

CONSCIENCE CLAUSES OFFER LITTLE PROTECTION

*Most Are Deficient, and Many Have Been Met
With Hostile Judicial Interpretations*

Certain medical treatment options raise serious moral concerns for some healthcare providers. Social, legal, and medical developments involving abortion, contraception, sterilization, artificial insemination, euthanasia, withdrawal of nutrition and fluids, blood transfusions, organ transplants, and routine autopsies have put healthcare providers at the epicenter of some of society's most controversial moral dilemmas.¹ Yet existing laws provide little protection for healthcare providers to exercise their rights of conscience.

The federal government and most states have enacted laws, commonly called "conscience clauses," that ostensibly protect healthcare providers' rights to refuse to provide or participate in procedures to which they have moral or religious objections. However, existing conscience clause laws have gaping holes that leave healthcare providers exposed to discrimination, coercion, and retaliation for attempting to follow their consciences. Most controversial procedures are not

covered by existing conscience clause laws. And a review of the judicial decisions interpreting these statutes shows that many courts are reluctant to enforce them. Drafting defects, compounded by unaccommodating judicial interpretations, have diminished the scope and strength of protections afforded by conscience clauses.

As a result, many healthcare providers have been coerced into abandoning or ignoring their moral or religious objections to providing or participating in some medical practices. Pressures on healthcare providers to abandon, ignore, or violate their moral and religious principles are likely to increase under emerging demographic, professional, and political constraints.

DEFICIENCIES IN EXISTING LAWS

The federal government and 44 states have enacted conscience clause statutes. However, nearly all these laws have deficiencies, including limitations on the specific conduct or procedures protected, restrictive definitions of the healthcare providers covered, and inadequate implementing proce-

Summary Although the federal government and most states have enacted laws protecting healthcare providers' rights to refuse to provide or participate in procedures to which they have moral or religious objections, most such laws are deficient and many have been met with hostile judicial interpretations that have diminished their scope and strength.

Deficiencies found in nearly all conscience clause laws include limitations on the specific conduct or procedures protected, restrictive definitions of the healthcare providers covered, and inadequate implementing procedures and remedies. Most conscience clause statutes fail to provide more than token protection for healthcare

providers' rights of conscience.

Increasing duress on healthcare providers who assert rights of conscience can be expected from three sources. First, some medical schools have considered refusal to participate as a negative factor in the admission process. Second, greater financial pressures on the American healthcare system may cause nonmonetary factors to be sacrificed to the exigencies of the moment. Third, all healthcare reform plans propose an increase in the federal government's role in providing healthcare. At present, the only federal statutory protection for healthcare providers' rights of conscience covers participants in only a few federal programs, is poorly conceived, and is sorely inadequate.

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dures and remedies.

Few Procedures Covered

The greatest flaw in existing statutes protecting healthcare providers' rights of conscience is the narrow definition of procedures covered. Twenty-eight states provide protection for rights of conscience *only* in the context of abortion. Nine states cover only abortion and contraception. Federal law and the law in five states cover only abortion and steriliza-

tion. One state protects rights of conscience regarding abortion, contraception, sterilization, euthanasia, and similar practices. One state covers abortion, sterilization, and artificial insemination. Forty-five jurisdictions provide at least some protection for some healthcare providers to decline to provide or perform some abortions, 10 states cover contraception, 7 jurisdictions cover sterilization, 1 state covers euthanasia, and 1 state covers artificial insemination. Only Illinois has a comprehensive law protecting healthcare providers' rights of conscience to refuse to participate in or provide *any* procedure that violates their moral or religious beliefs. (Two narrow subparts of the federal statute extend some protection to all medical procedures for some rights of conscience in some contexts; however, the federal law covers only a small class of persons.)

The narrow focus of most conscience clauses reflects the fact that most of them were enacted in response to *Roe v. Wade*.² Concern about discrimination against individuals and institutions that—for religious or other moral reasons—would not provide elective abortion services led to the widespread adoption of conscience clause statutes designed to prevent that kind of coercion of healthcare providers.

There is no justification for protecting rights of conscience for just one medical procedure but not others. Today, profound moral or religious objections have arisen over many healthcare services other than abortion. The rationale for respecting the rights of all persons to not be coerced into doing something that their moral or religious beliefs prohibit extends equally and fully to all medical procedures considered immoral or evil in a moral or religious value system. Moreover, extending legal protection for conscientious objection to abortion but not to other procedures may raise serious constitutional and

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statutory questions.

