

The Conscience Defense to Malpractice

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This Article presents the first empirical study of state conscience laws that establish explicit procedural protections for medical providers who refuse to participate in providing reproductive health services, including abortion, sterilization, contraception, and emergency contraception.

Scholarship and public debate about law's role in protecting health care providers' conscience rights typically focus on who should be protected, what actions should be protected, and whether there should be any limitations on the exercise of conscience rights. This study, conducted in accordance with best methodological practices from the social sciences for policy surveillance and legal mapping, is the first to provide concrete data on the vital but unanswered question of how these laws actually operate—that is, the precise procedural mechanisms by which laws protect medical providers who decline to provide services that violate their deeply held conscientious beliefs.

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This Article demonstrates that state laws vary dramatically in the types of protections they offer. States may immunize health care providers from a range of potential adverse consequences including civil liability, criminal prosecution, professional discipline, employment discrimination, discrimination in educational opportunities, and denial of public or private funding, among others. Of these, immunity from civil liability, or “civil immunity,” is by far the most common procedural protection. In a majority of states, civil immunity is absolute—providing no exceptions in cases of malpractice, denial of emergency treatment, or even patient death. In practice, these laws eliminate patients’ common law right to recover monetary damages when they suffer physical injury as a result of a health care provider’s conscience-based deviation from the standard of care.

While many scholars have examined the impact of conscience laws on patient access to medical care, there has been no comprehensive analysis of these laws’ impact on patients’ right to a tort law remedy when they are denied care. This Article not only raises awareness of the previously unrecognized breadth of protections established by U.S. conscience law, but also challenges basic assumptions about tort law’s ability to remedy harms suffered by victims of medical malpractice in reproductive health care contexts. These findings create an important opportunity for further policy discussion about the scope of health care conscience laws.

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INTRODUCTION

Tamesha Means was eighteen weeks pregnant and actively miscarrying when she sought care at the emergency room at Mercy Health Partners (Mercy) in Muskegon, Michigan—the only hospital in her county.¹ The doctors at Mercy diagnosed her with a ruptured amniotic sac, but sent her home.² When she returned the following day, she had a fever, was actively bleeding, and was in extreme pain—but the doctors sent her home again.³ When Ms. Means presented at the hospital a third time later that day, the hospital was prepared to discharge her again, but she went into labor, delivering an extremely premature baby who had no chance of survival and died within hours.⁴ Later testing showed that at the time of the delivery, Ms. Means suffered from a bacterial infection of the fetal membranes and umbilical cord caused by the amniotic rupture diagnosed during her first visit.⁵

According to Ms. Means’s complaint in federal court, the health care providers at Mercy never told her that her fetus would not survive the amniotic rupture, or that terminating the pregnancy and extracting the fetus would reduce the risk of serious health complications.⁶ Rather than offering her the option of termination, the providers at Mercy discharged her from the hospital without

1. Complaint at 4, Means v. U.S. Conference of Catholic Bishops, No. 1:15-CV-353, 2015 WL 3970046 (W.D. Mich. June 30, 2015), *aff’d*, 836 F.3d 643 (6th Cir. 2016).

2. *Id.* at 5.

3. *Id.* at 6.

4. *Id.* at 7.

5. *Id.*

6. *Id.* at 5–8.

informing her of the risks she faced in continuing the miscarriage without active medical management.⁷

In so doing, the health care providers at Mercy may have committed medical malpractice, and Mercy may have breached the legal duties it owed to Ms. Means. A basic principle of medical malpractice law is that health care providers owe patients a duty to exercise the same degree of care and skill that other reasonable providers would exercise under the same circumstances.⁸ Failure to follow the common practices of the medical profession constitutes a breach of the standard of care, and subjects a provider to tort liability.⁹ Failure on the part of Mercy's physicians, nurses, and other health care providers to inform Ms. Means of her medical options likely constituted malpractice; and Mercy, as an institution, likely breached its duty to Ms. Means.¹⁰

Yet even if Ms. Means could prove that the hospital or its doctors deviated from the standard of care, she would be barred from bringing a malpractice suit to recover damages for her injuries. This is because Michigan law, like many states' health care conscience laws, creates a "conscience defense" to malpractice which immunizes health care providers from civil liability, even when their conscience-driven refusal to provide information or treatment violates the standard of care.¹¹

7. *Id.* The main defendant in Means's lawsuit was the U.S. Conference of Catholic Bishops (USCCB), not Mercy Health Partners. The USCCB, which was being sued because it drafted the ethical and religious directives that bind all Catholic hospitals, did not dispute these factual claims. *See Means*, 2015 WL 3970046, at *2–3. Instead, USCCB, along with the other defendants, moved to dismiss for lack of jurisdiction and for failure to state a claim, arguing that it owed no duty to the plaintiff. *See id.* at *1–3, 10. Means's suit against the USCCB was dismissed. *Id.* at *14.

8. *See* BARRY R. FURROW ET AL., *HEALTH LAW* 76–78 (3d ed. 2014).

9. *Id.* at 78.

10. *See* Brief of *Amici Curiae* Obstetrician-Gynecologists in Support of Plaintiff-Appellant and Reversal at 6–8, *Means v. U.S. Conference of Catholic Bishops*, 836 F.3d 643 (6th Cir. 2016) (No. 15-1779) (describing the medical standard of care for previsible premature rupture of membranes); Ben. A. Rich, *Your Morality, My Mortality: Conscientious Objection and the Standard of Care*, 24 *CAMBRIDGE Q. HEALTHCARE ETHICS* 214, 216 (2015) (anticipating "expert testimony at trial that adherence to the prevailing standard of prenatal care for a patient in the clinical circumstances of Ms. Means would have been to at least offer, if not recommend, prompt termination of the pregnancy"); Amelia Thomson-Deveaux, *Bishops May Not Be the Crooks This Time*, *AM. PROSPECT* (Dec. 5, 2013), <http://prospect.org/article/bishops-may-not-be-crooks-time> [<https://perma.cc/K449-KDDJ>] (quoting law professor Robin Fretwell Wilson saying that if Ms. Means were to bring a suit against the hospital or treating physicians in connection with her experience, "this would be plain-vanilla medical malpractice").

11. *MICH. COMP. LAWS* § 333.20181 (2019) ("A hospital, clinic, institution, teaching institution, or other health facility is not required to admit a patient for the purpose of performing an abortion. A hospital, clinic, institution, teaching institution, or other health facility or a physician, member, or associate of the staff, or other person connected therewith, may refuse to perform, participate in, or allow to be performed on its premises an abortion. The refusal shall be with *immunity from any civil or criminal liability or penalty.*" (emphasis added)); *id.* § 333.20182 ("The refusal by the individual to participate [in abortion] *does not create a liability for damages on account of the refusal* or for any disciplinary or discriminatory action by the patient, hospital, clinic, institution, teaching institution, or other health facility against the individual." (emphasis added)); *id.* § 333.20183 ("(1) A physician who

While Michigan's law does not require refusing hospitals to justify their refusal to perform abortion,¹² Mercy had a religious reason for turning Ms. Means away without treatment: As a Catholic hospital, Mercy was obligated to follow the U.S. Conference of Catholic Bishops' Ethical and Religious Directives for Catholic Health Care Services (the ERDs), which prohibit direct and intentional termination of pregnancy in all circumstances.¹³ Mercy, like many Catholic hospitals, appears to have interpreted this prohibition as extending to miscarrying patients like Ms. Means.¹⁴ Under the plain language of the ERDs, termination and extraction of a pregnancy for the purposes of preventing future harm is an intentional act, rather than an "unintended but foreseeable consequence" of a curative treatment.¹⁵ Moreover, in cases where the patient's condition has not yet progressed to sufficient severity, termination would constitute a preventative procedure, not one intended to "cure . . . a proportionately serious pathological condition of [the] pregnant woman."¹⁶

Under the ERDs, Mercy also had a religious justification for denying Ms. Means basic information regarding the possibility of terminating her pregnancy. ERD 27, which lays out the provider's obligation to secure a patient's informed

informs a patient that he or she refuses to give advice concerning, or participate in, an abortion is *not liable* to the hospital, clinic, institution, teaching institution, health facility, or patient for the refusal. (2) A civil action for negligence or malpractice or a disciplinary or discriminatory action *may not be maintained* against a person refusing to give advice as to, or participating in, an abortion based on the refusal." (emphasis added)).

12. *Cf. id.* § 333.20181 (stating that a health facility "is not required" to admit a patient for abortion, without specifying conditions for refusal); *id.* § 333.20182 (stating that physicians and other health care facility staff "who state[] an objection to abortion on professional, ethical, moral, or religious grounds" are not required to participate).

13. ERD 45 states that abortion (defined as "the directly intended termination of pregnancy before viability or the directly intended destruction of a viable fetus") is "never permitted." U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 18 (6th ed. 2018), <http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf> [<https://perma.cc/7V3F-C834>]. Only where the death of a fetus is the unintended but foreseeable consequence of "[o]perations, treatments, and medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman . . . [and that] . . . cannot be safely postponed until the unborn child is viable," are such treatments permissible under ERD 47. *Id.* at 19.

14. Brief on Appeal of Defendants-Appellees Stanley Urban, Robert Ladenburger, and Mary Mollison at 30, *Means v. U.S. Conference of Catholic Bishops*, 836 F.3d 643 (6th Cir. 2016) (No. 15-1779) (arguing that Ms. Means's claim should be dismissed because it requires "a court to decide whether it is reasonable for a Catholic hospital to follow Catholic doctrine"). The ERDs' general language does not address particularized medical circumstances; therefore, any application of the ERDs to a specific clinical situation requires interpretation, which may vary from hospital to hospital. Notably, some Catholic organizations have argued that poor patient outcomes in cases of miscarriage management may not have been dictated by religious doctrine; rather, they argue that these outcomes may have been the result of "misinterpretation" of the ERDs by hospitals and doctors. *See* NAT'L WOMEN'S LAW CTR., *BELOW THE RADAR: HEALTH CARE PROVIDERS' RELIGIOUS REFUSALS CAN ENDANGER PREGNANT WOMEN'S LIVES AND HEALTH* 13 & nn.76-77 (2011), <http://www.nwlc.org/sites/default/files/pdfs/nwlcbelowtheradar2011.pdf> [<https://perma.cc/56MF-2UA9>].

15. *See* U.S. CONFERENCE OF CATHOLIC BISHOPS, *supra* note 13, at 18-19.

16. *See id.*

consent, establishes that the provider must only disclose “morally legitimate alternatives” to the recommended treatment.¹⁷ Mercy’s failure to inform Ms. Means that termination of pregnancy was a medically viable option was consistent with the ERDs, because termination would not have been considered a “morally legitimate” treatment option.

For nearly a half century, scholars of law, medicine, medical ethics, and philosophy have debated the role that conscience and religion should play in the delivery of health care. Much of the literature in this area has focused on laws codifying providers’ right to withhold health care for reasons of conscience. Specifically, the literature has focused on *who* should be protected by these laws,¹⁸ *what* conduct should be protected,¹⁹ and *whether and when* there should be any limitations on a provider’s right to act in accordance with their conscientious beliefs.²⁰ But these debates have overlooked a fundamental issue—the question of *how* law protects health care providers who exercise their right of conscientious refusal in the course of their professional practice.²¹ In other words, when providers refuse on grounds of conscience to participate in health care services, what consequences are they protected from?²²

17. *Id.* at 14.

18. By way of example, the 2014 *Hobby Lobby* case drew dramatic public attention to the question of whether institutions, or only individuals, should be entitled to conscience protections. *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014); see also Elizabeth Sepper, *Contraception and the Birth of Corporate Conscience*, 22 J. GENDER SOC. POL’Y & L. 303, 315–20 (2014) (raising concerns about the doctrine of “corporate conscience”); Daniel P. Sulmasy, *What is Conscience and Why is Respect for it so Important?*, 29 THEORETICAL MED. & BIOETHICS 135, 142–44 (2008) (“[H]ealth care institutions have consciences.”).

19. See, e.g., Kent Greenawalt, *Refusals of Conscience: What are They and When Should They Be Accommodated?*, 9 AVE MARIA L. REV. 47, 57, 60–61 (2010) (arguing that conscience protections should not apply where the nexus between a provider’s refusal to act and an objectionable medical procedure is too remote, as where the provider has minimal personal contact with the patient—for example, “those who type [patients’] forms, make their beds, dish out their meals, and clean their rooms”); Sulmasy, *supra* note 18, at 140–42 (analyzing the doctrine of moral complicity in cases of “indirect[] facilitat[ion] [of] wrongdoing”—such as the use of vaccines derived from the tissue of aborted fetuses).

20. See, e.g., R. Alta Charo, *The Celestial Fire of Conscience — Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471, 2473 (2005) (questioning whether offering legal protections for health care providers’ exercise of conscience is ever justified); Rebecca S. Dresser, *Freedom of Conscience, Professional Responsibility, and Access to Abortion*, 22 J.L. MED. & ETHICS 280, 281, 284 (1994) (suggesting that public policy regarding conscience protections should be changed in light of the “current scarcity of abortion providers,” particularly in rural areas); Jill Morrison & Micole Allekotte, *Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious, or Ethical Reasons*, 9 AVE MARIA L. REV. 141, 182–84 (2010) (arguing that conscience laws should not protect providers who refuse emergency services).

21. See generally Nadia N. Sawicki, *Disentangling Conscience Protections*, HASTINGS CTR. REP., Sept.-Oct. 2018, at 14 (arguing that policy discussions about health care conscience protections require a fuller understanding of how state laws currently operate).

22. Throughout this Article, these protections will be referred to as “procedural protections.” State conscience protections have both substantive and procedural components. The substantive components speak to the specific actions, beliefs, or objections that are protected—that is, the substance of the medical provider’s claim. The procedural components (the focus of this Article) address the procedural mechanisms used to respond to the provider’s substantive claim.

While health care conscience laws vary widely from state to state, they often include protections from civil liability, criminal prosecution, discipline by state licensing boards or other administrative agencies, adverse action by employers, discrimination in educational opportunities, and loss of funding, among others.²³ However, there is scant scholarship critically evaluating, or even acknowledging, the breadth of these legal protections.²⁴ Perhaps even more surprisingly, given the significant attention paid to tracking legislative developments related to U.S. conscience law,²⁵ no empirical data exist on how frequently these various types of procedural protections arise. In the absence of such data as a starting point for academic analysis, contemporary debates about health care conscience laws are necessarily incomplete.²⁶

This Article fills this gap in the literature by drawing upon an original dataset of reproductive health care conscience laws across the United States to present the first comprehensive empirical review of the procedural protections established by these laws.²⁷ The research was conducted in compliance with rigorous standards for policy surveillance and legal mapping established by a leading institute of public health law research.²⁸

The aim of this Article is to understand the scope of these procedural protections, with a particular emphasis on protections from civil liability granted to individual and institutional health care providers, and any limitations on those protections in cases of patient harm. The Article focuses on conscience laws that apply in the context of abortion, but also presents research findings relating to sterilization, contraception, and other reproductive health services. It demonstrates that immunity from civil liability is by far the most common type of procedural protection explicitly established for providers who refuse abortion on grounds of conscience.²⁹

Further, the majority of conscience laws are absolute in their protections. Such laws permit providers to refuse to participate in reproductive health services and shield them from civil liability for their refusals, even when their

23. See *infra* Part III.A.

24. See *infra* text accompanying notes 63–65.

25. See *infra* text accompanying notes 58–62.

26. Sawicki, *supra* note 21, at 15 (arguing that a better understanding of the procedural protections established by health care conscience laws may assist both conscience advocates and critics in crafting their arguments more precisely, and perhaps even in finding common ground).

