

TREATING AN UNHEALTHY CONSCIENCE: A PRESCRIPTION FOR MEDICAL CONSCIENCE CLAUSES

Tom C. W. Lin^{*†}

INTRODUCTION

She sits in an immaculate hospital room. She is eighteen and was raped a few hours ago. The officer has obtained the necessary evidence. The doctor has examined her. She sees a counselor, then leaves for home. She was not given any emergency contraception. The doctor makes no mention of it as the doctor is personally opposed to contraception on religious and moral grounds. The doctor struggled mightily in deciding whether to tell her, but in the end, the doctor chose to remain silent. Had the doctor wanted to tell her, he would have had to violate the hospital's explicit policy against all contraception in all situations. Two months later she is back in the hospital, pregnant.

This anecdote is stark, fictitious, and simple, but it sheds much light on the complex issues at the crossroads of conscience clauses and healthcare. While *She* in the introductory anecdote is only hypothetical, real people with stories like hers exist. Kathleen Brownfield is real. She was a young rape victim who was taken to a Catholic hospital that did not offer or mention emergency contraception even though Kathleen's mother explicitly asked the physician about it.¹ Kathleen Brownfield's attending physician is real. Perhaps he struggled over providing services deemed permissible by his profession, but deemed impermissible by his or his employer's values.² Julee Lacey is real. She is a young woman living in a Forth Worth suburb who was denied her prescribed birth-control pills by a pharmacist who opposed contraception on moral grounds.³ Karen Brauer is real. She was a Cincinnati pharmacist who refused to refill a prescription for birth-control pills on moral grounds. She stood bravely by her conscience and was fired.⁴

* Associate, Dewey Ballantine LLP; J.D. 2005, University of Pennsylvania Law School; Cert. in Business & Public Policy 2005, Wharton School of Business at the University of Pennsylvania; B.A. 2002, New York University.

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1. *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 242 (Ct. App. 1989).

2. *See id.* (noting that the hospital refused to provide information about the morning-after pill "because it was 'a Catholic hospital'").

3. Charisse Jones, *Druggists Refuse to Give Out Pill*, USA TODAY, Nov. 9, 2004, at A3.

4. *Id.*

Broadly, a conscience clause is “a clause in an act or law to ensure respect for the consciences of those affected.”⁵ In the healthcare context, conscience clauses permit healthcare professionals to refuse to provide services that they consider objectionable to their conscience without real consequences to themselves.⁶ Many healthcare providers struggle daily between their livelihoods and their consciences, between doing their jobs as others see fit and violating their personal mores. Many patients and victims are potentially harmed by the lack of information and the lack of choice. Ideally, doctors should never have to choose between their vocations and their consciences; and the quality of a woman’s healthcare should never have to depend on the conscience of her doctor or hospital.

The purpose of this Article is to address the growing concerns raised by conscience clauses and the need for solutions by examining the problems they raise in the context of women’s healthcare, and offering practical solutions for treating these problems. By addressing the issues of conscience clauses in women’s healthcare, this Article indirectly tackles a great challenge in the near future of healthcare—namely, what is the role of morality and law in a time of unparalleled medical breakthroughs? Part I provides a brief history of conscience clauses in America. This Part provides a guide to conscience clauses in America from their first appearance in federal legislation following the *Roe v. Wade* decision to their present-day permutations.⁷ Part II examines how conscience clauses fit within our constitutional framework with its separation of church and state. This Part explores how conscience clauses fit nicely within a First Amendment cocoon created by the jurisprudence of the Free Exercise Clause and the Establishment Clause. Part III addresses the primary benefits of conscience clauses. Part IV analyzes some of the problematic healthcare issues raised by conscience clauses. It introduces the various regimes created by healthcare providers and institutions that adhere to a conscience clause (for example, not requiring notice, requiring notice but not referrals, requiring no notice or referrals, etc.). It then explores more specific issues and implications of the various regimes such as access, notice, and informed consent. Finally, Part V proposes practical but imperfect solutions for the problematic issues raised by conscience clauses.

5. THE OXFORD ENGLISH DICTIONARY 755 (2d ed. 1989).

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

7. *Roe v. Wade*, 410 U.S. 113 (1973).

I. A BRIEF HISTORY OF CONSCIENCE CLAUSES IN AMERICA

Simply and broadly put, a conscience clause is “a clause in an act or law to ensure respect for the consciences of those affected.”⁸ Within the healthcare context, conscience clauses usually take the form of a refusal clause in that they allow healthcare providers to refuse to perform certain services that they oppose on religious and moral grounds without fear of retribution.⁹ The healthcare services that may lead to objections by providers vary widely; they might include filling a prescription for birth-control pills or transplanting a genetically enhanced organ. However, services concerning female reproductive care result in perhaps the most prominent and prevalent use of the shield of conscience clauses, which is not surprising, given its origins.¹⁰

Conscience clauses made their first appearance in federal and state legislation in the mid-1970s following the *Roe v. Wade* decision of 1973.¹¹ Later that year, Congress passed the Church Amendment, the first federal law protecting a healthcare provider’s right to object to performing certain medical services on moral or religious grounds.¹² The Church Amendment came about as a reaction to the Montana federal court case, *Taylor v. St. Vincent’s Hospital*, which enjoined a Catholic hospital from prohibiting a physician from performing a sterilization procedure that was against Catholic dogma.¹³ The Church Amendment, an amendment to the Public Health Service Act, was signed into law by President Nixon.¹⁴ The current codification reads in part:

8. THE OXFORD ENGLISH DICTIONARY, *supra* note 5, at 755.

9. Wardle, *supra* note 6, at 177. Retribution in this sense can come in various forms: professional, occupational, financial, etc. Some conscience clause proponents argue that, in their absence, healthcare providers who refuse to provide certain treatments may be deemed inferior and therefore more susceptible to lower wages or worse, termination.

10. Cf. Melissa Duvall, Comment, *Pharmacy Conscience Clause Statutes: Constitutional Religious “Accommodations” or Unconstitutional “Substantial Burdens” on Women?*, 55 AM. U. L. REV. 1485, 1491 (2006) (observing that, by 1978, more than forty states had passed conscience clauses regarding abortion and sterilization procedures).

11. *Id.*

12. Health Programs Extension Act of 1973 (Church Amendment), Pub. L. No. 93-45, § 401 (b), (c), 87 Stat. 95-96 (1973) (codified as amended at 42 U.S.C. § 300a-7(b), (c) (2000)). The Church Amendment is named after former U.S. Senator Frank Church of Idaho. Susan Berke Fogel & Lourdes A. Rivera, *Saving Roe Is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 746 (2004).

13. *Taylor v. St. Vincent’s Hosp.*, 369 F. Supp. 948, 950 n.1 (D. Mont. 1973), *aff’d*, 523 F.2d 75 (9th Cir. 1975). The court ultimately dissolved the preliminary injunction—after the sterilization procedure—and denied the woman relief for infringement upon her rights. *Id.* at 951.

14. Church Amendment § 401(b), (c).

(b) . . . The receipt of any [federal] grant . . . by any individual or entity does not authorize any court or any public official or other public authority to require—

(1) such individual to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions; or

(2) such entity to—

(A) make its facilities available for the performance of any sterilization procedure or abortion if . . . prohibited by the entity on the basis of religious beliefs or moral convictions, or

(B) provide any personnel for the performance or assistance in the performance of any sterilization procedure or abortion if the performance . . . by such personnel would be contrary to the religious beliefs or moral convictions of such personnel.

. . . .

(d) . . . No individual shall be required to perform or assist in the performance of any part of a health service program . . . if his performance or assistance . . . would be contrary to his religious beliefs or moral convictions.¹⁵

The law offers broad coverage and protection for institutions, healthcare providers, and even medical students who may object to performing certain medical procedures because of personal, religious, and moral beliefs.¹⁶

In the two decades following the passage of the Church Amendment, Congress passed little legislation significantly altering the scope of federal conscience clauses.¹⁷ However, during this period many state legislatures enacted conscience clauses of their own, specifically in response to burgeoning female reproductive rights.¹⁸

The conscience clause reemerged onto the legislative landscape in the late 1990s and the first half of the 2000s. Congress passed the Balanced Budget Act of 1997, which included a provision that extended conscience

15. 42 U.S.C. § 300a-7(b), (d) (2000).

16. *Id.* § 300a-7(b), (d)–(e).

17. Congress added § 300a-7(d) in 1974, prohibiting programs funded or administered by the Department of Health and Human Services from requiring an individual to perform health services contrary to his or her moral or religious beliefs. National Research Service Award Act of 1974, Pub. L. 93-348, sec. 214, § 300a-7(d), 88 Stat. 342, 353 (1974) (codified as amended at 42 U.S.C. § 300a-7(d)). In 1979, Congress further broadened this protection by prohibiting entities that receive certain federal funds from denying admission or discriminating against an applicant for training or study, including for internships or residencies, because of their refusal to perform abortions or sterilizations that contravene their religious or moral beliefs. Public Health Service Act Amendments, Pub. L. 96-76, sec. 208, § 300a-7(e), 93 Stat. 579, 583 (1979) (codified as amended at 42 U.S.C. § 300a-7(e)).

18. See Wardle, *supra* note 6, at 179–80 (1993) (surveying state-level conscience clauses).

clause protections to Medicare and Medicaid programs.¹⁹ Under the law, Medicare and Medicaid *may* refuse reimbursement for referral and counseling services at a secondary institution if a patient's primary healthcare institution opposed those services for religious and moral reasons;²⁰ thereby indirectly and illogically punishing the second institution for the beliefs of the first. Although the aforementioned provision is a "*may* clause," as opposed to a "*may not* clause" or "*must* clause," it gives stronger credence and justification (pretextual or not) for institutions to refuse certain female reproductive healthcare services.

More recently in November 2004, "House and Senate negotiators . . . tucked a potentially far-reaching anti-abortion provision into a \$388 billion must-pass [2005 Omnibus Appropriations Bill]," which was subsequently signed into law by President Bush on December 8, 2004.²¹ The new provision, the Hyde-Weldon Anti-Discrimination Amendment,²² creates even wider coverage for federal conscience clauses by "protect[ing] employees and hospitals from laws requiring them to provide abortions or even abortion referrals."²³

The abortion language would bar federal, state and local agencies from withholding taxpayer money from health care providers that refuse to provide or pay for abortions or refuse to offer abortion counseling or referrals. Current federal law, aimed at protecting Roman Catholic doctors, provides such "conscience protection" to doctors who do not want to undergo abortion training. The new language would expand that protection to all health care providers, including hospitals, doctors, clinics and insurers.²⁴

19. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 1852(j)(3)(B), 11 Stat. 251, 295-96 (1997) (codified at 42 U.S.C. § 1395w-22(j)(3)(B) (2000)).

20. *Id.*

21. Sheryl Gay Stolberg & Carl Hulse, *Negotiators Add Abortion Clause to Spending Bill*, N.Y. TIMES, Nov. 20, 2004, at A1.

22. The 2005 Omnibus Appropriations Bill included the Hyde-Weldon Amendment, which reads:

(1) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d), 118 Stat. 2809, 3163 (2004).