Limitations on Persons Protected

Another deficiency in existing conscience clauses is that many place restrictions on who is to be covered. Of the jurisdictions with conscience clauses, about 75 percent extend at least some protection to both individuals and institutions providing healthcare. Some provisions apply only to the "individual," which is arguably more re-

strictive than "person." (Corporations and other legal institutions are "persons," for at least some purposes, but they are not "individuals.") The intent to exclude institutions from coverage is evident in about 20 percent of the clauses, which provide conscience protection only for individuals.

The greatest opposition to laws protecting healthcare institutions' rights of conscience has come from advocates of reproductive choice.³ They fear that if healthcare providers, including organizations, were free to choose whether to provide or to participate in providing elective abortion services, fewer professionals and facilities would offer such services.

However, the difference between individuals and institutions has no real analytical significance for purposes of identifying who should be protected by conscience clauses. Legal entities, including hospitals, medical associations, and other healthcare corporations, are associations of individuals organized by individuals to achieve purposes that can best (or only) be achieved by collective action, including protecting or promoting values that individuals best (or only) can express and implement in collective form. To generally exclude institutional healthcare providers from conscience clause protection is merely an indirect way of denying the conscience and morality of the individuals whose choices the entities are created to effect.

To protect individuals' rights of conscience in the provision of healthcare service but deny protection to collective forms of individual conduct (or entities) is rather like arguing that the First Amendment protects only individual speech (e.g., direct, person-to-person, natural, unaided voice communication, or personally written, personally delivered letters) but not collective speech (e.g., by corporations, or through television,

books, or newspapers). But institutions, as well as individuals, enjoy the protections of the First Amendment. Thus exclusion of healthcare institutions from laws protecting conscience cannot be reconciled with other legal doctrines protecting rights of conscience.

Nearly a dozen institutional conscience clause provisions limit protection to *private* institutions. One state protects only healthcare facilities that are organized or operated by religious organizations. And at least four state conscience clause provisions deny certain protections to healthcare personnel working at or for public institutions.

Clearly, public personnel, no less than private personnel, are entitled to protection for their rights of conscience.⁴ Individuals who work for public healthcare institutions are certainly not less likely to encounter moral dilemmas. Rather, they are likely to encounter a wider array of moral dilemmas, as the financial barriers or patient self-selection that may protect some private facilities do not protect most public ones. And nothing in the distinction between a public employer and a private employer justifies denying them protection for their rights of conscience.

If a state both favors providing a controversial medical service and values healthcare providers' rights of conscience to refuse to provide the same service, the best solution is to give one value priority when they conflict. In our tradition, protection for the rights of conscientious refusal to participate in certain activities has a stronger and longer claim to priority and preference than the efficient provision of medical services some providers may find morally objectionable.

Many conscience clauses (nearly 50 percent) seem designed to limit protection to persons *directly* providing medical treatment or medical services—the ones in the operating room, at the place of delivery. Apparently, intake, records, accounting, janitorial, insurance, and kitchen personnel—and myriad other workers indirectly involved in providing complete medical services—are not protected.

However, this confined conception of the purpose of conscience clauses is inappropriate.⁵ No countervailing public policy will be seriously impeded if the conscience rights of persons who indirectly provide morally controversial medical services are protected. The critical perspective in respecting rights of conscience should be the perspective of the person who perceives a moral dilemma, not the person who fails to perceive a dilemma. Thus the state should not decline to protect the right of conscientious refusal for persons who consider it immoral to even secondarily or indirectly assist such procedures.

Types of Protections Most conscience clauses pro-

vide general protection from some (or all) forms of discrimination based on a refusal to provide or participate in a certain healthcare service. But broad protection against all forms of employment discrimination is necessary.

Many conscience clause laws prohibit employment discrimination. Some specifically prohibit firing, demoting, or refusing to hire because of refusal to provide or participate in the specific service. Some prohibit penalties, discipline, or reprimand. A handful of provisions prohibit denial of privileges, licenses, grants, or immunities. Other conscience clause laws prohibit placing conditions on, denying, or terminating government benefits or grants because of a refusal to provide or participate in a certain service.

Surprisingly, more than 33 percent of jurisdictions that have conscience clauses do not specify the grounds for conscientious objection. These statutes irrebuttably assume that any refusal to permit, perform, or participate in abortion will be based on conscientious objection. Some statutes make this assumption only in the case of institutional refusals.

A few statutes protect an individual's right to refuse for any reason, or without explanation. However, most conscience clauses protect only refusals based on (1) moral or religious grounds; (2) ethical, moral, or religious grounds; (3) religious or conscientious objections; or (4) just conscientious objections. They also prevent having to act against (1) conscience, (2) conscience or religious belief, or (3) stated ethical policy (of an institution).

A few statutes explicitly require the person to "state" (e.g., express orally) the objection; others require objection in writing. A few institutional conscience clauses require special steps, such as formally adopting a policy, posting notices of the policy, or informing patients of the institutional policy of refusal.