27. *Procedural Protections in Reproductive Health Care Conscience Laws*, POL’Y SURVEILLANCE PROGRAM, <http://lawatlas.org/datasets/procedural-protections-in-reproductive-health-care-conscience-laws> [<https://perma.cc/2PLM-9HW5>].

28. Temple University’s Beasley School of Law Center for Public Health Law Research has developed these standards in connection with its administration of LawAtlas, a project funded by the Robert Wood Johnson Foundation. For more detail about the Center for Public Health Law Research and the methodology used in this project, see *infra* Part II.

29. See *infra* Part III.A.

conduct violates the medical profession's standard of care and causes patient harm.³⁰

This study is the first to conclusively demonstrate that abortion conscience laws in most states create an absolute "conscience defense" to medical malpractice. These important and original research findings not only raise awareness of previously unexamined elements of U.S. conscience law, but also challenge basic assumptions about the availability of tort law as a remedy for medical malpractice in reproductive health contexts. When health care providers' conscientious beliefs about abortion drive deviations from the standard of care, victims in most states cannot rely on tort law to remedy their harms.

These findings are cause for concern and create an important opportunity for further policy discussion about how broadly health care conscience laws should be drafted. In particular, they highlight opportunities for future academic research, both normative and descriptive. Avenues for normative research include policy analyses of whether health care providers should be granted legal immunity from all possible adverse consequences of their conscientious refusals. Researchers could also explore whether these protections should, as a matter of policy or constitutional law, be balanced against state interests in ensuring that patients who are injured by provider refusals are not denied opportunities for tort recovery. Further empirical research might consider how the conscience protections applicable in reproductive health care contexts compare to those applicable in other medical contexts, such as end-of-life decision-making. Additionally, researchers could compare conscience laws to other laws protecting individuals from discrimination on the basis of their beliefs or personal characteristics, like the Americans with Disabilities Act, Title VII of the Civil Rights Act, and the Military Selective Service Act.³¹

The Article proceeds as follows: Part I offers a brief history and general overview of U.S. law's approach to conscientious refusal by health care providers. Part II describes the scope and methodology of this empirical study of procedural protections in reproductive health care conscience laws. Part III presents the research findings, emphasizing (1) the wide range and variability of procedural protections established by the fifty states and the District of Columbia; (2) the frequency with which conscience laws establish immunity from civil liability for both individual and institutional health care providers; and (3) the limited contexts in which some states, for reasons of patient protection, withdraw providers' rights of refusal and/or civil immunity. Part IV offers

30. See *infra* Part III.C.

31. Unlike health care conscience laws, these laws restrict the circumstances in which accommodations are granted in order to protect employers and the public from significant burdens. For further discussion, see Nadia N. Sawicki, *Unilateral Burdens and Third-Party Harms: Abortion Conscience Laws as Policy Outliers*, 95 IND. L. J. (forthcoming 2020), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3611011 [<https://perma.cc/BF3B-EDMY>].

evidence to show why unlimited civil immunity provisions are a cause for concern. This section draws on empirical research about the prevalence of conscientious objections among health care providers, as well as the harms experienced by patients when they are denied medically appropriate reproductive services. It demonstrates that immunizing providers from civil liability will prevent some patients from bringing successful tort suits. It also rebuts the claim that access to the tort system is unnecessary in light of the patient protections established by the Emergency Treatment and Active Labor Act (EMTALA). Finally, Part V describes possible avenues for future research inspired by the empirical findings presented herein.

I.

OVERVIEW OF U.S. HEALTH CARE CONSCIENCE LAWS

Public debates about conscientious objection in health care began in earnest around the time that criminal prohibitions on abortion faced their first challenges in court.³² These debates reached a tipping point after the U.S. Supreme Court's 1973 decision in *Roe v. Wade* establishing that a woman has a constitutional right to terminate a pregnancy in consultation with her physician, effectively legalizing abortion nationwide.³³ Individual and institutional health care providers expressed concern that as a result of the Court's decision, they might be forced to participate in a procedure they found morally objectionable.³⁴ The first federal and state conscience laws were enacted shortly thereafter in response to this concern,³⁵ but the passage of these laws by no means settled the issue.

Today, the scope of conscientious objection in health care has extended beyond physicians' objections to participation in abortion.³⁶ Other licensed health care professionals—like nurses, pharmacists, emergency medical technicians, and physician assistants—also claim rights to decline to participate

32. Robin Fretwell Wilson, Essay, *The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures*, 34 AM. J.L. & MED. 41, 47–50 (2008) [hereinafter Wilson, *The Limits of Conscience*] (describing the initial development of federal and state health care conscience protections); Robin Fretwell Wilson, *Empowering Private Protection of Conscience*, 9 AVE MARIA L. REV. 101, 106 (2010) [hereinafter Wilson, *Empowering Private Protection of Conscience*] (describing federal conscience laws as “dat[ing]back to just after the United States Supreme Court’s 1973 decision in *Roe v. Wade*.”).

33. See 410 U.S. 113 (1973); Wilson, *Empowering Private Protection of Conscience*, *supra* note 32, at 106–07.

34. Wilson, *Empowering Private Protection of Conscience*, *supra* note 32, at 107–08 (describing attempts to extend *Roe v. Wade*'s non-interference provisions into affirmative rights to access abortion services, the challenges faced by providers who were unwilling to perform abortions, and the subsequent congressional response in the form of the Church Amendment).

35. Wilson, *The Limits of Conscience*, *supra* note 32, at 47–48, 50.

36. Thaddeus Mason Pope, Legal Briefing, *Conscience Clauses and Conscientious Refusal*, 21 J. CLINICAL ETHICS 163 (2010) (describing the breadth of modern health care conscience laws); Adam Sonfield, *New Refusal Clauses Shatter Balance Between Provider ‘Conscience,’ Patient Needs*, GUTTMACHER REP. PUB. POL’Y, Aug. 2004, at 1, 1 (“[T]he refusal clause debate is expanding to implicate new participants and increasingly indirect forms of involvement.”).

in medical services they find objectionable.³⁷ Individuals who work in the health or public health industries but are not licensed by the state—like public health officials, medical students, and researchers—claim these rights as well.³⁸ Finally, institutional health care providers—like hospitals and skilled nursing facilities—also regularly claim religious and conscientious objections to certain medical services.³⁹ In the forty-seven years since *Roe*, conscience laws at both the state and federal level have extended to protect this broader scope of providers.⁴⁰

Conscientious refusals arise most commonly in the context of reproductive health services like abortion, sterilization, emergency contraception, and contraception. However, refusals arise in other contexts as well.⁴¹ The treatments available to patients at the end of life—for example, aid in dying, terminal sedation, artificial nutrition and hydration, and other life-sustaining medical treatments—are often impacted by health care providers’ conscientious beliefs.⁴² Medical services that have a connection with embryos or human stem cells—such as vaccines derived from research on fetal stem cells—are also a point of contention for some conscience-driven providers.⁴³ Other health care providers cite conscience to justify their refusal to treat LGBTQ individuals.⁴⁴

Health care conscience laws in many states have expanded to encompass a broad variety of medical services that some providers deem objectionable. A few states offer protections to health care providers who object on grounds of conscience to *any* medical service.⁴⁵ Moreover, many states’ laws have extended to protect not only providers who are unwilling to directly perform medical services they deem objectionable, but also those whose involvement is more

37. Sonfield, *supra* note 36 (citing objections by ambulance staff, pharmacists, and nurses).

38. *Id.* (citing objections by state employees, hospital workers who handle paperwork and clean surgical instruments, and police officers).

39. Edmund D. Pellegrino, *The Physician’s Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 3 FORDHAM URB. L.J. 221, 235–36 (2002) (citing objections by Catholic health care institutions); Elizabeth Sepper, *Taking Conscience Seriously*, 98 VA. L. REV. 1501, 1504 (2012) (citing the extension of conscience protections to “entire hospitals, healthcare systems, clinics, and practice groups”).

40. Wilson, *The Limits of Conscience*, *supra* note 32, at 49–50.

41. Pope, *supra* note 36, at 165–67 (citing objections to vaccination, terminal sedation, circumcision, genetic screening, and others); Sepper, *supra* note 39, at 1508 (citing objections to “condoms as part of HIV counseling; sterilization; contraception; removal or withholding of respirators, artificial hydration, or nutrition; vaccination; blood transfusions; circumcision; fertility treatments; euthanasia; pain management; [and] stem-cell-derived therapies.”).

42. Sepper, *supra* note 39, at 1508.

43. Pope, *supra* note 36, at 167.

44. *See, e.g.*, N. Coast Women’s Care Med. Grp., Inc. v. San Diego Cty. Superior Court, 189 P.3d 959, 959 (Cal. 2008) (holding that physicians may not claim a First Amendment religious freedom defense where they denied fertility treatment to a lesbian couple in violation of California’s Unruh Civil Rights Act); Tara M. Prairie et al., *Intersections of Physician Autonomy, Religion, and Health Care When Working with LGBT+ Patients*, 19 HEALTH PROMOTION PRAC. 542, 544 (2018) (finding in a survey of thirty-four physicians and residents that approximately one-third believed they have a right to refuse treatment to LGBT+ patients and cited religious or moral reasons for their opposition).

45. *See infra* note 73.

tangential. Health care providers have raised objections to performing various services that they view as morally complicit—such as providing referrals, transportation, and translation services; informing patients about the availability of the service; and transferring prescriptions and medical records.⁴⁶ Depending on how broadly a state’s conscience law is worded, these indirect forms of involvement may be protected as well.⁴⁷

It is important to note that the expansion of conscience protections beyond abortion refusals also makes the political implications of these laws more complex. Given their historical grounding in the abortion debate, conscience laws have often been viewed as redounding only to the benefit of religious conservatives.⁴⁸ However, providers with beliefs falling on the liberal side of the political spectrum also have the opportunity to benefit from their protections, especially as these laws have expanded to encompass a broader variety of medical services.⁴⁹ In the end-of-life context, for example, some physicians object to providing intensive treatment to dying patients who are unlikely to recover (sometimes called “futile treatment”), a position that is at odds with traditionally conservative perspectives about the inherent value of life.⁵⁰ Other health care providers argue that they have an affirmative conscience-based duty

46. See Pope, *supra* note 36, at 162 (describing examples of conscientious opposition to services “tangential” to abortion).

47. *Id.* For example, title 16, section 51.41 of the Pennsylvania Administrative Code protects providers who object to “performing, participating in, or cooperating in abortion or sterilization” and defines cooperating providers as those who, “whether or not directly involved in such procedures or in attendance at the time when and in the room where the procedure takes place,” maintain “duties . . . of a type peculiar to abortion or sterilization procedures and without whose services the procedure itself could not be performed.” The law offers examples of cooperation including “disposal of or assistance in the disposal of aborted fetuses” and “cleaning the instruments used in the abortion or sterilization procedure.” 16 PA. CODE § 51.41 (2019). Examples of duties that do not constitute cooperation under the law include ancillary services such as food preparation and housekeeping, record keeping by clerical personnel, management and repair of surgical facilities, pre-abortion lab testing, and participation in “any preparatory procedure leading to abortion or in the postabortion period.” *Id.*

48. Mark Campbell, *Conscientious Objection in Medicine: Various Myths*, 166 LAW & JUST. 28, 28–30, 36 (2011) (arguing that despite the historical, political, and practical connections between abortion and conscientious refusals in health care, it is a myth that “the debate about conscientious objection in medicine is a debate about abortion by proxy”).

49. *Id.* at 30 (noting the need “to find common ground on which to consider whether, how and to what extent conscientious objection in medicine might be justified in principle”); Sepper, *supra* note 39 (arguing that legal protections ought to extend to health care providers who, as a matter of conscience, feel compelled to deliver services that others might oppose).

50. See, e.g., Elizabeth Dzung et al., *Moral Distress Amongst American Physician Trainees Regarding Futile Treatments at the End of Life: A Qualitative Study*, 31 J. GEN. INTERNAL MED. 93, 95 (2016) (finding that many physician trainees experience moral distress at the prospect of providing futile treatment, which they equate to “torture” and “suffering”); Robert M. Veatch, *Why Some “Futile” Care is “Appropriate”*: The Implications for Conscientious Objection to Contraceptive Services, 60 PERSP. BIOLOGY & MED. 438, 447 (2017) (drawing an analogy between conscientious objection by “liberal” physicians who refuse to provide futile medical treatment and those from “traditional” belief systems who refuse to provide contraceptive services).

to provide services like abortion or aid-in-dying, and that conscience laws should protect them against discrimination if they serve patients seeking such care.⁵¹

The analysis of any health care conscience statute begins with an understanding of the conditions under which its protections arise: what medical services it applies to, what providers are protected, and what forms of participation are protected. In addition to specifying the conditions of protection, most conscience laws also establish *explicit procedural mechanisms* for protection, outlining the consequences of a provider's exercise of their right to refuse.

The simplest laws merely establish a health care provider's right to refuse to participate in a medical service on the grounds of conscience and do not elaborate on the consequences of the refusal. An illustrative example is a Connecticut public health regulation, which simply states, "No person shall be required to participate in any phase of an abortion that violates his or her judgment, philosophical, moral or religious beliefs."⁵² Such "refusal-only" laws, while simple on their face, are surprisingly difficult to interpret.⁵³ They grant a right of refusal, but they do not explicitly specify the consequences of a provider's exercise of that right. Thus, refusal-only laws fail to address the primary concern of most conscience-driven providers. What these providers hope for in legal protection is not a mere right to refuse—after all, physically compelling a provider to perform an objectionable procedure is rare. Rather, they seek relief from outside pressures and adverse consequences (for example, termination of employment) that might arise as a result of their refusal.

Thus, most conscience laws supplement the right of refusal with explicit procedural protections. These protective provisions establish that providers who exercise their right of conscientious refusal will be immunized from specific types of adverse consequences—whether adverse employment action, discipline by a professional licensing board, civil liability for medical malpractice, or other consequences. An illustrative example is Illinois's Health Care Right of Conscience Act, which includes language establishing a refusing provider's immunity from civil and criminal liability;⁵⁴ discrimination in licensing, employment, and privileging;⁵⁵ discrimination by employers and educational

51. See Lisa H. Harris, *Recognizing Conscience in Abortion Provision*, 367 NEW ENG. J. MED. 981 (2012); Nadia N. Sawicki, *Mandating Disclosure of Conscience-Based Limitations on Medical Practice*, 42 AM. J.L. MED. & ETHICS 85, 88 n.6 (2016).

52. CONN. AGENCIES REGS. § 19-13-D54(f) (2005).

53. See *infra* Part III.A.

54. "No physician or health care personnel shall be *civilly or criminally liable* to any person, estate, public or private entity or public official by reason of his or her refusal to perform . . . or participate in any way in any particular form of health care service which is contrary to [his or her] conscience." 745 ILL. COMP. STAT. 70/4 (2019) (emphasis added).

55. "It shall be unlawful for any person, public or private institution, or public official to discriminate against any person in any manner, including but not limited to, *licensing, hiring, promotion, transfer, staff appointment*, hospital, managed care entity, or any other privileges, because of such person's conscientious refusal." *Id.* 70/5 (emphasis added).

institutions;⁵⁶ and denial of government aid or benefits.⁵⁷ In delineating the specific types of immunities that conscience-driven providers are entitled to, laws like Illinois's provide greater assurance to those who fear that their conscientious refusals will subject them to adverse consequences.

