



AVE MARIA LAW REVIEW

DUTY FIRST: TOWARDS PATIENT-CENTERED CARE AND
LIMITATIONS ON THE RIGHT TO REFUSE FOR MORAL,
RELIGIOUS, OR ETHICAL REASONS

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**DUTY FIRST: TOWARDS PATIENT-CENTERED
CARE AND LIMITATIONS ON THE RIGHT TO
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Jill Morrison and Micole Allekotte[†]

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INTRODUCTION

This Article argues that patient-centered care is the model from which refusal policy should be derived. By entering the medical profession, practitioners agree to a set of ethical principles which ensure that they will put the patient's interests before their own. Medical professionals have superior scientific knowledge and skill to that of a patient, which puts them in a position of trust and influence. Modern medical practice continues to move away from a model of paternalistic physician control over patients towards patient decision-making, which requires the professional to impart enough medical information for the patient to make an informed decision. This Article argues that it is ethically improper for medical practitioners to use their position of influence that results from superior scientific knowledge to impose their moral preferences on the patient. Patient-centered policy means that the primary goal of medical policy is to ensure patient well-being, with secondary goals such as enhancing medical workforce satisfaction. A refusal policy should maximize the situations in which an individual practitioner can follow his moral code without interfering with the patient's rights to make moral and medical decisions and to access care.

A policy allowing for provider refusals is only appropriate when it averts conflict between patient and practitioner morality by helping practitioners to step away from treatment to which they object without compromising the patient's ability to access the treatment. However, where a conflict is inevitable, the patient has a superior claim to the primacy of her health-care decision over the practitioner's decision to refuse because the primary goal of medical care is patient welfare; medical practitioner welfare is secondary. In practice, these twin principles should result in a policy where practitioners retain the duty to ensure that patients are provided with sufficient medical information to allow the patient to make informed medical decisions for herself and to ensure that the patient has access to care; these duties cannot

be abrogated by physician or institutional objection. At the same time, the individual professional retains the right to pass these duties on to another non-objecting practitioner; he does not have the right to allow his moral objection to stand as an obstacle to the patient obtaining information or care.

To actualize a system where medical professionals are generally able to refuse without interfering with patient care, a refusal policy cannot shift the consequences of professionals' refusals to patients. Medical ethics place a duty on practitioners to place the patient's interests above their own, but ethics alone do not ensure that practitioners will set up systems to ensure that patients are not harmed by refusal if there is a legal system that shifts the damages resulting from such refusals away from the practitioner and onto the patient. Medical professionals must take responsibility for their own moral guideposts by accepting the burdens that result from such beliefs. A system that keeps legal burdens, such as liability and professional consequences, on professionals who breach their duties towards patients incentivizes practitioners to ensure that systems are in place to protect the patient from harm as a prerequisite to the practitioner's right to walk away from services to which he objects.

Part II describes the problems that result when practitioners place their moral positions over the patient's welfare by refusing services without ensuring that patient protections from harms resulting from their refusals are in place. Part III describes bases for the professional's duty to provide accurate and unbiased medical information, referrals, and treatment in emergencies. Part IV discusses how current refusal policy contravenes medical ethics by shifting the consequences of refusal from practitioners to patients. Part V provides recommendations for public policy on refusal that would provide maximum protection for practitioners' right to act in accordance with their consciences without abrogating their professional obligation to put the patient first.

I. THE PROBLEM WITH REFUSALS

Imagine your wife is nineteen weeks pregnant when her water breaks. You rush her to the emergency room. The doctor comes out and tells you that nothing can be done to save the baby. You ask how your wife is doing. The doctor says that she will not be stable until they remove the fetus, but the hospital's ethical rules prevent them from doing so until there are no fetal heart tones. Instead, she will be transferred to the intensive care unit and will

receive blood transfusions until the fetus dies in utero. Only then will she receive the treatment she needs.¹

Imagine your sister has been raped. She goes to a pharmacy for emergency contraception, which is an FDA-approved contraceptive that can be taken after unprotected sex.² She can see it behind the counter, but the

1. Description of this hypothetical incident is derived from facts described in NAT'L HEALTH LAW PROGRAM, HEALTH CARE REFUSALS: UNDERMINING QUALITY CARE FOR WOMEN 47 (2010), http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf (describing a patient whose membranes ruptured and who became septic, but was denied an abortion by the hospital ethics committee because there was still a fetal heartbeat; she was in the intensive care unit for ten days, during which time she had "substantial internal bleeding, and developed pulmonary disease, resulting in lifetime oxygen dependency").

2. The process of becoming pregnant involves release of an ovum, fertilization of the ovum by sperm, and implantation of the fertilized egg in the uterus. Press Release, Am. Cong. of Obstetricians & Gynecologists, Medical Groups Set the Record Straight on Emergency Contraception (May 4, 2004), http://www.acog.org/from_home/publications/press_releases/nr05-04-04-3.cfm. The majority of scientific and medical groups define pregnancy as beginning with the implantation of a fertilized egg in the uterine wall. *E.g.* Dennies Varughese, *Conscience Misbranded!: Introducing the Performer v. Facilitator Model for Determining the Suitability of Including Pharmacists Within Conscience Clause Legislation*, 79 TEMP. L. REV. 649, 672–73 (2006). Emergency contraception (EC) pills prevent pregnancy after intercourse by interfering with at least one of these stages (in the current forms, primarily ovulation), unlike medical abortion, which is used to end pregnancy after a fertilized egg has implanted in a woman's uterus. Office of Population Research, Princeton Univ. & Assoc. of Reproductive Health Prof'ls, *Emergency Contraception: Emergency Contraceptives Are Not Abortion*, <http://ec.princeton.edu/questions/ecabt.html> (last visited Feb. 7, 2011). Levonorgestrel, a synthetic progestin, is the only EC approved by the FDA for over-the-counter distribution. *See* FDA, U.S. DEPT. OF HEALTH & HUMAN SERV., POSTMARKET DRUG SAFETY INFORMATION: PLAN B (.75MG LEVONORGESTREL) (2010), available at <http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm109775.htm>; Office of Population Research, Princeton Univ. & Assoc. of Reproductive Health Prof'ls, *Emergency Contraception: Emergency Contraception OTC*, <http://ec.princeton.edu/questions/QA-OTC-access.html> (last visited Feb. 7, 2011) (explaining that progestin-only EC pills, such as Plan B One-Step and Next Choice, are available over the counter for consumers 17 and older, while ulipristal acetate is sold by prescription only). Levonorgestrel, currently marketed as Plan B One-Step and Next Choice, works primarily by preventing ovulation and may prevent fertilization, but there is no scientific evidence to support the idea that it can prevent implantation, and it is clear that it does not affect an implanted fertilized egg. CTR. FOR DRUG EVALUATION & RESEARCH, FDA, APPROVED LABELING FOR APPLICATION 21-045/S011, at 3 (2006) (labeling insert of application), available at http://www.accessdata.fda.gov/drugsatfda_docs/nda/2006/021045s011_Plan_B_PRNTLBL.pdf. ("Plan B works like a birth control pill to prevent pregnancy mainly by stopping the release of an egg from the ovary. It is possible that Plan B may also work by preventing fertilization of an egg (the uniting of sperm with the egg) or by preventing attachment (implantation) to the uterus (womb), which usually occurs beginning seven days after release of an egg from the ovary. Plan B will not do anything to a fertilized egg already attached to the uterus. The pregnancy will continue."); *see also* Sandra Reznik, "Plan B:" *How It Works*, HEALTH PROGRESS, Jan.–Feb. 2010, at 59, 61, available at <http://chusa.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=6159>. The Catholic Health Association (CHA) has acknowledged that traditional emergency contraception is not an abortifacient because scientific evidence does not support the claim that it prevents implantation of a fertilized egg. Reznik, *supra*, at 59, 61 ("[Plan B or] levonorgestrel acts to prevent pregnancy before, and only before,

pharmacist refuses to give it to her because he thinks it is immoral.³ She is distraught, yet she continues her search for the medication in an effort to reduce her risk of becoming pregnant from the traumatic act of violence.⁴

Imagine you are a newlywed, and you discover that you have testicular cancer. You and your wife want kids, so you ask the doctor how treatment is going to affect your fertility. He tells you not to worry about it. You get the treatment without taking steps to store your sperm, thinking that your doctor certainly would have told you if the treatment had a chance of reducing your fertility. In reality, your doctor is morally opposed to all assisted reproductive technologies and thinks that discussing these procedures with you would make him complicit in the sin.

Each of these situations is possible when providers are allowed to place their religious and moral beliefs above medically accepted standards of care and patients' needs.

[Major] health care provider organizations—including the American College of Obstetricians and Gynecologists, the American Hospital Association, and the American Public Health Association—have expressed concerns about the impact of refusals on patient care,⁵ [yet] some providers

fertilization occurs . . . [L]evonorgestrel prevents ovulation Some of the concerns about how Plan B works have been driven by the unfortunate and inaccurate description on the package insert, which includes a statement that levonorgestrel acts by preventing implantation. There are absolutely no data to support this statement, while there are plenty of data . . . to support the conclusion that levonorgestrel acts only before fertilization has occurred.”). Ulipristal acetate, approved in 2010 to be marketed as prescription-only Ella, is more effective than levonorgestrel because it can prevent the release of an ovum even after the hormone surge that triggers ovulation has begun; thus, its main mode of action is still preventing ovulation. WATSON PHARMA, INC., PRESCRIBING INFORMATION 5 (2010) (approved Aug. 13, 2010), *available at* http://www.accessdata.fda.gov/drugsatfda_docs/

label/2010/022474s0001b1.pdf. It is also possible that Ella inhibits implantation of a fertilized egg. *Id.* “No studies have been performed on the use of ulipristal acetate in pregnant women, but available data on inadvertent exposure of very early pregnancy to ulipristal acetate in clinical trials . . . at the to-be-marketed dose for EC indicates that the product does not interrupt an established pregnancy.” HRA PHARMA, BRIEFING MATERIALS FOR ADVISORY COMMITTEE FOR REPRODUCTIVE HEALTH DRUGS, FDA: ULIPRISTAL ACETATE 30 MG TABLET 84 (2010), *available at* <http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials/Drugs/ReproductiveHealthDrugsAdvisoryCommittee/UCM215510.pdf>.

3. Description of this hypothetical incident is based on widely reported facts described in Varughese, *supra* note 2, at 650 (describing a news account of a rape victim denied emergency contraception by three pharmacists on duty).

4. *Id.*

5. *See infra* Part III.B.

still assert a right to deny patients medically appropriate health care services, information and referrals.⁶

While providers have a right to their moral beliefs, this right does not allow health-care providers to violate their professional and legal obligations to the patient. Policies on health-care provider refusals should be carefully crafted to maximize the rights of individuals to their beliefs without extending this “protection” so far that it prevents patients from getting the medical care or information they need.

A. *Who is Harmed?*

There are three types of refusals: refusal to provide treatment, refusal to provide information and refusal to provide referrals. Each type of refusal can be undertaken by different types of providers. Providers include individuals, such as doctors, nurses, and other medical staff, as well as institutions, such as religiously-affiliated hospitals.⁷ The problem of refusals affecting patient care extends beyond hospitals and other institutions that actually provide health care.⁸ “Like hospitals, managed care plans may also be religiously-affiliated, and exclude coverage for reproductive health services.”⁹ Women have also been subject to refusals to sell them emergency contraception and ordinary birth control in pharmacies.¹⁰

6. NAT'L WOMEN'S LAW CTR., WHEN HEALTH CARE PROVIDERS REFUSE: THE IMPACT ON PATIENTS OF PROVIDERS' RELIGIOUS AND MORAL OBJECTIONS TO GIVE MEDICAL CARE, INFORMATION OR REFERRALS 1 (2009) (footnote added), <http://www.nwlc.org/sites/default/files/pdfs/April2009RefusalFactsheet.pdf>; see also Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 NEW ENG. J. MED. 593, 593 (2007) (“Many physicians do not consider themselves obligated to disclose information about or refer patients for legal but morally controversial medical procedures.”).

7. Catholic hospitals have the broadest range of religious restrictions on medical practice and are governed by the Ethical and Religious Directives for Catholic Health Care Services (hereinafter the Directives). U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (4th ed. 2001), available at <http://www.usccb.org/bishops/directives.shtml> (generally prohibiting sterilizations, abortions, artificial reproductive technologies, and contraception).

8. See NAT'L HEALTH LAW PROGRAM, *supra* note 1, at 6–7 (noting that reproductive health and sexual activity related services have been restricted by broad expansion of the contingent of physicians, other health-care providers and large religiously-controlled nonprofit health-care corporations who refuse to provide services to which they have personal and religious objections).

9. NAT'L WOMEN'S LAW CTR., *supra* note 6, at 2; see also NAT'L HEALTH LAW PROGRAM, *supra* note 1, at 7 (noting that many hospitals are now controlled by organizations that place religious or moral restrictions on the services the hospitals may offer).

10. Rob Stein, *Pharmacists' Rights at Front of New Debate: Because of Beliefs, Some Refuse to Fill Birth Control Prescriptions*, WASH. POST, Mar. 28, 2005, at A1.

People often ask of those who are refused health-care services—“Can’t they just go somewhere else?” Unfortunately, the answer is often no, particularly when the refusing entity is an institutional actor, such as a hospital or pharmacy, rather than an individual practitioner. When professionals refuse to provide treatment, there may be nowhere else in the patient’s community where she can go or going elsewhere may be financially out of reach.¹¹ Furthermore, a patient who is refused information may not know that she has been denied medically desirable treatment options.¹² A patient who is refused a referral may be prevented by the refusal itself from going elsewhere for the service if, for example, her managed care plan requires a physician referral.¹³

The consequences of refusals are particularly burdensome to marginalized populations. Women are disproportionately burdened because reproductive health services are the subject of the vast majority of refusals. Low-income people, people of color, Lesbian/Gay/Bisexual/ Transgendered (LGBT) people, and people who live in areas with few accessible providers also suffer disproportionately.¹⁴ A person in a rural area may need to travel long distances in order to get needed care; if the closest provider refuses, she may be left without an alternative source of care.¹⁵ Even in urban areas, a rape survivor who is refused emergency contraception may have to take public

11. See Letter from Tony Ogburn & Eve Espey, Chair & Vice Chair, Am. Coll. of Obstetricians & Gynecologists—N.M. Section, to Michael O. Leavitt, Sec’y, U.S. Dep’t of Health & Human Servs. 2 (Sept. 24, 2008), available at <http://www.regulations.gov/search/Regs/home.html#documentDetail?R=0900006480722c24> (“For patients without health insurance or access to transportation, [being forced by a refusal to seek care in another facility or another community] can mean no healthcare services at all.”).

