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Sarah M. Stephens
University of Georgia School of Law

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Freedom from Religion: A Vulnerability Theory Approach to Restricting Conscience Exemptions in Reproductive Healthcare

Sarah M. Stephens†

ABSTRACT: Conscience exemption laws, which permit refusals of service based on personal or religious belief, echo the formal equality approach embodied in antidiscrimination laws. They attempt to promote individual religious autonomy without taking into consideration the power and information disparities between institutional and individual actors and the harm that refusals can cause. Martha Fineman’s vulnerability theory turns formal equality on its head by dismantling our conception of independent individuals, who are freely able to achieve equal outcomes if they are treated alike, and by explaining that the shared vulnerability of all people requires a responsive state to address unequal access to resources that improve resiliency. Focusing on the reproductive healthcare setting, this Article uses vulnerability theory to identify the weaknesses in current conscience exemption laws and to argue the vulnerable patient’s right to information and unfettered medical decisionmaking outweighs the conscience exemption rights of institutions and individuals charged with providing such important social services. Accordingly, the state should take action to prohibit institutions from denying care on the basis of conscience and limit the ability of individual providers to conscientiously object.

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† J.D. 2008, University of Georgia School of Law; B.A. 2004, Emory University. Special thanks to Martha Fineman, Stu Marvel, and the Vulnerability and the Human Condition Initiative for their inspiration and support, the talented staff of the Yale Journal of Law and Feminism for their editorial prowess, and Behrouz Kianian for reading more drafts than anyone really should.

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INTRODUCTION

Many people know the story of Savita Halappanavar. Savita was seventeen weeks pregnant on October 12, 2012, when she went to a hospital in Galway, Ireland complaining of back pain. She learned she was miscarrying and there was no hope for the baby’s survival, so Savita requested several times that doctors complete the miscarriage through an abortion. Abortion to save the life of the mother is legal in Ireland, but the hospital waited three more days—until the fetus died—to complete the miscarriage. The hospital refused to perform an abortion while the fetus was still alive “because Ireland is a Catholic country.” By the time the hospital acted, it was too late to save Savita’s life from the deadly blood infection and septic shock caused by the dying fetus inside of her.

Savita’s story captured news headlines around the world and sparked international outrage. Fewer people hear the stories of the women who similarly are denied reproductive healthcare by religious healthcare organizations in the United States. When Mindy Swank’s water broke at twenty weeks and she

2. *Id.* The established standard of care for unstable patients who are miscarrying is an immediate surgical uterine evacuation, otherwise known as an abortion. Craig P. Griebel et al., *Management of Spontaneous Abortions,* 72 AM. FAM. PHYSICIAN 1243, 1246-48 (2005). Early intervention by abortion reduces the patient’s risk of complications, which can include blood loss, infection, and even death. Lori R. Freedman et al., *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals,* 98 AM. J. PUB. HEALTH 1774, 1776-77 (2008).
4. *Id.*
5. *Id.*
learned that her fetus would not survive, she was refused an abortion by a Catholic hospital in Illinois because there was still a fetal heartbeat. When she woke up bleeding a few weeks later, Mindy sought care at another nearby hospital. She asked the doctors there to complete the miscarriage through an abortion but they likewise refused, citing the religious affiliation of the Catholic hospital. As weeks passed and Mindy’s physical condition worsened, she returned to the hospital several times, and each time she was turned away without being informed that she could seek an abortion elsewhere. It was not until Mindy began severely hemorrhaging that the hospital induced labor. As expected, the baby died shortly after delivery.

Mindy is not alone. Numerous women in the United States have been denied care by healthcare facilities, doctors, nurses, pharmacists, and other healthcare workers based on their religious or personal beliefs. Savita’s healthcare providers questioned their legal ability to act in a predominantly Catholic country where Catholic beliefs are enshrined in law. In the United States, healthcare providers and institutions that refuse to provide care often do so because of their personal beliefs, not pursuant to any perceived or actual legal prohibition. Under laws known as conscience exemptions, the expense, time, embarrassment, emotional harm, and risk to a patient’s physical health caused by conscientious refusals of care are perfectly legal. This is because, in an effort to protect the religious exercise of healthcare providers and facilities, state and federal laws allow these individuals and entities to refuse to provide any treatment they believe is wrong, even when that refusal hurts patients.

Conscience exemptions embody the “formal equality” approach to anti-discrimination law. They attempt to promote individual religious autonomy without taking into consideration the power and information disparities between institutional and individual actors. In the healthcare setting, this can mean that

http://www.slate.com/blogs/xx_factor/2015/04/14/miscarrying_woman_denied_medication_misoprostol_can_be_used_for_both_abortion.html
7. Kaye et al., supra note 6, at 8.
8. Id. at 9.
9. Id.
10. Id.
11. Id.
12. Id.
13. Taggart & Smith-Spark, supra note 1. The death of Savita Halappanavar led to the passage of the Protection of Life During Pregnancy Act, which defines when a woman’s life is at risk such that an abortion may be performed. See Protection of Life During Pregnancy Act 2013 (Act No. 35/2013) (Ir.), http://www.irishstatutebook.ie/eli/2013/act/35/enacted/en/pdf.
14. In other words, conscience exemptions are meant to place all persons with their varying religious beliefs on equal footing before the law, so that no one is forced to act in a way that is contrary to his or her beliefs. “Formal equality promotes individual justice as the basis for a moral claim to virtue and is reliant upon the proposition that fairness (the moral virtue) requires consistent or equal treatment.” The Ideas of Equality and Non-Discrimination: Formal and Substantive Equality, EQUAL RTS. TRUST 2 (Nov. 8, 2007), http://www.equalrightstrust.org/content/ideas-equality-and-non-discrimination-formal-and-substantive-equality (citing Murray Wesson, Equality and Social Rights: An Exploration in Light of the South African Constitution, 2007 PUB. L. 748, 751).
conscience exemptions favor institutional conscience or religious beliefs over the beliefs and choices of individual providers and patients. In practice, conscience exemptions also often favor some religious beliefs over others.

Martha Fineman offers an alternative to traditional equal protection analysis—vulnerability theory—which, rather than concentrating on equal treatment of perceived independent individuals, recognizes that formally equal treatment under the law can reinforce existing inequalities in practice. Focusing on the reproductive healthcare setting, this Article re-frames the debate on conscience exemptions by using Fineman’s vulnerability theory to identify the weaknesses in current conscience exemption laws. The Article asserts that the vulnerable patient’s right to information and unfettered medical decisionmaking should outweigh the conscience exemption rights of institutions charged with providing such important social services. The conscientious objections of an individual provider may sometimes be balanced with the rights of the patient.

Part I of this Article discusses the history of conscience exemptions, beginning with the Church Amendment and other legislation implemented in the years following the Supreme Court’s decision in Roe v. Wade. Part I goes on to discuss recent interest in conscience exemption legislation as part of the conservative movement to limit women’s access to reproductive healthcare and to expand the religious freedom shield in favor of corporate and institutional actors. Part II challenges the formal equality framework underlying conscience exemptions and provides an explanation of vulnerability theory. Part III utilizes vulnerability theory to highlight the dangers of conscience exemptions by explaining how mergers of large Catholic hospital systems with secular institutions have greatly limited access to reproductive healthcare and created conflicts among healthcare institutions, providers, and patients. Part III also argues that, in order to balance the disparities among patients, healthcare providers, and organizations while meeting its obligation to ensure that vulnerable citizens have access to healthcare resources, the state must favor the conscience of the patient over those of more powerful institutional and individual actors. Part IV concludes by offering a prescriptive remedy in the form of draft federal legislation to prohibit institutions from denying care on the basis of conscience and limit the ability of individual providers to conscientiously object. The legislation provides a private right of action against healthcare institutions that fail to provide adequate care to their patients.