Current surveys of health care conscience laws, unfortunately, do not address these procedural protections. In the past decade, many advocacy groups,⁵⁸ news organizations,⁵⁹ research institutions,⁶⁰ scholars,⁶¹ and others⁶² have engaged in comprehensive surveys of current and proposed health care conscience laws. But these surveys typically offer only a bird's-eye view of the laws—identifying the services protected, and (at best) which providers are protected and under what conditions. They do not identify or track the mechanisms of protection established by conscience laws.

Furthermore, the academic literature on this issue is surprisingly barren. While some scholars writing about health care conscience laws have

56. "It shall be unlawful for any public or private *employer, entity, agency, institution, official or person*, including but not limited to, a *medical, nursing or other medical training institution*, to *deny admission* because of . . . [or] to *impose any burdens in terms or conditions of employment on*, or to otherwise discriminate against, any applicant, in *terms of employment, admission to or participation in any programs* for which the applicant is eligible . . . on account of the applicant's refusal." *Id.* 70/7 (emphasis added).

57. "It shall be unlawful for any *public official, guardian, agency, institution or entity* to *deny any form of aid, assistance or benefits*, or to condition the reception [of such aid to] . . . any person, otherwise entitled . . . because that person refuses to obtain, receive, accept, perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of health care services contrary to his or her conscience." *Id.* 70/8 (emphasis added).

58. See, e.g., *Refusing to Provide Health Services*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services> [<https://perma.cc/72A7-HZVM>] (tracking conscience laws relating to abortion, sterilization, and contraception by type of provider protected).

59. See, e.g., *Conscience and Refusal Clauses*, REWIRE.NEWS (Sept. 12, 2018), <https://rewire.news/legislative-tracker/law-topic/conscience-and-refusal-clauses> [<https://perma.cc/K4TU-SPPK>] (tracking proposed and current conscience legislation).

60. See, e.g., *Refusal to Perform Abortions*, POL'Y SURVEILLANCE PROGRAM (Dec. 1, 2018), <http://lawatlas.org/datasets/refusal-to-perform-abortions> [<https://perma.cc/EZ4C-XHEB>] (tracking abortion conscience laws by type of provider and type of participation protected).

61. See, e.g., Pope, *supra* note 36, at 162-68 (tracking state health care conscience laws); Wilson, *The Limits of Conscience*, *supra* note 32, at 47-52 (describing federal and state conscience legislation); Kevin H. Theriot & Ken Connelly, *Free to Do No Harm: Conscience Protections for Healthcare Professionals*, 49 ARIZ. ST. L.J. 549, 587-600 (2017) (tracking state health care conscience laws).

62. See, e.g., Brief of *Amici Curiae* 43 Members of Congress in Support of Petitioners app., *Stormans, Inc. v. Wiesman*, 136 S. Ct. 2433 (2016) (mem.) (No. 15-862) (surveying state and federal conscience laws related to abortion, contraception, fertility treatment, sterilization, military service, capital punishment, assisted suicide, and euthanasia); *Pharmacist Conscience Clauses: Laws and Information*, NAT'L CONF. OF STATE LEGISLATORS, <http://www.ncsl.org/research/health/pharmacist-conscience-clauses-laws-and-information.aspx> [<https://perma.cc/FD5Q-UDRD>] (tracking pharmacist conscience laws).

acknowledged the breadth of their procedural protections,⁶³ few have critically analyzed these protections.⁶⁴ Only a single academic article, published over twenty-five years ago, has ever categorized state conscience laws based on common procedural protections; and the article does not describe the author's research methodology.⁶⁵

Given the intense academic and public interest in the issue of conscientious refusal, this gap in the literature on health care conscience laws is surprising and troubling. It is difficult to imagine how scholars and policy-makers can engage in nuanced debate about the law's role in protecting the right of conscientious refusal when there is no clear understanding of how existing laws actually operate.⁶⁶

II.

RESEARCH AIMS AND METHODOLOGY

This Article draws upon an original dataset of state health care conscience laws relating to reproductive services to identify the procedural mechanisms by which these laws protect providers, with a particular focus on protections from civil liability for refusal to participate in abortion. The primary aims of this

63. See R. Alta Charo, *Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience*, 1 ADVANCE 119, 121 (2007) (pointing out that modern conscience laws "recite an expansive list of actions that can no longer be taken against professionals who refuse to provide health care services," including "immunity from medical or other professional malpractice liability; protection from state licensing board disciplinary action; and protection from employment [discrimination]"); Lawrence Nelson, *Provider Conscientious Refusal of Abortion, Obstetrical Emergencies, and Criminal Homicide Law*, 18 AM. J. BIOETHICS 43, 43 (2018) (noting that many conscience laws "offer sweeping immunity from legal liability," and arguing against criminal immunity); Elizabeth Sepper, *Doctoring Discrimination in the Same-Sex Marriage Debates*, 89 IND. L.J. 703, 723 (2014) (identifying "three distinct conflicts" covered by conscience laws: employer accommodation; civil, criminal, and professional penalties; and state funding); Jennifer E. Spreng, *Conscientious Objectors Behind the Counter: Statutory Defenses to Tort Liability for Failure to Dispense Contraceptives*, 1 ST. LOUIS U. J. HEALTH L. & POL'Y 337, 373 (2008) (noting that conscience laws include "protections against civil liability, employment discrimination, professional discipline, denial of admission to professional training programs, and denial of public funds").

64. Notable exceptions include Rich, *supra* note 10, at 228 (arguing that health care providers who depart from the standard of care should be subject to civil liability and administrative sanctions); Nelson, *supra* note 63, at 48 (arguing that health care conscience laws should not protect providers from criminal prosecution); 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, 801-04, 832 (2007) (arguing that when health care providers' conscientious refusals impose burdens on others, "exemptions from malpractice, disciplinary, or employment actions are not appropriate"); and Sepper, *supra* note 39, at 1572 (arguing that conscience laws should not provide immunity from civil liability, but recognizing that legal protection from adverse employment action may be necessary when the values of an individual and institutional health care provider conflict).

65. Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177, at 190-95 (1993) (identifying state laws establishing protections from civil liability; criminal liability; and discrimination in employment, licensure, government benefits, and education, and identifying the rare exceptions to these protections).

66. See generally Sawicki, *supra* note 21, at 15 (arguing for a "more nuanced policy debate" regarding procedural protections in health care conscience laws).

project are to discover (1) how frequently such laws include protections from civil liability as compared to other types of procedural protections; (2) which types of providers are granted civil immunity for their conscientious refusals; and (3) whether and when there are any patient-protective limitations on providers' rights to refusal or civil immunity (for example, in cases of medical emergency, malpractice, or patient injury). Understanding the prevalence and scope of civil immunity provisions will inform policy debates about how best to limit the harms experienced by patients who are denied services on grounds of conscience.

While fifty-state surveys are common in the legal academic literature, the methodology behind such surveys is often opaque.⁶⁷ Often, it is unclear how a researcher collected the relevant laws, how the laws were analyzed and/or coded, and whether the researcher established any mechanisms of quality control to ensure that the findings are reproducible. Only recently have legal scholars begun to take a more systematic approach to the collection and observation of law—one that satisfies the stringent requirements of social science research, and merits consideration by peer reviewers outside the world of legal scholarship.⁶⁸

The research upon which this Article was based was conducted in accordance with best practices for policy surveillance and legal mapping established by LawAtlas, a project funded by the Robert Wood Johnson Foundation and administered by the Center for Public Health Law Research at Temple University Beasley School of Law.⁶⁹ These research standards are grounded in principles of quality control and reproducibility, requiring redundant coding by multiple researchers, and an iterative process of resolving coding discrepancies. Importantly, these standards require that coding be done based on impartial *observation*, rather than *interpretation* by individual researchers whose perspectives may vary.

67. See Scott Burris et al., *Policy Surveillance: A Vital Public Health Practice Comes of Age*, 41 J. HEALTH POL. POL'Y & L. 1151, 1152 (2016) (arguing that law is poorly integrated in the data collection structure of public health and public health information, in part because "legal information remains trapped in text files and pdfs, and as such is excluded from the universe of usable data").

68. *Id.* at 1153–54 (comparing legal mapping using "traditional methods of legal research and analysis" with more modern methods that "transform the text of law into scientifically valid, quantitative data for analysis"); David Presley et al., *Creating Legal Data for Public Health Monitoring and Evaluation: Delphi Standards for Policy Surveillance*, 43 J.L. MED. & ETHICS 27, 27 (2015) (comparing the "long tradition of conducting '50 state surveys'" with "the use of scientific methods to create datasets of legal variables suitable for use in evaluation research").

69. See Burris et al., *supra* note 67, at 1154–55 (2016) (explaining the process by which the Center for Public Health Law Research developed best practices for scientific collection and coding of statutes); Scott Burris, *A Technical Guide for Policy Surveillance 1* (Pub. Health Law Research Program, Temple U. Beasley Sch. Of Law, Research Paper No. 2014-34, 2014), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2469895 [https://perma.cc/2QKJ-S6GP] (describing policy surveillance as "the ongoing, systematic collection, analysis and dissemination of information about laws and other policies" and outlining the methodology for creating and coding a legal dataset in accordance with best practices).

The full dataset, research protocol, and findings are publicly available on LawAtlas in an interactive format.⁷⁰ A brief description follows below.

A. Methodology: Data Collection

Identification of the laws included in the dataset began in 2018, with the collection of laws cited in two recent secondary source compilations⁷¹ of health care conscience laws in all fifty states and the District of Columbia. This initial set of laws was supplemented with Westlaw keyword searches of state statutes and regulations and was further supplemented by reviewing the relevant table of contents chapters for all identified laws. Two researchers conducted this research independently, and all discrepancies were discussed and addressed.

Most jurisdictions have several statutes and/or regulations pertaining to rights of conscience in health care. This dataset was narrowed to include only those laws relating to conscience in the provision of health care services in a health care setting by physicians, nurses, pharmacists, hospital employees, hospitals, and other individual and institutional health care providers. Excluded from the dataset were laws relating to conscience in health insurance or the financing of health care services as well as laws relating to conscience in the provision of health care services in prison settings (typically, laws relating to physician participation in capital punishment). The dataset upon which this research was based was further limited to those laws explicitly protecting conscience in the context of reproductive services, defined as abortion, sterilization, emergency contraception, contraception/family planning, and other services offered in the reproductive health context.⁷² This dataset does not include state laws that establish conscience protections for *all* health care services without referencing reproductive health services specifically, even though some of these laws also include protections from civil liability.⁷³

70. *Procedural Protections in Reproductive Health Care Conscience Laws*, *supra* note 27.

71. Brief of *Amici Curiae* 43 Members of Congress in Support of Petitioners, *supra* note 62, app.; Theriot & Connelly, *supra* note 61, at 575–76, 587–600.

72. “Other reproductive health care contexts” included assisted reproductive technology, genetic counseling, medical use of fetal tissue, umbilical cord blood banking, research on gametes and embryos, use of stem cells, and cloning. Because such laws are far less common than those applicable to abortion, sterilization, contraception, and emergency contraception, their procedural protections were not separately coded.

73. Few states establish conscience protections that are open-ended across all health care services. See 745 ILL. COMP. STAT. 70/4 (2019) (establishing protections for refusal to participate in “any particular form of health care service which is contrary to the conscience of [the provider]”); *id.* 70/3(a) (defining “[h]ealth care” as “any phase of patient care, including but not limited to, testing; diagnosis; prognosis; ancillary research; instructions; family planning, counselling, referrals, or any other advice in connection with the use or procurement of contraceptives and sterilization or abortion procedures; medication; surgery or other care or treatment rendered by a physician or physicians, nurses, paraprofessionals or health care facility, intended for the physical, emotional, and mental well-being of persons; or an abortion as defined by the Reproductive Health Act”); MISS. CODE ANN. §§ 41-107-5, -7 (2013) (establishing protections for refusal to participate in “a health care service that violates [the

B. Methodology: Coding and Quality Control

Once the dataset was established, the author conceptualized coding questions and variables and finalized them based on feedback from LawAtlas staff. Coding questions and variables were then entered into MonQcle, a web-based software-coding platform developed by Legal Science LLC and the Center for Public Health Law Research at Temple University Beasley School of Law.

A team of five researchers coded the laws of each jurisdiction by: (1) the type of medical service they are applicable to; (2) which explicit procedural protections, if any, they establish; (3) which providers, if any, benefit from civil immunity; (4) whether there are any patient-protective limitations to the right of refusal or civil immunity; and (5) whether the laws had been held unenforceable in whole or in part by a judicial decision. Initial coding was based on the laws in effect as of December 17, 2018.

All fifty-one jurisdictions were 100% redundantly coded, meaning that each state record was placed in a set of ten (or eleven) jurisdictions and coded by two researchers working independently. After each set, the author identified each instance where two researchers coded different variables for the same question and used this data to calculate the divergence rate. Under LawAtlas methodology, divergence rates under 10% are considered satisfactory; if a set's divergence rate is satisfactory, only 20% (rather than 100%) of the remaining records must be redundantly coded.⁷⁴ The team's divergence rates all fell below 10%,⁷⁵ but, to ensure the strongest possible quality control, the author continued to require 100% redundant coding for the entire project. All divergences were resolved through consultation and discussion with the team at weekly coding review meetings.

Researchers coded these laws in accordance with a coding protocol that included specific rules for coding each question, and which was periodically

provider's] conscience"); *id.* § 41-107-3(a) (defining "health care service" as "any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions"); WASH. REV. CODE § 48.43.065(2)(a) (2019) (establishing limited protections for refusal to participate in "the provision of or payment for a specific service if [a provider, facility, or carrier] object[s] to so doing for reason of conscience or religion"); *id.* § 70.47.160(2)(a) (same); *id.* § 48.43.005(25) (defining "health care service" as a "service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease"); D.C. Mun. Regs. tit. 22-B, § 9006.1 (2017) (prohibiting discrimination against employees of public benefit corporations for refusal to participate in "aspects of direct patient care that are in conflict with their religious, or ethical beliefs").

74. Published work on research methodology in policy surveillance references both 5% and 10% as acceptable divergence rates. *See, e.g.*, Burris, *supra* note 69, at 5, 24–25. Such differences of opinion proved irrelevant as the author chose to code all data redundantly.

75. The divergence rates were as follows: 5.18% for Set 1; 9.91% for Set 2; 3.60% for Set 3; 2.39% for Set 4; and 5.66% for Set 5.

revised through the course of the project.⁷⁶ Questions and variables that were causing confusion were edited for clarity. Some new variables were added and then checked across the dataset to make sure coding was consistent. After all jurisdictions were coded and discrepancies resolved, eleven jurisdictions were coded by a naïve coder who had not been previously involved with the project. The naïve coder was given a brief orientation and instructed to code the records in accordance with the coding protocol all researchers had been using. The rate of divergence between the naïve coding and original coding was 5.46%, which is more than satisfactory.⁷⁷ There were only five substantive discrepancies that required discussion and resolution; these were reviewed and resolved as a team.

C. 2019 Update

The initial dataset collected and coded laws were in effect as of December 17, 2018. In 2019, a team of two researchers updated the dataset and coding based on the laws in effect as of December 31, 2019. The researchers reviewed all laws in the original dataset and re-ran the original Westlaw search to capture any additional legislative changes since the previous dataset was coded. Eight states had amended, repealed, or added legislation relevant to the scope of this project. The rate of divergence for the coding of these eight states was 2.02%.⁷⁸

III.

