ANN. § 16-34-1-3 (West 2005); see also UTAH CODE ANN. § 76-7-306(2) (West 2005).
\item[61] \textit{In re Quinlan}, 355 A.2d 647 (N.J. 1976). In fact, Karen lived for ten years after the respirator was removed. Ascension Health: Healthcare Ethics, Quinlan, Karen Ann (2005), http://www.ascensionhealth.org/ethics/public/cases/case21.asp. Ten "living will" statutes were enacted between 1976 through 1980 and twenty-nine were enacted between 1981 and 1986. \textsc{Society for the Right To Die, Handbook of Living Will Laws} 5 (1987). Other states waited to enact "living will" legislation until the U.S. Supreme Court decided the case of Nancy Cruzan, in which the parents of a young woman in a persistent vegetative state petitioned the court to authorize the removal of the woman's artificial nutrition and hydration. Cruzan v. Mo. Dep't of Health, 497 U.S. 261 (1990). In her concurring opinion in \textit{Cruzan}, Justice Sandra Day O'Connor specifically encouraged the use of various types of advance directives as "a valuable additional safeguard of the patient's interest in directing his medical care." \textit{Cruzan}, 497 U.S. at 291-92 (O'Connor, J., concurring).
\end{footnotes}
family’s wishes due to the health care professionals’ personal beliefs.63

As the 1990s progressed, Congress began to focus again on ways to accommodate health care providers who refused to perform various reproductive services. In 1991, Congress adopted the Coats Amendment, which prohibits the government from “discriminating” against medical residency programs or other entities that lose accreditation because they fail to provide or require training in abortion services.64 In 1997, Congress extended “conscience protections” to cover Medicaid and Medicare managed care plans, enabling them to refuse to “provide, reimburse for, or provide coverage of a counseling or referral service if the . . . organization offering the plan . . . objects to the provision of such service on moral or religious grounds . . . .”65 Two years later, after a long battle, Congress agreed to require health plans that insure federal employees to cover prescription contraception; however, Congress explicitly exempted religiously affiliated health plans from this requirement.66 Other conscience clauses proscribe “discrimination” against individuals in specified government-funded health plans that refuse to provide contraceptives due to their “religious beliefs or moral convictions,”67 or against organizations funded under various international health funding programs that limit the types of treatment they provide based on

63. See, e.g., ALASKA STAT. § 13.52.060(e) (2004) (providing that “[a] health care provider may decline to comply with an individual instruction or a health care decision for reasons of conscience”); N.H. REV. STAT. ANN. § 137-H:6(l) (2005) (providing that a physician is not required to comply with an advance directive if, “because of his personal beliefs or conscience, [he] is unable to comply”); W. VA. CODE § 16-30-12(b) (2005) (providing that no individual health care provider is required to comply with a patient’s health care decision if it is “contrary to the individual provider’s sincerely held religious beliefs or sincerely held moral convictions”). Very few states do not require unwilling providers to make transfer arrangements. Among that small number are Michigan, which has no Natural Death Act; Minnesota, which establishes explicitly that an unwilling provider need not transfer the patient unless the patient becomes mentally incapacitated and unable to seek transfer, MINN. STAT. ANN. § 145B.06 (West 2005); North Carolina, which interprets N.C. GEN. STAT. § 90-321 (2005) not to require an unwilling institution to transfer a patient, Advisory Opinion: Institutional Objections to Advance Directives, 1996 WL 925107 (May 23, 1996); and Washington, which is silent on the issue of transfer, WASH. REV. CODE ANN. §§ 43.70.480, 70.122.060 (West 2006).


their "religious or conscientious commitment" or "religious or moral objection." 68

Currently, virtually all states have legislated refusal clauses that excuse health care professionals or institutions from providing medical care under specified circumstances. 69 Among the types of treatments and services covered are: abortion, 70 contraception, 71 insurance to cover contraception, 72 family planning services or referrals, 73 sterilization, 74 assisted reproduction, 75 human cloning, 76 fetal experimentation, 77 euthanasia, 78 and termination of life support. 79


69. See GUTTMACHER INSTITUTE, STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES (2006), available at http://www.guttmacher.org/pubs/spib_RPHS.pdf (listing all federal and state laws allowing nonparticipation in reproductive health care as of Mar. 1, 2006). Forty-six states allow some health care providers to refuse to provide abortion services; all permit individual health care providers to refuse to provide abortion services; forty-three states allow institutions to refuse to provide abortion services (fifteen states limit the exemption to private or denominational institutions, and one state allows only religious health care entities to refuse to provide abortion services); thirteen states allow some health care providers to refuse to provide services related to contraception (eight states allow individual health care providers to refuse to provide contraceptive-related services; four states explicitly permit pharmacists to refuse to dispense contraceptives; four additional states have broad refusal clauses that may apply to pharmacists); ten states allow health care institutions to refuse to provide services related to contraception (six states limit the exemption to private entities, and one state limits it to religious entities); seventeen states allow some health care providers to refuse to provide sterilization services (sixteen states allow individual providers to refuse to provide sterilization services, and fifteen states allow institutions to refuse to provide sterilization services; four limit the exemption to private entities). Id.

70. See id.

71. E.g., ARK. CODE ANN. § 20-16-304(5) (West 2005); FLA. STAT. ANN. § 381.0051(6) (West 2005); GA. CODE ANN. § 49-7-6 (2005); ME. REV. STAT. ANN. tit. 22, § 1903(4) (2005); OR. REV. STAT. ANN. § 435.225 (West 2003); TENN. CODE ANN. § 68-34-104(5) (2005); W. VA. CODE ANN. § 16-2B-4 (West 2006); WYO. STAT. ANN. § 42-5-101(d) (2005); see also GUTTMACHER INSTITUTE, supra note 69.


74. See GUTTMACHER INSTITUTE, supra note 69.


76. Id.

77. Id.

78. Id.; see also N.J. STAT. ANN. § 30:11-9 (West 2006) ("Nothing in this act... shall give the licensing authority or agency herein provided for the power or authority to require any hospital to
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

Proponents of expanding the coverage of conscience clauses advocate the application of these clauses to many other procedures, including autopsies, organ transplants, blood transfusions, medical experimentation, and physician-assisted suicide. Participation in human embryonic stem cell research has already been included in the most recently proposed refusal clauses. Within the past three years, at least two states have enacted far-reaching refusal statutes that define "health care" or "health care services" so broadly as to cover virtually all types of treatment, and at least three additional state legislatures have proposed similarly far-reaching statutes.

All refusal statutes, as currently enacted, apply to health care providers who provide direct care to patients. Many also permit institutions to refuse to practice or permit sterilization of human beings, euthanasia, birth control or any other similar practice contrary to the dogmatic or moral beliefs of any well established religious body or denomination. [S.D. CODIFIED LAWS § 36-11-70 (2005) ("No pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to . . . [c]ause the death of any person by means of an assisted suicide, euthanasia, or mercy killing.").]

80. Wardle, supra note 28, at 177, 181.
82. See, e.g., 745 ILL. COMP. STAT. ANN. 70/3 (West 2006) (defining "health care" to include "any phase of patient care, including but not limited to, testing; diagnosis; prognosis; ancillary research; instructions; family planning, counseling, 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"); MISS. CODE ANN. § 41-107-3(1) (2005) (defining "Health Care Service" to be "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"); see also N.Y. EDUC. LAW § 6527(4)(c) (McKinney 2006) (permitting physicians employed by certain insurers or hospitals to refuse "to perform an act constituting the practice of medicine to which he is conscientiously opposed by reason of religious training and belief"): WASH. REV. CODE, ANN. § 70.47.160 (West 2006) ("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.").
84. Advance directive statutes tend to focus on physicians. See, e.g., IOWA CODE § 144A.8 (West 2005). Abortion refusal laws, conversely, often include other direct providers. See, e.g., CAL.
provide certain types of medical treatment. Moreover, some more recently adopted provisions expand coverage to include health care providers not originally envisioned, such as pharmacists. In doing so, legislators are extending the protection beyond direct providers of care to include indirect providers of care. Pharmacists are often considered indirect providers of care because they do not have prescriptive authority; rather, they are the “middlemen” dispensing medications that have been prescribed by physicians. Finally, many recently enacted statutes have extended coverage beyond both direct and indirect providers of care to embrace the insurance companies that pay for care.

This expansion raises questions regarding how far removed from direct care

HEALTH & SAFETY CODE § 123420(a) (West 2006) (“a physician, a registered nurse, a licensed vocational nurse, or any other person employed or with staff privileges at a hospital, facility, or clinic [may refuse] to directly participate in the induction or performance of an abortion . . . ”); MINN. STAT. ANN. § 145.42 (West 2006) (providing that “[n]o physician, nurse or other person who refuses to perform or assist in the performance of an abortion”).

85. Some statutes limit institutional refusal rights to private and denominational institutions. E.g., S.C. CODE ANN. § 44-41-40 (2005) (providing that “[n]o private or nongovernmental hospital or clinic shall be required to admit any patient for the purpose of terminating a pregnancy”); TENN. CODE ANN. § 68-34-104(5) (2005) (providing that “[n]o private institution . . . shall be prohibited from refusing to provide contraceptive procedures . . . when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal”); see also Wardle, supra note 28, at 182-85 (describing the coverage of institutions in state conscience clauses).

86. See, e.g., ARK. CODE ANN. § 20-16-304(4)-(5) (2006) (permitting pharmacists to refuse to furnish “any contraceptive procedures, supplies or information”); MISS. CODE ANN. § 41-107-3(b), -3(c), -5(1) (West 2005) (permitting pharmacists and pharmacies not to participate in any health care service if they object on religious, moral, or ethical principles); S.D. CODIFIED LAWS § 36-11-70 (2006) (permitting pharmacist not to dispense drugs that might result in abortion, euthanasia, suicide, or mercy-killing); see also S.B. 1485, 47th Leg., 1st Reg. Sess. (Ariz. 2005) (permitting pharmacies and pharmacists not to participate in abortions, contraception, emergency contraception, or sterilizations on “moral or religious grounds”); Baldas, supra note 8 (reporting that, in 2004, fourteen states introduced thirty-seven bills to permit pharmacists and other health care providers not only to refuse to participate in abortions, but also to refuse to dispense emergency contraception or other drugs on the basis of personal “moral” objections).

87. This may explain the American Medical Association’s support of legislation that requires pharmacists to fill valid prescriptions or to refer patients immediately to other pharmacies that will do so. AMA Passes Resolution Saying Pharmacists Should Be Required To Fill All Prescriptions or Provide Immediate Referrals, KAISER FAM. FOUND.: DAILY REP. (June 21, 2005), http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=30867.

88. E.g., Hyde-Weldon Amendment, Consolidated Appropriations Act 2005, Pub. L. No. 108-447, Division F, Title V § 508(d), 118 Stat. 2809 (2004); MISS. CODE ANN. § 41-107-3 (2005) (enacting the most extensive refusal clause that has been adopted to date, covering a wide variety of health care providers, institutions, and payers).
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

an individual may be to qualify for protection under a refusal clause. As one commentator inquired:

What if receptionists refused to make an appointment or refused to give the physician a telephone message because they did not approve of something? The pharmacist might refuse to fill a prescription, the cashier might refuse to sell the prescribed item, or the driver of the distributor's delivery truck might refuse to transport it. 89

There have already been cases by clerks who refused to file information about abortion, 90 a county health department employee who refused to translate into Spanish information about abortion options, 91 and an emergency medical technician who refused to drive a woman to an abortion clinic. 92

Some of these refusal statutes require the objecting health care professional to notify her employer of her objection to participating in a particular medical treatment. 93 However, the states disagree as to whether written notice is required, 94 or whether oral notification will suffice. 95 In the case of abortion, no state requires notice to be provided at any specific time in advance of the health care professional's refusal, 96 although some states do require health plans to provide advance notice to patients about services they do not cover in order to give patients an opportunity to choose their insurer based upon such knowledge. 97 Regarding end-of-life care, some statutes require that institutions

89. Wolfe Nadoolman, Correspondence, 353 NEW ENG. J. MED. 1301, 1302 (2005).
96. But see H.B. 4741 § 6, 93d Leg., 1st Reg. Sess. (Mich. 2005) (covering all medical services, and requiring the objecting health care provider to “assert his or her conscientious objection”: (a) “[u]pon being offered employment,” (b) “[a]t the time the health care provider adopts an ethical, moral, or religious belief system that conflicts with participation in a health care service,” or (c) “[w]ithin 24 hours after he or she is asked or has received notice that he or she is scheduled to participate in a health care service to which he or she conscientiously objects”).
97. For example, in California, health insurers, including managed care organizations, are required to post information in their provider directories informing their members that some providers do not offer a full range of reproductive health services, listing the specific services that may not be available, and providing a toll-free number where consumers call to obtain more
have written policies in place regarding objections, but require no similar
documentation for individual health care providers. Most statutes require
institutions and individual health care providers to provide “timely” or “prompt”
communication of their refusal policies to patients or their surrogates. Meanwhile, some states either impose no notification requirement at all or impose no time requirements. This means that patients may find themselves in health care institutions or under the care of health care professionals who object to the type of care they desire, without ever having received any advance notification of the positions of these health care providers. Although the Patient Self-Determination Act and the regulations promulgated pursuant to that Act
information about how to access such services. CAL. HEALTH & SAFETY CODE § 1363.02 (West 2000 & Supp. 2004); CAL. INS. CODE § 10604.1 (West 1988 & Supp. 2004); CAL. WELF. & INST. CODE § 14016.8 (West 2001). In Washington state, health carriers are required to: “(i) provide written notice to enrollees, upon enrollment with the plan, listing services that the carrier refuses to cover for reason of conscience or religion; (ii) provide written information describing how an enrollee may directly access services in an expeditious manner; and (iii) ensure that enrollees refused services under this section have prompt access to the information developed pursuant to (b)(ii) of this subsection.” WASH. REV. CODE. § 48.43.065(b) (2006). See generally Fogel & Rivera, Saving Roe is Not Enough, supra note 38, at 740-42.
98. E.g., ME. REV. STAT. ANN. tit. 18-A, § 5-807(e) (2005) (noting that “[a] health-care provider may decline to comply with an individual instruction or health-care decision if the instruction or decision appears not to be in compliance with this Act or for reasons of conscience. A health-care institution may decline to comply with an individual instruction or health-care decision if the instruction or decision . . . is contrary to a policy of the institution that is expressly based on reasons of conscience ”); cf. 20 PA. CONS. STAT. ANN. § 5409(b) (2005) (permitting a health care provider’s employer to require that her refusal be expressed in writing).
99. See, e.g., ALASKA STAT. § 13.52.060(e-g) (2005); DEL. CODE ANN. tit.16 § 2508(e) (2005); HAW. REV. STAT. ANN. § 327E-7(e) (LexisNexis 2004); ME. REV. STAT. ANN. tit. 18, §5-807 (2005); N.H. REV. STAT. ANN. § 137-H:6(I) (2005); N.M. STAT. ANN. § 24-7A-7(E) (West 2005); 20 PA. CONS. STAT. ANN. § 5409(a) (2005) (requiring the attending physician or health care provider to “promptly” inform the patient); W. VA. CODE § 16-30-12(b)(2) (2005) (requiring the individual health care provider to “promptly inform” the health care decision-maker). But see N.Y. PUB. HEALTH LAW § 2984(3)(a) (McKinney 2006) (requiring private hospitals to inform patients or health care agents of conscience-based refusals prior to or upon admission, if reasonably possible).
100. See, e.g., IND. CODE ANN. § 16-36-4-13 (West 2005) (imposing no requirement on the physician to inform the patient of her objections); TENN. CODE. ANN. § 32-11-108(a) (West 2005) (imposing no time requirements for notification).
101. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat 1388 (1990) (codified as amended in relevant part at 42 U.S.C. 1395cc(f) (2000)) (requiring health care facilities to provide patients with written information about their rights under state law to refuse medical treatment). Regulations promulgated pursuant to the Act require institutions to inform patients of any written policies that limit the institution’s willingness to comply with a patient’s wishes, including a clarification of “any differences between institution-wide conscience objections
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

do require health care institutions to provide written information to patients about their written policies, “including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience,” the notice is generally provided to a patient only at the time of admission, often too late for a patient preparing to undergo urgent surgery to choose another provider. Even when the patient is “on notice” that a health care institution objects to a certain type of care because of religion-based policies, the patient may not be in a position to obtain care elsewhere. This is the case when a patient is brought to a hospital emergency room by ambulance. This situation may also occur when patients, either as a result of their employment relationships or because they are poor, are involuntarily placed into managed care programs that restrict the facilities from which they may seek covered care. Finally, patients seeking routine treatment are unlikely to base their hospital choice on the hospital’s position regarding a procedure that the patient assumes she will not encounter. For example, a patient entering a hospital for a routine appendectomy may not anticipate an “adverse medical event” that renders her permanently unconscious, thereby triggering the need for enforcement of her advance directive.

Unlike abortion refusal statutes, advance directive statutes usually require individuals and institutions to cooperate in facilitating the transfer of the patient to an institution that will comply with a patient’s wishes. However, some of these statutes leave arrangements for the transfer up to the patient’s surrogate, rather than the objecting health care professional or institution. In many cases,
transferring a terminally ill patient to another institution or even another physician within the same institution can be a difficult, if not impossible, task for health care professionals, let alone family members. The New Jersey Supreme Court acknowledged this in the case of \textit{In re Jobes}, in which the nursing home where the patient resided wanted to discharge her rather than comply with the wishes of her family to withdraw her artificial nutrition. The court wrote, “it would be extremely difficult, perhaps impossible, to find another facility that would accept Mrs. Jobes as a patient.”

Presumably, this is because few institutions would accept an unfamiliar patient for the sole purpose of withdrawing life support. Personal and professional relationships among physicians also often make it uncomfortable to transfer the care of patients within a hospital.

Finally, transferring a patient at such a late stage in treatment is unduly stressful for both the patient and her family. The Superior Court of New Jersey considered this issue in \textit{In re Requena}, when it required a hospital to comply with a patient’s request that her artificial nutrition be withdrawn, rather than transfer her to a willing hospital seventeen miles away. The court wrote:

The subverting of hospital policy and offending the sensibilities of hospital administrators and staff were reasonably determined . . . to be subordinate to the psychological harm to be visited upon Mrs. Requena at this time . . . . Mrs. Requena . . . finds assurance in the familiar surroundings and the familiar nursing and professional personnel who have been taking care of her . . . . [M]oving her from St. Clare’s . . . would be a hard psychological and emotional blow to her.

