

FREE TO DO NO HARM: Conscience Protections for Healthcare Professionals

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INTRODUCTION

The right to conscience of medical practitioners and related healthcare professionals has come under increasing attack in recent years. Examples abound of individuals and institutions being compelled to act against their will and their beliefs. Yet despite this unfortunate reality, it is difficult to conceive of a scenario in which the right to conscience for medical practitioners should not prevail in a conflict with some other claimed imperative, especially given its historical and philosophical pedigree.

Indeed, the right to conscience was central to the founding of the Republic.¹ James Madison deemed conscience an “unalienable right,”² “the most sacred of all property.”³ Thomas Jefferson concurred, noting that conscience “could not [be] submit[ted]” to governmental oversight or

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1. Lynn D. Wardle, *Religious Liberties: “Conscience Exemptions,”* 14 ENGAGE 77, 78–79 (2013) (explaining that protecting “conscience was one of the essential purposes for the founding of the United States of America and one of the great motivations for the drafting of the Bill of Rights”).

2. JAMES MADISON, *Memorial and Remonstrance Against Religious Assessments*, in SELECTED WRITINGS OF JAMES MADISON 21, 22 (Ralph Ketcham ed., 2006).

3. MADISON, *Property*, in SELECTED WRITINGS OF JAMES MADISON, *supra* note 2, at 222, 223.

authority.⁴ This same right of conscience has also been essential to the practice of medicine for millennia, as evidenced by the Hippocratic Oath⁵ and medicine's status as an autonomous profession concerned with doing right and avoiding wrong.⁶

Given this pedigree, it is perhaps not surprising that soon after the United States Supreme Court discovered in the Constitution a right to elective abortion, Congress and the vast majority of state legislatures saw fit to provide explicit protections for conscience.⁷ In fact, the Supreme Court itself indicated in *Roe v. Wade*,⁸ and its companion case *Doe v. Bolton*,⁹ that the right to be free from governmental interference in procuring an elective abortion did not entail the power to compel another to provide that procedure against his or her will.¹⁰

These consistent legislative and judicial pronouncements in favor of conscience, when taken together with its historically recognized nature as a paramount right, should definitively establish that the right cannot be trumped by any other claimed imperative (absent compelling interests), no matter how aggressively or vociferously the alternative may be contended for. In other words, if the right to conscience means anything, it is this—the propriety of its exercise cannot be open to perpetual debate or veto. Yet at present quite the opposite is true—conscience is seemingly under constant siege, and is tolerated by many in the political and cultural ascendancy only when the reason for its exercise “conforms to their own agenda.”¹¹

The right to conscience, put simply, is imperiled now more than ever before. Its opponents variously claim, for instance, that it “obstruct[s] access

4. THOMAS JEFFERSON, NOTES ON THE STATE OF VIRGINIA 235 (1782).

5. See ALL. DEFENDING FREEDOM, A LEGAL GUIDE FOR HEALTHCARE PROFESSIONALS: CONSCIENCE PROTECTIONS FOR PEOPLE OF FAITH 1 (2016) (describing the genesis of the Oath and its importance in moving medicine toward a profession that “reverence[s] human life”).

6. Edmund D. Pellegrino, *Toward a Reconstruction of Medical Morality*, 6 AM. J. BIOETHICS 65, 65 (2006) (stating that “[m]edicine is a moral enterprise . . . conducted in accordance with a definite set of beliefs about what is right and wrong”).

7. See ALL. DEFENDING FREEDOM, *supra* note 5, at 9, 14 (describing the legislative “flurry” in the wake of *Roe*).

8. 410 U.S. 113 (1973).

9. 410 U.S. 179 (1973).

10. See *id.* at 197–98 (noting that under the challenged law that “a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure”); *Roe*, 410 U.S. at 143 n.38 (quoting AMA resolutions confirming that “no party to the [abortion] should be required to violate personally held moral principles”).

11. Stephen J. Genuis & Chris Lipp, *Ethical Diversity and the Role of Conscience in Clinical Medicine*, 2013 INT’L J. FAM. MED. 1, 6 (2013).

to goods and services,”¹² imposes “dignitary harms” on patients,¹³ and constitutes an abdication of the medical practitioner’s duty.¹⁴ It is argued that the “monopolistic nature of health care professionals’ state-granted licenses” obliges them “to provide requested medical care that is not medically contraindicated, is not outside generally accepted medical or professional ethics, and is not illegal.”¹⁵

Unfortunately, the growing acceptance of this “public utility”¹⁶ model of medicine means in practice that extant federal and state laws protecting conscience—most of which cover only a limited range of procedures and medical practitioners, lack meaningful enforcement mechanisms, and often garner little respect from courts in any event¹⁷—are inadequate to the task of protecting the right to conscience, especially in light of the pervasive challenges it faces in the Brave New World of the here and now.

The reasons for these challenges are not terribly difficult to discern and have been amply discussed in the literature treating of medical conscience. Put simply, the swift pace of scientific advancement and the expansion of

12. Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2566 (2015).

13. *Id.* at 2574–78; Susan T. Rouse, *Professional Autonomy in Medicine: Defending the Right of Conscience in Health Care Beyond the Right to Religious Freedom*, 79 LINACRE Q. 155, 158 (2012) (noting that opponents contend that the exercise of conscience “renders a negative value judgment on the patient”).

14. *See, e.g.*, Julian Savulescu, *Conscientious Objection in Medicine*, 332 BMJ 294, 294 (2006) (arguing that “[c]onscience . . . can be an excuse . . . invoked to avoid doing one’s duty”).

15. Martha S. Swartz, “*Conscience Clauses*” or “*Unconscionable Clauses*”: *Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL’Y L. & ETHICS 269, 279 (2006).

16. R. Alta Charo, *The Celestial Fire of Conscience—Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471, 2473 (2005) (comparing the practice of medicine to “a kind of public utility” where exercising the right to conscience constitutes “an abuse of the public trust” and even perhaps “an attempt at cultural conquest”).

17. *See* Michael J. Frank, *Safeguarding the Consciences of Hospitals and Health Care Personnel: How the Graduate Medical Education Guidelines Demonstrate a Continued Need for Protective Jurisprudence and Legislation*, 41 ST. LOUIS U. L.J. 311, 349 (1996) (noting that “[l]ittle generosity is shown to laws designed to protect consciences,” and that “[s]trict interpretation of the statutory language is the ordinary rule in cases involving conscience clauses”) (internal quotation marks omitted); Lynn D. Wardle, *Protection of Health-Care Providers’ Rights of Conscience in American Law: Present, Past, and Future*, 9 AVE MARIA L. REV. 1, 27–28, 44 (2010) (“Most state conscience protection laws are very narrow—focused on specific procedures and particular work groups (such as doctors or nurses), and most state laws have been construed very narrowly and grudgingly [P]rivate individuals in health-care professions have little means for vindicating and redressing violations of their personal rights of conscience. Likewise, the current legislative conscience clauses provide very few meaningful mechanisms for ascertaining compliance, and little meaningful mechanisms even for institutional private enforcement of the promises of conscience rights protection.”).

medical capabilities have greatly increased the chances that a growing number of medical practitioners will face a crisis of conscience sooner rather than later in carrying out their vocation.¹⁸ Moreover, experience shows that the encroachment of government into the provision of healthcare,¹⁹ combined with the trend toward what could be termed the increasing moral and ideological diversity in medicine,²⁰ will not resolve these inevitable conflicts but rather exacerbate them. In sum, under the present circumstances the “centre cannot hold.”²¹

In this Article we take the position that the way to restore balance to the system—no matter what one’s ideology or agenda—is to comprehensively bolster conscience protections across the spectrum of medical practitioners and medical procedures. Part I presents examples of contemporary attacks on conscience. Part II details the many reasons why robust conscience protections are desirable for medical practitioners, patients, and society as a whole, no matter what substantive issue is implicated by any particular exercise of conscience. Part III discusses the continued and pervasive challenges to conscience posed by ideological advocates, scholars, professional organizations, and the State itself. Part IV discusses what is

18. Genus & Lipp, *supra* note 11, at 3 (listing examples of “clinical situations that may result in ethical tension or conscientious refusal”); Edmund D. Pellegrino, *The Physician’s Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221, 244 (2002) (predicting that “[a]s medical technology endows humans with ever greater power . . . crises of conscience will surely increase for those who hold religious beliefs about human life, its creation, and ending”); Wardle, *supra* note 17, at 2–3 (listing a panoply of modern medical procedures and medications that may implicate conscience objections, including “human stem cell research; cloning; genetic engineering (including gender pre-selection); DNA screening and medical treatment for various genetic disorders; surgical abortion (by a variety of procedures including so-called ‘partial-birth abortion’); pharmaceutical abortion (by such pills as RU-486 and the ‘morning after pill’ (MAP)); sterilization; capital punishment; assisted suicide; sex-change procedures; provision of contraceptives to minors; and provision of assisted reproduction technologies”).

19. See discussion *infra* Part V for examples; see also Mark L. Rienzi, *The Constitutional Right Not to Participate in Abortions: Roe, Casey, and the Fourteenth Amendment Rights of Healthcare Providers*, 87 NOTRE DAME L. REV. 1, 6 (2011) (predicting that “[n]ew legislation establishing greater government involvement in the healthcare system will likely present additional conflicts between government mandates and provider conscience”).

20. Genus & Lipp, *supra* note 11, at 1 (“In a climate of plurality about the concept of what is ‘good,’ one of the most daunting challenges facing contemporary medicine is the provision of medical care within the mosaic of ethical diversity. Juxtaposed with escalating scientific knowledge and clinical prowess has been the concomitant erosion of unity of thought in medical ethics.”).

21. William Butler Yeats, *The Second Coming*, POETRY FOUND., <https://www.poetryfoundation.org/poems-and-poets/poems/detail/43290> (last visited May 3, 2017).

really at the heart of contemporary resistance to conscience protections for medical practitioners. Part V briefly outlines extant conscience protections on both the state and federal levels. Part VI provides recommendations to remedy the various infirmities present in these protections, with the hope of returning conscience to its proper place as an unalienable right.

I. CONTEMPORARY THREATS TO MEDICAL CONSCIENCE

Cathy Cenzon-DeCarlo is a surgical nurse who was hired by New York City's Mt. Sinai Hospital in 2004.²² As a devout Catholic, she explicitly expressed to the hospital her unwillingness to participate in abortion and completed paperwork to that effect upon beginning her tenure there.²³ That agreement was willfully ignored by the hospital when it compelled Cathy to assist in the abortion of a twenty-two-week old preborn baby on Saturday, May 24, 2009.²⁴ Rather than accommodate what it knew to be Cathy's religious beliefs and longstanding objections to such participation, the hospital instead opted to threaten her with charges of "insubordination and patient abandonment" if she did not immediately comply with its demands, despite the fact that the case did not even involve emergency circumstances.²⁵ Unable to prevail upon her supervisors to relent, and unable to sustain the loss of her job or her nursing license, Cathy was compelled to assist.²⁶ But she did so under protest.²⁷ Soon thereafter she filed a union grievance,²⁸ and later suits against the hospital in both federal²⁹ and state court.³⁰ The Second Circuit Court of Appeals eventually affirmed the dismissal of her federal case, finding that Cathy had no right under federal law to bring suit in the first place.³¹ She was instead beholden to the federal bureaucracy to pursue the complaint her attorneys filed with the Department of Health and Human

22. Complaint at 5, *Cenzon-DeCarlo v. Mount Sinai Hosp.*, No. 09-CV-3120, 2010 WL 169485 (E.D.N.Y. Jan. 15, 2010).

23. *Id.* at 6–7.

24. *Id.* at 10.

25. *Id.* at 12.

26. *Id.* at 13.

27. *Id.*

28. *Id.* at 16.

29. *See Cenzon-DeCarlo v. Mount Sinai Hosp.*, No. 09-CV-3120, 2010 WL 169485 (E.D.N.Y. Jan. 15, 2010).

30. *See Cenzon-DeCarlo v. Mount Sinai Hosp.*, 962 N.Y.S.2d 845 (2010).

31. *Cenzon-DeCarlo v. Mount Sinai Hosp.*, 626 F.3d 695, 698–99 (2d Cir. 2010).

Services.³² After a delay, the department investigated Cathy's complaint but did not resolve it.³³ Mt. Sinai, perhaps out of fear of losing its federal funding, eventually revised its policies to respect the right of conscience anyway.³⁴ The ordeal nonetheless inflicted upon Cathy emotional and psychological trauma that leaves lasting scars to this day.³⁵

The Stormans family owns and operates Ralph's Thriftway, a fourth-generation grocery store and pharmacy in Olympia, Washington.³⁶ As Christians they object to participating in the destruction of human life.³⁷ They refrain from stocking or dispensing Plan B in their pharmacy, as the FDA has confirmed that the medication can prevent implantation and therefore destroy a human embryo.³⁸ Instead, if they receive a request for these medications, they commonly refer customers to one of the more than thirty nearby pharmacies that regularly stocks and dispenses them—not surprisingly, given the fact that these pharmacies are all within five miles of Ralph's, no one has ever been denied timely access to these medications.³⁹ Moreover, referrals are a commonplace of the pharmacy practice and are supported by the American Pharmacists Association and more than thirty other medical and pharmacy associations.⁴⁰ Referral is also legal in every state—except Washington.⁴¹ That is because in 2007—after Governor Christine Gregoire and Planned Parenthood had restocked the Washington State Pharmacy Commission with their supporters—the Commission enacted a rule prohibiting conscience-based referrals.⁴² As a result, the Stormans had to bring suit to protect their right to conscience, and, after years of litigation, a federal district court ruled that the new regulations—which permitted referrals for almost every conceivable reason save for conscience—violated the Free Exercise Clause

32. See *NY Nurse Forced to Participate in Abortion Files Additional Suit against Mt. Sinai Hospital*, ALL. DEFENDING FREEDOM (Apr. 29, 2010), <http://www.adfmedia.org/News/PRDetail/4000>.

33. See Letter from Linda C. Colon, Reg'l Manager, Dep't of Health & Human Servs., to Matthew S. Bowman, Attorney, All. Defending Freedom, and David Reich, Interim President, Mount Sinai Hosp. (Feb. 1, 2013), <http://www.adfmedia.org/files/Cenzon-DeCarloHHSfindings.pdf>.

34. *Mt. Sinai Ends Forced Abortion-Participation Policy*, ALL. DEFENDING FREEDOM (Feb. 12, 2013), <http://www.adfmedia.org/News/PRDetail/2895>.

35. See Complaint, *supra* note 25, at 15.

36. *CASE SNAPSHOT: Stormans v. Wiesman*, ALL. DEFENDING FREEDOM (June 28, 2016), <http://www.adfmedia.org/files/StormansSnapshot.pdf>.

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.*

41. *Id.*

42. *Id.*

of the First Amendment to the United States Constitution.⁴³ Unfortunately, the Ninth Circuit Court of Appeals eventually reversed the trial court,⁴⁴ and the United States Supreme Court declined to hear the appeal, making Washington the only state that currently bans conscience referrals for pharmacists.⁴⁵

Trinity Health operates ninety-three hospitals and 120 continuing care facilities throughout the U.S.⁴⁶ It provides healthcare in accordance with Roman Catholic teaching, and is particularly dedicated to serving impoverished communities.⁴⁷ In keeping with the dictates of Catholic doctrine—which is the source of its charitable mission—Trinity Health hews to Ethical and Religious Directives issued by the United States Conference of Catholic Bishops,⁴⁸ which states that “[a]bortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted.”⁴⁹ That same Directive, however, permits Catholic hospitals like those in Trinity Health’s network to take steps to save the life of the mother, even if such steps may unintentionally and indirectly result in harm to her unborn baby.⁵⁰ But none of this—neither the moral belief that abortion is a morally illicit practice, nor the Directive’s reasonable provision protecting the life of the mother—proved acceptable to the ACLU. That organization sued Trinity Health in October 2015, claiming that Trinity Health’s convictions presented a threat to women who might—for “health reasons”—need an abortion and might only have access to Trinity Health’s hospital network.⁵¹ The ACLU specifically alleged that Trinity Health’s refusal to intentionally perform

43. *Stormans, Inc. v. Selecky*, 854 F. Supp. 2d 925, 967–90 (W.D. Wash. 2007), *rev’d sub nom.* *Stormans, Inc. v. Wiesman*, 794 F.3d 1064 (9th Cir. 2015).