I. CONSCIENCE EXEMPTIONS IN THE HEALTHCARE SETTING

Under common law, medical personnel and institutions typically have no legal duty to provide patients with medical services or to accept any person as a
patient. However, courts have recognized that once a provider accepts an individual as a patient, the physician is in a fiduciary relationship with that individual; as a result, "undivided loyalty to a patient should guide a physician's decisions, and . . . any influence on a physician's decisions—other than the patient's welfare—must be disclosed to the patient." Providers also have a legal duty to obtain informed consent from their patients, which includes providing sufficient information on all of the options that "either fit within the standard of care or would be considered material to a reasonable patient's decision." The duty to obtain informed consent "is based on professional ethical standards, many of which have been incorporated into law by statute, regulation, and common law." The American Medical Association (AMA), the nation's largest provider group, recognizes the duty of physicians to place patient welfare above all other considerations. Likewise, the American Congress of Obstetricians and Gynecologists has advised that the primary duty to the patient must be fulfilled regardless of the provider's personal beliefs. Additionally, the Code of Ethics of the International Federation of Gynecology and Obstetrics requires that a physician's right to preserve his or her own moral or religious values cannot result in the imposition of those values on the patient, nor can the physician's

15. However, there are many statutes that create a duty to treat in emergency situations. Federal and state statutes require emergency rooms to stabilize or treat all patients suffering from emergency conditions or in active labor. See, e.g., Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2012).


17. All fifty states and the District of Columbia recognize physician liability based on lack of informed consent. Id. at 164.

18. Id.

19. AM. MED. ASS'N, CODE OF MED. ETHICS, § 1.1.1 (2016) ("The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare."); id. § 1.1.5 (noting that a physician may not terminate treatment without giving the patient reasonable assistance and time to make alternative arrangements for care); id. § 1.1.7 (instructing physicians to "[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects"); id. § 2.1.1 (explaining that informed consent must be honored by physicians and requires accurate presentation of medical facts and therapeutic alternatives); id. § 2.1.3 ("Except in emergency situations in which a patient is incapable of making an informed decision, withholding information without the patient's knowledge or consent is ethically unacceptable.").

20. ACOG Committee Opinion: The Limits of Conscientious Refusal in Reproductive Medicine, AM. CONG. OBSTETRICIANS & GYNECOLOGISTS (Nov. 2007), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine. The opinion makes several recommendations to balance the obligations of providers with a respect for conscience. For example, "providers with moral or religious objections should practice in proximity to individuals who do not share their views" and should not staff sites where objectionable requests are likely to arise. In emergency situations, the obligation to provide medically indicated and requested care must override the provider's objections. Providers must give their patients prior notice of personal or moral commitments, without arguing or advocating for the provider's position. They must provide "scientifically accurate and professionally accepted characterizations of reproductive health services," regardless of their personal beliefs. Finally, "institutions that uphold doctrinal objections should not position themselves as primary providers" where those objections could impact patient care.
right absolve the physician from the duty to "tak[e] immediate steps in an emergency to ensure that the necessary treatment is given without delay."\textsuperscript{21}

Under legal, ethical, and professional standards, a hospital or provider that refuses to discuss treatment options or their effects with a patient, or that provides medically inaccurate or incomplete information, violates the patient's right to information and to accept or refuse treatment and breaches its legal and ethical duties to the patient. However, federal and state conscience exemptions override the rights of patients in this regard. Conscience exemptions permit providers and healthcare institutions to opt out of their ethical and moral duties to treat their patients and provide information or patient referrals, putting the health and safety of their patients at risk.

\textit{A. History of Conscience Exemptions}

Although conscience exemptions today are sometimes used to restrict access to any type of medical care, they were initially designed to limit access only to abortion, sterilization, and birth control. Congress passed the first conscience exemption in the early 1970s in response to the Supreme Court's decisions in \textit{Roe v. Wade}\textsuperscript{22} and \textit{Doe v. Bolton}\textsuperscript{23} and a district court ruling that enjoined a Catholic hospital from refusing to permit tubal ligations following delivery.\textsuperscript{24} The Church Amendment allowed individuals and entities that receive federal funding to resist requirements that they perform or provide facilities for abortions or sterilizations if those procedures would be "contrary to [the individual or entity's] religious beliefs or moral convictions."\textsuperscript{25} The Church Amendment, borrowing language from recently passed civil rights laws, also prohibited entities that receive certain federal funds from discriminating in the employment, promotion, or termination of personnel who refuse to perform or participate in the performance of abortion or sterilization procedures.\textsuperscript{26} After the Church Amendment, states passed their own conscience exemption laws, over time.

\textsuperscript{22} 410 U.S. 113 (1973) (recognizing a limited constitutional right to abortion).
\textsuperscript{23} 410 U.S. 179 (1973) (holding that states must permit abortions where necessary to preserve the life or health of the mother).
\textsuperscript{25} Health Programs Extension Act of 1973, 42 U.S.C. § 300a-7(b) (2012). The Church Amendment is one of the few conscience exemption laws that prohibit discrimination against medical personnel who do perform abortions or sterilizations, not just those who refuse to do so. 42 U.S.C. § 300a-7(c). Two states, Kentucky and Michigan, do prohibit discrimination based on prior or off-site performance of abortion or sterilization procedures. KY. REV. STAT. ANN. § 311.800(5)(b)-(c) (West, Westlaw through 2017 Reg. Sess.); MICH. COMP. LAWS § 333.20184 (West, Westlaw through 2016 Reg. Sess.).
expanding the types of services, healthcare professionals, and institutions that were allowed to refuse to provide healthcare services. By the end of 1974, more than half of the states had enacted laws mirroring or expanding the federal protections; within four years, nearly all states had enacted such laws.  

In the backlash against the introduction of emergency contraception in the late 1990s, states and the federal government began to expand the scope of conscience legislation. The new laws broadened conscience exemptions by expanding them beyond abortion and sterilization to contraception, end-of-life care, stem cell research, and in some cases to any healthcare service to which a religious or moral objection might be raised. The new laws also expanded conscience exemptions to apply to more types of organizations. Conscience exemptions have expanded to cover not just doctors, nurses, and healthcare institutions, but also pharmacists, emergency medical technicians, orderlies, administrative staff, a wide array of health facilities, and even insurance companies. Increasingly distant interactions now fall within permissible refusal. For example, the Coats Amendment was passed in 1996 to prohibit the federal government and recipients of government funding from discriminating against providers that refuse to offer training in abortion services due to religious objections. The Balanced Budget Act of 1997 allowed insurance companies administering Medicare and Medicaid benefits to object to the provision of information about healthcare, as well as to the provision of services. The Budget Act provided that Medicaid managed-care plans and Medicare Choice plans may object to providing counseling or referral services on moral or religious grounds. Yet, in all other contexts, Medicaid managed-care

27. Elizabeth B. Deutsch, Expanding Conscience, Shrinking Care: The Crisis in Access to Reproductive Care and the Affordable Care Act’s Nondiscrimination Mandate, 124 YALE L.J. 2470, 2478 (2015). “Even in the 1970s, as refusal laws were just beginning to take hold, the dangers were clear; the Iowa Attorney General cautioned that ‘one could eventually get to the point where the man who mines the iron ore that goes to make the steel, which is used by a factor to make instruments used in abortions, could refuse to work on conscientious grounds.’” Id. at 2483.


29. Deutsch, supra note 27, at 2482.


31. See, e.g., MISS. CODE ANN. § 41-107-3(a) (West, Westlaw through Jan. 18, 2017) (allowing any “health care provider” to object to any phase of a patient’s medical care, treatment, or procedure—right down to the orderlies, who can refuse to change the bedding for a patient undergoing a medical procedure to which the orderly objects).


organizations are explicitly prohibited from imposing gag rules on doctors.35 The Weldon Amendment of 2005 prohibited Health and Human Services appropriations from being made available to any state or local government that "subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions."36 The amendment defines "health care entity" to include HMOs and insurance plans.37 It thus limits the ability of states to require care, referral, or insurance coverage for abortion, and opens the door to conscientious refusals several steps removed from the direct provision of care.