When the medical treatment involved is controversial, such as abortion, it may be difficult to find other willing providers in a convenient location. Where timing is crucial, for example, in the case of emergency contraception, transferring a patient to another willing provider might delay the administration of the drug to the point that it is no longer effective. Moreover, some health care providers would object not only to participating in a transfer, but even to

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109. \textit{Id.} at 870.

110. \textit{See} discussion \textit{infra} Part IV.
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CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

informing a patient of the availability of such services elsewhere. This was the case in Brownfield v. Daniel Freeman Marina Hospital, in which the police brought a patient to the emergency room at a Catholic Hospital after having been raped. Although the patient’s mother inquired about the “morning-after pill,” the hospital refused to provide information concerning this treatment; moreover, it failed to inform the patient that if she wished to receive emergency contraception, she would have to contact another health provider within the required time period.

Refusal statutes also differ in how they address situations in which a patient might suffer adverse consequences if she does not receive prompt medical attention. Some statutes contain emergency exceptions, that is, they do not permit health care providers to exercise their refusal rights in emergencies. Others do not address situations in which other health care professionals are unavailable to provide the medically necessary care. Statutes that do provide for emergency exceptions often do not define “emergency” or provide extremely limited definitions. Other states address the emergency issue in a round-about way by limiting the immunity of the refusing health care provider to situations that do not result in serious injury or death to a patient.

111. 256 Cal. Rptr. 240 (Ct. App. 1989).
112. Id. at 242.
113. E.g., NEV. REV. STAT. ANN. § 632.475 (West 2005).
114. See, e.g., 745 ILL. COMP. STAT. ANN. 70/1-14 (West 2006) (providing for no emergency exceptions and appearing to supersede earlier requirements at 745 ILL. COMP. STAT. 70/6, 70/9 that did not relieve health care providers from providing care against their consciences if they had legal obligations to provide “emergency medical care”).
115. See, e.g., KY. REV. STAT. ANN. § 311.800(1) (West 2005) (prohibiting the performance of abortions in publicly owned health care facilities “except to save the life of the pregnant woman”); OKLA. STAT. ANN. tit. 63, § 1-741 (West 2005) (permitting health care providers to refuse to provide medical procedures in connection with an abortion “except when the aftercare involves emergency medical procedure which are necessary to protect the life of the patient”). But see H.B. 4741, 93d Leg., 1st Reg. Sess. § 9 (Mich. 2005) (providing a clearer definition of “emergency,” refusing to excuse objecting health care professionals from providing treatment in the following circumstances: “(a) A patient’s condition, in the reasonable medical judgment of an attending physician or medical director, requires immediate action and no other qualified health care provider is available to provide that health care service. (b) In the event of a public health emergency”).
116. See, e.g., MD. CODE ANN. HEALTH-GEN. § 20-214(d) (West 2005) (permitting non-referral, but specifying liability may arise if the failure to refer “would reasonably be determined as: (1) [t]he cause of death or serious physical injury or serious long-lasting injury to the patient; and (2) [o]therwise contrary to the standards of medical care”; OKLA. STAT. ANN. tit. 63, § 1-741 (West 2005) (providing that the immunities granted by the law “shall not include medical procedures in which a woman is in the process of the spontaneous, inevitable abortion of an unborn child, the death of the child is imminent, and the procedures are necessary to prevent the death of the

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Many of these statutes provide civil and criminal immunity to objecting health care providers and prohibit employers from disciplining or discriminating against these health care providers in employment. Illinois law provides for the award of treble damages, plus the costs of suit and attorney’s fees, for violations of its refusal statute. The Pennsylvania statute further requires all facilities offering abortions—except for those devoted exclusively to abortion services—to post a notice entitled “Right of Conscience” for the “exclusive purpose of informing medical personnel, employees, agents and students of such facilities of their rights” under the law. Failure to post an adequate notice may result in a civil penalty of up to $5,000. Yet, Pennsylvania does not require hospitals or individual providers to notify their prospective patients of their objections, so a patient might not realize when seeking an abortion that the provider is unwilling to provide the service sought.

The most significant difference among the various refusal statutes pertains to the beliefs that may be invoked to justify a refusal to provide medical treatment. At least one state, West Virginia, authorizes individuals and institutional providers to refuse to comply with a patient’s wishes regarding end-of-life care only on the basis of “sincerely held religious beliefs” or “sincerely held moral convictions.” However, West Virginia appears to be in a very small minority. Many state refusal statutes, especially those regarding abortions and related services, do not even require a health care provider to explain her reasons for refusing to participate in treatment. The Hyde-Weldon Amendment, along with several state statutes, adopts this approach. For example, New Jersey’s abortion refusal statute states simply: “[n]o person shall be required to perform or assist in the performance of an abortion or sterilization.” No reason must be given.
South Carolina’s abortion refusal statute requires a “physician, nurse, technician or other employee of a hospital, clinic or physician to advise the hospital, clinic or employing physician in writing that he objects to performing, assisting or otherwise participating in such procedure.”127 However, it states specifically that “[s]uch notice will suffice without specification of the reason therefor.”128

As of 1993, more than one-third of jurisdictions in the United States that had enacted conscience clauses failed to state what the acceptable grounds for conscientious objection were.129 Lynn Wardle argues that these statutes “irrefutably assume” that the refusal to participate in certain medical treatments is based on conscientious objection.130 However, some of these provisions are drafted so broadly that they would equally protect the right of a health care professional to refuse to participate in a medical treatment because the procedure was scheduled too early in the morning or because the procedure was controversial. Thus, their categorization as “conscience” clauses, rather than as pure refusal clauses, is questionable.

Those statues that do specify that a health care professional’s refusal to participate in the provision of certain health services must be based on her personal beliefs are often ambiguously drafted. Among the phrases used are “moral, ethical or religious basis,”131 “moral or religious grounds,”132 “personal beliefs or conscience,”133 “sincerely held religious beliefs or sincerely held moral convictions,”134 “reasons of conscience”135 and “contrary to the conscience.”136

(providing that “[n]othing in this section requires a hospital or person to participate in an abortion”); OR. REV. STAT. ANN. § 435.485 (West 2003) (“(1) No physician is required to give advice with respect to or participate in any termination of a pregnancy if the refusal to do so is based on an election not to give such advice or to participate in such terminations and the physician so advises the patient. (2) No hospital employee or member of the hospital medical staff is required to participate in any termination of a pregnancy if the employee or staff member notifies the hospital of the election not to participate in such terminations.”); Wardle, supra note 28, at 179.

126. But see H.B. 4741, 93d Leg., 1st Reg. Sess. § 5(2) (Mich. 2005) (“A health care provider shall notify his or her employer in writing of a conscientious objection . . . . The written notice shall be given directly to his or her supervisor and shall include a statement explaining his or her conscientious objection and the health care service or services to which he or she specifically objects to providing or participating in under this act.”).


128. Id.

129. Wardle, supra note 28, at 196.

130. Id. at 197.

131. E.g., NEV. REV. STAT. ANN. § 632.475 (West 2005).

132. E.g., N.M. STAT. ANN. § 30-5-2 (West 2005).


134. E.g., W. VA. CODE § 16-30-12 (West 2005).

135. E.g., ALASKA STAT. § 13.52.060(3) (2005); ME. REV. STAT. ANN. tit. 18, § 5-807(e) (2006).
The refusal bar is set very low, permitting health care providers to refuse to participate in a procedure with only vague justifications.

While most states do not set forth any statutory definitions of the terms they use, the two most comprehensive and most recently passed refusal clauses do provide a detailed definition of "conscience." The Illinois Health Care Right of Conscience Act defines "conscience" as "a sincerely held set of moral convictions arising from belief in and relation to God or which, though not so derived, obtains from a place in the life of its possessor parallel to that filled by a deity among adherents to religious faiths." The Mississippi statute defines "conscience" as follows:

the religious, moral or ethical principles held by a health care provider, the health care institution or health care payer. . . a health care institution or health care payer's conscience shall be determined by reference to its existing or proposed religious, moral or ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations or other relevant documents.

While the Illinois statute limits the definition of conscience to quasi-religious moral convictions, Mississippi references religious, moral, and ethical principles; however, it is not clear whether the legislature intended to refer to professional or personal ethical principles, which is a crucial distinction. Furthermore, although some statutes (at least in the case of refusals to comply with a patient's wishes concerning life support) require institutions to have specific written policies that define their positions, no refusal statutes require the individual health care professional to provide in-depth justification of her position either to the health care professional's employer or to the patient seeking treatment.139 Requiring health care professionals to support their objections with detailed justification is not the answer, however. This Article maintains that refusals for reasons other than those based on commonly accepted medical standards should be discouraged whether or not they are supported with a detailed explanation.

It is not clear whether state refusal clauses are sufficiently broad to protect the rights of health care professionals not only to refuse to participate in

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136. E.g., 745 ILL. COMP. STAT ANN. 70/4 (West 2006).
137. 745 ILL. COMP. STAT ANN. 70/3(e) (West 2006); see also 18 PA. CONS. STAT. ANN. § 3203 (West 2005) (adopting substantively the same language).
138. MISS. CODE ANN. § 41-107-3(h) (West 2005).
139. But see H.B. 4741, 93d Leg., 1st Reg. Sess. § 5(2) (Mich. 2005) (requiring a health care provider to "notify his or her employer in writing of a conscientious objection," which shall include "a statement explaining his or her conscientious objection and the health care service or services to which he or she specifically objects to providing or participating in under this act").
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

particular procedures, but also to refuse on the basis of their religious beliefs to treat particular groups of patients, such as homosexuals.\textsuperscript{140} For example, may a physician refuse to perform artificial insemination for a lesbian simply because it is against her moral beliefs for lesbians to raise children?\textsuperscript{141} May she refuse to treat a homosexual with AIDS because she frowns on his sexual activities? What about the conservative Muslim orthopedist who prefers not to treat the sports injury of a female athlete, on the basis that under his interpretation of Islam women should not participate in athletics? Or the physician who refuses to deliver the ninth baby of a patient on Medicaid because she does not believe poor people should have babies? How about the pediatrician who refuses to treat sexually active teenagers because of her “religious convictions”?\textsuperscript{142}

Legislatures have only recently begun to address this type of selectivity based on the status of the patient rather than on the type of procedure requested.\textsuperscript{143} While these statutes represent a laudable effort in discouraging health care professionals from discriminating against classes of individuals, none of them is comprehensive in its list of protected groups. For example, while Mississippi’s statute prohibits discrimination on the basis of a patient’s race, color, national origin, ethnicity, sex, religion, creed, or sexual orientation,\textsuperscript{144} it does not prohibit discrimination against many other groups, including, for example, unmarried persons. Pending legislation in Michigan offers a fairly comprehensive list: “religion, race, color, national origin, age, gender, height, weight, familial status, marital status, participation in high-risk activities, past or

\textsuperscript{140} However, professional ethics may discourage refusals on these bases. \textit{See, e.g.}, Snyder & Leffler, \textit{supra} note 29, at 565 (stating specifically that “[t]he denial of appropriate care to a class of patients for any reason, including disease state, is unethical”).

\textsuperscript{141} \textit{See, e.g.}, N. Coast Women’s Care Med. Group, Inc. v. Superior Court, No. D045438, 2006 WL 618767 (Cal. Ct. App. Mar. 14, 2006); John C. Fletcher, \textit{Artificial Insemination in Lesbians, Ethical Considerations}, 145 ARCHIVES OF INTERNAL MED. 419, 420 (1985) (showing no reluctance in asserting his values in medical decision-making when he argues that since there is “no evidence of concrete harm to such children thus far . . . a physician can act ethically to help a lesbian couple with [artificial insemination] if the partners show a prevailing pattern of responsibility”). \textit{See generally} James W. Jones et al., \textit{Ethics of Refusal To Treat Patients as a Social Statement}, 40 J. VASCULAR SURGERY 1057, 1058 (2004).

\textsuperscript{142} \textit{See, e.g.}, American Health Lawyers Association, Credentialing and Peer Review Listserve (Feb. 24, 2006) (on file with author) (reporting a case involving a physician refusing to treat sexually active teenagers because of “religious convictions”).

\textsuperscript{143} \textit{E.g.}, MISS. CODE ANN. \S 41-107-5(1) (West 2005) (“Rights of Conscience. A health care provider has the right not to participate, and no health care provider shall be required to participate in a health care service that violates his or her conscience. However, this subsection does not allow a health care provider to refuse to participate in a health care service regarding a patient because of the patient’s race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.”).

\textsuperscript{144} \textit{Id.}
present medical disease or condition, sexual orientation, employment status, insurance coverage, ability to pay, or method of payment. However, the apparent inclusiveness of this list suggests that other categories may need to be added in the future. For example, does “gender” or “sexual orientation” cover transgendered individuals? In fact, it is probably impossible to compile an exhaustive list of all the possible groups that might face discrimination, thus limiting the attempted protection afforded by this type of provision.

As the foregoing demonstrates, most states have refusal clauses that can be exercised by both individual and institutional direct health care providers in the context of specified medical procedures. However, the most recently enacted refusal clauses may be invoked by all types of medical providers and payers and may be applied to all kinds of health care services. As Wardle correctly points out in arguing for an expansion of conscience clauses, there is every reason to believe that, as technological innovations increase and health care professionals become more religiously and ethnically diverse, the number of health care professionals who object to participating in certain medical services will also increase. We already see some evidence of the expansion of refusal clauses to include new technologies in pending legislation in Rhode Island, which specifically includes human cloning and human embryonic stem cell research among the health care services in which health care professionals need not participate. Before the technique of artificial insemination became generally available, the issue as to whether it was morally appropriate to provide the procedure to a lesbian never arose. As new technologies develop, it is likely that at least some health care providers may object to the application of some technology to some patient on the basis of some religious or moral belief. As certain health care providers object to certain treatments, patients may be forced to choose their health care provider not according to the provider’s professional abilities, but according to her religious and moral beliefs. One commentator suggests that this may lead to a “balkanization of medicine, whereby patients will go only to doctors of their own sect, who prescribe only for pharmacists of that sect, and refer only to specialists of that sect.”

146. Wardle, supra note 28, at 181.
148. Nadoolman, supra note 89, at 1302. The beginning of “balkanization” can be seen in Susannah Meadows, Halfway to Heaven: A Catholic Millionaire’s Dream Town Draws Fire, NEWSWEEK, Feb. 27, 2006, at 39, which describes a Catholic millionaire’s attempt to build a community in southwestern Florida that represents his conservative values. He has asked that pharmacies in the community not carry contraceptives. Naples Community Hospital, which plans to open a clinic in the town, has agreed not to provide birth control to students, although it will provide the pill to the general public. Id.
On the contrary, this Article contends that continued expansion of the coverage and breadth of health care professionals' refusal rights will increasingly threaten patient access to medical care. Broader statutes create a slippery slope, in which an increasing number of medical procedures fall into the category of being morally objectionable to some health care professionals, and there is little reason to think that such expansion will abate. As a result, institutions may find it increasingly difficult to provide care and more patients will be denied access to care. If the medical professional is subsequently viewed as placing her self-interest before the patient's best interest, her status, as well as the status of the medical profession writ large, will be detrimentally affected.

II. JUDICIAL TREATMENT OF CONSCIENCE CLAUSES: THE DISPARITY BETWEEN INSTITUTIONAL AND INDIVIDUAL REFUSALS

While state and federal legislators generally have been sympathetic to the introduction of broad-based legislation to expand the refusal rights of health care professionals, the courts have been somewhat less willing to grant such blanket protection, particularly to institutional actors. Courts have been relatively unsympathetic to institutional refusals in two ways. When courts have characterized institutions as public or quasi-public, they have been less willing to permit the institution to refuse to provide requested care. In other cases, courts have interpreted laws so narrowly as to preclude protection for the institution.


150. See, e.g., Doe v. Charleston Area Med. Ctr., 529 F.2d 638, 642-43 (4th Cir. 1975); Wolfe v. Schoering, 541 F.2d 523, 527 (6th Cir. 1976); Valley Hosp. Ass’n v. Mat-su Coal. for Choice, 948 P.2d 963, 972 (Alaska 1997); Doe v. Bridgeton Hosp. Ass’n, 366 A.2d 641, 645 (N.J. 1976). But cf. Greco v. Orange Mem’l Hosp. Corp., 513 F.2d 873, 880-81 (5th Cir. 1975) (finding that hospital receipt of Hill-Burton grants, county funding of construction of the hospital facilities, lease of county property, requirement under the lease from the county that the hospital accept indigent patients, and benefits accruing to tax-exempt status were insufficient to transform the hospital into a state actor); Taylor v. St. Vincent’s Hosp., 523 F.2d 75 (9th Cir. 1975) (holding that the Church Amendment prohibits courts from finding that a hospital that receives Hill-Burton funds is acting under the color of state law for the purpose of deciding the applicability of the Civil Rights Statute of 1964, 42 U.S.C § 1983 (1979)); Doe v. Bellin Mem’l Hosp., 479 F.2d 756, 757 (7th Cir. 1973) (holding that the hospital’s receipt of Hill-Burton grants and state funding, and the fact that the hospital was subject to state regulation, was insufficient to transform it into a state actor); Jones v. E. Me. Med. Ctr., 448 F. Supp. 1156, 1162 (D. Me. 1978) (finding that the hospital’s receipt of certain federal funds was insufficient to find “state action” under the Civil Rights Act of 1871 where there was no other state nexus).

In contrast, courts have tended to protect the rights of individual health care professionals to refuse to participate in care, at least insofar as their refusals have applied to reproductive services; however, courts have been less likely to protect the rights of health care providers to refuse to participate in other kinds of care.

A. Institutional Refusals

Shortly after Congress enacted the Church Amendment, the Fourth Circuit established a comparably high bar for determining whether a health care provider’s reasons for refusing to perform an abortion fell within the “moral or religious” language of the statute. In this case, Doe v. Charleston Area Medical Center, a plaintiff brought suit under 42 U.S.C. § 1983 claiming that the private, nonprofit hospital violated her constitutional rights while acting under “color of state law” in enforcing its policy on abortions—i.e., not permitting the performance of abortions at its facility except where necessary to save the life of the pregnant woman. The Fourth Circuit rejected the hospital’s argument that the Church Amendment precluded the court from finding that the hospital was acting under the color of state law based on its receipt of Hill Burton funds.