12. Letter from Georges C. Benjamin, Exec. Dir., Am. Pub. Health Ass’n, to Michael O. Leavitt, Sec’y, U.S. Dep’t of Health & Human Servs. 2 (Sept. 25, 2008), available at <http://www.regulations.gov/search/Regs/home.html#documentDetail?R=0900006480723fce> (“[P]atients might not even learn which services, information or referrals they may have been denied, eliminating their right to fully informed consent, which involves a discussion on all medically recommended treatments and alternative treatment methods.”).

13. See Cal. Office of the Patient Advocate, *What Is an HMO?*, http://www.opa.ca.gov/report_card/hmowhat.aspx (last visited Feb. 7, 2011) (“If members [of HMOs] get services without a referral and approval they may have to pay for the service themselves.”).

14. Letter from Tony Ogburn to Michael Leavitt, *supra* note 11, at 3 (“[T]he lowest income women . . . suffer the most” from refusal regulations that do “not take into account the needs and rights of patients.”); Letter from Marcia D. Greenberger & Judy Waxman, Co-President & Vice President for Health & Reproductive Rights, Nat’l Women’s Law Ctr., to Charles Johnson, Acting Sec’y, U.S. Dep’t of Health & Human Servs. 3–6 (Apr. 9, 2009), available at <http://www.nwlc.org/sites/default/files/pdfs/NWLC%20Rescission%20Comments%20FINAL.pdf>.

15. See generally FED. OFFICE OF RURAL HEALTH POL’Y, U.S. DEP’T OF HEALTH & HUMAN SERVS., FACTS ABOUT . . . RURAL PHYSICIANS (Sept. 1997), http://www.shepscenter.unc.edu/rural/pubs/finding_brief/FB53.pdf (noting the areas that are underserved by health-care professionals in the United States).

transportation or hire a taxi to try to find a willing pharmacy late at night. In the face of anxiety, embarrassment, or trauma, a woman may not continue her search in the wake of multiple refusals.¹⁶ These refusals have the greatest negative impact on low-income people who may not have transportation, the job flexibility to take time off to seek needed health care or who may not be able to afford an out-of-network provider or a second visit after a first visit ends in refusal.¹⁷

Many patients, especially those who are less educated or who cannot afford second opinions, must trust and rely on their providers to tell them about all of the medically appropriate treatment options they might consider.¹⁸ But some doctors withhold information on certain diagnoses, available diagnostic tests, and treatment options due to their religious beliefs.¹⁹ Less educated patients are more likely to be harmed by refusals to provide information because they may not be aware that they have encountered a refusal at all. For example, a study of California women shows that 72 percent of women with a college diploma were aware of emergency contraception, compared to only 48 percent with a high school diploma and 29 percent with less than a high school diploma.²⁰

Inaccurate medical information undermines the practice of modern medicine, which is based on a model that treats the patient as the central decision maker and is dependent on a patient's confidence that he or she is receiving evidence-based care and information.²¹ A prior model, paternalism, which posited that the doctor should make decisions on the patient's behalf, "is widely criticized for violating the right of adults to self-determination."²² Because modern medicine treats patients as participants in their own care, final decisions about what treatment to undergo are left to

16. Kristen Marttila Gast, *Cold Comfort Pharmacy: Pharmacist Tort Liability for Conscientious Refusals to Dispense Emergency Contraception*, 16 TEX. J. WOMEN & L. 149, 153 (2007)

17. See Susan Berke Fogel & Lourdes A. Rivera, *Religious Beliefs and Healthcare Necessities: Can They Coexist?*, HUMAN RIGHTS, Spring 2003, at 8, 8–9, available at <http://www.abanet.org/irr/hr/spring03/religiousbeliefs.html> ("Restriction of services affects everyone, but low-income women are particularly vulnerable due to lack of resources to either pay out-of-pocket fees or to travel long distances to obtain services.").

18. See Diana G. Foster et al., *Trends in Knowledge of Emergency Contraception Among Women in California, 1999–2004*, 17 WOMEN'S HEALTH ISSUES 22, 22 (2007) ("Foreign-born Hispanic women, women whose income falls below the poverty level, and women who did not complete high school" are least likely to know about emergency contraception).

19. NAT'L WOMEN'S LAW CTR., HOW RELIGIOUS REFUSALS TO PROVIDE INFORMATION ABOUT REPRODUCTIVE HEALTH SERVICES CAN VIOLATE PATIENTS' RIGHT TO INFORMED CONSENT 1–2 (2009), <http://www.nwlc.org/sites/default/files/pdfs/InformedConsent09.pdf>.

20. Foster et al., *supra* note 18, at 24–25.

21. See NAT'L HEALTH LAW PROGRAM, *supra* note 1, at 12–13.

22. Curlin et al., *supra* note 6, at 599.

them.²³ If patients receive inaccurate or incomplete information, their ability to make an optimal medical decision is compromised.

B. *What is the Harm?*

Refusals subject women to serious physical, emotional, and financial consequences. They also damage public health efforts and violate patients' rights. Refusals to provide information and referrals also undermine the trust that patients place in their providers.

1. *Physical Harms*

Refusals to provide information cause patients to lose control of their health-care decisions, and can result in serious physical health consequences.²⁴ If a provider is opposed to family planning and refuses to counsel a woman with a condition such as diabetes about her increased risks during pregnancy and the benefits of delaying pregnancy until her condition is under control, she may be denied the essential information she needs to reduce her risks of serious health complications, including high blood pressure, kidney disease, nerve damage, heart disease, and blindness.²⁵ Likewise, if a patient believes her doctor's statement that her inability to get

23. Some commentators on conscience in the religious context have asserted that not only medical ethics, but also religious ethics dictate that the right of the patient to make medical decisions based on her own conscience must be accorded deference by providers. See, e.g., Sara Hutchinson, *In Good Conscience? Examining the Abuse of Conscience Clauses in the U.S.*, 31 CONSCIENCE 35, 35–36 (2010) (“Catholic teaching requires due deference to the conscience of others in making decisions—meaning that healthcare providers must not dismiss the conscience of the person seeking care.”)

24. See NAT'L WOMEN'S LAW CTR., *supra* note 19, at 1–2; Am. Pub. Health Ass'n, *Ensuring that Individuals Are Able to Obtain Contraceptives at Pharmacies*, APHA.ORG (Nov. 8, 2006), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1335> (explaining that access to contraceptives is essential for some women, for whom “pregnancy can entail great health risks and even life endangerment”).

25. *Diabetes and Pregnancy*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 10, 2010), <http://www.cdc.gov/Features/DiabetesPregnancy/> (explaining that if a woman's diabetes cannot be controlled before and during pregnancy, it can cause or worsen problems such as “high blood pressure, kidney disease, nerve damage, heart disease, or blindness”); see also Alan L. Graber et. al, *Planning for Sex, Marriage, Contraception, and Pregnancy*, 1 DIABETES CARE 202, 203 (1978) (“The diabetic condition should be under good control in the nonpregnant state, since pregnancy will aggravate diabetes and make it harder to control.”); Inge M. Evers et. al, *Risk of Complications of Pregnancy in Women with Type I Diabetes: Nationwide Prospective Study in the Netherlands*, 328 BRIT. MED. J. 915, 917 (2004), available at <http://www.bmj.com/content/328/7445/915.abridgement.pdf> (Even in a sample in which diabetes is generally well controlled, the risks of pregnancy complications were considerably higher than in the general population; however, “[t]he incidence of major congenital malformations was significantly lower in the planned pregnancies than in unplanned pregnancies.”).

pregnant is “all in her head”—when in fact the doctor is opposed to giving her a referral to an infertility specialist—she may delay seeking time sensitive treatment and lose her opportunity to bear biologically related children.

Refusals to provide treatment also impose serious health consequences.²⁶ The Ethical and Religious Directives for Catholic Health Care Services (the Directives) govern the provision of care at Catholic-affiliated hospitals. The Directive addressing abortion states:

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.²⁷

The United States Conference of Catholic Bishops, which authors the Directives, interprets the Directive on abortion to mean that any abortion that involves the direct removal of the fetus by a doctor is never permissible for any reason.²⁸ However, there is a separate Directive regarding circumstances where a treatment that is not considered a “direct abortion” would be permitted. Directive 47 states: “Operations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman are permitted when they cannot be safely postponed until the unborn child is viable, even if they will result in the death

26. NAT’L HEALTH LAW PROGRAM, *supra* note 1, at 12 (“Decisions to deny information and services based on personal and religious beliefs rather than scientific evidence ultimately result in poor health outcomes for women.”).

27. U.S. CONF. OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 26 (5th ed. 2009), available at http://www.nccbuscc.org/meetings/2009Fall/docs/ERDs_5th_ed_091118_FINAL.pdf.

28. According to the Bishops, the Directives prohibit “direct abortion” under all circumstances. COMM. ON DOCTRINE, U.S. CONF. OF CATHOLIC BISHOPS, THE DISTINCTION BETWEEN DIRECT ABORTION AND LEGITIMATE MEDICAL PROCEDURES 2 (2010), <http://uscbb.org/doctrine/direct-abortion-statement2010-06-23.pdf> (explaining that a “direct abortion” is one in which “[i]t is the surgical instrument in the hands of the doctor that causes the child’s death” and that such an act “is never morally permissible. . . . no matter what the reason”). Directive 47 allows medical procedures that result in the removal of the fetus, but only if the removal of the fetus is not accomplished directly; the Directive would, for example, allow the removal of a pregnant woman’s uterus if her uterus developed cancer and treatment could not be delayed until the fetus was viable. *Id.* at 2–3. However, Directive 47 does not allow the removal of the fetus from the uterus “where the mother’s health or even life is at risk during a pregnancy.” *Id.* at 1, 3. Following the examples provided to their conclusion, if a pregnant woman’s uterine cancer mass could be removed by surgery, saving her uterus and future fertility as well as her life, but an abortion would be required first to allow doctors access to her cancer mass, a woman in a facility following the Directives would not be offered that option.

of the unborn child.”²⁹ Interpretations regarding whether an abortion is considered a direct abortion and therefore prohibited under any circumstance or an indirect abortion and therefore permitted under some narrow circumstances has enormous implications for women’s ability to access the standard of care at Catholic-affiliated hospitals.

The potentially devastating health outcomes that sometimes flow from refusal to perform “direct abortion” under any circumstances is illustrated by a case in Phoenix, where the Diocese of Phoenix stripped a Catholic hospital of its affiliation with the Church after the hospital performed an abortion on a woman whose “risk of death was nearly 100 percent” if she did not receive the abortion because the fetus was “directly killed.”³⁰ The CHA supported the hospital’s decision to allow the procedure, stating that it acted ethically under the Directives by “saving the only life it was possible to save.”³¹ While in this case the hospital performed the procedure and suffered the consequences from the Diocese, in other cases the Directives have limited the medical treatment available in Catholic hospitals; one study showed that Catholic hospitals refused to provide medically necessary emergency treatment to women who were miscarrying because the doctors could still detect a fetal heartbeat.³²

Ectopic pregnancies, which occur when the embryo implants in the fallopian tube rather than the uterus, never result in live birth; if left untreated, the woman risks fallopian tube rupture and infection, which can be deadly. There are four treatment options for treating an ectopic pregnancy:

29. U.S. CONF. OF CATHOLIC BISHOPS, *supra* note 28. The Catholic Health Association, the membership organization for Catholic-affiliated institutions, has opined that a procedure including membrane rupture and induced labor would be considered “indirect” abortion if the pregnant woman had a uterine infection and the drug used to induce labor was necessary to treat the uterine infection itself; in this case, the “drug helped cure the infection (a treatment that was directly intended) and brought on delivery of a viable fetus (an outcome that was not directly intended).” Sr. Jean deBlois & Fr. Kevin D. O’Rourke, *Care for the Beginning of Life: The Revised Ethical and Religious Directives Discuss Abortion, Contraception and Assisted Reproduction*, HEALTH PROGRESS, Sept.– Oct. 1995, at 36, 39.

30. Amanda Lee Myers, *Ariz. Diocese Revokes Hospital’s Status After Surgery*, VALLEYNEWSLIVE.COM (Dec. 21, 2010 1:49P.M.), <http://www.valleynewslive.com/Global/story.asp?S=13721814>.

31. Catholic Health Association Statement Regarding St. Joseph’s Hospital and Medical Center in Phoenix (Dec. 22, 2010), <http://chausa.org/newsdetail.aspx?id=2147488971>. The U.S. Conference of Catholic Bishops publicly disagreed with the hospital’s position that the Directives permit abortion where in the absence of an abortion both the woman and the fetus would not survive. COMM. ON DOCTRINE, U.S. CONF. OF CATHOLIC BISHOPS, *supra* note 29, at 3 (“direct abortion is never permissible because a good end cannot justify an evil means”).

32. Lori R. Freedman et al., *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774, 1774 (2008) (documenting that a qualitative study showed some Catholic-affiliated hospitals refuse to evacuate the uterus of women who are miscarrying if there is still a detectable fetal heartbeat).

administering a medication to expel the embryo from the fallopian tube (methotrexate), surgical removal of the embryo from the fallopian tube (salpingostomy), surgical removal of the fallopian tube where the embryo is embedded (salpingectomy) and expectant management—monitoring the condition to see if it resolves on its own.³³ The Directive on abortion, which does not differentiate between ectopic and intra-uterine pregnancy, has been interpreted by some Catholic hospitals to allow only expectant management and removal of the fallopian tube because removing the fallopian tube is not a direct action against the embryo, while administering medication to expel the embryo or removing the embryo itself would be “direct abortion.”³⁴ A salpingectomy could reduce the woman’s fertility, where a treatment that would simply remove the embryo from the fallopian tube, either by surgery or through use of medication, could have saved her life with less negative effect on her future fertility.³⁵ Medication to remove the embryonic tissue, the medically appropriate option that could possibly preserve fertility in many cases, though one that is often disallowed by the Directives, has the added benefit of not exposing the woman to the risks of surgery.³⁶

Restrictive interpretations of the Directives can force physicians to refuse to admit women who are medically unstable, forcing these patients to endanger their health by going elsewhere or staying and receiving sub-

33. Anne-Marie Lozeau & Beth Potter, *Diagnosis and Management of Ectopic Pregnancy*, 72 AM. FAM. PHYSICIAN 1707 (2005), available at <http://www.aafp.org/afp/2005/1101/p1707.html>.