Currently, forty-seven states and the District of Columbia have at least one law that allows medical providers or institutions to refuse to provide at least one medical service.38 Of these states, only California, Maryland, Nevada, and the District of Columbia have exceptions to each refusal law that require a provider or institution to take actions that may contravene their objections where patient safety or an emergency requires it.39 Four other states have an exception for when the life of the patient is endangered in at least one, but not all, of their laws allowing refusal.40 This "leaves forty-three states with at least one refusal law that does not ensure that patients will receive emergency care if that care conflicts with a provider's conscience, even in some situations where the patient's life is in danger."41 Under most of today's conscience clauses, providers who refuse to provide services, information, or referrals are protected from discrimination in hiring, staff privileges, or promotion,42 and from professional discipline, civil action, or regulatory or criminal sanctions.43 Likewise, refusing institutions are


37. Id.


40. IDAHO CODE § 18-611(6) (2004); IOWA CODE § 146.1 (2010); MO. REV. STAT. § 188.100(2) (2009); OKLA. STAT. ANN. tit. 63, §§ 1-728c(1), 1-741(C) (West 2010); TEX. OCC. CODE ANN. § 103.004 (West 2010).

41. Morrison & Allekotte, supra note 16, at 177-78. "Alabama, New Hampshire, and Vermont do not have refusal laws." Id. at 178 n.143; see also Refusing to Provide Health Services, supra note 28; Emergency Contraception, supra note 28.


protected from civil action and regulatory or criminal sanctions, regardless of the harm caused by their refusal.  

B. The Expansion of Conscience Exemptions

In the past few years, conscience exemptions have further broadened the categories of people who have the right of refusal and the places in which that right may be exercised. Now, not only are some providers able to refuse to perform medical procedures—no matter the circumstances and without consequences—but they can refuse to give information or a referral to a patient who requires medical care. Third parties wholly uninvolved in the provision of care can interfere with a patient’s ability to access information or care because the third party argues he or she would be “complicit” in someone else’s immoral behavior. In what has been called the “conscience creep,” for-profit employers, independent business owners, and secular employees are making “complicity-based conscience claims” to impose their worldview on employees, customers, coworkers, and others. For example, in Burwell v. Hobby Lobby, employers argued that the Affordable Care Act’s mandate that they provide employees health insurance that covered reproductive healthcare would “make them complicit with employees who might use the insurance to purchase forms of contraception that the employers viewed as sinful.” The Supreme Court accepted that argument, finding Hobby Lobby’s free exercise of religion was substantially burdened by the contraception mandate and therefore the contraception mandate violated the federal Religious Freedom Restoration

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44. In addition, “twenty-seven states shift responsibility for injury resulting from refusals to the patient by immunizing individuals or hospitals from liability stemming from a refusal to provide care.” Morrison & Allekotte, supra note 16, at 178.


48. NeJaime & Siegel, supra note 46, at 2516.


Act. In response, federal legislation was proposed that would expand the Court’s ruling by allowing any employer or insurance company to refuse to cover any of the preventative services or essential health benefits required to be covered by the Affordable Care Act, including prenatal testing, birth control, or other prescription drugs. Additionally, the legislation would not only make the Weldon Amendment permanent, but would expand it by extending its scope to any healthcare professional who “participate[s]” in the provision of abortion, regardless of how tangential that participation.

Unfortunately, the success of conscience exemption laws in limiting access to reproductive healthcare has led to their use as models for the creation of religious exceptions in other contexts. In the wake of Hobby Lobby, state and federal religious freedom bills have proliferated as conservatives have used the language of conscience exemptions to permit discrimination against LGBT individuals. The proposed federal First Amendment Defense Act, for example, would prohibit governmental actors from taking “discriminatory” action against a person who “believes or acts in accordance with a religious belief or moral conviction that marriage is or should be recognized as the union of one man and one woman, or that sexual relations are properly reserved to such a marriage,” thus allowing discrimination against LGBT persons, single mothers, unmarried couples, and others. Just as with conscience exemptions in the healthcare context, the stated intent of such legislation is to prevent discrimination against individuals and institutions on the basis of their beliefs. The next Part explains

52. *Hobby Lobby*, 134 S. Ct. at 2759; see also Sarah M. Stephens, *An Employer’s Conscience After Hobby Lobby and the Continuing Conflict Between Women’s Rights and Religious Freedom*, 24 BUFF. J. GENDER L. & SOC. POL’Y 1 (2015) (discussing the Court’s application of the Religious Freedom Restoration Act to Hobby Lobby’s challenge). The contraceptive mandate continues to be challenged. In 2016, the Supreme Court heard oral arguments in seven consolidated cases challenging the Court’s amendment to the contraceptive coverage mandate. Several religious nonprofits argued that submitting a notification to the government that they have a religious objection to providing contraceptive insurance coverage substantially burdens their free exercise of religion. In a per curiam opinion, the Court vacated the judgments of the lower courts and remanded with instructions to the parties to reach a compromise that accommodates the petitioners’ religious exercise while simultaneously ensuring full and equal healthcare coverage, including contraceptive coverage. *Zubik v. Burwell*, 136 S. Ct. 1557, 1559-60 (2016). The Court notably refused to express any views on the merits of the case. *Id.* at 1560.


57. H.R. 2802 § 3(a).
how conscience exemptions fail to achieve the equal protection goals they purportedly pursue and analyzes conscience exemptions through the lens of vulnerability theory, with the goal of eliminating barriers to reproductive healthcare.

II. VULNERABILITY THEORY: AN ALTERNATIVE TO THE FORMAL EQUALITY APPROACH TO CONSCIENCE EXEMPTIONS

Formal equality requires that "things that are alike should be treated alike."\textsuperscript{58} Thus, the formal equality approach is concerned with applying the same rules to similar situations; it aims for procedural equality, rather than equality of outcome or substantive equality. Under the formal equality paradigm, the government does not normally intervene in interactions between private actors unless there is a claim of discrimination based on some characteristics protected by law. For example, under Title VII of the Civil Rights Act of 1964, employers are prohibited from taking adverse employment actions against employees because of certain discrete characteristics, such as religious belief, race, or gender.\textsuperscript{59} The formal equality approach mandates that employers act without regard to these and other specific protected characteristics in an effort to eradicate discrimination and ensure equal opportunity regardless of those protected characteristics.

Conscience exemptions borrow from the language and the approach of civil rights law to prohibit adverse actions against healthcare employees, healthcare workers who are not employees, and healthcare institutions that exercise their conscience by refusing to provide necessary reproductive healthcare. However, the formal equality approach used in civil rights law and borrowed by conscience exemptions is highly problematic in both design and effect. Currently protected characteristics are both over- and under-inclusive because not all members of a protected class are disadvantaged, while individuals who are outside of protected classes (e.g., an under-forty, able-bodied white male) may be disadvantaged in ways that are not protected (e.g., by poverty).\textsuperscript{60} Therefore, the formal equality approach does not adequately take into account the bases on which people are discriminated against. Moreover, because the enforcement mechanism of the formal equality paradigm is to punish wrongdoers who act with discriminatory animus, it can only stamp out surface-level discrimination. It has no mechanism to address "existing structural, social, societal, and individual inequalities," which result in substantively unequal outcomes even when individuals are given

\begin{itemize}
\item \textsuperscript{58} Erwin Chemerinsky, \textit{In Defense of Equality: A Reply to Professor Westen}, 81 MICH. L. REV. 575, 578 (1983) (citing ARISTOTLE, ETHICA NICOMACHEA 1131a-31b (W. Ross. trans. 1925)).
\item \textsuperscript{59} 42 U.S.C.A. § 2000e (West 2015).
\item \textsuperscript{60} See generally Martha Albertson Fineman, \textit{Evolving Images of Gender and Equality: A Feminist Journey}, 43 NEW ENG. L. REV. 437 (2009).
\end{itemize}
formally equal opportunities.\textsuperscript{61} Formal equality fails to achieve the desired effect of eliminating discrimination. In fact, it is unable to address or even truly consider existing social imbalances or "disrupt persistent forms of inequality."\textsuperscript{62} As Fineman puts it, "[f]ormal equality is inevitably uneven equality because existing inequalities abound throughout society and a concept of equality that is merely formal in nature cannot adequately address them."\textsuperscript{63}

Even to the extent formal equality is sometimes useful in remedying certain types of discriminatory treatment, conscience exemptions are a poor fit for this theoretical framework and end up exacerbating existing inequalities between patients and the healthcare industry. Conscience exemptions prohibit discrimination against providers and institutions that exercise their religious or personal beliefs, even when doing so conflicts with their primary duty of care. While drafted in the language of laws meant to remedy historical discrimination against disenfranchised and less powerful groups of people, conscience exemptions actually have the opposite effect. Indeed, if the intent of formal equality is to provide equal opportunity, conscience exemptions fail because they afford more opportunity to the more powerful party in interactions between patient and provider, patient and institution, and provider and institution, instead of privileging or at least protecting the weaker party—the patient—in order to provide a more even playing field. Guaranteeing the right to deny care in the middle of a course of treatment or in an emergency only exacerbates the disparity in power between the individual and the healthcare provider or institution and greatly increases the risk of harm to the dependent patient.