23. Ellen Goodman, Editorial, *Mixing Medicine and Faith*, BOSTON GLOBE, Sept. 30, 2004, at A17.

24. Stolberg & Hulse, *supra* note 21.

This reemergence of conscience clauses also took place on the state level. State legislatures, like their federal counterparts, also passed new conscience clauses or provisions that broadened the coverage of older ones. According to a recent survey, at least “[f]orty-six states have enacted conscience clauses protecting providers’ right to refuse to provide abortions. Forty-two of these states also protect health care facilities with policies opposing abortion on religious grounds. Four states have passed recent laws specifically including HMOs within the scope of conscience clause protections.”²⁵ In 2006, South Dakota enacted a law that would ban most abortions in the state.²⁶ “The law . . . make[s] it a crime for doctors to perform an abortion unless it [is] necessary to save the woman’s life, with no exception for cases of rape or incest.”²⁷ The survey, of course, does not include the various bills still pending or forthcoming from numerous state legislatures.²⁸

The rebirth of the Republican Party (and social conservatives), with their strong convictions concerning religious values and abortion rights, will most likely solidify the place of conscience clauses in the years to come.²⁹ The Party’s control of the executive and legislative branches in the federal government, as well as the Party’s majority in state governorships, in the early part of the new millennium will likely result in a reinforcement of the Party’s values and agenda.³⁰ Conservative appointments to federal and state

25. Katherine A. White, Note, *Crisis of Conscience: Reconciling Religious Health Care Providers’ Beliefs and Patients’ Rights*, 51 STAN. L. REV. 1703, 1709 (1999) (footnotes omitted).

26. Women’s Health and Human Life Protection Act, S.D. CODIFIED LAWS § 22-17-7 to -12 (Supp. 2006).

27. John Holusha, *South Dakota Governor Signs Abortion Ban*, N.Y. TIMES, Mar. 6, 2006, <http://www.nytimes.com/2006/03/06/politics/06cnd-abort.html?ex=1299301200&en=6bfae1957bc1dc1a&ei=5088>.

28. See Eleanor Clift, *At Risk*, NEWSWEEK, Dec. 10, 2004, <http://www.msnbc.msn.com/id/6645204/site/newsweek> (stating that “13 states are considering 22 pieces of similar legislation” that can be classified as a conscience clause or an extension of a preexisting conscience clause).

29. See, e.g., Robin Toner, *Changing Senate Looks Much Better to Abortion Foes*, N.Y. TIMES, Dec. 2, 2004, at A34.

As a result of November’s election, the next Senate will have a bigger, more conservative Republican majority and several new opponents of abortion—including some of the most intense abortion foes in politics, like Tom Coburn, a doctor and newly elected senator from Oklahoma, who campaigned as “a committed defender of the sanctity of life in all of its stages.”

With those additions, on top of their gains in the 2002 election, anti-abortion leaders say several abortion restrictions previously introduced on Capitol Hill have a better chance for full consideration and passage.

Id.

30. See Nat’l Republican Comm., 2004 Republican Party Platform: A Safer World and a More Hopeful America (Aug. 26, 2004), <http://www.gop.com/media/2004platform.pdf>.

We oppose school-based clinics that provide referrals, counseling, and related

courts may also strengthen the socially conservative position on conscience clauses and similar issues. The confirmations of Chief Justice John Roberts and Justice Samuel Alito in 2006 have likely swayed the persuasions of the highest court toward the right.³¹ The Roberts and Alito confirmations have also emboldened those who oppose abortion and favor the conscience clause to take more political action to solidify their position.³² And so, based on contemporary political realities, it may be difficult for opponents of conscience clauses to work toward abolishing them. Instead, it may be more constructive to work toward finding practical solutions to the concerns raised by them.

II. FIRST AMENDMENT ISSUES AND NON-ISSUES

Many opponents of conscience clauses inevitably wonder, “How could conscience clauses exist when our government adheres to the legal principle of separation between church and state?” After all, our founding fathers intended to frame a system where government was free from the grasp of religion, and religion was free from the grasp of government, so that each could progress independently.³³ In the seminal case, *Everson v. Board of*

services for contraception and abortion.

....

... We support a human life amendment to the Constitution and we endorse legislation to make it clear that the Fourteenth Amendment’s protections apply to unborn children. Our purpose is to have legislative and judicial protection of that right against those who perform abortions. We oppose using public revenues for abortion and will not fund organizations which advocate it. We support the appointment of judges who respect traditional family values and the sanctity of innocent human life.

Id.

31. See, e.g., NOAH FELDMAN, *DIVIDED BY GOD* 4 (paperback ed. 2006).

For most of our history, the relationship between religion and government has been determined through the political process. Only in the last fifty years have the courts become a major battleground. Today, new developments on the Supreme Court suggest that we are in for some significant changes in church-state affairs. In her quarter century on the Court, Justice Sandra Day O’Connor crafted a compromise position, often allowing state funding of religious schools and activities while blocking many public displays of religious symbols. Time after time, she cast the key vote in 5–4 decisions. In January 2006, she was replaced by Justice Samuel A. Alito, Jr., a conservative whose views seem likely to differ, especially when it comes to public expressions of religion.

Id.

32. See, e.g., Monica Davey, *South Dakota Bans Abortion, Setting Up a Battle*, N.Y. TIMES, Mar. 7, 2006, at A1 (reporting that South Dakota Representative Roger Hunt, who sponsored legislation banning abortions in that state, pointed to the Alito and Roberts appointments and remarked, “This is our time.”).

33. See, e.g., LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1158–60 (2d ed. 1988).

Education, the Supreme Court emphatically affirmed this separation between church and state: “The First Amendment has erected a wall between church and state. That wall must be kept high and impregnable.”³⁴ Logically, this separation could not be much clearer, but the reality is much murkier.³⁵ Students and scholars of the law have come to understand that “[t]he life of the law has not been logic: it has been experience.”³⁶ Our nation’s motto is “In God We Trust.”³⁷ Our Pledge of Allegiance contains the words “under God.”³⁸ Our secular Supreme Court is invoked annually with the phrase, “God save this honorable Court.”³⁹ Numerous other allusions to God and religion exist in our government.⁴⁰ “No perfect or absolute separation is really possible; the very existence of the Religion Clause is an involvement of sorts—one that seeks to mark boundaries to avoid excessive entanglement.”⁴¹ And so, if a wall does exist between church and state, that wall is porous at best. Where, then, do conscience clauses reside within this legal framework?

A large part of the answer can be found in the First Amendment’s “Establishment Clause” and “Free Exercise Clause.” The First Amendment reads, in part, “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.”⁴² Succinctly put,

[w]hile the Free Exercise Clause determines the minimum accommodation that the government is required to make for religious believers, the Establishment Clause sets the maximum amount of assistance that the government may offer. In their most

[A]t least three distinct schools of thought . . . influenced the drafters . . . first, the evangelical view (associated primarily with Roger Williams) that “worldly corruptions . . . might consume the churches if sturdy fences against the wilderness were not maintained”; second, the Jeffersonian view that the church should be walled off from the state in order to safeguard secular interests (public and private) “against ecclesiastical depredations and incursions”; and third, the Madisonian view that religious and secular interests alike would be advanced best by diffusing and decentralizing power so as to assure competition among sects rather than dominance by any one.

Id. (footnotes omitted).

34. *Everson v. Bd. of Educ.*, 330 U.S. 1, 18 (1947).

35. *See generally* *McCreary Co. v. ACLU*, 125 S.Ct. 2722, 2748–2751 (2006) (Scalia, J., dissenting) (recounting the many ways in which religious references have become institutionalized elements of our modern government).

36. Oliver Wendell Holmes, Jr., Book Review, 14 AM. L. R. 233, 234 (1880).

37. *McCreary Co.*, 125 S.Ct. at 2750.

38. *Id.*

39. *Id.*

40. *Id.*

41. *Walz v. Tax Comm’n*, 397 U.S. 664, 670 (1970).

42. U.S. CONST. amend. I.

stark forms, the Free Exercise Clause prevents government from banning religion, while the Establishment Clause prevents government from requiring anyone to practice a particular religion.⁴³

Conscience clauses, I would like to suggest, fit snugly within the parameters demarcated by the Establishment Clause and the Free Exercise Clause.

A. Establishment Clause Analysis

The Supreme Court articulated a three-part test for the Establishment Clause in *Lemon v. Kurtzman*: “First, the statute must have a secular legislative purpose; second, its principal or primary effect must be one that neither advances nor inhibits religion; finally, the statute must not foster ‘an excessive government entanglement with religion.’”⁴⁴ The *Lemon* test has not been used consistently by the Court for Establishment Clause cases, and has been harshly criticized by jurists.⁴⁵ Despite the Court’s inconsistent use and its shortcomings, however, the *Lemon* test remains the most prominent and prevalent rubric for analyzing Establishment Clause issues.⁴⁶

Under the *Lemon* test, most conscience clauses that protect healthcare providers satisfy the secular-effects prong because they apply indiscriminately to healthcare providers of all religious and moral affiliations.⁴⁷ Additionally, because they are enacted for the purpose of

43. White, *supra* note 25, at 1729 (footnote omitted); see also ERWIN CHEREMINSKY, CONSTITUTIONAL LAW 1139–43 (2d ed. 2002) (articulating the “compatibility and tension” between the Establishment Clause and the Free Exercise Clause).

44. *Lemon v. Kurtzman*, 403 U.S. 602, 612–13 (1971) (citation omitted).

45. See, e.g., *Lamb’s Chapel v. Ctr. Moriches Union Free Sch. Dist.*, 508 U.S. 384, 398–99 (1993) (Scalia, J., dissenting).

Like some ghoul in a late-night horror movie that repeatedly sits up in its grave and shuffles abroad, after being repeatedly killed and buried, *Lemon* stalks our Establishment Clause jurisprudence once again Over the years, however, no fewer than five of the currently sitting Justices have, in their own opinions, personally driven pencils through the creature’s heart (the author of today’s opinion repeatedly), and a sixth has joined an opinion doing so

. . . .

The secret of the *Lemon* test’s survival, I think, is that it is so easy to kill. It is there to scare us (and our audience) when we wish it to do so, but we can command it to return to the tomb at will. When we wish to strike down a practice it forbids, we invoke it; when we wish to uphold a practice it forbids, we ignore it entirely.

Id. (citation omitted); see also CHEREMINSKY, *supra* note 43, at 1159 (noting Justice Scalia’s dissent and the uncertain future of the *Lemon* test).