34. ANGEL M. FOSTER ET AL., IBIS REPRODUCTIVE HEALTH, ASSESSING HOSPITAL POLICIES & PRACTICES REGARDING ECTOPIC PREGNANCY & MISCARRIAGE MANAGEMENT 5 (2010), available at http://nwlc.org/sites/default/files/pdfs/ibis_rh_-_nwlc_qualitative_study_report.pdf. See also William E. May, *Arguments Against Salpingostomy and Methotrexate*, in CATHOLIC HEALTH CARE ETHICS: A MANUAL FOR PRACTITIONERS 119–21 (arguing that methotrexate and salpingostomy are incompatible with the Directives). While in practice some Catholic hospitals acting on their interpretations of the Directives have refused to provide methotrexate or removal of the embryo from the fallopian tube, other Catholic ethicists have disagreed with this interpretation of “direct abortion.” NAT’L CATHOLIC BIOETHICS CTR., CATHOLIC HEALTH CARE ETHICS: A MANUAL FOR PRACTITIONERS 121–23, The Ethics of Treating Ectopic Pregnancy, Arguments in Favor of Salpingostomy 121–23. (Edward J. Furton et al. eds., 2d ed. 2009) (supporting the use of both tube-sparing surgery and methotrexate). The Catholic Health Association has noted that there is a lack of clarity regarding what the Directives require and prohibit in ectopic pregnancy management. See Fr. Kevin D. O’Rourke, *Applying the Directives: The Ethical and Religious Directives Concerning Three Medical Situations Require Some Elucidation*, HEALTH PROGRESS, July–Aug. 1998, at 64, 65–66 (referring to the use of methotrexate, Fr. O’Rourke said “[I]t seems well within moral probity for the obstetrician to intend the removal of the trophoblast and to employ the means to fulfill the intention, even though that means the death of the fetus will result.”).

35. FOSTER ET AL., *supra* note 34, at 4; Mylene Yao & Togas Tulandi, *Current Status of Surgical and Nonsurgical Management of Ectopic Pregnancy*, 67 FERTILITY & STERILITY 421 (1997) (intrauterine pregnancy rates are around 61% for patients who undergo salpingostomy and 54% for patients who take methotrexate but just 38.1% for patients who undergo partial or total salpingectomy).

36. *Id.*

standard treatment.³⁷ One doctor recounted how a Catholic hospital refused to admit his patient for an abortion, even though she was having an inevitable miscarriage and delaying the removal of the fetus put her at risk of serious infection.³⁸ The hospital wanted him to wait until she actually contracted an infection that would put her life in danger:

“I was told I could not admit her unless there was a risk to her life,” . . .
“They said, ‘Why don’t you wait until she has an infection or she gets a fever?’ They were asking me to do something other than the standard of care. They wanted me to put her health in jeopardy.”³⁹

Even when the patient is admitted, “[i]n terms of miscarriage treatment, patients are often bleeding very heavily before a dilation and curettage is allowed.”⁴⁰ Individual practitioners have also refused in similar situations, which can endanger their patients. For example, a nurse working in a nonsectarian hospital’s labor and delivery section refused to treat a pregnant patient with a ruptured membrane “which the Hospital describe[d] as a life-threatening condition” and another patient with “complete placenta previa—a condition in which the fetus’s placenta completely covers the mother’s cervix,” which was also “life-threatening.”⁴¹

37. See FOSTER ET AL., *supra* note 34, at 15; Ramesh Raghavan, *A Question of Faith*, 297 J. AM. MED. ASS’N 1412, 1412 (2007).

38. Tom C.W. Lin provides an account of this incident:

Kathleen Hutchins, a Medicaid patient of Manchester, New Hampshire, . . . 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.

Ultimately, Dr. Goldner hired a cab to take Ms. Hutchins eighty miles to the nearest hospital that would treat her. Perhaps more troubling is the fact that most conscience clauses would protect the hospital from any liability under similar circumstances. Tom C.W. Lin, *Treating an Unhealthy Conscience: A Prescription for Medical Conscience Clauses*, 31 VT. L. REV. 105, 130 (2006) (footnotes omitted).

39. Sabrina Rubin Erdely, *Doctors’ Beliefs Can Hinder Patient Care*, MSNBC.COM (June 22, 2007, 2:26 PM) (quoting Dr. Goldner), <http://www.msnbc.com/id/19190916>.

40. FOSTER ET AL., *supra* note 34, at 13 (discussing Dr. Y’s experiences at a Catholic hospital in California).

41. *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 222–23 & n.3 (3d Cir. 2000). The court ruled that the hospital offered a “reasonable accommodation” to transfer the nurse to a different ward when she refused to treat certain pregnancy complications on the grounds that the treatment, in her view, amounted to an abortion. *Id.* at 226. The nurse was fired after she refused the transfer. *Id.* at 223–24. The court wrote “we believe public trust and confidence requires that a public hospital’s health care

Refusals to provide treatment extend beyond refusals to treat conditions caused by reproductive health problems to independent conditions that a doctor may object to treating because the woman is pregnant. For example, an Obstetrician/Gynecologist refused to remove a large mass from an Oklahoma woman's uterus because it would endanger her pregnancy, despite the woman's desire to terminate the pregnancy.⁴² The mass was shutting off the woman's colon and bladder, but she was in a Catch-22; the doctor refused to remove the mass as long as she was pregnant, but an abortion could not be performed with the mass in place.⁴³ By the time the woman found a doctor who would remove the mass, he had to remove her uterus, which would have been unnecessary had the surgery been performed earlier.⁴⁴

2. *Emotional Harms*

Refusals, misinformation and resulting physical harms may inflict emotional trauma. Many refusals take place in a context already fraught with emotion, such as following sexual assault or during pregnancy complications.⁴⁵ A woman experiencing an ectopic pregnancy or miscarriage likely is already saddened by the loss of her pregnancy.⁴⁶ Refusals imply an outsider's judgment that these women are doing something wrong and invoke shame during a fragile time.

Rape is traumatizing because it destroys the sense of control that a woman has over her body.⁴⁷ The experience of having another person assert control over an intimate bodily function is a dissociative one that deeply affects a woman's sense of self. Women experience rape as dehumanizing

practitioners—with professional ethical obligations to care for the sick and injured—will provide treatment in time of emergency.” *Id.* at 228.

42. NAT'L HEALTH PROGRAM, *supra* note 1, at 7.

43. *Id.*

44. *Id.*

45. See Susan Berke Fogel & Lourdes A. Rivera, *Saving Roe is Not Enough: When Religion Controls Healthcare*, 31 FORDHAM URB. L.J. 725, 735–36 (2004) (discussing abortions done in hospitals, which are therefore more likely to be subject to refusals, as occurring often with women who have just been raped, or who are medically fragile, as well as further into their pregnancies; for example, a woman might need a hospital abortion if her fetus is anencephalic, meaning that it does not have a cranium).

46. *Early Pregnancy Loss: Miscarriage and Molar Pregnancy*, AM. CONG. OF OBSTETRICIANS & GYNECOLOGISTS (2002), http://www.acog.org/publications/patient_education/bp090.cfm (“For many women, miscarriage . . . results in feelings of loss and grief.”).

47. Marianne Winters, *Violence Against Women*, in OUR BODIES, OURSELVES FOR THE NEW CENTURY 158, 167 (1998), available at http://www.feminist.com/resources/ourbodies/viol_sa.html (describing loss of control and powerlessness experienced by many rape survivors, noting that “healing can occur when you begin to regain a sense of power”).

because it demonstrates another person's lack of regard for her as an equal human being entitled to make her own moral decisions. A central tenet of rape treatment, counseling and recovery is that a woman's humanity and moral value must be reflected back to her by the people around her who do this by listening to her decision-making process and respecting her decisions. For this reason, rape crisis counselors are trained to provide non-directive counseling. For example, a crisis counselor will not recommend that a woman report her rape to law enforcement; instead, she will offer the options of reporting or not reporting, will ask open-ended questions to help the survivor consider her options, and will respect the woman's decision even if it is not the one the counselor would have made. Refusals to provide medical information to a rape victim traumatize her again by substituting someone else's decision about what should happen to her body and bypassing her moral decision making authority completely in the same way that rape forces an outsider's decision on the woman's body without the involvement of her decision making capacity, making her feel powerless.⁴⁸ It is especially important that a rape survivor's moral autonomy be respected because it empowers her to make her own decisions regarding her body and shows her that other people respect her moral agency and her personhood.

On top of the profound feeling of loss of power that many rape survivors experience, a rape survivor may also be worried that she will become pregnant.⁴⁹ Refusals to provide information regarding emergency contraception and emergency contraception itself increase the chance that this fear will be realized.⁵⁰ In order for rape survivors to decide whether or not to use emergency contraception, their doctors must provide them with information about it; "While nonprescription availability [of traditional emergency contraception] makes adult women less dependent on a physician's prescription than in years past, studies repeatedly show that some women do not know about EC, and even well-informed patients still rely on their physician's advice."⁵¹ Individual practitioners who refuse to administer emergency contraception themselves should nonetheless ensure that the woman receives both information about emergency contraception and the

48. See Erdely, *supra* note 39 ("I felt victimized all over again. First the rape, and then the doctor making me feel powerless.") (quoting woman who was refused emergency contraception during her examination after being raped).

49. See *Pregnancy, RAPE, ABUSE & INCEST NAT'L NETWORK* (2009), <http://rainn.org/get-information/sexual-assault-recovery/medical-information/pregnancy>.

50. See Varughese, *supra* note 2, at 654 ("Emergency contraception can prevent pregnancy by [a variety of methods] . . . [It] does not cause an abortion and, unlike abortifacients such as RU-486, is not effective once the fertilized egg implants in the uterine wall establishing pregnancy.").

51. Ryan E. Lawrence et al., *Obstetrician-Gynecologist Physicians' Beliefs About Emergency Contraception: A National Survey*, 82 *CONTRACEPTION* 324, 329 (2010).

treatment itself through another practitioner at the same location because if she is refused emergency contraception, a rape survivor may not feel comfortable asking someone else at the hospital for treatment, may feel too humiliated to ask a friend for transportation to a willing provider, or may be afraid to walk to a pharmacy.

3. *Financial Harms*

Refusals reduce efficiency in health care delivery for low- and high-income people alike.⁵² But the additional costs imposed on patients may mean that low-income people are denied access altogether. Refusals impose additional costs because of insurance limitations. If a woman's insurance covers only one visit to her gynecologist per year, a common provision, her doctor's refusal to counsel her about family planning, write a prescription for oral contraceptives, or provide such services as intra-uterine device (IUD) insertion or diaphragm fitting means that she will have to pay out of her own pocket to see another gynecologist in order to get the services for which she should be insured. A woman who is raped may not be able to afford emergency contraception at a pharmacy, while her insurance would cover it if it were administered at a hospital. All of the in-network hospitals may refuse to provide certain services, forcing a woman to shoulder an unaffordable cost-sharing burden by going to an out-of-network hospital.⁵³ Insurance providers themselves may include religious refusals. Some states automatically enroll Medicaid beneficiaries into religiously affiliated managed care plans that do not provide family planning services. The beneficiary may be barred from seeing another doctor for a certain period of time, or may face administrative difficulties in switching managed care plans so that she can get the care she needs.

In addition to insurance and access issues, refusals can impose additional costs for treatment.⁵⁴ Two examples are miscarriage management and tubal ligation. "With respect to the management of miscarriages, a number of

52. See FOSTER ET AL., *supra* note 34, at 12 (discussing a physician who reported "that a primary difference between" practicing in a Catholic versus a secular setting is that one "must be '100% sure that the pregnancy isn't viable'" before performing a uterine evacuation, which she noted "often requires additional paperwork and clinical tests including serial β hCGs and/or additional ultrasounds," and, "given that ultrasonography is often inconclusive, physicians are often unclear as to what their options are [under the Catholic hospital's requirements]").

53. See, e.g., Laura Parker, *Case Involves a Collision of Rights: Calif. Doctors Accused of Using Faith to Violate Law Against Anti-Gay Bias*, USA TODAY, Aug. 3, 2007, at 3A (relating the story of Guadalupe Benitez, a lesbian who was forced outside of her insurance network coverage after fertility clinic doctors refused to treat her on the basis of their religious beliefs).

54. NAT'L WOMEN'S LAW CTR., *supra* note 6, at 5.

[physicians in Catholic hospitals] reported having to order additional tests and/or perform diagnostic surgery in order to definitively ascertain that a pregnancy was not viable.”⁵⁵ Despite the fact that a woman was having a miscarriage, the doctors had to perform medically unnecessary tests before they could treat her miscarriage, increasing the likelihood of negative health outcomes for the woman as well as increasing the costs of the procedures. Another example of unnecessary duplication of services occurs when hospitals and individuals refuse to provide tubal ligation services to women who are in the hospital to give birth or undergo cesareans. Postpartum sterilization, which does not require additional hospitalization, and when performed with cesarean avoids an additional surgery event and additional anesthesia, is often more convenient, costs less, and is safer for the patient than having a sterilization performed later.⁵⁶

4. *Harms to Public Health*

Refusals to provide information or treatment are harmful to public health efforts.⁵⁷ “In an effort to circumvent a hospital or other institution’s religiously based opposition to contraception, some doctors may falsely indicate that a patient needs contraception for a medical reason, such as endometriosis or an irregular menstrual cycle. However, this practice ultimately can harm the patient in the long run” because this diagnosis will be in her medical records and future insurers and doctors will believe that she has a preexisting medical condition where none exists.⁵⁸

Refusals may result in increased rates of unintended pregnancy. Almost half of all pregnancies in the United States are unintended and there has been a growing concentration of such pregnancies among less educated and low-income women.⁵⁹ Together, this may indicate a need for greater public understanding of reproduction and birth control.⁶⁰ Proactive medical

55. FOSTER ET AL., *supra* note 34, at 20.

56. See Keri Tonn, Note, *Fraud on Your Conscience: Refusal to Offer Postpartum Sterilization and Its Consequences*, 11 MICH. ST. U. J. MED. & L. 203, 203 (2007).