The court found not only that the hospital’s receipt of federal funds was in itself a sufficient nexus to make it a state actor for the purposes of Section 1983, but it further concluded that the hospital’s policy was based on its belief


155. Id. at 640.

156. Hill-Burton funds are federal funds disbursed under Title VI of the Public Health Service Act, 42 U.S.C. § 291 (2000), to assist public and nonprofit medical institutions in constructing or modernizing their facilities.

157. Charleston Area Med. Ctr., 529 F.2d at 642-43. The Court noted, however, that the receipt
that the policy was required by the West Virginia criminal abortion statute, making the hospital a state actor when it enforced its policy.\textsuperscript{158} The court found that the Church Amendment did not prevent it from concluding that the hospital’s receipt of Hill Burton funds made the hospital a state actor, finding inadequate the hospital’s passing reference in its supporting brief that its policy “is naturally related to the long existing Statute of West Virginia and motivated thereby from a moral standpoint.”\textsuperscript{159} The court found that this meager “attempt [by the hospital] to invoke a moral obligation falls short of an assertion that the policy rests upon moral and religious belief [as required to invoke the protections of the Church Amendment] rather than the West Virginia criminal statute.”\textsuperscript{160}

Several subsequent state courts also characterized private hospitals as “quasi-public” institutions and therefore found that they could not refuse to perform constitutionally protected abortions.\textsuperscript{161} In 1976, the New Jersey Supreme Court in \textit{Doe v. Bridgeton Hospital Ass’n}\textsuperscript{162} held that several private, nonprofit, nonsectarian hospitals were quasi-public institutions because they were nonprofit corporations organized to serve the public, received substantial financial support from federal and local governments and the public, benefited from tax exemptions, were available to the public, and because their properties were “devoted to a use in which the public has an interest and are subject to control for the common good.”\textsuperscript{163} As such, these hospitals could not refuse to permit their facilities to be used for first trimester abortions under the state’s refusal statute, since to hold otherwise would constitute state action in violation of the federal constitutional right to an abortion during the first trimester.\textsuperscript{164}

Similarly, the Alaska Supreme Court concluded in 1997 that a hospital was a “quasi-public” institution on the grounds that it had a special relationship with...
the state through the state’s Certificate of Need program, received construction funds from state, local, and federal governments, and also received a significant portion of its operating funds from governmental sources; as such, it could not abridge the plaintiff’s right to abortion as protected under the Alaska Constitution. The court rejected the hospital’s reliance on the state’s “conscience clause” which permitted hospitals to “decline to offer abortions for reasons of moral conscience,” holding that constitutional rights “cannot be allowed to yield simply because of disagreement with them.”

The Sixth Circuit, in a case challenging the constitutionality of various provisions of Kentucky’s abortion statute, also distinguished the ability of “public” hospitals from “private” facilities to invoke Kentucky’s “conscience clause,” which permits hospitals, other health care facilities, and various health providers to refuse to participate in abortions for “ethical . . . moral, religious or professional reasons.” The court held that the conscience clause was not invalid when invoked by private hospitals, but “as applied to public hospitals, unconstitutionally interfered with the woman’s constitutional right to abortion.”

Like the Fourth Circuit in Charleston, other courts have rejected hospitals’ arguments that they should not be obliged to offer certain health services by narrowly interpreting the applicable law. In 1989, a California appellate court interpreted the refusal clause in California’s Therapeutic Abortion Act as not immunizing a Catholic hospital that refused to provide information about the “morning-after-pill” to a rape victim, concluding that the “morning-after-pill” was not an abortion. At least two state courts have narrowly interpreted the applicable refusal clauses invoked in actions brought before them, finding in each case that, since the refusal clause specifically referred only to abortions and sterilizations, it could not be invoked to justify the refusal of a health care institution to participate in other types of medical procedures like withdrawing

165. Valley Hosp. Ass’n, 948 P.2d at 972.
166. Id.
167. Id. at 971.
168. Id. at 972 (quoting Brown v. Bd. of Educ., 349 U.S. 294, 300 (1955)).
170. Id.
Conscience Clauses or Unconscionable Clauses

artificial life support.172

In the related area of state mandated contraceptive insurance coverage, the California Superior Court, in Catholic Charities of Sacramento, Inc. v. Superior Court,173 denied Catholic Charities’ petition for declaratory relief and to enjoin the application of California’s Women’s Contraception Equity Act, which would have required the organization to provide contraceptive insurance coverage to its employees. Narrowly interpreting the “religious employer” exemption under the statute, the court concluded that the exemption did not apply to a charitable corporation, like Catholic Charities: (1) for which the inculcation of religious values is not the purpose of the entity; (2) which serves people of all faiths; (3) which employs mainly non-Catholics; (4) which offers social services to the general public; and (5) which benefits from a federal tax exemption.174

The contrast between judicial and legislative approaches is clear in St. Agnes Hospital of Baltimore v. Riddick,175 in which the U.S. District Court for the District of Maryland held that a Catholic hospital was not exempt from providing or arranging for abortion, contraception, and sterilization training in its medical training program as required for accreditation.176 However, the effect of the court’s decision was vitiated when Congress passed the Coats Amendment,177 which prevents the government from denying accreditation residency training programs that, for religious reasons, refuse to require, refer for, or arrange for abortion training.178 Thus, like the Church Amendment, which was a reaction to a district court decision in Taylor v. St. Vincent’s Hospital,179 the Coats Amendment demonstrates how legislatures have taken steps to undermine the effect of the judicial decisions that limit the rights of health care providers to exercise refusal rights.

172. Gray v. Romeo, 697 F. Supp. 580, 589-90 (D.R.I. 1988) (holding that Rhode Island’s conscience clause only covers abortion and sterilization); Elbaum v. Grace Plaza of Great Neck, Inc., 544 N.Y.S.2d 840, 847 (App. Div. 1989) (rejecting the nursing home’s reliance on the Church Amendment when it refused to withdraw a patient’s artificial nutrition and hydration since it concluded that the Church Amendment only applies to abortion and sterilization); see also Wardle, supra note 28, at 202.
173. 85 P.3d 67 (Cal. 2004).
174. Id. at 94-95.
176. Id. at 331-32.
178. 42 U.S.C. § 238n(b). Thus, physicians training in obstetrics and gynecology in certain religious hospitals will be certified without having the skills to provide comprehensive health care to their patients.
179. 523 F.2d 75, 76 & n.1 (9th Cir. 1975) (discussing the legislative history of the Church Amendment).
B. Individual Refusals

In the context of individual refusals, courts have tended to be comparatively more sympathetic to plaintiffs who refuse to participate in abortions and sterilizations than those who refuse to participate in other medical services, and more sympathetic to refusals based on moral or religious beliefs than those based on professional ethical principles or public policy. However, in the cases in which plaintiffs asserted that their refusal to participate in certain medical services arose from their professional ethics or public policy concerns, courts often have affirmed the validity of invoking a public policy justification even while finding that the facts in the cases before them failed to support such a justification.

Most cases in which courts have upheld the refusal rights of health care professionals have involved health care professionals who have been discharged


182. See, e.g., Ravenstahl, 1985 WL 378; Kenny, 400 So. 2d 1262; Swanson, 597 P.2d 702; Larson, 676 N.Y.S.2d 293.

183. See, e.g., Free, 505 N.E.2d 1188; Pierce, 417 A.2d 505; Warthen, 488 A.2d 229; Farnam, 807 P.2d 830.
from their employment or demoted due to their religion-based refusals to participate in abortions or sterilizations. Health care professionals have sued their employers asserting that their termination or demotion violated a state conscience clause, a state or federal civil rights statute, the First Amendment rights to freedom of religion and free expression of religion, or public policy under the common law. Although not specifically enacted with health care professionals in mind, the federal statute most frequently invoked by employees of health care institutions to protect their right of conscience is Title VII of the Civil Rights Act of 1964. As amended in 1972, the Civil Rights Act requires employers to accommodate the religious beliefs of their employees unless such accommodation results in undue hardship for the employer. Several plaintiffs have brought successful suits against their employers based on their employers’ alleged refusal to accommodate satisfactorily the employee’s religion-based refusals to participate in certain medical procedures.

184. See, e.g., Moncivaiz v. DeKalb County, No. 03 C 50226, 2004 WL 539994 (N.D. Ill. Mar. 12, 2004); Free, 505 N.E.2d 1188; Swanson, 597 P.2d 702; Farnam, 807 P.2d 830.
186. See, e.g., Moncivaiz, 2004 WL 539994 (addressing claims under 42 U.S.C. § 1983 for violations of the rights to freedom of speech and free exercise of religion under the First and Fourteenth Amendments and denial of equal protection under the Fourteenth Amendment); Ravenstahl, 1985 WL 378 (addressing claims based on the rights to freedom of religion, freedom of speech, due process, and equal protection under the U.S. Constitution).
187. See, e.g., Pierce, 417 A.2d 505; Warthen, 488 A.2d 229; Farnam, 807 P.2d 830.
190. See, e.g., Moncivaiz, 2004 WL 539994 (refusing to dismiss the claim of a part-time secretary that she was denied a promotion on the basis of her religious beliefs because she refused to translate abortion related materials); Kenny v. Ambulatory Ctr. of Miami, 400 So. 2d 1262, 1267 (Fla. Dist. Ct. App. 1981) (applying Title VII analysis when interpreting Florida’s refusal statute and therefore requiring the reinstatement of a nurse who refused to participate in abortions). But see, e.g., Shelton, 223 F.3d at 228 (finding a hospital not liable to a nurse under Title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e(j), 2000e(2)(a)(1) (2000), since the hospital had attempted to accommodate the nurse’s religion-based objections); Ravenstahl, 1985 WL 378 (rejecting a nun-nurse’s claims under the Civil Rights Acts of 1871 and 1964 that she was discriminated against for expressing her opposition to a late abortion, stating that “persons opposed
In *Swanson v. St. John’s Lutheran Hospital*, the Montana Supreme Court permitted a nurse anesthetist to invoke the state’s conscience clause to justify her refusal to participate in a sterilization procedure, notwithstanding the fact that she had participated in many previous sterilization procedures without objection and that she had not indicated at the time of her objection that her refusal was based on the “religious beliefs or moral convictions” required by the statute. The court found that there was “overwhelming evidence that all parties knew at the time why she was refusing to participate,” that the Montana statute required the objecting health care professional to state her moral or religious objections only if requested, and that the hospital did not make such a request in this case. Therefore, the court concluded that the nurse’s failure to state the reasons for her refusal at the time of the refusal was not determinative. The court found further that the nurse was not bound to state the “precise commandment, dogma, or tenet that leads to her refusal: [because] the intent of the legislature in so providing is manifest: A person’s conscience about sterilization need not be related to any particular religion, cult, or sect, but may be a part of the person’s indefinable concept of the natural law, not easily explained in an A-B-C fashion.” Thus, this court set a very low bar for health care professionals who choose to refuse to participate in certain types of medical care: they need to provide only vague, “indefinable” justification for their refusals.

Likewise, a Florida appellate court in *Kenny v. Ambulatory Centre of Miami, Florida, Inc.* did not focus on the substance of the religious beliefs of a nurse who sued an ambulatory care center after she was demoted for refusing to participate in abortions and other related birth control and sterilization operations. Rejecting the lower court’s finding that the employer’s decision was based on “fiscal necessity” and applying a federal Title VII analysis to Florida’s civil rights statute, the court concluded that accommodating the nurse would not have created “undue hardship” for the clinic, and, thus, the nurse was entitled to reinstatement.

In four other cases, courts in Pennsylvania, New York, Illinois, and California found that employees of medical centers stated causes of action under

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191. 597 P.2d 702 (Mont. 1979).
192. Id. at 704.
193. Id. at 710.
194. Id.
195. 400 So. 2d 1262.
196. Id. at 1263.
197. Id. at 1267.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

referenced statutes for religious discrimination based upon their religious or moral positions against abortion. The U.S. District Court of Eastern Pennsylvania in *Ravenstahl v. Thomas Jefferson Hospital*198 concluded that a nun-nurse who had been discharged for expressing her opposition to abortion stated a cause of action for religious discrimination under Title VII of the Civil Rights Act of 1964.199 Likewise, a New York appellate court found that employees who alleged that their discharge was due to letters sent to their employer (a medical center) announcing their moral stance against abortion stated a sufficient cause of action for violation of New York’s Civil Rights and Executive Laws, which made it an unlawful discriminatory practice to terminate employees because of their religious beliefs.200 The court concluded that the employees’ “moral stance” constituted “an expression held with the strength of traditional religious conviction.”201 In *Moncivaiz v. DeKalb County*,202 the court found that a part-time secretary stated a cause of action against the county under Title VII, 42 U.S.C. § 1983, and the Illinois Health Care Right of Conscience Act when she claimed that she did not receive a promotion after she refused, on the basis of her religious beliefs, to translate abortion-related information. Finally, in an unreported case, a federal jury in Riverside, California, ordered a county public health clinic to pay a born-again Christian nurse damages for back pay and emotional distress, concluding that the County had violated the nurse’s constitutional right to free exercise of religion by firing her for refusing to give patients emergency contraception.203

In contrast, in the *Noesen* case, involving the Wisconsin pharmacist who refused to dispense birth control pills or to transfer the patient’s prescription, both the administrative law judge and the circuit court judge concluded that the state’s interest in assuring that professionals practice their professions in a competent manner and that patients have access to requested care outweighed the

199. *Id.* at *1. However, in granting the hospital’s motion for partial summary judgment, the court rejected her claims under the Civil Rights Act of 1871 that the hospital had conspired to interfere with her civil rights, since it concluded not only that religion might not be the kind of immutable trait that defines a class that is protected by the Act, but also that “persons opposed to abortion on moral, religious, or professional grounds do not constitute the kind of class, animus against which provides a basis for recovery under [42 U.S.C. § 1985 or 1986].” *Id.* at *3.
201. *Id.* at 296.
pharmacist’s constitutional rights to exercise his religion freely. The Noesen case is an exception, however, and may be explained by the context in which it was brought. Unlike the employment cases in which the “victim” was an employee penalized by her employer for refusing to participate in certain medical treatments, in Noesen the complainant was an injured patient who brought an action before a state professional licensing board.

Notwithstanding the Noesen case, courts in most reported cases involving employees who refused to participate in reproductive services have found in favor of the employee. Only where plaintiffs rejected their hospital-employers’ extensive attempts to find alternative placements have courts held against plaintiffs who objected to participating in reproductive services based on their religious beliefs. In Spellacy v. Tri-County Hospital, a Pennsylvania court held that a part-time admissions clerk was not protected under the Pennsylvania abortion refusal statute when she refused to perform her clerical duties for patients who were scheduled to have abortions. The Pennsylvania statute protects physicians, nurses, staff members, and employees who state in writing their “objection to performing, participating in, or cooperating in abortion or sterilization on moral, religious or professional grounds.” However, the court relied on specific language in Pennsylvania regulations that exclude from the definition of “cooperation” the activity of “functioning in ancillary services, such as . . . recordkeeping by clerical personnel.” The court further concluded that even if there were a duty to accommodate the plaintiff’s religious objections, the hospital had made extensive efforts to offer the plaintiff alternative employment, all of which had been rejected by the plaintiff.

Similarly, in Shelton v. University of Medicine & Dentistry of New Jersey, the Third Circuit found that the hospital had satisfied its duty when it offered to transfer the nurse to a newborn intensive care unit. In that case, the plaintiff nurse brought a Title VII action against a state hospital alleging that the hospital failed to reasonably accommodate her religious beliefs when she repeatedly refused to participate in abortions, even in emergency situations. Although the court did acknowledge the nurse’s sincere religious beliefs, it criticized her for “[h]er unwillingness to pursue an acceptable alternative nursing position . . . [which]
undermines the cooperative approach to religious accommodation issues that Congress intended to foster.\textsuperscript{210}

Where health care professionals have refused to participate in medical procedures or related activities other than abortion or contraception, they have generally based their objections on professional ethical or public policy concerns, rather than on religious beliefs—and courts have been much less sympathetic to their concerns.\textsuperscript{211} Interpreting the Illinois Right of Conscience Act narrowly to exclude objections based on ethical, as opposed to religious, concerns, an Illinois appellate court, in \textit{Free v. Holy Cross Hospital},\textsuperscript{212} refused to hold in favor of a discharged nurse. The nurse had been terminated after arguing against the allegedly premature discharge of a patient, based on her “ethical duty as a registered nurse not to engage in dishonorable, unethetical or unprofessional conduct.”\textsuperscript{213} Although the Illinois refusal statute prohibits discrimination against health care providers who refuse, “contrary to their conscience or conscientious convictions . . . to . . . deliver medical services and medical care,”\textsuperscript{214} the court held: “[W]e do not believe that the Act contemplates the protection of ethical concerns as opposed to sincerely held moral convictions arising from religious beliefs.”\textsuperscript{215}

Conversely, while the Illinois court found the \textit{Free} nurse’s “ethical concerns,” as opposed to her “moral convictions,” to be unprotected by the state refusal statute, two New Jersey courts found “professional ethics,” as opposed to “personal morals,” to be the type of “public policy” that would justify a health care professional’s refusal to participate in an assigned task.\textsuperscript{216} In these cases, the courts distinguished refusals based on “professional ethics,” which they concluded might in some cases constitute a public policy reason for upholding the discharged employee’s right to refuse, from refusals based on the “personal morals” of the plaintiff, which were not justifiable.

In \textit{Pierce v. Ortho Pharmaceutical Corp.},\textsuperscript{217} a physician sued her employer, a pharmaceutical company, for discharging her after she refused to participate in research involving the use of saccharine in a medication to be provided to

\textsuperscript{210} Id. at 228.


\textsuperscript{212} 505 N.E. 2d 1188.

\textsuperscript{213} Id. at 1190.

\textsuperscript{214} Id. (quoting 745 ILL. COMP. STAT. ANN. 70/2 (West 2006) (amended 1998)).

\textsuperscript{215} Free, 505 N.E.2d at 1190.