46. CHEREMINSKY, *supra* note 43, at 1141.

47. Cf. *N.J. Ass’n of Health Care Facilities v. State*, 665 A.2d 399, 402–03 (N.J. Super. Ct. 1995) (“This [law] directly advances religion. The impact is not merely incidental; there is no rational, secular explanation that can be propounded.”).

safeguarding a provider's freedom to act legally within the bounds of their consciences, they satisfy the secular purpose prong of the test.⁴⁸ Since no religion is favored or disfavored, these types of conscience clauses are generally permissible under the *Lemon* rubric. With regard to the excessive-entanglement prong, conscience clauses are permissible because they normally do not require "comprehensive, discriminating, and continuing state surveillance," which has been deemed an unconstitutional entanglement by the Court.⁴⁹

However, conscience clauses that grant special exemptions to religiously affiliated healthcare institutions from certain federally or locally mandated requirements may prove to be violative of the Establishment Clause if they grant special status to those institutions primarily because of their religious affiliations.⁵⁰ Nonetheless, this may also prove to be a difficult strike against conscience clauses, as the Court has long held that the mere fact that a hospital is operating under the auspices of the Roman Catholic Church does not automatically make it a religious institution governed by the restrictions of the Establishment Clause.⁵¹

B. Free Exercise Clause Analysis

The Court has said that the Free Exercise Clause "embraces two concepts,—freedom to believe and freedom to act. The first is absolute but, in the nature of things, the second cannot be."⁵² Whereas government cannot regulate religious opinion and beliefs, government certainly can and does regulate religiously motivated conduct.⁵³

48. Congress and state legislatures are fully aware of the more than thirty-year-old specter of *Lemon* when it comes to drafting legislation that may impact religion. As a result, most legislation is tailored so as not to offend the principles articulated in *Lemon*. See Klint Alexander, *The Road to Vouchers: The Supreme Court's Compliance and the Crumbling of the Wall of Separation Between Church and State in American Education*, 92 KY. L.J. 439, 450 (2003) (suggesting that the *Lemon* test aids legislatures in their interpretation of the Establishment Clause). The careful wordings of conscience clauses are a prime example of carefully crafted legislative language.

49. *Comm. for Pub. Educ. & Religious Liberty v. Nyquist*, 413 U.S. 756, 794 (1973) (quoting *Lemon*, 403 U.S. at 619).

50. See, e.g., *Children's Healthcare Is a Legal Duty, Inc. v. Vladeck*, 938 F. Supp. 1466, 1486–87 (D. Minn. 1996) (striking down a special exemption from a portion of the Medicare Act granted to Christian Science nursing homes in Minnesota); *N.J. Ass'n of Health Care Facilities*, 665 A.2d at 400 (holding that exempting religiously affiliated healthcare institutions from a state regulatory scheme violated the establishment clause).

51. *Bradfield v. Roberts*, 175 U.S. 291, 298 (1899).

52. *Cantwell v. Connecticut*, 310 U.S. 296, 303–04 (1940).

53. *Employment Div., Dep't of Human Res. v. Smith*, 494 U.S. 872, 878–79 (1990) (holding that the First Amendment does not excuse non-compliance with laws of general applicability on the basis of one's religious beliefs), *superseded by statute*, Religious Freedom Restoration Act (RFRA) of 1993, Pub. L. No. 103-141, 107 Stat. 1488 (1993) (codified at 42 U.S.C. § 2000bb (2000)), *invalidated by* City of

Free Exercise jurisprudence evolved dramatically over the last four decades. A seminal case for Free Exercise claims is *Employment Division, Department of Human Resources v. Smith*, where the Court held that a law banning the use of peyote did not violate the Free Exercise Clause even though peyote is used for sacramental purposes in some Native American religions.⁵⁴ The Court held that:

[T]he free exercise clause cannot be used to challenge a neutral law of general applicability. . . . [N]o matter how much a law burdens religious practices, it is constitutional under *Smith* so long as it does not single out religious behavior for punishment and was not motivated by a desire to interfere with religion.⁵⁵

Following *Smith* and its progeny, the Court applies strict scrutiny to laws aimed at religious practices, but applies the rational basis standard of review to laws of that are religion-neutral.⁵⁶ Congress attempted to impose strict scrutiny for all Free Exercise claims with the Religious Freedom Restoration Act of 1993,⁵⁷ but the Act was subsequently overturned by the Court in *City of Boerne v. Flores*.⁵⁸ More recently in 2001, President Clinton signed into law the Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA), which requires strict scrutiny or a “compelling governmental interest” for governmental decisions that burden religion in the areas of land use and institutionalized persons.⁵⁹ Subsequently, in *Cutter v. Wilkinson*, a group of corrections officials challenged the constitutionality of RLUIPA.⁶⁰ In *Cutter*, a group of inmates in Ohio claimed that the prison officials violated their First Amendment rights when the prison officials failed to provide certain religious accommodations and restricted certain religious practices.⁶¹ The state challenged RLUIPA on grounds that it impermissibly advances religion in violation of the Establishment Clause; the Sixth Circuit Court of Appeals agreed and held that the law was unconstitutional.⁶² On appeal, the Supreme Court ruled unanimously that RLUIPA was constitutional:

Boerne v. Flores, 521 U.S. 507 (1997).

54. *Smith*, 494 U.S. at 874, 890.

55. CHEMERINSKY, *supra* note 43, at 1201.

56. *Id.* at 1202.

57. 42 U.S.C. § 2000bb.

58. *City of Boerne*, 521 U.S. at 511.

59. Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA), Pub. L. No. 106-274, 114 Stat. 803–04 (2000) (codified at 42 U.S.C. §§ 2000cc to 2000cc-1 (2000)).

60. *Cutter v. Wilkinson*, 544 U.S. 709, 713 (2005).

61. *Id.* at 712–13.

62. *Cutter v. Wilkinson*, 349 F.3d 257, 260 (6th Cir. 2003), *rev'd*, 544 U.S. 709 (2005).

Our decisions recognize that “there is room for play in the joints” between the Clauses, some space for legislative action neither compelled by the Free Exercise Clause nor prohibited by the Establishment Clause. . . . [W]e hold that §3 of RLUIPA fits within the corridor between the Religion Clauses: On its face, the Act qualifies as a permissible legislative accommodation of religion that is not barred by the Establishment Clause.⁶³

The Free Exercise Clause is often implicated in three general scenarios: (1) when government requires conduct that is contrary to one’s religion;⁶⁴ (2) when one’s religion requires conduct that is prohibited by the government;⁶⁵ and (3) when laws burden the practice of religion.⁶⁶ Under the rubric of *Smith* and its progeny, conscience clauses rarely invoke the third scenario as they are generally religiously neutral. However, conscience clauses may run afoul of the Free Exercise Clause when they protect healthcare providers who refuse to provide services that are mandated by other laws or codes. Currently, few federal or state laws exist that explicitly require the performance of certain female healthcare services.⁶⁷ Accordingly, there are few occasions for this explicit (and perhaps readily litigable) collision between governmental interests and personal conscience to occur.⁶⁸

63. *Cutter*, 544 U.S. at 719–20 (citation omitted).

64. *See, e.g.*, *United States v. Lee*, 455 U.S. 252, 261 (1982) (holding that social security taxes did not violate the Free Exercise Clause as applied to Amish employees and employers who argued that such laws violate their religious beliefs), *superseded by statute*, Religious Freedom Restoration Act (RFRA) of 1993, Pub. L. No. 103-141, 107 Stat. 1488 (1993) (codified at 42 U.S.C. § 2000bb (2000)), *invalidated by City of Boerne*, 521 U.S. 507 (1997), *superseded by statute*, Religious Land Use and Institutionalized Persons Act of 2000 (RLUIPA), Pub. L. No. 106-274, 106 Stat. 803 (2000) (codified at 42 U.S.C. § 2000cc-1(a)(1)–(2) (2000)).

65. *See, e.g.*, *Reynolds v. United States*, 98 U.S. 145, 165–67 (1878) (upholding a law banning polygamy despite arguments from Mormons stating that such conduct is required by their religion).

66. *See, e.g.*, *Sherbert v. Verner*, 374 U.S. 398 (1963) (holding that the denial of unemployment benefits for a woman discharged for refusing to work on the Sabbath was unconstitutional).

67. Adam Sonfield, *New Refusal Clauses Shatter Balance Between Provider ‘Conscience,’ Patient Needs*, GUTTMACHER REP., Aug. 2004, at 1, 3. *But see* ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2005) (requiring pharmacists to dispense contraceptives or suitable alternatives without delay when presented with a valid prescription); Bruce Mohl, *State Orders Wal-Mart to Sell Morning-After Pill*, BOSTON GLOBE, Feb. 15, 2006, at F1 (reporting on a decision by the Massachusetts Board of Registration in Pharmacy ordering Wal-Mart to stock and dispense emergency contraception).

68. *Contra Lee*, 455 U.S. at 261 (“When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity.”), *superseded by statute*, An Act to Make Technical Corrections Relating to the Tax Reform Act of 1986, and For Other Purposes, Pub. L. No. 100-647, § 3217, 102 Stat. 3781 (1988) (codified at 26 U.S.C. § 3127 (2000)) (exempting employers and employees from religious faiths opposed to participation in the Social Security Act program from paying Federal Insurance Contributions Act taxes); *St. Agnes Hosp. v. Riddick*,

Therefore, conscience clauses are reasonably safe from this legal collision.⁶⁹ Conscience clauses, I would like to suggest, may reside in the “room for play in the joints” between the Establishment and Free Exercise Clause articulated by the Supreme Court in *Cutter*.⁷⁰

III. BENEFITS OF CONSCIENCE CLAUSES

Although a majority of this Article deals with the concerns raised by conscience clauses, this Part will deal with some of their benefits.⁷¹ While the concerns raised by conscience clauses are concrete and explicit, the benefits of conscience clauses, with some exceptions, are generally more amorphous and subtle.⁷² Three broad benefits of conscience clauses are: (1) they give more meaning and accountability to medicine and science; (2) they promote a culture of life within society; and (3) they promote a respect for the autonomy of healthcare providers.⁷³

A. Conscience Clauses Give More Meaning and Accountability to Medicine

At the core of the conscience clause debate is a fundamental tension that has existed since the beginning of history—the tension between religion and science or medicine. From Galileo and Copernicus, to Einstein and the present time, science and religion have coexisted in an uneasy relationship, with each fearful of the other encroaching upon its domain. The conscience clause debate can be inelegantly summed up with two questions: (1) Should doctors play God? and (2) Should God play doctor? For proponents of conscience clauses, certain medical procedures offend their morality and religion because they involve acts that they believe only the divine should perform. Many of these procedures fall within the domain of female

748 F.Supp. 319, 327–29 (D. Md. 1990) (considering whether a Catholic hospital was denied residency-training accreditation due to its policy against clinical training in sterilization and abortion procedures).

69. In the final analysis, the constitutional reality is that conscience clauses exist in a gray refuge created by the respective legal ceiling and floor of the Establishment Clause and Free Exercise Clause. Therefore, opponents and advocates of conscience clause reform should not look to the First Amendment as a source of resolution for the concerns raised by conscience clauses.

70. *Cutter*, 544 U.S. at 719.

71. Prior to delving into the benefits of conscience clauses, it is important to note that physicians already have a right to refuse treatment, unless they are under contractual obligation to do otherwise. Thus, conscience clauses or refusal clauses are not entirely radical or novel. However, serious concerns arise when a doctor decides to treat a patient then refuses to perform or inform the patient of certain procedures or treatments.