57. NAT’L WOMEN’S LAW CTR., *supra* note 6, at 5–6.

58. *Id.*

59. Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, 38 PERSPECTIVES ON SEXUAL & REPRODUCTIVE HEALTH 90, 90 (2006), available at <http://www.guttmacher.org/pubs/psrh/full/3809006.pdf>.

60. KELLEEN KAYE ET AL., THE NAT’L CAMPAIGN TO PREVENT TEEN & UNPLANNED PREGNANCY, THE FOG ZONE: HOW MISPERCEPTIONS, MAGICAL THINKING, AND AMBIVALENCE PUT YOUNG ADULTS AT RISK FOR UNPLANNED PREGNANCY 35–51 (2009) (discussing study findings that lack of knowledge about contraceptive methods, overestimation of the side effects of contraceptives, misinformation about pregnancy and contraception, and disbelief that contraception is effective are contributing factors to unplanned pregnancy).

provider counseling on family planning can reduce unintended pregnancy.⁶¹ Conversely, refusals without ensuring that patients are provided family planning counseling services through another provider leaves an information gap because “[y]oung adults overwhelmingly say that their most trusted source of information about contraception is a medical provider.”⁶² Without medical professional involvement, patients may not have sufficient information to know that birth control is effective,⁶³ to choose between methods,⁶⁴ or to use the chosen method effectively, and will not be able to obtain the most effective methods, which currently require prescriptions or practitioner insertion.⁶⁵

Refusals also result in higher rates of sexually transmitted infections (STIs). Physicians, in primary care and wellness visits as well as more specialized sexual health visits, play a major role in reducing the spread of STIs, including HIV and other STIs that cause long-lasting physical effects, such as infertility, by providing risk avoidance counseling to uninfected and infected patients. A review of studies of HIV interventions for people living with HIV found that the interventions which significantly reduced sexual risk behaviors included “deliver[y] by health-care providers or counsellors” and “deliver[y] in settings where [people living with HIV] receive routine services or medical care.”⁶⁶ Similarly, previous review of scientific studies has shown that interventions in health-care settings also reduce risk be-

61. *Id.* at 12 (“[T]he health care system can do more to help unmarried young adults plan and prevent pregnancy by . . . [e]nsuring that providers who care for young adults are well trained in family planning, aware of the full range of contraceptive methods now available, . . . comfortable providing them to young adults[, and by e]ncouraging providers to do more counseling about pregnancy planning and prevention.”).

62. *Id.* at 64.

63. *Id.* at 9 (“Many unmarried young adults, both men and women, simply don’t believe that contraception is very effective. For example, 42% of men and 40% of women believe that the chance of getting pregnant within a year while using the birth control pill is 50% or greater (despite research suggesting that the pill is typically 92% effective).”(emphasis omitted)).

64. *Id.* at 8 (stating that while only 30% of unmarried young adults say they know “*little or nothing*” about condoms, “63% say they know *little or nothing* about birth control pills” and “56% say they have *not heard* of the birth control implant.”).

65. The most effective forms of contraception are only available through contact with medical professionals; over-the-counter barrier methods are less effective than birth control pills, and intrauterine devices and birth control implants, which require insertion and removal by medical professionals, are more effective than birth control pills. *E.g.*, OFFICE ON WOMEN’S HEALTH, U.S. DEP’T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS: BIRTH CONTROL METHODS 7–10 (2009), <http://www.womenshealth.gov/faq/birth-control-methods.pdf>.

66. Nicole Crepez et al., *Do Prevention Interventions Reduce HIV Risk Behaviours Among People Living with HIV? A Meta-Analytic Review of Controlled Trials*, 20 AIDS 143, 143 (2006), available at http://journals.lww.com/aidsonline/Fulltext/2006/01090/Do_prevention_interventions_reduce_HIV_risk.2.aspx.

haviors among uninfected individuals.⁶⁷ Hospitals or health-care providers that refuse to counsel sexually active patients on the use of condoms to prevent the sexual transmission of HIV or other STIs contribute to higher rates of these infections by missing a major opportunity to counsel on risk avoidance.

Refusals reinforce and perpetuate the idea that medical professionals are morally judging the behaviors of their patients. Research shows that when patients are afraid of moral judgment, they are less forthcoming about their health needs.⁶⁸ Actually experiencing a refusal to provide treatment may make a patient feel guilty, ashamed, alienated from the health-care system, and fearful of being judged by other providers.⁶⁹ The more stigmas a person encounters from the health provider community, the more opportunities are missed to ensure adherence to treatment and prevention of negative public health outcomes.⁷⁰ A patient who has had a bad experience may avoid contact with the health-care system entirely, including use of preventive care, until his or her condition becomes more serious, reducing the chances of the patient recovering and contributing to greater health-care costs. A patient may delay seeking medical attention until an illness becomes unbearable enough to force him or her to go to one of our nation's already overburdened emergency rooms, losing opportunities for early treatment and education on preventing further spread in the community.

67. See, e.g., Mary Spink Neumann et al., *Review and Meta-Analysis of HIV Prevention Intervention Research for Heterosexual Adult Populations in the United States*. 30 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES S106, S110 (2002), available at <http://journals.lww.com/jaids/pages/articleviewer.aspx?year=2002&issue=07011&article=00010&type=fulltext> (discussing interventions found to be successful at reducing sexual risk behaviors among uninfected people and noting that "interventions were conducted most frequently in health care settings").

68. E.g., *Stigma, Information Gaps Contribute to Silence on Sexual Health Matters; National Survey Finds Many Women Not Discussing HIV, Other Sexually Transmitted Diseases with Providers or Partners*, ASCRIBE NEWSWIRE (June 17, 2003), <http://newswire.ascribe.org/cgi-bin/behold.pl?ascribeid=20030616.155710&time=21%2002%20PDT&yeaer=2003&public=0> (noting that, according to a national survey, "[a]pproximately half of women, ages 18 to 49, report never having discussed . . . STDs[] with a health care provider," and one of the most common reasons for forgoing discussion is "embarrassment or concern about being judged").

69. See, e.g., Erdely, *supra* note 39 (reporting that a patient refused emergency contraception at a rape crisis hospital visit "remained haunted by the ER doctor's refusal—so profoundly, she [did not] see a gynecologist in the two and a half years since," and that she hadn't "gotten the nerve up to go, for fear of being judged again").

70. See Shalini Bharat & Vaishali Sharma Mahendra, *Meeting the Sexual and Reproductive Health Needs of People Living with HIV: Challenges for Health Care Providers*, 15 REPROD. HEALTH MATTERS 93, 93 (2007) ("Supportive and knowledgeable providers are crucial for helping HIV-positive people seek and adhere to treatment, prevent sexually transmitted infections, unintended pregnancies and vertical transmission of HIV and support positive living free from stigma and discrimination.").

5. *Violation of Patient Rights*

Under the informed consent doctrine, patients have a right to be given the full range of treatment options for their condition and told the risks and benefits of each alternative, as well as the risks and benefits of abstaining from treatment.⁷¹ All fifty states and the District of Columbia recognize physician liability based on lack of informed consent.⁷² The doctrine of informed consent is generally applicable to professionally-provided medical care of all specialties and exists in large part to protect the patient's right to be his own decision-maker.⁷³ Under the generally applicable standards of informed consent, a hospital or provider who refuses to discuss treatment options or their effects with a terminally ill patient violates the patient's rights to informed consent to accept or refuse treatment.⁷⁴ Similarly, a provider who leaves a patient unaware of available treatments or gives her medically inaccurate information violates her right to informed consent. For example, an ultrasound technician or doctor who refuses to reveal fetal anomalies or an oncologist who refuses to discuss gamete preservation before radiation treatments that will compromise fertility violate the patient's right to informed consent.⁷⁵ However, under federal law and the laws of some states, the well established right of patients to informed consent has been subject to carved out exceptions, whereby the right to informed consent has been overridden by statutes that allow certain people and institutions to opt-out of compliance with these otherwise generally applicable laws (discussed further, *infra* Part III.B.).⁷⁶

71. Suzanne K. Ketler, Note, *The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine After Schreiber v. Physicians Insurance Co. of Wisconsin*, 95 NW. U. L. REV. 1029, 1037 (2001); Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 901 (1994) (contract based conception of "individual autonomy" survives in the public health contexts of "mandated disclosures for patients whose care is financed under federal programs, and other statutorily required disclosures") (footnote omitted).

72. Jon F. Merz, *On a Decision-Making Paradigm of Medical Informed Consent*, 14 J. LEGAL MED. 231, 231 (1993); see also NAT'L WOMEN'S LAW CTR., *supra* note 19, at 1 (noting that "most states include the failure . . . to give informed consent in their medical malpractice laws").

73. Merz, *supra* note 72, at 231–32.

74. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) ("The informed consent doctrine has become firmly entrenched in American tort law."); *id.* at 277 ("[T]he common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.").

75. See NAT'L WOMEN'S LAW CTR., *supra* note 19, at 2.

76. Fogel & Rivera, *supra* note 45, at 727.

C. *How Common Are Refusals and How Often Are Patients Harmed?*

While there are many cases on record, the true scope of the problem is both unknown and unknowable. “Religious hospitals represent approximately 13% of all US community-based hospitals and provide nearly 20% of hospital beds,” and many prohibit “certain end-of-life” and reproductive health treatments.⁷⁷ Based on the percentage of physicians who “do not believe they are obligated to . . . provide referrals” when a patient requests a treatment the physician finds morally objectionable, “29% of patients—or nearly 100 million Americans” may have physicians who would refuse to refer for certain procedures.⁷⁸ “Advocates on both sides say the refusals appear to be spreading, often surfacing only in the rare instances when women file complaints.”⁷⁹

Complaints regarding institutional or individual refusals are “rare” for many reasons, including that people who have been refused do not know that they have experienced a refusal, because they are not aware that such a refusal is unethical or illegal and may have a remedy, or because they have privacy concerns. Because some providers refuse to give information, some patients will never know that they have experienced a different standard of care because of their doctor’s religious beliefs.⁸⁰ Where the institution, such as the hospital, initiates the refusals, even the physicians may not be aware that the limitations on their practices are the result of a religious refusal. For example, some Catholic hospitals do not make methotrexate, the nonsurgical treatment for ectopic pregnancy, available within their institutions, and “[a]lthough physicians from all institution types described methotrexate as their preferred line of treatment, it appears that some physicians in Catholic hospitals are not directly associating the lack of availability of methotrexate as a policy governed by the *Directives*.”⁸¹

Even if she is refused treatment, a patient may not be aware that she has experienced a refusal based on a nonmedical reason. For example, a woman who was denied a dilation and curettage procedure at a hospital after a sonogram showed that her baby was stillborn was unaware that the denial was due to the hospital’s religious affiliation and not just standard practice

77. Debra B. Stulberg et al., *Religious Hospitals and Primary Care Physicians: Conflicts over Policies for Patient Care*, 25 J. GEN. INTERNAL MED. 725, 725 (2010). Over 40% of physician respondents in this study reported having taken care of patients in a religious-affiliated institution. *Id.* at 727.

78. Curlin et al., *supra* note 6, at 597.

79. Stein, *supra* note 10.

80. Erdely, *supra* note 39 (“In many cases, women don’t even know a doctor is withholding treatment.”).

81. FOSTER ET AL., *supra* note 34, at 19.

for her condition. Likewise, a patient may be transferred from a hospital emergency room that refuses to provide ectopic pregnancy treatment, and may never know the reason for the refusal-based transfer. Similarly, some pharmacists will simply say that a drug is out of stock in order to avoid a confrontation.⁸² Because these women are unaware that they have experienced a religious refusal, they may never report their experiences.⁸³

Even a patient who is aware that she has been refused treatment based on providers' personal beliefs may not know that her rights may have been violated, that there is anything she can do about it, or who to call, and may therefore never report the refusal to a non-profit organization, enforcement agency, or media outlet.⁸⁴ Some patients also do not want to incur the time, effort or possible expense involved in filing a complaint. Still others do not complain about refusals because of shame or embarrassment regarding the private nature of the services sought, reluctance to open themselves to the possibility of having to share sexual details publicly, or unwillingness to relive traumatic experience such as a rape or miscarriage.⁸⁵ Because patients do not know that they have been subject to religious refusals or do know but face disincentives to make reports, such as perceived ineffectiveness, feeling of powerlessness over the medical establishment, or concerns over privacy, refusal incidents are likely under-counted substantially.

II. ORIGINS OF THE PROVIDER'S DUTY

Providers have a duty to provide informed consent, which consists of providing sufficient information on all of the options which (depending on the jurisdiction) either fit within the standard of care or would be considered material to a reasonable patient's decision, as well as a duty to obtain consent

82. See, e.g., Keren Rivas, *Many Local Pharmacists Refuse to Fill Prescriptions for Emergency Contraceptive*, TIMES NEWS (Burlington, N.C.), Apr. 30, 2005; see also Complaint at 1–2, Brown, No. 200610078 (Ill. Dep't of Fin. & Prof'l Regulation Mar. 27, 2006), available at <http://www.idfpr.com/newsrfs/032706BrownOrder.pdf> (alleging pharmacist lied when he said the pharmacy carried "Plan B" in the store).

83. See NAT'L WOMEN'S LAW CTR., NATIONAL WOMEN'S LAW CENTER COMMENTS ON "NOTICE OF RIGHTS REGARDING THE DISPENSING OF CONTRACEPTIVES" 3–4 (2006), available at <http://www.nwlc.org/sites/default/files/pdfs/TestimonyNoticeRule052406.pdf>.

84. See *id.* at 3 ("A woman subjected to a pharmacy refusal who is unaware of her rights under the existing rule might leave the pharmacy without a necessary contraceptive drug or the resources she needs to find it elsewhere.").

85. See Erdely, *supra* note 39 (reporting that patients denied treatment by physicians rarely complain because "the situation tends to feel so humiliatingly personal;" quoting Lori Boyer, a rape patient who was denied emergency contraception and did not come forward until a newspaper reported on the same doctor because he refused to provide another rape survivor with emergency contraception, "The whole situation was traumatizing and embarrassing, and I just wanted to put it behind me.").

for all treatments actually performed. This duty is based on professional ethical standards, many of which have been incorporated into law by statute, regulation, and common law. For example, states license health-care practitioners, bringing such practitioners under the purview of laws designed to protect public health and patient welfare and subjecting them to professional discipline for violations of their duties. Other state statutes impose criminal penalties on medical providers for failure to conform to specific duties. Finally, informed consent and the standard of care are enforced as civil duties arising under fiduciary duty and malpractice law.