Overall, existing conscience clauses fail to provide specific remedies for violations of rights of conscience. Only nine states explicitly provide a civil cause of action for violation, although an implied civil cause of action would presumably be found in the absence of such provisions. Fewer still provide for injunctive relief. Three states provide for exemplary damages of some sort in some cases. Only Illinois has adopted a comprehensive civil rights act providing both rights and remedies.⁶ Most lawmakers have simply neglected to devise effective remedies for healthcare providers whose rights of conscience have been violated.

TROUBLING JUDICIAL INTERPRETATIONS

The failure of most conscience clause statutes to provide more than token protection for healthcare

providers' rights of conscience is compounded by unsupportive judicial interpretations. Strict interpretation of the statutory language is the ordinary rule in cases involving conscience clauses.

The U.S. Supreme Court set the example for hostile interpretation of conscience clauses. In *Doe v. Bolton*⁷ (the companion case to *Roe v. Wade*) the Court reviewed, inter alia, a Georgia institutional conscience clause that provided: "Nothing in this section shall require a hospital to admit any patient . . . for the purpose of performing an abortion."⁸ With no basis in the statutory language, examination of legislative intent, or case authority, Justice Harry A. Blackmun summarily declared: "These provisions *obviously* are in the statute in order to afford protection to the individual and to the *denominational* hospital."⁹ Three years later, the New Jersey Supreme Court followed suit and held that its state conscience clause, which on the surface protected all hospitals, does not protect nonsectarian not-for-profit hospitals (e.g., private, nondenominational hospitals).¹⁰

One federal appeals court early on manifested reluctance to find that the refusal to participate in a specific medical procedure was based on eligible moral grounds.¹¹ A similar bias was reflected in the dissenting opinion in *Swanson v. St. John's Lutheran Hospital*.¹² In *Swanson*, a nurse anesthetist was discharged after announcing she would no longer participate in sterilizations. The Montana trial court and two of five Montana Supreme Court justices argued that the nurse was not protected by the Montana conscience clause. The dissenting Montana justices would have denied her the statute's protection because they considered her reason for refusal to participate in the sterilizations to be based on mere emotion, rather than moral considerations. In other cases, courts have stretched to find that a particular procedure was not covered by a conscience clause.¹³

The threat of withdrawal of accreditation for hospitals and residency programs that do not provide ample opportunity for obstetric-gynecologic residents to perform abortions is another problem, illustrated by *St. Agnes Hospital of the City of Baltimore v. Riddick*.¹⁴ After a Catholic

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hospital strictly construed the ethical standards of Catholic hospitals to forbid its residents from participating in sterilizations or abortions while on rotation at other hospitals, an accreditation association withdrew accreditation. The accrediting group asserted that the hospital did not meet standards for training in, inter alia, abortion and sterilization. Although the trial court ultimately reject-

ed the hospital's conscience clause claims because the hospital failed to prove causation, *Riddick* raises serious concerns for administrators of and residents in institutions that try to exercise rights of conscience in the face of pressure for increased training in certain controversial procedures.

Some statutes protect such a limited category of persons or procedures that a court need not wrest with the language to deny conscience clause protection. For example, in *Doe v. Hale Hospital*, the federal appeals court noted that the Massachusetts institutional conscience clause explicitly applied only to "privately controlled hospitals" and did not extend protection to the public hospital that was sued because it would not admit patients for first-trimester elective abortions.¹⁵ Another example is *Gray v. Romeo*.¹⁶ In this case a federal court held that employees of a healthcare institution did not have any federal protection for refusing to participate in the court-ordered withdrawal of a feeding tube and life-support system from a patient, because the federal conscience clause applies only to participants in federal healthcare service programs.

Other courts have rejected appeals for protection by healthcare providers because the relevant conscience clause explicitly covers one or two specific procedures, not including the particular procedure involved in the case.¹⁷

These conscience clause cases illustrate the inadequate protection provided by current conscience clauses for healthcare providers' rights of conscience. Clearly, broader statutory protections are needed.