72. See *infra* Parts IV and V (discussing the concerns raised by conscience clauses).

73. Admittedly, each broad benefit has its faults and shortcomings, which is not discussed in this Part. Parts IV and V explore these faults and shortcomings in greater detail and with consideration for the benefits discussed here in Part III.

reproductive care, such as abortion and artificial insemination, because reproductive healthcare implicates many fundamental notions of life-creation. For these proponents, neither medicine nor science should dominate the sacred realm of morality and religion. Opponents of conscience clauses, however, believe it is wrong for someone else's God to play your doctor without your knowledge or permission. For them, someone else's religion and morality should never encroach upon the sacred realm of science and health.

While some may see medicine/science and religion as mutually exclusive domains, in reality they are connected and—more than merely connected—they sustain one another.⁷⁴ Religion and morality give science and medicine meaningful aims. Science and medicine give religion and morality the means to achieve those aims. Science and the practice of medicine cannot and should not be reduced to a series of emotionally empty, automated, rational actions.⁷⁵ Einstein perhaps said it best when he said,

74. See, e.g., ALBERT EINSTEIN, Symposium, *Science, Philosophy and Religion*, CONFERENCE ON SCIENCE, PHILOSOPHY AND RELIGION IN THEIR RELATION TO THE DEMOCRATIC WAY OF LIFE (1941), reprinted in *IDEAS AND OPINIONS* 41, 45 (Carl Seelig ed., Crown Publishers, Inc. 1954).

For science can only ascertain what *is*, but not what *should be*, and outside of its domain value judgments of all kinds remain necessary. Religion, on the other hand, deals only with evaluations of human thought and action: it cannot justifiably speak of facts and relationships between facts. According to this interpretation the well-known conflicts between religion and science in the past must all be ascribed to a misapprehension of the situation

Id.

75. The turf war between science and religion is historically well documented from the time of the Renaissance to the present in scholarship, art, and pop culture. For example, the fiction of Dan Brown illustrates this tension in contemporary popular culture:

Science may have alleviated the miseries of disease and drudgery and provided an array of gadgetry for our entertainment and convenience, but it has left us in a world without wonder. Our sunsets have been reduced to wavelengths and frequencies. The complexities of the universe have been shredded into mathematical equations. Even our self-worth as human beings has been destroyed. Science proclaims that Planet Earth and its inhabitants are a meaningless speck in the grand scheme. A cosmic accident. . . . Even the technology that promises to unite us, divides us. Each of us is now electronically connected to the globe, and yet we feel utterly alone. . . . Skepticism has become a virtue. Cynicism and demand for proof has become enlightened thought. Is it any wonder that humans now feel more depressed and defeated than they have at any point in human history? Does science hold anything sacred? Science looks for answers by probing our unborn fetuses. Science even presumes to rearrange our own DNA. It shatters God's world into smaller and smaller pieces in quest of meaning . . . and all it finds is more questions.

. . . .

. . . [I]t is the church who points out the fallacy of this reasoning.

And all the while, you proclaim that the church is ignorant. But who is more ignorant? The man who cannot define lightning or the man who does not respect its awesome power?

“[S]cience without religion is lame, religion without science is blind.”⁷⁶

Conscience clauses, despite their worst consequences, have the best of intentions in bridging the meaningful aims of morality and religion with the awesome means of medicine and science. They intend to inject more morality and meaning into medicine. Conscience clauses allow healthcare providers to serve their patients without doing a disservice to themselves. Conscience clauses, in part, raise the level of accountability in the practice of medicine:

Whether or not you believe in God, . . . you must believe this. When we as a species abandon our trust in the power greater than us, we abandon our sense of accountability. Faith . . . *all* faiths . . . are admonitions that there is something we cannot understand, something to which we are accountable . . . With faith we are accountable to ourselves, to each other, and to a higher truth.⁷⁷

What guides a physician when he or she chooses between two professionally acceptable alternatives with diverse consequences for a patient? What guides a physician’s decision when a patient is physically ready but emotionally unready to receive an optional procedure?⁷⁸ (Hopefully, not blind faith in the dogma of medicine.) Good doctors and healthcare providers are trained not only to deal with the physical ailments of their patients, but also the emotional and psychological ones.⁷⁹ Conscience clauses challenge doctors to think harder about the decisions they make, and allow them to stand by tough personal and professional decisions without fear of retribution. Conscience clauses, in part, help make medicine not just a collection of scientific procedures, but a collective service toward meaningful aims. After all, the highest form of medicine is guided not by a desire for profit or prestige, but by our noblest ideals to heal and do no harm. And so one of the broad general benefits of conscience clauses, intended or not, is that they give greater meaning and moral accountability to the practice of medicine.

DAN BROWN, *ANGELS & DEMONS* 474–75, 478 (Pocket Books 2000). Arguably, the appeal of such works lies in the powerful social forces of science and religion that are at the bedrock of human communities.

76. EINSTEIN, *supra* note 74, at 46.

77. BROWN, *supra* note 75, at 478–79.

78. For each of these precarious dilemmas faced by the physician, the patient faces similar dilemmas on the other side of the proverbial coin that is the doctor-patient relationship.

79. The modern Hippocratic Oath that many doctors recite upon graduation from medical school echoes this very principle. Louis Lasagna, *The Hippocratic Oath—Modern Version* (1964), *available at* http://www.pbs.org/wgbh/nova/doctors/oath_modern.html.

B. Conscience Clauses Promote a Culture of Life

One of the most obvious (and controversial) benefits of conscience clauses is that they promote a culture of life.⁸⁰ Assuming that life and living are good, conscience clauses allow certain healthcare providers an opportunity to remain faithful to their profession while furthering the greater good as they see fit, albeit with consequences. Although there are disputes about the definition of life, there is little dispute that in the area of female reproductive healthcare, concepts of life are in the forefront—whether it be the life of the woman, the life of the mother-to-be, or the potential life growing in her womb. Conscience clauses and analogous institutional provisions challenge healthcare providers and their patients to think harder about their already hard decisions concerning life and health. Conscience clauses create a legal means for healthcare providers to promote that goodness and preciousness. Admittedly, there is a fine line between passive promotion and active proselytizing—the former is a good externality, and the latter is a good externality taken to a bad extreme because, while the former tends to respect differences, the latter does not. Regardless, conscience clauses at their best promote the idea that life is valuable and precious, and so healthcare decisions about them must be made with the utmost compassion and care.⁸¹

C. Conscience Clauses Protect the Autonomy of Healthcare Providers

One of the clearer and more concrete benefits of conscience clauses is that they protect the autonomy of healthcare providers, namely physicians. Protecting the autonomy of physicians and other healthcare providers is important both to medicine as a profession and to us as a society.⁸²

80. What exactly does “culture of life” mean? Many critics argue that proponents of conscience clauses and other pro-life advocates are primarily concerned with life before birth and not life after birth. They often argue that pro-life advocates focus on a fetal-centric notion of life while subordinating the life a woman and the life of a child. See Frances Kissling, *Is There Life After Roe?: How to Think About the Fetus*, CONSCIENCE: THE NEWSJOURNAL OF CATH. OPINION, Winter, 2004-2005, http://www.catholicsforchoice.org/conscience/archives/c2004win_lifeafterroe.asp (stating that those opposed to abortion hold a monolithic view regarding the value of the fetus).

81. The Hippocratic Oath further reinforces this approach. See generally Hippocratic Oath—Modern Version, *supra* note 79 (“Most especially must I tread with care in matters of life and death. . . . Above all, I must not play at God.”).

82. See generally Edmund D. Pellegrino, *The Physician’s Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221, 228 (2002) (highlighting the important moral benefits and challenges of the physician’s conscience in the practice of medicine).

1. Freedom of Choice Is for Everyone, Even Physicians

By protecting the autonomy of physicians, conscience clauses safeguard the freedom of choice for all citizens in a democratic society. First, a person's choice to enter the healthcare profession should not mean a restriction on his or her freedom as a citizen of this country. Julie Cantor and Ken Baum, two bioethical scholars, examined conscience clauses in the context of pharmacists refusing to administer emergency contraception and concluded in part that conscience clauses are rooted in emblematic characteristics of a free society. "[T]he right to refuse to participate in acts that conflict with personal ethical, moral, or religious convictions is accepted as an essential element of a democratic society."⁸³ (But, of course, a healthcare professional's actions or inactions will have consequences.) Conscience clauses codify this notion into law. Choosing to enter the healthcare profession does not mean choosing to abdicate one's moral judgment, nor does it mean choosing to have less occupational freedom. "Society does not require professionals to abandon their morals. Lawyers, for example, choose clients and issues to represent. Choice is also the norm in the health care setting. Except in emergency departments, physicians may select their patients and procedures."⁸⁴ This autonomy applies to all physicians; no special exception should be made for those in the area of female reproductive care. As noted by Cantor and Baum, "[t]he reproductive-rights movement was built on the ideal of personal choice; denying choice for pharmacists in matters of reproductive rights and abortion seems ironic."⁸⁵ The same logic applies to physicians.

Second, conscience clauses ensure that the independent professional judgment of physicians and other healthcare providers remains in all areas of healthcare, including female reproductive healthcare. Doctors are professionals who have had years of schooling and training. Their patients rely on their independent professional judgment on matters of healthcare. Like pharmacists, doctors "are not automatons completing tasks; they are integral members of the health care team. Thus, it seems inappropriate and condescending to question" or restrict a physician's right to exercise his or her independent professional judgment by choosing to speak or remain silent about certain procedures when treating a patient.⁸⁶ In the absence of conscience clauses and the presence of institutional mandates, physicians and

83. Julie Cantor & Ken Baum, *The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW ENG. J. MED. 2008, 2009 (2004).

84. *Id.*

85. *Id.*

86. *Id.* at 2008–09.

other healthcare providers may be conscripted into offering alternatives against their better judgment.⁸⁷ Admittedly, physicians owe their patients a duty of care, but that does not mean a blind adherence to medical catechism. The same can be said of most healthcare providers in most areas of healthcare, not just female reproductive health.

2. A Matter of Labor Economics

Conscience clauses may also help to ensure an adequate supply of physicians in the area of female reproductive health. If all medical students thinking about entering the area of female reproductive health were forced to perform procedures they found morally objectionable, surely a number of them would avoid that practice and enter another.⁸⁸ In a broader sense, if all healthcare providers were mandated to perform procedures they found morally objectionable, a significant number of people considering the vocation might completely opt out of that labor market and enter another specialty. Conscience clauses, by protecting the autonomy of healthcare providers, prevent a potential exodus of qualified people from the area of female reproductive health.

IV. PROBLEMATIC ISSUES AND CONCERNS OF CONSCIENCE CLAUSES

Despite their best intentions and benefits, conscience clauses raise grave concerns and problems in the area of female reproductive healthcare. What is a doctor who objects to emergency contraception to do when she is treating a rape victim? What type of care should a patient expect to receive when she sees a doctor who opposes certain standard procedures in female reproductive health? What is expected of a doctor or patient at a Catholic hospital while they are providing treatment or being treated, respectively? When does conscientious objection become unconscionably objectionable? These questions and many more are raised by the specter of conscience clauses in healthcare—especially female reproductive healthcare. These issues arise from a fundamental tension between respecting the healthcare provider's

87. Of course, this line of argument can be made against conscience clauses themselves, especially when an institution denies a provider the option to offer certain services to a patient. *See infra* Parts IV and V.