44. *Stormans, Inc. v. Wiesman*, 794 F.3d 1064, 1087–88 (9th Cir. 2015).

45. *See Stormans, Inc. v. Wiesman*, 136 S. Ct. 2433, 2433 (2016) (Alito, J., dissenting) (stating that “[the] case is an ominous sign” because “[i]f this is . . . how religious liberty claims will be treated in the years ahead, those who value religious freedom have cause for great concern”).

46. *About Us*, TRINITY HEALTH, <http://www.trinity-health.org/about-us> (last visited Feb. 26, 2017).

47. *Id.*

48. *American Civil Liberties Union v. Trinity Health*, ALL. DEFENDING FREEDOM, <https://www.adflegal.org/detailspages/case-details/american-civil-liberties-union-v.-trinity-health> (last visited May 3, 2017).

49. *See UNITED STATES CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 26* (5th ed. 2009), <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>.

50. *Id.*

51. *American Civil Liberties Union v. Trinity Health*, *supra* note 48.

abortions violates the Emergency Medical Treatment and Active Labor Act, and the Rehabilitation Act, which protects people with disabilities.⁵² But in essence what the ACLU really wanted was to compel Trinity Health to reject its Catholic beliefs and commit abortions.⁵³ A federal district court eventually dismissed the case for lack of standing,⁵⁴ but attacks on institutions like Trinity Health will likely continue unabated given current trends.

II. THE IMPORTANCE OF MEDICAL CONSCIENCE PROTECTIONS

Attacks on conscience like the ones described above represent an ever-burgeoning trend of thought and action that is decidedly alien to our tradition.⁵⁵ Stories of the travails of these individuals and institutions—and many others just like them—are growing all too common.⁵⁶ Taken together, these entirely avoidable conflicts show that the right to conscience is no longer seen as “unalienable” by many of those who wield power and influence. To the contrary, it would now be more accurate to say that such

52. Amended Complaint at 15, *Am. Civil Liberties Union v. Trinity Health Corp.*, 178 F. Supp. 3d 614 (E.D. Mich. 2016) (No. 15-CV-12611).

53. Indeed, in another recent case, the ACLU sued Dignity Health—the nation’s fifth largest health care provider, which operates Catholic hospitals in California, Nevada, and Arizona—because one of its hospitals, Mercy Medical Center, refused to perform a requested tubal ligation on a patient following a C-section delivery, which procedure is not in keeping with the dictates of Catholic doctrine. *See* Associated Press, *Judge: California Hospital Doesn’t Have to Do Tubal Ligation*, NBC NEWS (Jan. 14, 2016 3:35 PM), <http://www.nbcnews.com/news/us-news/fight-over-tubal-ligation-heads-court-california-n496516> (detailing ACLU’s suit against Dignity Health and Mercy Medical Center). Notwithstanding the sincerity and longstanding clarity of Catholic doctrine on this point and notwithstanding the great cost, the ACLU still seeks to compel Mercy Medical Center to violate its conscience, and characterizes the expansion of “Catholic hospital chains” as “interference with the doctor-patient relationship” which “presents a real threat to women’s ability to access basic healthcare across the country.” *Chamorro v. Dignity Health (Religious Refusals)*, ACLU N. CAL. (Apr. 27, 2016), <http://www.aclunc.org/our-work/legal-docket/chamorro-v-dignity-health-religious-refusals>.

54. *Am. Civil Liberties Union*, 178 F. Supp. 3d at 617–20.

55. *See* *W. Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624, 642 (1943) (“If there is any fixed star in our constitutional constellation, it is that no official, high or petty, can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein. If there are any circumstances which permit an exception, they do not now occur to us.”).

56. This Article can only present a few of the egregious attacks on conscience, as a compendium of such abuses is beyond its scope. Suffice to say, however, that there are far more attacks on conscience than formal court cases treating of these disputes. For a more comprehensive list of various attacks on conscience and their effect on medical professionals, see CHRISTIAN MED. ASS’N, *ABRIDGING THE FREEDOM TO PROTECT PATIENTS: THREATS TO HEALTHCARE PROFESSIONALS’ CONSCIENCE RIGHTS 2–7* (2008), http://www.freedom2care.org/docLib/20090313_needforconscienceprotection.pdf.

opponents to conscience view it not so much as a right but rather as a mere impediment to the realization of an ideologically-driven agenda.⁵⁷ Unfortunately, these persistent and often successful attacks on conscience—both as to its exercise in particular cases and its philosophical justification—continue despite the myriad state and federal protections which ostensibly exist for the very purpose of preventing them.⁵⁸ But law, history, and the nature of medicine itself all support a robust right to conscience.

Indeed, it is a grave mistake for a society to dictate to its medical practitioners that they must violate their ethical principles.⁵⁹ Conscripting the conscience of the medical practitioner to do the bidding of another benefits no one. Conscience must be preserved inviolate precisely because without it medical decision-making suffers.⁶⁰ In fact, no matter what one's ideological predilections, protecting the conscience of medical professionals is a good idea—good for patients, good for individual practitioners and medical institutions, and good for society as a whole. This section seeks to outline the many reasons why robust protections for medical conscience are not only necessary but essential to the maintenance of a healthy polity.

A. *Legal Reasons to Protect Conscience*

Perhaps the most obvious place to start is in the legal realm. The fact that the *Roe* and *Bolton* Court essentially recognized the propriety of a right to medical conscience at the same time it announced a right to abortion is powerful evidence that contemporary attempts to eradicate conscience should be summarily rejected. Moreover, given the ubiquity of extant protections for conscience on both the federal and state levels—which erupted in the wake of *Roe* and *Bolton* (despite whatever infirmities those laws might exhibit)—it must be concluded that protections for medical conscience are not only necessary but essential to the practice of medicine and the ethic of the nation as well. Finally, given the substantive rationale behind the Court's justification for the right to abortion itself, it can hardly be claimed that the right to conscience is on any less solid footing from a constitutional perspective—in fact it would appear that the right to medical conscience, at

57. See discussion *infra* Section II.A.3.

58. See discussion *infra* Part V for a discussion of these protections.

59. See discussion *infra* Section II.B (presenting examples of doctors adopting the societal “drift” rather than exercising their individual consciences).

60. See, e.g., Elizabeth Sepper, *Not Only the Doctor's Dilemma: The Complexity of Conscience in Medicine*, 4 FAULKNER L. REV. 385, 391 (2013) (arguing that “ethical reasoning is in fact deeply embedded in the practice of medicine” and concluding that “[a]s a profession that is largely self-regulated, medicine demands conscientiousness”).

least with respect to abortion but perhaps even more broadly, is even more firmly grounded than the right to any particular form of medical care.

1. The Solicitude for Protecting Medical Conscience Exhibited by the United States Supreme Court Signals the Importance of the Right

Roe was “undeniably . . . decided in the context of and with the explicit judicial acknowledgement of strong existing official professional protection for rights of conscience of health-care providers.”⁶¹ Indeed, “[t]he actual holding[] of *Roe* . . . , far from authorizing a woman to co-opt a physician into aborting her baby, focuses on the physician’s freedom of self-determination.”⁶² The *Roe* Court saw fit to cite the American Medical Association’s (AMA) resolution to the effect that “[n]either physician, hospital, nor hospital personnel shall be required to perform any act violative of personally-held moral principles.”⁶³ The *Doe* Court was, if anything, even more clear in its acceptance of medical conscience—in fact, in *Doe*, “the constitutionality of statutory protection for rights of conscience of health-care providers was challenged, noted, and explicitly upheld.”⁶⁴ More specifically, the *Doe* Court unanimously affirmed that portion of the Georgia abortion law under review that ensured that “a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure,” a provision the Court characterized as “afford[ing] appropriate protection” for individuals and institutions alike.⁶⁵ Thus, “at the same time the Court was legalizing abortion, the Court itself recognized the potential clash between its decision and the consciences of those to whom abortion was repugnant, and expressly recognized . . . the constitutionality of statutory measures designed to protect the right of conscience.”⁶⁶ The right to

61. Wardle, *supra* note 17, at 22.

62. M. Casey Mattox & Matthew S. Bowman, *Your Conscience, Your Right: A History of Efforts to Violate Pro-Life Medical Conscience, and the Laws That Stand in the Way*, 77 LINACRE Q. 187, 189 (2010).

63. *Roe v. Wade*, 410 U.S. 113, 143 n.38 (1973).

64. Wardle, *supra* note 17, at 16.

65. *Doe v. Bolton*, 410 U.S. 179, 197–98 (1973).

66. Francis J. Manion, *Protecting Conscience Through Litigation: Lessons Learned in the Land of Blagojevich*, 24 REGENT U. L. REV. 369, 370 (2012).

abortion does not then entail a concomitant right to conscript an unwilling practitioner or institution to provide that procedure.⁶⁷

2. Extant Legal Protections for Conscience Themselves Signal the Importance of Maintaining the Right to Medical Conscience

It has been argued 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.”⁶⁸ But such cavalier treatment of conscience is seemingly rejected not only by *Roe* and *Doe* themselves, but also by the myriad federal and state laws protecting conscience.⁶⁹ Indeed, “the near unanimous—and virtually immediate—action of state and federal governments to protect conscience in the wake of *Roe* . . . marks the conscience right as fundamental and . . . unique in our history.”⁷⁰ Moreover, those myriad protections, having been codified into law, “are just as legal (or even more so) than are services such as abortion.”⁷¹ In other words, the very edifice of legal protections for conscience that grew out of *Roe* and *Doe*, an edifice that has stood for decades, should definitively rebut—once and for all—any contention that medical practitioners must simply perform all legally permitted procedures, no matter their moral qualms.⁷²

67. Mattox & Bowman, *supra* note 62, at 190 (“[N]either *Roe* nor *Doe* provide any support for—and even implicitly rejected—the idea that a woman has the right to require a medical professional to perform an abortion against his conscience or professional judgment.”).

68. Swartz, *supra* note 15, at 278.

69. For a discussion of the legal protections for conscience that erupted in the wake of *Roe* and *Doe* and have continued apace since that time, see generally Matthew S. Bowman & Christopher P. Schandavel, *The Harmony Between Conscience Rights and Patients’ Right of Access*, 6 PHX. L. REV. 31, 49–52 (2012); Manion, *supra* note 66, at 370 (“One of the effects of the Supreme Court’s decisions in *Roe v. Wade* and *Doe v. Bolton* was the creation within the American health care system of a potential class of conscientious objectors of a kind and on a scale previously unknown.”); Rienzi, *supra* note 19, at 30–35; Swartz, *supra* note 15, at 269; Wardle, *supra* note 17, at 33.

70. Rienzi, *supra* note 19, at 40–41.

71. Bowman & Schandavel, *supra* note 69, at 48.

72. See, e.g., Wardle, *supra* note 17, at 33 (“The persistent federal effort to see that new developments in medicine, law, regulation, and the economy do not result in erosion of legal protection for the rights of conscience of health-care providers is strong evidence that the principle of protection of rights of conscience for health-care providers is deeply embedded in our political consciousness, and a continuing concern in the American people.”).

3. Because the Right Not to Participate in Abortion is at Least as Firmly Grounded in the Constitution as the Right to Abortion Itself, the Right to Conscience Cannot Be Trumped by Lesser Considerations

As Professor Mark Rienzi and others have amply demonstrated, the right not to participate in abortions, when viewed through the substantive due process lens the Supreme Court has used to divine various unenumerated liberty interests, turns out to have a constitutional pedigree of more heft and clarity than the abortion right itself.⁷³ Indeed, whereas abortion was found to be a right despite the fact that its practice “was illegal, discouraged, and/or widely regarded as unethical for much of our pre-*Roe* history,”⁷⁴ the right not to participate in abortions, “[f]ar from being illegal . . . was affirmatively legally required conduct in many circumstances.”⁷⁵ Under these historical facts it becomes difficult to deny that the right not to participate in abortions was “deeply rooted in this Nation’s history and tradition . . . such that ‘neither liberty nor justice would exist if they were sacrificed,’”⁷⁶ which is the standard used by the Court to determine whether a liberty interest warrants constitutional protections.⁷⁷ The implications of this studied conclusion are

73. See Rienzi, *supra* note 19, at 9–10 (concluding that the “right of healthcare providers to refuse to participate in abortions is . . . sufficiently rooted in the nation’s history and traditions to fall within the Fourteenth Amendment’s substantive protections,” and in fact, “actually better satisfies the required Fourteenth Amendment test than the abortion right itself,” and further concluding that the right to refuse to participate in an abortion “fits squarely within the zone of individual decision making about abortion protected by the Court’s decisions in *Casey* and *Lawrence v. Texas*”) (emphasis omitted); see also Luke W. Goodrich, *The Health Care and Conscience Debate*, 12 ENGAGE: J. FEDERALIST SOC’Y PRAC. GROUP 121, 124 (2011) (arguing that “‘freedom of choice’ goes both ways,” and concluding that “the rationale for the right of abortion . . . counsels in favor of conscience protections,” because “[i]f the government cannot decide the morality of abortion for a pregnant woman, it cannot decide the morality of abortion for a Catholic hospital, doctor, or pharmacist”); Wardle, *supra* note 17, at 21–22 (concluding that “a more-than-plausible claim exists that the constitutional liberty (to use *Casey*’s preferred terminology) and fundamental right of privacy (to use *Roe*’s preferred terminology) established in *Roe* and its judicial progeny (including *Casey*) also provides constitutional protection for decisions by health-care providers to decline to provide or assist in providing controversial medical procedures”).

74. Rienzi, *supra* note 19, at 9–10.

75. *Id.* at 40 (emphasis omitted).

76. *Washington v. Glucksberg*, 521 U.S. 702, 721 (1997) (citations omitted).

77. Professor Rienzi also argues that “recognition of a right to refuse [to participate in abortions] protects healthcare providers from the types of psychological harm that the Court recognized as justifying protection for the abortion right in *Roe* and *Casey*.” Rienzi, *supra* note 19, at 10. Put simply then, if the liberty to “define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life,” *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992), includes the right to have an abortion, it must also encompass a medical

profound, especially when it is considered that much of the modern objection to medical conscience amounts to little more than an ideological objection to those who refuse to take part in abortion or related medical procedures, including controversial contraceptive techniques or medications. A constitutional right cannot be conditioned upon the fulfillment of another's ideological agenda. Put simply, the right to conscience exists no matter what its substantive content.

B. *Historical and Societal Reasons to Protect Conscience*

With respect to the founding dedication to conscience previously described, it must be said that history commends maintaining the right to medical conscience in as strong a form as possible, for the benefit of patients, the medical practitioner, and society as a whole.

As has already been discussed above, the right to conscience was no accidental by-product of our founding but rather a hallmark. In fact, according to Professor Lynn Wardle, “[p]rotection for individual exercise of rights of conscience was one of the essential purposes for the founding of the United States of America and one of the great motivations for the drafting of the Bill of Rights.”⁷⁸ More specifically, “[p]rotection of rights of conscience and religious liberty had structural significance for the Constitution, for liberty is the soil in which virtue grows, and virtue is the precondition for our constitutional system of republican government.”⁷⁹ The right to conscience, then, properly understood, “is a fundamental, inalienable human right,” and not a mere prerogative susceptible to being “suspended or superseded when political or other circumstances warrant.”⁸⁰ This conception of conscience as a paramount right is no doubt why its exercise has historically been respected and protected in a host of otherwise unrelated contexts.⁸¹

This view of conscience is also remarkably consonant with the traditional, historical view of the medical practitioner as an autonomous professional

practitioner's right to avoid complicity in what he or she believes to be a killing. See Mark L. Rienzi, *The Constitutional Right Not to Kill*, 62 EMORY L.J. 121, 171–74 (2012).