\textsuperscript{217} 417 A.2d 505.
children and elderly persons. She based her refusal on her conclusion that the safety of saccharine was “controversial,” that her interpretation of the Hippocratic Oath prevented her from participating in such controversial research, and that her refusal was therefore justified under the “public policy” exception to the wrongful discharge doctrine.²¹⁸ Although the New Jersey court held in favor of the pharmaceutical company in this case, observing that there was no public policy (and no professional ethical code) against participating in research that is merely asserted to be “controversial,” the court noted that, in some cases, a professional code of ethics would constitute a public policy that would justify the physician’s refusal.²¹⁹ In the case before it, however, the court concluded that “an employee should not have the right to prevent his or her employer from pursuing its business because the employee perceives that a particular business decision violates the employee’s personal morals, as distinguished from the recognized code of ethics of the employee’s profession.”²²⁰ Furthermore, it observed that “[c]haos would result if a single doctor engaged in research were allowed to determine, according to his or her individual conscience, whether a project should continue.”²²¹

Following the decision in Pierce, the New Jersey Superior Court in Warthen v. Toms River Community Memorial Hospital²²² held that public policy did not preclude a hospital from discharging a nurse for refusing to administer kidney dialysis to a terminally ill double-amputee patient who on previous occasions had suffered from cardiac arrest and severe internal hemorrhaging during dialysis. The court rejected the nurse’s assertions that continuing to participate in this treatment violated the nursing code of ethics, which obligates nurses to “respect . . . human dignity.”²²³ Relying on Pierce, it warned against confusing reliance on “professional ethics” with reliance on “personal morals.”²²⁴ The court held that the nursing code provision “defines a standard of conduct beneficial only to the individual nurse and not to the public at large” since it would have allowed the nurse’s interpretation of “human dignity” to prevail at the expense of the patient’s life and the family’s wishes.²²⁵ It observed that a patient’s right not to have medical treatment terminated against his will is a public policy mandate that “clearly outweighs any policy favoring the right of a nurse to refuse to participate in treatments which he or she personally believes threatens human

²¹⁸. Id. at 507-08.
²¹⁹. Id. at 512.
²²⁰. Id. (emphasis added).
²²¹. Id. at 514.
²²³. Id. at 233.
²²⁴. Id.
²²⁵. Id.
dignity." 226 Adopting the hospital’s argument, the court wrote: “It would be a virtual impossibility to administer a hospital if each nurse or member of the administration staff refused to carry out his or her duties based upon a personal private belief concerning the right to live . . . .” 227

The Washington Supreme Court also distinguished between stances assumed by health care professionals that further their own personal goals from positions that promote the public good. In Farnam v. Crista Ministries,228 a nursing home employee sued her nonprofit Christian organization employer after she was fired for reporting to the state ombudsman the removal of a patient’s nasal gastric tube, which she believed was in violation of the organization’s Christian principles.229 To state a cause of action under Washington’s common law policy protecting whistleblowers, the court observed that “Farnam must have been seeking to ‘further the public good, and not merely private or proprietary interests.’” 230 Since the removal of the naso-gastric tube was not illegal under state law, the court denied Farnam’s claim, concluding that “[w]hile the sincerity of Farnam’s belief is not questioned, her concern appears to be directed at urging Christian health care providers to adopt her view rather than furthering the public good.” 231

The Shelton court, in dicta, made a similar point with respect to public hospital employees. Citing Rodriguez v. City of Chicago,232 in which the Seventh Circuit held that a police department had reasonably accommodated the religious objections of a police officer who refused to guard an abortion clinic, the Third Circuit noted:

It would seem unremarkable that public protectors such as police and firefighters must be neutral in providing their services. We would include public health care providers among such public protectors . . . . [W]e believe public trust and confidence requires that a public hospital’s health care practitioners—with professional obligations to care for the sick and injured—will provide

226. Id. at 234 (emphasis added).
227. Id. Whether the physician in Pierce and the nurse in Warthen were, in fact, relying on “personal morals” rather than “professional ethics” is debatable. The physician in Pierce referred specifically to a clause in the Hippocratic Oath which read: “I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone.” Pierce v. Ortho Pharm. Corp., 417 A.2d 505, 513 (N.J. 1980). The nurse in Warthen referred to language regarding “human dignity” in the Nursing Code, Warthen, 488 A.2d at 233.
229. Id. at 832.
230. Id. at 836 (quoting Dicomes v. State, 782 P.2d 1002, 1008 (Wash. 1989)).
231. Farnam, 807 P.2d at 836 (emphasis added).
232. 156 F.3d 771 (7th Cir. 1998).
The Rodriguez court was concerned that the police officer's invocation of his personal religious views to justify his refusal to guard an abortion clinic would have a negative impact on public safety.\(^\text{234}\) Similarly, in Kalman v. Grand Union Co.,\(^\text{235}\) the court expressed concern about the public's safety. In that case, a pharmacist refused to leave un-staffed a pharmacy counter in a grocery store, contrary to the grocery store manager's instructions, because he said that both state law and his professional code of ethics required the pharmacy to be staffed at all hours during which the grocery store remained open. The court found that the pharmacy code's requirement and the public interest both supported having the pharmacy counter staffed at all times because leaving the counter un-staffed "would have exposed the public to the risk that dangerous drugs might be accessible to the public . . . .\(^\text{236}\) Thus, the court remanded the case to determine whether the pharmacist's discharge had in fact resulted from his refusal to close the counter.\(^\text{237}\)

The risk to the public of a physician's refusal to treat patients was also essential to the court's holding in Fineman v. New Jersey Department of Human Services.\(^\text{238}\) In that case, a physician brought an action against his employer under the New Jersey Conscientious Employee Protection Act (CEPA)\(^\text{239}\) after he was discharged from a nursing home for refusing to treat patients not assigned to him in order to "cover" for another physician who was on vacation. The physician had contended that taking responsibility for so many patients would violate his ethical responsibilities based on the Hippocratic Oath and the American Medical Association Principles of Medical Ethics.\(^\text{240}\) The court distinguished between expressing one's objections, which is protected by CEPA, and "overt acts such as refusal to give medical assistance,"\(^\text{241}\) which are not protected by the law.

\(^{233}\) Shelton v. Univ. of Med. & Dentistry of N.J., 223 F.3d 220, 228 (3d Cir. 2000) (emphasis added).
\(^{234}\) Rodriguez, 156 F.3d at 779-80.
\(^{236}\) Id. at 730.
\(^{237}\) Id. at 731.
\(^{239}\) N.J. STAT. ANN. § 34:19-3(c)(3) (West 2006) ("An employer shall not take any retaliatory action against an employee because the employee . . . [o]bjects to, or refuses to participate in any activity, policy or practice which the employee reasonably believes . . . is incompatible with a clear mandate of public policy concerning the public health, safety or welfare or protection of the environment.").
\(^{240}\) Fineman, 640 A.2d at 1166.
\(^{241}\) Id. at 1170.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

Moreover, the court observed:

When a professional employee merely raises an objection, the consequences, and therefore the necessary weighing of competing interests, are apt to differ materially from those produced when the objection is expressed by overt acts such as refusal to give medical assistance. . . . Given the advanced age of most residents, it can reasonably be assumed that [the] plaintiff’s refusal to see or treat residents whose needs were brought to his attention by the nursing staff, could itself raise competing questions of medical ethics and responsibility.  

Thus, the court concluded that “a balancing of interests test [the physician’s interpretation of his medical ethics as weighed against the health interests of the nursing home residents] could not here support an objectively reasonable determination that there was a clear ethical and legal mandate of public policy requiring a physician to refuse to treat patients in distress.”

The administrative law judge in Noesen engaged in the type of balancing test referred to in Fineman, but found herself in the position of weighing a health care professional’s religious beliefs, as opposed to his professional ethics, against the potential harm to a patient. After hearing testimony from pharmacist experts about the appropriate standard of care for pharmacists and referencing the American Pharmacist Association’s Policy Committee Report on Conscience Clauses and the Pharmacist Code of Ethics, Administrative Law Judge Baird concluded that Noesen had departed from the “standard of care ordinarily exercised by a pharmacist and which harmed or could have harmed the patient.” In arriving at this conclusion, she pointed specifically to Noesen’s failure to inform the managing pharmacist or pharmacy that he would not transfer a prescription for contraceptives, his refusal to advise the patient of her options in getting her prescription filled elsewhere, his failure to ask the patient if she had any medical conditions that might be adversely affected by a pregnancy, and his refusal to transfer the patient’s prescription to another pharmacy. Baird observed that Noesen was more concerned with “satisfying his own personal

242. Id. (emphasis added).
243. Id. at 1171. The clarity of the public mandate was also an issue in Birthisel v. Tri-Cities Health Services Corp., 424 S.E.2d 606 (W. Va. 1992), in which the court found that a Social Work Code of Ethics did not provide sufficiently specific guidance to justify a social worker’s refusal to add information to the hospital’s Master Treatment Plan in preparation for a visit from an accreditation team.
245. Id. at 7.
246. Id. at 18-19.
moral code” than with the health interests of the patient.247 Among other penalties, Judge Baird ordered that Noesen’s license be restricted for two years and required him to attend ethics classes.248 In addition, she ordered him to submit to future employers a detailed notice of the procedures he refuses to perform, as well as the steps he will take to ensure a patient’s access to medication is not impeded by his refusal.249 Judge Baird’s decision was affirmed by the Barron County Circuit Court.250 The Circuit Court also addressed Noesen’s argument that the free exercise of religion protected by the First Amendment of the U.S. Constitution and Article 1, Section 8 of the Wisconsin State Constitution exempted him from complying with the requirements of the Wisconsin Pharmacy Code. Applying a compelling interest/least restrictive means test as required by the Wisconsin Constitution, the court found that the state had compelling interests “in ensuring that health care professionals practice in a competent manner”251 as well as “in ensuring that patients are able to access the medications that have been prescribed to them.”252

In balancing the potential harm to the patient against the religious rights of the pharmacist, both Judge Baird and the appellate court in Noesen concluded that the state’s dual compelling interests in assuring that professionals perform their duties in a competent fashion and that patients receive their prescribed medication were sufficient to override the pharmacist’s right to freely exercise his religious beliefs. The Noesen case presents a promising approach toward limiting the effect of legislatively enacted refusal clauses—an approach that is consistent with the thesis of this Article. Since refusing to provide medically indicated treatment arguably violates the standard of care required by various state professional regulations, and thereby potentially endangers patient health, aggrieved patients might bring disciplinary actions against offending professionals before applicable state professional boards. Although Noesen did not address the issue of patient abandonment, aggrieved patients might make abandonment arguments in cases in which a health care professional has an ongoing relationship with a patient, arguing that the refusal to treat the patient constitutes an “abandonment” of the health care professional’s responsibility to her patients. Like the failure to satisfy the general standard of care required by health care professionals, patient abandonment also often constitutes “unprofessional conduct” under various states’ professional licensing

247. Id. at 7.
248. Id. at 7-8.
249. Id. at 7.
251. Id. at 15.
252. Id. at 16.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

Judge Baird and the appellate court in *Noesen* are in the minority in penalizing a health care professional for refusing to provide treatment to a patient on the basis of his religious beliefs. However, the *Noesen* courts are also in the minority in that they were confronted with a patient who was injured as a result of a health care professional’s assertion of his refusal rights. In contrast, the courts in the employment cases faced discharged or demoted health care professionals as the aggrieved plaintiffs. Once injury to patients is at issue, it may be more difficult for courts to be sympathetic to the health care professional’s assertion of her refusal rights.

Thus, with the *Noesen* case as a noted exception, most courts have tended to protect the rights of individual health care professionals to refuse to participate in medically indicated treatment on the basis of the health care professional’s personal religious beliefs, even if such beliefs are “indefinable.”

This is especially true in cases in which the medical treatment involved is abortion. In contrast, courts generally have interpreted the common law public policy exception specifically to exclude reliance on personal beliefs, as opposed to professional ethics or the “public good.” As the New Jersey courts have pointed out, allowing the personal religious or moral beliefs of each individual health care professional to determine whether she will practice her profession could potentially create chaos for health care administration and patient care. On the other hand, allowing a health care professional to object to participating in patient treatment because of generally accepted professional ethics is unlikely to have such ramifications simply because professional standards have been developed by consensus and, over time, these standards can easily be shared in

253. See, e.g., 49 PA. CODE § 16.61 (2006) (stating, in relevant part, that a physician commits “unprofessional conduct” when she “abandon[s] a patient. Abandonment occurs when a physician withdraws his services after a physician-patient relationship has been established, by failing to give notice to the patient of the physician’s intention to withdraw in sufficient time to allow the patient to obtain necessary medical care”).


255. In view of the fact that abortion is the only type of medical care that enjoys specific constitutional protection, this finding is paradoxical and suggests a failure to attribute sufficient weight to the state’s interest in protecting the right to abortion in balancing this interest against the health care professional’s religious or moral beliefs. The Alaska Supreme Court made this point in *Valley Hospital Ass’n v. Mat-su Coalition for Choice*, 948 P.2d 963 (Alaska 1997), in which it held against a quasi-public hospital that refused to permit abortions on the basis of its moral beliefs because “constitutional rights ‘cannot be allowed to yield simply because of disagreement with them.’” Id. at 979 (quoting Brown v. Bd. of Educ., 349 U.S. 294, 300 (1955)).


313
advance with the public.

Focusing on the individual’s rights of conscience, both refusal statutes and civil rights legislation generally do not consider the ramifications of the health care professional’s refusal on patient care. In contrast, when courts have considered health care professionals’ refusals in the context of public policy, the effects of the refusals have had a substantial influence on the courts’ conclusions. The effects of refusal were central to the courts’ holdings in Kalman, where the possibility of public access to dangerous drugs was considered an unacceptable public risk, and in Noesen, where harm to the public was made concrete by the injured plaintiff. In line with this reasoning by courts, this Article posits that, in considering the potential ramifications of the health care professional’s refusal to provide care, there should be an affirmation of the general rule that the personal interests of health care professionals should not be permitted to prevail over the health needs of their patients.

III. PROFESSIONALS’ RIGHTS OF REFUSAL VERSUS PATIENT AUTONOMY

The trend toward expanding health care professionals’ rights to refuse to participate in certain types of medical care has overlapped with an opposing trend toward increasing patients’ rights to direct their own medical care. Since the end of World War II, there has been a trend toward respecting patients’ autonomous decisions, notwithstanding the objections of physicians or medical institutions. Alan Meisel has called this trend toward “the assertion of citizen autonomy,” as reflected, in part, by the recognition of individual autonomy in the doctor-patient relationship, “the greatest revolution of twentieth century American society.”

Prior to the post-World War II period, most medical decisions were made by physicians with little input from patients. This model of medical decision-making

259. See also Shelton v. Univ. of Med. & Dentistry of N.J., 223 F.3d 220, 228 (3d Cir. 2000) (“It would seem unremarkable that public protectors such as police and firefighters must be neutral in providing their services. We would include public health care providers among such public protectors . . . . [W]e believe public trust and confidence requires that a public hospital’s health care practitioners—with professional obligations to care for the sick and injured—will provide treatment in time of emergency.”).
261. Id. at 1397.
262. Id.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

has been referred to as “medical paternalism” and has been defined as “an action taken by one person in the best interests of another without their consent.”262 This principle is illustrated by the case of John F. Kennedy Memorial Hospital v. Heston,264 in which the New Jersey Supreme Court held that a twenty-two year old woman’s physician was justified in ordering a life-saving blood transfusion over the patient’s surrogate’s religion-based objections. The court reached this ruling not only because the state had a compelling interest in the preservation of life, but also because permitting the physician to act otherwise would violate the professional standards of the medical staff. The court wrote:

Hospitals exist to aid the sick and the injured. The medical and nursing professions are consecrated to preserving life. That is their professional creed. . . . When the hospital and staff are. . . involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards.265

However, beginning slowly in the post-World War I period and quickly following the World War II period,266 challenges to authority resulted in a trend

262. David C. Thomasma, Beyond Medical Paternalism and Patient Autonomy: A Model of Physician Conscience for the Physician-Patient Relationship, 98 ANNALS OF INTERNAL MED. 243, 244 (1983) (citing James F. Childress, Paternalism and Health Care, in MEDICAL RESPONSIBILITY: PATERNALISM, INFORMED CONSENT, AND EUTHANASIA 15, 18 (Wade L. Rovison & Michael S. Pritchard eds., 1979)). Thomasma provides the example of a physician who recommends a bypass operation to save a patient’s life, while the patient prefers medications over surgery. If the physician tries to talk the patient into the surgery “for his own good,” he is acting paternalistically. Thomasma, supra, at 246.

264. 279 A.2d 670 (N.J. 1971), overruled in part by In re Conroy, 486 A.2d. 1209 (N.J. 1984) (overruled to the extent that the court attributed more weight to the physicians’ professional creed than to the competent patient’s privacy rights); see also In re Application of the President and Directors of Georgetown College, 331 F.2d 1000, 1009 (D.C. Cir. 1964) (ordering a hospital to administer a blood transfusion over the religious objections of a twenty-five year old woman in part because she had voluntarily sought medical attention and had exposed the hospital and its doctors to potential civil and criminal liability either for administering the transfusion or allowing her to die); United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965) (emphasizing that a patient should not be able to dictate a course of treatment that required his physicians to ignore their own conscience and to commit virtual malpractice).

265. Heston, 279 A.2d at 673.

of rejecting paternalism in various institutions (including unions, schools, and families) and placing enhanced value on the rights of the individual. As the result of the growing consumer and civil rights movements of the 1950s and 1960s, the emphasis among both medical ethicists and the courts began to center on a model of medical decision-making that emphasized patient autonomy and self-determination, rather than physicians’ rights. In this model, it is the competent patient, not the physician, who ultimately makes decisions regarding her care, based on the physician’s description of the relative risks, benefits, and alternatives available. This model is reflected in the doctrine of informed consent, which has become the “core principle of American bioethics.”

The law of informed consent originated in the oft-quoted statement by Judge Cardozo in the case of Scholendorff v. Society of New York Hospital: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .” Subsequent cases have affirmed the concept of informed consent and further delineated its legal requirements such that it is now generally accepted that physicians must obtain their patients’ consent before treating them and that such consent is not valid unless it is “informed;” that is, unless the physician has disclosed to the patient the benefits, risks, and possible alternatives to treatment.