88. In the market for labor, as in the market for goods, if a demanded product becomes undesirable for one reason or another (i.e., higher prices) the consumer will avoid that good and choose a comparable substitute. For example, a sudden rise in the costs of maple syrup may lead consumers to switch to honey as a substitute for maple syrup. Likewise, in our case, a resident training to become a pediatrician may choose to avoid that specialty altogether should it become less desirable and a comparable substitute exists.

conscience and honoring the patient's rights. These two positions are not, however, completely in opposition or inconsistent. In many circumstances, a fine balance can be reached, but problems arise when the middle road is not taken and the patient's or the provider's concerns are cast aside.⁸⁹

This Part of the Article will address some of the more critical concerns raised by conscience clauses. It will start with a categorization of conscience clause regimes, then delve into the specific problems and concerns they raise.

A. A Menu of Conscience Clause Regimes

Two fundamental problematic issues raised by conscience clauses are notice and access. Inherent to these problems are sub-issues concerning consent, referrals, and alternatives. For each of the fundamental issues there are various conscience clause permutations featuring varying types of institutional involvement. The following chart provides a menu of the key regimes:

Notice & Referral	Access & Alternatives	Institutional Involvement
1. No notice	1. Alternative provider within an institution	1. No institutional involvement
2. Active notice	2. Alternative provider within X miles	2. Internal regulation
3. Passive notice	3. Alternative provider beyond X miles	3. State legislation
4. Notice with referral		4. Federal legislation
5. Notice without referral		

Under the "Notice & Referral" column, the terms are defined as follows: (1) "No notice" means that the patient is completely unaware that the provider conscientiously objects to certain procedures or treatments; (2)

89. Although a fine balance can be reached on contentious issues concerning conscience clauses and female reproductive healthcare, these workable solutions usually leave both sides of the issue dissatisfied (which is perhaps a good sign). Moreover, these compromised solutions may be viewed by some on both sides as unprincipled, temporary fixes. This perception is probably partly accurate. Principled, consistent positions would be ideal in a perfect world; however, the lives of real women are harmed in the pursuit of those quixotic positions. Therefore, in the interim, we should pursue compromised and practical solutions because the price of being principled or practical on these issues may mean the difference between healing or harming, living or dying. See WILLIAM SHAKESPEARE, KING RICHARD III act 5, sc. 3, lines 193–195 (Richard White ed., Houghton Mifflin 1923) ("My conscience hath a thousand several tongues,/ And every tongue brings in a several tale,/ And every tale condemns me for a villain.").

“Active notice” means that an individual informs the patient that the provider conscientiously objects to certain procedures and may inform the patient of said procedures; (3) “Passive notice” means that the institution informs the patient of the provider’s conscientious objection to certain services in writing via a sign or form; (4) “Notice with referral” means that the institution or provider refers—directly or indirectly—the patient to an alternative institution or provider; finally, (5) “Notice without referral” means that the institution or the provider offers no alternatives or information about alternatives to the patient.

Under the “Access & Alternatives” column, the terms are self-explanatory. “X” will be a variable representing the number of miles beyond which travel would become unduly burdensome to the patient.

The “Institutional Involvement” column addresses the various types and levels of institutional involvement in a provider’s decision to speak or remain silent about certain services on moral or religious grounds.⁹⁰ Under that column, the terms are defined as follows: (1) “No institutional involvement” means that the provider is conscientiously objecting to certain procedures of their own volition without the influence of any direct institutional, state, or federal regulation; (2) “Internal regulation” refers to internal codes and guidelines issued by institutions, binding on providers who work at those institutions; finally, (3) “State legislation” and “Federal legislation” are self-explanatory.

B. A Problem of Notice and Consent

One of the fundamental concerns raised by conscience clauses is the serious implications that they have for notice and consent. Much of this concern is rooted in the asymmetrical knowledge between the provider and the patient. There are over a hundred medical colleges and hundreds of other institutions that teach people to be good doctors, pharmacists, and nurses, but there is not a single school that teaches people to be good patients.⁹¹ Patients rely on the specialized, objective, and complete knowledge of their healthcare provider when they seek healthcare treatment. When providers use the shield of conscience clauses to remain silent on certain treatments, patients

90. The varying types of institutional involvement are not mutually exclusive.

91. American Association of Medical Colleges, <http://www.aamc.org/medicalschoools.htm> (last visited Aug. 31, 2006) (stating there are 125 accredited medical schools); American Association of Colleges of Pharmacy, U.S. Colleges and Schools of Pharmacy, <http://www.aacp.org/issi/membership/schools.asp?action=view&TRACKID=&wh=A&CID=593&DID=4224> (last visited Sept. 28, 2006) (listing nearly 100 pharmacy schools in the United States and Puerto Rico); Nursing Schools.com, The Nursing School Directory, <http://www.nursingschools.com> (last visited Sept. 25, 2006) (indicating the existence of 1,972 nursing schools).

unknowingly receive incomplete knowledge regarding their healthcare.

Notice, or the lack thereof, is one of the main concerns raised by conscience clauses. How is a woman supposed to know that she is receiving incomplete knowledge if she is not given notice by her doctor who opposes certain procedures and treatments? How can she be sure that her provider is giving her the best treatment possible when she is unaware of the fact that certain relevant and permissible alternatives are not being offered to her? The patient's choice regarding the type of healthcare she should receive should not be subordinated. In healthcare, choice matters a great deal. Although the autonomy and rights of the provider are important, so are the autonomy and rights of the patient, and those rights of the patient are infringed upon when notice is not given by providers who refuse to perform certain services.⁹²

Related to the issue of notice is the issue of consent. How can a patient grant "informed consent" for a treatment when she does not receive all of the relevant information? Informed consent is "[a] person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives."⁹³ One, of course, could argue that the information left out by the conscience-clause-shielded physician is not necessary to make an informed decision, but shouldn't the patient decide what information is necessary or not? One could also argue that the patient could sign a consent-waiver form prior to receiving treatment to avoid this concern completely, but is the patient informed enough to know what she is waiving? And, on policy grounds, is this something we want people to contractually waive?⁹⁴

92. See generally CATHOLICS FOR A FREE CHOICE, YOU CAN'T ALWAYS GET WHAT YOU NEED: A WOMAN'S GUIDE TO CATHOLIC HEALTH CARE 2-25 (2004), available at <http://www.catholicsforchoice.org/topics/healthcare/documents/2003youcantalwaysgetwhatyouneed.pdf> (reporting on restrictions to healthcare for both patients and clinicians under the Ethical and Religious Directives for Catholic Health Care Services).

93. BLACK'S LAW DICTIONARY 323 (8th ed. 2004); see also *ZeBarth v. Swedish Hosp. Med. Ctr.*, 499 P.2d 1, 8 (Wash. 1972):

Informed consent, therefore, is the name for a general principle of law that a physician has a duty to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care, would disclose to his patient as to whatever grave risks of injury may be incurred from a proposed course of treatment so that a patient, exercising ordinary care for his own welfare, and faced with a choice of undergoing the proposed treatment, or alternative treatment, or none at all, can, in reaching a decision, intelligently exercise his judgment by reasonably balancing the probable risks against the probable benefits. Failure to impart such information to the patient is by the great weight of authority deemed negligence rendering the physician liable for injuries proximately caused thereby.

Id. (citation omitted).

94. Consent may be a swift way to right many offenses, but as a society there are certain things we believe people should not be able to grant consent for, such as murder, slavery, assisted suicide, and other issues that concern the human body. Therefore, consenting to waive informed-consent should be

In the healthcare market, like other marketplaces, there is asymmetrical information between the supplier/provider and the buyer/patient. However, unlike other marketplaces, the information gap cannot be readily narrowed, and comparison shopping cannot be readily done despite advances in information technology.⁹⁵ Moreover, this information gap coupled with the lack of notice and informed consent can have serious consequences; it could literally be a matter of life or death.

C. A Problem of Access and Alternatives

Another major concern raised by conscience clauses is the problem of access and alternatives.⁹⁶ Even if a patient is given proper notice and information, they sometimes lack feasible access to alternative healthcare providers.⁹⁷ This is especially true in single-hospital rural towns or for women who are uninsured.⁹⁸ Take the extreme case in the State of Mississippi—in the entire state there is only one healthcare clinic that provides abortions.⁹⁹

The United States is slowly turning into two places when it comes to abortion. In one, easy access to the procedure is being eroded by regulations, while conservative legislators dream up new

discouraged as a quick fix to this concern. LEO KATZ, *ILL-GOTTEN GAINS: EVASION, BLACKMAIL, FRAUD, AND KINDRED PUZZLES OF THE LAW* 194 (1996); see also Tresa Baldas, *Fighting Refusal to Treat*, NAT'L L. J., Feb. 7, 2005, at 1:

The ABA opposes governmental actions that interfere with patients' abilities to receive from their health care providers, in a timely way, relevant information to make informed health care decisions . . . It's critical . . . to ensure that the doctrine of informed consent, which has both legal and ethical underpinnings, remains effective and strong.

Id. (quoting Robyn Shapiro, Am. Bar Ass'n Section of Individual Rights & Responsibilities).

95. How is a patient to compare the quality of Doctor X to Doctor Y like a laptop consumer is to compare laptop X to laptop Y? Should the patient simply assume the risk? It seems perverse to transplant the principle of *caveat emptor* from the marketplace of goods to healthcare. See generally Elliott K. Wicks & Jack A. Meyer, *Making Report Cards Work*, 18 HEALTH AFF. 152, 153–155 (1999) (discussing some of the difficulties in measuring quality in healthcare).

96. See Julia Lichtman, Note, *Restrictive State Abortion Laws: Today's Most Powerful Conscience Clauses*, 10 GEO. J. POVERTY LAW & POL'Y 345, 351–357 (2003) (discussing the problems of access to female reproductive healthcare for poor and rural women).

97. *Id.*

98. See *A Review of Hospital Billing and Collection Practices: Hearing Before the Subcomm. on Oversight & Investigations of the H. Comm. on Energy and Commerce*, 108th Cong. 31 (2004) (statement of Mark Rukavina, Executive Director, The Access Project) (detailing, in part, the plight of the uninsured in receiving access to healthcare).

99. *Frontline: The Last Abortion Clinic* (PBS television broadcast Nov. 10, 2005), available at <http://www.pbs.org/wgbh/pages/frontline/clinic/etc/script.html> (documenting the anti-abortion movement in the United States).

restrictions, waiting periods, and consent laws. In the other, abortion is accessible, inexpensive—often government-subsidized—and safeguarded by powerful interest groups.¹⁰⁰

The uneven realities of access and alternatives raise many concerns for female healthcare: What is a woman seeking an emergency, life-saving abortion to do when her local hospital is a Catholic hospital that does not perform abortions, and the next nearest hospital is more than 200 miles away?¹⁰¹ What if the only pharmacy in town is staffed on Tuesdays by a man who does not believe in dispensing emergency contraception?¹⁰² While the concerns of access and alternatives for rural and poor populations are emblematic of American healthcare in general, these concerns of adequate access and alternatives to female reproductive care have been uniquely exacerbated, in part, by the proliferation of Catholic hospitals and the reemergence of conscience clauses.