78. Wardle, *supra* note 1, at 78.

79. Wardle, *supra* note 17, at 6.

80. *Id.* at 8.

81. See Rienzi, *The Constitutional Right Not to Kill*, *supra* note 77, at 125–29 (discussing the right to conscience in the context of military conscription, capital punishment, assisted suicide, and abortion); Brief of Amici Curiae 43 Members of Congress in Support of Petitioners at 3, *Stormans, Inc., v. Wiesman*, 136 S. Ct. 2433 (2016) (No. 16-862) (discussing the traditional solicitude for protecting conscience rights, up to and including the conscience rights of healthcare professionals).

committed to virtue, to doing right and avoiding wrong. The “venerable Hippocratic Oath,” for instance, “points to a 2,400-year-old autonomous profession.”⁸² Anthropologist Margaret Mead characterized the Oath as “dedicated completely to life under all circumstances, regardless of rank, age, or intellect,” and further warned that “society is always attempting to make the physician into a killer—to kill the defective child at birth, [or] to leave the sleeping pills beside the bed of the cancer patient.”⁸³ In many ways the Hippocratic Oath has served as a bulwark against the societal compulsion recognized by Mead by, according to former United States Surgeon General C. Everett Koop, “call[ing] upon physicians to commit themselves to a higher ethical standard.”⁸⁴ And “[a]lthough not included in the Oath, the promise to do no harm, *Primum Non Nocere*, is also irrevocably bound to the Hippocratic principle of the sanctity of human life.”⁸⁵

The duties imposed by these principles can only, however, be properly discharged when the free exercise of conscience flourishes. For history itself teaches us that when the conscience of the medical practitioner has been sacrificed to the collective will of the age, human suffering ensues. Indeed,

[h]istory is rife with instances where delivery of independent, ethical medical care was compromised with disastrous results. The atrocities committed by Nazi physicians and, more recently, those of some American physicians working in Iraq and Afghanistan are testaments to the potential brutal activity that can occur when governments stifle the consciences of physicians.⁸⁶

This is not, of course, to say that any resistance to medical conscience in particular circumstances causes or threatens to produce mass atrocities or egregious ethical abuses, but it is to say that the “widespread dismissal of conscience socializes physicians to be muted participants in atrocities and suboptimal care rather than advocates of health and humanity.”⁸⁷ Thus,

82. T.A. Cavanaugh, *Professional Conscientious Objection in Medicine with Attention to Referral*, 9 AVE MARIA L. REV. 189, 193 (2010).

83. MAURICE LEVINE, PSYCHIATRY AND ETHICS 325 (George Braziller ed., 1972) (quoting Margaret Mead).

84. C. Everett Koop, *Introduction*, 35 DUQ. L. REV. 1, 1–2 (1996) (“The Hippocratic Oath and the tradition surrounding it served mankind well for several millennia and became the medical ethics and value system that has made western medicine the art that it is. . . . The Hippocratic Oath has kept physicians on the right course for more than two thousand years.”).

85. *Id.*

86. Genuis & Lipp, *supra* note 11, at 5.

87. *Id.*; see also Matthew Lippman, *The Nazi Doctors Trial and the International Prohibition on Medical Involvement in Torture*, 15 LOY. L.A. INT’L & COMP. L. REV. 395, 403–04 (1993) (“The Nazi regime took steps to insure that medical doctors were inculcated into ‘the eugenic way of thinking.’ Medical professionals were expected to support the government with

compelling doctors and other medical professionals—as a matter of principle—to take part in activity that is alien to their calling as healers, no matter what the claimed imperative, can ultimately redound only to the detriment of patients, practitioners, and society as a whole.⁸⁸ Faced with this undeniable historical lesson, the importance of preserving medical conscience cannot be gainsaid.⁸⁹

both the ‘marching boot and the book.’ Rudolf Ramm of the University of Berlin’s medical faculty admonished doctors that their primary duty was no longer to minister to the sick.”); *Id.* at 431 (concluding that “the utilization of medicine to harm rather than to heal did not end with the trial of the Nazi doctors,” and recounting “[s]everal studies attest[ing] to the medical profession’s involvement in the practice of torture”); Benjamin Mason Meier, *International Criminal Prosecution of Physicians: A Critique of Professors Annas and Grodin’s Proposed International Medical Tribunal*, 30 AM. J.L. & MED. 419, 419 (2004) (arguing that “[s]ociety benefits from physicians who seek truth and healing for the good of humanity,” but concluding that “[d]espite ethical admonishments to ‘do no harm,’ . . . physicians have caused some of the most appalling human rights abuses of the twentieth century”).

88. See, e.g., ROBERT JAY LIFTON, *THE NAZI DOCTORS: MEDICAL KILLING AND THE PSYCHOLOGY OF GENOCIDE* 4–5, 14 (Basic Books, Inc. ed., 2000) (contrasting the “ordinariness of most Nazi doctors” with the “demonic acts” many perpetrated, and concluding that what was “[a]t the heart of the Nazi enterprise . . . [was] . . . the destruction of the boundary between healing and killing”).

89. It might be objected that the Holocaust is too extreme an example to proffer in such a debate, but such an objection would seem to be predicated on the scale rather than the philosophical genesis of the atrocity itself. For it is in fact the movement away from the idea of healing as paramount to medicine that always precedes the actual medical abuse of human beings—as such, the Nazi genocide simply cannot be so easily dismissed. Moreover, history is replete with many other examples of medical practitioners who have ignored conscience for other imperatives, and the results are not salutary. *Id.* at xii (“[T]he Nazis were not the only ones to involve doctors in evil. One need only look at the role of Soviet psychiatrists in diagnosing dissenters as mentally ill and incarcerating them in mental hospitals; of doctors in Chile (as documented by Amnesty International) serving as torturers; of Japanese doctors performing medical experiments and vivisection on prisoners during the Second World War; of white South African doctors falsifying medical reports of blacks tortured or killed in prison; of American physicians and psychologists employed by the Central Intelligence Agency in the recent past for unethical medical and psychological experiments involving drugs and mind manipulation; and of the ‘idealistic’ young physician-member of the People’s Temple cult in Guyana preparing the poison (a mixture of cyanide and Kool-Aid) for the combined murder-suicide in 1978 of almost a thousand people.”); Pellegrino, *supra* note 18, at 224 (discussing the “recent historical experience of past and present totalitarian governments subverting the uses of medical knowledge to political and economic purposes” including “the way the Soviet Union distorted the Hippocratic Oath to make it serve the purposes of Communism, the Nazi physicians’ acquiescence in using their knowledge in the service of genocide, or the participation of physicians as instruments of torture or terrorism by so many petty dictators and war lords”).

C. *Medical Practitioner and Patient Care Reasons to Protect Conscience*

Inextricably linked to the historical and societal reasons to protect conscience are the related concerns for medical practitioner integrity and life-affirming patient care, both of which justify maintaining a robust right of conscience.

1. *The Right to Conscience Protects the Integrity of the Medical Practitioner and the Medical Profession*

Despite increasing pressure to conform to some prefabricated set of ephemeral norms, it is likely safe to say that it is still the case that the majority of those who enter medicine view it as a noble calling, a vocation which the individual practitioner will be free to himself or herself determine what is right and wrong for his or her patient. There is a reason, after all, that for millennia medical practitioners and institutions have adhered to the aforementioned duty to “do no harm.” That reason is this—“[m]edicine is at heart a moral enterprise[,] and those who practice it are de facto members of a moral community.”⁹⁰ Indeed, “since Hippocratic times . . . it has been conducted in accordance with a definite set of beliefs about what is right and wrong medical behavior.”⁹¹

But this manner of practicing medicine cannot perdure unless the right to conscience is respected and defended. The medical practitioner cannot do right and avoid wrong if he is merely some technocrat delivering whatever procedure is requested or demanded, whether the request comes from an individual patient or from society more broadly. Such a system—which those objecting to broad medical conscience protections would seem to favor—not only devalues the autonomy and moral agency of the medical practitioner,⁹²

90. Edmund D. Pellegrino, *The Medical Profession as a Moral Community*, 66 BULL. N.Y. ACAD. MED. 221, 222 (1990).

91. Pellegrino, *supra* note 6, at 64; *see also* Elizabeth Sepper, *Doctoring Discrimination in the Same-Sex Marriage Debates*, 89 IND. L.J. 703, 730–31 (2014) (noting that “[a] number of scholars identify ‘professional conscience’ informed by moral precepts internal to medicine as essential to medical practice,” and concluding that medical practitioners, “[t]o navigate ethically complex medical questions, physicians need ethical virtues as much as they need clinical skills”).

92. *See* Azgad Gold, *Physicians’ “Right of Conscience”—Beyond Politics*, 38 J.L. MED. & ETHICS 134, 139 (2010) (recognizing that “[f]rom an ethical perspective, exactly as it is wrong to ignore the patient’s right to autonomy by expecting him to conform to the physician’s perspective, in the same way, it would be unfair to treat physicians with a different standard”); Pellegrino, *supra* note 6, at 67 (“[T]he patient cannot ask the physician to override his values. To respect the

but also entirely misunderstands the nature of medicine itself.⁹³ Indeed, because the practice of medicine “involves particular vulnerabilities on the part of patients and carries the potential to elicit powerful and conflicting psychological and emotional impulses on the parts of both physicians and patients,” it can be argued that “medical professionals should be given greater deference in pursuit of their ethical obligations than other professionals.”⁹⁴ The autonomy and conscience of the medical practitioner must therefore be jealously guarded, precisely because medicine is “a fundamentally human and personal enterprise” that is susceptible to being “compromised when the profession is subservient to the state or overarching social and professional dictates.”⁹⁵ In a very real sense, it is the perennial challenge posed to medical conscience by “tyrants, law, custom, and professional colleagues” that itself justifies and demands that the right never be relinquished.⁹⁶

2. The Right to Conscience Protects the Patient

Abandoning the right to conscience of the medical practitioner not only harms the individual practitioner but also threatens harm to his patients as well—the harms, however paradoxical it might seem, are actually inseparable from one another. In fact, the “public utility” model of medicine is not only a “challenge [to] a conscientious physician’s integrity as a physician,” it also “depreciates his expertise, reduces his discretionary latitude in decisionmaking, and makes him a technical instrument of another person’s wishes,” thereby “subvert[ing] the healing purpose for which medicine is intended in the first place.”⁹⁷ The myopic view of medicine that views a medical practitioner as a mere service provider “can redound to the patient’s harm by undermining the physician’s moral obligation to provide sound

patient’s moral agency does not mean submitting to whatever he wishes if it violates the physician’s moral beliefs.”).

93. See *William Osler & His Inspirational Words*, THE OSLER SYMPOSIA, <http://www.oslersymposia.org/about-Sir-William-Osler.html> (last visited Mar. 7, 2016) (“You are in this profession as a calling, not a business Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed.”).

94. Michael K. Gottlieb, *Executions and Torture: The Consequences of Overriding Professional Ethics*, 6 YALE J. HEALTH POL’Y L. & ETHICS 351, 355–56 (2006).

95. Genuis & Lipp, *supra* note 11, at 9.

96. Pellegrino, *supra* note 18, at 223 (noting that “[e]ach era has had its own challenges to the physician’s conscience”).

97. Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL’Y 47, 59 (1993).

advice and sound practice and to avoid medically useless or futile treatments.”⁹⁸

Moreover, despite claims that the right to medical conscience limits access to medical practitioners,⁹⁹ the opposite is actually true. Prohibiting medical practitioners who have conscience objections to particular medical procedures or medications from practicing in their chosen field means in practice that those who seek, for instance, a pro-life OB/GYN or geriatric specialist, will be unable to access one.¹⁰⁰ In the name of patient access, those who oppose medical conscience—unwittingly or not—would actually be reducing the pool of available medical practitioners.¹⁰¹ But on the other hand, if the right to conscience were robustly defended, all patients—no matter their political, religious, or ideological beliefs—would presumably be able to access and receive care from medical practitioners who share their values,

98. *Id.*

99. *See, e.g.,* Nejaime & Siegel, *supra* note 12, at 2556–57 (arguing that it is “clear . . . that healthcare refusal laws empower a substantial segment of the healthcare industry to operate in conformity with religious principles that dictate limitations on services relating to abortion and contraception”).

100. *See, e.g.,* CHRISTIAN MED. ASS’N, TWO NATIONAL POLLS REVEAL BROAD SUPPORT FOR CONSCIENCE RIGHTS IN HEALTH CARE 1 (2009), <https://cmda.org/library/doclib/Pollingsummary-handout.pdf> (last visited Mar. 12, 2017) (noting that 91% of faith-based physicians agreed with the statement that they would “rather stop practicing medicine altogether than be forced to violate [their] conscience[s]”).

101. Bowman & Schandavel, *supra* note 69, at 44 (noting that if the forced-access arguments of those who objected to medical conscience were to be “adopted as legal and professional standards in health care, women who oppose abortion would be deprived of the ability to choose physicians who unequivocally value the lives of preborn children and who would never assist with an abortion,” because “[s]uch physicians simply would not be allowed to exist”; further noting that a similar logic would apply to end-of-life issues, where such a system “would deprive the sick and the elderly of the ability to choose a physician whom they trust to never assist in prescribing death-inducing drugs or regimens”); Michael A. Fragoso, *Taking Conscience Seriously or Seriously Taking Conscience?: Obstetricians, Specialty Boards, and the Takings Clause*, 86 NOTRE DAME L. REV. 1687, 1696 (2011) (arguing that the ACOG Ethics Opinion would, if followed, be “limiting conscientious objection and mandating complicity in abortion and related procedures . . . mak[ing] obstetrics an unappealing specialty for those who have moral objections to abortion,” thereby forcing those practitioners “out of the field, or preclud[ing] their entering into it”); Robert P. George, Remarks at the President’s Council on Bioethics: Conscience in the Practice of Health Professions (Sept. 11, 2008), <https://bioethicsarchive.georgetown.edu/pcbe/transcripts/sept08/session3.html> (“If [the ACOG Ethics Committee’s] advice were followed . . . [the obstetric] fields of medical practice would be cleansed of pro-life physicians whose convictions required them to refrain from performing or referring for abortions. The entire field would be composed of people who could be relied on either to agree with or at a minimum go along with their convictions, those of the report’s authors, on this most profound of moral questions upon which reasonable people of goodwill disagree, yet must somehow find a way to live together in peace and discuss their differences with civility and mutual respect.”).

which is an important component of the physician-patient relationship in its own right.¹⁰² Thus quality of care and patient access would be ameliorated rather than hampered under a system of robust conscience protections.

III. THE PERVASIVE AND PERSISTENT CHALLENGES TO THE RIGHT OF CONSCIENCE

Notwithstanding the myriad legal, historical, and medical reasons to champion the right to conscience, many still seek to jettison it altogether or at the very least drastically circumscribe its scope. This concerted opposition to conscience continues a trend that arose in the wake of *Roe*. According to Professor Robin Fretwell Wilson, “*Roe* opened a real can of worms both for institutional . . . and . . . individual providers who objected to performing [abortions]” because “[f]amily planning advocates worked diligently to extend the non-interference rights recognized in *Roe* into affirmative entitlements to another’s assistance.”¹⁰³ In many ways that same dynamic continues apace today, if perhaps in an even more aggressive form, and it is aided and abetted by scholars, ideological advocacy groups, professional organizations, and even the State itself.

Dr. Julie Cantor argues that physicians with moral objections to certain procedures should simply avoid practicing in a field that implicates their objections: “Qualms about abortion, sterilization, and birth control? Do not practice women’s health.”¹⁰⁴ R. Alta Charo, Professor of Law and Bioethics at the University of Wisconsin–Madison, likens a conscience objection to participating in abortions or other controversial procedures to “an abuse of the public trust” or “an attempt at cultural conquest.”¹⁰⁵ Professor Jesse Hill, formerly with the Reproductive Freedom Project of the ACLU, has stated that if medical procedures such as “abortion, emergency contraception for rape victims, and so on” are deemed to be “within the range of appropriate medical

102. See CHRISTIAN MED. ASS’N, *supra* note 100 (reporting that “[f]ully 88% of American adults surveyed said it is either ‘very’ or ‘somewhat’ important to them that they enjoy a similar set of morals as their doctors, nurses, and other healthcare providers”); Rouse, *supra* note 13, at 163, 166 (arguing that “patients want to be served by physicians that follow their conscience,” and further arguing that “mandating that medical professionals check their moral convictions at the door of their employment devalues the sense of loyalty and fidelity that patients hold dear in their health-care providers”).