A. *Duty in Licensing*

Medical professionals, including doctors, nurses and pharmacists, are licensed by states. The license to practice medicine or pharmacy is a privilege granted by the state in order to promote the public interest in enforcing the professional standard that the patients' interests will be paramount.⁸⁶ The privilege to practice medicine comes with a duty to serve and advance the state's interest in public health.⁸⁷ Many states govern medical providers' licenses based on ethical criteria set by providers' professional organizations, which are often incorporated by reference into state licensing statutes and regulations. Many of these provisions limit refusals based on nonmedical considerations.

Many regulations limiting refusals are aimed at pharmacists because pharmacists traditionally have a duty to dispense prescribed medication and are traditionally strongly discouraged from intervening in the doctor-patient relationship. Many states' regulations mandate transfer of prescriptions at the request of the patient, and explicitly state that refusal to transfer by a pharmacy or pharmacist constitutes unprofessional conduct or another violation of the state's pharmacy rules and regulations.⁸⁸ South Carolina has

86. *E.g.*, Robert S. Crausman, *About the Board*, BD. OF MED. LICENSURE & DISCIPLINE, R.I. DEP'T OF HEALTH, <http://www.health.ri.gov/hsr/bmld/> (last visited Feb. 7, 2011) ("Upon entering the profession we all pledge to uphold a high standard of professional behavior that selflessly places our patients' interests above our own. So extraordinary is this role and so necessary is this commitment, that every state operates a governmental agency to monitor and enforce the professional conduct of physicians.").

87. *See, e.g.*, Am. Pub. Health Ass'n, *supra* note 24 ("The practice of pharmacy is regulated by each state for the purpose of protecting public health.").

88. *See, e.g.*, MINN. R. 6800.3120 Subp. 9 (2009) ("The board shall consider it evidence of unprofessional conduct for a pharmacist to refuse to provide a transfer of original prescription information to another pharmacist who is acting on behalf of a patient and who is making a legal request for this information under this part."); OHIO ADMIN. CODE 4729-5-24(D)(2) (2010) ("No pharmacy shall refuse to transfer information about a previously dispensed prescription to another pharmacy when requested by the patient. Prescription information shall be transferred in accordance with this rule as soon as possible in order to assure that the patient's drug therapy is not interrupted."); 22 TEX. ADMIN. CODE §

codified the American Pharmaceutical Association's Code of Ethics, discussed *infra*, giving it the force of law.⁸⁹ North Dakota has adopted the National Association of Boards of Pharmacy's Model "Pharmacy Patient's Bill of Rights" as law.⁹⁰ Pharmacists must provide care consistent with the patient's right "[t]o have the pharmacist serve as one of the patient's advocates for appropriate drug therapy and to make reasonable efforts to recommend alternative choices in cooperation with the patient's physician" and "[t]o have the patient's prescriptions dispensed and pharmacy services provided at a pharmacy of the patient's choice in an atmosphere that allows for confidential communication."⁹¹

State pharmacy boards in Delaware, New York, North Carolina, Oregon, and Texas have issued policy statements supporting patients' right to receive their medications and clarifying that obstruction or harassment of patients by pharmacists are inappropriate and, in some instances, may give rise to discipline under existing laws and regulations.⁹² Many states also require pharmacists to dispense medications without obstruction or delay and provide patients with options if their medication is out of stock.⁹³ Disciplinary actions against pharmacists for refusals to fill and transfer prescriptions have been undertaken because these refusals constitute a departure from the professional obligation to adhere to the standard of care.⁹⁴

291.34(d)(5) (2010) ("A pharmacist or pharmacist intern may not refuse to transfer original prescription information to another pharmacist or pharmacist intern who is acting on behalf of a patient and who is making a request for this information as specified in paragraph (4) of this subsection.")

89. S.C. CODE ANN. § 40-43-86(W) (2009) (codifying the American Pharmaceutical Association's Code of Ethics for pharmacists).

90. N.D. ADMIN. CODE 61-04-07-01 (2010).

91. *Id.*

92. *Considering Moral and Ethical Objections*, DSBP NEWS (Del. State Bd. of Pharmacy, Dover, Del.) Mar. 2006, at 4; Letter from Lawrence H. Mokhiber, Exec. Sec'y, N.Y. State Bd. of Pharmacy, to Supervising Pharmacists (Nov. 18, 2005), available at <http://www.op.nysed.gov/prof/pharm/pharmconscienceguideline.htm>; *Pharmacist FAQs: Frequently Asked Questions for Pharmacists on Conscience Clause*, N.C. BD. OF PHARMACY (Apr. 2005), http://www.ncbop.org/faqs/Pharmacist/faq_ConscienceClause.htm *Position Statement: Considering Moral and Ethical Objections*, OR. BD. OF PHARMACY (June 7, 2006), available at http://www.oregon.gov/Pharmacy/M_and_E_Objections_6-06.pdf; TEX. STATE BD. OF PHARM., *Plan B*, <http://www.tsbp.state.tx.us/planb.htm> (last visited Feb. 7, 2011).

93. *E.g.*, ILL. ADMIN. CODE tit. 68, § 1330.500(e) (2010). NEV. ADMIN. CODE § 639.753 (2010) (Nevada pharmacists can only decline to fill prescriptions for professional reasons); *see also Pharmacy Asked to Withhold Judgment*, LASVEGASUN.COM (May 6, 2006), <http://www.lasvegassun.com/news/2006/may/06/pharmacy-asked-to-withhold-judgment/> (refusals based on moral or personal beliefs could result in discipline from the state).

94. *E.g.*, JODY FEDER, CONG. RESEARCH SERV., RS22293, FEDERAL AND STATE LAWS REGARDING PHARMACISTS WHO REFUSE TO DISPENSE CONTRACEPTIVES 3-4 (2005), available at <http://maloney.house.gov/documents/olddocs/women/ALPHA/RS22293.pdf> (citing *In re Disciplinary*

State regulations of professionals also outline the duty to provide care for other health professionals. In New York, the rules applicable to all licensed medical professionals, including pharmacists, define “[a]bandoning or neglecting a patient under and in need of immediate professional care, without making reasonable arrangements for the continuation of such care” as “professional misconduct.”⁹⁵ Similarly, in the District of Columbia the statute applicable to licensed medical professionals defines abandoning a patient as “termination, without adequate notice, of the professional relationship between a health care provider and a patient or client at a time when the patient or client is in need of further emergency care.”⁹⁶ Similarly, informed consent requirements are defined by statute in most states, and are based on common law in others.

These licensing laws, and laws like them in other states, are designed to ensure that the focus of professionals is on providing seamless care to patients. The personal, unscientific beliefs of professionals do not generally allow them to breach the standard of care, but they may refuse to provide any service so long as the refusal does not conflict with the professional duty to ensure the patient’s rights to informed consent or to access treatment that conforms to professional standards of care. However, in some states laws governing refusals have altered this general rule so that professionals can be exempted from the duty to provide the standard of care based on personal ethical beliefs. Nonetheless, professionals have ethical obligations not to breach these standards.

B. *Ethical Duty*

National professional associations for pharmacists, doctors, and other medical and health professionals issue guidance to their membership outlining the duties owed to patients.⁹⁷ These ethical duties require health professionals to privilege the welfare of the patient over their own interests.

Proceedings Against Neil T. Noesen, Final Decision and Order LS0310091PHM of the State of Wis. Before the Pharmacy Examining Bd. (April 13, 2005), available at <https://online.drl.wi.gov/decisions/2005/ls0310091phm-00068882.pdf>; Am. Pub. Health Ass’n, *supra* note 24.

95. N.Y. EDUC. LAW § 6530(30) (2010).

96. D.C. CODE § 3-1205.14 (2001). Many other states have similar patient abandonment clauses. *E.g.* GA. CODE ANN. § 43-34-8 (2011); N.H. REV. STAT. ANN. § 329:17 (2011).

97. See *infra* Part III.B. In addition, the American Academy of Physician Assistants has also issued a guideline stating that “[p]hysician assistants have an ethical obligation to provide balanced and unbiased clinical information about reproductive health care.” AM. ACAD. OF PHYSICIAN ASSISTANTS, GUIDELINES FOR ETHICAL CONDUCT FOR THE PHYSICIAN ASSISTANT PROFESSION 8 (2008), available at <http://www.aapa.org/images/stories/Advocacy-Professional-Employment/19-EthicalConduct.doc>.

They emphasize the informed consent paradigm, which stresses that patients rather than physicians make decisions about their care based on information physicians provide them explaining risks, benefits, and alternatives to a given treatment, is central to modern medical ethics.⁹⁸ These policies support the idea that conscience protections for providers are acceptable only insofar as arrangements are made to ensure that resulting refusals do not interfere with patient care.⁹⁹

1. *American Medical Association*

The American Medical Association (AMA), the nation's largest provider group, recognizes the duty of physicians to place patient welfare above all other considerations. "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."¹⁰⁰ Provisions of the AMA's Code of Medical Ethics make absolutely clear that physicians have a duty to provide patients with all pertinent medical information and may not stop treating a patient without providing assistance to patients to make alternate arrangements for care.¹⁰¹ Furthermore, the AMA weighed in on the issue of pharmacist refusals at its 2005 annual meeting. Noting the potential impact on patient care, and the role of the pharmacist in working with the physician to meet the needs of the patient, the AMA stated that it would support laws that require dispensation or meaningful and timely referral processes.¹⁰²

98. Martha S. Swartz, "Conscience Clauses" or "Unconscionable Clauses": *Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL'Y L. & ETHICS 269, 316 (2006).

99. See Letter from Am. Med. Ass'n et al., to Brenda Destro, Office of Public Health and Science, Dep't of Health and Human Servs., at 2 (Sept. 24, 2008) ("[W]hile we support the legitimate conscience rights of individual health care professionals, the exercise of these rights must be balanced against the fundamental obligations of the medical profession and physicians' paramount responsibility and commitment to serving the needs of their patients.').

100. AM. MED. ASS'N, CODE OF MED. ETHICS, § 10.015: 348 (2008–2009 ed. 2008).

101. *Id.* § 8.08: 245–51 (discussing that informed consent must be honored by physicians; informed consent requires accurate presentation of medical facts and therapeutic alternatives); *id.* § 8.082: 253 ("Withholding [pertinent] medical information from patients . . . is ethically unacceptable."); *id.* § 10.01: 341–47 (discussing that the physician may not terminate treatment without giving the patient reasonable assistance and time to make alternative arrangements for care).

102. Am. Med. Ass'n, *Preserving Patients' Ability to Have Legally Valid Prescriptions Filled*, MEMORIAL RESOLUTIONS (2005).

2. American College of Obstetricians and Gynecologists

The American College of Obstetricians and Gynecologists (ACOG) issued an advisory opinion in November 2007 describing the ethical duties that reproductive health-care providers have to their patients, despite any personal objections.¹⁰³ It affirmed the primacy of respect for patient autonomy in all medical professional conduct. The opinion held that “[c]onscientious refusals that conflict with patient well-being should be accommodated only if the primary duty to the patient can be fulfilled.”¹⁰⁴

Specifically, ACOG’s opinion makes clear that a physician’s duty is to provide “complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion” so that patients can make informed decisions.¹⁰⁵ Charging doctors with the ethical obligation to provide scientific information keeps physicians in an unambiguous role of providing medical information rather than moral information and allows a patient to trust that she is getting relevant medical facts so that she can make her own informed moral decisions.¹⁰⁶ In addition to requiring the provision of accurate information, the opinion requires doctors to give advance notice of any objections that would cause them to deviate from standard practices to potential patients.¹⁰⁷ The opinion states that “[p]hysicians and other health care professionals have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.”¹⁰⁸ Emergency care must be provided despite moral objection.¹⁰⁹

This policy allows physicians to conform their behavior to their ethical beliefs, but requires them to notify employers and potential patients so that situations in which the patient would bear the burden of the refusal will be minimized. And in emergencies, those instances where advance notice and information does not allow the patient to access care she needs from another provider, the physician has an obligation to treat her, preventing his personal beliefs from placing a serious burden on the patient. This system respects

103. *The Limits of Conscientious Refusal in Reproductive Medicine*, ACOG Committee Opinion No. 385 (Am. C. Obstetricians & Gynecologists, D.C.), Nov. 2007, http://www.acog.org/from_home/publications/ethics/co385.pdf.

104. *Id.* at 1.

105. *Id.* at 3.

106. *See id.* at 3.

107. *Id.* at 5.

108. *Id.*

109. *Id.*

doctors' beliefs while recognizing that professionalism requires that the patient come first.¹¹⁰

3. *American Pharmacists Association*

The American Pharmacists Association (APhA) recognizes the right of conscience, but emphasizes that the duty falls on the pharmacist to ensure patient access. "APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."¹¹¹ Some pharmacists refuse to provide referrals or transfer prescriptions, claiming that their desire to avoid being complicit in an act they find immoral should exempt them from the standard obligation to provide the general standard of care.¹¹² APhA has disagreed, stating that a pharmacist is prohibited from "taking any action to obstruct patient access to clinically appropriate, legally prescribed therapy."¹¹³

APhA's policy, like those of the AMA and the ACOG, emphasizes the primacy of the patient and strives to ensure that refusals do not negatively impact that patient. The organization suggests that the objecting pharmacist is responsible for ensuring that a system is in place so that the patient can get the medication, stating "[the] right of conscience comes with responsibility to assure patient access to the legally prescribed therapy."¹¹⁴ This policy has been interpreted by the APhA to require a pharmacist to refer a prescription that he refuses to fill on grounds of conscience to another pharmacist if referral is the alternative system adopted by the pharmacist and his employer.¹¹⁵ The APhA has extended the policy that employers and

110. The AMA's position regarding the primacy of the patient is echoed by public health organizations. See, e.g., Letter from Georges C. Benjamin to Michael O. Leavitt, *supra* note 12, at 1 ("APHA takes the position that patients' health and well-being must come first in health care delivery and in the formulation of health policy.").