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An autonomous person is an individual capable of deliberation about personal goals and of acting under the direction of such deliberation. To respect autonomy is to give weight to autonomous persons’ considered opinions and choices while refraining from obstructing their actions unless they are clearly detrimental to others. To show lack of respect for an autonomous agent is to repudiate that person’s considered judgments, to deny an individual the freedom to act on those considered judgments, or to withhold information necessary to make a considered judgment, when there are no compelling reasons to do so.

Id. at B(1). These concepts have been applied both by biomedical ethicists and the courts not only in research, but also in clinical contexts.

267. Meisel, supra note 260, at 1398.
268. Id. at 1399.
269. 105 N.E. 92, 93 (N.Y. 1914).
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

Just as individuals have the right to consent to treatment, they also have the right to refuse treatment. That right has been tested and upheld, most often in cases in which a patient’s life is threatened due to his refusal of life-sustaining or life-prolonging treatment. However, the patient’s right to refuse treatment is not absolute. It is balanced against four state interests: the preservation of life, the protection of dependents, the prohibition against suicide, and the protection of the “integrity of medical professionals.”

In general, the “integrity of medical professionals” has not been afforded significant weight in these end-of-life cases because courts have concluded that recognizing the right of the patient to refuse life-prolonging treatment does not, in fact, compromise medical ethics. As the court noted in Superintendent of Belchertown State School v. Saikewicz:

Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather . . . the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State’s interest in protecting the same . . . . [I]f the doctrines of informed consent and right of privacy have as their foundations the right to bodily integrity . . . and control of one’s own fate, then those rights are superior to the institutional considerations.

As a result, most subsequent courts that have faced this issue have concluded that

prudent patient would require to make an informed decision as to that procedure. The physician shall be entitled to present evidence of the description of that procedure and those risks and alternatives that a physician acting in accordance with accepted medical standards of medical practice would provide.”).

272. Meisel, supra note 260, at 1400.
274. Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425 (Mass. 1977) (holding that a mentally incapacitated patient suffering from acute myeloblastic monocytic leukemia had the right, through his surrogates, to refuse chemotherapy).
275. Id. at 426-27; see also Bouvia v. Superior Court, 225 Cal. Rptr. 297, 303-04 (Ct. App. 1986) (“Where the performance of one duty [to sustain life] conflicts with the other [to relieve suffering], the choice of the patient . . . should prevail.”) (quoting COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS’N, WITHHOLDING OR WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT (1986)); Alan Meisel, Refusing Treatment, Refusing To Talk and Refusing To Let Go: On Whose Terms Will Death Occur, 17 L. MED. & ETHICS 221 (1989).
the patient’s right to refuse life-prolonging treatment, based on her right to privacy, her liberty interests, or her right to self-determination, should prevail over objections based on outdated concepts regarding what constitutes prevailing medical ethics. As Alan Meisel, a legal authority on the right to die, points out, “[n]ot a single reported case—certainly not a right-to-die case in which the patient was terminally ill and would die relatively soon even if treatment were administered—has ever found this interest [medical integrity] to outweigh a patient’s claim not to be treated.”

Even in cases in which health care providers raised religious objections to disconnecting a seriously ill patient’s ventilator, courts have concluded that the physicians had a professional obligation to support the patient’s wishes. For example, in Bartling v. Glendale Adventist Medical Center, a competent adult patient with serious, but not terminal, illnesses requested that his ventilator be withdrawn. The hospital submitted a declaration “to the effect that [Glendale Adventist] is a Christian, pro-life oriented hospital, the majority of whose doctors would view disconnecting a life-support system in a case such as this one as inconsistent with the healing orientation of physicians.” However, while the court did “not doubt the sincerity of real parties’ moral and ethical beliefs, or their sincere belief in the position they have taken in this case,” it held that “if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interest of the patient’s hospital and doctors.” Thus, the court held that the lower court erred in denying the patient’s petition for a mandatory injunction.

Chemotherapy and artificial ventilation are not the only types of treatment that courts have approved withdrawing, in compliance with a patient’s wishes. Courts have also condoned the withdrawal of artificial nutrition and hydration.

276. Alan Meisel, supra note 275, at 223-24; see also Bouvia, 225 Cal. Rptr. at 301 (declaring, in a case involving the right to refuse medical intervention, including nutrition, that the patient’s “right to refuse medical treatment is basic and fundamental . . . . Its exercise requires no one’s approval. It is not merely one vote subject to being overridden by medical opinion.”); In re Guardianship of Browning, 568 So. 2d 4, 14 (Fla. 1990) (noting that maintenance of the ethical integrity of the medical profession is the least significant of various State interests in a case involving the right to direct medical treatment). But cf. McIver v. Krischer, 697 So. 2d 97 (Fla. 1997) (reversing a lower court order of declaratory and injunctive relief and noting that the state has a compelling interest in maintaining the integrity of the medical profession in the context of a patient’s request for a physician’s assistance in committing suicide).


278. Id. at 225.

279. Id. The patient’s intervening death rendered the case moot, so no court order to transfer the patient was considered.

280. Id. at 226 & n.8.
upon a patient’s or surrogate’s request, even though there was at one time a
dispute within the medical community about withholding care that was
considered “ordinary,” like artificial nutrition and hydration, as opposed to care
that was considered “extraordinary,” like ventilators.\(^\text{281}\) For example, in \textit{In re Jobes}\(^\text{282}\), a private nursing home opposed, on religious grounds, a patient
representative’s request for the removal of a terminally ill patient’s feeding tube.
The New Jersey Supreme Court held that the patient’s privacy rights superseded
the refusal rights of the institution and staff and declined to allow the nursing
home to continue the patient’s artificial feeding while the patient awaited
transfer.\(^\text{283}\) One year earlier, in \textit{In re Requena}\(^\text{284}\), the New Jersey Superior Court
had similarly required a Catholic medical center to comply with a patient’s
wishes to have her artificial feeding tube withdrawn, reasoning that “the
subverting of hospital policy and offending the sensibilities of hospital
administration and staff were reasonably determined . . . to be subordinate to the
psychological harm to be visited upon Mrs. Requena at this time.”\(^\text{285}\)

\(^{281}\) The early end-of-life cases established a distinction between “extraordinary” care, e.g.,
ventilators, that are extremely invasive and “ordinary” care, e.g., naso-gastric feeding tubes, that
are not very invasive and that provide “comfort care.” See, e.g., \textit{In re Quinlan}, 355 A.2d 647 (N.J.
\textit{Brophy} court took note of evolving standards within the medical ethical community when it
concluded that its primary focus should be on the patient’s “desires and experience of pain and
enjoyment—not the type of treatment involved.” \textit{Id.} at 636. However, because it found that “[t]here
is substantial disagreement in the medical community over the appropriate medical action,” and
more importantly, because the hospital was willing to transfer the patient to a willing institution,
the court refused to order physicians, over their ethical objections, to discontinue the artificial
nutrition and hydration of a terminally ill patient at the patient’s guardian’s request. \textit{Id.} at 639.

\(^{282}\) 529 A.2d 434 (N.J. 1987).

\(^{283}\) Id. at 450-51.


\(^{285}\) In re Requena, 517 A.2d at 870; \textit{see also Gray v. Romeo}, 697 F. Supp. 580, 591 (D.R.I.
1988); \textit{Bartling}, 209 Cal. Rptr. 220 (Ct. App. 1984); \textit{Elbaum v. Grace Plaza of Great Neck, Inc.},
626; Conservatorship of Morrison, 253 Cal. Rptr. 530, 534 (Ct. App. 1988) (holding that a
physician had the right to refuse on “personal moral grounds” to follow a patient’s conservator’s
direction to remove a life-sustaining naso-gastric tube from a patient as long as the physician was
willing to transfer the patient). The court in \textit{Morrison} refrained from ruling on whether a physician
could refuse to comply with a conservator’s request if no physician were available who agreed to
comply with the conservator’s wishes, writing: “The issue of whether a court could compel
physicians to act contrary to their ethical views is too profound for gratuitous discussion in a
dictum.” \textit{Morrison}, 253 Cal. Rptr. at 535. The court uses the word “moral” interchangeably with
the word “ethical,” so that it is unclear whether the court is referring to the physician’s personal
moral beliefs or his interpretation of his profession’s ethical guidelines.

319
Thus, in end-of-life cases, it is generally accepted within both the medical community and the judiciary that a patient’s autonomous wishes should prevail over a health care provider’s objections to terminating care. Moreover, courts have even found in favor of patients when physicians and institutions have asserted religion-based objections to terminating treatment.\textsuperscript{286} This is in contrast to cases involving health care professionals who object to participating in reproductive health care where courts often have been sympathetic to religion-based objections.\textsuperscript{287}

Many commentators have concluded that while health care professionals may be required to respect a patient’s right to refuse treatment, respect for patient autonomy cannot compel health care professionals affirmatively to provide treatment requested by patients, but to which the medical professional objects.\textsuperscript{288} These commentators point out that the law routinely distinguishes between honoring a patient’s decision to refuse care and honoring a patient’s decision to demand care.\textsuperscript{289} The President’s Commission on Biomedical Ethics specifically declares, “[a]lthough competent patients . . . have the legal and ethical authority to forego some or all care, this does not mean that patients may insist on

\begin{itemize}
\item \textsuperscript{286} See, e.g., Bartling, 209 Cal. Rptr. 220; Jobes, 529 A.2d 434.
\item \textsuperscript{288} See, e.g., \textsuperscript{PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMEDICAL & BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983) [hereinafter PRESIDENT’S COMM’N]; Eric M. Levine, \textit{A New Predicament for Physicians: The Concept of Medical Futility, the Physician’s Obligation To Render Inappropriate Treatment, and the Interplay of the Medical Standard of Care}, 9 J.L. & HEALTH 69 (1994-1995); James J. Murphy, \textit{Beyond Autonomy: Judicial Restraint and the Legal Limits Necessary To Uphold the Hippocratic Tradition and Preserve the Ethical Integrity of the Medical Profession}, 9 J. CONTEMP. HEALTH L. & POL’Y 451 (1993).
\item \textsuperscript{289} U.S. v. George, 239 F. Supp. 752, 754 (D. Conn. 1965) (“[T]he doctor’s conscience and professional oath must . . . be respected . . . [The patient in this case] sought to dictate to treating physicians a course of treatment amounting to medical malpractice . . . . The patient may knowingly decline treatment, but he may not demand mistreatment.”); \textit{In re Farrell}, 529 A.2d 404, 412 (N.J. 1987) (observing that “even as patients enjoy control over their medical treatment, health-care professionals remain bound to act in consonance with specific ethical criteria . . . [A] patient has no right to compel a health-care provider to violate generally accepted professional standards”). \textit{But see Jobes}, 529 A.2d at 450 (holding that a nursing home that had no formal policy against withdrawing artificial nutrition must comply with a family’s wishes to withdraw artificial nutrition from a patient in a permanent vegetative state since the family “had no reason to believe that they were surrendering the right to choose among medical alternatives when they placed her in the nursing home”).
\end{itemize}
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

particular treatments." No medical association has recognized the right of patients to demand any treatment they want. For example, a physician cannot, at a patient's request, be compelled to prescribe antibiotics for a virus or to perform heart surgery when the physician believes that medication is likely to produce similar results with less risk.

However, a number of courts have refuted this position by ordering that medical professionals provide therapy that the health care professional considers "ineffective" or not beneficial to the patient. For example, in In Re Wanglie, a Minnesota court rejected a hospital's and physician's argument that the care of a patient in a persistent vegetative state—dependent on a ventilator for breathing and a nasogastric tube for feeding—should be withdrawn because further care would be, according to the physicians, "non-beneficial" and "medically inappropriate." The court concluded that the patient's husband was the appropriate decision-maker, and, since he had not requested the termination of treatment, the physicians could not initiate a withdrawal order.

Several commentators have pointed out that the treatment requested by the patient's husband-conservator in the Wanglie case was not "medically futile" since it had the desired effect; that is, it maintained the patient's life. Conversely, the patient's physicians considered continued treatment to be "medically futile" in the sense that, in the physicians' opinions, being kept alive would be of no benefit to the patient in light of her hopeless prognosis. This conclusion, these commentators suggest, was not scientifically based, but rather was based on the physician's "values," which conflicted with those of the patient's conservator who believed that a "miracle" would save his wife. Since "[t]he physicians in no way could claim expertise in knowing the value of their patient's vegetative life," their recommendations should not be decisive. According to this logic, the patient's autonomous treatment preferences (as expressed by her conservator) were correctly attributed more weight by the court than the physicians' "medical integrity."

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290. President's Comm'n, supra note 288, at 44.
291. See Murphy, supra note 288, at 478.
295. Murphy, supra note 288, at 457.
296. Veatch & Spicer, supra note 293, at 29; see also Murphy, supra note 288, at 463.
297. The Wanglie court did not engage in balancing the physicians' "medical integrity" against the patient's autonomy since it limited itself to deciding who the appropriate decision-maker should
Similarly, in *In re Doe*, a case involving a thirteen-year-old girl with a neurological degenerative disorder, massive brain damage, and no reasonable hope of recovery, the physicians and the hospital bioethics committee recommended, over the girl’s parents’ objections, that all extraordinary life-sustaining measures be discontinued. One of the treating physicians concluded that “[i]t’s to the point the patient is being abused through medical technology.” This physician further testified that he found it “ethically and morally unconscionable” to continue treatment. Notwithstanding this testimony, as well as evidence that the lingering death of the patient “was having a disastrous effect on the Hospital personnel and [was] demoralizing to the nursing and house staff,” the court rejected the hospital’s and physicians’ request to discontinue life support. Instead, physicians were required to continue therapy that they found inappropriate.

Veatch and Spicer distinguish between “physiologically futile care,” that is, care that is not technically effective in that it is unlikely to achieve the medical goal (for instance, antibiotics will not cure a virus), and “normatively futile care,” that is, care that will not produce a “worthwhile outcome.” Veatch and Spicer conclude that the patient herself, and not the physician, is the “appropriate

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be, not what the decision should be.

300. Id.
301. Murphy, supra note 288, at 458 (quoting *In re Doe*, No. D-93064, slip op. at 23 (Ga. 1991)).
302. See also *In re Baby K*, 16 F.3d 590, 597 (4th Cir. 1994) (holding that the Emergency Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2000), “does not provide an exception for stabilizing treatment [that] physicians may deem medically or ethically inappropriate,” finding that EMTALA preempts the Virginia statute that does provide such an exception, and therefore requiring physicians to treat an anencephalic infant, notwithstanding the physician’s argument that it was outside the prevailing standard of medical care to treat aggressively an infant without a complete brain who was doomed to die within a short time); *Gray v. Romeo*, 697 F. Supp. 580, 589, 591 (D.R.I. 1988) (“[C]onsideration of the integrity of medical ethics does not present a compelling justification to refuse Marcia Gray’s wishes. Indeed, medical ethics incorporates the principle that the patient, not the health care provider, determines what the course of care should be . . . . Accordingly, if Marcia Gray cannot be promptly transferred to a health care facility that will respect her wishes, the Rhode Island Medical Center must accede to her requests.”); *John J. Paris, Physicians’ Refusal of Requested Treatment: The Case of Baby L.*, 322 NEW ENG. J. MED. 1012 (1990) (describing *In re Baby L*, in which a mother sought continued treatment for her two year old child who suffered from repeated bouts of pneumonia and cardiopulmonary arrests, but who was unresponsive, except to pain. Physicians unanimously agreed that further medical intervention was not in the best interests of the patient. Ultimately, the case was rendered moot when the patient was transferred to a willing physician).
303. Veatch & Spicer, supra note 293, at 23.
decision-maker” to evaluate whether a particular outcome is normatively beneficial to the patient. While it is generally accepted that physicians have no duty to provide physiologically futile care, there is an ongoing controversy about their obligation to provide patients with requested care that the physician believes to be futile from a normative perspective.

Wanglie and Doe, among other cases in which health care providers were compelled by courts to provide treatment to patients whom the health care providers considered “hopeless,” have caused a backlash within the medical community against the dominance of patient autonomy in medical decision-making. Many physicians and commentators believe that patient autonomy has “gone too far” in demanding that physicians provide care that they consider ineffective or “futile,” arguing that the competing ethical value of “beneficence” requires doctors to “do only what is medically helpful” and that “[i]ndividual autonomy cannot be so inflated in importance as to destroy the principle of beneficence.” These commentators assert that the physician has the right to not provide a medical treatment, even if technically effective, if the physician concludes that the treatment will not benefit the patient.

Discontent within the medical community about this trend has led many states to pass statutes that permit physicians to refuse to provide “medically ineffective” care or care that is “contrary to applicable health-care standards.”