103. Robin Fretwell Wilson, *Empowering Private Protection of Conscience*, 9 AVE MARIA L. REV. 101, 107 (2010).

104. Julie Cantor, *Conscientious Objection Gone Awry—Restoring Selfless Professionalism in Medicine*, 360 NEW ENG. J. MED. 1484, 1485 (2009).

105. Charo, *supra* note 16, at 2473.

treatment,” then a medical practitioner must “enable patients to choose those procedures.”¹⁰⁶ Martha Swartz concludes that “health care professionals should be admonished that conscientious objections based on personal beliefs, as opposed to professional ethics, will entail consequences.”¹⁰⁷ A group of philosophers and bioethicists recently echoed that pronouncement, proposing that those practitioners who exercise a right to conscience “should be required to compensate society and the health system for their failure to fulfil their professional obligations.”¹⁰⁸ They further intoned that “[m]edical students should not be exempted from learning how to perform basic medical procedures they consider to be morally wrong.”¹⁰⁹ Julian Savulescu, Uehiro Professor of Practical Ethics at the University of Oxford, goes even further—he labels conscience a potential “excuse for vice” that “can be . . . invoked to avoid doing one’s duty,” and concludes that “[a] doctor’s conscience has little place in the delivery of modern medical care.”¹¹⁰

Many advocacy groups similarly view conscience protections with little regard. The Center for Reproductive Rights refers to conscience protections as mere “refusal clauses.”¹¹¹ The ACLU has flatly stated that the “law should not permit an institution’s religious strictures to interfere with the public’s access to reproductive health care.”¹¹² And just this year thirty-six organizations—including the Human Rights Campaign, the National Organization for Women, and People for the American Way—signed a letter expressing their opposition to the Conscience Protection Act of 2016,¹¹³

106. The Federalist Soc’y, *Conscience and the Medical Profession 4-14-11*, YOUTUBE (Apr. 18, 2011), <https://www.youtube.com/watch?v=P5BuMf701hc>, *quoted in* Bowman & Schandavel, *supra* note 69, at 38–39.

107. Swartz, *supra* note 15, at 278.

108. Xavier Symons, *Bioethicists Challenge Right to Contentious Objections*, BIO EDGE (Sept. 3, 2016), https://www.bioedge.org/bioethics/bioethicists-challenge-right-to-conscientious-objection/11988#disqus_thread.

109. *Id.*

110. Savulescu, *supra* note 14, at 294.

111. *Resources and Materials on Refusal Laws*, CTR. FOR REPROD. RIGHTS, (June 27, 2012), <https://www.reproductiverights.org/feature/center-for-reproductive-rights-resources-and-materials-on-refusal-laws>.

112. CATHERINE WEISS ET AL., RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS: ACLU REPRODUCTIVE FREEDOM PROJECT 8 (2002).

113. The Act would have strengthened the Weldon Amendment by providing meaningful enforcement mechanisms. *See* Conscience Protection Act of 2016, H.R. 4828, 114th Cong. (2016).

characterizing the law as “discriminatory legislation” that “jeopardized” “[t]he health and well-being of too many women.”¹¹⁴

Professional medical associations have also proved less than vigorous in protecting conscience, and this despite medicine’s history as an autonomous profession. The Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) has opined that physicians have a duty to either refer for abortion and other related procedures or, in the alternative, when such referral is not feasible, “provide medically indicated and requested care regardless of the provider’s personal moral objections,” up to and including abortion.¹¹⁵ ACOG is not alone in its decision to elevate abortion access over the right to conscience. After the Bush Administration sought to bolster federal conscience protections in 2008, the American Medical Association, along with the American Psychological Association, the American Nurses Association, and the American Society of Pediatrics submitted comments in opposition, claiming that “[d]octors who follow their consciences might violate their ‘paramount responsibility and commitment to serving the needs of their patients.’”¹¹⁶ Notably, the Guttmacher Institute, the ACLU, and the Human Rights Campaign also issued comments opposing the regulations, reflecting the commonality of opposition to robust conscience protections shared by advocacy groups and professional organizations.¹¹⁷

States too have shown a propensity to neglect the right to conscience. In response to the aforementioned Bush Administration attempts to shore up federal conscience protections, thirteen state attorneys general signed a letter

114. *Oppose the Conscience Protection Act of 2016 (S. 304)*, AM. COLL. OF NURSE-MIDWIVES (July 12, 2016), http://www.midwife.org/acnm/files/ccLibraryFiles/FileName/000000006156/Coalition_Letter_Opposing_Conscience_Protection_Act_July2016.pdf.

115. COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *THE LIMITS OF CONSCIENTIOUS REFUSAL IN REPRODUCTIVE MEDICINE* 5 (2007).

116. William L. Saunders & Michael A. Fragoso, *Conscience Protection in Health and Human Services*, 10 ENGAGE: J. FEDERALIST SOC’Y PRAC. GROUPS 115, 117 (2009) (quoting AMA comments); see also NAT’L WOMEN’S LAW CTR., *HEALTH CARE REFUSALS HARM PATIENTS: THE THREAT TO REPRODUCTIVE HEALTH CARE* 1 (2014), http://nwlc.org/wp-content/uploads/2015/08/refusals_harm_patients_repro_factsheet_5-30-14.pdf (“[T]he provider’s personal beliefs ‘must be balanced against the fundamental obligations of the medical profession and physicians’ paramount responsibility and commitment to serving the needs of their patients.’”) (citation omitted).

117. See Adam Sonfield, *Proposed ‘Conscience’ Regulation Opposed Widely as Threat to Reproductive Health and Beyond*, GUTTMACHER INST. (Oct. 27, 2008), <https://www.guttmacher.org/gpr/2008/10/proposed-conscience-regulation-opposed-widely-threat-reproductive-health-and-beyond> (listing groups that opposed the regulations); see also Saunders & Fragoso, *supra* note 116, at 117.

denouncing the regulations,¹¹⁸ and seven states later filed suit to block them.¹¹⁹ More recently, Illinois—which otherwise provides broad protection for medical conscience—amended its Healthcare Right of Conscience Act to require medical practitioners and institutions to provide abortion referrals.¹²⁰ Vermont medical regulatory agencies have construed Act 39, the state’s recently enacted assisted suicide law, to require medical professionals to counsel (or refer for counseling) their terminal patients for physician-assisted suicide.¹²¹ And California passed AB 775, which requires licensed medical centers offering free, pro-life assistance to pregnant women to post a disclosure informing those women that California provides free or low-cost abortion and contraception services, along with a phone number for those services.¹²² And the federal government too has shown itself more than willing to sacrifice the right to conscience, as regulations promulgated pursuant to the Affordable Care Act (ACA) could be interpreted to outlaw a doctor’s conscientious objection to providing abortion or emergency contraception services to a pregnant woman.¹²³

IV. THE REAL OBJECTION TO ROBUST CONSCIENCE PROTECTIONS

A common theme emerges from these various challenges to conscience. It would appear that many believe that the right to conscience should be

118. See Saunders & Fragoso, *supra* note 116, at 117 (citing Press Release, Ariz. Attorney Gen.’s Office, Terry Goddard Urges Proposed Abortion Rule Be Withdrawn (Sept. 24, 2008), <https://www.azag.gov/press-release/terry-goddard-urges-proposed-abortion-rule-be-withdrawn> (“The proposed regulation completely obliterates the rights of patients to legal and medically necessary health care services in favor of a single-minded focus on protecting a health care provider’s right to claim a personal moral or religious belief.”)).

119. *Id.* (describing Complaint allegations).

120. See Complaint, Pregnancy Care Ctr. of Rockford v. Rauner, No. 2016-MR-000741 (Ill. Cir. Ct. Aug. 5, 2016), <https://adflegal.blob.core.windows.net/web-content-dev/docs/default-source/documents/case-documents/the-pregnancy-care-center-of-rockford-v.-rauner/the-pregnancy-care-center-of-rockford-v-rauner---complaint.pdf?sfvrsn=6>.

121. See Complaint at 2–3, Vt. All. for Ethical Healthcare, Inc. v. Hoser, No. 5-16-cv-205 (D. Vt. July 19, 2016).

122. See Brief for Appellants at 10–16, Nat’l Inst. of Family & Life Advocates v. Harris, No. 16-55249 (9th Cir. Mar. 17, 2016).

123. Affordable Care Act § 1557, 42 U.S.C. § 18116 (2012); see also 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, 2493–95, 2493 n.111 (2015) (stating that “Section 1557’s specific reliance on Title IX’s definition of sex discrimination suggests that the ACA aims to provide meaningful protections to women in healthcare . . . specifically care related to reproduction,” and concluding that the law may be seen as “a counterweight to expansive protections for religious liberty at the federal and state levels”). The regulations could also be interpreted to require doctors to perform or participate in treatments related to gender transition.

permitted only insofar as the reason for its exercise in any particular instance accords with the collective conscience of the professional community (however conveniently defined) or the approved judgment of those in the political ascendancy. Not much, it seems, has changed since *Roe* was decided—the campaign against conscience still has almost everything to do with the substantive imperative of abortion and related procedures, and very little to do with the right to conscience itself.

A historical case of remarkably shifting—and self-serving—loyalties to the exercise of conscience is instructive:

[C]onsider the acrimonious issue of termination of pregnancy: some sources in the 1960s advocated for [freedom of conscience] for abortion providers who defied the existing law and [the standard of care] at the time, yet some of these same sources have morphed into principal antagonists against [freedom of conscience] for those who oppose the current law which permits such procedures. In 1965, for example, an article entitled “*Free the Doctor*,” published in a prominent Canadian newspaper (*Globe and Mail*), demanded liberalization of the abortion law “to enable doctors to perform their duties according to their conscience and their calling.” After abortion was legalized in Canada, however, this same erstwhile public defender of [freedom of conscience] advocated on the same issue that all public hospitals should be denied any choice on this issue for any reason—conscience or otherwise.¹²⁴

This astonishing intellectual and professional turnabout can hardly be dismissed as *sui generis*, especially when the work of the scholars, advocacy groups, professional organizations, and government actors discussed above is considered. It turns out that the Canadian experience with respect to the right to conscience and abortion is not an outlier but rather a paradigm for the mistaken but all too common view that the right to conscience should be “support[ed] . . . only when it agrees with one’s own beliefs.”¹²⁵

That paradigm works something like this: Favor the procedure or medication? Any conscience objections must be rejected and the medical practitioner calumniated as irresponsible and unprofessional. Oppose the procedure or medication? Extol conscience and praise the medical practitioner as a noble example of the autonomous professional. How else to explain, for instance, that those “who oppose conscientious objection in the abortion or contraception context often *support* conscientious objection for doctors who refuse to administer a lethal injection”?¹²⁶

124. Genuis & Lipp, *supra* note 11, at 6.

125. Goodrich, *supra* note 73, at 124.

126. *Id.*

But why should that be so? In many ways capital punishment implicates the same concerns abortion does with respect to the exercise of conscience, including the legality of the procedure, the medical standard of care, patient autonomy and access, practitioner autonomy and professional judgment, and the professional association's position on the issue.

Consider for a moment the case of a hypothetical internal medicine physician who is employed by the state prison system. There is an execution set to take place at the prison next week. The inmate has long ago been found guilty beyond a reasonable doubt by a jury of his peers and been sentenced to die by lethal injection by a court of competent jurisdiction. There is no doubt regarding his guilt or his mental competency. The inmate has decided to forego all appeals and proclaims that he is not only ready to die, but hopes that his execution will finally bring closure to his victim's family, to whom he has apologized. He does have one request however—he has read of the many “botched” executions involving lethal injections and is quite understandably terrified of something like that happening to him.¹²⁷ The physician has treated him in the clinic previously and the inmate has now asked him to personally administer the lethal injection, as the inmate has grown to trust his medical skill, judgment, and compassion. The warden orders the doctor to carry out the execution.

But the physician has taken the Hippocratic Oath and has concluded that he cannot oblige the inmate, as he is forsworn to do nothing to harm or cause the death of another.

Should the physician be able to exercise his right of conscience to decline the inmate's request? It may be true that many professional associations have indicated that medical professionals should not participate in executions.¹²⁸ But it is equally true that capital punishment remains legal in the state and no court has ever held that medical personnel can be professionally disciplined for participating in an execution procedure.¹²⁹ Moreover, as some have argued, those sentenced to die by lethal injection should not be treated as a

127. See, e.g., Eric Berger, *The Executioners' Dilemmas*, 49 U. RICH. L. REV. 731, 735–36 (2015) (detailing the “astounding . . . mistakes” that have been made in carrying out lethal injection executions).

128. See Cavanaugh, *supra* note 82, at 196–97 (discussing the AMA Ethics opinion on capital punishment, along with that of the North Carolina Medical Board, which sought to restrict physician participation in capital punishment).

129. N.C. Dep't of Corr. v. N.C. Med. Bd., 675 S.E.2d 641, 651 (2009) (holding that the state medical board's position completely prohibiting physician involvement in executions ran afoul of state law, which “envision[ed] some sort of medical participation in [executions]”); Ty Alper, *The Truth About Physician Participation in Lethal Injection Executions*, 88 N.C. L. REV. 11, 26 (2009) (“Without exception, courts have rejected the notion that state medical boards can discipline doctors for participating in lawfully authorized executions.”).

special class of patients particularly unable to receive the care they desire from a physician, especially at their time of greatest need.¹³⁰ Are condemned inmates somehow undeserving of patient autonomy and solicitude in a way no other class of patient is? Why is it imperative that medical practitioners check their conscience at their door for abortion but not for capital punishment? After all, many medical professionals view abortion as the unjust taking of an innocent human life, and thus conclude that they cannot participate in such a procedure, especially because they view their vocation as being dedicated to preserving and not ending life. So too, many medical professionals view the death penalty as an unjust killing, or are at the very least professionally conflicted about participating in such a procedure, and they routinely conclude they cannot participate in such conduct, especially because they view their profession as dedicated to healing and not harming.

The stark difference in the treatment of conscience as to these two issues belies the fact that both implicate serious and in many instances non-negotiable moral imperatives for medical practitioners. Given this undeniable fact, it should be clear that the solution to the abortion and death penalty dilemmas—and all other moral dilemmas faced by medical practitioners for that matter—should be the same. And that is to preserve conscience as sacrosanct, no matter what the procedure or medication involved. Those who contend, for instance, that medical practitioners must cede their conscience or moral authority to the collective¹³¹ not only misunderstand the nature of the right but also ignore the fact that “something [does not] become good or evil based on what authorities decide or [in] what geographical area it is undertaken.”¹³² Put simply, as an unalienable right conscience cannot be

130. Kenneth Baum, “*To Comfort Always*”: *Physician Participation in Executions*, 5 N.Y.U. J. LEGIS. & PUB. POL’Y 47, 60–62 (2002) (“Condemned death row inmates are, for all practical purposes, terminally ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such. Therefore, physicians should do what any compassionate physician would do for a dying patient—preside over the condemned’s final moments to minimize complications and suffering, and maximize the patient’s comfort until the end of his life. Physicians are expected to provide these services to all others facing imminent death. Why should they deny comforting care to the condemned? It is the physician who abandons his or her patient by failing to provide such comforting care who truly violates the ethical code of the profession.”). *But see* Jonathan I. Groner, *The Hippocratic Paradox: The Role of the Medical Profession in Capital Punishment in the United States*, 35 FORDHAM URB. L.J. 883, 907–08 (2008) (arguing that “lethal injection corrupts the medical profession . . . [and] . . . induce[s] physicians to perform unethical activities”).