Martha Fineman developed vulnerability theory in response to the failures of a formal equality framework to achieve substantively equal outcomes. In the words of Fineman:

Our equality is weak, its promise largely illusory because it fails to take into account the existing inequalities of circumstances created both by inevitable and universal vulnerability inherent in the human condition and the societal institutions that have grown up around them. It is as though these inequalities were the products of natural forces beyond the ability of the state or law to remedy or rectify. They may be beyond the ability of the state under current ideological configurations, but they are certainly not natural. The state and legal institutions confer senses of entitlement and values, including through a regime of equality that facilitates some results and protects and privileges some persons over, or instead of, others.\textsuperscript{64}

\textsuperscript{61} Id. at 449.
\textsuperscript{62} Martha Albertson Fineman, The Vulnerable Subject: Anchoring Equality in the Human Condition, 20 YALE J.L. & FEMINISM 1, 8 (2008).
\textsuperscript{63} Fineman, supra note 60, at 447-48.
\textsuperscript{64} Id. at 450.
Fineman insists that political and legal theorists recognize the futility of the prevailing ideologies of autonomy, self-sufficiency, and personal responsibility, which are predicated on the existence of a liberal subject who is competent, rational, and able to negotiate contract terms, assess options, and play "multiple and concurrent societal roles." She offers an alternative framework that concentrates on the common vulnerability within and impacting all people, "claim[ing] the term 'vulnerable' for its potential in describing a universal, inevitable, enduring aspect of the human condition that must be at the heart of our concept of social and state responsibility" necessary to achieve substantive equality for all people. Vulnerability theory begins with recognizing the inherent and constant state of vulnerability across all people's lifetimes and then explores strategies to mitigate that vulnerability.

According to vulnerability theory, human beings cannot become more or less vulnerable, but they can become more or less resilient to their inherent vulnerability. Importantly, resilience is not innate but is "is produced within and through institutions and relationships of privilege defined and reinforced by law." The role of the government is inescapable; "the state is always actively involved in the allocation, preservation, or maintenance of privilege and disadvantage" because of the law's role in shaping public and private societal relationships and institutions. Therefore, governments have a responsibility to ensure that all people have equal access to "the societal institutions that distribute resources" and improve human resiliency. As Fineman puts it, "[v]ulnerability thus freed from its limited and negative associations is a powerful conceptual tool with the potential to define an obligation for the state to ensure a richer and more robust guarantee of equality than is currently afforded under the equal protection model." Vulnerability theory places the individual in social context and "redirect[s] focus onto the societal institutions that are created in response to individual vulnerability." In defining the obligations of the state, Fineman draws on the work of Peadar Kirby to identify different types of assets that social organizations and institutions provide, including what Kirby termed "human assets." Kirby and Fineman conclude that health is one of the primary "human assets" that affect material well-being. Fineman argues that "asset accumulation by individuals
and the creation and maintenance of social institutions . . . coupled with the fact that asset conferring institutions initially are brought into legal existence only through state mechanisms, places such institutions within the domain of state responsibility. Accordingly, the shared vulnerability of all people legitimates claims upon the state by individuals for meaningful access to healthcare institutions that create the opportunity for better health and therefore more resiliency, leading to greater substantive equality. Since healthcare institutions, as "asset-conferring entities," distribute important social goods, they should be heavily monitored by the state to ensure that the distribution of healthcare is equitable and fair.

III. PRIVILEGING INSTITUTIONAL CONSCIENCE OVER INDIVIDUAL CONSCIENCE

Indeed, the healthcare industry is heavily regulated by local, state, and federal governments, which dictate everything from licensing requirements, to how drugs can be prescribed, to the width of the hallways in surgical facilities. However, the healthcare industry is not regulated in a way that ensures access to healthcare resources that will improve human resiliency. To the contrary, the state of the law actually discourages access to critical reproductive care that can improve not only individual health outcomes but broader social and economic outcomes for patients, their families, and, in turn, their wider communities. As explained, under most of today’s conscience exemptions, an entire hospital, healthcare system, clinic, or practice group may refuse to provide treatment, information, and referrals. In several jurisdictions, broad conscience clauses allow any corporation or entity associated with healthcare to decline to participate in, refer for, or give information about any healthcare service for reasons of conscience. When an entity wishes to refuse to provide certain services, “[e]mployees and medical staff of all faiths, beliefs, and backgrounds

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74. Fineman, supra note 62, at 15.
75. Id.
76. Id.
79. Broad conscience exemption legislation typically does not differentiate between religious and secular, public and private, or for-profit and not-for-profit institutions. However, Arkansas, Maine, and Tennessee limit the reach of institutional conscience clauses to private institutions, and California and New Jersey limit the reach of institutional conscience exemptions to religious institutions or organizations. For example, in Doe v. Bridgeton Hospital Ass’n, New Jersey’s Supreme Court determined that the state’s conscience clause could not extend to private, nonsectarian hospitals because those hospitals are quasi-public institutions with obligations to serve the public. 366 A.2d 641, 645-47 (N.J. 1976). Alaska’s conscience clause was similarly construed to prohibit a nonsectarian hospital from restricting the availability of abortions. Valley Hosp. Ass’n v. Mat-Su Coal. for Choice, 948 P.2d 963, 970-72 (Alaska 1997).
must then abide by the institutional policy of refusal.”

This has led to a rapid reduction in the availability of reproductive healthcare as religious healthcare institutions have merged with other religious and secular institutions and then imposed mandatory refusal policies throughout the resulting mega-healthcare organizations.

A. Catholic Hospital Mergers and the Influence of Hospital Directives on Secular Hospitals

The spread of religious healthcare mergers is most clearly seen in the proliferation of Catholic healthcare conglomerates. A 2013 study released by the ACLU and MergerWatch, a consumer watchdog agency that advocates for patients’ rights when hospitals merge, found that by 2011, 10% of all acute-care hospitals were Catholic-sponsored or -affiliated. The percentage was much higher in some states. For example, the figure rose to 28% in Washington, 29% in Wisconsin, 28% in Iowa, and 20% in Missouri. More recent mergers have only increased the number of Catholic hospitals and healthcare systems. By 2016, 14.5% of all acute care hospitals in the United States were Catholic-owned or -affiliated. Over the period between 2001 and 2016, the number of Catholic-owned or -operated hospitals “increased by 22 percent, while the number of acute care hospitals overall dropped by 6 percent.” Today, “one in six hospital beds in the United States is in a Catholic hospital.” In some places, such as Washington State and Wisconsin, more than 40% of all hospital beds are in Catholic hospitals.

Increasingly, Catholic facilities are the sole or primary providers of healthcare for a given region. The ACLU/MergerWatch Study found that thirty Catholic hospitals were designated by the federal government as sole community providers in 2011. Today, that number has risen to forty-six. Sole community providers receive higher levels of reimbursements from the federal government for providing care to a region. In fact, Catholic facilities receive billions of taxpayer dollars each year. In 2011 alone, Catholic hospitals “billed Medicare $81 billion and Medicaid $34 billion, for a combined total of $115 billion in
'gross patient revenues.' These public sources accounted for 45.7% of total revenues for Catholic hospitals, "on par with the percentages for other types of hospitals, such as other religious non-profit hospitals (46.4 percent), for-profit hospitals (44.6 percent), secular non-profit hospitals (45.2 percent), and public hospitals (44.6 percent)." This is despite the fact that Catholic hospitals provide far less charity care than public hospitals and no more than other religiously affiliated hospitals.

The disproportionate share of the healthcare market owned and operated by Catholic hospitals is greatly concerning because religious—and particularly Catholic—healthcare organizations are more likely than secular institutions to take advantage of conscience exemptions by imposing strict rules about what types of medical care and information they will or will not provide. After the passage of the Church Amendment, Catholic hospitals began widely adopting the Ethical and Religious Directives for Catholic Health Care Services, which are promulgated by the United States Conference of Catholic Bishops (USCCB). Adoption of the Directives helped Catholic hospitals bolster their claim that they need conscience exemptions that override medical standards of care and patient wishes.