1. The Prevalence and Proliferation of Catholic Hospitals

Catholic-affiliated or Catholic-operated hospitals make up a significant percentage of hospitals in the United States. The numbers and facts speak for themselves:

The Catholic health care system is the largest private, nonprofit provider of health care in the United States. More than 11% of the nation's community hospitals are Catholic, accounting for just over 16% of all community hospital beds, according to the Catholic Health Association. The Catholic health care industry is comprised of 618 Catholic hospitals, 61 Catholic health care systems, 382 Catholic nursing homes, 260 sponsors and over 550 related organizations such as hospices, outpatient service centers and physician groups. . . .

Many of the nation's largest hospital systems are Catholic, including nine of the 20 largest systems. The \$6-billion Ascension Health System, which is comprised of 65 hospitals, is the nation's largest nonprofit hospital system.¹⁰³

100. Ryan Lizza, *The Abortion Capital of America*, N.Y. MAG., Dec. 12, 2005, at 38, 40.

101. The lack of available abortion providers has created a "new underground railroad" for women seeking the service, forcing them to travel hundreds and sometimes thousands of miles to find a willing provider. Debbie Nathan, *The New Underground Railroad*, N.Y. MAG., Dec. 12, 2005, at 42.

102. See Clift, *supra* note 28 (noting that "in small-town America there is often only one pharmacy in town").

103. CATHOLICS FOR A FREE CHOICE, MERGER TRENDS 2001: REPRODUCTIVE HEALTH CARE IN

This would be of little interest or importance if it were not for the fact that . . . a full range of reproductive health care services are routinely not offered at Catholic facilities. This especially impacts people living in areas where the only health facility is a Catholic one, where it is not obvious that a local facility is Catholic and low-income people . . . routinely rely on emergency rooms at charitable hospitals for primary health care.¹⁰⁴

These statistics, coupled with their continuing growth via mergers and joint ventures, help solidify the dominance of Catholic hospitals on the American healthcare landscape.¹⁰⁵ Catholic hospitals and their affiliates are normally regulated by the Ethical and Religious Directives for Catholic Health Care Services, issued by the U.S. Conference of Catholic Bishops.¹⁰⁶ The Directives ban abortion under any circumstance and severely restrict or ban outright certain generally accepted treatments and procedures in female reproductive health.¹⁰⁷ This means that Catholic healthcare institutions and

CATHOLIC SETTINGS 4 (2002), *available at*

<http://www.catholicsforchoice.org/topics/healthcare/keypubs.asp>. “A health care system is a grouping of one or more hospitals plus ancillary services such as outpatient clinics, social service centers, and continuing care facilities.” CATHOLICS FOR A FREE CHOICE, THE FACTS ABOUT CATHOLIC HEALTH CARE IN THE UNITED STATES, CATHOLIC HEALTH CARE UPDATE 1 (2005), *available at* http://www.catholicsforchoice.org/topics/healthcare/documents/2005factsaboutcatholichealthcare_000.pdf.

104. CATHOLIC HEALTH CARE UPDATE, *supra* note 103, at 1.

105. *See generally* Monica Sloboda, Recent Development, *The High Cost of Merging With a Religiously Controlled Hospital*, 16 BERKELEY WOMEN’S L.J. 140 (2001) (discussing the consequences of mergers between Catholic hospitals and secular healthcare institutions); *see also* CATHOLICS FOR A FREE CHOICE, MERGER TRENDS 2001, *supra* note 103, at 11 (noting the large number of mergers between Catholic and non-Catholic hospitals during the 1990s, with a total of 159 mergers between 1990 and 2000). Notably, under many of these transactions, post-merger, both institutions are frequently bound by the regulations of the Catholic hospital, regardless of whether the Catholic institution is the buyer or the target. *Id.* at 12.

106. U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 2 (4th ed. 2001) (noting that the Directives “express the Church’s moral teaching” and “provide standards and guidance[,]” “are concerned primarily with institutionally based Catholic health care services[,]” and “address the sponsors, trustees, administrators, chaplains, physicians, health care personnel, and patients or residents of these institutions and services”).

107. *See id.* at 26–28 (outlining the Catholic Church’s official position on artificial fertilization, abortion, pre-natal diagnosis, non-therapeutic experiments on living embryos, contraception, and sterilization).

Abortion (that is, the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus) is never permitted. Every procedure whose sole immediate effect is the termination of pregnancy before viability is an abortion, which, in its moral context, includes the interval between conception and implantation of the embryo. Catholic health care institutions are not to provide abortion services, even based upon the principle of material cooperation. In this context, Catholic health care institutions need to be concerned about the danger of scandal in any association with abortion providers.

their affiliates often ban those services and also impose an institutional gag order on their employees regarding certain services in the area of female healthcare.¹⁰⁸

Because of their sheer size, Catholic institutions are the only available alternative for women in some localities. “In 1999, there were ninety-one counties in the United States where a Catholic institution was the sole hospital provider.”¹⁰⁹ For women with resources, they can commute to a different location for the care that they desire, albeit sometimes at great lengths and great costs, often from rural towns in more conservative regions to New York City.¹¹⁰ For poor women, they are simply left to the mercy of the choice they have locally, or have not.¹¹¹

2. The Reemergence of Conscience Clauses

The reemergence of conscience clauses, as previously discussed in Part I, coupled with the prevalence of Catholic healthcare institutions, has heightened the concerns about access and alternatives to female reproductive healthcare. Federal and state conscience clauses have explicitly made it virtually impossible for government agencies to mandate the offering of certain female reproductive treatments and procedures.¹¹² Less stringent means, such as offering government subsidies and incentives to encourage the offering of certain procedures, have also been explicitly banned by several federal and state conscience clauses. Furthermore, the states that have passed broad conscience clauses are usually states that have strong pro-life persuasions in their population and governing bodies.¹¹³ As a result,

Id. at 26.

108. See *60 Minutes: God, Women and Medicine* (CBS television broadcast Dec. 10, 2000) (transcript on file with the Vermont Law Review) (reporting on the serious implications of Catholic hospitals on female reproductive healthcare).

109. Sloboda, *supra* note 105, at 146.

110. Nathan, *supra* note 101, at 44; see generally Lizza, *supra* note 100 (noting that women historically traveled to New York City to obtain abortions unavailable in their home states—and continue to do so from Pennsylvania, Massachusetts, and other states).

111. See LOIS UTTLEY & RONNIE PAWELKO, MERGERWATCH, NO STRINGS ATTACHED: PUBLIC FUNDING OF RELIGIOUSLY-SPONSORED HOSPITALS IN THE UNITED STATES 26, 31 (2002), available at http://www.mergerwatch.org/pdfs/bp_no_strings.pdf (noting the disproportionate effect that religious restrictions on healthcare have on poor and rural women who may have little access to alternative care systems); see also Martha Minow, *Partners, Not Rivals?: Redrawing the Lines Between Public and Private, Non-Profit and Profit, and Secular and Religious*, 80 B.U. L. REV. 1061, 1071 (2000) (“In small cities and rural areas . . . mergers reduce or even eliminate choice regarding health care providers.”).

112. See, e.g., Balanced Budget Act of 1997, 42 U.S.C. § 1395w-22(j)(3)(B) (2000) (exhibiting the general scope and language of conscience clauses).

113. See generally Jed Miller, Note, *The Unconscionability of Conscience Clauses: Pharmacists’ Consciences and Women’s Access to Contraception*, 16 HEALTH MATRIX 237, 239–45 (2006) (recounting pharmacists’ attitudes and decisions about dispensing contraception and reviewing conscience clauses in

avenues of possible alternatives for women in those states are often foreclosed or difficult to navigate.

D. A Problem of Emergency Care

Perhaps the most troubling implications of conscience clauses arise in the area of emergency care. During emergencies, patients are usually at their most vulnerable, often unconscious, traumatized, or near death. A doctor who morally objects to possibly life-saving procedures¹¹⁴ without proper regard for the patient's wishes and expectations could cause serious harm or death. Similarly, an institution that forbids a doctor from taking certain emergency measures could seriously endanger the life of a patient. Take the case of Kathleen Hutchins:

Kathleen Hutchins, a Medicaid patient of Manchester, New Hampshire, who was denied an emergency termination of her fourteen-week pregnancy at Elliot Hospital when her amniotic sac broke prematurely. Elliot Hospital had previously merged with the only other hospital in Manchester, Catholic Medical Center. As a condition of the merger agreement, Elliot Hospital had agreed to ban abortions except to save a woman's life. Despite the warnings of Hutchins' physician, Dr. Wayne Goldner, that if the procedure was not performed she could face a lethal infection, administrators at Elliot Hospital told Dr. Goldner that he could not terminate Hutchins' pregnancy at Elliot Hospital unless her life was at immediate risk.¹¹⁵

Ultimately, Dr. Goldner hired a cab to take Ms. Hutchins eighty miles to the nearest hospital that would treat her.¹¹⁶ Perhaps more troubling is the fact that most conscience clauses would protect the hospital from any liability under similar circumstances.

different parts of the country); *see also* Editorial, *Raising Abortion Risks*, ATLANTA J.-CONST., Mar. 6, 2006, at A12 (responding to three bills that restrict abortion passed in a one-week period by a Republican state senate in Georgia, including one that established conscience clauses for pharmacists).

114. Some people see female reproductive healthcare procedures such as abortion as purely elective, but for some patients abortion is not a choice, but a medical necessity. These procedures can sometimes mean the difference between life and death, and many women—even when given the choice—find it an incredibly difficult decision to make. *See* President William J. Clinton, Remarks By the President on House Resolution 1833 (Apr. 10, 1996) (transcript available at <http://www.clintonfoundation.org/legacy/041096-speech-by-president-on-hr183396-speech-by-veto.htm>) (addressing his veto of an abortion restriction, accompanied by five women who had undergone life-saving female reproductive healthcare procedures that would have been banned by the bill).

115. Sloboda, *supra* note 105, at 147.

116. UTTLEY & PAWELKO, *supra* note 111, at 26.

In the case of emergencies, it is not hard to argue that there needs to be a better balance between the rights of the doctor and the rights of the patient when it comes to the use of conscience clauses.

E. A Problem of Lemons—Higher Aggregate Costs Due to Bad Information

Another major concern raised by the specter of conscience clauses is that, in the long run, conscience clauses may raise the costs of healthcare in general, and specifically of female reproductive healthcare. Furthermore, conscience clauses may unintentionally harm the very doctors (and providers) that they were intended to protect. The bedrock of these economic consequences is the widening of the information gap between patients and doctors caused by conscience clauses, creating what Nobel Prize winning economist George Akerlof termed a market for lemons, in the marketplace for female reproductive healthcare.¹¹⁷

First, as previously alluded, there already exists a huge information gap between the doctor and the patient due simply to the specialized nature of medicine. Conscience clauses widen this information gap by permitting doctors to remain silent, without consequence, about certain treatments generally accepted in medicine. In the long run, as patients become more aware of this practice in medicine, especially in female reproductive medicine, patients will become more vigilant in seeking information about their treatments. This could lead to longer visits to their doctors and/or multiple visits to various doctors to ascertain that they are receiving complete and unfiltered information from their healthcare providers. Ultimately, this pursuit for more and better information on the aggregate will be costly to the patient and the provider both in terms of time and money.¹¹⁸

Second, given the information asymmetry¹¹⁹ and quality uncertainty¹²⁰

117. George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q. J. OF ECON. 488, 490 (1970) (discussing the detrimental impact of asymmetrical information and quality uncertainty in a marketplace).