SOURCES OF GROWING PRESSURE

Increasing pressure on healthcare providers who assert rights of conscience can be expected from

three sources. First, some medical schools have considered refusal to participate in certain procedures as a negative factor in the admission process.¹⁸ A recent report indicates that abortion training is mandatory in approximately a third of the certified obstetric-gynecologic residency programs.¹⁹ A symposium of the National Abortion Federation and the American College of Obstetricians has recommended that abortion care be made "a required component of ob/gyn residency training" for both accreditation of the hospital and for board examination of the physician.²⁰

Subordinate healthcare workers, especially students in nursing, paraprofessional, and medical training programs, are particularly vulnerable to coercive pressure to violate their consciences. A landmark empirical study of nurses revealed that approximately 5 percent of the nurses sampled (which would extrapolate to about 50,000 nurses nationwide) believed their assignments or professional opportunities had been limited by their religious or moral beliefs about abortion. About 7 percent of Catholic nurses know someone whose beliefs had limited his or her opportunities.²¹

Second, the aging of the baby-boom generation will create greater financial pressures on the American healthcare system, and that may cause nonmonetary factors—including rights of conscience of individual and institutional healthcare providers—to be sacrificed to the exigencies of the moment.

Third, the increasing cost of healthcare in the United States has made reform a leading political issue. Although many different plans have been proposed, common to all of them is an increase in the federal role in providing healthcare. At present, the only federal statutory protection for healthcare providers' rights of conscience, the so-called Church Amendment, covers participants in a few federal programs, is poorly conceived, and is sorely inadequate. If the federal government plays a larger role in healthcare delivery, more comprehensive federal protections for rights of conscience will be needed.

STRONGER STATUTORY PROTECTIONS NEEDED

Current state and federal conscience clause laws:

- Are narrow and easily circumvented
- Cover few healthcare providers in too few situations
- Provide inadequate and ineffective remedies and procedures

The hostile interpretation given such provisions by some courts underscores the need for clearer, stronger statutory protections. □

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NOTES

1. See W. Cole Durham, Jr., Mary Anne Q. Wood, and Spencer J. Condie, *Accommodation of Conscientious Objection to Abortion: A Case Study of the Nursing Profession*, 1982 B.Y.U.L. Rev. 253, 287 n.80; Bruce G. Davis, *Defining the Employment Rights of Medical Personnel within the Parameters of Personal Conscience*, 3 Det. Coll. L. Rev. 847, 847 (1986).
2. 410 U.S. 113 (1973).
3. See Harriet F. Pilpel and Dorothy E. Patton, *Abortion, Conscience and the Constitution: An Examination of Federal Institutional Conscience Clauses*, 6 Colum. Hu. Rts. L. Rev. 279 (1974-75).
4. See, for example, *Rutan v. Republican Party*, 497 U.S. 62 (1990); *Perry v. Sinderman*, 408 U.S. 593, 596-98 (1972); *Keyishan v. Board of Regents of Univ. of New York*, 385 U.S. 589, 597 (1967).
5. Durham, Wood, and Condie, note 1, at 319.
6. Ill. Ann. Stat. chapter 111½, paragraphs 5,301-5,314 (Smith-Hurd 1988).
7. 410 U.S. 179 (1973).
8. Georgia Criminal Code section 26-1202, quoted in the Bolton Appendix, 410 U.S. at 205.
9. 410 U.S. at 197-198 (emphasis added).
10. *Doe v. Bridgeton Hospital Association, Inc.*, 71 N.J. 478, 366 A.2d 641, 647 (1976).
11. *Doe v. Charleston Area Medical Center*, 529 F.2d 638, 632 n.7 (4th Cir. 1975).
12. 597 P.2d 702 (1979).
13. See, for example, *Brownfield v. Daniel Freeman Marina Hospital*, 208 Cal.App.3d 405, 256 Cal.Rptr. 240, 245 (1989) (refusal to recommend use of "morning-after" pill is not protected).
14. 748 F.Supp. 319 (D.Md. 1990).
15. 500 F.2d 144 (1st Cir. 1974).
16. 697 F.Supp. 580, 590 (D.R.I. 1988).
17. See *Gray by Gray v. Romeo*, 697 F.Supp. 580, 590 (D.R.I. 1988); *Elbaum by Elbaum v. Grace Plaza of Great Neck*, 148 App. Div. 2d 244, 255, 544 N.Y.2d 840, 847 (1989).
18. See also Durham, Wood, and Condie, note 1 at 266 fn. 46, and accompanying text (citing Diamond, *Do the Medical Schools Discriminate against Anti-Abortion Applicants?* 43 Linacre Q. 29, 30-31 [1976]).
19. National Abortion Federation (NAF) and American College of Obstetricians and Gynecologists (ACOG), *Who Will Provide Abortions?* 8 (Oct. 25-26, 1990). (Abortion training is optional in half of the 72 percent of obstetric-gynecologic programs that offer it.)
20. NAF and ACOG at 6 (recommendation 1). The report also recommended that "physician attitudes" about abortion be addressed in the medical school or residency programs. NAF and ACOG (recommendation 3). See also American Public Health Association Resolution 9117 (recommending mandatory abortion training in all obstetric-gynecologic programs).
21. Durham, Wood, and Condie, note 1, at 257, 287.