Today, the Directives prohibit nearly all reproductive services, including all birth control methods except natural family planning; emergency contraception; infertility treatment; sterilization; and abortion. Research and therapy using treatments derived from fetal tissue or embryonic stem cells are likewise disallowed. The Directives also limit the information doctors may provide to what the USCCB considers to be morally legitimate healthcare alternatives. The Directives further prohibit doctors from providing information that could ultimately lead a patient to make a healthcare decision that the USCCB deems immoral and would therefore make the USCCB complicit in the patient's sin, regardless of the beliefs, desires, or needs of the patient. For example, Catholic clinics "have refused to instruct HIV-positive patients as to the importance of condoms and of cleaning needles used for intravenous drugs to prevent transmission"; prohibited the release of prenatal testing results, even where the

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90. Id. at 10. The hospitals reported $27 billion in combined Medicare and Medicaid net revenues that year. Id.
91. Id.
92. Id. at 13. In 2011, Catholic hospitals "provided the lowest proportional level of service to Medicaid patients of any type of hospital, as measured by the percentage of gross patient revenues that came from Medicaid. . . ." Id. at 6.
94. See generally Directives, supra note 93.
95. Id. at 25.
96. Id. at 27.
97. Id.
test shows the fetus is not viable, because it might result in the woman’s decision to abort the fetus; and prohibited doctors from counseling rape victims about emergency contraception. The Directives contravene and provide a stark contrast to ethical and professional standards, which require physicians to place patient welfare and care above their own personal beliefs and which patently prohibit physicians from withholding medical information from patients.

As a result of hundreds of mergers between religious and nonreligious facilities since the 1990s, many healthcare systems that appear to be secular now limit their services based on religious doctrine and refuse to comply with professional and ethical standards of care. Further, ancillary care organizations, such as healthcare clinics or nursing homes, that enter into cooperative arrangements with Catholic healthcare systems are often required to comply with the Directives and restrict the services they provide. Even public hospitals that are managed by Catholic healthcare systems and historically Catholic hospitals that are now owned by secular non-profit or for-profit healthcare systems often must follow the Directives. Catholic healthcare systems are increasingly dominating the healthcare industry, with great power to influence national health policy, impede the caregiving of over half a million full-time healthcare workers, and limit the accessibility of reproductive healthcare for individual patients throughout the country in small and large markets alike.

Although its discretion over healthcare regulation is broad, the government has failed to put in place laws to improve the resiliency of vulnerable individuals. The government is critical in shaping the relationships among patients, providers, and institutions because it regulates the creation and maintenance of all healthcare facilities, public and private, and it contracts or expands access to healthcare through its use of taxpayer money. The healthcare industry as it exists today would collapse without government tax breaks, government funding, and public insurance dollars. Non-profit hospitals, including Catholic healthcare systems, receive billions of dollars in state and federal tax credits for providing “charity care and community benefits.” Instead of using its regulatory

98. Sepper, supra note 43, at 1521; see also ACLU v. Burwell, No. 3:16-cv-3539 (N.D. Cal. filed June 24, 2016) (alleging that unaccompanied immigrant minors in the legal custody of the federal government have been denied post-sexual assault care, including contraception and abortion, by religiously affiliated organizations that are paid millions of dollars by the government to provide medical care to these young people).

99. See supra text accompanying notes 16-21.

100. Sepper, supra note 43, at 1523-24; see also Uttley et al., supra note 35, at 7.

101. Sepper, supra note 43, at 1523-24. In some cases, even after Catholic healthcare systems are acquired by for-profit investor groups, the system continues to require compliance with the Directives. Id. at 1523.

102. Kaye et al., supra note 6, at 7; Uttley et al., supra note 35, at 2-3.


104. See Uttley et al., supra note 35, at 32 n.64.
authority to empower the vulnerable public, the government financially and structurally supports the individuals and institutions that limit access to resources. The government’s failure to act has enabled monopolies on healthcare by Catholic organizations, which use conscience exemptions to restrict access to reproductive and other forms of healthcare. This problem might be addressed through legislation that limits the ability of religious healthcare organizations to buy out secular healthcare systems and monopolize the market. This Article proposes a broader solution: legislation that prohibits healthcare institutions from dictating individual healthcare choices or limiting access to care on the basis of institutional beliefs.

B. Conflicts Between Refusing Institutions and Willing Providers

With numerous changes in corporate affiliation and ownership becoming common, providers at formerly secular workplaces often find new limitations imposed on the care that they can provide. For example, following the Directives is a condition of employment for the healthcare workers employed at Catholic institutions and a condition of admitting privileges for Catholic hospitals. When a Catholic facility merges with another healthcare facility, the merged facility and its individual providers must also abide by the Directives. Providers at recently acquired or merged facilities must choose between accepting new limits on care and finding alternative employment, which may not be an option if the resulting entity is the largest or only provider in the area. In one study, 43% of physicians “reported having practiced in a religiously affiliated institution during their careers,” and many of those facilities had institutional policies of refusal. In another study, one in five family physicians, general internists, and general practitioners at religiously affiliated institutions reported having experienced “conflict with the institution’s religiously based policies for patient care.” The rates of conflict are even higher in facilities with wide-ranging restrictions, as well as in certain specialties. For example, one survey reported that 37% of obstetrician-gynecologists (ob-gyns) who practice in a religiously affiliated institution have faced conflicts over “religiously based

105. Sepper, supra note 43, at 1520. Restrictive admitting privileges make it even harder for abortion providers to comply with Targeted Regulation of Abortion Providers (TRAP) laws. See infra note 115 and accompanying text.
108. See Debra B. Stulberg et al., Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care, 25 J. GEN. INTERNAL MED. 725, 727 (2010).
109. See Debra B. Stulberg et al., Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies, 207 AM. J. OBSTETRICS & GYNECOLOGY 73.e1, 73.e1, 73.e4 (2012).
policies for patient care." More than half of ob-gyn respondents who work in Catholic institutions reported conflicts.

For some doctors and nurses, the decision to provide abortion or other reproductive healthcare implicates deeply felt moral, ethical, and religious values. Dr. Willie J. Parker, a well-known board-certified ob-gyn who provides abortion care in the South, reflected that a sermon by Dr. Martin Luther King Jr. “challenged [him] to a deeper spiritual understanding” of the biblical Good Samaritan and led him to the conclusion that he should provide care to women seeking abortions to show the compassion required of him by his religion. However, conscience exemption laws do not protect Dr. Parker or his beliefs. Instead, conscience exemption laws are, for the most part, completely one-sided in favor of beliefs that disapprove of reproductive and other types of healthcare. Conscience exemptions allow providers in non-objecting hospitals to refuse to provide certain services without professional, employment, or legal consequence, but they do not protect physicians who want to provide those services in an institution that refuses. This leaves a physician who does not object to a particular service and who believes that she or he has a religious, moral, or professional obligation to provide that service without protection from an institutional prohibition.