RESEARCH FINDINGS

This study found that reproductive conscience laws vary dramatically in the types of procedural protections they offer to providers but that most states establish far stronger protections for health care providers than for patients.

State laws immunize health care providers and others from a range of potential adverse consequences. For example, providers may be immunized from civil liability, criminal prosecution, professional discipline, employment discrimination, discrimination in educational opportunities, and loss of funding. Immunity from civil liability, for both individuals and health care facilities, is by far the most common of the various procedural protections established by these state laws.

Moreover, in the majority of states that protect those who refuse to participate in abortion, rights of refusal and civil immunity appear to be absolute. In such states, there are no exceptions for cases of malpractice, denial of

76. NADIA N. SAWICKI, POLICY SURVEILLANCE PROGRAM, RESEARCH PROTOCOL: PROCEDURAL PROTECTIONS IN REPRODUCTIVE HEALTH CARE CONSCIENCE LAWS (2019), <https://monqcle.com/upload/5eb429e85594f4245c8b4571/download> [<https://perma.cc/K2EH-DM9J>].

77. *See supra* note 74.

78. However, only two of these eight states amended their legislation in a way that affected the coding and final data. Of its Compiled Statutes, Illinois repealed chapter 720, act 510, section 13 and chapter 745, act 30, section 1, and amended chapter 745, act 70, section 3. 2019 Ill. Legis. Serv. P.A. 101-13, §§ 905-15, -30, 910-73 (West). Vermont, which previously had no conscience law, enacted into its Statutes title 18, sections 9496 and 9497. 2019 Vermont Laws No. 47 (H. 57).

emergency treatment, or patient injury. It will likely come as a surprise to many readers, including scholars knowledgeable in the field, that most states' abortion conscience statutes have eliminated patients' common law right to recover monetary damages for physical injuries caused by a health care provider's conscience-based deviation from the standard of care.

A. *Distribution of Procedural Protections*

As described in Part II, most health care conscience laws operate by establishing specific procedural protections for providers who decline to participate in medical services that violate their conscientious beliefs. This study found that the most common protection established by state law is protection from civil liability. The next most common protections relate to disciplinary action, discrimination, and adverse action by employers.⁷⁹

The majority of U.S. jurisdictions (forty-seven states) have passed conscience laws that speak to participation in abortion. Forty-six of these states establish a right on the part of individual and/or institutional health care providers to refuse participation in abortion.⁸⁰ One state, Vermont, protects only providers who choose to actively participate in abortion.⁸¹ Fewer jurisdictions have laws relating to conscience-driven refusal to participate in sterilization (seventeen states), contraception (sixteen states), or emergency contraception (five states).⁸² Other health services related to reproductive health and

79. For more detail on how these terms were defined, see SAWICKI, *supra* note 76.

80. This study did not separately code what types of conduct were protected (e.g., refusal to perform, participate, assist, refer) or whether a specific justification was required for refusal (e.g., based on conscience, religion, ethics, personal beliefs). For data on the types of conduct protected by abortion conscience laws, see *Refusal to Perform Abortions*, *supra* note 60.

81. VT. STAT. ANN. tit. 18 §§ 9497(3)–(4) (2019) (stating that public entities shall not prohibit, interfere with, or restrict a health care provider's choice to terminate or assist in terminating a pregnancy). Of the forty-six states that protect provider refusals, six also protect the positive rights of those who affirmatively choose to participate in abortion. See KY. REV. STAT. ANN. § 311.800(5)(b)–(c) (West 2020) (prohibiting disciplinary action due to “the *willingness* or refusal of such physician, nurse or staff member or employee to perform or participate in abortion by reason of objection thereto on moral, religious or professional grounds” (emphasis added)); MICH. COMP. LAWS § 333.20184 (2019) (prohibiting adverse employment action employment taken “for the sole reason that [individuals, staff, or employees] *previously participated in, or expressed a willingness to participate in*, a termination of pregnancy” (emphasis added)); 16 PA. CODE § 51.33(a) (2019) (establishing possible protections for a health care facilities that “*express a willingness* or an objection to the performance of abortion or sterilization” (emphasis added)); *id.* §§ 51.42(a), .43(a) (establishing protections for physicians, nurses, hospital staff, students, and others “who *express[] a willingness* to participate in the performance of abortion or sterilization” (emphasis added)); S.D. CODIFIED LAWS § 34-23A-13 (2020) (prohibiting employment discrimination against any “physician, nurse, or other person who *performs* or refuses to perform or assist in the performance of an abortion” (emphasis added)); TEX. OCC. CODE ANN. § 103.002(b) (West 2020) (providing that a “health care facility may not discriminate against a physician, nurse, staff member, or employee because of the person’s *willingness to participate* in an abortion procedure at another facility” (emphasis added)); WASH. REV. CODE § 9.02.150 (2019) (prohibiting discrimination “in employment or professional privileges because of the person’s *participation* or refusal to participate in the termination of a pregnancy” (emphasis added)).

82. See *infra* Appendix A.

reproductive technology are also implicated in some state conscience laws: stem cell research and treatment (three states), research on gametes and embryos (two states), cloning (two states), assisted reproductive technology (one state), medical use of fetal tissue (one state), umbilical cord blood banking (one state), and genetic counseling (one state).⁸³

This discussion, however, focuses primarily on the findings relating to abortion conscience laws. The reason for this focus is twofold. First, abortion conscience laws are far more common than conscience laws relating to other reproductive services, and thus offer a richer perspective on how the vast majority of states approach conscientious objection in the reproductive health care sphere. Second, many of the serious patient harms described in Part IV.B—such as injuries arising from sub-standard miscarriage management—arise as a result of denial of abortion. While conscience-driven denials of other reproductive services, like sterilization and contraception, may also result in patient harm, these harms are less likely to be recoverable under tort law for a variety of reasons.⁸⁴

As detailed further in Appendix B, and illustrated in Figure 1 below, of the forty-seven jurisdictions with abortion-specific conscience laws (forty-six of which protect rights of refusal),⁸⁵ thirty-seven explicitly establish immunity from civil liability for individual and/or institutional health care providers who refuse to participate in abortion.⁸⁶ Thirty states protect providers from “disciplinary action.”⁸⁷ This term is often unspecified and undefined, though it is occasionally tied to specific adverse actors like employers. Twenty-six states protect providers from “discrimination,” a similarly vague term. Another twenty-six states provide explicit protection against adverse actions by employers (for example, decisions relating to hiring, dismissal, demotion, transfer, wages, or staff privileges). Protections against adverse action by government actors, educational institutions, criminal prosecutors, state licensing boards, and funding sources

83. See *infra* Appendix A.

84. See *infra* Part IV.C.

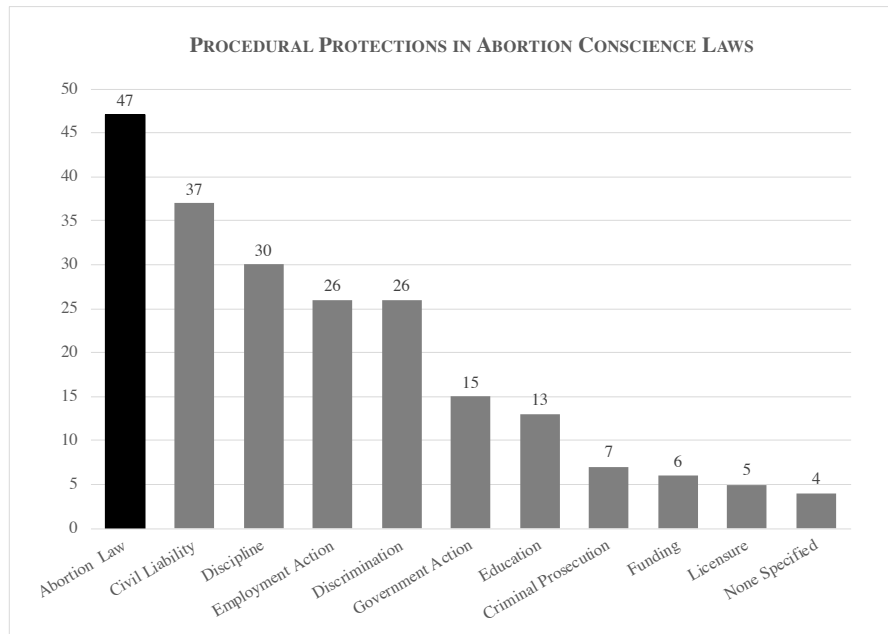
85. Among the seventeen states with sterilization-specific conscience laws, fifteen provide for civil immunity. Civil liability protections were less common in laws relating to contraception and emergency contraception. Sixteen states have contraception-specific laws, but only five establish immunity from civil liability. Five states have laws relating to emergency contraception, but only one establishes immunity from civil liability.

86. In this study, only the beneficiaries of civil liability protections were identified. For the other categories of procedural protections, coding did not include whether the beneficiaries of those protections were individual or institutional health care providers, or some subset thereof.

87. Per the Coding Protocol, “disciplinary action” was coded where a law referenced “discipline,” “professional discipline,” “disciplinary action,” “disciplinary or recriminatory action,” “recrimination,” “recriminatory action,” “sanction,” “penalty,” or “punishment.” SAWICKI, *supra* note 76.

were less common.⁸⁸ Only four states establish a right to refuse but do not explicitly delineate *any* specific procedural protections.⁸⁹

Figure 1. Procedural Protections in Abortion Conscience Laws



In interpreting these findings, it is important to recognize that the *absence* of a particular procedural protection (or, indeed, of any procedural protections) in state law does not mean that providers exercising their conscience rights in those states are in fact unprotected from consequences. The findings presented herein are based on coders' observation of statutory text alone. Thus, the fact that only thirty-seven of the forty-six states with abortion-specific conscientious refusal laws include explicit language protecting refusing providers from civil liability should not be interpreted to mean that nine states⁹⁰ *do* affirmatively allow patients to bring tort suits. Rather, a more accurate interpretation would be that legislation in nine states is silent on the issue of civil immunity for refusing providers. Therefore, in these states, the question of whether injured patients

88. These categories were selected to increase the precision of coding in light of states' varying levels of statutory specificity. That said, there is clearly some overlap between the categories. For example, statutes protecting providers from sanctions by state medical licensing boards were coded as both "Government" and "Licensing," and statutes protecting providers from employment discrimination were coded as both "Employment" and "Discrimination."

89. ARIZ. REV. STAT. ANN. § 36-2154 (2020); CONN. AGENCIES REGS. § 19-13-D54 (2005); TENN. CODE ANN. §§ 39-15-204, 39-15-205 (2007); W. VA. CODE § 16-2F-7 (2020).

90. Five of these states (Indiana, New Mexico, North Dakota, Texas, and Washington), establish other types of procedural protections besides including civil immunity. Four (Arizona, Connecticut, Tennessee, and West Virginia) are "refusal-only" states that give no guidance regarding the potential consequences of a refusal.

retain the right to sue in cases of conscience-driven malpractice would have to be decided by a judge.⁹¹

Unfortunately, there has been very little litigation shedding light on how best to interpret refusal-only conscience laws. In the few cases that have touched on related questions, courts have reached varying conclusions.⁹² However, as a matter of logical statutory construction, it would seem difficult to interpret refusal-only laws as granting providers a right of refusal without also eliminating patients' right to a tort cause of action. Conscientious refusal statutes effectively eliminate any duty a provider might have to participate in a requested service. As a result, it would seem illogical to argue that the patient in such a case would nevertheless maintain a right to sue for a breach of that former duty.⁹³

In the five states that explicitly establish procedural protections not including civil immunity, the same reasoning would likely apply. Certainly, a textualist argument could be made that when a state law enumerates certain protective mechanisms but excludes others, that exclusion should be taken at

91. See Harry H. Wellington & Lee A. Albert, *Statutory Interpretation and the Political Process: A Comment on Sinclair v. Atkinson*, 72 YALE L.J. 1547, 1552 (1963) (stating that legislative silence is as consistent with intent to relegate interpretation to the courts as it is with a desire or preference for a particular result or interpretation).

92. Compare, e.g., *Planned Parenthood Ariz., Inc. v. Am. Ass'n of Pro-Life Obstetricians & Gynecologists*, 257 P.3d 181, 197 (Ariz. Ct. App. 2011) (declining to read Arizona's refusal-only law broadly enough to include civil immunity for refusing providers, in reliance on a state constitutional prohibition on "abrogation of . . . actions in tort which trace origins to the common law" (citation omitted)), with *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008) (dismissing the State of California's challenge to the federal Weldon Amendment—which prohibits government discrimination against health care providers who refuse to participate in abortion, but does not include an explicit emergency exception—concluding that "[t]here is no clear indication" that enforcement of EMTALA or California's emergency treatment law "would be considered 'discrimination' under the Weldon Amendment if the required medical treatment was abortion-related services"). While the *Means* case did not directly address this issue (because the suit was brought against the United States Conference of Catholic Bishops, an entity that was not protected by Michigan's conscience law), one scholar has interpreted dicta in the Sixth Circuit's opinion as "demonstrate[ing] [that] these statutes potentially deny women civil redress by obviating the physician's duty to the patient in accordance with the standard of care." Jane A. Hartsock, *Provider Conscientious Refusal, Malpractice, and the Right to Civil Recourse*, 18 AM. J. BIOETHICS 66, 67 (2018) (citing *Means v. U.S. Conference of Catholic Bishops*, 836 F.3d 643, 652 (6th Cir. 2016)). Another scholar, however, interprets the district court's discussion of hospitals' duties as suggesting that the court "seems not to regard state liability protections as a bar to medical malpractice claims." William L. Allen, *Accommodating Conscience Without Curtailing Women's Rights, Health, and Lives*, 18 AM. J. BIOETHICS 64, 65 (2018).

93. See Kristen Marttila Gast, *Cold Comfort Pharmacy: Pharmacist Tort Liability for Conscientious Refusals to Dispense Emergency Contraception*, 16 TEX. J. WOMEN & L. 149, 171 (2007) (arguing, in the context of emergency contraception, that "the existence of a refusal clause . . . appears effectively to limit the pharmacist's duty of care with respect to that act," and concluding that if such a refusal does not violate a duty of care, "it cannot provide the basis for negligence liability, regardless of whether or not the operative refusal clause states specifically that the pharmacist will not be held liable"). But see Spreng, *supra* note 63, at 382 (interpreting a conscience law that provides explicit protection only against employment discrimination and concluding that while the law "states a strong public policy about conscience protection, . . . it does not create a religious defense from tort liability").

face value. Consider, for example, section 9.02.150 of the Revised Code of Washington, titled *Refusing to Perform*, the text of which states in full:

No person or private medical facility may be required by law or contract in any circumstances to participate in the performance of an abortion if such person or private medical facility objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the termination of a pregnancy.

The text of the Washington law grants certain providers a right to refuse participation in abortion, and explicitly protects providers from discrimination in employment and professional privileges. It does not explicitly establish civil immunity for refusing providers. However, given that the law effectively eliminates any duty providers may have to participate in abortion, it would be difficult to argue that a provider's refusal constitutes a breach of duty for which an injured patient might recover in tort.