131. *See, e.g.*, Swartz, *supra* note 15, at 325 (arguing that a provider’s “professional advice must be informed by the professional ethics generally accepted within their respective professional communities and not by their own professional belief systems”).

132. *See* Genuis & Lipp, *supra* note 11, at 10.

subjected to the vote of a committee or exercised only upon the approval of the self-appointed cognoscenti.¹³³

V. EXTANT STATE AND FEDERAL CONSCIENCE PROTECTIONS

One could be forgiven for concluding that the foregoing concerns about the demise of conscience are overblown, given the superstructure of state and federal laws designed to protect conscience that were passed in the wake of *Roe*. But although those laws are numerous, many have proven ineffective in protecting against violations of conscience. Most of those protections, for instance, understandably restrict their focus to abortion and related procedures, and so fail to ward off challenges to a host of other controversial, morally problematic procedures and medications. Many also tend to cover a relatively discrete set of medical practitioners directly related to the covered medical procedures or medications. And the infirmities do not end there. Many states fail to protect medical institutions altogether, while others would seemingly permit violations of conscience so long as a practitioner works in a public facility. Perhaps the most glaring oversight—as is the case with federal laws like the Church Amendment—is that many states fail to provide for a private right of action whereby practitioners can vindicate their rights to conscience. There are some states—Mississippi and Illinois chief among them—which do provide conscience protections to medical practitioners and employees across a broad spectrum of procedures and medications, and also provide for a private right of action. But they are outliers. Practically speaking, this means that there is much work to do to remedy deficiencies in extant state (and for that matter, federal) conscience protections. The following section outlines extant state and federal protections and is followed by recommendations for shoring up these protections, so that they are adequate to the task of defending conscience in the modern world.

133. See, e.g., Martha Swartz, “Conscience Clauses” or “Unconscionable Clauses”: *Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL’Y L. & ETHICS 269, 339–41 (2006) (discussing an idea to pass conscience claims by an organizational review board, proposed by William A. Nelson and Cedric K. Dark in *Evaluating Claims of Conscience*, HEALTHCARE EXECUTIVE, Mar.–Apr. 2003); *Consensus Statement on Conscientious Objection in Healthcare*, UNIV. OF OXFORD: PRACTICAL ETHICS (Aug. 29, 2016) <http://blog.practical-ethics.ox.ac.uk/2016/08/consensus-statement-on-conscientious-objection-in-healthcare/> (suggesting that the reasons healthcare practitioners offer for their conscientious objection “could be assessed by tribunals, which could test the sincerity, strength and the reasonability of healthcare practitioners’ moral objections to certain medical services”).

A. State Laws Protecting Conscience

1. Arizona Law

Arizona law protects the ability of medical professionals to refuse to participate in abortion and emergency contraception measures. The law provides that:

[a] hospital is not required to admit any patient for the purpose of performing an abortion. A physician, or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital, doctor, clinic or other medical or surgical facility in which an abortion has been authorized . . . is not required to facilitate or participate in the medical or surgical procedures that will result in the abortion.¹³⁴

The law further provides that:

[a] pharmacy, hospital or health professional, or any employee of a pharmacy, hospital or health professional, who states in writing an objection to abortion, abortion medication, emergency contraception or any medication or device intended to inhibit or prevent implantation of a fertilized ovum on moral or religious grounds is not required to facilitate or participate in the provision of an abortion, abortion medication, emergency contraception or any medication or device intended to inhibit or prevent implantation of a fertilized ovum.¹³⁵

The Arizona Court of Appeals, in passing on a challenge to the state's abortion regulations, rejected a facial challenge to this conscience protection, holding that the Arizona Constitution "does not limit the legislature's authority to enact statutes that provide greater protections to individual liberty of conscience than those provided in the constitution" itself.¹³⁶ More specifically, the court held that "a woman's right to an abortion or to contraception does not compel a private person or entity to facilitate either," and further held that "[e]ven a state actor can refuse to facilitate an abortion, as long as the woman is not effectively denied her right to an abortion as a result."¹³⁷

134. ARIZ. REV. STAT. ANN. § 36-2154(A) (2016).

135. § 36-2154(B).

136. *Planned Parenthood Ariz., Inc. v. Am. Ass'n of Pro-Life Obstetricians & Gynecologists*, 257 P.3d 181, 197 (Ariz. Ct. App. 2011).

137. *Id.* at 196.

Arizona law also protects the right of a health care provider, based upon that provider's conscience, to refuse to comply with a health care decision or directive, so long as "the provider promptly makes known the provider's unwillingness and promptly transfers the responsibility for the patient's care to another provider who is willing to act in accordance with the agent's direction."¹³⁸ Finally, Arizona law protects the right of religiously affiliated employers to provide health insurance plans that do not provide coverage for contraceptives designed or used for contraceptive, abortifacient, abortion, or sterilization purposes.¹³⁹

2. Other State Laws¹⁴⁰

Pertinent conscience protections throughout the remaining states can be found in Appendix I.

B. Federal Laws Protecting Conscience

1. Principle Federal Conscience Protections

The **Church Amendment** to the Public Health Service Act (named after its sponsor, Senator Frank Church (D-Idaho)),¹⁴¹ enacted in 1973 in the wake of *Roe v. Wade*, provides a wide range of protections to healthcare professionals, including doctors, nurses, midwives, and other personnel, as well as hospitals.¹⁴² It applies to entities that receive certain federal health-related funds, and it prohibits those entities from discriminating against healthcare personnel because they refuse—for religious or moral reasons—to assist in the performance of abortions or sterilizations. The Church Amendment is framed broadly as a non-discrimination provision, which Congress has labeled as protecting "individual rights."¹⁴³ Notably, it protects all individuals' rights when it comes to abortion—whether a medical practitioner chooses to perform abortions or not, he or she is protected from discrimination under this law.

138. ARIZ. REV. STAT. ANN. § 36-3205(C)(1) (2016).

139. *Id.* §§ 20-826(Z), -1057.08(B), -1402(M), -1404(V), -2329(B), -2329(C).

140. *See infra* Appendix I for detailed treatment of state-by-state conscience protections.

141. 42 U.S.C. § 300a-7 (2012).

142. *Id.*

143. Pub. L. No. 93-348, § 214, 88 Stat. 253, 253 (1974) (codified at 42 U.S.C. § 300a-7 (2012)).

The **Coats-Snowe Amendment**, enacted in 1996, broadly protects any health care entity or individual physician from being forced to perform, refer for, or even make arrangements to refer for an abortion.¹⁴⁴ It applies to any government entity—federal, state, or local—that receives any federal financial assistance.¹⁴⁵ This law is notable for the particular protections it adds for medical schools, residency programs, and medical residents, in that it prevents medical schools from having to provide training for abortion, and prevents medical students from having to participate in such training.

The **Weldon Amendment**, which has been a part of the appropriations acts passed by Congress every year since 2004, prohibits federal agencies and programs, and state and local governments receiving certain federal funding, from discriminating against any healthcare entity, professional, or insurance plan because of their decision not to provide, pay for, provide coverage for, or refer for abortions.¹⁴⁶

2. Other Federal Laws Affecting Conscience Rights¹⁴⁷

The **Danforth Amendment**, enacted in 1988, ensures that Title IX of the Education Amendments Act of 1972 cannot be construed to “require or prohibit any person, or public or private entity, to provide or pay for any benefit or service, including the use of facilities, related to an abortion.”¹⁴⁸

The **Federal Employees Health Benefits Acquisition Regulation** ensures that “[p]roviders, health care workers, or health plan sponsoring organizations are not required to discuss treatment options that they would not ordinarily discuss in their customary course of practice because such options are inconsistent with their professional judgment or ethical, moral or religious beliefs.”¹⁴⁹

The **Legal Services Corporation Act** provides that funds for legal services may not be used

to provide legal assistance with respect to any proceeding or litigation which seeks to procure a nontherapeutic abortion or to compel any individual or institution to perform an abortion, or assist in the

144. 42 U.S.C. § 238n(a) (2012).

145. *Id.*

146. *See, e.g.*, Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 507(d), 128 Stat. 2130, 2515 (2014).

147. The entirety of federal conscience protections is not presented here, as that is beyond the scope of this Article.

148. 20 U.S.C. § 1688 (2012).

149. 48 C.F.R. § 1609.7001(c)(7) (2016).

performance of an abortion, or provide facilities for the performance of an abortion, contrary to the religious beliefs or moral convictions of such individual or institution.¹⁵⁰

The **Federal Death Penalty Act** of 1994 protects the “moral or religious convictions” of persons who object to participating in federal executions or prosecutions.¹⁵¹

The **Affordable Care Act** (ACA) prohibits any recipient of federal funds under the act from discriminating “on the basis that [a health care] entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.”¹⁵² There are, however, interpretations of the various regulations issued pursuant to the ACA that suggest that the act may imperil the conscience rights of medical practitioners.¹⁵³

The **Hyde Amendment**, while not strictly a conscience protection provision, nonetheless indirectly protects conscience by prohibiting the use of federal monies for abortions, except in limited circumstances.¹⁵⁴

VI. RECOMMENDATIONS FOR COMPREHENSIVE CONSCIENCE PROTECTIONS

Contemporary threats to conscience, both in their breadth and their uncompromising nature, put both the medical practitioner and healthcare institutions in a no-win situation—they must either pledge complete fealty to the regnant orthodoxy or suffer the consequences of noncompliance. But the extant conscience protections already described herein are, in the main, essentially powerless to protect medical professionals and conscientious institutions against this unforgiving and myopic regime. This is especially so

150. 42 U.S.C. § 2996f(b)(8) (2012).

151. 18 U.S.C. § 3597(b) (2012).

152. 42 U.S.C. § 18113 (2012).

153. See Deutsch, *supra* note 123, at 2493–95.

154. See, e.g., Pub. L. No. 113-76, § 202–03, 128 Stat. 5, 66–67 (2014) (providing that “none of the funds appropriated by this title shall be available to pay for an abortion, except where the life of the mother would be endangered if the fetus were carried to term, or in the case of rape,” and that “none of the funds appropriated under this title shall be used to require any person to perform, or facilitate in any way the performance of, any abortion”). The 2016 Democratic Party Platform indicates the intention to repeal the Hyde Amendment. See 2016 DEMOCRATIC PARTY PLATFORM 37 (Democratic Platform Comm. ed., July 21, 2016), http://www.presidency.ucsb.edu/papers_pdf/117717.pdf (“We will continue to oppose—and seek to overturn—federal and state laws and policies that impede a woman’s access to abortion, including by repealing the Hyde Amendment.”).

when we consider that medical advancements and scientific knowledge will likely continue to bring new and unforeseen challenges to conscience, and government involvement in healthcare will likely bring more countervailing imperatives and less accommodation.¹⁵⁵ Under these circumstances, a comprehensive overhaul of conscience protections for the medical professional is necessary. This section aims to identify what elements a robust medical conscience protection should include. It should be noted, however, that the normative standard suggested here is not always synonymous with what the political reality will permit.

A conscience clause worthy of the present challenges should:

1. Provide Broad Protection Across the Spectrum of Medical Procedures and Medications

The majority of extant conscience protections were animated by a concern that medical professionals would have to participate in abortion or related services.¹⁵⁶ But while that initial focus was understandable and the goals of legislators laudable, it must be said that such targeted restrictions now make those laws woefully inadequate to the task of protecting conscience. Thus, the conscience protection of the here and now and also of the future must remove the focus on particular procedures or medications, and must apply to all stages of a particular procedure, to include not only participation but also assistance, facilitation, or referral.¹⁵⁷ Put simply, “[t]here is no rational justification for protecting rights of conscience in the context of [some] morally controversial medical procedures (for example, abortion) but not

155. In addition to those procedures and medications already mentioned, see Genuis & Lipp, *supra* note 11, at 3 tbl.1 (detailing “clinical situations that may result in ethical tension or conscientious refusal”); see also discussion *supra* Part III for examples of the effects of the new government involvement in healthcare on the right to conscience.

156. See Wilson, *supra* note 103, at 106–10 (discussing the genesis of conscience protections for the medical practitioner).

157. Mississippi’s conscience protection provides a good example: “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.” MISS. CODE ANN. § 41-107-5 (2016). “Health-care service” is defined very broadly so as to encompass not only the known, and currently controversial medical procedures and medications, but also to provide the definitional leeway to encompass future but yet unanticipated conscience objections: “‘Health-care service’ means 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.” *Id.*

others.”¹⁵⁸ Rather, a “sensible conscience clause” should “attempt[] to establish an acknowledged forum for the exercise of conscience in a milieu increasingly characterized by dissensus.”¹⁵⁹ In other words, the conscience of the medical professional must be left free to determine what is or is not permissible, and is not to be confined to operate within only a preordained set of circumstances.¹⁶⁰ Ultimately, expanding conscience protections in this manner will not only benefit all practitioners going forward, but will also obviate the need to legislatively revisit these protections in the future.¹⁶¹

Of course, such broad protection will likely prove to be a legislative impossibility in the large majority of states and at the federal level.¹⁶² In this scenario it may be the case that the recommendations that follow below will simply have to be incorporated as to the procedures (i.e., abortion, sterilization, assisted suicide, capital punishment) already covered by extant conscience protections, at least until the political climate will permit further expansion.

2. Protect Both Individual Medical Practitioners and Institutions

It is not just the individual medical practitioner who needs conscience protections—institutions do as well.¹⁶³ The United States Supreme Court itself has recognized that a corporation—even a for-profit one—can exercise

158. Lynn Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177, 181 (1993).

159. Cavanaugh, *supra* note 82, at 202.

160. See W. Cole Durham, Mary Anne Wood & Spencer Condie, *Accommodation of Conscientious Objection to Abortion: A Case Study of the Nursing Profession*, 1982 BYU L. REV. 253, 319 (“[I]f the aim of the conscience clause is to protect individuals who experience work-related conflicts as a result of conscientious objections to [a particular procedure], the protection ought to be defined by reference to what the employee sees as a conflict, not by reference to what an administrative agency thinks is the legitimate scope of acceptable conflict situations.”).

161. See Cavanaugh, *supra* note 82, at 202–04 (noting that expanded coverage “treats all parties equally” because “[a]ll recognize that they may have recourse to the exception made for conscience, if not now, perhaps at some future date,” and furthermore, “by not limiting the clause to any one intervention, one makes room for responses to unforeseen developments and less widely yet still controverted matters”).

162. The fact that only a few states have protections as broad as Mississippi’s lends credence to this conclusion and illustrates the difficulty of actually achieving the “gold standard” in conscience protection at this time.

163. Many extant protections already protect both individuals and institutions. See, e.g., MISS. CODE ANN. § 41-107-7 (2016) (“A health care institution has the right not to participate, and no health care institution shall be required to participate in a health care service that violates its conscience.”); Coats-Snowe Amendment, 42 U.S.C. § 238n (2012) (protecting “health care entit[ies]”). But to the extent that current protections do not so expressly state, such coverage should be made explicit.

religion, so there is no reason not to protect institutions with respect to the right of conscience.¹⁶⁴ Human beings, after all, act through institutions.¹⁶⁵ Thus, the former as well as the latter should be explicitly protected in law. Failing to do that “contradicts the central purpose of conscience clauses, which is to protect the moral sensibilities and deeply-held beliefs of the individuals who make up the institution.”¹⁶⁶

3. Provide Protections for Health Insurance Providers

The burgeoning entanglement of the State with the provision of healthcare often brings with it demands that insurers and organizations providing healthcare insurance to their employees provide certain services that may be morally problematic to those entities. Conscience protections should therefore cover healthcare payers as well.¹⁶⁷

4. Provide Protections for the Full Range of Potentially Implicated Health Care Personnel

Conscience protections should cover not only those medical professionals who directly provide the medical procedure or prescribe the medication, but should be extended as well to those healthcare practitioners or assistants who facilitate or assist in the provision of such services or medications.¹⁶⁸ The

164. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2771 (2014) (“For-profit corporations . . . support a wide variety of charitable causes, and it is not at all uncommon for such corporations to further humanitarian and other altruistic objectives. . . . If for-profit corporations may pursue such worthy objectives, there is no apparent reason why they may not further religious objectives as well.”).