110. Id. at 73.e4.
111. Id. On April 27, 2016, the California Medical Association moved to join a lawsuit against Dignity Health, a Catholic hospital system, filed by a patient who had been denied a tubal ligation. The California Medical Association objects to the Directives’ improper lay interference with the physician’s medical judgment and the doctor-patient relationship, as well as the risk they pose to the quality and accessibility of reproductive healthcare for women. See Memorandum of Points and Authorities in Support of California Medical Ass’n’s Motion for Leave to File Complaint in Intervention, Chamorro v. Dignity Health, No. 15-549626 (Cal. Super. Ct. Apr. 27, 2016).
112. See generally LORI FREEDMAN, WILLING AND UNABLE: DOCTORS’ CONSTRAINTS IN ABORTION CARE (2010); see also Kaye et al., supra note 6 (recounting the stories of doctors who were unable to provide care due to their affiliation with a religious hospital, or who took over care at a secular institution after a patient was refused care at a Catholic institution).
114. In the abortion context, conscience exemptions that protect the objecting provider but not the provider who wants to deliver care tip the scales by impossibly favoring certain religious beliefs over others. See Barber v. Bryant, 193 F. Supp. 3d 677, 689 (N.D. Miss. 2016) (citing Santa Fe Indep. Sch. Dist. v. Doe, 530 U.S. 290, 309-10 (2000)) (explaining that the Establishment Clause is violated when “persons who hold contrary religious beliefs are unprotected”).
115. Willing providers are further hindered by TRAP laws, which single out medical practices and providers that offer abortion services and impose on them more burdensome requirements than are imposed on similar medical procedures. For example, many TRAP laws restrict the performance of an abortion, be it surgical or medical (i.e., by pill), to licensed doctors, thus limiting the number of abortion providers by excluding nurse practitioners and others who are otherwise licensed to perform medical procedures and prescribe and administer medication. State Laws and Policies: Targeted Regulation of Abortion Providers, GUTTMACHER INST. (Mar. 1, 2017), https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers. Other TRAP laws have required physicians who perform abortions to have admitting privileges in a local hospital, a requirement that is not medically
As Fineman explains, vulnerability theory “redirect[s] focus onto the societal institutions that are created in response to individual vulnerability,” with the goal of creating a state that is “more responsive to, and responsible for, vulnerability.” Viewed through the lens of vulnerability theory, it is clear that a conscience-based prohibition by an institution should yield in the face of a willing individual provider. After all, the provider is increasing the healthcare resources in the market and thereby facilitating the accumulation of material resources that bolster individuals’ resilience in the face of vulnerability. Therefore, the conscience exemption paradigm as it currently exists must be repealed or reframed in a way that increases access to care, rather than restricting it.

C. Conflicts Between Refusing Institutions and Willing Patients: Diminishing Women’s Access to Information and Reproductive Healthcare Services

The effect of current conscience exemptions on access to healthcare is significant. Although we do not know exactly how common healthcare refusals are, according to one report, “29% of patients—or nearly 100 million Americans—may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for . . . treatments” to which the physician objects. Complaints regarding institutional or individual refusals are rare for many reasons. Often, people do not know that they have been subjected to a refusal, that a refusal is unethical or illegal, or that they may have a remedy; they may also be concerned about their privacy. Moreover, there is

justified and is made even more difficult by the fact that most local hospitals operate under religious restrictions that prohibit admitting privileges for physicians who perform abortions. See Whole Woman’s Health v. Hellerstedt, 136 S. Ct. 2292 (2016) (holding that Texas’s requirements that abortion providers be admitted to a hospital within thirty miles of the abortion facility and that abortion facilities meet surgical center requirements not otherwise applied to outpatient procedures placed a substantial obstacle in the path of women seeking a pre-viability abortion and therefore created an unconstitutional undue burden on abortion access); Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908 (7th Cir. 2015) (holding that a Wisconsin law requiring an abortion provider to have admitting privileges to a hospital within thirty miles of where the abortion was performed imposed an unconstitutional undue burden), cert. denied, 136 S. Ct. 2545 (2016); Jackson Women’s Health Org. v. Currier, 760 F.3d 448 (5th Cir. 2014) (holding that an admitting privileges requirement that would have closed the only facility providing abortions in Mississippi was unconstitutional), cert. denied, 136 S. Ct. 2536 (2016). Despite the Court’s holding in Whole Woman’s Health, a number of states still have active laws that restrict the design of abortion facilities, hospital transfer agreements, geographical location of abortion-providing facilities, and the classes of health professionals who can perform abortions. Targeted Regulation of Abortion Providers, REWIRE (Mar. 19, 2016), https://rewire.news/legislative-tracker/leg-topic/targeted-regulation-of-abortion-providers/ (tracking state restrictions on abortion); see also Jessica Picklo, Symposium: Abortion Rights Come Out of the Shadow, SCOTUSBLOG (Jun. 27, 2016), http://www.scotusblog.com/2016/06/symposium-abortion-rights-come-out-of-the-shadow/.

118. See Morrison & Allekotte, supra note 16, at 163.
often a stigma attached to refusal, both because of the requested procedure or treatment itself (such as abortion or emergency contraception) and because of the embarrassment that can stem from being refused.\textsuperscript{119} Still, an increasing number of complaints are being made and drawing attention to the very real danger conscience exemptions create for patients.

For example, in 2013, the ACLU filed a lawsuit against the USCCB on behalf of Tamesha Means, a woman who was twice sent home from Mercy Health Partners in Muskegon, Michigan, after her water broke at eighteen weeks.\textsuperscript{120} The Catholic-affiliated hospital told Means there was nothing it could do.\textsuperscript{121} The hospital failed to inform Means that she was miscarrying, that there was no way that the fetus could survive, and that termination was the medically prescribed and safest option.\textsuperscript{122} Instead, the hospital sent her home twice, despite the fact that she was in extreme pain and had contracted an infection. The hospital even attempted to send her home a third time before she began to deliver and was admitted.\textsuperscript{123} This is not the first time Mercy Health Partners has been accused of denying care to a woman who was miscarrying. According to a report by a former Muskegon County, Michigan, health official, Mercy Health Partners risked the lives of five women between August 2009 and December 2010 by forcing them to undergo painful, dangerous miscarriages of non-viable fetuses when the standard of care would have been to immediately terminate the pregnancy.\textsuperscript{124} Tamesha Means' case and others like it demonstrate how conscience exemptions allow healthcare institutions and providers to deny care to patients at the time when they are least resilient and the disparity in power between provider and patient is greatest.

In 2015, the ACLU filed an ultimately unsuccessful lawsuit against another Catholic hospital system in Michigan, Trinity Health Corporation, for its "repeated[] and systemic[] fail[ure] to provide women suffering pregnancy complications" with medically indicated emergency abortions as required by federal law.\textsuperscript{125} The use of conscience exemptions to deny care is exacerbated by the extent to which religious institutions serve as the primary sources of care throughout much of the country. Trinity Health Corporation is one of the largest

\textsuperscript{119} Id. at 160-61.
\textsuperscript{121} Id. at 6.
\textsuperscript{122} Id. at 5.
\textsuperscript{123} Id. at 2-3.
Catholic healthcare systems in the country, owning and operating more than ninety hospitals across the United States and treating thousands of patients each year. According to the Complaint, because of Trinity’s adherence to the Directives, a number of pregnant women who sought emergency care at Trinity hospitals were denied that care and “bec[a]me septic, experienced hemorrhaging, contracted life-threatening infections, and/or unnecessarily suffered severe pain for several days at a time.”

As a result of the Directives, Catholic hospitals violate federal emergency medical treatment law by categorically refusing to provide medically necessary emergency abortions to women who are miscarrying as long as there is a fetal heartbeat. Often, this means that a hospital will deliberately allow a woman’s life to become endangered before taking action. In one case, a physician was told that he could not admit a miscarrying woman until she contracted a life-threatening infection, even though his ethical duty was to prevent such an infection—a task easily achieved by providing immediate care. Even in the case of ectopic pregnancy, which can never result in a live birth and is deadly to the woman if left untreated, abortion is not allowed under the Directives. Instead of administering a medication to expel the embryo from the fallopian tube, some Catholic hospitals will force the woman to undergo invasive surgery to remove her fallopian tube, thereby reducing her ability to become pregnant in the future and exposing her to the dangers associated with surgery; other times, hospitals will take a “wait and see” approach, putting the patient’s health and life at risk.