B. Beneficiaries of Civil Liability Protections

The research team further analyzed abortion refusal laws with civil liability protections to assess which categories of health care providers are entitled to civil immunity. As detailed further in Appendix C, each of the thirty-seven states that expressly established civil immunity for abortion refusal identified specific categories of providers entitled to such immunity. The most commonly protected groups were "any person" (twenty-six states), health care facilities (twenty-six states), physicians (seventeen states), registered nurses (sixteen states), and staff working at health care facilities (fourteen states). Other categories of providers also singled out for civil immunity included private health care facilities (nine states), health care providers (six states), students (five states), pharmacists (three states), any licensed professionals (two states), mental health professionals (two states), public employees (two states), and religious health care facilities (one state).⁹⁴

Overall, all but two states protected extremely broad categories of individuals—either "persons" generally (not defined as health care professionals), health care providers, or staff and employees of health care facilities.⁹⁵ All but five states provided civil immunity to at least some health care facilities.⁹⁶ An additional five states limited institutional protections to

94. Again, although there is overlap between these categories, these variables were selected so that analysis of the state laws could be as granular as possible.

95. The two outlier states did not extend their civil immunity provisions to any individual providers. NEV. REV. STAT. § 449.191 (2019) (protecting only private health facilities); OR. REV. STAT. § 435.475 (2019) (protecting only hospitals).

96. GA. CODE ANN. § 16-12-142 (2013) (protecting only persons and pharmacists); IOWA CODE § 146.2 (2020) (protecting only persons); MASS. GEN. LAWS ch. 112, § 12I (2003) (protecting only physicians and health facility staff); N.C. GEN. STAT. § 14-45-1 (2019) (protecting only health care

private facilities,⁹⁷ and one state protected facilities only if they were religiously affiliated.⁹⁸

Although most states explicitly identify narrower categories of providers for civil immunity, almost every state protects a very broad range of individuals (thirty-five of thirty-seven states), and all or some health care facilities (thirty-two of thirty-seven states). Thus, in civil immunity states, most individuals and facilities are immune from suit if their unwillingness to participate in abortion falls below the standard of care and causes patient injury.⁹⁹

C. Patient-protective Limitations

Finally, the researchers analyzed the laws to determine whether there existed any significant statutory limitations on providers' right to refuse participation in abortion and/or be immunized from civil suit for such refusals. This study focused exclusively on limitations and conditions that most directly impact patients. For example, a requirement that a physician or hospital inform the patient of their refusal *would* be coded, but a requirement that a refusing physician notify only their employer would not.

One might imagine that states with health care conscience laws might carve out some exceptions with the intent of protecting patients from serious harm. However, surprisingly few states have established any meaningful patient protections by restricting providers' right to refuse to participate in abortion. Such restrictions might, for example, limit providers' rights of refusal and/or civil immunity in situations where patients require emergency treatment. Alternatively, they might condition providers' rights on affirmative disclosure of information regarding access to the requested services. However, as illustrated in Figure 2 below, twenty-six of the forty-six states with abortion-specific refusal laws impose no limitations on the right of refusal.¹⁰⁰ Thus, in over half of U.S. states, patients harmed by conscience-driven denials of abortion (even denials that depart from the standard of care) might have no civil remedies available.

providers, physicians, and nurses); 23 R.I. GEN. LAWS § 23-17-11 (2002) (protecting only physicians and health facility staff).

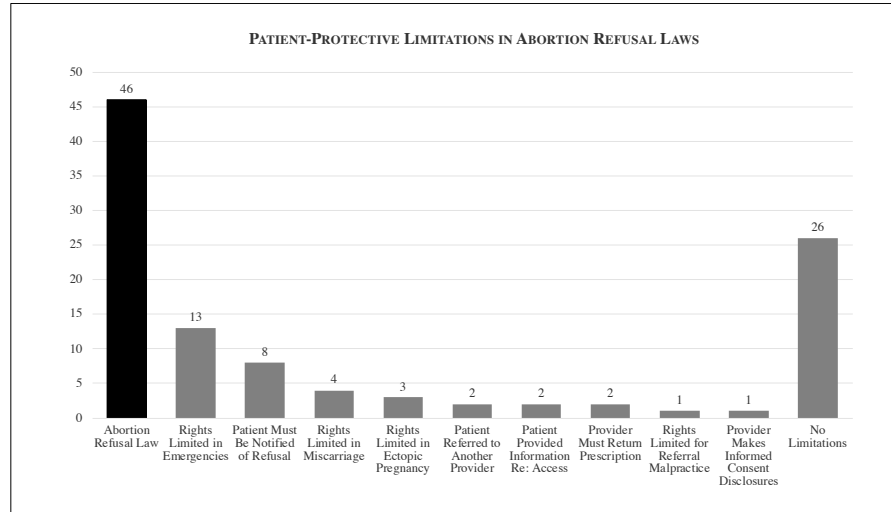
97. KY. REV. STAT. ANN. § 311.800 (West 2020) (protecting private facilities, and also physicians, nurses, hospital employees, and public employees); NEV. REV. STAT. § 449.191 (protecting only private facilities); OKLA. STAT. tit. 63 § 1-741 (2019) (protecting private facilities, and also persons, physicians, pharmacists, nurses, and facility staff); S.C. CODE ANN. § 44-41-40 (2019) (protecting private facilities, and also persons, physicians, and nurses); WYO. STAT. ANN. §§ 35-6-105, 35-6-106 (2019) (protecting private facilities, and also persons).

98. CAL. HEALTH & SAFETY CODE § 123420(c) (West 2020) (protecting "nonprofit hospital[s]" and "other facility[ies] or clinic[s] . . . organized or operated by a religious corporation or other religious organization," and also persons, physicians, nurses, and facility staff).

99. Among the fifteen states with sterilization-specific conscience laws that explicitly establish civil immunity, all protect at least one broad category of individual providers (persons, providers, or facility staff), and all but three protect health care facilities.

100. See *infra* Appendix D.

Figure 2. Patient-Protective Limitations in Abortion Refusal Laws



In other reproductive health contexts, we see similar patterns. Of the seventeen states with conscience laws relating to sterilization, only four limit providers’ refusal rights in any way.¹⁰¹ Of the sixteen states with contraception laws, only six states limit providers’ refusal rights or impose conditions to protect

101. ALA. CODE § 22-21B-4(b) (2019) (establishing civil immunity for providers who refuse to participate “except when failure to do so would immediately endanger the life of a patient”); 745 ILL. COMP. STAT. 70/6 (2019) (specifying that the law does not relieve physicians from “any duty . . . under any laws concerning current standards of medical practice or care, to inform his or her patient of the patient’s condition, prognosis, legal treatment options, and risks and benefits of treatment options,” nor from legal obligations regarding emergency medical care); *id.* 70/6.1 (requiring health care facilities to adopt “access to care and information protocols . . . designed to ensure that conscience-based objections do not cause impairment of patients’ health,” where such protocols must ensure that patients be given informed consent disclosures; be either transferred, provided with the service by another provider in the facility, or given information in writing about other providers who may offer the service; and, in cases of transfer or referral, have their medical records transferred); MD. CODE ANN., HEALTH-GEN. § 20-214(d) (West 2020) (limiting civil immunity for providers who refuse to refer patients for abortion or sterilization in cases where the refusal “would reasonably be determined as: (1) The cause of death or serious physical injury or serious long-lasting injury to the patient; and (2) [o]therwise contrary to the standards of medical care”); 16 PA. CODE § 51.31(e) (2019) (requiring that a hospital’s ethical policy regarding abortion and sterilization be “freely available and conspicuously posted for public inspection”); *id.* §§ 51.42(a), .43(a) (establishing that protections for individual providers do not apply where the providers’ “willingness, refusal, objection, statement or manifestation of attitude [regarding abortion or sterilization] constitutes an overt act which disrupts hospital procedures, operations, or services or which endangers the health or safety of any patient”).

patients.¹⁰² Of the five states with emergency contraception laws, three states limit providers' refusal rights.¹⁰³

Among the forty-six states with abortion refusal laws, only a single state, Maryland, explicitly limits a provider's civil immunity where their conduct has violated the standard of care. However, Maryland's law does not provide patients with a remedy for all harms. Rather, it only applies in cases where the provider breaches a duty to give a referral and that breach causes the patient's "death or serious physical injury."¹⁰⁴

Other states limit providers' conscience protections in situations where conscience-based refusals might seriously endanger patients. Thirteen states limit the right to refuse participation in abortion cases where a patient requires emergency treatment.¹⁰⁵ A few states restrict the scope of abortion objections to

102. CAL. CODE REGS. tit. 16, § 1746.1(b)(9) (2020) (requiring refusing pharmacists to "refer the patient to another appropriate health care provider"); GA. CODE ANN. § 49-7-6 (2001) (requiring agency directors to "reassign the duties of [refusing] employees"); 745 ILL. COMP. STAT. 70/6 (specifying that the law does not relieve physicians from "any duty . . . under any laws concerning current standards of medical practice or care, to inform his or her patient of the patient's condition, prognosis, legal treatment options, and risks and benefits of treatment options," nor from legal obligations regarding emergency medical care); *id.* 70/6.1 (requiring health care facilities to adopt "access to care and information protocols . . . designed to ensure that conscience-based objections do not cause impairment of patients' health," where such protocols must ensure that patients be given informed consent disclosures; be either transferred, provided with the service by another provider in the facility, or given information in writing about other providers who may offer the service; and, in cases of transfer or referral, have their medical records transferred); N.Y. COMP. CODES R. & REGS. tit. 18 § 463.6(d) (2020) (requiring employees of social service departments to report their conscientious refusals to supervisors, "who in turn shall assign another appropriate staff member . . . in [their] place"); OR. REV. STAT. § 435.225 (2019) (requiring employees of the Oregon Health Authority to report their conscientious refusals to supervisors "in order that arrangements may be made for eligible persons to obtain such information and services from another employee"); WIS. STAT. ANN. § 253.075(3)(b) (2020) (requiring agency directors to "reassign the duties of [refusing] employees in order to carry out the [statute's] provisions").

103. ARIZ. REV. STAT. ANN. § 36-2154(B) (2020) (requiring return of the patient's prescription); CAL. CODE REGS. tit. 16, § 1746(b)(5) (2020) (requiring pharmacists to "refer the patient to another emergency contraception provider"); IDAHO CODE § 18-611(4), (6) (2019) (limiting rights to refusal and civil immunity in "life-threatening situations").

104. MD. CODE ANN., HEALTH-GEN. § 20-214(d) (limiting civil immunity for providers whose refusal to refer a patient "would reasonably be determined as: (1) The cause of death or serious physical injury or serious long-lasting injury to the patient; and (2) [o]therwise contrary to the standards of medical care").

105. ALA. CODE § 22-21B-4(b) (limiting civil immunity for refusing providers in cases where such refusal "would immediately endanger the life of a patient"); CAL. HEALTH & SAFETY CODE § 123420(d) (West 2020) (limiting refusal rights and civil immunity in cases of "medical emergency . . . and spontaneous abortions"); IDAHO CODE § 18-611(4) (limiting immunity from civil liability for refusing providers in "life-threatening situations"); *id.* § 18-611(6) (requiring a provider who "invokes a conscience right in a life-threatening situation where no other health care professional capable of treating the emergency is available" to "provide treatment and care until an alternate health care professional capable of treating the emergency is found"); 745 ILL. COMP. STAT. 70/6 (specifying that the law does not relieve providers "from obligations under the law of providing emergency medical care"); IOWA CODE § 146.1 (2020) (excluding from the definition of abortion medical care intended to treat "a serious physical condition requiring emergency medical treatment necessary to save the life of a mother"); KY. REV. STAT. ANN. § 311.800(1) (West 2020) (prohibiting public health care facilities

exclude procedures intended to treat miscarriage (four states)¹⁰⁶ or ectopic pregnancy (three states),¹⁰⁷ conditions that can seriously threaten a pregnant patient's health.

Some states have also established patient-protective conditions on the exercise of providers' refusal rights. Eight states impose a duty to notify the patient of the refusal or of the hospital's general policy opposing abortion.¹⁰⁸

from performing abortions "except to save the life of the pregnant woman"); LA. STAT. ANN. § 40:1061.23 (2020) (limiting refusal rights where "a medical emergency compels the immediate performance of an abortion because the continuation of the pregnancy poses an immediate threat and grave risk to the life or permanent physical health of the pregnant woman"); *id.* § 40:1061.5 (limiting state employees' refusal rights where a physician-employee "is acting to save or preserve the life of the pregnant woman"); MD. CODE ANN., HEALTH-GEN. § 20-214(d) (limiting immunity from civil liability "if the failure to refer a patient [for abortion] would reasonably be determined as: (1) The cause of death or serious physical injury or serious long-lasting injury to the patient; and (2) [o]therwise contrary to the standards of medical care"); NEV. REV. STAT. § 632.475(3) (2019) (limiting nurses' refusal rights and protection from employment discrimination in "medical emergency situations"); OKLA. STAT. tit. 63, § 1-741(B) (2019) (limiting rights to refuse to "participate in medical procedures . . . which involve aftercare of an abortion patient" where such aftercare "involves emergency medical procedures which are necessary to protect the life of the patient"); *id.* § 1-741(C) (limiting refusal rights and protections from civil liability and disciplinary action in cases where "a woman is in the process of the spontaneous, inevitable abortion of an unborn child, the death of the child is imminent, and the procedures are necessary to prevent the death of the mother"); *id.* § 1-728c(1) (limiting protections from employment discrimination in cases where a "pregnant woman suffers from a physical disorder, physical injury, or physical illness which . . . causes the woman to be in imminent danger of death unless an abortion is immediately performed or induced and there are no other competent personnel available to attend to the woman"); *id.* § 1-568(E) (limiting protections from civil liability where "abortion is necessary to prevent the death of the mother"); 16 PA. CODE §§ 51.42(a), .43(a) (limiting protections where an individual's refusal "endangers the health or safety of any patient"); *id.* § 51.43(b) (1977) (limiting student and employee refusal rights in cases of "emergency surgical procedure which involves an inevitable abortion"); S.C. CODE ANN. § 44-41-40 (2019) (establishing protections from civil liability for private facilities that refuse to allow abortion, but prohibiting facilities from "refus[ing] an emergency admittance"); TEX. OCC. CODE ANN. § 103.004 (West 2020) (limiting private facilities' refusal rights where "a physician determines that the life of the mother is immediately endangered").

106. CAL. HEALTH & SAFETY CODE § 123420(d) (speaking to refusal rights and civil immunity in the context of "spontaneous abortions"); LA. STAT. ANN. § 40:1061.9(1)(b) (2020) (excluding, from the definition of abortion, any action done with the intent to "[r]emove a dead unborn child or induce delivery of the uterine contents [where] the pregnancy has ended or is in the unavoidable and untreatable process of ending due to spontaneous miscarriage, . . . spontaneous abortion, missed abortion, inevitable abortion, incomplete abortion, or septic abortion"); OKLA. STAT. tit. 63, § 1-741(C) (limiting providers' rights and immunities with respect to "medical procedures in which a woman is in the process of the spontaneous, inevitable abortion of an unborn child, the death of the child is imminent, and the procedures are necessary to prevent the death of the mother"); 16 PA. CODE § 51.43(b) (limiting the right "to refuse to participate in an emergency surgical procedure which involves an inevitable abortion").

107. ARIZ. REV. STAT. ANN. § 36-2151(1) (2020) (excluding, from the definition of abortion, "the use of any means to . . . terminate an ectopic pregnancy"); LA. STAT. ANN. § 40:1061.9(1)(c) (excluding, from the definition of abortion, any action done with the intent to "[r]emove an ectopic pregnancy"); UTAH CODE ANN. § 76-7-301(1)(b)(ii) (West 2019) (excluding, from the definition of abortion, "removal of an ectopic pregnancy").