165. Stanley W. Carlson-Thies, *Keynote Address: Beyond Right of Conscience to Freedom to Live Faithfully*, 24 REGENT U. L. REV. 351, 359 (2012) (noting that “[m]ost significant projects and occupations require us to work together with others in a structured way”).

166. Wardle, *supra* note 156, at 181; see also Kent Greenawalt, *Objections in Conscience to Medical Procedures: Does Religion Make a Difference?*, 2006 U. ILL. L. REV. 799, 824 (“Although it is somewhat difficult to say what gives a collective entity an objection in conscience, we do understand that a hospital that is run by a religious group has a powerful reason not to allow actions on its premises that the religion regards as murder or as another serious moral wrong.”).

167. See, e.g., WASH. REV. CODE ANN. § 70.47.160 (2016) (“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.”).

168. Mississippi, for instance, provides conscience protections across the spectrum of healthcare personnel, defining the covered “health care provider” broadly as “any individual who may be asked to participate in any way in a health care service, including, but not limited to: a

propriety of this extension should be readily evident, for as Professor Kent Greenawalt has written, “people should not have to render services that they believe are forbidden directly by God or are deeply immoral.”¹⁶⁹ That principle must encompass both direct and indirect practitioners if conscience is to mean anything, precisely because “[o]ne may feel morally culpable even if one is not the immediate or direct provider of an immoral act.”¹⁷⁰

5. Provide Protections for Both Private and Public Institutions and Their Employees

The right to conscience as envisioned by the Founders and exercised by medical practitioners for millennia should not require an inquiry into the precise employment status of those practitioners in order for the right to be validated. As has already been established, the right to conscience is not only a paramount imperative to the individual or institution but also an asset to the larger body politic. Moreover, to the extent that the right to conscience comes into conflict with the right to a controversial medical treatment, the solution is to give the former pride of place, because “[i]n our tradition, including our basic social compact, protection for the rights of conscientious refusal to participate in morally objectionable government-valued activities has a stronger and longer claim to priority and preference than the efficient provision of morally controversial medical services.”¹⁷¹ In sum, there is no logical distinction to be made with respect to the exercise of conscience in the public as opposed to the private realm, so the right should be preserved in both.¹⁷²

physician, physician’s assistant, nurse, nurses’ aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student or employee, counselor, social worker or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health care procedure.” MISS. CODE ANN. § 41-107-3 (2016).

169. Greenawalt, *supra* note 166, at 823–24; *see also* Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1528 (2012) (“Acting according to conscience has real importance less because it is about being (morally or politically) right than because it is central to being a whole person. Both theory and experience indicate that conscience is closely related to one’s moral integrity.”).

170. Wardle, *supra* note 158, at 187–88.

171. *Id.* at 189.

172. Not surprisingly, Mississippi does just that, defining “health care institution” to mean “any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity” MISS. CODE ANN. § 41-107-3(c) (2016). Illinois also provides a broad definition: “‘Health care facility’ means any public or private hospital, clinic, center, medical school, medical training institution, laboratory or diagnostic facility, physician’s office” 745 ILL. COMP. STAT. 70/3(d) (2016).

6. Define Conscience Itself Broadly, to Encompass Religious, Moral, and Ethical Beliefs

The right to conscience need not, and should not, be limited solely to the religious predicate. A more inclusive conscience protection regime—one that includes moral, ethical, or philosophical bases along with the religious—is consistent with the idea of conscience as an unalienable right.¹⁷³ Moreover, and perhaps even more important from a practical perspective, such an expansive construction would also prevent courts from construing such protections unduly narrowly¹⁷⁴ and would make those protections less susceptible to constitutional challenge as well.¹⁷⁵ Of course, this definition of conscience should cover both individual medical practitioners and institutions.¹⁷⁶

7. Provide a Notice Requirement So That Medical Practitioners Know Their Rights to Conscience

Many of Cathy DeCarlo's fellow nurses informed her that, until she brought her suit against Mt. Sinai, they were unaware that they could refuse to participate in abortions.¹⁷⁷ Given the paramount nature of the right, such ignorance is intolerable. Conscience clauses should require all healthcare institutions to inform all potentially affected personnel of their rights to conscience, should post such rights prominently at the workplace, and should

173. The acceptability of such a definition in the realm of conscience also finds some support in the case law regarding conscientious objection to war. *See, e.g.,* *Welsh v. United States*, 398 U.S. 333, 340 (1970) (holding “moral, ethical, or religious beliefs about what is right and wrong [that are held] with the strength of traditional religious convictions” are within the ambit of religious beliefs).

174. *See* Kimberly D. Phillips, *Promulgating Conscience: Drafting Pharmacist Conscientious Objector Clauses that Balance a Pharmacist's Moral Right to Refuse to Dispense Medication with Non-Beneficiaries' Economic and Legal Rights*, 15 MICH. ST. U. J. MED. & L. 227, 243 (2011) (arguing that “[s]tates should determine what conscientious objection conviction categories—religious, moral, and/or ethical—its statute aims to protect” and “must carefully define these terms because courts may construe these words narrowly,” and noting episodes of narrow judicial construction *supra* despite seemingly broad legislative language defining conscience).

175. Greenawalt, *supra* note 166, at 824 (reasoning that “because a broader law is less vulnerable to challenge . . . general privileges to refuse should not be limited to religious claimants”).

176. Again, Mississippi provides a definition of conscience worthy of the current threats: “‘Conscience’ means the religious, moral or ethical principles held by a health care provider, the health care institution or health care payer.” MISS. CODE ANN. § 41-107-3(h) (2016).

177. *See* ALL. DEFENDING FREEDOM, *supra* note 5, at 21.

incorporate the communication of those rights into human resources orientations and trainings.¹⁷⁸

8. Provide an Effective Means of Enforcement in the Form of a Private Right of Action

This is perhaps the most crucial modification that must be made. A multitude of conscience clauses provide practitioners and institutions with immunity from liability and protection from discrimination.¹⁷⁹ While these are important and necessary protections, they are unfortunately far from sufficient, precisely because many extant protections lack a meaningful enforcement mechanism. In fact, one of the lessons to be drawn from the tragic ordeal endured by nurse Cathy DeCarlo—aside from the conclusion that conscience protections will often be willfully ignored by the very people and institutions whom they are intended to bind—is that medical practitioners often lack a clear legal path to remedy even the most egregious of conscience abuses visited upon them. The problem in Cathy’s case is that the Church Amendment—ostensibly passed to prevent the very violation she suffered—contains no private right of action.¹⁸⁰

In practical terms this means that, despite the fact that Mt. Sinai and its agents had clearly violated federal law, Cathy could not herself seek legal recourse, but rather was beholden to the federal government to enforce her rights.¹⁸¹ It should go without saying that such an alternative is unacceptable, as it leaves the protection of conscience to the whim of a federal executive agency or similar state entity, which may or may not value the right to

178. Pennsylvania has one such requirement in the abortion context. *See* 18 PA. CONS. STAT. § 3213(f)(1) (2016) (“Except for a facility devoted exclusively to the performance of abortions, every facility performing abortions shall prominently post a notice, not less than eight and one-half inches by eleven inches in size, entitled ‘Right of Conscience,’ for the exclusive purpose of informing medical personnel, employees, agents and students of such facilities of their rights . . .”).

179. *See, e.g.*, Church Amendment, 42 U.S.C. § 300a-7(c) (2012) (prohibiting discrimination against individuals and institutions for their refusal to participate in abortion or sterilization); N.Y. CIV. RIGHTS LAW § 79-i (McKinney 2016) (“[N]o . . . hospital, person, firm, corporation or association shall discriminate against the person so refusing to act. . . . No civil action for negligence or malpractice shall be maintained against a person so refusing to act based on such refusal.”).

180. *Cenzon-Decarlo v. Mount Sinai Hosp.*, No. 09-CV-3120, 2010 WL 169485, at *4 (E.D.N.Y. Jan. 15, 2010), *aff’d*, 626 F.3d 695 (2d Cir. 2010) (“The Court finds no basis for implying a private right of action under the Church Amendment.”).

181. Wilson, *supra* note 103, at 110, 122 (labeling the Church Amendment a “[p]rotection[] without teeth” and concluding that, if “the U.S. Department of Health and Human Services[] refuses to sanction Cathy’s employer, there is little Cathy can do” absent a right of private action).

conscience, depending on the prevailing political predilections of a particular administration. Put simply, this is no way to protect an unalienable right.¹⁸² Consequently, conscience protections—both federal¹⁸³ and state¹⁸⁴—must be amended to explicitly provide a private right of action, which should include the opportunity to pursue not only equitable relief but monetary and punitive damages as well.¹⁸⁵

VII. CONCLUSION

It might of course be objected that these recommendations are one-sided and unduly value practitioner autonomy over patient needs. But it is a fact that the vast majority of controversial medical procedures implicating conscience are elective in nature.¹⁸⁶ Thus any concerns with regard to the quality or availability of patient care can be almost wholly alleviated by clear and timely disclosure of a conscience objection by either an individual

182. See James S. Cole, *Have US Conscience Clause Protections Been Eviscerated?*, MERCATORNET (Nov. 30, 2010), https://www.mercatornet.com/articles/view/have_us_conscience_clause_protections_been_eviscerated/8368 (discussing Cathy DeCarlo’s case and concluding that with respect to many conscience protections, including the Church Amendment, “[w]here there is no remedy, there is effectively no right”).

183. The Conscience Protection Act of 2016, passed by the United State House of Representatives on July 13, 2016, would, if enacted into law, provide a private right of action for a violation of the federal conscience protections. See Conscience Protection Act of 2016, H.R. 4828, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/4828>.

184. Some state conscience protections do already in fact provide for such a right. See, e.g., MISS. CODE ANN. § 41-107-11(1) (2016) (“A civil action for damages or injunctive relief, or both, may be brought for the violation of any provision of this chapter.”); NEB. REV. STAT. §§ 28-340, -341 (2016) (providing for damages, attorney’s fees, and injunctive relief in connection with discrimination for the refusal to participate in abortions).

185. See Wilson, *supra* note 103, at 119 (arguing that the private right of action should include all these potential remedies and explaining that many federal statutes provide for the availability of punitive damages, and further noting that “[t]he availability of monetary damages can sometimes be crucial because injunctive relief may not always be available after an objector has been forced to provide or assist with a service in violation of her conscience”); see also Wardle, *supra* note 158, at 196 (concluding that a private right of action, along with provisions for “statutory minimum damages, and either multiple damages or punitive damages, plus attorneys’ fees, would be sufficient protections for rights of conscience”).

186. See Denise M. Burke & Anna Franzonello, *A Primer on Protecting Healthcare Freedom of Conscience*, in DEFENDING LIFE 2012: BUILDING A CULTURE OF LIFE, DECONSTRUCTING THE ABORTION INDUSTRY 555, 561 (2012), <http://www.aul.org/wp-content/uploads/2012/04/primer-protecting-freedom-conscience.pdf> (noting that “[c]onscientious objections are most often raised concerning elective services, such as abortion, contraception, sterilization, physician-assisted suicide, and withdrawal of nutrition and hydration, rather than necessary or lifesaving services”).

medical practitioner or healthcare institution, or both.¹⁸⁷ In this manner, the legitimate needs of patients can be met while preserving the inalienable right of conscience for medical practitioners.¹⁸⁸

187. See Pellegrino, *supra* note 18, at 242–43 (conceding that “physicians must make their positions publicly known,” and suggesting that “[i]ndividual physicians should prepare a leaflet outlining what they can, and cannot, in good conscience do”); Wardle, *supra* note 158, at 199 (suggesting that medical practitioners exercising a right to conscience should be required “to object in a timely fashion” and that “institutions should be required either to adopt a refusal policy and post notice of it, or to give prompt notice of refusal to a specific request”).

188. Pellegrino, *supra* note 18, at 243 (stating that “[p]atients should know in advance of a crisis that what they desire and believe to be morally acceptable may not be acceptable to the physicians they may be engaging,” and, while conceding that such knowledge “will not be possible in emergencies or remote areas where the choice of physicians is limited,” still concluding that, “[e]ven under these circumstances, [a] Catholic physician cannot violate her conscience to provide a morally objectionable procedure or treatment”); Rouse, *supra* note 13, at 165 (“Since abortion is an elective procedure, it is incumbent on the patient to find health-care providers who actually provide that service. It is not the responsibility of the medical professional to help her get an abortion.”).

APPENDIX I

OTHER STATE CONSCIENCE PROTECTIONS¹⁸⁹*Alabama*

Alabama law protects the ability of medical professionals to refuse to participate in capital punishment if any aspect of the execution process “is contrary to the person’s moral or ethical beliefs.”¹⁹⁰

Alaska

Alaska law protects the ability of both hospitals¹⁹¹ and individuals to refrain from participating in abortions,¹⁹² and more generally protects the right of a “health care provider [to] decline to comply with an individual instruction or a health care decision for reasons of conscience.”¹⁹³

Arkansas

Arkansas law protects persons from having to “perform or participate in medical procedures which result in the termination of pregnancy”¹⁹⁴ and further provides that “[n]o hospital, hospital director, or governing board shall be required to permit the termination of human pregnancies within its institution.”¹⁹⁵ The state also provides protections for medical personnel and institutions that refuse to “furnish any contraceptive procedures, supplies, or information” and specifically references “religious or conscientious objection” as an acceptable predicate for such refusal.¹⁹⁶

California

California law provides protection for medical professionals who refuse to “directly participate in the induction or performance of an abortion.”¹⁹⁷ The law also provides protections for medical students and those physicians seeking hospital staff privileges who may refuse to participate in abortions

189. What follows is merely a broad survey of extant protections and does not exhaust every state law pertaining to medical conscience, or the proper construction of those laws to specific factual circumstances. That analysis is beyond the scope of this Article.

190. ALA. CODE § 15-18-82.1(i) (2016).

191. *But see* Valley Hosp. Ass’n v. Mat-Su Coal. for Choice, 948 P.2d 963, 965 (Alaska 1997) (finding that the statute cannot be applied to quasi-public institutions).

192. ALASKA STAT. § 18.16.010(b) (2016).

193. *Id.* § 13.52.060(e).

194. ARK. CODE ANN. § 20-16-601(a) (2016).

195. *Id.* § 20-16-601(b).

196. *Id.* § 20-16-304(4) to (5).

197. CAL. HEALTH & SAFETY CODE § 123420(a) (West 2016).

“for moral, ethical, or religious reasons.”¹⁹⁸ Medical practitioners may refuse to participate in assisted suicide “for reasons of conscience, morality, or ethics,”¹⁹⁹ and physicians may not be compelled to “attend [an] execution.”²⁰⁰ More generally, California law provides that a “health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience.”²⁰¹

Colorado

Colorado law permits “religious or conscientious objection” with regard to the provision of contraceptive services,²⁰² including the provision of emergency contraception for sexual assault survivors.²⁰³ The state also permits any city and county employee to “refuse to accept the duty of offering family planning and birth control services to the extent that such duty is contrary to his personal religious beliefs.”²⁰⁴

Connecticut

Connecticut law provides protection for those who, based upon the person’s “judgment, philosophical, moral or religious beliefs,” object to participation in “any phase of an abortion.”²⁰⁵

Delaware

Delaware law provides that “[n]o person shall be required to perform or participate in medical procedures which result in the termination of pregnancy,”²⁰⁶ and that “[n]o hospital, hospital director or governing board shall be required to permit the termination of human pregnancies within its institution.”²⁰⁷

District of Columbia

District regulations provide that “[d]epartment heads shall not discipline or in any way penalize an employee for refusing to participate in certain aspects of direct patient care that are in conflict with their religious, or ethical beliefs.”²⁰⁸

198. *Id.* § 123420(b).

199. *Id.* § 443.14(e).