In addition to the irreparable physical damage that can occur in emergency care situations, conscience exemptions also create the opportunity for unnecessary physical and emotional harm—as well as conflict among providers, institutions, and patients—in the provision of relatively routine reproductive healthcare. Conscience exemptions allow providers to refuse to prescribe or discuss emergency contraception with rape victims or women who simply want to avoid an unplanned pregnancy. Likewise, conscience exemptions allow providers and institutions to prevent women from accessing other family planning methods. For example, Dignity Health, the fifth-largest healthcare system in the United States and the largest hospital provider in California, complies with the Directives’ prohibition on sterilization. In December 2015,

127. Amended Complaint, supra note 125, at 2.
131. Id.
the ACLU filed suit in Northern California against Dignity Health for refusing to allow patient Rebecca Chamorro to undergo a tubal ligation, as recommended by her doctor, during her scheduled caesarean section in late January 2016.133 Dignity Health’s Mercy Medical Center is the only hospital in Chamorro’s hometown with a labor and delivery ward, and there are no hospitals with birthing facilities within a seventy-mile radius that do not follow the Directives.134 Nevertheless, a superior court judge denied Chamorro an injunction, leaving her with the difficult choice to either give birth far from her home (which might not be possible should she go into labor early) or undergo two expensive, separate surgeries: the birth of her child and a later tubal ligation.135

Beyond the physical and emotional harm that they cause, conscience exemptions create financial burdens for many patients. Chamorro, for example, had to choose between the expense of separate surgeries and the expense associated with traveling far away to give birth. Financial harms also occur when a woman has to travel to several pharmacies before a pharmacist will fill her legal contraceptive prescription, or when a woman has to pay out-of-pocket for an out-of-network provider who will offer her medically indicated treatment. The broad nature of conscience exemptions exacerbates the harm of a refusal; because institutions may refuse to provide referrals or even information without the risk of liability, refusal by an individual provider often means that the patient will not be able to access care at all—or even know that care exists. When an entire institution refuses to provide common medical procedures like contraception and abortion, it further magnifies the risk to patients, particularly those who need emergency or time-sensitive care.

As Fineman has explained, the formal equality framework does not challenge “existing allocations of resources and power” and may in fact “validate . . . existing institutional arrangements that privilege some and disadvantage others.”136 This is certainly true in the case of conscience exemptions. They may

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133. Id. On October 25, 2016, the American Civil Liberties Union and its Michigan branch filed an administrative complaint with the U.S. Department of Health and Human Services’ Office of Civil Rights against Ascension Health and its subsidiary Genesys Health System for refusing Jessica Mann’s request for a tubal ligation during her planned C-section in violation the Affordable Care Act’s prohibition on sex discrimination. Administrative Complaint, Mann v. Ascension Health, U.S. DEP’T HEALTH & HUM. SERVS. (Oct. 25, 2016), https://www.aclu.org/sites/default/files/field_document/section_1557_complaint_on_behalf_of_jessica_mann_and_the_aclu_oct_25_2015.pdf. Mann suffers from a brain tumor, and her doctor recommended sterilization because the brain tumor could become life-threatening if strained by another pregnancy. Id. at 2. Genesys refused to allow Mann’s doctor to perform the tubal ligation procedure because it would violate the Directives. Id. at 3. Ascension Health receives billions of dollars in federal funding annually and is the largest non-profit health system in the United States. Id. at 3-4.

134. Gill, supra note 132.


136. Fineman, supra note 62, at 3.
have a stated goal of ensuring religious freedom for all, but they have the effect of privileging the beliefs of a few while denying information and care to an untold number of patients and contributing to a legal landscape of diminishing access to reproductive healthcare. The state has an obligation to respond to this inequality by limiting the ability of institutions and individual providers to withhold information or care. Doing so would ensure that healthcare resources are allocated to individuals who need them, and who will in turn become more resilient in the face of human vulnerability.

IV. PRESCRIPTIVE REMEDIES THROUGH A VULNERABILITY THEORY LENS

The idea of the liberal subject who can negotiate for a service with equal opportunity for information and relatively equivalent bargaining power is at its most farcical in the healthcare setting. All humans are vulnerable to illness and injury, but very few are privy to the knowledge and experience that healthcare providers have. Individuals are in an even more precarious position due to the increased prevalence of healthcare systems that control the actions of every hospital, outpatient facility, clinic, and healthcare worker for miles around. In the most extreme examples, as when a woman is doubled over in pain because something in her pregnancy has gone very wrong, it is absurd to argue that she must research her local hospitals and individual healthcare providers to ensure that she finds a provider who will tell her the truth and a healthcare system that will provide her the standard of care. It is also repugnant to tell a woman she must go without critical healthcare if not a single institutional provider within a seventy-mile radius is willing to perform a legal medical procedure or fill a legal prescription even when her own doctor recommends the procedure or has prescribed the medication.

Substantive equality within the reproductive healthcare setting cannot exist alongside conscience exemptions as they are currently conceptualized. Achieving substantive equality will require some state intervention to reallocate the benefits that now accrue to the objecting institution or provider and the burdens that fall on the willing patient. The vulnerable patient should not be forced to bear what may be significant costs of another's exercise of conscience. The burden that is now placed on the patient whose care is precariously dependent on the conscience of her provider, hospital, or even insurance company, should be shifted to those who hold the objection. Limiting conscience exemptions would ensure that all people have more equal access to one of the most important societal institutions. Within this already comprehensively regulated industry, there is no reason why the government should not act to limit the vulnerability of patients and demand that all patients have equal access to the

137. Sepper, supra note 30, at 406.
medical standard of care in exchange for the government’s role in the institution’s creation and funding.

A more balanced alternative to the current conscience exemption regime would ensure that direct providers of care are accommodated so long as they provide notice of their objections and an opportunity for alternative care in non-emergency cases. This approach would comport with medical ethical guidelines, which historically have allowed physicians to conscientiously object, subject to the ethical compromise that physicians (and by extension all direct providers of care) inform patients of treatment objections, refer for treatments they do not provide, and do not abandon a patient already under their care. Healthcare institutions would not be permitted to dictate moral positions on medical care. A doctor who sought to perform a tubal ligation following a caesarian section, for example, could not be prevented from doing so by institutional religious or conscience-based policies against sterilization. By placing the burden on the institution to ensure that care is provided so long as the institution has the capability to do so, this approach largely resolves the potential for conflict between patients and institutions. It also allows objecting healthcare providers to, in most cases, transfer care seamlessly without damaging relationships with patients.

A good example of this approach can be found under Washington law as it regulates the practice of pharmacy in that state. In 2007, the Washington Pharmacy Quality Assurance Commission, tasked with promulgating rules to regulate pharmacy practice, adopted two new administrative rules known as the “Pharmacist Responsibility Rule” and the “Delivery Rule.” The Pharmacist Responsibility Rule regulates the individual professional conduct of pharmacists. While the Pharmacist Responsibility Rule prohibits discrimination, harassment, or intimidation of patients, it “does not require an individual pharmacist to dispense medication in the face of a personal objection.” Rather, pharmacies may accommodate an objecting pharmacist as they deem appropriate, “including [by] having another pharmacist available in person or by telephone.” On the other hand, the Delivery Rule, which requires pharmacies to “deliver lawfully prescribed drugs or devices to patients and to distribute drugs

139. The Washington Pharmacy Quality Assurance Commission regulates the practice of pharmacy in the state of Washington and promulgates rules requiring the timely delivery of all prescription medications by licensed pharmacies. WASH. REV. CODE §§ 18.64.001-.005 (West, Westlaw through 2016 Reg. & Spec. Sess.).
140. WASH. REV. CODE § 18.64.005.
143. Stormans, Inc. v. Selecky, 586 F.3d 1109, 1116 (9th Cir. 2009).
144. Id.
and devices . . . or provide a therapeutically equivalent drug or device in a timely manner," contains no exemption for a conscientiously objecting pharmacy.\textsuperscript{145}

These rules, like the one at issue in \textit{Hobby Lobby},\textsuperscript{146} were challenged by Stormans, a family-owned, privately held corporation.\textsuperscript{147} However, Washington does not have a state analogue of the federal Religious Freedom Restoration Act,\textsuperscript{148} so the Pharmacist Responsibility Rule and the Delivery Rule were tested on free exercise and other constitutional grounds.\textsuperscript{149} The Ninth Circuit first explained that, under First Amendment jurisprudence, neutral laws of general applicability need only survive rational basis review to be constitutional.\textsuperscript{150} The court then held that the rules were both facially neutral and operationally neutral because they specifically protect religiously motivated conduct of pharmacists and, as applied to pharmacies, “the rules’ delivery requirement applies to \textit{all} objections to delivery that do not fall within an exemption, regardless of the motivation behind those objections.”\textsuperscript{151} The court also found that the rules were generally applicable, despite their enumerated exceptions, because the exceptions were “necessary reasons for failing to fill a prescription.”\textsuperscript{152} Applying rational basis review, the court determined that the rules were rationally related to “Washington’s legitimate interest in ensuring that its citizens have safe and timely access to their lawful and lawfully prescribed medications.”\textsuperscript{153} Importantly, the Washington rules demonstrate that it is possible to balance respect for an individual pharmacist’s beliefs with the right of patients to access care at their local pharmacies.