108. CAL. HEALTH & SAFETY CODE § 123420(c) (requiring refusing facilities to "post notice of that proscription in an area . . . that is open to patients and prospective admittees"); 745 ILL. COMP. STAT. 70/6.1 (2019) (requiring health care facilities to "adopt written access to care and information

Two states require that providers who refuse to participate directly in abortions nevertheless ensure that the patient can access the service from another provider (coded as “Referral”).¹⁰⁹ Two states require refusing providers to give the patient information regarding access to the requested service.¹¹⁰ Two states require that a refusing provider return the patient’s prescription.¹¹¹ Only one state imposes a statutory requirement that refusing providers satisfy the duty to secure a patient’s informed consent, including the duty to inform patients of “legal treatment options” and the risks and benefits of these options.¹¹²

While these types of conditions provide weaker patient protections than emergency treatment requirements, they nevertheless play an important role in ensuring that patients have the option of seeking care elsewhere.¹¹³ Consider Tamesha Means, whose provider did not fully inform her about the risks of her

protocols . . . designed to ensure that conscience-based objections do not cause impairment of patients’ health” and requiring that patients of refusing providers “either be provided the requested health care service by others in the facility or be notified that the health care will not be provided and be referred, transferred, or given information”); LA. STAT. ANN. § 40:1061.20(4) (2020) (requiring a refusing individual to “notify any patient before such person provides any consultation or service . . . of the existence of a health care service that he will decline to provide” on grounds of conscience); NEB. REV. STAT. § 28-337 (1977) (requiring that a refusing facility “inform the patient of its policy not to participate in abortion procedures.”); N.Y. COMP. CODES R. & REGS. tit. 10, § 405.9(b)(10) (2020) (conditioning refusal rights and civil immunity for hospitals on a requirement that the hospital “inform the patient of its decision not to participate”); OR. REV. STAT. § 435.475(1) (2019) (conditioning refusal rights and civil immunity for hospitals on a requirement that the hospital “notify the person seeking admission to the hospital of its policy”); 16 PA. CODE § 51.31(e) (2019) (requiring that a hospital’s ethical policy regarding abortion and sterilization be “freely available and conspicuously posted for public inspection”); WYO. STAT. ANN. § 35-6-105 (2019) (requiring refusing facilities to “inform any prospective patient seeking an abortion of its policy not to participate in abortion procedures”).

109. GA. CODE ANN. § 16-12-142(b) (2013) (granting refusal rights and civil immunity to pharmacists who decline to fill prescriptions for drugs whose intent is termination of pregnancy, but requiring that “the pharmacist shall make all reasonable efforts to locate another pharmacist who is willing to fill such prescription” or, alternatively, return the patient’s prescription); 745 ILL. COMP. STAT. 70/6.1 (requiring health care facilities to adopt “access to care and information protocols” ensuring that patients either be provided with the service by another provider in the facility, or transferred, referred elsewhere, or given information about other providers who may offer the service).

110. 745 ILL. COMP. STAT. 70/6.1; N.Y. COMP. CODES R. & REGS. tit. 10, § 405.9(b)(10) (establishing refusal rights and civil immunity for hospitals, “provided that the hospital . . . shall inform the patient of appropriate resources for services or information”).

111. ARIZ. REV. STAT. ANN. § 36-2154(B) (2020) (requiring a refusing pharmacy, hospital, health professional, or employee to “return to the patient the patient’s written prescription order”); GA. CODE ANN. § 16-12-142(b) (requiring a refusing pharmacist to “immediately return the prescription to the prescription holder”).

112. 745 ILL. COMP. STAT. 70/6 (2019) (“Nothing in this Act shall relieve a physician from any duty, which may exist under any laws concerning current standards of medical practice or care, to inform his or her patient of the patient’s condition, prognosis, legal treatment options, and risks and benefits of treatment options, provided, however, that such physician shall be under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience.”)

113. That said, the option of seeking care elsewhere may not be available to some patients. In particular, patients in rural areas with few health care facilities, patients whose health insurance plans limit their choice of providers, and patients with serious medical conditions who do not have the option of safe transfer may have limited alternative treatment options.

condition. She did not know about the risks and benefits of the various treatment options available to her (including termination and extraction of the pregnancy), Mercy Health System's prohibition on pregnancy termination, or the availability of treatment elsewhere. Had one or more of these requirements been in place in Michigan, Ms. Means may have been able to seek care at another facility and possibly avoid the injuries she experienced.

Notably, even those statutes that limit providers' conscience rights in an effort to prevent immediate harm to patients prioritize patient safety only in limited contexts. For example, Maryland maintains a patient's right to bring civil suit for violations of the standard of care only where a provider's refusal to make a referral for an abortion (as opposed to refusal to participate in an abortion) causes "death or serious physical injury or serious long-lasting injury."¹¹⁴ If a Maryland provider declines to participate in an emergency abortion but does make a referral, they would be immune from civil liability, even if the resulting delay causes the patient's death. In all cases, patients lose the opportunity to recover tort damages if they do not suffer injuries that a court or jury concludes are "serious" or "long-lasting."

In other states, emergency exceptions may protect some patients but not others, depending on the identity of the refusing provider. For example, Texas does not require that private health care facilities "make [their] facilities available for the performance of an abortion unless a physician determines that the life of the mother is immediately endangered," and presumably, these facilities would not be held liable for failure to do so.¹¹⁵ Although Texas also protects individual providers who refuse to participate in abortion, their protections do not include emergency exceptions. Thus, a patient denied an emergency abortion in Texas might be able to bring a cause of action against a private hospital but not against an individual provider.

D. Summary of Civil Liability Protections

Taken together, the findings paint a troubling picture for patients who have suffered injuries as a result of conscience-based deviations from the medical standard of care. In most states, patients do not have the opportunity for legal recovery when an individual or institutional health care provider's refusal to terminate a pregnancy violates the standard of care. These legal limitations will likely have the greatest impact on patients experiencing miscarriages, ectopic pregnancies, or other pregnancies that threaten their life or health.¹¹⁶ And in most states, providers who deny abortion services have no duty to notify patients that such services may be medically appropriate and available at another facility.

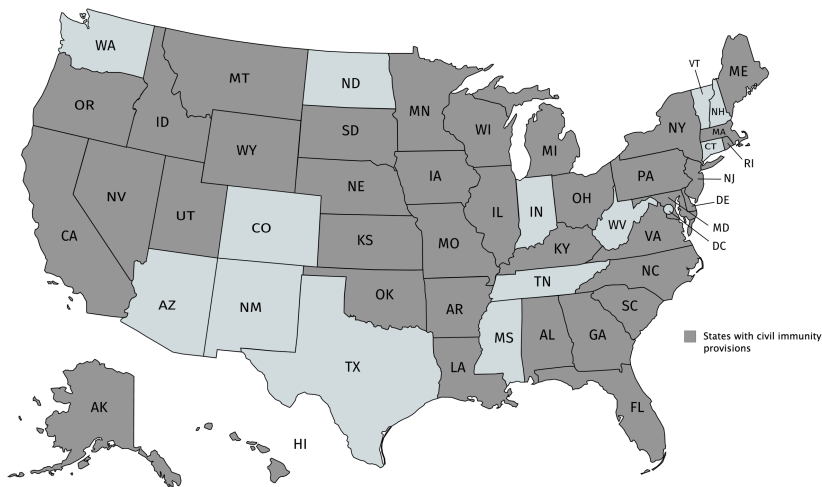
114. MD. CODE ANN., HEALTH-GEN. § 20-214(d) (West 2020).

115. The Texas law does not explicitly state the obligations of public hospitals. TEX. OCC. CODE ANN. § 103.004 (West 2020).

116. See *infra* Part IV.B.

Most states with abortion-specific conscience laws either implicitly or explicitly grant providers immunity from civil liability. As detailed further in Part III.A, and illustrated in Figure 3 below, thirty-seven states explicitly immunize providers from civil liability for their conscience-based refusal. Another nine states have conscience laws that would likely be interpreted as establishing civil immunity despite the absence of explicit language.

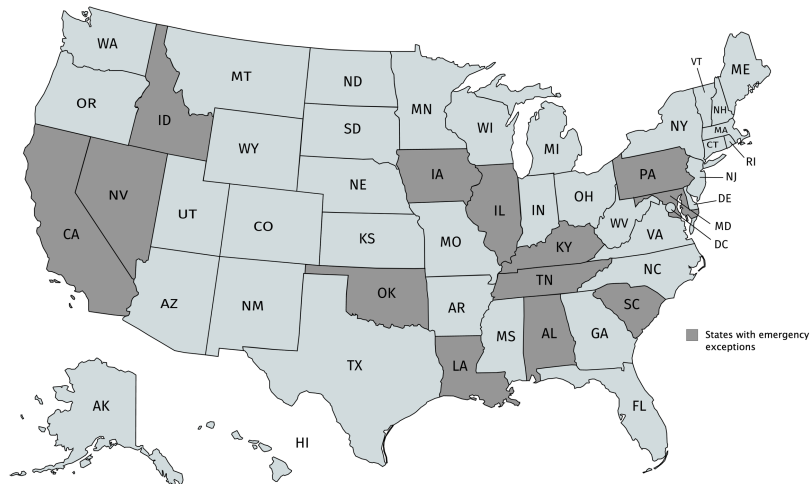
Figure 3. Immunity from Civil Liability in Abortion Refusal Laws



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As detailed further in Part II.C., and illustrated in Figure 4 below, only thirteen of the forty-six states with abortion refusal laws limit providers' right to refuse treatment and/or permit patients to bring civil suit in life-threatening or emergency situations. However, these laws limit liability only for some providers and in some circumstances.

Figure 4. Emergency Exceptions in Abortion Refusal Laws



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Only one state that establishes a right to refuse to participate in abortion, Illinois, requires providers to fulfill their common law duty to inform patients of all available treatment options, which may include abortion.¹¹⁷ No state limits providers' right of refusal or civil immunity when their refusal to participate in abortion in a non-emergent situation violates the standards of medical care.

Finally, four states and the District of Columbia do not have legislation explicitly protecting health care providers who decline to participate in abortions for reasons of conscience.¹¹⁸ That said, one of these states—Mississippi—has a general conscience law that grants individual and institutional providers the right to refuse to participate in *any* health care service and grants them civil immunity

117. 745 ILL. COMP. STAT. 70/6 (2019) (requiring physicians to comply with any duties arising from “laws concerning current standards of medical practice or care” to inform a patient of their “condition, prognosis, legal treatment options, and risks and benefits of treatment options,” but stating that physicians have no duty to “counsel, suggest, recommend, [or] refer . . . [for any] health care service that is contrary to his or her conscience”); *id.* 70/6.1(1) (requiring health care facilities, personnel, and physicians to inform patients of their “condition, prognosis, legal treatment options, and risks and benefits of the treatment options in a timely manner, consistent with current standards of medical practice or care”).

118. Colorado, the District of Columbia, Mississippi, and New Hampshire do not have any abortion specific conscience laws. Vermont’s abortion conscience law protects providers who choose to participate in abortion, but not those who refuse. VT. STAT. ANN. tit. 18 §§ 9497(3)–(4) (2019) (stating that public entities shall not prohibit, interfere with, or restrict a health care provider’s choice to terminate or assist in terminating a pregnancy).

in such cases.¹¹⁹ The District of Columbia also has a general conscience law, but it protects only employees of public benefit corporations from employment discrimination.¹²⁰ It does not explicitly address civil liability.¹²¹ That said, the District of Columbia law, unlike Mississippi's, establishes exceptions in cases where the patient's "safety is in jeopardy," and it requires that managers "assess and ensure appropriate staffing so that patient care needs are met."¹²² Colorado has laws protecting providers' rights of conscience in the context of sterilization, contraception, and emergency contraception, but not abortion.¹²³ New Hampshire does not appear to have any health care conscience laws. In 2019, Vermont's legislature passed the Freedom of Choice Act, which was aimed at safeguarding reproductive freedom and prohibits public entities from interfering with a health care provider's choice to participate in abortion; it does not protect providers who refuse to participate.¹²⁴ Thus, in four of the five jurisdictions with no abortion-specific conscientious refusal law, an injured patient could potentially bring a lawsuit if a health care provider's refusal to participate in abortion violated the standard of care.¹²⁵

Considering all the data, a patient injured by a provider's conscience-driven refusal to participate in abortions would be barred from recovering tort damages in all but seventeen states.¹²⁶ In the seventeen states with no statutory bar, recovery would likely be permitted only in life-threatening or emergency situations, rather than in all contexts where the provider's conscientious refusal violates the standard of care. Moreover, a patient's remedy may be further limited as most states bar tort recovery against some type of providers. Thus, these states deny patients like Tamesha Means, who are physically imperiled when they are unable to access abortion services, the opportunity to recover in tort for their injuries.

119. MISS. CODE. ANN. §§ 41-107-5, -7 (2013). The law does not include any patient-protective limitations.

120. D.C. Mun. Regs. tit. 22-B, § 9006.1 (2017) (protecting employees of public benefit corporations from employment discrimination for their conscientious refusal to participate in "certain aspects of direct patient care that are in conflict with their religious, or ethical beliefs").

121. Nevertheless, a judge might interpret it as implicitly establishing civil immunity. *See supra* Part III.A.

122. §§ 9006.1, -2(e).

123. COLO. REV. STAT. § 25.5-10-235 (2019) (sterilization); *id.* §§ 25-6-102, 25-6-207 (contraception); *id.* § 25-3-110 (emergency contraception).

124. VT. STAT. ANN. tit. 18 § 9497 (2019). Prior to 2019, Vermont had no health care conscience laws.

125. Colorado (establishing reproductive conscience laws applicable only to sterilization, contraception, and emergency contraception), New Hampshire (no reproductive conscience laws), Vermont (no abortion refusal law, no other reproductive conscience laws), and the District of Columbia (establishing general conscience protections applicable only to employees and managers of public benefit corporations).

126. These include the thirteen states that restrict providers' refusal rights in emergencies and four of the five states with no abortion-specific refusal laws.

IV.

THE IMPORTANCE OF CIVIL REMEDIES FOR INJURED PATIENTS

The prevalence of open-ended liability protections in reproductive health conscience laws creates a cause for concern. The data demonstrate that in most states, patients who suffer injury as a result of a provider's conscientious refusal to participate in abortion lose their right to seek legal recovery for their injuries.

Critics may challenge the significance of these findings, arguing that civil liability protections do not significantly impact patients' ability to recover tort damages for their injuries. This Section counters four potential arguments that might be used to minimize the claim that state laws establishing a "conscience defense to malpractice" harm patients.

First, some may argue that legally sanctioned conscientious refusals impact only a few patients because only a minority of health care providers decline to participate in reproductive services for reasons of conscience. This Section demonstrates, however, that conscience-based objections to reproductive services like abortion are quite common, particularly at the institutional level.

Second, critics may claim that even if a high number of providers claim conscience protections, patients might not suffer severe injuries that would warrant tort recovery. While some denials of reproductive care are unlikely to cause serious injury, numerous cases demonstrate that serious physical injuries warranting tort recovery can and do occur.

Third, critics may argue that a patient with significant injuries would be unlikely to prove breach of duty in a malpractice suit because health care providers have no legal duty to participate in abortion. However, given that the termination of a pregnancy is a medically appropriate treatment for many health-harming pregnancies, a jury might reasonably conclude that a denial of such treatment—and more importantly, denial of information about this treatment option—violates the standard of care.