200. CAL. PENAL CODE § 3605(c) (West 2016).

201. CAL. PROB. CODE § 4734(a) (West 2016).

202. COLO. REV. STAT. § 25-6-102(9) (2016).

203. *Id.* § 25-3-110(3)(a).

204. *Id.* § 25-6-207.

205. CONN. AGENCIES REGS. § 19-13-D54(f) (2016).

206. DEL. CODE ANN. tit. 24, § 1791(a) (2016).

207. *Id.* § 1791(b).

208. D.C. MUN. REGS. tit. 22-B, § 9006.1 (2016).

Florida

Florida law provides that no “hospital or any person” must “participate in the termination of a pregnancy,”²⁰⁹ and also protects “physician[s] or other person[s]” who “refus[e] to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons.”²¹⁰ Florida also permits medical practitioners to refuse to participate in “any aspect of an execution which is contrary to the person’s moral or ethical beliefs.”²¹¹

Georgia

Georgia law provides that neither medical facilities nor physicians are required “to admit any patient . . . for the purpose of performing an abortion,” and further provides that “any person who . . . [objects] to any abortion or all abortions on moral or religious grounds shall not be required to participate in procedures which will result in [an] abortion.”²¹² Georgia also permits pharmacists to decline to fill prescriptions based on their “ethical or moral beliefs.”²¹³ Georgia protects those with “moral or religious” objections to sterilization procedures.²¹⁴ The state permits physicians to refuse to “participate in the execution of a death sentence.”²¹⁵

Hawaii

Hawaii law provides that no hospital or any person must participate in an abortion.²¹⁶ More generally, Hawaii law provides that “[a] health-care provider may decline to comply with an individual instruction or health-care decision for reasons of conscience.”²¹⁷

Idaho

Idaho law provides broad conscience protections by ensuring that “[n]o health care professional shall be required to provide *any health care service* that violates his or her conscience.”²¹⁸ More specifically, Idaho law does not require any hospital to furnish any abortion facilities or to provide for abortion procedures, and further provides that no medical practitioners or any related employees or assistants shall be required to “participate in the performance or provision of any abortion” if they object on the basis of

209. FLA. STAT. § 390.0111(8) (2016).

210. *Id.* § 381.0051(5).

211. *Id.* § 922.105(9).

212. GA. CODE ANN. § 16-12-142(a) (2016).

213. GA. COMP. R. & REGS. 480-5-.03(n) (2016); *see also* GA. CODE ANN. § 16-12-142(b).

214. GA. CODE ANN. § 31-20-6(b) (2016).

215. *Id.* § 17-10-38(d).

216. HAW. REV. STAT. § 453-16(e) (2016).

217. *Id.* § 327E-7(e).

218. IDAHO CODE § 18-611(2) (2016) (emphasis added).

“personal, moral or religious reasons.”²¹⁹ Idaho extends those protections to sterilization procedures as well.²²⁰ State law further provides that “[e]mployers of health care professionals shall reasonably accommodate the conscience rights of their employees.”²²¹

Illinois

Illinois law provides extensive protections for medical conscience, providing that a “physician shall be under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience.”²²² More specifically, Illinois law provides that “[n]o physician, hospital, ambulatory surgical center, nor employee thereof, shall be required against his or its conscience declared in writing to perform, permit or participate in any abortion.”²²³ However, the state recently passed Senate Bill 1564, an amendment to the Illinois Healthcare Right of Conscience Act, which requires medical facilities and physicians who conscientiously object to involvement in abortions to adopt policies that provide women who ask for abortions with a list of providers “they reasonably believe may offer” them.²²⁴

Indiana

Indiana law provides that “[n]o private or denominational hospital shall be required to . . . perform[] . . . abortions,”²²⁵ and further provides that no physician, employee, or staff member is required to provide or participate in an abortion if such an individual “objects . . . on ethical, moral, or religious grounds.”²²⁶ Indiana provides for the right to file a civil action for a violation of this latter provision.²²⁷

Iowa

Iowa law provides that no individual shall be required, “against that individual’s religious beliefs or moral convictions to perform, assist, or

219. *Id.* § 18-612.

220. *Id.* § 39-3915.

221. *Id.* § 18-611(3).

222. 745 ILL. COMP. STAT. 70/6 (2016). The law does not however, “relieve a physician or other health care personnel from obligations under the law of providing emergency medical care.” *Id.* But emergency medical care does not encompass emergency contraception. *See Morr-Fitz, Inc. v. Quinn*, 976 N.E.2d 1160, 1174–75 (Ill. App. Ct. 2012).

223. 720 ILL. COMP. STAT. 510/13 (2016).

224. 745 ILL. COMP. STAT. 70/6.1(3) (2016).

225. IND. CODE § 16-34-1-3 (2016).

226. *Id.* § 16-34-1-4.

227. *Id.* § 16-34-1-7.

participate in” abortions,²²⁸ and further provides that a non-public hospital “shall not be required to permit the performance of an abortion.”²²⁹

Kansas

Kansas law provides that no person or medical facility “shall be required to perform, refer for, or participate in” abortion procedures.²³⁰ These protections also extend to sterilization procedures.²³¹

Kentucky

Kentucky law provides that “[n]o physician, nurse staff member or employee of a public or private hospital or employee of a public or private health care facility . . . [shall] be required to . . . perform, participate in, or cooperate in . . . abortion” if they object on “moral, religious or professional grounds.”²³² The state further prohibits a “publicly owned hospital or other publicly owned health care facility . . . [from] . . . perform[ing] or permit[ing] the performance of abortions, except to save the life of the pregnant woman.”²³³ Finally, state law provides that “[n]o private hospital or private health care facility shall be required to, or held liable for refusal to, perform or permit the performance of abortion contrary to its stated ethical policy.”²³⁴ Kentucky extends its solicitude on matters of conscience to sterilization as well.²³⁵

Louisiana

Louisiana law provides that “[a]ny person has the right not to participate in, and no person shall be required to participate in *any health care service* that violates his conscience to the extent that patient access to health care is not compromised.”²³⁶ More specifically, Louisiana law provides extensive protections for medical facilities—both public and private—which opt not to permit their facilities to be used for abortions.²³⁷ It further provides protection for “physician[s], nurse[s], student[s] or other person[s] or corporation[s]” who “refus[e] for any reason to recommend, counsel, perform, assist with or

228. IOWA CODE § 146.1 (2016).

229. *Id.* § 146.2.

230. KAN. STAT. ANN. §§ 65-443 to -444 (2016).

231. *Id.* §§ 65-446 to -447.

232. KY. REV. STAT. ANN. § 311.800(4) (West 2016).

233. *Id.* § 311.800(1).

234. *Id.* § 311.800(3).

235. *Id.* § 311.800(5)(c).

236. LA. STAT. ANN. § 40:1061.20 (2016) (emphasis added).

237. *Id.* § 40:1061.4.

accommodate an abortion.”²³⁸ Louisiana’s conscience protections extend to cases involving capital punishment.²³⁹

Maine

Maine law provides conscience protections for individual medical practitioners who “refuse[] to perform or assist in the performance of an abortion,” and for hospital or healthcare facilities who refuse to permit their facilities to be used for the performance of abortions.²⁴⁰ These protections extend to sterilization procedures as well.²⁴¹ More generally, Maine permits medical practitioners to “decline to comply with an individual instruction or health-care decision . . . for reasons of conscience.”²⁴²

Maryland

Maryland law provides that “[a] person may not be required to perform or participate in, or refer to any source for, any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy,” and further provides that a hospital “may not be required . . . [t]o permit . . . [or refer to any source] . . . the performance of any medical procedure that results in artificial insemination, sterilization, or termination of pregnancy.”²⁴³

Massachusetts

Massachusetts law provides that physicians, staff, and hospital employees need not “participate in . . . medical procedures which result in . . . abortion or sterilization.”²⁴⁴ State law further provides that “[n]o privately controlled hospital or other health facility shall be required to admit any patient for the purpose of performing an abortion, performing any sterilization procedure, or receiving contraceptive devices or information.”²⁴⁵

Michigan

Michigan law protects individual medical practitioners as well as institutions from having to participate in abortions.²⁴⁶

Minnesota

Minnesota law provides that “[n]o person and no hospital or institution shall be coerced, held liable or discriminated against in any manner because

238. *Id.* § 40:1061.2(A).

239. *Id.* § 15:569.

240. ME. STAT. tit. 22, § 1591 (2016); *see also id.* § 1592.

241. *Id.* tit. 34-B, § 7016.

242. *Id.* tit. 18-A, § 5-807(E).

243. MD. CODE ANN., HEALTH-GEN. § 20-214(a) to (b) (LexisNexis 2016).

244. MASS. GEN. LAWS ch. 112, § 12I (2016).

245. *Id.* ch. 272, § 21B.

246. MICH. COMP. LAWS §§ 333.20181–.20183 (2016).

of a refusal to perform, accommodate, assist or submit to an abortion for any reason.”²⁴⁷

Mississippi

Mississippi extends broad protections for the right to medical conscience, providing that “[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.”²⁴⁸ These same extensive protections are granted to health care institutions and payers as well.²⁴⁹ Mississippi permits a civil action to be brought for any violation of these provisions.²⁵⁰

Missouri

Under Missouri law a medical practitioner or hospital—public or private—can refuse, based on “moral, ethical or religious beliefs,” “to treat or admit for . . . abortion.”²⁵¹

Montana

Montana law protects individual medical practitioners from having to “advise concerning, perform, assist, or participate in abortion because of religious beliefs or moral convictions,”²⁵² and further provides that private hospitals and health care facilities need not permit or admit any person to their facilities for an abortion procedure.²⁵³ State conscience protections also extend to sterilization procedures.²⁵⁴

Nebraska

Nebraska law provides that “[n]o person shall be required to perform or participate in any abortion,”²⁵⁵ and further provides that “[n]o hospital, clinic, institution, or other facility in this state shall be required to admit any patient for the purpose of performing an abortion nor required to allow the performance of an abortion therein.”²⁵⁶ Nebraska provides a private right of action to individuals whose conscience rights have been violated.²⁵⁷

247. MINN. STAT. § 145.414(a) (2016).

248. MISS. CODE ANN. § 41-107-5 (2016) (emphasis added).

249. *Id.* §§ 41-107-7, -9.

250. *Id.* § 41-107-11.

251. MO. REV. STAT. § 197.032 (2016).

252. MONT. CODE ANN. § 50-20-111(2) (2016).

253. *Id.* § 50-20-111(1).

254. *Id.* §§ 50-5-502 to -505.

255. NEB. REV. STAT. § 28-338 (2016).

256. *Id.* § 28-337.

257. *Id.* §§ 28-340 to -341.

Nevada

Nevada law provides that “[a]n employer shall not require a registered nurse, a licensed practical nurse, a nursing assistant or any other person employed to furnish direct personal health service to a patient to participate directly in the induction or performance of an abortion.”²⁵⁸ Additionally, “[a] hospital or other medical facility . . . not operated by the State or a local government or an agency of either is not required to permit the use of its facilities for the induction or performance of an abortion, except in a medical emergency.”²⁵⁹

New Jersey

New Jersey law provides that “[n]o person shall be required to perform or assist in the performance of an abortion or sterilization,”²⁶⁰ and further provides that “[n]o hospital or other health care facility shall be required to provide abortion or sterilization services or procedures.”²⁶¹ Religious employers may request an exemption of coverage of fertility treatment services if those services are not compatible with the employer’s religious beliefs and practices.²⁶²

New Mexico

New Mexico law provides that a “person . . . who objects . . . on moral or religious grounds shall not be required to participate in medical procedures which will result in the termination of pregnancy,” nor is a hospital required to “admit any patient for the purposes of performing an abortion.”²⁶³ These protections also extend to sterilization.²⁶⁴ More generally, “[a] health-care practitioner may decline to comply with an individual instruction or health-care decision for reasons of conscience.”²⁶⁵

New York

New York law provides that when “the performing of an abortion on a human being or assisting thereat is contrary to the conscience or religious beliefs of any person, he may refuse to perform or assist in such abortion by filing a prior written refusal.”²⁶⁶ Additionally, no hospital is required to admit a patient for an abortion procedure, but the hospital must “inform the patient

258. NEV. REV. STAT. § 632.475 (2016).

259. *Id.* § 449.191.

260. N.J. STAT. ANN. § 2A:65A-1 (West 2016).

261. *Id.* § 2A:65A-2.

262. *Id.* §§ 17B:27-46.1x(b), 17:48-6x(b), 17:48A-7w(b), 17:48E-35.22(b), 26:2J-4.23(b).

263. N.M. STAT. ANN. § 30-5-2 (2016).

264. *Id.* § 24-8-6.

265. *Id.* § 24-7A-7(E).

266. N.Y. CIV. RIGHTS LAW § 79-i (McKinney 2016).

of its decision not to participate” and “inform the patient of appropriate resources or information.”²⁶⁷

North Carolina

North Carolina law provides that “[n]o physician, nurse, or any other health care provider who shall state an objection to abortion on moral, ethical, or religious grounds shall be required to perform or participate in medical procedures which result in an abortion,”²⁶⁸ and further provides that no “hospital, other health care institution, or other health care provider [is required to] to perform an abortion or to provide abortion services.”²⁶⁹

North Dakota

North Dakota law provides that “[n]o hospital, physician, nurse, hospital employee, nor any other person is under any duty, by law or contract, nor may such hospital or person in any circumstances be required to participate in the performance of an abortion, if such hospital or person objects to such abortion.”²⁷⁰ More generally, a “provider may decline to comply with a health care decision . . . for reasons of conscience.”²⁷¹

Ohio

Ohio law provides that “[n]o person is required to perform or participate in medical procedures which result in abortion,” and no public or private “hospital, . . . hospital director, or governing board . . . is required to permit an abortion.”²⁷²

Oklahoma

Oklahoma law provides that “[n]o person may be required to perform, induce or participate in medical procedures which result in an abortion,” and further provides that “[n]o private hospital, hospital director or governing board of a private hospital . . . is required to permit abortions to be performed or induced in such hospital.”²⁷³ Additionally, no health care facility is required to admit any patient or to allow the use of the premises for abortion, procedures not related to beneficial treatment that could endanger in vitro human embryos, assisted suicide, or euthanasia; and individual medical practitioners may refuse to participate in these procedures if they put their

267. N.Y. COMP. CODES R. & REGS. tit. 10, § 405.9(b)(10) (2016).

268. N.C. GEN. STAT. § 14-45.1(e) (2016).

269. *Id.* § 14-45.1(f).

270. N.D. CENT. CODE § 23-16-14 (2016).

271. *Id.* § 23-06.5-09.

272. OHIO REV. CODE ANN. § 4731.91 (LexisNexis 2016).

273. OKLA. STAT. tit. 63, § 1-741 (2016).

objection in writing.²⁷⁴ The state provides a person the right to “bring a civil action for equitable relief, including reinstatement or damages, or both”²⁷⁵

Oregon

Oregon law provides that “[n]o physician is required to give advice with respect to or participate in any termination of a pregnancy” and “[n]o 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.”²⁷⁶ Furthermore, “[n]o hospital is liable for its failure or refusal to participate in such termination if the hospital has adopted a policy not to admit patients for the purposes of terminating pregnancies.”²⁷⁷ With regard to contraception, “[a]ny employee of the Oregon Health Authority may refuse to accept the duty of offering family planning and birth control services to the extent that such duty is contrary to the personal or religious beliefs of the employee.”²⁷⁸ Finally, no health care provider has any duty to participate in physician-assisted suicide²⁷⁹ or to participate in the withdrawal of any life sustaining procedures or nutrition or hydration.²⁸⁰

Pennsylvania

Pennsylvania law provides that “[n]o physician, nurse, staff member or employee of a hospital or other health care facility . . . shall be required to . . . perform, participate in, or cooperate in . . . abortion or sterilization,” and no “hospital or other health care facility shall be required to . . . perform or permit the performance of abortion or sterilization contrary to its stated ethical policy.”²⁸¹ State law also provides that “[e]xcept for a facility devoted exclusively to the performance of abortions, no medical personnel or medical facility, nor any employee, agent or student thereof, shall be required against his or its conscience to aid, abet or facilitate performance of an abortion or dispensing of an abortifacient.”²⁸²

274. *Id.* §§ 1-728c to d.