The right to safe and timely access to all forms of healthcare, including reproductive healthcare, is no less important than the right of access to prescription medication. Using vulnerability theory as a guide and incorporating lessons learned from the Stormans cases, this Article proposes the following federal legislation to reinstate the rights of patients and achieve balance between powerful institutions and informed providers, on the one hand, and patients who rely on institutions and providers for information and care, on the other:\textsuperscript{154}

\textsuperscript{145} WASH. ADMIN. CODE § 246-869-010(1). The rule does provide that a pharmacy need not deliver a drug or device under certain enumerated exceptions, including where the prescription may potentially be fraudulent, the prescription contains an error, there is a known contraindication, there is a national or state emergency affecting availability or supply, or the drug or device is unavailable. \textit{Id.}


\textsuperscript{147} Stormans, Inc. v. \textit{Weisman}, 794 F.3d 1064 (9th Cir. 2015), \textit{cert. denied}, 136 S. Ct. 2433 (2016).


\textsuperscript{149} \textit{Stormans v. Weisman}, 794 F.3d at 1071.

\textsuperscript{150} \textit{Id.} at 1075 (citing Emp’t Div. v. Smith, 494 U.S. 872, 879 (1990); Church of Lukumi Babalu Aye, Inc. v. City of Hialeah, 508 U.S. 520, 531 (1993)).

\textsuperscript{151} \textit{Id.} at 1076.

\textsuperscript{152} \textit{Id.} at 1080 (quoting \textit{Stormans v. Selecky}, 586 F.3d 1109, 1134 (9th Cir. 2009)).

\textsuperscript{153} \textit{Id.} at 1084.

\textsuperscript{154} The proposed legislation also takes into consideration § 1557 of the Patient Protection and Affordable Care Act (ACA), which prohibits discrimination of the basis of sex and other protected
(1) Whereas the government has a compelling interest in ensuring all people have safe, timely, and equal access to medical care without regard to personal characteristic or personal belief, institutions, agencies, or individuals who receive Federal financial assistance from the Department of Health and Human Services or other financial assistance, including credits or subsidies from the Federal government which relate to the provision of or are in exchange for the provision of medical care to the public ("entities"), and which provide medical care to the public, must comply with the following:

(a) Such entities have no right to (1) deny a person medical care which is most likely to result in the best health outcome, or (2) deny a person a non-contraindicated course of medical treatment requested by the person, so long as the entities have the appropriate facilities and individual medical providers freely willing to provide such care or course of treatment in non-emergency situations.

(b) In the case of an emergency, medical care which is most likely to result in the best health outcome for the person must be provided using all available resources and personnel, regardless of any non-medically based objection by an individual provider or institution.

(c) In emergent and non-emergency cases, institutions and individual providers are jointly responsible for the provision of medical referrals upon request and medically correct information regarding all possible courses of treatment, regardless of whether the institution is able to provide any individual course of treatment or whether an individual provider is willing to provide any individual course of treatment.

(2) Violations of this statute will be enforced through criminal and civil sanctions by the federal government, as well as through a civil private right of action which accrues to any person harmed by an individual or entity's refusal of care, referral, or information.

This proposed legislation is designed to balance the rights and obligations of all parties to an exchange of healthcare services and is drafted to withstand a challenge on First Amendment or Religious Freedom Restoration Act grounds. The proposed legislation is facially neutral in that it makes no

characteristics in health programs administered or supported by the Department of Health and Human Services and entities established under Title I of the ACA. See Office for Civil Rights, Section 1557 of the Patient Protection and Affordable Care Act, U.S. DEP’T HEALTH & HUM. SERVS., https://www.hhs.gov/civil-rights/for-individuals/section-1557/. For example, hospitals receiving financial assistance through their participation in Medicare are prohibited from discriminating against patients, including those who are transgender, on the basis of sex. Rumble v. Fairview Health Servs., No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015). Notably, § 1557 does not contain a religious or conscience exemption to its requirement of nondiscrimination in the provision of healthcare. Unfortunately, though, § 1557 does not displace existing conscience exemptions. Thus, legislation like the draft provided in this Article is critical to ensuring equal access to healthcare for all patients regardless of the personal beliefs of those in the healthcare industry.

155. As explained in Stormans v. Weisman, free exercise legal challenges under the First Amendment continue to be governed by Employment Division v. Smith, 498 U.S. 872 (1990), which held
reference to any religious practice or belief. It is also operationally neutral because the requirements for individual providers to provide care in emergency situations, for institutions to provide care in all situations, and for providers and institutions to ensure patients have access to all medically relevant information and referrals make no exceptions and therefore treat those who might object on secular grounds the same as those who might object on religious or conscience-based grounds. The proposed legislation allows individual providers to conscientiously object when doing so would not put a patient’s care at risk, but denies accommodation to institutions in similar circumstances where a willing provider is available to provide care because, as described throughout, an institutional conscience exemption would inevitably result in a lack of access to care. This legislation is the least restrictive means of achieving the government’s compelling interest in ensuring that citizens and residents have safe and timely access to medical care regardless of their personal characteristics or beliefs. Further, this legislation is guided by the precepts of vulnerability theory, which teaches that the state should intervene to ensure that individuals have access to societal institutions that distribute resources that improve human resiliency. Finally, it is designed to eliminate barriers that limit access to reproductive healthcare.

CONCLUSION

The human body is fragile, and all people are vulnerable to injury and disease. Healthcare institutions are some of our most important social institutions because they increase the resiliency of the vulnerable human by preventing disease and caring for the ill or injured. Vulnerability theory teaches that it is the role of the state to respond to the vulnerability of all people by ensuring everyone has access to healthcare institutions. Conscience exemptions have the opposite effect: limiting access to care for people at their least resilient and privileging powerful healthcare institutions and providers over patients in the name of religious freedom and formal equality. In rejecting a due process challenge to the regulations at issue in Stormans, the Ninth Circuit held:

[W]e are unconvinced that the right to own, operate, or work at a licensed professional business free from regulations requiring the

that a neutral law of general applicability need only satisfy rational basis review, Stormans, Inc. v. Weisman, 794 F.3d 1064, 1075 (9th Cir. 2015). The proposed statute satisfies rational basis review because the federal government has a legitimate interest in ensuring all citizens have access to safe, timely medical care. The Religious Freedom Restoration Act requires that, to be enforceable, a law that substantially burdens the free exercise of religion must have a compelling government interest and must be the least restrictive means to further that interest. 42 U.S.C. §§ 2000bb-2000bb-4 (2012). Assuming arguendo that the proposed law substantially burdens the free exercise of religion, the text sets forth a compelling government interest and meets the least-restrictive-means test by limiting the circumstances under which a provider might have to act against his or her conscience.
business to engage in activities that one sincerely believes leads to the taking of a human life is "so rooted in the traditions and conscience of our people as to be ranked as fundamental."\textsuperscript{156}

Rather, it is the right to healthcare and the right to access social institutions that improve the resiliency of vulnerable humans that are fundamental.\textsuperscript{157} Conscience exemptions must be limited in order to ensure that everyone has the greatest possible access to healthcare.

\textsuperscript{156} Stormans v. Weisman, 794 F.3d at 1088 (citing Snyder v. Massachusetts, 291 U.S. 97, 105 (1934)) (holding that the Washington regulations did not violate the due process rights of plaintiff pharmacy and pharmacists).

\textsuperscript{157} While the U.S. Constitution does not explicitly contain a right to healthcare and the Supreme Court has never expressly found a fundamental right to healthcare, its "decisions in the areas of the right to privacy and bodily integrity suggest the Constitution implicitly provides an individual the right to access healthcare services at one's own expense from willing medical providers." KATHLEEN S. SWENDIMAN, CONG. RESEARCH SERV., HEALTH CARE: CONSTITUTIONAL RIGHTS AND LEGISLATIVE POWERS 2 (July 9, 2012) (citing Cruzan v. Mo. Dep't of Health, 497 U.S. 261 (1990); Roe v. Wade, 410 U.S. 113 (1973)).