118. See Jonathan Levin, *Information and the Market for Lemons*, 32 RAND J. OF ECON. 657, 657 (2001).

Better information on the selling side worsens the “buyer’s curse,” thus lowering demand, but may shift supply as well. Whether trade increases or decreases depends on the relative sizes of these effects. A characterization is given. On the other hand, improving the buyer’s information—i.e., making private information public—unambiguously improves trade so long as market demand is downward sloping.

Id.

119. See David Dranove et al., *Is More Information Better?: The Effects of “Report Cards” on Health Care Providers*, 111 J. POL. ECON. 555, 581 (2003) (highlighting the information asymmetry in healthcare between providers and patients).

120. How does a lay person or even an expert go about assessing the quality of healthcare? This is

about their healthcare provider, patients (assuming that they have a choice) will not be willing to pay top dollar for healthcare services. In the car market, if buyers cannot distinguish between a good used car and a lemon, they will likely infer the value of the car in general is an amount between the value of a good car and a lemon.¹²¹ In the healthcare market, if a patient is unable to tell which doctor is willing to consider and inform her of all available alternatives, she is likely to infer the value of the doctor as an amount between the value of a “good doctor” and a “lemon doctor.” In turn, this may drive down the overall wage of all doctors in the area of female reproductive healthcare.

Third, in response to lower wages, certain doctors who do not oppose any permissible treatments will want to signal their practice philosophy to potential patients to differentiate and shield themselves from the lower wages.¹²² The signaling mechanism, which will come in the form of a notice of some sort, will allow the patient-to-be to readily distinguish between a doctor who morally objects to certain services and one who does not, thereby leading to a bifurcated marketplace within female reproductive healthcare, like the automobile marketplace with a new car market and an used car market.

In the automobile market, people (who have the resources) prefer to purchase new cars over used cars, due in large part to asymmetrical information. The result is greater demand for new cars and higher profit margins for new car dealers. “[A] major reason as to why people preferred to purchase new cars rather than used cars was their suspicion of the motives of the sellers of used cars. . . . [T]he informational advantage of sellers of used cars over buyers of new cars[] would force car buyers into the new car market”¹²³ Theoretically, a similar trend would also occur in the healthcare market, assuming that resources and access to both markets are not an issue. After all, if a patient could afford and access the fully-loaded, Rolls Royce equivalent of healthcare treatments, why would they settle for anything less?¹²⁴ Ultimately, patients would be driven into the market of

a fundamental difficulty in healthcare today made only more difficult by the implications of conscience clauses. See Wicks & Meyer, *supra* note 95, at 152–55 (discussing some of the difficulties in measuring quality in healthcare).

121. Akerlof, *supra* note 117, at 489.

122. See Arnold M. Epstein et al., *Paying Physicians for High-Quality Care*, 350 NEW ENG. J. MED. 406, 406–10 (2004) (discussing the use of financial incentives for physicians to generate higher quality healthcare).

123. George A. Akerlof, *Writing the “The Market for ‘Lemons’”: A Personal and Interpretative Essay*, NOBELPRIZE.ORG, Nov. 14, 2003, <http://nobelprize.org/nobel-prizes/economics/articles/akerlof/index.html>.

124. See Amy Zipkin, *The Concierge Doctor is Available (at a Price)*, N.Y. TIMES, July 31, 2005, § 3 at 6 (reporting on the willingness of affluent patients to pay top-dollar for premium healthcare service).

doctors who do not morally object to any permissible medical treatments; thereby giving those doctors higher wages than their counterparts who morally object to certain treatments.¹²⁵

Therefore, in the long run, conscience clauses may inadvertently hurt the very people that they intend to protect, and raise serious economic implications for the costs of healthcare. This will be felt most acutely in the area of women's health since conscience clauses are most prevalently invoked in this area of medicine.

V. TOWARD IMPERFECT PRACTICAL SOLUTIONS

The previous Part discussed some of the crucial problems and concerns raised by conscience clauses; this Part will provide solutions for those concerns. None of these solutions are silver bullets for the problematic issues raised by conscience clauses; instead they are practical and political compromises that have a legitimate chance of being implemented—albeit with some inevitable protests.¹²⁶ These solutions can be implemented preferably via legislation or through voluntary adoption by the institutions or providers themselves.¹²⁷ Regardless, these politically viable solutions are needed because of the grave concerns raised by conscience clauses, and the lack of remedies from traditional sources of social correction such as tort law and market competition.¹²⁸

125. See generally Debra A. Draper & Gary Claxto, *Managed Care Redux: Health Plans Shift Responsibilities to Consumers*, at 1, 1–4 (Center for Studying Health System Change, Issue Brief No. 79, Mar. 2004), <http://www.hschange.org/CONTENT/666/666.pdf> (discussing how consumer choice may shape the future of the healthcare landscape in America).

126. Most, if not all, of the proposed solutions are morally murky and arguably inconsistent with the principles of both sides of the conscience clause debate. The proposed solutions are not intended to fully satisfy the wants of both sides; instead they respect the principles of both sides in reaching practical third-way solutions. See generally KATZ, *supra* note 94, at 1–132 (discussing how stratagems can be developed to create for uncomfortable, but acceptable, solutions).

127. Many of the proposed solutions, if implemented through legislation, may implicate governmental regulation of commercial speech. Nonetheless, these solutions can be narrowly tailored to pass constitutional muster regarding compelled commercial free speech. In fact, even absent constitutional restrictions, it would probably be best for the solutions to be narrowly tailored so as to allow for greater compromise and acceptance. Cf. *Pac. Gas & Elec. Co. v. Pub. Utils. Comm'n of Cal.*, 475 U.S. 1, 20–21 (1986) (declaring unconstitutional a regulation requiring a utility company to include pamphlets prepared by a public interest group with its billing statements because the order was not narrowly tailored to further a compelling state interest).

128. Tort law has traditionally been a source of compensation and deterrence for harmful acts, but it offers little solace to patients who are harmed by providers who fail to treat them properly because the providers morally object to certain procedures/treatments. Tort law is problematic and inadequate as a source of redress because: (1) conscience clauses exist, in part, to shield providers from these liabilities; and (2) tort law normally requires actual harm *before* a prima facie claim can be established, and so it requires patients to pay a very steep price in order to change bad policy.

Although issues concerning life and choice inherent in conscience clauses often appear to be black and white and without compromise, there exists common ground when parties transcend the sometimes narrow real estate of their respective positions. First, both sides can (perhaps reluctantly) agree that one of the benefits of legalized abortion is that women no longer have to turn to dangerous means in their own homes, the backs of vans, or back alleys for the procedure.¹²⁹ For that reason alone, abortion should be legal and accessible, but also rare.¹³⁰ Furthermore, perhaps both sides can also agree that life before birth is just as important as life after birth—both the life of the woman as well as the life of the fetus. For this reason, while it is important to respect the rights of the doctor, it is equally important to respect the well-being of the patient. This is the common ground from which the following proposed solutions spring forth.

A. Notice to the Institution

One of the critical concerns raised by conscience clauses is lack of notice. Not all healthcare providers disclose to their patients that they morally object to certain treatments and procedures. As previously discussed, this legally permissible non-disclosure can have some serious consequences. In order to begin to address this problem, healthcare providers must give notice to their institutions if they morally object to certain treatments and procedures. This is especially important if the provider works at a secular facility where there are no institutional bars to medical services on moral or religious grounds.¹³¹

By giving notice to the institution, the provider—particularly one that works at a secular institution—allows the institution to take remedial measures to address the potential concerns of the patient. For example, a

Market competition can sometimes serve as a source of correction for harmful policies, but it offers little to address the problematic issues raised by conscience clauses, given the nature of the healthcare market. The healthcare market lacks the conditions essential to a good competitive marketplace. For example, it has serious information deficiencies and it lacks an adequately sensitive demand curve. Given the healthcare market's dearth of key competitive marketplace ingredients, it serves as a poor corrective mechanism in the short term. *See supra* Part IV.E.

129. *See generally* President William J. Clinton, Videotaped Remarks by the President on the 25th Anniversary of Roe v. Wade, 1 PUB. PAPERS 108 (Jan. 22, 1998), *available at* <http://www.clintonfoundation.org/legacy/012298-speech-by-president-on-the25th-annv-of-roe-v-wade.htm> (noting legalized abortion's "major positive impact on the health and well-being of American women" through the near-elimination of the "dangerous, clandestine conditions" that harmed women who sought illegal abortions).

130. *Id.*

131. Institutional notice at a secular facility is especially important because patients are less likely to expect providers there to object to certain treatments or procedures on moral or religious grounds.

municipal hospital that is aware of a doctor who morally objects to oral contraception may offer a patient multiple-provider care in the form of access to a resident who does not share those objections. Or a pharmacist who morally objects to dispensing emergency contraception can be placed on shifts with a pharmacist who does not, so that emergency contraception is always available to anyone who needs it.

B. Mandatory Passive Notice to Patients

In order to better balance the rights of the patient and the provider, notice to the patient is necessary. While most institutions and providers who morally object to certain procedures oppose compelled, explicit disclosure or notice on their part, they may be more receptive toward passive notice.¹³² Furthermore, passive notice may alleviate some of the worries of conscience clause opponents, while making it more politically attractive to lawmakers by allowing them to appeal to a larger portion of their constituency.¹³³

Passive notice means that patients will be informed of a provider or institution's moral objections to certain procedures indirectly via signs or forms. Perhaps a "notice clause" could be included in one of the standard forms that a patient normally reads and signs prior to treatment. As an example, such a clause could read as follows:

IMPORTANT NOTICE: This provider and institution morally objects to and DOES NOT PROVIDE certain medical procedures and treatments: (1) emergency contraceptives; (2) abortion in all circumstances; and (3) sterilization. If you are seeking any of the above procedures or treatments, we strongly urge you to consider other alternatives provided at this institution; AND please also consult another healthcare provider who does not have objections about offering the treatments and procedures not offered here.

Under a passive notice regime, patients will be informed of their provider's objections, and the providers' conscientious objections will be respected as they themselves would not be compelled to speak about procedures that they

132. See William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL'Y 455, 532 (2001) (noting that religious lobbyists argued that those who morally object to abortion also oppose referral and counseling for abortion procedures).

133. Passive notice coupled with conscience clauses would give moderate politicians more politically inclusive real estate to stand upon concerning the abortion issue. It would allow them to more plausibly take the principled position that, while they are pro-life, they respect the health and concerns of women; or, in the alternative, that while they are pro-choice, they respect the rights of the providers who find abortion morally objectionable.

find morally objectionable.