304. Id.
305. See, e.g., James F. Drane & John L. Coulehan, The Concept of Futility: Patients Do Not Have a Right To Demand Medically Useless Treatment, HEALTH PROGRESS, Dec. 1993, at 28, 30; Stephen H. Miles, Informed Demand for “Non-Beneficial” Medical Treatment, 325 NEW ENG. J. MED. 512 (1991) (arguing that respect for patient autonomy does not obligate physicians to provide treatment “in ways that are fruitless or inappropriate”); Robert M. Sade, Medical Care as a Right: A Refutation, 28 NEW ENG. J. MED. 1288 (1971) (contending that viewing medical care as the right of the patient is immoral). But see Allen S. Brett & Laurence B. McCullough, When Patients Request Specific Interventions: Defining the Limits of the Physician’s Obligation, 315 NEW ENG. J. MED. 1347, 1349 (1986) (advancing the position that if there is a “theoretical medical basis for a patient’s request for medical treatment, the patient’s unique circumstances and stated reasons for wanting the intervention should guide the final decision-making process”); Robert M. Veatch & Carol Mason Spicer, Futile Care: Physicians Should Not Be Allowed To Refuse To Treat, HEALTH PROGRESS, Dec. 28, 1993, at 22, 27 (distinguishing normative from physiological futility and concluding that “the licensed professional who is given a monopoly over the control of life should be expected to promise to use that technology when patients or surrogates ask for it”).
307. See, e.g., id. at 29.
308. ALASKA STAT. § 13.52.060(f) (2005) (“A health care provider . . . may decline to comply with an individual instruction or a health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the provider, institution, or facility. In this subsection, ‘medically ineffective health care’ means health care that...
The Society of Critical Care Medicine, the American Thoracic Society, and the American Medical Association have all issued policy statements affirming that physicians have no obligation to provide treatment that in their best judgments would be futile, offer no benefit to the patient, and only prolong the dying process.\(^\text{309}\) The American Thoracic Society adopted the Saikewicz court’s reference to the “ethical integrity of the medical profession” when it wrote: “Forcing physicians to provide medical interventions that are clearly futile would undermine the ethical integrity of the medical profession.”\(^\text{310}\) Thus, there has been some effort within the medical community to re-assert the authority of physicians to direct patient care even over the patient’s objection.\(^\text{311}\)

Criticizing the focus on patients’ rights, Edmund Pellegrino observes: “In


\[^{310}\] American Thoracic Soc’y, supra note 309, at 477; see also Sade, supra note 305, at 1290-91 (“Any doctor who . . . is compelled by law to make any decision he would not otherwise have made, is being forced to act against his own mind, which means forced to act against his own life. He is also being forced to violate his most fundamental professional commitment, that of using his own best judgment at all times for the greatest benefit of his patient.”).

\[^{311}\] However, it is unclear whether these medical organizations acknowledge the difference between treatment that is technically ineffective and treatment that is unlikely, in the physician’s view, to continue or improve the patient’s quality of life. For example, the AMA does not appear to advocate leaving to the physician whether a particular treatment will benefit a patient since it defines resuscitative efforts to be “futile” if “they cannot be expected to restore cardiac or respiratory function to the patient or to achieve the expressed goals of the informed patient.” Murphy, supra note 288, at 468 n.122 (emphasis added) (citations omitted). This quote seems to suggest that the determination of whether a treatment will benefit a patient from a normative standpoint should be made by the patient, and not the physician.
the last twenty-five years autonomy has superseded beneficence as the first principle of medical ethics.” 312 This is the most radical reorientation in the long history of the Hippocratic tradition. 313 Pellegrino argues for a balancing of the patient’s right to autonomy with the physician’s right to autonomy. 314 Others oppose the idea of physicians becoming “vending machines” dispensing treatment as ordered by their patients. 315 Still others suggest that to demand that a physician provide treatment that is “morally unpalatable . . . [is] likely to have a corrosive effect upon the dedication and zeal with which [a physician] ministers to patients.” 316 In objecting to a mother’s insistence that her severely handicapped infant be aggressively treated, Gordon B. Avery suggests that, without some authority over their actions, physicians cannot be held responsible for their acts. 317

This Article does not suggest that health care providers sacrifice their ability to provide professional advice to patients or that beneficence has no role in medical decisions. Rather, it suggests that health care providers’ professional advice must be informed by the professional ethics generally accepted within their respective professional communities and not by their own personal belief systems. Both those who argue in favor of permitting physicians to withhold care that they determine to be medically futile and those that posit that it is patients, not physicians, who should decide whether care is beneficial focus their inquiry on the benefit to the patient. 318 “Personal medical benefit consists of such advantages as restoration of health, cure, pain relief, comfort, alleviation of suffering, and improved well-being or quality of life. The principle of beneficence calls on physicians to help patients achieve those particular goals . . . .” 319 The disagreement among commentators revolves around who is in

313. Id.
314. Pellegrino, supra note 40, at 51-52.
318. Although Murphy argues in favor of physicians’ rights to refuse to provide treatment that they believe is medically futile, he confirms that one of the fundamental tenets of the Hippocratic tradition is that “physicians must act solely for the benefit of their patients.” Murphy, supra note 288, at 466.
319. Drane & Coulehan, supra note 305, at 32.
the best position to make that determination—the patient or the physician.

In contrast, those who favor expanding refusal statutes and the rights of health care professionals to decline to administer care based on their personal beliefs base their reasoning on whether participation in the treatment will harm the health care professional; that is, whether such treatment will offend the health care professional’s personal sense of morality. For example, Pellegrino proposes a tripartite model of physician autonomy that recognizes the physician’s “autonomy as a person which gives moral status to the physician’s personal moral values and conscience.” While Pellegrino acknowledges that the physician does not have the right to impose her will or conception of the good on the patient, he concludes that even where a physician’s adherence to her sense of morality potentially will harm a patient, “the Catholic physician cannot violate her conscience to provide a morally objectionable procedure or treatment.” This Article challenges this approach, advocating instead an approach in which the patient’s interests prevail, even if ministering to these interests compromises the physician’s personal beliefs (but not the medical ethics to which she is bound).

Traditional concepts of medical ethics instruct that medical decision-making should be based on four core ethical principles: patient autonomy (patient self-determination), non-maleficence (health care professional should do no harm), beneficence (health care professional should do “good”), and justice (a concept involving the fair distribution of scarce medical resources). Other than the ethical principle of justice, which commentators generally agree should not be considered in individual medical decisions, these ethical principles focus on the patient’s needs. Refusal statutes, conversely, inappropriately permit the health

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320. Pellegrino, supra note 40, at 51-52. The other components of physician autonomy are “autonomy as a physician, which gives moral status to the physician’s knowledge and obligation to use it wisely and well”; and “autonomy as a member of a profession, of a moral community with collective obligations to patients and society.” Id.

321. Edmund D. Pellegrino, The Physician’s Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective, 30 FORDHAM URB. L.J. 221, 243 (2002). Pellegrino advises: “Conscientious objection implies the physician’s right not to participate in what she thinks morally wrong, even if the patient demands it.” Id. at 242. To his credit, he suggests that religious physicians who refuse to provide certain types of care should notify their patients in advance of their objections. However, while he acknowledges that such advance notification may not be possible in emergencies or in remote locations, he nevertheless concludes that the religious physician should not provide the objectionable treatment. Id. at 243.


323. See, e.g., President’s Comm’n, supra note 288, at 100; Brett & McCullough, supra note 305, at 135-51.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

care professional to place her personal moral, religious, or political judgment ahead of her patients’ health interests.\textsuperscript{324}

IV. PROPOSED COMPROMISES: BALANCING THE ACCESS RIGHTS OF PATIENTS AGAINST THE PERSONAL BELIEFS OF HEALTH CARE PROFESSIONALS

Unlike professional ethics that are based on a consensus of values generally accepted by the medical professional community, personal morals are usually viewed to derive from religion.\textsuperscript{325} The right to religious freedom is firmly entrenched in the United States and has enjoyed protection throughout American history. However, since there is no corresponding right to health care in the United States, it is not surprising that the rights of religious health care professionals have taken priority over the access needs of patients. According to commentator Katherine White, refusal clauses are neither constitutionally mandated by the Free Exercise Clause, nor constitutionally forbidden by the Establishment Clause; as a result, they remain in political play.\textsuperscript{326}

The First Amendment provides, “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . . .”\textsuperscript{327} Some religious health care providers argue that requiring them to provide access to health services to which they have religion-based objections burdens their rights to exercise their religion freely.\textsuperscript{328} Thus, for example, they argue that their free exercise rights are abridged by state laws requiring religious hospitals to provide their employees with medical insurance that covers contraception or mandating that religious hospitals dispense emergency contraception to rape victims.

At least two commentators have suggested reasons why this argument cannot be supported. In analyzing the somewhat muddled law concerning the Free Exercise Clause, both Brietta Clark and Katherine White conclude that


\textsuperscript{325}. This is not to say that an atheist cannot have personal morals that are as firmly entrenched as that of religious believers.

\textsuperscript{326}. White, supra note 149, at 1729-30.

\textsuperscript{327}. U.S. CONST. amend. I. The First Amendment has been interpreted to apply to the states through the Fourteenth Amendment of the U.S. Constitution. Cantwell v. Connecticut, 310 U.S. 296, 303 (1940). The free exercise of religion is also protected by statute, see, e.g., Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-2(a)(1) (2000), which provides in relevant part that it is an unlawful employment practice to “discharge . . . or otherwise . . . discriminate against any individual with respect to his compensation, terms, conditions or privileges of employment, because of . . . religion.”

\textsuperscript{328}. See Clark, supra note 10, at 649-65; White, supra note 149, at 1728.
under the more recent, less stringent test established by Employment Division v. Smith, as well as under the stricter test developed in Sherbert v. Verner and required under various state “Religious Freedom Restoration Acts” (RFRAs), religious health care providers would be unlikely to prevail. In Smith, the appellants were arrested under an Oregon law criminalizing possession of a controlled substance when they were caught using peyote. At least one of the appellants argued that his use of peyote was part of his religious practice and therefore protected by the Free Exercise Clause. In the majority opinion, Justice Scalia distinguished between absolute protection for religious belief and qualified protection for religious conduct, and concluded that, since the Oregon criminal law was a neutral law of general applicability that did not target religion, its application to the appellant was not prohibited by the Free Exercise Clause. According to the Court, the stricter Sherbert test applies only where a law is non-neutral or not of general applicability (for example, an unemployment compensation law that requires consideration of the individual circumstances of the employee in deciding whether she deserves compensation) or where a law implicates other constitutional rights.

Like the Court in Smith, the Court in Sherbert distinguished governmental regulation of religious beliefs, which is impermissible, from governmental regulation of “certain overt acts prompted by religious beliefs or principles . . .” which is permissible where the actions regulated “pose . . . some substantial threat to public safety, peace or order.” However, because it found that the appellant’s conduct in refusing to work on her Sabbath Day due to her Seventh Day Adventist beliefs did not pose such a threat, the Court required the state to

332. Smith, 494 U.S. at 897.
333. Id. at 877-79.
334. Id. at 878-82.
335. Id. at 890.
336. Id. at 881-82.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

justify its denial of unemployment compensation to the appellant with a "compelling state interest." The Court found that the mere possibility that "unscrupulous claimants feigning religious objections to Saturday work might . . . dilute the unemployment compensation fund" was not substantiated in the record and did not constitute such a compelling interest. Furthermore, the Court concluded that even if such a possibility did "threaten to dilute the fund and disrupt the scheduling of work, it would plainly be incumbent upon the appellees to demonstrate that no alternative forms of regulation would combat such abuses without infringing First Amendment rights.

Thus, while Smith applies a rational basis test to generally-applicable neutral state laws that do not target religion, Sherbert and various state RFRAs apply a compelling interest test to state laws that potentially impair the free exercise of religion. Whether the rational basis test or the compelling interest is applied, Clark and White contend that, because of the strong policy arguments in favor of state laws requiring health care providers to offer reproductive services, states should be able to demonstrate that they have compelling interests that justify their laws. Clark observes:

Thus, in the religious hospital conflict [i.e. as in Sherbert], even if courts do apply . . . [the compelling interest test], an exemption would probably still be denied in light of the countervailing government interests to ensure access to medically necessary care and to help counter gender discrimination in the health care system.

Regarding individual health care professionals, the state may also have a compelling interest in assuring that these professionals practice in a competent manner.

While the Free Exercise Clause may not protect the rights of religious providers to refuse to provide health services that the government considers necessary to protect public health, the Establishment Clause does not appear to prohibit the adoption of refusal clauses. The Establishment Clause "sets a maximum amount of assistance" that the government may offer religious entities. One might also argue that in adopting refusal laws that exempt

338. Id.
339. Id. at 407.
340. Id.
341. Clark, supra note 10, at 664; White, supra note 149, at 1728.
342. Clark, supra note 10, at 664.
343. See, e.g., Noesen v. Wis. Dep't of Reg. & Licensing Pharm. Examining Bd., No. 05CV212, slip op. at 15-16 (Wis. Cir. Ct. Feb. 3, 2006).
344. White, supra note 149, at 1729.
religious providers from, for example, general laws requiring the dispensing of emergency contraception for rape victims, states are unconstitutionally endorsing the practice of religion. However, since most refusal clauses exempt objectors who base their position on either religious or moral convictions, it is likely these clauses would survive a challenge based on the Establishment Clause. Even if the clauses exempted religious providers only, the trend among courts is to permit broad governmental accommodation of religion short of actual endorsement of a particular religion.

Still, an Establishment Clause challenge might be raised successfully if a refusal clause permits only members of one religious sect to assert their religious-based refusals; conversely, a clause that exempts all religious providers might be viewed as relieving from religious objectors burdens that otherwise would interfere with their free exercise of religion. In *Children’s Healthcare Is a Legal Duty, Inc. v. Min de Parle*, the Eighth Circuit Court of Appeals held that a provision in the Medicare Act that exempted sanitaria operated by “Religious Non-Medical Health Care Institutions” from various medical standards that were required from other institutions receiving reimbursement under the Act does not violate the Establishment Clause. Although a lower court had held that the original version of the provision was unconstitutional because it specifically exempted only sanitaria operated by “Christian Science” practitioners, Congress amended the law to refer to religious providers in general, causing the Court of Appeals to conclude that the provision was “by its terms sect-neutral.” Moreover, the court determined that the exemption “possessed a secular legislative purpose because it removes a special burden imposed by the Medicare and Medicaid Acts upon persons who hold religious objections to

345. Id.

346. See, e.g., County of Allegheny v. ACLU Greater Pittsburgh Chapter, 492 U.S. 573, 601 n.51 (1989) (noting that government efforts to accommodate religion are permissible under the Establishment Clause when they remove burdens on free exercise of religion).

347. The *Allegheny* court observed: “Whatever else the Establishment Clause may mean (and we have held it to mean no official preference even for religion over nonreligion), it certainly means at the very least that government may not demonstrate a preference for one particular sect or creed . . . .” *Allegheny*, 492 U.S. at 605 (citation omitted).

348. 212 F.3d 1084 (8th Cir. 2000).

349. Id. at 1100.


351. *Min de Parle*, 212 F.3d at 1090. As the dissent points out, this is a curious conclusion since the legislative history of the provision demonstrates that the “sole impetus for the present law was the alleged plight of Christian Scientists.” Id. at 1102.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

medical care.\textsuperscript{352} Thus, even if a refusal statute limits itself to religious, as opposed to moral, objectors, proponents might successfully argue that that such statutes are merely "relieving a burden" from religious health care providers so that they would be able to freely exercise their religious beliefs.\textsuperscript{353}

Because refusal clauses seem to lie in a legally gray area, they have been subject to an abundance of political play in the past thirty years. The increasing political influence of religious groups in America during this period has resulted in an increase and broadening of religion-based refusal clauses passed by state legislatures and Congress. Meanwhile, no corresponding lobbying group has been effective in passing legislation to protect patient access to health care.

In fact, with the development of large managed care plans and the increase in the number of hospital mergers, patients' freedom to choose their health care providers has decreased. Since many managed care plans and merged hospitals involve religiously affiliated institutions, the availability of certain types of medical procedures, especially in the areas of emergency contraception, abortion, sterilization, and assisted reproduction, has decreased.\textsuperscript{354} Catholic hospitals have been one of the fastest growing segments of health care. Susan Fogel and Lourdes Rivera report that in 1999, Catholic systems reported a 25.1% increase in the number of Catholic-owned acute care hospitals and a 22.8% increase in staffed beds, while the number of non-Catholic hospitals during the same time period decreased.\textsuperscript{355} Additionally, Fogel and Rivera report that by 2002 seven of the top ten hospitals in the United States were Catholic. Further, they note that by 2004, five of the ten largest health care systems in the United States were Catholic; Catholic institutions controlled the largest single group of non-profit hospitals in the United States; the Ascension Health System was the largest non-profit system with net patient revenues of over $7.2 billion; and eighteen percent of all hospitals and twenty percent of all hospital beds in the United States were controlled by Catholic systems.\textsuperscript{356} They also report that there were 171 mergers or acquisitions of secular hospitals by Catholic health systems between 1990 and 2001.\textsuperscript{357} In addition to the growing influence of religious hospitals as the result of

\textsuperscript{352} Id. at 1093.

\textsuperscript{353} Notwithstanding the courts' general sympathy to governmental accommodations of religion, White suggests that where the government provides funding to health care institutions, but allows religious institutions to modify the package of services they provide, an Establishment Clause challenge might be successful. White, supra note 149, at 1732.

\textsuperscript{354} See Fogel & Rivera, Saving Roe is Not Enough, supra note 38, at 729-32.

\textsuperscript{355} Id.

\textsuperscript{356} Id.

\textsuperscript{357} Id. In addition to formal mergers, many religious hospitals and long-term care facilities develop other types of corporate relationships, including the creation of for-profit subsidaries, joint ventures, acquisitions or other contractual affiliations with for-profit hospital systems or mergers
mergers, their influence is spreading as the result of what William Bassett calls the “corporate transformation of hospitals and acute care medical facilities under the impetus of managed care imperatives.” He points out that patients are often not in the position to choose their health insurers, let alone their own health providers since, increasingly, those choices are being made by their employers or unions or, if they are poor, by the government.

Catholic hospitals are governed by the Ethical and Religious Directives for Health Care Services, promulgated by the United States Conference of Catholic Bishops. These directives prohibit virtually all reproductive health services, including contraception other than “natural family planning,” most infertility treatments, sterilizations, and abortion. There are no exceptions for rape, incest, or to protect the life or health of the pregnant woman. The directives also prohibit harvesting the eggs of cancer victims for later implantation and permit Catholic hospitals to refuse to withdraw artificial nutrition in accordance with a terminally ill patient’s wishes. The United States Catholic Conference Board opposes counseling HIV-infected patients regarding the use of condoms to prevent the spread of HIV. Some or all of these positions are taken by health facilities owned by other religious denominations, for example, Seventh-Day Adventists, the Southern Baptist, and American Baptist hospitals. Thus, many patients may be deprived of medically indicated care simply because the hospital that serves their geographic area is owned by a religious institution.

Patient access to care is particularly affected in rural areas where there may be few providers who offer the care required. For example, in 2000, eighty-seven involving public and community hospitals. Unless the religious hospital is completely absorbed by a for-profit system, the religious hospitals’ moral directives often apply to these ventures. See Bassett, supra note 38.

358. Bassett, supra note 38 at 457.
359. Id.
360. Id. at 517-18. The Federal Medicaid statute requires that recipients have access to family planning. However, the Balanced Budget Act, enacted in 1997, permits religious hospitals and Medicaid and Medicare managed care plans to refuse to provide reproductive health services to which they object on moral grounds. If they do so object, the state is charged with providing information to recipients about where such service is available. Id.
361. Fogel & Rivera, Saving Roe is Not Enough, supra note 38, at 732.
362. Id.
363. Id.
364. Id. at 737.
365. Bassett, supra note 38, at 511-12. However, while the Board does not promote the use of condoms, it does permit the provision of accurate information about prophylactic devices proposed by some medical experts as ways to reduce the transmission of HIV. Id.
366. Id. at 504-07.
percent of counties in the United States had no abortion provider. One third of American women lived in these counties, which means that they had to travel to other counties or other states to obtain this constitutionally protected service. Of women obtaining abortions in 2000, twenty-five percent traveled at least fifty miles, and eight percent traveled more than one hundred miles. As of February 2006, fourteen out of sixty-seven Pennsylvania counties did not have hospital emergency rooms with policies requiring the dispensing of emergency contraception on-site.