111. AM. PHARMACISTS ASS'N, GOVERNMENT AFFAIRS ISSUE BRIEF: FEDERAL CONSCIENCE CLAUSE 3 (2009), available at <http://www.pharmacist.com/AM/Template.cfm?Section=Home2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=15688>.

112. See Stein, *supra* note 10.

113. AM. PHARMACISTS ASS'N, *supra* note 111, at 3 ("APhA supports the ability of the pharmacist to step away, not in the way, and supports the establishment of an alternative system for delivery of patient care.").

114. Suzanne Price, *Conscience & Care: APhA Responds to Prevention Article*, PHARMACIST.COM (2004), <http://www.pharmacist.com/AM/Template.cfm?Section=Search1&Template=/CM/HTMLDisplay.cfm&ContentID=8347> (quoting Susan Winckler, APhA's vice president of policy and communications).

115. See AM. PHARMACISTS ASS'N, *supra* note 111.

pharmacists should establish systems that “provid[e] a timely alternative for consumers” to the emergency contraception over-the-counter context.¹¹⁶ Moreover, APhA also urges pharmacists to carefully consider their choice in practice setting to minimize conflicts, recognizing that they might have to choose between their practice of the profession and practice of their religion.¹¹⁷ The National Association of Boards of Pharmacy wrote in its newsletter that “[p]harmacists should also consider their career trajectory in light of their moral views; for example, a pharmacist with strong beliefs against contraceptive drugs might prefer to work in a setting that would not normally dispense EC.”¹¹⁸

C. *Fiduciary Duty*

One legal theory that has yet to be sufficiently tested is whether allowing nonmedical personal concerns to cloud professional judgment or advice violates a physician’s fiduciary duty to the patient. Courts have recognized that the physician is in a fiduciary relationship with his patient.¹¹⁹ Breach of fiduciary duty “claims object to the physician’s failure to conform to the ethical principles that undivided loyalty to a patient should guide a physician’s decisions, and that any influence on a physician’s decisions—other than the patient’s welfare—must be disclosed to the patient.”¹²⁰ The fiduciary duty exists in the physician-patient relationship because the professional is in a position of power with respect to the vulnerable patient,

116. L. Michael Posey, *Dual-Status Plan B Approved by FDA*, PHARMACIST.COM (2006), http://www.pharmacist.com/AM/Template.cfm?Section=Pharmacy_News&Template=/CM/HTMLDisplay.cfm&ContentID=8007.

117. For example, a pharmacist who plans to refuse to provide particular drugs for moral reasons may prefer to work at a larger pharmacy with more than one pharmacist on duty at a time. See Letter from Georges C. Benjamin to Michael O. Leavitt, *supra* note 12, at 3 (describing how under Title VII small pharmacies with only one pharmacist available at a particular time “would have difficulty upholding the rights of a pharmacist who objects to filling certain prescriptions and the rights of patients to obtain those prescribed medications in a timely manner”).

118. *Plan B Availability OTC Raises Logistical and Administrative Challenges*, NAT’L ASS’N OF BOARDS OF PHARMACY NEWSL. (Nat’l Ass’n of Bds. of Pharmacy, Mount Prospect, Ill.), Nov.–Dec. 2006, at 199, 200, available at <http://www.nabp.net/publications/assets/NovDec06NABP.pdf>.

119. Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 350 n.211 (1994) (citing *Gonzalez v. Palo Verde Mental Health Servs.*, 783 P.2d 833, 835 (Ariz. Ct. App. 1989)); Mary Crossley, *Infected Judgment: Legal Responses to Physician Bias*, 48 VILL. L. REV. 195, 251 (2003) (citing *Hoopes v. Hammargren*, 725 P.2d 238, 242 (Nev. 1986)).

120. Crossley, *supra* note 119, at 249.

who is dependent on the physician for competent and responsible medical care.¹²¹

While the fiduciary duty sometimes

preclude[s] the fiduciary from engaging in economic or other arrangements that may create a conflict of interest between the fiduciary and the beneficiary of the relationship, . . . in some instances the risks posed by such arrangements may be mitigated by the fiduciary's disclosure of and the beneficiary's consent to the arrangement.¹²²

For example, failure to disclose a financial interest, which may affect the doctor's advice, violates his fiduciary duty, but he may be allowed to continue the conflicting economic activity so long as it is disclosed. Similarly, failure to disclose a moral bias, which may affect the medical care or information offered by a physician, could violate his fiduciary duty, but full disclosure of the professional's limitations to the patient might be sufficient to comply with the fiduciary duty so long as the disclosure mitigates the potential for harm flowing from the refusal.

D. *Recognition in Malpractice and Tort Law*

"Health professionals owe duties to their patients according to accepted standards of care and, in the absence of a conscience clause, cannot simply refuse to treat or counsel their patients without exposure to liability for abandonment [or] malpractice."¹²³ Medical professionals "have a duty of care to conform to the generally recognized and accepted practices in their profession."¹²⁴ If a doctor fails to provide a treatment in specific circumstances where the standard of care calls for it, he could be held civilly liable for malpractice.¹²⁵

Most states treat failure to provide informed consent as a medical malpractice claim where the specific failure to provide sufficient information is measured against the information required by the standard of care.¹²⁶ However, in many states it is difficult to win a malpractice suit based on lack of informed consent because one must articulate a tangible injury. One such

121. Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 FLA. ST. U. L. REV. 779, 809–10 (2007).

122. Crossley, *supra* note 119, at 252.

123. Harrington, *supra* note 121, at 804.

124. Gast, *supra* note 16, at 157 (quoting *Evans v. Rite Aid Corp.*, 478 S.E.2d 846, 849 (S.C. 1996)).

125. See NAT'L WOMEN'S LAW CTR., *supra* note 19, at 1.

126. Crossley, *supra* note 119, at 248.

injury resulting from lack of informed consent is “wrongful birth,” a tort recognized in many states when a physician negligently fails to either diagnose a genetic defect or fails to inform the parents of the need for or the results of genetic testing. “Damages are awarded for emotional distress, medical expenses associated with pregnancy and birth, and, in some states, expenses the parents will incur from raising an impaired child.”¹²⁷ There is also a possibility for recovery for a category of nonphysical damages, sometimes known as dignitary harms; the claim is that the absence of informed consent is an injury “to [the] plaintiff’s personal dignity and right of privacy.”¹²⁸

An individual who is refused her prescription may have a private cause of action against a pharmacy or pharmacist. “Case law supports the proposition that the pharmacist, as the possessor of a legal monopoly on the dispensing of prescription drugs, may not exercise non-medical discretion by refusing to dispense prescriptions he or she finds objectionable, but rather must accurately fill all safe, valid prescriptions presented by a client.”¹²⁹ Disclosure of private medical information in a public place, which often accompanies pharmacy refusals, is also actionable under various state and federal laws.¹³⁰

E. *Duty of the Institution*

In general, hospitals do not have to provide any particular care or allow any particular procedure. However, there are slight limitations on institutional ability to refuse treatment in hospitals receiving public funds,

127. Harrington, *supra* note 121, at 812 (citing Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141, 142–43, 160 (2005) (stating that more than half of all jurisdictions have endorsed “wrongful birth” actions)). Many states, however, have refused to recognize a “wrongful life” action brought on behalf of the impaired child under a variety of concerns over an inability to value any life. Hensel, *supra*, at 161; *see also* Willis v. Wu, 607 S.E.2d 63, 65–66 (S.C. 2004) (discussing the difference between wrongful birth, wrongful life, and wrongful pregnancy actions).

128. Lugenbuhl v. Dowling, 701 So. 2d 447, 455–56 (La. 1997); *see also* Alan Meisel, A “Dignitary Tort” as a Bridge Between the Idea of Informed Consent and the Law of Informed Consent, 16 J.L. MED. & HEALTH CARE 210, 212 (1988) (noting that courts have increasingly allowed tort claims to protect dignitary interests).

129. Gast, *supra* note 16, at 157 (citing Coyle v. Richardson-Merrell, Inc., 584 A.2d 1383, 1386 (Pa. 1991); Heredia v. Johnson, 827 F. Supp. 1522, 1525 (D. Nev. 1993)).

130. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers, including pharmacies, to protect patient information. *See generally* Pub. L. No. 104-191, 110 Stat. 1936. The privacy provision is enforced by the Department of Health and Human Services Office for Civil Rights. OFFICE FOR CIVIL RIGHTS, U.S. DEP’T OF HEALTH & HUMAN SERVS., SUMMARY OF THE HIPAA PRIVACY RULE 1 (2003), available at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf>.

such as Medicare funding. These hospitals have additional obligations regarding informed consent and emergency care which could be breached by refusals. The Medicare Conditions of Participation regulation regarding informed consent states:

The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.¹³¹

Furthermore, the Emergency Medical Treatment and Active Labor Act (EMTALA) imposes a duty on hospitals to stabilize a patient who is in unstable condition and prohibits transfer of an unstable patient.¹³² EMTALA does not provide any exemption for the moral, religious or ethical beliefs of providers or institutions.

Pharmacies in some states have state law obligations to stock or dispense medications. For example, some chain and individual pharmacies refuse to stock emergency contraception. In some states, such stocking bans could violate provisions in state pharmacy laws that require pharmacies to meet "community needs" or maintain an adequate stock of drugs.¹³³ The "community needs" argument was successful in challenging Wal-Mart's well-publicized corporation-wide ban on stocking emergency contraception.¹³⁴ In Massachusetts, local advocates filed a lawsuit and complaints with the pharmacy board on behalf of three women who were denied emergency contraception at Wal-Mart, alleging a violation of Massachusetts's community needs provision.¹³⁵ The Massachusetts Board of Pharmacy responded unanimously, finding that the Wal-Mart policy violated this provision and that Wal-Mart pharmacies in the state are required to stock and dispense EC.¹³⁶

131. 42 C.F.R. § 482.13(b)(2) (2009).

132. 42 U.S.C. § 1395dd(b)(1), (c)(1) (2000).

133. See, e.g., IND. CODE § 25-26-13-18(a)(2) (2010) ("The pharmacy will maintain a sufficient stock of emergency and frequently prescribed drugs and devices as to adequately serve and protect the public health."); S.D. CODIFIED LAWS § 36-11-41(1) (2010) ("The pharmacy . . . shall possess a stock of pharmaceuticals adequate to serve the needs of the community in which the pharmacy is located.")

134. Michael Barbaro, *In Reversal, Wal-Mart Will Sell Contraceptive*, N.Y. TIMES, Mar. 4, 2006, at C4; see also Dana Canedy, *Wal-Mart Decides Against Selling a Contraceptive*, N.Y. TIMES, May 14, 1999, at C1 (discussing Wal-Mart's initial decision not to carry Plan B).

135. See Complaint at 1-3, *McCarty v. Wal-Mart Stores, Inc.*, No. 06-0422 (Mass. Dist. Ct. filed Feb. 1, 2006).

136. Bruce Mohl, *State Orders Wal-Mart to Sell Morning-After Pill*, BOSTON GLOBE, Feb. 15, 2006, at F1.

III. INADEQUATE PROTECTION OF PATIENTS

General informed consent and standard of care doctrines require medical professionals to provide the patient with medical information from which she can make an informed decision regarding care. Refusal clauses “are statutory provisions that allow people or entities to opt out of complying with laws and regulations based on religious or moral objections.”¹³⁷ Despite the robust basis in generally applicable law and medical ethics for placing protection of the patient at the center of medical decision-making, current conscience laws allow the religious beliefs of individual and institutional providers to take precedence over the needs of patients. Laws which allow medical professionals to opt out of providing the generalized standard of care and informed consent allow providers to abdicate their role as neutral provider of medical rather than moral information and to co-opt the role of the patient as decision maker by substituting the professional’s moral judgments for the patient’s.

A. *Legal Protections for the Right to Refuse and Impact on Patients’ Rights*

Professional ethical obligations are undermined by laws that exempt practitioners from the consequences that generally flow from failure to follow the applicable professional standards. Unfortunately, professional ethical obligations without legal enforcement are not always sufficient to protect patients. A poll reported in the *New England Journal of Medicine* showed that 18 percent of the doctors surveyed think that they are not obligated to provide a referral, and 8 percent think it is fine to withhold information about treatment options.¹³⁸ These attitudes show the willingness of some providers to privilege their personal beliefs over patient welfare and autonomy despite professional ethical obligations. Too many laws that govern refusals do not attempt to minimize the effect of the providers’ beliefs on the patient. Current laws, which allow providers to make conscience-based refusals to provide care without fear of legal consequences, fail to protect the patient from harm as a result of these refusals.

The first refusal clause was the Church Amendment, passed after *Roe v. Wade* to allow individuals and entities that receive federal funding to resist requirements that they perform or provide facilities for abortions or sterilizations if those procedures would be “contrary to [the individual or

137. Fogel & Rivera, *supra* note 17, at 1.

138. Curlin et al., *supra* note 6, at 597.

entity's] religious beliefs or moral convictions.”¹³⁹ After the Church Amendment, states then passed their own laws, usually expanding the types of services, health-care professionals, and institutions that were allowed to refuse health-care services. Forty-seven states and the District of Columbia have at least one law which allows medical providers or institutions to refuse at least one medical service.¹⁴⁰ Out of these states, only three and the District of Columbia have exceptions to each refusal law that requires a provider or institution to take actions that may contravene his or its objections where patient safety or an emergency requires it.¹⁴¹ Iowa includes a provision in its

139. 42 U.S.C. § 300a-7(b) (1976); JODY FEDER, CONG. RESEARCH SERV., RS21428, THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS 1-3 (2006) (discussing the history of conscience clause laws in response to *Roe v. Wade*, 410 U.S. 113 (1973)).