275. *Id.* § 1-728f.

276. OR. REV. STAT. § 435.485 (2016).

277. *Id.* § 435.475.

278. *Id.* § 435.225.

279. *Id.* § 127.885(4).

280. *Id.* § 127.625(1).

281. 43 PA. CONS. STAT. § 955.2 (2016); *see also* 16 PA. CODE §§ 51.1–.61 (2016).

282. 18 PA. CONS. STAT. § 3213(d), (f)(1) (2016).

Rhode Island

Rhode Island law provides that individuals “shall not be required to participate in . . . medical procedures which result in . . . abortion or sterilization” if they state in writing an objection on “moral or religious grounds.”²⁸³

South Carolina

South Carolina law provides that “[n]o physician, nurse, technician or other employee . . . shall be required to recommend, perform, or assist in the performance of an abortion,”²⁸⁴ and further provides that “[n]o private or nongovernmental hospital or clinic shall be required to admit any patient for the purpose of terminating a pregnancy, nor shall such institutions be required to permit their facilities to be utilized for the performance of abortions.”²⁸⁵

South Dakota

South Dakota provides that that “[n]o physician, nurse, or other person” is required to “assist in the performance of an abortion,”²⁸⁶ and further provides that no hospital “is required to admit any patient for the purpose of terminating a pregnancy.”²⁸⁷ Counselors and social workers are also protected from “refusal to arrange or encourage abortion.”²⁸⁸ South Dakota also protects pharmacists, who may not be “required to dispense medication if there is reason to believe that the medication would be used to . . . [c]ause an abortion[,] . . . [d]estroy an unborn child[,] . . . or cause the death of any person by means of an assisted suicide, euthanasia, or mercy killing.”²⁸⁹

Tennessee

Tennessee law provides that “[n]o physician shall be required to perform an abortion and no person shall be required to participate in the performance of an abortion,” and “[n]o hospital shall be required to permit abortions to be performed therein.”²⁹⁰ Tennessee law also ensures that “[n]o private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection.”²⁹¹

283. R.I. GEN. LAWS § 23-17-11 (2016).

284. S.C. CODE ANN. § 44-41-50 (2016).

285. *Id.* § 44-41-40.

286. S.D. CODIFIED LAWS § 34-23A-12 (2016).

287. *Id.* § 34-23A-14.

288. *Id.* § 34-23A-11.

289. *Id.* § 36-11-70.

290. TENN. CODE ANN. § 39-15-204 (2016).

291. *Id.* § 68-34-104(5).

Texas

Texas law recognizes the right of medical practitioners to refuse to participate in or perform an abortion.²⁹² A “private hospital or private health care facility” also need not be so implicated, “unless a physician determines that the life of the mother is immediately endangered.”²⁹³ Texas provides a private right of action for those whose rights have been violated under these laws.²⁹⁴

Utah

Utah law provides that “[a] health care provider may, on religious or moral grounds, refuse to perform or participate in any way, in . . . an abortion . . . or . . . a procedure that is intended to, or likely to, result in the termination of a pregnancy.”²⁹⁵ Health care facilities are also protected.²⁹⁶ Utah provides a private right of action for those seeking redress for violations of these protections.²⁹⁷

Vermont

Vermont law provides that “[a] physician, nurse, pharmacist, or other person shall not be under any duty, by law or contract, to participate in the provision of a lethal dose of medication to a patient.”²⁹⁸ However, state medical licensing authorities recently determined that Act 39, Vermont’s assisted suicide bill, requires all healthcare professionals to counsel or refer for assisted suicide.²⁹⁹

Virginia

Virginia law does not require a hospital, medical facility, or physician “to admit any patient . . . for the purpose of performing an abortion,” and “any person who [objects] to any abortion or all abortions on personal, ethical, moral or religious grounds shall not be required to participate in procedures which will result in such abortion.”³⁰⁰ Virginia law also protects genetic counselors from having to participate in genetic counseling that violates the provider’s conscience.³⁰¹

292. TEX. OCC. CODE ANN. § 103.001 (West 2016).

293. *Id.* § 103.004.

294. *Id.* § 103.003.

295. UTAH CODE ANN. § 76-7-306(2) (West 2016).

296. *Id.* § 76-7-306(3).

297. *Id.* § 76-7-306(6).

298. VT. STAT. ANN. tit. 18, § 5285(a) (2016); *see also id.* § 5286.

299. *See* Complaint, *supra* note 121.

300. VA. CODE ANN. § 18.2-75 (2016).

301. *Id.* § 54.1-2957.21.

Washington

Washington law provides that “[n]o person or private medical facility may be required . . . to participate in the performance of an abortion if such person or private medical facility objects to so doing.”³⁰² More generally, state law provides that “[n]o individual health care provider, religiously sponsored health carrier, or health care facility may be required . . . to participate in the provision of or payment for a specific service if they object to so doing for reason of conscience or religion.”³⁰³ Finally, state law provides that no healthcare provider has a duty to “participate in the provision to a qualified patient of medication to end his or her life.”³⁰⁴ It is important to note that in 2007, Washington adopted an administrative rule requiring pharmacies to “deliver medication,” which rule contains no exemptions for those who object to such delivery on religious, moral, philosophical, or personal grounds.³⁰⁵

West Virginia

West Virginia law provides that “an individual health care provider” may refuse “to honor a health care decision . . . if[] [t]he decision is contrary to the individual provider’s sincerely held religious beliefs or sincerely held moral convictions.”³⁰⁶ A health care facility may have a “published policy . . . that is expressly based on sincerely held religious beliefs or sincerely held moral convictions.”³⁰⁷ State law further provides that a state employee “may refuse to accept the duty of offering family planning services to the extent that such duty is contrary to his personal religious beliefs.”³⁰⁸ No “hospital or other medical facility [is required] to admit any patient for the purpose of undergoing a sterilization operation.”³⁰⁹

Wisconsin

Wisconsin law provides that medical practitioners or hospital employees are not required to participate in sterilization or abortion procedures, and further provides that “[n]o hospital shall be required to admit any patient or to allow the use of the hospital facilities for the purpose of performing a

302. WASH. REV. CODE § 9.02.150 (2016).

303. *Id.* § 48.43.065; *see also id.* § 70.47.160(2).

304. *Id.* § 70.245.190(d).

305. *Stormans, Inc. v. Wiesman*, 794 F.3d 1064, 1080 (9th Cir. 2015), *cert. denied*, 136 S. Ct. 2433 (2016).

306. W. VA. CODE § 16-30-12(b)(1) (2016).

307. *Id.* § 16-30-12(a).

308. *Id.* § 16-2B-4.

309. *Id.* § 16-11-1.

sterilization procedure or removing a human embryo or fetus.”³¹⁰ A state employee may also “refuse to accept the duty of offering family planning services to the extent that the duty is contrary to his or her personal beliefs.”³¹¹

Wyoming

Wyoming law provides that “[n]o person shall, in any way, be required to perform or participate in any abortion or in any act or thing which accomplishes or performs or assists in accomplishing or performing a human miscarriage, euthanasia or any other death of a human fetus or human embryo,”³¹² and further establishes that “[n]o private hospital, clinic, institution or other private facility in this state is required to admit any patient for the purpose of performing an abortion nor to allow the performance of an abortion therein.”³¹³ The state also ensures that “[a]ny person may refuse to accept the duty of offering family planning and birth control services to the extent the duty is contrary to his personal or religious beliefs.”³¹⁴

310. WIS. STAT. § 253.09(1) (2016).

311. *Id.* § 253.07(3)(b).

312. WYO. STAT. ANN. § 35-6-106 (2016).

313. *Id.* § 35-6-105.

314. *Id.* § 42-5-101(d).

APPENDIX II

Model Conscience Protection Act³¹⁵**Section 1. Title.**

This chapter may be known and cited as the “Medical Conscience Protection Act.”

Section 2. Legislative Findings and Purpose.

The legislature finds that the right to conscience is a fundamental and unalienable right. It was central to the founding of the United States, has been deeply rooted in our Nation’s history and tradition for centuries, and has been central to the practice of medicine—through the Hippocratic Oath—for millennia. Despite its preeminent importance, however, threats to the right to conscience of medical practitioners, healthcare institutions, and healthcare payers have become increasingly more common and severe in recent years. The swift pace of scientific advancement and the expansion of medical capabilities—along with the mistaken notion that medical practitioners, healthcare institutions, and healthcare payers are mere public utilities—promise only to exacerbate the current crisis, unless something is done to restore conscience to its rightful place.

With this purpose in mind, the legislature declares that it is the public policy of this state to protect the right of conscience for medical practitioners, healthcare institutions, and healthcare payers. As the right to conscience is fundamental, no medical practitioner, healthcare institution, or healthcare payer should be compelled to participate in or pay for any medical procedure or prescribe or pay for any medication to which it objects on the basis of conscience, whether such conscience is informed by religious, moral, ethical, or philosophical premises. It is the purpose of this Act to protect all medical practitioners, healthcare institutions, and healthcare payers from discrimination, punishment, or retaliation as a result of any instance of conscientious medical objection.

315. This Model Act is in many ways substantially similar to those few extant state protections that provide expansive coverage for medical conscience. *See, e.g.*, MISS. CODE ANN. §§ 41-107-1 to -13 (2017); *see also Healthcare Freedom of Conscience Act*, AMERICANS UNITED FOR LIFE, http://www.aul.org/downloads/2016-Legislative-Guides/ROC/Healthcare_Freedom_of_Conscience_Act_-_2016_LG.pdf (last visited May 24, 2017).

Section 3. Definitions.

a. “Conscience” means the religious, moral, ethical, or philosophical beliefs or principles held by any medical practitioner, healthcare institution, or healthcare payer. Conscience with respect to institutional entities or corporate bodies, as opposed to individual persons, is determined by reference to that body’s governing documents, including but not necessarily limited to any published religious, moral, or ethical guidelines or directives; mission statements; constitutions; articles of incorporation; bylaws; or regulations.

b. “Discrimination” means any adverse action taken against, or any threat of adverse action communicated to, any medical practitioner, healthcare institution, or healthcare payer as a result of his or her or its decision to decline to participate in a healthcare service on the basis of conscience. Discrimination includes, but is not limited to, termination of employment; transfer from current position; demotion from current position; adverse administrative action; reassignment to a different shift or job title; increased administrative duties; refusal of staff privileges; refusal of board certification; loss of career specialty; reduction of wages, benefits, or privileges; refusal to award a grant, contract, or other program; refusal to provide residency training opportunities; denial, deprivation, or disqualification of licensure; aid assistance; impediments to creating any healthcare institution or payer, or expanding or improving said healthcare institution or payer; impediments to acquiring or associating or merging with any other health care institution or payer; the threat thereof with regard to any of the proceeding; or any other penalty, disciplinary, or retaliatory action, whether executed or threatened.

c. “Employer” means any individual or corporate or institutional entity that pays for or provides health benefits or health insurance coverage as a benefit to its employees by any means.

d. “Healthcare service” means medical care provided to any patient at any time over the entire course of treatment. This includes but is not limited to initial examination; testing; diagnosis; referral; the dispensing and/or administering of any drug, medication, or device; psychological therapy or counseling; research; prognosis; therapy; any other care or necessary services performed or provided by medical practitioners, including but not limited to allied health professionals, paraprofessionals, or employees of healthcare institutions. Examples of particular healthcare services covered include but are not limited to abortion, the prescription of contraceptive medications and devices, assisted reproductive technologies, fetal experimentation, human stem cell research, cloning,

gender reassignment procedures, genetic engineering, DNA screening, sterilization, participation in capital punishment, and assisted suicide.

e. “Healthcare institution” means any public or private hospital, clinic, medical center, physician organization, professional association, ambulatory surgical center, private physician’s office, pharmacy, nursing home, medical school, nursing school, medical training facility, or any other entity or location in which healthcare services are performed on behalf of any person. Healthcare institutions may include but are not limited to organizations, corporations, partnerships, associations, agencies, networks, sole proprietorships, joint ventures, or any other entity that provides health care services.

f. “Healthcare payer” means any employer, health plan, health maintenance organization, insurance company, management services organization, or any other entity that pays for—or arranges for the payment of—any healthcare service provided to any patient, whether that payment is made in whole or in part.

g. “Medical Practitioner” means any person or individual who may be or is asked to participate in any way in any healthcare service. This includes but is not limited to doctors, nurse practitioners, physician’s assistants, nurses, nurses’ aides, allied health professionals, medical assistants, hospital employees, clinic employees, nursing home employees, pharmacists, pharmacy technicians and employees, medical school faculty and students, nursing school faculty and students, psychology and counseling faculty and students, medical researchers, laboratory technicians, counselors, social workers, or any other person who facilitates or participates in the provision of healthcare services to any person.

h. “Participate” in a healthcare service means to provide; perform; assist with; facilitate; refer for; counsel for; advise with regard to; admit for the purposes of providing, or take part in any way in providing, any health care service or any form of such service.

i. “Pay” or “payment” means to pay for, contract for, arrange for the payment of, (whether in whole or in part), reimburse, or remunerate.

j. “Sex” refers to the binary reality signaling a person is a male or female of the human species. Sex is genetically determined at conception, may be visually ascertained at or before birth, and is evidenced by biological indicators such as gonads, hormones, and genitalia. Sex also includes a person’s capacity to either donate (male) or receive (female) genetic material, a definition which is common to all sexually reproducing species.

Section 4. Rights of Conscience of Medical Practitioners, Healthcare Institutions, and Healthcare Payers.**a. Freedom of Conscience**

A medical practitioner, healthcare institution, and healthcare payer have the right not to participate in, or pay for, any healthcare service which violates his or her or its conscience. This right to conscience does not, however, include the right to refuse to participate in a healthcare service because of a patient's race, color, national origin, religion, sex, ethnicity, or creed.

b. Immunity from Liability

No medical practitioner, healthcare institution, or healthcare payer shall be civilly, criminally, or administratively liable for exercising his or her or its right to conscience with respect to a healthcare service.

c. Discrimination

No medical practitioner, healthcare institution, or healthcare payer shall be discriminated against in any manner as a result of his or her or its decision to decline to participate in a healthcare service on the basis of conscience.

Section 5. Notice Requirement.

a. Every healthcare institution and employer shall prominently post a notice, not less than eight and one-half inches by eleven inches in size, entitled "Right of Conscience for Medical Practitioners, Students, and Employees," in a location where other such notices are normally posted, or if such notices are not so normally posted, in a location in which such personnel are likely to see such a notice. The purpose of this notice is to fully inform such medical personnel of their rights to conscience with respect to the delivery of healthcare services.

b. Every healthcare institution and employer shall also ensure that every medical practitioner, student, or employee is duly informed of his or her right to conscience with respect to the delivery of healthcare services upon his or her start of employment or service at such entities.

c. Any violation of this section shall subject the healthcare institution or employer to a civil fine of up to \$10,000 per occurrence.

Section 6. Civil Remedies.**a. Civil Action for Violation of Right to Conscience.**

A civil action for damages or injunctive relief—or both—may be brought by any medical practitioner, healthcare institution, or healthcare payer for any violation of any provision of this Act. Any additional burden or expense on another medical practitioner, healthcare institution, or

healthcare payer arising from the exercise of the right to conscience shall not be a defense to any violation of this Act.

b. Remedies.

Any party aggrieved by any violation of this Act may commence a civil action and shall be entitled—upon the finding of a violation—to recover threefold his or her or its actual damages sustained (but in no case shall recovery be less than \$5,000), along with the costs of the action and reasonable attorney’s fees. Such damages shall be cumulative and in no way limited by any other remedies which may be available under any other federal, state, or municipal law. A court considering such civil action may also award injunctive relief, which may include but is not limited to reinstatement of a medical practitioner to his or her previous position, reinstatement of board certification, and relicensure of a healthcare institution or healthcare payer.