Finally, some will argue that even if civil immunity laws withdraw patients' rights to tort recovery in state court, patients have adequate protections established by federal law under EMTALA. However, this Section demonstrates that EMTALA provides only limited protections and may not be a viable remedy for many patients injured by conscience-based refusals.

A. Provider Conscientious Refusals Impact the Delivery of Health Care

While it is impossible to quantify precisely how many patients may be affected by conscience-driven refusals, numerous studies suggest that the impact may be significant. Individual and institutional providers frequently report that they would decline to offer medically indicated health services when they oppose those services on conscience grounds. If the prevalence of conscience-based denials of care is as high as these studies suggest, millions of patients risk being denied reproductive health care services. And as a result of civil immunity laws in the majority of states, these patients lack the opportunity

to seek legal redress if they were injured by a conscientious refusal that violated the standard of care.

1. *The Effect of Institutional Religious Perspectives on Delivery of Health Care Services*

At the institutional level, religious commitments have a dramatic impact on the delivery of care. As of 2016, four of the ten largest hospital systems in the U.S. were Catholic.¹²⁷ In addition, according to the Catholic Health Association of the United States, Catholic hospitals treat one in seven patients.¹²⁸ The United States Conference of Catholic Bishops' Ethical and Religious Directives for Catholic Health Care Services bind these hospitals by limiting the services that they can provide, including nearly absolute prohibitions on abortion, sterilization, and contraception.¹²⁹ As a result of state laws that protect institutional conscience rights, patients seeking care at religiously affiliated hospitals face these prohibitions even when they conflict with common medical practice.

Surveys of physicians working in religiously affiliated hospitals demonstrate that institutional policies may conflict with providers' clinical judgment about best practices in reproductive care.¹³⁰ One national survey found that among OB/GYNs working in religiously affiliated health care institutions, 37% had experienced "conflict with the institutions regarding religiously based policies for patient care."¹³¹ Among OB/GYNs practicing in Catholic hospitals, this figure rose to 52%.¹³²

127. LOIS UTTLEY & CHRISTINE KHAIKIN, MERGERWATCH, GROWTH OF CATHOLIC HOSPITALS AND HEALTH SYSTEMS 8 (2016), http://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf [<https://perma.cc/2GKR-86NZ>].

128. *Facts - Statistics*, CATHOLIC HEALTH ASS'N OF THE U.S., <https://www.chausa.org/about/about/facts-statistics> [<https://perma.cc/W6XK-DMKM>].

129. See ETHICAL AND RELIGIOUS DIRECTIVES, *supra* note 13, at 4 (describing the purpose of the USCCB Directives as "reaffirm[ing] the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person" and "provid[ing] authoritative guidance on certain moral issues that face Catholic health care today."); *id.* at 18–19 (prohibiting abortion, which is defined as the "directly intended" termination of pregnancy or destruction of a fetus; "contraceptive practices"; and "direct sterilization"). However, in accordance with the ethical principle of double effect, the ERDs permit medical interventions whose "direct effect" or "direct purpose" cures or alleviates a serious pathological condition, even if those interventions have the foreseeable but unintended consequence of inducing sterility or causing the death of an unborn child. *Id.* at 19.

130. See 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) (surveying 446 general internists, family physicians, and general practitioners, and finding that among those who had worked in religiously affiliated institutions, 19% had experienced conflicts regarding clinical treatment and religiously driven hospital policies).

131. Debra B. Stulberg et al., *Obstetrician-Gynecologists, Religious Institutions, and Conflicts Regarding Patient-Care Policies*, 207 AM. J. OBSTETRICS & GYNECOLOGY 73.e1 (2012) (surveying 1,800 OB/GYNs practicing in Catholic, Christian but non-Catholic, Jewish, and other facilities).

132. *Id.*

In another study, the authors conducted qualitative interviews with OB/GYNs who currently practice or have practiced at Catholic hospitals to better understand the types of clinical conflicts that can arise.¹³³ Reported conflicts included cases in which hospital policies impacted physicians' ability to offer treatment to patients experiencing obstetric emergencies such as ectopic pregnancy, molar pregnancy, miscarriage, premature rupture of membranes, and other pregnancy-related health problems.¹³⁴ In such cases, physicians reported that hospital authorities objected to the standard of care treatment on the grounds that it equated to abortion.¹³⁵

One physician, for example, drew a direct contrast between how a patient might be cared for at a Catholic hospital and at a non-denominational hospital. "Say somebody ruptured their membranes, or . . . had a lethal anomaly, or . . . had no [amniotic] fluid and the prognosis was zero[.] [I]n the non-Catholic hospital you would just . . . put in some medicine to put them through labor, or do a D&E [dilation and extraction]. And in the Catholic hospital you had to wait till they get sick, which was kind of foolish when you knew the prognosis was so poor."¹³⁶ Another physician, who sought to evacuate the uterus of a patient experiencing a life-threatening molar pregnancy, was told by the hospital's ethics committee, "You can't do it here. Take her to another hospital to do it."¹³⁷ Other physicians described "stretching the truth" to secure permission to treat patients at risk before their conditions became life-threatening.¹³⁸ The authors of the study concluded that, under the "Catholic bioethical approach, women bear risk in ways that conflict with the training of . . . physicians"¹³⁹

133. Lori R. Freedman & Debra B. Stulberg, *Conflicts in Care for Obstetric Complications in Catholic Hospitals*, 4 AM. J. BIOETHICS PRIMARY RES., no. 4, 2013, at 1.

134. *Id.* at 4–7; see also Angel M. Foster et al., *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study*, 21 WOMEN'S HEALTH ISSUES 104 (2011) (describing findings of a qualitative study of OB/GYNs and emergency medicine physicians, finding that some Catholic hospitals do not provide women with access to and information about treatment options for ectopic pregnancy); Lori R. Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUB. HEALTH 1774 (2008) (describing findings of a qualitative survey of OB/GYNs whose medical judgment about the treatment of miscarriage patients was interfered with by religiously motivated institutional policies); Stulberg et al., *supra* note 130 (surveying OB/GYNs as to institutional limitations on treatment of ectopic pregnancy with fetal heart tones present).

135. Freedman & Stulberg, *supra* note 133, at 6 ("Dr. C took issue with equating the treatment to an elective abortion because this was a deeply desired pregnancy . . . They told her, 'We allow women with ruptured membranes to stay pregnant all the time at 20 weeks.' To which she recalled replying, 'Yes, we do, but even that is not completely standard of care.'").

136. *Id.*

137. *Id.* at 5.

138. *Id.* at 7 ("So, if . . . normal temperature was 98.6, true infection's probably not [until] 100.6—but . . . if they got to 99, we would call it a fever. And we would induce them. Because we were protecting their life and trying to salvage their uterus, so they didn't get a serious infection, that they needed a hysterectomy.").

139. *Id.* at 9.

State laws like those described in Part III protect the rights of religiously affiliated hospitals to limit the reproductive treatments they offer and often immunize these hospitals from tort suits for their refusals. Physicians working at these hospitals report that these institutional limitations prevent them from providing patients with the best possible care. The proliferation of conscience laws, therefore, increases the likelihood that patients will have no recourse when hospitals deny them the treatment that their physicians would offer if not for institutional policies.

2. *The Effect of Individual Conscience on Delivery of Health Care Services*

Studies of physicians' perspectives on conscientious objection suggest that many physicians prioritize their personal ethical and religious beliefs over patients' ability to access services and information. While conscientious refusals among individual providers are less common than among institutional providers, a substantial percentage of physicians express strong support for rights of conscientious refusal, particularly in the context of reproductive care. According to the authors of a 2007 article in the *New England Journal of Medicine*, "14% of patients—more than 40 million Americans—may be cared for by physicians who do not believe they are obligated to disclose information about medically available treatments they consider objectionable."¹⁴⁰ Additionally, "29% of patients—or nearly 100 million Americans—may be cared for by physicians who do not believe they have an obligation to refer the patient to another provider for such treatments."¹⁴¹

The most widely-cited findings about the relationship between conscience and medical practice come from a 2009 study of primary care physicians.¹⁴² In this study, 77% of physicians surveyed believed they would have no duty to perform a legal medical procedure requested by a patient if they objected to that

140. Farr A. Curlin et al., *Religion, Conscience, and Controversial Clinical Practices*, 356 *NEW ENGL. J. MED.* 593, 597 (2007) (surveying 2,000 U.S. physicians from all specialties regarding their willingness to provide information and referrals about services they object to on the grounds of conscience).

141. *Id.*

142. Ryan E. Lawrence & Farr A. Curlin, *Physicians' Beliefs About Conscience in Medicine: A National Survey*, 84 *ACAD. MED.* 1276 (2009) (surveying 1,000 U.S. primary care physicians). This study had additional valuable findings, including that many respondents gave contradictory responses to some questions. For example, 78% of respondents agreed with the following statement: "A physician should never do what he or she believes is morally wrong, no matter what experts say." *Id.* at 1277. However, 36% of those respondents who agreed also expressed agreement with an incompatible statement: "sometimes physicians have a professional ethical obligation to provide medical services even if they personally believe it would be morally wrong to do so." *Id.* According to the authors of the study, "we intended the two statements to be incompatible with one another." *Id.* at 1281. The authors therefore concluded that "42% of primary care physicians believed that physicians are *never* obligated to do what they personally believe is wrong; 22% believed that, as professionals, physicians are *sometimes* obligated to do what they personally believe is wrong; and 36% held a middle view, in which they agreed with both [statements]." *Id.* at 1278 (emphasis added).

procedure for religious or moral reasons.¹⁴³ Another study focusing specifically on religion in health care found that a majority of physicians would give religious guidelines at least some weight when making ethically complex decisions about patient care.¹⁴⁴ When asked whether patient autonomy should outweigh moral guidelines from religious traditions when making “ethically complex medical decisions,” 22% of respondents agreed that physicians could refrain from providing patients with legal medical options that conflicted with their religious beliefs.¹⁴⁵ Among physicians with high intrinsic religious motivation, this figure rose to 37%.¹⁴⁶

Physicians are not alone in these perspectives. In a 2012 survey of Idaho nurses, almost 25% of respondents stated that as a general matter, a nurse’s right to conscientious objection ought to take precedence over a patient’s “right to health care choices.”¹⁴⁷ Among nurses who reported that their ethical beliefs were primarily driven by religious beliefs, this figure rose to almost 50%.¹⁴⁸

With respect to referral duties in particular, physician responses are more varied, particularly depending on their levels of religiosity. A 2009 study found that most physicians believed they would have a duty to provide a referral for a medical treatment they opposed on conscience grounds.¹⁴⁹ Only 11% of physicians believed they would have no duty to refer; 7% were undecided.¹⁵⁰ However, other studies have found greater opposition to referral duties,

143. *Id.* at 1279. An additional 9% of physicians were undecided. *Id.*

144. Ryan E. Lawrence & Farr A. Curlin, *Autonomy, Religion and Clinical Decisions: Findings from a National Physician Survey*, 35 J. MED. ETHICS 214, 216 (2009) (surveying 1,000 U.S. primary care physicians). The study found that 47% of physicians would give religious guidelines “some weight,” 16% would give them “a lot of weight,” and 5% would give religious guidelines “the highest possible weight.” *Id.* Only 15% disagreed and 7% strongly disagreed with the following statement: “Physicians should not let their religious beliefs keep them from providing patients legal medical options.” *Id.*

145. *Id.* (finding that 15% of respondents disagreed and 7% strongly disagreed with the statement that doctors should not let their religious beliefs keep them from providing patients with legal medical options).

146. *Id.* at 217 (finding that 63% of respondents with high intrinsic religiosity agreed or strongly agreed with the statement above).

147. Shoni Davis et al., *Influencers of Ethical Beliefs and the Impact on Moral Distress and Conscientious Objection*, 19 NURSING ETHICS 738, 743, 745 (2012) (surveying 1,144 registered nurses in Idaho).

148. *Id.* at 745. Surprisingly, an even greater number of respondents believed they should have refusal rights in “a small rural health care setting.” *Id.* at 744. The study revealed that 66.4% of all respondents and 86.9% of religiously-driven respondents concluded that in such settings they should not have to provide non-emergency medical services that violate their beliefs. *Id.* at 746. This finding is particularly striking given that many scholars suggest that the conscience rights of providers in rural settings should be more limited than the rights of practitioners in settings where patients have greater alternatives for seeking care. *See, e.g.*, Dresser, *supra* note 20; Robert K. Vischer, *Individual Rights vs. Institutional Identity: The Relational Dimension of Conscience in Health Care*, 9 AVE MARIA L. REV. 67, 75 (2011) (arguing that in rural areas, states might be more justified in requiring pharmacies to dispense contraceptives).

149. Lawrence & Curlin, *supra* note 144, at 1279.

150. *Id.*

particularly among physicians for whom religion plays a significant role in their lives. More recent studies show that between a quarter and a half of surveyed physicians do not believe they have an ethical duty to refer patients for objectionable medical treatments.¹⁵¹ Among highly religious physicians, opposition to such patient referrals ranges from 44% to 62%.¹⁵²

Studies of physicians' perspectives on providing patients with access to general information about legal but controversial medical procedures also show support for conscientious refusal. One study found that 14% of physicians across all specialties were either undecided or believed they would not be obligated to "present all possible options to the patient, including information about obtaining the requested procedure" if they objected to that procedure for moral reasons.¹⁵³ Among physicians with high "intrinsic religiosity," 19% believed there was no such ethical obligation.¹⁵⁴ Among gynecologic oncologists in particular, 45% reported that their personal religious and spiritual beliefs "play[ed] a role in the medical options they offered patients."¹⁵⁵

Other providers of reproductive health services also report that personal beliefs impact their medical practices in the contexts of abortion, contraception, and sterilization. For example, the 2007 *New England Journal of Medicine* study cited above explored physicians' attitudes about clinical practices including abortion and prescription of birth control.¹⁵⁶ A majority of respondents (52%) reported objection to an abortion resulting from failed contraception.¹⁵⁷ Furthermore, 42% of physicians reported objection to prescribing birth control to an adolescent without parental approval.¹⁵⁸

151. Compare Curlin et al., *supra* note 140, at 597–98 (finding that 18% of respondents believed they had no obligation to refer a patient for a morally objectionable medical treatment while 11% were undecided), with Michael P. Combs et al., *Conscientious Refusals to Refer: Findings from a National Physician Survey*, 37 J. MED. ETHICS 397, 397 (2011) (surveying 2,000 U.S. physicians from all specialties and finding that 44% of respondents moderately or strongly disagreed with the following statement: "Physicians have a professional obligation to refer patients for all legal medical services for which the patients are candidates, even if the physician believes that such a referral is immoral.").

152. Compare Curlin et al., *supra* note 140, at 598 (finding that 56% of physicians with high "intrinsic religiosity" believe there is an obligation to refer), with Combs et al., *supra* note 151, at 399 (finding that among physicians who identified religion as a "very important" part of their lives, 48% agreed that they are obligated to provide a referral even if they believe that referral is immoral, and among those for whom religion was "the most important" part of their lives, 38% agreed).

153. Curlin et al., *supra* note 140, at 597–98 (finding that 8% of respondents said they were not obligated to give information and that 6% were undecided).

154. See *id.* at 595, 597–98 (finding that 81% of respondents with high "intrinsic religiosity"—defined as "the extent to which a person embraces his or her religion as the 'master motive' that guides and gives meaning to his or her life"—agreed that they had an obligation to disclose all options).