One of the problems with the various new corporate forms assumed by religious hospitals is that it is often difficult for patients to know in advance which hospitals have policies restricting access to certain procedures. In order to maintain federal funding, many religious hospitals have expanded their boards of directors to add members of the public and have opened their hiring policies beyond members of their particular religious sect. With the decline of charitable immunity protections, they have also begun to restructure to protect their assets from suit. The result of this “re-incorporation movement,” according to Bassett, is to separate hospital facilities as independent corporations from their sponsoring religious bodies to dampen religious symbolism and religious control . . . [and to hide] the religious ministry to the sick behind bland neutral facades. For prospective hospital patients and insurance purchasers today it is not always easy to distinguish a religious hospital from another private, community, or in many cases, commercial health care franchises.

This point was confirmed by a national survey in 2000 that found that almost half of the women questioned believed that if they were admitted to a Catholic hospital, they would be able to get services that were contrary to Catholic teachings.

The Hyde-Weldon Amendment, as well as the most recently enacted state refusal statutes, allow health care providers not only to refuse to provide certain types of care, but also to refuse even to inform patients of the availability of

368. ACLU of Penn., PA Hospital List (Feb. 8, 2006), http://www.aclupa.org/education/clarabellduvalreproductiv/emergencycontraceptionproj/ (follow “Do the hospitals in my county provide EC to rape victims?” hyperlink; then follow “Counties A-E” hyperlink).
369. Bassett, supra note 38, at 545.
370. Id. at 549.
371. Id. at 551-52.
372. Fogel & Rivera, Saving Roe is Not Enough, supra note 38, at 740.
certain types of care, thus further restricting patients’ rights to receive medically indicated care. There has been some movement by states to require managed care organizations and insurance companies to inform their members of any restrictions on the covered services. For example, California enacted the Kuehl-Thomson Health Benefits Act of 1999, which requires a paragraph to be inserted in twelve-point boldface type and posted in a prominent location on the websites of health plans, disability plans, and Medi-Cal plans that specifically states which services might not be covered. However, until all states follow California’s lead, patients will be disadvantaged by lack of information in their choice of providers. Medicaid recipients outside of California who are mandatorily enrolled in managed care plans that refuse to provide certain services are often not given information about how to obtain the services that their health care provider refuses to provide. Moreover, as Fogel and Rivera point out, even if these patients “have the right to go out-of-plan to obtain these services . . . that assumes that there are out-of-plan geographically-accessible services and that the women know how to access them.”

Several authors have suggested that, in view of these changes in the health care system, the prerogative of religious institutions to adhere to their religious beliefs should no longer be viewed as absolute, but instead should be balanced against the rights of patients to have access to health care. Among the so-called compromise tactics suggested to achieve the balance between patients’ rights to access and health care professionals’ rights to refuse treatment are: (1) full disclosure so that patients know, before they sign up for a managed care plan or enter a hospital, whether the health care provider objects to providing particular types of care; (2) open and direct access laws that allow patients whose

373. *Id.* at 741; *see also* Bassett, *supra* note 38, at 579 (reporting that eleven states require that subscribers be notified of any restrictions on services provided by their plans).

374. CAL. HEALTH & SAFETY CODE § 1363.02 (West 2006); *see also*, WASH. REV. CODE ANN. § 48.43.065(2)(b) (West 2006) (requiring notification of the service the carrier refuses to cover and written information about where such services may be obtained).

375. Fogel & Rivera, *Saving Roe is Not Enough*, *supra* note 38, at 742.


377. White, *supra* note 149, at 1742-43; *see also* Patient Self-Determination Act, Pub. L. No. 101-508, § 4206, 104 Stat. 1388-44 (1990) (codified as amended in relevant part at 42 U.S.C. 1395cc(f) (2000)) (requiring hospitals to inform patients at the time of admission of “an individual’s rights under State law (whether statutory or as recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives” and of “the written policies of the provider or organization respecting the implementation of such rights . . . “); *In re Requena*, 517 A.2d 869, 870 (N.J. Super. Ct. App. Div. 1986) (holding that the family of a patient seeking withdrawal of artificial nutrition should have received advance notification of the nursing home’s
managed care providers refuse to provide certain types of care to seek care directly from other providers whose reimbursement will be paid by the managed care plan;\(^\text{378}\) (3) referrals to other qualified providers;\(^\text{379}\) (4) merger agreements that provide for care that is objected to by the religious partner to be provided by the secular partner;\(^\text{380}\) (5) classification of hospitals as either secular and truly sectarian institutions, with laws permitting only the latter to refuse to provide certain services;\(^\text{381}\) (6) harsher standards that allow refusal to treat only on the basis of "true conscientious objection";\(^\text{382}\) and (7) suggestions that objectors consider shifting specialties or selecting a different occupation.\(^\text{383}\)

Each of these proposed compromises raises problems of its own. Full disclosure and open access will only work under limited conditions. The recipient must be sufficiently educated to understand the materials provided by the managed care plan and sufficiently sophisticated to understand the potential ramifications of her choice of health plans on her future health care; there must be alternative health plans available; and they must be convenient. Under-educated (often poor) clients may not comprehend the necessary information. In fact, many educated health care consumers have found themselves bewildered in trying to choose among various health plans, considering the range of services addressed in their brochures. Also, managed care plans have little incentive to provide information about providers outside of their networks, since providing such information reduces a managed care plan's control over its members' health care.\(^\text{384}\) Moreover, it can be difficult for an individual to anticipate at the time she joins a health plan exactly what services she may need in the future. For example, a woman might enroll in a health plan anticipating that she will require prenatal

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\(^\text{378}\) White, supra note 149, at 1745.

\(^\text{379}\) Fogel & Rivera, Saving Roe is Not Enough, supra note 38, at 729; Law, supra note 38, at 290.

\(^\text{380}\) Fogel & Rivera, Saving Roe is Not Enough, supra note 38, at 747 (suggesting that mergers are one of several "creative solutions to preserve some range of access to otherwise prohibited services," but noting that "the solutions are limited" and produce results with which "not everyone is always happy"); White, supra note 149, at 1736-37.

\(^\text{381}\) ACLU REPROD. FREEDOM PROJECT, supra note 8.

\(^\text{382}\) Law, supra note 38, at 303.


\(^\text{384}\) White, supra note 149, at 1746.
Encouraging referrals to other qualified providers is a helpful alternative only in non-emergency situations and only if other qualified providers are available and convenient. A few statutes, as well as some codes of ethics, require that patients be transferred to other willing providers, at least in the context of end-of-life care. However, in addition to the possibility that there may be no willing provider available, especially in rural areas (and even in urban areas when the treatment is a controversial one), this option overlooks some possibilities. As a threshold matter, a patient may be unwilling to accept a new provider. Even more notably, a health care professional may decide that her personal beliefs are so inflexible that she cannot condone participating in the requested treatment even if her participation is limited to informing or referring the patient to another provider (as in the Noesen case). Likewise, Pellegrino states that “[r]espect for the patient’s autonomy does not include referral to a physician who will carry out the procedure if that procedure involves an act the physician deems intrinsically and seriously wrong. For a conscientious physician, this would be an inadmissible degree of formal cooperation.”

Bassett addresses a number of “creative accommodations” that have been advocated, including referrals, “contracting out” services to another provider, creation of separate facilities, and financing and sharing resources with out-patient clinics. However, he also concludes that these options “are not a principled solution” in that they constitute “moral cooperation” in care that the health care professional finds objectionable. Furthermore, he cites examples from Germany where mandated referral by organizations with moral objections “was so profoundly humiliating to women petitioning [for referral] that it set off
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

strident opposition in Germany that continues until today.\textsuperscript{393}

The fourth proposal, involving merger agreements between religious and non-religious health care institutions, can work only if the religious partner agrees that the secular partner may provide the objectionable services. Like referral, this option constitutes a type of “creative accommodation” that would be considered “moral cooperation.” However, White cites several instances in which these types of arrangements seemed to work. For example, Deaconness Hospital in Montana deeded real estate property to Planned Parenthood prior to merging with a Catholic-affiliated hospital.\textsuperscript{394} White also discusses arrangements in which Catholic facilities have created independent physician-sponsored clinics to provide reproductive services, either inside Catholic facilities (but with a separate entrance) or at separate nearby facilities.\textsuperscript{395} Yet, White also notes that as Catholic hospital involvement in mergers has increased, the church hierarchy has become more involved in the negotiations and has sought to enforce the directives more strictly, thus terminating many consolidation negotiations between Catholic and non-Catholic health care entities. In 1996-1997, five of nine consolidation negotiations between Catholics and non-Catholic health care entities were terminated due to Catholic doctrinal issues.\textsuperscript{396}

Another more useful suggestion for addressing the problems proposed by the conflict between health care institutions’ religious tenets and the medical needs of patients has been proposed by the American Civil Liberties Union Reproductive Rights Project. The ACLU suggests that refusal clauses should be analyzed using the following principles: (1) the more the burdens of refusal fall on people who do not share the beliefs that motivate the refusal, the less acceptable any claimed right to refuse; and (2) the more public and secular the setting, the less acceptable an institution’s claimed right to refuse.\textsuperscript{397}

Thus, religiously affiliated hospitals that treat the public would not be permitted to refuse, on the basis of their religious beliefs, to dispense emergency contraception, perform abortions and sterilizations, withdraw life support, etc. On
the other hand, truly sectarian institutions that open their doors only to people who share their beliefs would be permitted to refuse to provide insurance coverage for contraception to their employees. Yet, this proposal fails to address situations in which a religiously affiliated hospital is the only hospital in the region, where a Medicaid recipient is involuntarily assigned to a religious managed care plan, or where, due to corporate restructuring, the religious nature of the hospital is obscured.

In a similar vein, William Bassett proposes that religious health care institutions should not be permitted to refuse to provide certain types of care unless they make full disclosure to patients and patients are able to choose freely other available providers:

To remain free to curtail otherwise legally-permissible medical procedures the hospitals must accentuate their religious identity in unmistakable terms so that patients know what their choices are, avoid monopolization of general health services in particular communities, and restrain the semblance of competitive commercialization. Patients must know in advance what services are or are not available from contract health care providers and practically and feasibly be able to act on those choices. 398

Bassett further suggests that, notwithstanding the line of cases that protect the rights of religious health care institutions to freely exercise their religious beliefs, the state should be permitted to abridge such rights in four cases: (1) when children and handicapped victims require treatment for rape or incest; (2) when adult female victims of sexual crimes require emergency treatment; (3) in the provision of blood transfusions, organ transplants, or medically routinized and standard care procedures, such as dialysis, or to save or prolong the life of mentally incompetent adults entrusted to the care of the hospital; and (4) in providing care to sexually active AIDS patients. 399 Since Bassett himself recognizes a generalized inability, due to various social forces, of individuals to choose their health care providers, it is not clear why he would limit the State’s ability to override the religious rights of health care institutions only to these limited instances. Following his line of reasoning, whenever individuals’ freedom to choose their health care providers is limited, these providers should be required to offer the requested and medically indicated care.

Also problematic is the fact that the solutions proposed by both the ACLU and Bassett pertain to institutional health care providers only. Neither challenges the right of individual health care professionals to assert their religious or moral objections to patient care. In fact, the ACLU lauds the Church Amendment as a

399. Id. at 572-73.

http://digitalcommons.law.yale.edu/yjhple/vol6/iss2/2
useful model for protecting the rights of individual health care professionals to refuse to participate in medically indicated treatments based on their personal moral or religious beliefs.\textsuperscript{400} provided that the refusing health care professional furnishes the patient with accurate and complete information, refers the patient to another provider, and provides the "objectionable" medical care in emergency situations.\textsuperscript{401} None of the proposed compromises suggest that individuals who choose to become health care professionals, who obtain monopolistic licenses awarded by the state, and who assume a fiduciary duty to "put their patients' interests first" should be precluded from imposing their personal religious or moral beliefs on their patients.

While accepting the general principle that individual health care professionals have the right to refuse to participate in certain treatments, at least one author has suggested that refusals should not be honored without challenge. Raising the possibility that many refusal clauses may relieve health care professionals from participating in abortions when in reality they hold no strong religious convictions but merely want to avoid a controversial issue, Sylvia Law suggests that the reasons for the health care professional's refusal should be evaluated.\textsuperscript{402} Like those who conscientiously object to military service, physicians should be excused from participating in abortions only if they have "true conscientious objections."\textsuperscript{403} Presumably, this would require health care professionals to "make their case" before some sort of professional or institutional review board.

This idea is explored further in an article by William Nelson and Cedric Dark,\textsuperscript{404} suggesting that "claims of conscience" should be first brought to a health care professional's immediate supervisor to evaluate such claims for validity. Claims that appear to be valid would then be passed on to an organizational review board composed of members from various ethnic, religious, and academic settings. The mission of this board would be to evaluate the genuineness of the claim based on the following factors: (1) whether the objection fits within "a coherent system of moral, religious, cultural or philosophical beliefs; (2) whether the belief reflects "a consistently and diligently held core value of the petitioner"; (3) whether the belief is such "a key component of the petitioner's internal

\textsuperscript{400} ACLU REPROD. FREEDOM PROJECT, supra note 8, at 10; see also Bassett, supra note 38, at 456 ("While the rights of conscience of each and every health care professional must be securely safeguarded at law, institutional ambiguities should be resolved in favor of the individual patient.").
\textsuperscript{401} Fogel & Rivera, Saving Roe is Not Enough, supra note 38, at 729.
\textsuperscript{402} Law, supra note 38, at 303.
\textsuperscript{403} Id.; see also Conscientious Objectors, 32 C.F.R. §§ 75.3-5 (2006) (requiring conscientious objectors to demonstrate a "firm, fixed and sincere" belief).
framework that violation of that belief would cause significant harm to him or her”; and (4) whether it would be “inconsistent with the petitioner’s core values to participate in the procedure or treatment.”

If the claim is found to be valid, some sort of reasonable accommodation should be made by the institution that does not create undue hardship for the organization, its employees, or the patient. If the claim is found not to be valid, the petitioner should be reassigned or possibly terminated, in which case the petitioner would retain the right to file an appeal, including possibly an external one.

Whether any health care settings other than those affiliated with universities would have the knowledge, interest, and resources to undertake the establishment of such boards is questionable. Moreover, it is likely that these health care institutional boards, in an attempt to avoid litigation, would find in favor of the health care professionals in the majority of cases that would come before them. Nevertheless, establishing a formal procedure that would require health care professionals to articulate and defend their objections would filter out health care professionals whose objections do not arise from their “core values.” Of course, this procedure would apply only to health care professionals working in an institutional setting, and not to health care practitioners in private practice. The only potential existing mechanisms for reviewing the justification for provider refusals among private practitioners are their respective professional boards. However, these boards are often under-staffed, under-funded, and without the requisite expertise; consequently, their willingness and ability to undertake such a task is dubious. Furthermore, this type of examination, at least in public hospitals and state licensing boards, may raise questions under the Free Exercise Clause because it would require a neutral body to inquire into the “centrality” of the refusal to the individual’s core beliefs. This mode of inquiry was rejected by the Supreme Court, insofar as it would be exercised by courts since it “would enmesh judges in an impermissible inquiry into the centrality of particular beliefs or practices to a faith.”

Most importantly, it is arguable that the depth of a health care professional’s personal beliefs is irrelevant in light of her undertaking the responsibility to put the patient’s best interest ahead of her own interests.

Finally, several commentators have suggested that if a physician cannot participate in a medical procedure due to her personal moral or religious beliefs, she should consider practicing in an area of medicine in which the patient’s access to care would not be compromised. However, since changing medical

405. Id. at 54.
406. Id. at 55.
408. See, e.g., Adams, supra note 383, at 225-26 (maternal-fetal medicine); Blustein & Fleischman, supra note 383, at 26 (same); Thorp et al., supra note 383, at 28 (same).
technology and changing social mores may implicate a clinician’s moral and religious beliefs in ways that cannot be foreseen at the outset of her professional training, this suggestion is impractical. For example, an internist training today might not consider whether she has moral objections to the application of technologies and treatments derived from stem cell research simply because the technology has not yet been developed.

A key assumption in most of these proposals is that individual, as opposed to institutional, health care providers generally have a right, based on their religious beliefs or personal moral codes, to refuse to provide medically indicated health care to their patients. This Article contests this assumption on the grounds that the primary goal of health care professionals should be to promote their patients’ health, not to advance their own personal moral judgments.

V. DISTINGUISHING PROFESSIONAL ETHICS AND THE PERSONAL BELIEFS OF HEALTH CARE PROVIDERS

In cases involving reproductive issues, health care professionals have tended to assert religious or moral objections, whereas they have generally asserted professional ethical objections, rather than religious objections, in cases involving end-of-life issues. While courts often have refused to accept health care professionals’ personal interpretations of their professional ethical responsibilities, they generally attribute significant weight to commonly accepted professional ethics. Thus, in upholding patients’ legal rights to refuse medical treatment, courts have relied upon the medical community’s generally accepted ethical principle that patients have the right to refuse unwanted medical care. The ethical principle that favors patient autonomy has also manifested itself in many of the cases that address issues of medical futility, “trumping” physicians’ objections based on their personal value judgments regarding what constitutes “quality of life.”

409. These cases generally involve the provision of care that has the desired physiological effect, but where there is a dispute between caregivers and the patient’s surrogate about the net benefit of the treatment to the patient’s quality of life. Conversely, several physicians’ organizations have issued statements and several states have passed statutes that state that physicians are not required to provide “ineffective” treatment. See, e.g., ALASKA STAT. § 13.52.060(f) (2005); ME. REV. STAT. ANN. tit 18-A, § 5-807 (2005); MD. CODE ANN., HEALTH-GEN. § 5-611(b)(1) (West 2005); N.D. CENT. CODE § 23-06.5-09(3) (2005); WYO. STAT. ANN. § 35-22-410(v) (2005); American Thoracic Soc’y, Withholding and Withdrawing Life-Sustaining Therapy, 155 ANNALS OF INTERNAL MED. 478, 481-83 (1991); Task Force on Ethics, Soc’y for Critical Care Med., Consensus Report on the Ethics of Forgoing Life-Sustaining Treatments in the Critically Ill, 18 CRITICAL CARE MED. 1435 (1990); Am. Med. Ass’n, E-2.035, Futile Care (Jan. 4, 2005), http://www.ama-assn.org (search “E-2.035”; then follow “Professionalism: E-2.035 Futile Care”).