140. ALASKA STAT. § 18.16.010 (2010); ARIZ. REV. STAT. § 36-2154 (LexisNexis 2010); ARK. CODE ANN. §§ 20-16-304, -601 (2010); CAL. HEALTH & SAFETY CODE § 123420 (West 2010); CAL. PROBATE CODE §§ 4734-4736 (West 2010); COLO. REV. STAT. §§ 18-6-104, 25-6-102, -207, 27-10.5-132 (2010); CONN. AGENCIES REGS. § 19-13-D54(f) (2010); DEL. CODE ANN. tit. 24, § 1791 (2010); D.C. CODE § 22-B9006 (LexisNexis 2010); FLA. STAT. ANN. §§ 381.0051(6), 390.0111(8) (West 2009); GA. CODE ANN. §§ 16-12-142, 31-20-6, 49-7-6 (2010); GA. COMP. R. & REGS. 480-5-.03(n) (2010); HAW. REV. STAT. ANN. §§ 327E-7, 453-16 (LexisNexis 2010); IDAHO CODE ANN. §§ 18-611 to -612, 39-3915 (LexisNexis Supp. 2010); 745 ILL. COMP. STAT. ANN. 70/1-14 (West 2010); IND. CODE ANN. §§ 16-34-1-3 to -7 (LexisNexis 2010); IOWA CODE §§ 146.1 to .2 (2010); KAN. STAT. ANN. §§ 65-443 to -444, -446 to -447 (2009); KY. REV. STAT. ANN. § 311.800 (LexisNexis 2010); LA. REV. STAT. ANN. § 40:1299.31 to .33 (2009); ME. REV. STAT. tit. 22, §§ 1591-1592, 1903; tit. 34-B, § 7016 (2009); MD. CODE ANN., HEALTH-GEN. § 20-214(a) (LexisNexis 2010); MASS. ANN. LAWS ch. 112, § 12I; ch. 272, § 21B (LexisNexis 2010); MICH. COMP. LAWS SERV. §§ 333.20181 to .20184 (LexisNexis 2010); MINN. STAT. §§ 145.42, .414, .925(6) (2009); MISS. CODE ANN. §§ 41-41-215(5), 41-107-5, -7, -11 (West 2007); MO. REV. STAT. §§ 188.100, .105, .110, .115, .120, 197.032 (2009); MONT. CODE ANN. §§ 50-5-501 to -505, -20-111 (2010); NEB. REV. STAT. ANN. §§ 28-337 to -341 (LexisNexis 2010); NEV. REV. STAT. ANN. §§ 449.191, 632.475 (West 2010); N.J. STAT. ANN. § 2A:65A-1 to -4, 30:11-9 (West 2010); N.M. STAT. ANN. §§ 24-7A-7(E), -8-6, 30-5-2 (LexisNexis 2010); N.Y. CIV. RIGHTS LAW § 79-i (McKinney 2009); N.Y. COMP. CODES R. & REGS. tit. 10, § 405.9(b)(10); tit. 18, § 463.6(d) (2010); N.C. GEN. STAT. § 14-45.1(e) (2010); N.D. CENT. CODE ANN. § 23-16-14 (West 2010); OHIO REV. CODE ANN. § 4731.91 (West 2010); OKLA. STAT. ANN. tit. 63, §§ 1-728a-f, -741 (West 2010); OR. REV. STAT. ANN. §§ 435.225, .475, .485 (West 2010); 43 PA. CONS. STAT. ANN. § 955.2 (West 2010); 16 PA. CODE §§ 51.1 to .2, .31-.33, .41-.44, .51-.52, .61 (2010); R.I. GEN. LAWS ANN. § 23-17-11 (West 2010); S.C. CODE ANN. §§ 44-41-40, -50 (2010); S.D. CODIFIED LAWS §§ 34-23A-11 to -14, 36-11-70 (2010); TENN. CODE ANN. §§ 39-15-204 to -205, 68-34-104 (2010); TEX. OCC. CODE ANN. §§ 103.001 to .004 (West 2010); UTAH CODE ANN. § 76-7-306 (West 2010); VA. CODE ANN. §§ 18.2-75, 32.1-134 (2010); WASH. REV. CODE §§ 9.02.150, 48.43.065 (2010); W.VA. CODE §§ 16-2B-4, -11-1, -30-12 (2010); WIS. STAT. §§ 253.07(3)(b), .09, 441.06(6), 448.03(5)(a) (2008); WYO. STAT. ANN. §§ 35-6-105 to -106, -114, 42-5-101 to -102 (2010); the states without medical refusal laws are Alabama, New Hampshire, and Vermont.

141. CAL. HEALTH & SAFETY CODE § 123420(d) (West 2010); D.C. CODE § 22-B9006 (LexisNexis 2010); MD. CODE ANN., HEALTH-GEN § 20-214(d) (2010); and Nevada, NEV. REV. STAT. ANN. § 449.191 (West 2010). Maryland's emergency exception is very limited in that it exempts from immunity from liability only in cases where the refusal resulted in death or serious long-lasting injury and was otherwise contrary to the standards of care; therefore, a doctor would not incur liability for refusal in an emergency situation where the patient lived and incurred only temporary serious injury. Illinois and Louisiana have an emergency exception in some, but not all, of their refusal laws. See 745 ILL. COMP. STAT. ANN. 70/6 (West 2010) & 70/9 (2010); LA. REV. STAT. ANN. § 40:1299.34 (2009); *but see* LA. REV. STAT. ANN. §

law governing refusals that requires the professional or institution to provide emergency care that may be in conflict with his or its conscience when the patient's life is endangered, and three other states include a life exception in at least one, but not all, of their laws allowing refusal.¹⁴² This leaves forty-three states with at least one refusal law that does not ensure that patients will receive emergency care if that care conflicts with a provider's conscience, even in some situations where the patient's life is in danger.¹⁴³ While the professional organizations provide ethical guidance suggesting that providers should place considerations of the patient's health above all other considerations, these ethical guidelines do not sufficiently protect patients because many providers privilege their personal beliefs over the patient's health by allowing their nonmedical beliefs to justify going beyond refusing to provide care when it can be provided by a different practitioner into the professionally unsound realm of refusing to provide care when that refusal will have adverse effects on the patient's health outcome or refusing to provide enough information for a patient to make a meaningful decision.

In addition to permitting refusals, twenty-seven states shift responsibility for injury resulting from refusals to the patient by immunizing individuals or hospitals from liability stemming from a refusal to provide care.¹⁴⁴ For example, an Oklahoma law passed in April 2010 prohibits damages in wrongful birth lawsuits where the medical professionals withhold information about abnormal fetal development from a pregnant woman to ensure that she will not choose to terminate the pregnancy.¹⁴⁵ This means that medical professionals will not be subject to liability if they diagnose

40:1299.31 (2009) (shielding from liability and discrimination health-care practitioners who refuse "for any reason to recommend, counsel, perform, assist with or accommodate an abortion").

142. See, e.g., IOWA CODE § 146.1 (2010); see also IDAHO CODE ANN. § 18-611(6) (LexisNexis Supp. 2004); MO. REV. STAT. § 188.100(2) (2009); OKLA. STAT. ANN. tit. 63, § 1-728c(1), -741(C) (West 2010); TEX. OCC. CODE ANN. § 103.004 (West 2010).

143. See *supra* notes 140–142 (Alabama, New Hampshire, and Vermont do not have refusal laws, and California, Iowa, Maryland, and Nevada include exceptions to every refusal law).

144. ALASKA STAT. § 18.16.010(b) (2010); ARK. CODE ANN. § 20-16-601(a) (2010); DEL. CODE ANN. tit. 24, § 1791(a) (2010); FLA. STAT. ANN. § 390.0111(8) (2009); GA. CODE ANN. § 16-12-142 (2009); HAW. REV. STAT. ANN. § 453-16(e) (LexisNexis 2010); 745 ILL. COMP. STAT. ANN. 70/4 (West 2010); KAN. STAT. ANN. § 65-443 (2009); KY. REV. STAT. ANN. § 311.800 (LexisNexis 2010); LA. REV. STAT. ANN. § 40:1299.31 (2009); MD. CODE ANN., HEALTH-GEN. § 20-214(a)(2) (2010); MICH. COMP. LAWS SERV. § 333.20181 (LexisNexis 2010); MINN. STAT. § 145.42(1) (2009); MISS. CODE ANN. § 41-107-5(2) (West 2007); MO. REV. STAT. § 197.032(1) (2009); MONT. CODE ANN. § 50-20-111 (2010); N.J. STAT. § 2A:65A-3 (2010); N.Y. CIV. RIGHTS LAW § 79-i(2) (2009); OHIO REV. CODE ANN. § 4731.91(C) (West 2010); OKLA. STAT. ANN. tit. 63, § 1-741 (West 2010); OR. REV. STAT. ANN. § 435.475(1) (West 2010) (hospital only); 43 PA. CONS. STAT. ANN. § 955.2(a) (West 2010); S.C. CODE ANN. § 44-41-40 (2010); S.D. CODIFIED LAWS § 34-23A-12 (2010); UTAH CODE ANN. § 76-7-306(1) (West 2010); WIS. STAT. § 253.09 (2008); WYO. STAT. ANN. § 35-6-106 (2010).

145. OKLA. STAT. tit. 63, § 1-741.11(C) (West 2010).

abnormal fetal development, but withhold this information from the parents, determining on the woman's behalf that she will continue the pregnancy and birth the child unprepared for the emotional, financial, and physical toll and deprived of the opportunity to come to terms with her own moral worldview and determine what is best for her and her family. The law absolves doctors of the consequences of their refusal to abide by modern medical norms of informed consent, which requires that doctors share medical information and diagnoses in order to allow the patient to draw their own moral conclusions and make medical decisions for themselves. In many cases, by allowing refusal to provide information and referrals without liability, the laws governing refusal work to increase the harms that refusal to provide services causes to the patient by ensuring that a refusal by an individual provider will result in the patient not being able to access the standard of medical care.

Many state laws have expanded the scope of federal refusal law by expanding the services that may be refused. Fourteen states have extended refusal clauses to services related to contraception for at least some practitioners.¹⁴⁶ For example, Idaho passed a refusal law in 2010 that exempts health-care professionals licensed by the state who refuse to provide a number of services, including "dispensation of an abortifacient drug," from liability.¹⁴⁷ The law defines abortifacient to include "emergency contraception."¹⁴⁸ This extends the ability to legally refuse to provide services beyond abortion because emergency contraception, like regular contraception, functions primarily by preventing ovulation and may prevent fertilization of a released ovum or implantation. This bill includes a form of contraception, which is not chemically different from other forms of contraception, among the services a provider may refuse without consequence, extending the realm of refusal beyond objection to abortion and into objection to contraception.¹⁴⁹ In addition, because the abortion pill, also known as RU-486 or mifepristone, which actually does terminate an existing pregnancy, is not available at pharmacies, the Idaho law extends the ability to refuse to provide the general standard of care to pharmacists where a refusal law dealing only with abortion and not with contraception would not.

146. GUTTMACHER INST., STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES 1 (2011), available at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.

147. IDAHO CODE ANN. § 18-611 (LexisNexis 2010).

148. *Id.*; but see *supra* note 2 (stating that it is scientifically clear that levonorgestrel, the traditional form of emergency contraception, does not cause abortions, defined as the termination of an existing pregnancy).

149. This law would also expand the ability to refuse without consequence to cases where doctors and pharmacists refuse to dispense the Ella, which is not an identical chemical to other forms of birth control, but is nonetheless classified as a contraceptive by the FDA. For additional discussion see *supra* note 2.

Other state laws expand exemption from the legal consequences of not complying with otherwise applicable professional norms to a wider range of practitioners. For example, many state laws allow pharmacists to refuse to fill prescriptions based on their religious, moral, or personal beliefs or protect pharmacists from adverse employment action for doing so.¹⁵⁰ In 2008, the George W. Bush Administration's Department of Health and Human Services (HHS) issued a Rule on Provider Conscience, which interpreted existing law to expand the universe of health-care services that can be refused and individuals who may refuse.¹⁵¹ The Obama Administration has taken inconclusive steps towards rescinding this regulation out of concern about patient access to contraception and other services.¹⁵²

While the patient's ability to make her own medical decisions is limited by laws which exempt providers from the duty to provide information, laws theoretically designed to protect patients who are making abortion decisions exacerbate the problem. While some states statutorily protect a woman's right not to be coerced into having an abortion,¹⁵³ these laws do not provide equivalent protection of the woman's right not to be coerced against having an abortion.¹⁵⁴ Some state laws even encourage or require doctors to give inconclusive medical information to patients considering abortion.¹⁵⁵

Laws designed to protect practitioners from conflicts with institutions are similarly one-sided. Refusal policies, as outlined *infra*, allow providers in

150. See ARK. CODE ANN. § 20-16-601 (2010); GA. COMP. R. & REGS. 480-5-.03 (2010); MISS. CODE ANN. § 41-107-5 (West 2007); S.D. CODIFIED LAWS § 36-11-70 (2010).

151. 73 Fed. Reg. 78,072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88); see also Letter from Rick Pollack, Exec. Vice Pres., Am. Hosp. Ass'n, to Michael O. Leavitt, Sec'y, U.S. Dep't of Health & Human Servs. 1 (Sept. 25, 2008), available at <http://www.regulations.gov/search/Regs/home.html#documentDetail?R=090000648071ebc8> (asking for more than the typical 30-day comment period for considering the adoption of administrative rules).

152. See Rob Stein, *Heath Workers' "Conscience" Rule Set to Be Voided*, WASH. POST, Feb. 28, 2009, at A1.

153. See *Monthly State Update: Major Developments in 2010, Prohibiting Forcing a Woman to Have an Abortion*, GUTTMACHER.ORG (Oct. 1, 2010), <http://www.guttmacher.org/statecenter/updates/index.html#coercion> (stating that eleven states have introduced requirements that a woman seeking an abortion be informed that she cannot be coerced into having an abortion, mentioning specifically legislation passed in 2010 in Oklahoma and Tennessee); *Counseling and Waiting Periods for Abortion*, STATE POLICIES IN BRIEF 1-2 (Guttmacher Inst., New York, N.Y.), Oct. 1, 2010, at 1, 2 [hereinafter STATE POLICIES IN BRIEF], http://guttmacher.com/statecenter/spibs/spib_MWPA.pdf (illustrating in a chart that nine states (Alabama, Arizona, Arkansas, Kansas, Louisiana, Pennsylvania, Utah, West Virginia, and Wisconsin) have an anti-coercion policy).

154. See ALA. CODE § 26-23A-5 (LexisNexis 2009); KAN. STAT. ANN. § 65-6710 (2009); LA. REV. STAT. ANN. § 40:1299.35.6 (2009); UTAH CODE ANN. § 76-7-305.5, -312 (LexisNexis 2010).