C. Indirect Referrals

With conscience clauses, a traditional source of medical information and referral—the healthcare provider—may be foreclosed to some patients.¹³⁴ Notice to the patient, while good, may not be adequate. Another small step in the right direction would be for the providers and institutions to offer indirect referrals to their patients or potential patients in order to better facilitate the patient’s pursuit for the care that they desire. The advent of the internet has made the search for a suitable provider or hospital much easier for many people.¹³⁵ Unfortunately, not all people have convenient access to the internet and finding an appropriate healthcare provider can be difficult. Therefore, referrals are still needed—whether via the more challenging, direct, traditional-referral regime¹³⁶ or the less problematic, proposed indirect-referral regime.

Indirect referral means that patients will be made aware of sources of information to aid them in receiving the treatment that they desire if their institution or provider does not offer it. Under this regime, the providers can continue to remain silent about medical services they find morally objectionable. Indirect referral could simply mean a small card with a few phone numbers that a patient could call for more information to assist them in finding an alternative provider. The cards or other simple mechanisms would be funded and distributed by third parties in a discreet and respectful manner. They could be distributed simply via a card holder at a clinic or a small card stapled to a medical form with the proposed passive notice. Furthermore, much of the informational infrastructure such as referral hotlines already exists, so implementation would not be difficult or costly.¹³⁷

With indirect referrals, the healthcare provider does not have to actively do anything contrary to their morals, and the patient can obtain the information they need through “self-referral.” Ultimately, indirect referral, like passive notice, respects the conscience of doctors and institutions while

134. See, e.g., DEBORAH FRIEDMAN, PLANNED PARENTHOOD FED’N OF AM., REFUSAL CLAUSES: A THREAT TO REPRODUCTIVE RIGHTS, <http://www.plannedparenthood.org/news-articles-press/politics-policy-issues/birth-control-access-prevention/refusal-clauses-6544.htm> (noting that the Hyde-Weldon Amendment “overrides Title X guidelines that require women to be referred for abortions upon their request”).

135. National organizations such as Planned Parenthood Federation of America currently provide referral services for women. Planned Parenthood Fed’n of Am., <http://www.plannedparenthood.org> (last visited Sept. 10, 2006).

136. Direct referral refers to when healthcare providers directly give the patient information regarding alternative providers and/or institutions.

137. Planned Parenthood Fed’n of Am., *supra* note 135.

still protecting the rights of the patients.

D. Independent Contractors and Joint Ventures

Passive notice and indirect referral, if implemented, would be significant steps toward alleviating some of the problematic issues raised by conscience clauses. However, the greatest concern raised by conscience clauses may be the issue of access, which is admittedly a problem for healthcare in general. Notice and referral may be completely meaningless for someone who lacks access to an alternative healthcare provider because of geography or resources.¹³⁸ Therefore, the most significant and most challenging proposed solution would be for institutions that oppose certain services on moral and religious grounds to indirectly provide access to those services.¹³⁹ Indirect access can be provided through the use of independent contractors and joint ventures.

Independent contractors funded by third parties can be kept as part of the staff—for example, at a Catholic hospital, but located in an independent wing—to serve women who seek services that are prohibited by the hospital's internal regulations.¹⁴⁰ Admittedly, this proposal might be difficult to implement, given that it would take place within a Catholic hospital and require the hospital to take certain direct, proactive steps toward procedures that it deems objectionable. A compromise alternative may mean hiring independent physicians who have no moral objections to exploring and performing all permissible procedures in female reproductive healthcare, but only for emergency care.¹⁴¹ Instead of being situated within the hospital complex, those physicians can be situated at a nearby, off-site location readily accessible to the patient without great inconvenience.

138. See Lichtman, *supra* note 96, at 351–57 (discussing the problems of access to female reproductive healthcare for poor and rural women); Clift, *supra* note 28 (“[I]n small-town America there is often only one pharmacy in town.”).

139. See *60 Minutes: God, Women and Medicine*, *supra* note 108 (reporting on the serious issues concerning access to female reproductive healthcare due to the growth in Catholic healthcare institutions).

140. See PATRICIA MILLER & RONNIE PAWELKO, MERGERWATCH, FIGHTING RELIGIOUS HEALTH RESTRICTIONS: RESPONDING TO THE CATHOLIC BISHOPS' CRACKDOWN ON HOSPITAL MERGER COMPROMISES THAT WOULD SAVE REPRODUCTIVE SERVICES 6 (2004),

http://www.edfundpa.org/edfund_docs/fact_sheets/Bishops%20Crackdown.pdf (describing a compromise system at the former Leila Hospital in Battle Creek, MI, where a separate, four-bedroom “condominium hospital” that has its own operating room, board, and financing stream—and permits women to undergo sterilization procedures after childbirth—exists on the top floor of a hospital operated by a Catholic health system).

141. Emergency care should be allotted special consideration given the inherently precarious nature of its patients, such as women with life-threatening pregnancy complications and rape victims. See Goodman, *supra* note 23, at A17 (“At last count, only 28 percent of [Catholic hospitals'] 600 emergency rooms offered emergency contraception to rape victims.”).

Aside from the limited use of independent contractors, joint ventures can be set up to better meet the healthcare needs of the patient. For example, a Catholic hospital can set up a joint venture with a secular clinic so that all of the needs of its patients are met. Ideally, the secular institution will be near the Catholic hospital so that it is readily accessible, but that is not a necessity. Although this proposal seems radical and impractical, a few Catholic hospitals have tried similar arrangements with some success.¹⁴² “Community Hospital in Springfield, Ohio, created an organizationally separate reproductive health care clinic adjacent to Mercy Medical when the facilities decided to merge. Hospitals in West Palm Beach, Florida, made similar arrangements when they decided to merge.”¹⁴³

Furthermore, Catholic hospitals should allow their doctors to serve as independent contractors in joint ventures to provide services that they object to at offsite clinics without fear of retribution.¹⁴⁴ Ironically, the vague wording of some conscience clauses could protect the decisions of these doctors to act.¹⁴⁵

Ultimately, the implementation of using independent contractors and joint ventures is a difficult one. If realized, however, it would go a long way in addressing the crucial issues concerning access raised by conscience clauses.

CONCLUSION

The debate concerning conscience clauses in the area of female reproductive healthcare is part of the larger debate about abortion, but the issues raised by conscience clauses will have a significant impact on the future of healthcare in general. The conscience clause may be perceived by some as a calculated “chipping away” of the right to abortion, with some serious unintended consequences. If so, this use of conscience clauses to abrogate and subvert abortion rights would give greater credence to former

142. See GREGORY G. LABEL & WILLIAM L. PIERRON, REPRODUCTIVE HEALTH AT RISK: A REPORT ON MERGERS AND AFFILIATIONS IN THE CATHOLIC HEALTH CARE SYSTEM 1990-1995 9-11 (1995) (giving examples of joint ventures between Catholic institutions and non-Catholic reproductive clinics and raising concerns about such mergers).

143. White, *supra* note 25, at 1737.

144. For examples of doctors facing retribution for performing certain reproductive healthcare services, see *Watkins v. Mercy Med. Ctr.*, 364 F. Supp. 799 (D. Idaho 1973), *aff'd*, 520 F.2d 894 (9th Cir. 1975); Heather Ratcliffe, *Doctor Who Does Abortions at Clinic Is Demoted by Catholic Hospital*, ST. LOUIS POST-DISPATCH, Dec. 21, 2000, at B2.

145. See *Watkins*, 364 F.Supp. at 802-03 (recognizing that, though laws protect objecting hospitals from being forced to make their facilities available for abortion or sterilization procedures, those laws can act as a “double-edged sword[,]” prohibiting such hospitals from discriminating against doctors who do not “adhere to the religious or moral beliefs which support the hospital’s policy”).

Chief Justice Rehnquist's famous line in *Planned Parenthood of Southeastern Pennsylvania v. Casey*: "Roe continues to exist, but only in the way a storefront on a western movie set exists: a mere facade to give the illusion of reality."¹⁴⁶ Since the *Roe v. Wade* decision in 1973, both sides have engaged each other in a heated emotional, moral, and intellectual discussion. The arguments of both sides have many merits as well as problems, consistencies as well as inconsistencies.¹⁴⁷ These arguments may rage on forever. But regardless of the significance of the debates and discussions, the true significance lies in the policies that spring forth from them affecting the lives of countless people and giving birth to benefits as well as challenges. From a policy perspective, conscience clauses offer healthcare providers an avenue to do their jobs in accordance with their conscience without fear of retribution; however, conscience clauses also raise serious problems concerning the rights and well-being of female patients.¹⁴⁸

Fortunately, workable solutions like passive notice, indirect referrals, and joint ventures do exist; and Congress and state legislatures need to give them serious consideration. The (perhaps uneasy) reality is that the rights of both the provider and the patient are important, and so a fine balance must be reached because too strong of a tilt in one direction on this "legislative seesaw" can have serious health implications and consequences. While both sides can have strong disagreements, both sides should agree that the quality of a woman's healthcare should not depend on her geography or the conscience of her provider.¹⁴⁹ While both sides should work toward reducing

146. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 955 (1992) (Rehnquist, J., concurring in part and dissenting in part).

147. See Kissling, *supra* note 80.

For both supporters and opponents of abortion rights, single focus positions have presented some difficulties. Supporters of abortion rights are pushed to the limits on abortions later in pregnancy and on the question of the extent to which abortion can be regulated if not restricted. Those who oppose abortion rights have struggled with the logical conclusion of the claim that there is no distinction in fetal value at any stage in pregnancy and have ended up opposing abortion in tragic cases, such as after rape and for very young women who have been victims of incest. Consistency (and here the phrase, "A foolish consistency is the hobgoblin of little minds," comes to my mind) has meant that they have had to oppose embryonic stem cell research that could contribute to saving lives and emergency contraception for women who have been raped on the slight chance that a conception may have already taken place.

Id.

148. Conscience clauses should be used to protect the beliefs of providers and institutions. However, they should not be used as "legislative chisels" to chip away at a woman's right to choose. The vague and broad general language of certain conscience clauses should be viewed as a marker of flexibility regarding the rights of the provider, not as a marker for linguistic licentiousness to make meaningless the legal rights of patients and women in America.

149. Implicit in the conscience clause debate, while not directly addressed in the Article, is the

unwanted and dangerous pregnancies, both sides should also work toward making sure that certain services in female reproductive healthcare remain safe and accessible. How we deal with the challenges in female reproductive healthcare now raised by conscience clauses will have a profound impact on the future of healthcare. The near and distant future will inevitably bring with it unparalleled medical breakthroughs and possibilities such as human cloning, genetic engineering, and limb transplantation. And with these new breakthroughs there will inevitably be new ethical controversies and moral challenges, thereby broadening the influence and use of conscience clauses. In the end, by addressing the present concerns raised by conscience clauses in women's health, we may become better prepared to address similar issues in the future of healthcare at large. By addressing and resolving some of these concerns now, we begin to ask better questions, which hopefully will lead us to better and healthier answers.

issue of quality of healthcare. Who decides what quality healthcare is, the provider or the patient? Do we want doctors to decide what is in our best interests or do we want doctors to give us the information to make that decision for ourselves?