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Professions establish their own acceptable standards of competence, as well as unique professional ethics. General medical malpractice standards require physicians to practice in accordance with "the degree of skill and care ordinarily possessed by a reasonable and prudent physician in the same medical specialty acting under the same or similar circumstances." Departing from this standard may result in liability or professional disciplinary actions. The standard of care is established through expert testimony on the customary practice within a particular specialty, reference to medical literature, and guidelines established by institutions, accrediting agencies, and professional associations. Thus, a physician or other health care professional who refuses to provide medically indicated treatment to a patient because the health care professional has determined that providing the treatment would violate her religious beliefs is likely to be found to have committed professional malpractice; most refusal statutes, however, wrongly provide immunity for this type of malpractice.

The prevailing ethical norms of professionals are codified in their codes of professional ethics. These are standards that are collectively defined and accepted. An individual physician, nurse, or pharmacist may have her own personal beliefs and values derived from her religion, culture, family, and community. However, these are personal beliefs, as opposed to professional standards. Clearly, professional ethics have a place in professional decision-making, since they are at the core of every profession. The question is what place, if any, an individual health care provider's personal moral and religious beliefs should have in medical decision-making.

"Professional integrity" in medicine, according to Miller and Brody, "represents what it means normatively to be a physician; it encompasses the values, norms and virtues that are distinctive and characteristic of physicians."
Unlike “personal integrity” which relates to “the full identity of persons which characterizes their lives as a whole,” professional integrity relates to the “moral identity of those who occupy a distinctive social role.” While there remains some free scope for individuality in the practice of medicine, and a good physician may have a unique personal style, professional identity generally constrains individual expression in a way that personal identity does not.

Thus, an athletic orthopedic surgeon may, due to his personal values, believe that a patient should undergo repair of the tendon in his knee so that the patient can continue skiing, but the patient might decide that the risks of surgery outweigh the value to him of continuing his own athletic pursuits. A reconstructive plastic surgeon may, on the basis of her personal aesthetic values, believe that nasal reconstructive surgery on a woman with an already small nose would not be aesthetically pleasing, but most people would agree that, while the surgeon might discuss with the patient the patient’s reasons for requesting the surgery (as well as the risks of surgery), the surgeon’s aesthetic opinions should not be determinative. A heart surgeon might recommend against bypass surgery in a homosexual patient dying from AIDS because surgery would be too risky and unlikely to extend the patient’s life, but not because she thought that the patient “deserved to die” as a result of his assumptively promiscuous behavior. No one would suggest that the physician’s personal values should prevail over the patient’s wishes in these medical decisions, all of which will affect the patient’s, and not the physician’s, life.

Similarly, a physician’s personal attitudes about medical procedures should not influence his advice to patients who do not share his beliefs. A Jewish physician should not advise non-Jewish parents to circumcise their newborn son unless his advice is based on prevailing medical standards. A nurse who is a Jehovah’s Witness should not advise a hemophiliac not to accept blood transfusions. Physicians, like all other humans, carry their own personal biases and prejudices that affect who their friends are, what clubs they join, and so on. No one expects physicians to carry these prejudices into their medical practices. Yet many refusal clauses allow physicians to refuse to provide certain controversial medical procedures for any reason, including personal prejudice. Even those that require some moral or religious justification rarely provide explicit exceptions when the result of the exercise of such moral or religious beliefs is denial of care to an identifiable group or class of people. The physician who refused to provide artificial insemination to a lesbian may be just one

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414. Id.
415. Id.

343
example of this type of situation. Another example would be a nurse who refuses to participate in the care of a homosexual with AIDS because her religion instructs her that AIDS is the homosexual’s just punishment for immoral behavior.

While Miller and Brody distinguish personal integrity from professional integrity, they argue that a physician should not have to sacrifice her personal integrity in the exercise of her professional integrity. They argue, for example, that a physician who is conscientiously opposed to performing abortions should not be obligated to compromise her personal integrity or her conscience by performing abortions, even if performing abortions would not violate her professional integrity. Similarly, Pellegrino views physicians as forming “consciences in two inseparable dimensions of their lives—the professional and the personal” where “[b]oth professional and personal conscience are owed protection.” In defending the rights of religious physicians to exercise their religious objections to participating in certain medical treatments, Pellegrino goes so far as to state that a secular society’s demands for “value neutrality” “is a psychological schism that violates the integrity of the person as a unity of body, soul, and psyche,” and that “value neutrality” elevates “secularism to the level of a social orthodoxy.” He argues that “[p]ersonal and professional ethics are not fully separable from each other” and that the autonomy of the physician demands that she be allowed to express her beliefs through her actions. As far as Catholic physicians are concerned, Pellegrino writes that “to... ignore,

416. N. Coast Women’s Care Med. Group, Inc. v. Superior Court, No. D045438, 2006 WL 618767 (Cal. Ct. App. Mar. 14, 2006) (ordering the superior court to vacate its summary judgment for the plaintiff in a case involving a physician’s refusal to inseminate a patient involved in a lesbian relationship, finding that there is an issue of fact as to whether the refusal was based on the patient’s status as a lesbian or as an unmarried person). In either case, the physician allegedly based her refusal on her personal prejudices, as opposed to medical or professional ethical considerations. 17. Miller & Brody, supra note 413, at 10. 18. Pellegrino, supra note 321, at 229; see also Pellegrino, supra note 40, at 51-53. 19. Pellegrino, supra, note 321, at 240. The “human potential” movement at the end of the twentieth century promoted the concept that an individual should seek “wholeness” in his life and work. This movement was reflected in discussions within the legal profession along two axes. Those at one pole believed that “the lawyer needs a role-specific ethic which puts the client first, even in relation to the lawyer as a fully connected, rooted person...” Stephen L. Pepper, Autonomy, Community, and Lawyers’ Ethics, 19 CAP. U. L. REV. 939, 960 (1990). The other pole consisted of those who were critical of professional norms that “bleach out” one’s religion. See, e.g., Howard Lesnick, The Religious Lawyer in a Pluralist Society, 66 FORDHAM L. REV. 1469, 1486 (1997-1998). 20. Pellegrino, supra note 321, at 240. 21. Pellegrino, supra note 40, at 51. 22. Pellegrino, supra note 389.
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

repress, or act against conscience for any reason is a violation of philosophical as well as theological ethics, an error in moral agency and a sin against God."\(^{423}\)

If separating the personal from the professional creates a psychically damaging schism in the individual, this would mean that the physician who personally believes that experiencing pain without complaint will hasten a person's journey to heaven is justified in applying this strongly held belief in his medical practice by withholding pain medication. Or that a physician who believes that abortions are so antithetical to her personal beliefs that she is unwilling to participate in the procedure even to save the life of the pregnant woman nonetheless is fulfilling her professional responsibilities. These are untenable positions.\(^{424}\)

Mark Wicclair takes a more thoughtful approach. He argues for a more limited basis upon which physicians would be justified in conscientiously objecting to participating in certain types of medical treatment.\(^{425}\) He asserts that "an appeal to conscience has significant moral weight only if the core ethical values on which it is based correspond to one or more core values in medicine."\(^{426}\) A physician's personal beliefs, which arise from her moral framework or religious orientation, have less weight. Wicclair uses the following examples to illustrate his point.\(^{427}\) One physician, Dr. K, disagrees with her patient's decision to reject aggressive therapy for his life-threatening condition. Her patient, who is suffering from terminal cancer, prefers to become a hospice patient to experience as little pain and loss of dignity as possible. However, Dr. K believes that she would be betraying her calling as a physician if she lets the patient die without further efforts to stop the disease's progress. Another physician, Dr. L, is opposed to providing pain medication because he believes that pain is a sign of a moral flaw and is therefore deserved. Because of this belief, when his patient requests pain medication, Dr. L responds that he cannot, in good conscience, prescribe any. Wicclair suggests that Dr. K's conscientious objection has more moral weight than Dr. L's moral objections because Dr. K's objections "can be defended by citing certain values within medicine, such as life and health,"\(^{428}\) even though it fails to consider other important goals such as the

\(^{423}\) Pellegrino, supra note 321, at 227-28.
\(^{424}\) Nevertheless, Pellegrino argues that even emergency situations “cannot excuse physicians from fidelity to their personal or moral beliefs. Genuine efforts by patients or families to find a physician whose beliefs are congruent with the patient’s must continue; meanwhile, the attending physician must continue to care for the patient in accord with the physician’s deepest held beliefs.” Pellegrino, supra note 389, at 80.
\(^{425}\) Mark R. Wicclair, Conscientious Objection in Medicine, 14 BIOETHICS 205 (2000).
\(^{426}\) Id. at 217.
\(^{427}\) Id. at 215-21.
\(^{428}\) Id. at 216.
amelioration of suffering, patient autonomy, and dignity. In contrast, Dr. L’s opposition to pain medication “is based on beliefs and values which are foreign to medicine.”\textsuperscript{429} This approach is consistent with the approach of this Article in positing that health care professionals should be encouraged to apply principles of professional ethics in treating their patients; however, they should be discouraged from injecting their personal moral or religious beliefs into their practice.

Describing medical professionalism “as an activity that involves both the distribution of a commodity and the fair allocation of a social good but that is uniquely defined according to moral relationships,”\textsuperscript{430} Wynia and colleagues propose a normative guide of medical professionalism that focuses on the cultivation by physicians of a “devotion to health care values by placing the goals of individual and public health ahead of other goals,”\textsuperscript{431} and by placing the health interests of others ahead of their own personal interests to avoid “even the appearance that they are primarily devoted to their own interests rather than to the interests of others.”\textsuperscript{432} This medical professionalism, for example, requires physicians to provide health care during an epidemic when they risk their own health,\textsuperscript{433} a value that was sorely tested during the AIDS epidemic of recent decades.\textsuperscript{434} However, according to Wynia and colleagues, it is not enough to hold these values; physicians must also speak out about these values, demonstrating “the shared standards of the profession, which may sometimes conflict with personal beliefs.”\textsuperscript{435} Although these authors were most concerned about the role of medical professionalism within the context of market competition and financial self-interest, their emphasis on returning to core medical values applies equally in the context of physicians who put their own personal moral judgments above their patient’s interests. Just as the rise in physicians’ incomes in the past forty years has, according to Wynia and colleagues, “fostered the trust-destroying belief, whether true or not, that physicians as a group are greedy and take

\begin{footnotes}
\item[429] Id. at 217.
\item[431] Id. at 1613.
\item[432] Id. While the authors focus on financial self-interest, the same point applies to physicians who place their personal morality ahead of their obligations to patients.
\item[433] Snyder & Leffler, supra note 29, at 565.
\item[434] See Glanz v. Vernick, 750 F. Supp. 39 (D.C. Mass. 1990) (involving an estate that filed a legal suit against a hospital and surgeon alleging that the surgeon had refused to perform surgery on the decedent because of his HIV status); Lindsey Gruson, AIDS Fear Spawns Ethics Debate as Some Doctors Withhold Care, N.Y. TIMES, July 11, 1987, at A1.
\item[435] Wynia et al., supra note 430, at 1614.
\end{footnotes}
advantage of patients,"436 so the assertion by health care professionals that their personal moral judgments trump patients’ health interests is likely to undermine patient trust.

Health care professionals’ fiduciary duty to their patients has been well established in various contexts. Legal actions against physicians for breaching their fiduciary duty to patients have increased in recent years as patients have suspected that their physicians’ treatment decisions were motivated by financial incentives provided by managed care organizations, rather than by the patients’ health interests.437 The American Medical Association emphasized physicians’ fiduciary duty to their patients when it issued a report on physicians who refer to facilities in which they have a financial interest, noting that “the profession of medicine is unique and that physicians are expected to put their patients’ interests first.”438 In the context of medical malpractice litigation, one court described the physician’s fiduciary duty as follows:

The relation of physician and patient has its foundation on the theory that the former is learned, skilled, and experienced in those subjects about which the latter ordinarily knows little or nothing, but which are of the most vital importance and interest to him, since upon them may depend the health, or even life, of himself or family; therefore the patient must necessarily place great reliance, faith, and confidence in the professional word, advice, and acts of the physician.439

That reliance and faith is undermined when a physician or other health care professional puts her own needs above those of her patient.

The fact that health care professionals control patient access to medical care is also relevant in determining the degree to which their personal beliefs should affect their provision of care. Arguing that the physicians in the Wanglie case should not have had the right to withhold life support over the objections of the patient’s husband, Veatch and Spicer contend that the decision to stop mechanical ventilation was based on the physicians’ personal ethical and philosophical standards, rather than medical science. In such cases, the clinicians’ beliefs and values should not prevail over the patient’s conservator’s wishes, especially since the medical profession is a “licensed professional

436. Id. at 1613.
This idea received additional attention in R. Alto Charo’s recent article in the *New England Journal of Medicine*, in which she criticized the growing invocation of refusal statutes by health care professionals to excuse them from participating in abortions, prescribing contraception, and performing other controversial medical treatments. She suggests that it would be easier to permit health care professionals to refuse to participate in certain procedures, based on their consciences if states did not give these professionals the exclusive right to offer such services. By granting a monopoly, they turn the profession into a kind of public utility, obligated to provide service to all who seek it. Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust—all the worse if it is not in fact a personal act of conscience but, rather, an attempt at cultural conquest.

In other words, in view of physicians’ exclusive ability to provide the requested resource, it would be unjust to allow physicians’ personal beliefs to prevail over the patient’s autonomous decision.

**VI. PRESUMPTION AGAINST THE RIGHT TO REFUSE**

The widely accepted ethical principle that patients are autonomous individuals with the right to make the final decisions concerning their medical care, along with the corresponding principle that appears in all medical professionals’ codes of ethics that the “patient’s interest comes first” leads to the following general rule: patient care decisions should be based on patient autonomy, as mediated by the clinician’s conclusion that the requested therapy (1) is not medically contraindicated (since it is both medically effective and not considered unethical within the profession’s generally accepted concept of ethical practice) and (2) is not illegal. A similar position is taken by Allan Brett and Laurence McCullough in discussing patients who request specific medical interventions. They suggest the following rule:

When a patient seeks to exercise a positive right to an intervention, a necessary condition is that there is either an established or a theoretical medical basis for the patient’s request. If that necessary condition has been satisfied, the patient’s unique circumstances and stated reasons for wanting the intervention should

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440. Veatch & Spicer, *supra* note 293, at 36; see also *id.* at 26-28.
442. *Id.* at 2473.

348
CONSCIENCE CLAUSES OR UNCONSCIONABLE CLAUSES

guide the final decision-making process.\textsuperscript{444}

A health care professional’s personal religious or moral beliefs should not enter into the decision-making process. Under this model, health care professionals would be discouraged from invoking their personal moral, religious, or political beliefs to justify their refusal to participate in abortions, prescribe contraception, or withdraw life support at the request of the patient.

Where there is ongoing disagreement within the medical ethics community about a particular form of treatment, physicians would not be obligated to provide it. For example, health care professionals would not be obligated to participate in physician-assisted suicide, notwithstanding the patient’s request, since the requested action is not generally accepted from a medical ethics standpoint\textsuperscript{445} and, moreover, is currently illegal in all states except Oregon.\textsuperscript{446} If the status of this activity changes from both the viewpoint of prevailing medical ethics and the law, the obligations of health care professionals would similarly change.

This does not mean that a health care professional could not object to participating in certain types of treatment on the basis of her personal conscience; that is, based on her personal religious, moral, or political beliefs. However, personal conscientious objections should be discouraged. Professional schools and organizations should actively promote the concept that the patient’s best interests must prevail over the health care professional’s personal beliefs. There should be a presumption against the validity of conscientious objection based on personal, as opposed to professional, values by health care

\textsuperscript{444} Id. at 1349.
\textsuperscript{445} In Washington v. Glucksberg, 521 U.S. 702 (1997), the Court found against several terminally ill patients and their physicians when they challenged as unconstitutional a Washington statute prohibiting assisted suicide. In holding that the statute did not violate the patients’ Fourteenth Amendment liberty interests, the Court relied on statements of the American Medical Association and other medical groups that “[p]hysician-assisted suicide is fundamentally incompatible with the physician’s role as healer.” Id. at 731. Balancing this interest in the integrity of the medical profession, along with several other important state interests, against the patient’s liberty interest in physician-assisted suicide, the Court upheld the constitutionality of the statute. Id. at 735. This is one of the few cases in which a physician’s professional integrity, along with other state interests, was found to outweigh patients’ liberty interests in making autonomous decisions concerning their health. Cf. Gonzales v. Oregon, 126 S. Ct. 904 (2006), in which the Court, on other grounds, effectively upheld Oregon’s Death with Dignity Act, Ore. Rev. Stat. §§ 127.800-897 (2003), by enjoining enforcement of the Federal Controlled Substances Act, 21 U.S.C. §§ 801-971 (2000), against physicians acting pursuant to the Oregon law. Oregon’s statute permits physicians to prescribe lethal doses of medications to patients that the patients may self-administer.
\textsuperscript{446} Gonzales v. Oregon, 126 S. Ct. at 911.
professionals, whose first obligation should be to promote patient health, not their own interests, and who, through their state-granted licenses, control patient access to medical care.

CONCLUSION

This Article has reviewed current legislation and judicial opinions concerning the right of health care professionals to refuse to participate in health care treatments to which they object on the basis of their personal moral or religious beliefs. Ultimately, this Article proposes a new model for such “conscientious objections,” one that presumes the general obligation of health care professionals, who hold monopolistic state licenses, to participate in requested medical care that is not contraindicated or illegal, notwithstanding their personal moral objections. This model is based on the premise that it is the patient’s best interest (as determined by the patient, but mediated by the health care professional’s medical judgment), not the health care professional’s personal interests, that should govern the professional relationship. This should be the standard taught in professional schools and promoted by professional associations. “Conscientious objections” should be permissible based on prevailing medical ethics; however, to the extent that they are based on the personal morals of the health care professional, they should be actively discouraged.