155. See STATE POLICIES IN BRIEF, *supra* note 153, at 3 (illustrating in a chart that two states (South Dakota and Texas) inaccurately portray risk to future fertility in their abortion counseling materials, and five states (Alaska, Mississippi, Oklahoma, Texas, and West Virginia) assert a possible link between breast cancer and abortion).

non-objecting hospitals to refuse to provide certain services without professional consequence, but they do not protect physicians who want to provide the service in an institution that refuses.¹⁵⁶ This leaves a physician who does not object to a particular service and believes he has a professional obligation to provide that service without protection from an institutional policy prohibiting such a service.¹⁵⁷

B. *Limitations of Title VII*

Title VII requires employers to accommodate employees' religious beliefs, but allows employers to refuse accommodations that would constitute an "undue hardship" on the employer's business.¹⁵⁸ Courts have found that employers do not have to accommodate employees' religious practices if they burden patients, customers or coworkers because such burdens present an "undue hardship" under Title VII.¹⁵⁹ In order for this standard to protect the patient, the employee must be willing to disclose the need for a religious accommodation in time to set up an accommodation that meets the needs of all patients, and the employer must want to protect the patient's access to health-care services and information through an appropriate accommodation and alternate delivery system. Title VII provides a standard for employers who want to set up a system to protect the patient while accommodating providers' religious beliefs, but it fails to protect patients where the employer is a participant or uninterested bystander in the refusal.

156. See, e.g., *Watkins v. Mercy Med. Ctr.*, 364 F. Supp. 799, 803 (D. Idaho 1973) (discussing the prevailing right of religious hospitals to refuse to grant staff privileges to a doctor who refuses to abide by religious restrictions on sterilization or abortion procedure within the institution), *aff'd*, 520 F.2d 894 (9th Cir. 1975).

157. Stulberg et al., *supra* note 77, at 729.

158. Letter from Am. Med. Ass'n to Brenda Destro, *supra* note 99, at 3.

159. See, e.g., *Anderson v. U.S.F. Logistics, Inc.*, 274 F.3d 470, 475–76 (7th Cir. 2001) (holding that employer's ban against employee using the phrase "Have a Blessed Day" with a certain customer, but not all, was a reasonable accommodation); *Chalmers v. Tulon Co. of Richmond*, 101 F.3d 1012, 1021 (4th Cir. 1996) (noting, in dicta, the need for a company to protect itself from other employees' claims of religious harassment when one employee claimed that religious belief compelled her to write letters to coworkers questioning their behavior); *Grant v. Fairview Hosp. & Healthcare Servs.*, No. 02-4232, 2004 WL 326694, at *5 (D. Minn. Feb. 18, 2004) (holding that employer was not required to risk breaching duty of care to patients to accommodate ultrasound technician whose religious beliefs compelled him to counsel patients against having abortions).

IV. CONCLUSION: TOWARD PATIENT-CENTERED CARE

Individual health-care providers are entitled to their religious and moral beliefs and are also entitled to accommodations for these beliefs so long as such accommodations do not impose providers' beliefs on a patient by limiting her access to care.¹⁶⁰ Patients are entitled to a standard of care based on scientific medical understanding that is unaffected by a medical professionals' personal beliefs. Medical ethics require health-care providers to put the patient first. Therefore, policies must be crafted to provide the maximum protection for providers' conscientious objections consistent with the obligation to ensure that patients receive care that is based on consideration of the patient's medical condition and the patient's personal beliefs.¹⁶¹

A. Amendments to Existing Conscience Clauses

Existing conscience clauses are too vague and leave patients vulnerable to denials of information, referrals and care. They focus on provider rights to the exclusion of patient rights by setting up systems of refusal without accompanying requirements that providers ensure that their refusal to participate in particular services will not compromise the patient's ability to access those services. Refusal clauses are especially egregious when they privilege institutional "conscience" over individual patients' rights because there is an extreme imbalance of power between institutional actors and individual patients. Laws governing refusals should not make exceptions to the few patient protective duties that institutions do have under generally applicable law, such as the duty to provide emergency care in certain circumstances or the duty not to abandon patients, because such exceptions simply shift legal responsibility for the harms that result from refusals from the institution to the patient.

But policies that accommodate individual refusals to participate in services can ensure the type of "seamless" patient interaction supported by the major medical associations. Requirements that an individual notify the employer ahead of time allow institutions to prepare for individual refusals so that the employer can determine whether it can accommodate the employee's refusal and put a system in place to guarantee seamless delivery

160. See Fogel & Rivera, *supra* note 17, at 8.

161. See Fogel & Rivera, *supra* note 76, at 728–29 (“[L]aws and regulations . . . [should] protect individual rights of both patients and individual health care professionals In the reproductive health context, it is possible to accommodate individual—as opposed to institutional—refusals to provide certain health services without imposing inappropriate burdens on patients’ rights.”).

of care to the individual. For example, laws governing refusals in the pharmacy can ensure timely delivery by requiring that the pharmacy provide in-stock medications while encouraging individual objecting pharmacists to notify the employer in advance so that their personal preferences can be accommodated where possible. Such a law might require that where a medication is in stock it must be provided at that particular pharmacy in a timely manner (for example, by having a non-objecting employee provide it), that where it is not in stock a patient will be given options for obtaining the medication, including having the pharmacy order the medication or transferring the prescription to a pharmacy that is known to have the medication in stock, and that harassment of patients or misrepresentation of drug activity or availability by any pharmacy employee will remain prohibited.¹⁶²

Conscience laws should also be amended to make it clear that employers retain their right, pursuant to Title VII, to deny accommodation that may cause harm to patients.¹⁶³ Laws governing refusals should not shield providers or institutions from liability for harms resulting from their refusals, thus providing employers an incentive to ensure that the generally applicable standard of care is always met. The burden should remain on health-care professionals and institutions to ensure that the patient receives treatment that meets the standard of care.

All laws allowing individual medical professionals to refuse to participate in services should include clear emergency exceptions when refusals are not permitted. Conscience clauses should be amended to make clear that they do not abridge individual medical professionals' duty to provide the information necessary for informed consent. Laws which allow refusals to participate should ensure that they are consistent with doctors' ethical duty not to deprive a patient of her right to make decisions about her own medical care by withholding information. State policymakers should clarify that laws governing refusals do not give health-care providers the right to attempt to manipulate women in their decision-making by presenting information that is not medically accurate or is misleading, or by presenting information in a psychologically abusive manner.

162. See Am. Pub. Health Ass'n, *supra* note 24 (recommending three principles for refusal policies to follow). Advocates for patient-centered pharmacy refusal laws can contact the National Women's Law Center for model dispensation law language drafted to incorporate the highest standards for the practice of pharmacy and ensures seamless delivery of all legally prescribed medications.

163. See Adam Sonfield, *Delineating the Obligations that Come with Conscientious Refusal: A Question of Balance*, GUTTMACHER POL'Y REV., Summer 2009, at 6, 7.

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B. *Enforcement of Current Protections*

Health-care providers, employers and employees alike, need consistent enforcement of both Title VII protections and informed consent requirements so that they can align their expectations and behavior. Employers must know the requirements of informed consent and emergency treatment so that they can set outer limits on possible religious accommodations. Employees must have confidence that there is a system in place that will accommodate their religious beliefs when possible without burdening patient care so that they are comfortable sharing these beliefs with employers before a refusal situation arises, allowing the employer to create an accommodation that will not burden patients.¹⁶⁴

1. *Informed Consent and Other Legally Enforceable Duties*

Patients and advocates must file more complaints to state and federal enforcement agencies, professional boards and licensing agencies to ensure that professional and legal obligations, such as obligations to ensure informed consent or to provide emergency treatment, will be fulfilled.¹⁶⁵ These complaints, based on existing laws and regulations, such as those prohibiting patient abandonment or defining unprofessional conduct, ensure that medical providers are aware of their professional responsibilities. They also highlight the outer bounds of conscience protection laws by demarcating acceptable ways to conduct a refusal that do not impact patient care from the unprofessional refusals which impose providers' beliefs on patients.

2. *Title VII*

Clear enforcement of Title VII would allow institutions and individual employees to ensure that accommodations of employees would not interfere with the seamless provision of services to patients. When employers are aware of Title VII requirements, they can talk to employees about whether or not they need accommodations, and can set up systems that accommodate employee refusals without compromising patient care by having another

164. *See id.* at 6–9 (illustrating that in order for health-care professionals or institutions to exercise their conscience without “intentionally or otherwise block[ing] patients’ access to care . . . any objection to providing a specific service must be made transparent to all relevant parties”).

165. For an example of a complaint, *see* Letter from Laura W. Murphy, Director, Washington Legislative Office, Am. Civil Liberties Union et al., to Marilyn Tavenner, Acting Administrator, Ctrs. for Medicare and Medicaid Servs. (July 1, 2010), *available at* http://www.aclu.org/files/assets/Letter_to_CMS_Final_PDF.pdf.

employee take their place.¹⁶⁶ Employees who simply want to be able to avoid providing services to which they object benefit when they are able to disclose their need for accommodation before a religious refusal situation arises, allowing their employer the opportunity to accommodate them in a way that will not present an undue burden. The patient also benefits because a clear system to accommodate employees' known religious needs allows the employer to ensure that the patient will not be harmed by the accommodation.¹⁶⁷

C. Patient Education

Most people do not know that doctors can be restricted from providing certain services based on their affiliations with religious institutions. Similarly, patients may be unaware of their providers' individual objections and refusals to disclose all treatment options or to make referrals, or may be unaware that their insurance plan is religiously affiliated and will not cover certain services. Patients who are unaware that providers may be withholding medical information, advice, and care based on the providers' personal beliefs or the institutions' nonmedical-based restrictions are unable to protect themselves by asking about refusals and recognizing situations in which they may have experienced a refusal.

D. Provider Education

Providers must understand their professional and legal obligations, as well as the scope of the protections that apply to them, so that they may protect their ability to participate in or refuse participation in particular services while ensuring that the patient is not harmed by their or the institution's refusal.¹⁶⁸ Unfortunately, current medical ethics and legal protections are often in tension, with medical ethics requiring practitioners to focus on ensuring that the patient is not harmed by the professional's moral

166. *Id.* at 7 (discussing EQUAL EMP'T OPPORTUNITY COMM'N, COMPLIANCE MANUAL, § 12: *Religious Discrimination* 69 (2008) (providing as an example of a reasonable accommodation, a Wisconsin pharmacy's agreement to allow a pharmacist, who objected to dispensing contraception, to signal a coworker to serve customers seeking contraception)).

167. See Letter from Rick Pollack to Michael O. Leavitt, *supra* note 151, at 1 (describing necessity of health-care professionals working together to ensure that, in fulfilling their responsibility as employers to make reasonable accommodations of employees' religious beliefs, they are able to provide alternatives so that their obligations to provide timely patient access to care are met).

168. See Stulberg et al., *supra* note 77, at 730 ("Hospital administrators may wish to better involve physicians in the policy-making process, communicate policies more clearly, and develop means of hearing and accommodating physician concerns in order to reduce conflict and its impact on patient care.").

beliefs, while many legal norms shift responsibility for any patient harm that does result from refusals away from the refusing practitioner and towards the patient. One benefit to realigning legal standards with ethical requirements, as described *supra* Part I.A., so that medical professionals unambiguously have a duty to put the patient first is that keeping the burden of refusals on medical professionals incentivizes the medical professions, which have control over refusal policy in a way that patients do not, to craft careful policies that protect patient welfare and protect the practitioner's conscience. For example, professionals who know that they must always treat a patient in an emergency if there is no other provider available, even if they have a moral objection, have an incentive to support the training, hiring, and peaceful coexistence of non-objecting providers in their communities and practice settings.

Whether objecting practitioners are legally exempt from liability and disciplinary action for failure to provide services or not, medical ethics still requires them to ensure that their moral beliefs do not prevent any patient from exercising her right to make informed medical decisions. Medical associations and boards should ensure that their ethical opinions and the applicable standards of care for controversial procedures are widely known by providers. In order to minimize situations in which a provider will have to act against his conscience, providers and their professional associations should take a proactive role in ensuring that all communities have sufficient professionals willing to provide comprehensive services so that no provider who objects will be forced to participate because a patient is in need and no other provider is available.¹⁶⁹

Doctors need information about what it means to practice in religiously affiliated settings and how it limits their ability to practice medicine according to the generally applicable standard of care so that they can recognize and evaluate the legal and professional implications of institutional refusals, choose a practice setting that will allow them to provide the full array of services they are willing to provide and advocate for their patients.¹⁷⁰ They also need to be aware of limitations on the institution and individual's ability to refuse to provide information and emergency services. In addition,

169. See Sonfield, *supra* note 163, at 10.

170. FOSTER ET AL., *supra* note 34, at 24 ("Although participants in our study demonstrated considerable awareness that the *Directives* prohibit the provision of comprehensive contraception and abortion services, far fewer drew an explicit connection between the *Directives* and ectopic pregnancy and miscarriage management. Highlighting this link to clinicians may help raise awareness about the impact of mergers on their professional autonomy regarding a wider array of reproductive health issues."); see also Fogel & Rivera, *supra* note 45, at 725 (illustrating that when Catholic Healthcare West purchased the only hospital in Gilroy, Cal., doctors had to stop performing sterilizations and abortions, and family planning supplies and contraception were no longer available at the hospital or in the emergency room).

providers, especially pharmacists, need education about the medical services they are charged with providing, particularly regarding the mechanism of action of emergency contraception, so that they can give accurate information and avoid unnecessary refusals based on lack of knowledge.¹⁷¹ Knowledge of their professional ethical and legal duties, such as the legal duty to provide all information patients need to make treatment decisions or the duty in some states for pharmacists to provide prescription contraception, allows providers to protect themselves and their employers from malpractice suits.¹⁷²

Finally, practioners need education about the protection available to them through conscience laws and Title VII and the limitations of these protections. This knowledge should encourage providers to give their employers and patients notice of their religious restrictions so that the health-care setting can ensure seamless patient services while providing maximum accommodations to the provider. Clear expectations that individual providers' beliefs will be accommodated through means that do not compromise patient access allow medical professionals to step away from services that violate their consciences without imposing the burdens of the providers' beliefs on the patient, thus allowing providers to fulfill their professional duties without violating their personal beliefs.

171. Am. Pub. Health Ass'n, *supra* note 24 ("The education of pharmacists about emergency contraception, particularly its time frame of effectiveness and mechanism of action, has also been identified as a critical need."); *see also* Varughese, *supra* note 2, at 660 (discussing the beliefs of some pharmacists regarding mechanisms of action of emergency contraception).

172. NAT'L WOMEN'S LAW CTR., *supra* note 83, at 4–5.