155. Lois Ramondetta et al., *Religious and Spiritual Beliefs of Gynecologic Oncologists May Influence Medical Decision Making*, 21 INT'L J. GYNECOLOGICAL CANCER 573, 573 (2011) (surveying 1,972 members of the International Gynecologic Oncologists Society and the Society of Gynecologic Oncologists).

156. Curlin et al., *supra* note 140, at 596.

157. *Id.*

158. *Id.*

Rates of conscientious objection to reproductive health care services tend to be lower among OB/GYNs and others who regularly provide such services (e.g., pharmacists who dispense contraceptives). Thus, patients are probably less likely to be denied services when they seek treatment from such providers, as compared to general practitioners or other providers who rarely encounter patients seeking reproductive care. However, even some providers who specialize in reproductive care maintain conscience-based objections to some services. In a 2011 study of U.S. OB/GYNs' perspectives on contraception and sterilization, 4.9% reported having a moral or ethical objection to at least one contraceptive method, and 6.8% said they would not offer one or more contraceptive methods to patients who requested them.¹⁵⁹ Another study found that 6% of OB/GYNs would not offer emergency contraception to anyone under any circumstances.¹⁶⁰ Another 6% would only offer it to victims of sexual assault.¹⁶¹ Rates of refusal were higher among doctors who "consider religion the most important part of their lives," 36% of whom reported that they would never offer emergency contraception, or would offer it only in cases of sexual assault.¹⁶² Rates of objection among pharmacists are also noteworthy. A 2008 survey of Nevada pharmacists found that 7.5% would refuse to dispense emergency contraception and 17.2% would refuse to dispense medical abortifacients.¹⁶³

In demonstrating the prevalence of health care providers with absolute objections to specific medical services, these studies support the claim that patients are impacted by conscience-based denials of care, particularly when those denials are protected by law.

159. Ryan E. Lawrence et al., *Obstetrician-Gynecologists' Views on Contraception and Natural Family Planning: A National Survey*, 204 AM. J. OBSTETRICS & GYNECOLOGY 124.e1, 124.e3 (2011) (surveying 1,800 OB/GYNs). The most common objections were to "intrauterine devices (4.4% object, 3.6% would not offer), followed by progesterone implants and/or injections (1.7% object, 2.1% would not offer), tubal ligations (1.5% object, 1.5% would not offer), oral contraceptive pills (1.3% object, 1.1% would not offer), condoms (1.3% object, 1.8% would not offer), and the diaphragm or cervical cap with spermicide (1.3% object, 3.3% would not offer)." 1.1% of surveyed physicians had a moral or ethical objection to all six contraceptives.

160. Ryan E. Lawrence et al., *Obstetrician-Gynecologist Physicians' Beliefs about Emergency Contraception: A National Survey*, 82 CONTRACEPTION 324, 329 (2010) (surveying 1,800 OB/GYNs).

161. *Id.*

162. *Id.* at 327. The authors note that while "nonprescription availability [of 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 [emergency contraception], and even well-informed patients still rely on their physician's advice." *Id.* at 329.

163. Laura A. Davidson et al., *Religion and Conscientious Objection: A Survey of Pharmacists' Willingness to Dispense Medications*, 71 SOC. SCI. & MED. 161, 163 (2010) (surveying 668 pharmacists in Nevada). Of the 7.5% who would refuse to dispense emergency contraception, 2.3% would also refuse to transfer the patient's prescription. *Id.* Of the 17.2% who would refuse to dispense medical abortifacients, 5.9% would also refuse to transfer the prescription. *Id.* Respondents also reported objections to erectile dysfunction drugs (1.7%); infertility drugs (1.4%); and oral contraceptives (0.5%). *Id.*

Some conscience-based objections are more situational, however, which makes it far more difficult to track their prevalence. Thus, some researchers have used vignette-based studies to assess the impact of conscience on the delivery of health care services in particular contexts. One study demonstrated that the reason for a patient's request dramatically impacts providers' willingness to provide the service.¹⁶⁴ For example, only 16% of respondents held moral objections to abortion in the case of a twenty-four-year-old with "a cardiopulmonary abnormality associated with a 25% chance of death with gestation."¹⁶⁵ However, 82% objected in the case of a thirty-eight-year-old with "five daughters and no sons" who was pregnant with a "chromosomally normal female."¹⁶⁶ In a scenario that OB/GYNs likely encounter more frequently—that of a "22-[year]-old single woman 6 [weeks] pregnant after failed hormonal contraception"—41% of respondents objected to abortion; nevertheless, 85% said they would "help the patient obtain an abortion if asked," either by providing a referral or performing the abortion themselves.¹⁶⁷

Another vignette-based study evaluated OB/GYNs' perspectives about whether conscientious refusal would be "appropriate" in various contexts.¹⁶⁸ Respondents were presented with a scenario in which a physician conscientiously refused to provide an elective abortion to a twenty-three-year-old single graduate student who was eight weeks pregnant.¹⁶⁹ The researchers found that overall, 43% of respondents agreed that "the conscientious refusal exercised by the vignette physician was very or somewhat appropriate."¹⁷⁰

Taken together, these data indicate that many health care providers hold conscientious beliefs that impact their willingness to participate in, inform patients about, or refer patients for abortion and other reproductive health

164. Lisa H. Harris et al., *Obstetrician–Gynecologists' Objections to and Willingness to Help Patients Obtain an Abortion*, 118 *OBSTETRICS & GYNECOLOGY* 905 (2011) (surveying 1,800 OB/GYNs about how their conscientious beliefs might impact their responses to patient requests for treatment). The vignettes involved a variety of circumstances in which women might seek abortion: failed contraception, fetal sex selection, breast cancer, difficult-to-control diabetes, rape, selective reduction, and cardiopulmonary disease. *Id.* at 906. The authors concluded that their findings "contrast with public debates about the ethics of abortion, which often focus only on the moral status of the fetus: if the fetus is considered a person, then abortion is the moral equivalent of murder; if the fetus is not considered a person, then abortion may be permissible." *Id.* at 909.

165. *Id.* at 908.

166. *Id.*

167. *Id.* Of those who held moral objections to abortion, around two-thirds of respondents reported that they would nevertheless help the patient "in the case of failed contraception." *Id.*

168. Kenneth A. Rasinski et al., *Obstetrician-Gynaecologists' Opinions About Conscientious Refusal of a Request for Abortion: Results from a National Vignette Experiment*, 37 *J. MED. ETHICS* 711 (2011) (surveying 1,800 OB/GYNs).

169. *Id.* at 711–12.

170. *Id.* Variations of the scenario contrasted physicians who did and did not provide a referral to the patient and physicians who did or did not disclose the reason for their objection. 70% of respondents expressed approval of the vignette physician who provided a referral. *Id.* at 713. 54% approved of the physician who did not disclose the reason for his objection. *Id.* 88% approved of the physician who both provided a referral and did not disclose the reason for his objection. *Id.*

services. Given that nearly every U.S. state grants providers a right to decline to participate in abortion, millions of patients may be affected by these refusals. In most states, a patient has no legal remedy if that refusal violates the standard of care.

B. Some Patients Suffer Serious Compensable Injuries as a Result of Conscience-driven Refusals

Conscientious refusals to provide reproductive health services can result in serious injuries to some patients. A vast body of scholarship has investigated and documented the harms that patients can suffer when they are denied access to medical services as a result of health care providers' exercise of conscience rights.¹⁷¹ Because patients can suffer serious harms as a result of at least some denials of reproductive care, civil immunity provisions in state conscience laws have a meaningful impact on tort recovery.

Patients may experience a broad spectrum of consequences when a health care provider declines to provide a service for reasons of conscience. In the most challenging cases, a patient may be unable to access the needed service. Reasons for inaccessibility may include geographic restrictions, insurance limitations, immediacy of need, or because the patient has not been informed that the service is medically appropriate and available elsewhere.¹⁷² Of course, when an institutional provider has established effective policies to ensure patient access in cases of individual provider objection, the patient may experience no direct harm. Indeed, if the institutional process is seamless enough, the patient may not even be aware that a conscience-driven refusal has occurred.¹⁷³ But even when the patient is aware that their provider has refused to provide a service on grounds of conscience and is still able to access that service elsewhere, she may nevertheless suffer dignitary harms¹⁷⁴ or inconvenience in accessing services elsewhere.¹⁷⁵ Because it is not clear whether these types of harms would be

171. See, e.g., Sawicki, *supra* note 51, at 97–99 (describing the “range of consequences, from mere inconvenience to . . . serious adverse health outcomes” that may result from delays in securing reproductive health services that have been refused on grounds of conscience).

172. See *id.* at 128.

173. See HOLLY FERNANDEZ LYNCH, *CONFLICTS OF CONSCIENCE IN HEALTH CARE* (2008) (arguing for institutional solutions to resolve access problems relating to individual providers' conscientious objections).

174. See Douglas NeJaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 *YALE L.J.* 2516, 2576–77 (2015) (arguing that patients can suffer serious dignitary harms as a result of conscience-driven denials of care).

175. See Robert K. Vischer, *Conscience in Context: Pharmacist Rights and the Eroding Moral Marketplace*, 17 *STAN. L. & POL'Y REV.* 83, 113 (2006) (arguing that there is a legally relevant distinction between inconvenience and true lack of access); Wilson, *The Limits of Conscience*, *supra* note 32, 52–54 (arguing, in the context of emergency contraception, that allowing providers to exercise conscience rights will not result in an “access crisis,” and challenging the claim that patients should be protected from “even the smallest inconvenience in obtaining contraceptives”).

compensable as a matter of law,¹⁷⁶ the impact of civil immunity laws is likely to be greater when denials of care result in physical injury.

Whether a provider's conscience-based refusal delays a patient's access to services or prevents her from receiving care entirely, the range of harms suffered can vary widely depending on the context in which the refusal occurs. Denial of access to contraception, emergency contraception, or abortion may result in an unwanted pregnancy.¹⁷⁷ Denial of access to assisted reproductive technology services such as in vitro fertilization may result in an inability to conceive a much-wanted child.¹⁷⁸ Denial of access to termination of pregnancy in cases where continuation of pregnancy is dangerous may result in serious physical injury or even death.¹⁷⁹ Indeed, there are many examples of patients, like Tamesha Means, who experience grievous physical harms as a result of denial of access to appropriate miscarriage management by religious hospitals and health care providers.¹⁸⁰

176. While tort law does compensate for some dignitary harms, numerous scholars have criticized the fact that there is no coherent tort theory for the protection of dignitary interests. *See, e.g.*, Kenneth S. Abraham & G. Edward White, *The Puzzle of the Dignitary Torts*, 104 CORNELL L. REV. 317, 317 (2019) (describing “[t]he absence of a robustly-articulated conception of the interest in dignity that tort law protects” as “puzzling”); Stephen D. Sugarman and Caitlin Boucher, *Re-Imagining the Dignitary Torts* 1 (Sept. 17, 2019), <https://ssrn.com/abstract=3450107> [<https://perma.cc/2W5A-4VLU>] (pointing out “unjustified inconsistencies” in tort law’s approach to dignitary torts, and arguing for a more unified theory).

177. There is a strong foundation in contemporary common law for claims of “wrongful conception” and “wrongful pregnancy.” These causes of action arise where a provider’s malpractice in dispensing contraception, diagnosing pregnancy, performing sterilization, or performing abortion results in the conception or birth of an unwanted child. *See* Dov Fox, Essay, *Reproductive Negligence*, 117 COLUM. L. REV. 149, 166 (2017) (describing judicial recognition of “wrongful pregnancy” claims, where parents of an unwanted but healthy child are granted recovery for the costs of gestation and delivery – and, in rare cases, the costs of child-rearing); Gast, *supra* note 93, at 174 (noting that wrongful conception is a valid cause of action, but finding no case law alleging wrongful conception as a result of a conscience-based refusal to dispense emergency contraception). That said, some courts have argued that the birth of an unwanted child does not constitute a legally cognizable injury. *See, e.g.*, *Fulton-DeKalb Hosp. Auth. v. Graves*, 314 S.E.2d 653, 655 (Ga. 1984) (stating that where a negligently performed sterilization procedure resulted in the conception and birth of a child with a club foot, “[w]e instinctively recoil from the notion that parents may suffer a compensable injury on the birth of a child”).

178. *See, e.g.*, *Benitez v. N. Coast Women’s Care Med. Grp., Inc.*, 131 Cal. Rptr. 2d 364, 367–68 (Ct. App. 2003) (alleging common law claims against health care providers who refused to provide the plaintiff with fertility treatments on the basis of her sexual orientation); *see also* Fox, *supra* note 177, at 193–200 (discussing cases grounded in negligent denial of the opportunity to procreate).

179. *See infra* Part IV.C.

180. Several recent reports on denials of care at Catholic hospitals highlight cases in which miscarrying patients suffered hemorrhaging, infection, and even death as a result of being denied access to emergency termination of pregnancy. *See, e.g.*, JULIA KAYE ET AL., ACLU, HEALTH CARE DENIED: PATIENTS AND PHYSICIANS SPEAK OUT ABOUT CATHOLIC HOSPITALS AND THE THREAT TO WOMEN’S HEALTH AND LIVES (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf [<https://perma.cc/27FX-NYKM>]; NAT’L WOMEN’S LAW CTR., *supra* note 14; UTTLEY & KHAIKIN, *supra* note 127 (describing the growth of Catholic hospitals since 2013); LOIS UTTLEY ET AL., ACLU & MERGERWATCH, MISCARRIAGE OF MEDICINE: THE GROWTH OF CATHOLIC HOSPITALS AND THE THREAT TO

Thus, while some patients may experience no adverse consequences as a result of a provider's exercise of conscience, there are some cases where a conscience-driven denial unquestionably resulted in serious patient injury. While such injuries would ordinarily be compensable under tort law, state conscience laws with civil immunity clauses eliminate the possibility of tort recovery in these cases.

C. Refusal to Provide Services May Constitute a Breach of Duty

Even where injury can be proven, a patient seeking tort recovery must prove negligent conduct on the part of the health care provider. In cases of medical malpractice or general negligence against health care institutions, plaintiff-patients must successfully demonstrate that the provider's action or inaction violated the standard of care.

One of the most common arguments among supporters of strong conscience protections is that conscience-based denials of reproductive health services do not violate the standard of care because physicians are under no legal duty to provide these services.¹⁸¹ Indeed, there is no generally established "duty to treat" under common law. First, a physician has no duty accept a patient with whom they have no pre-existing treatment relationship.¹⁸² In the context of an existing treatment relationship, a physician has no duty to comply with a patient's request for a service that falls outside the standard of care or is not medically appropriate.¹⁸³ Finally, a physician has the right to withdraw from an existing treatment relationship after giving the patient reasonable notice.¹⁸⁴

But as I have argued elsewhere, "there is no question that abortion, sterilization, and contraception . . . fall within the scope of treatments that reasonably competent physicians might offer in some circumstances."¹⁸⁵ Under such circumstances, failure to offer those services—or at the very least, failure

REPRODUCTIVE HEALTH CARE (2013), <https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf> [<https://perma.cc/8L8W-ZY94>] (first version of the 2016 UTTLEY & KHAIKIN report, *supra* note 127).

181. See, e.g., Harrington, *supra* note 64, at 782, 801–04 (describing the absence of a common law "duty to treat," and recognizing that "a health care professional is free to define the parameters of his or her practice and may refuse to provide services to prospective patients"); Maureen Kramlich, *Coercing Conscience: The Effort to Mandate Abortion as a Standard of Care*, 4 NAT'L CATHOLIC BIOETHICS Q. 29 (2004) (stating that there is "no duty in either law or medical ethics for health care providers to participate in abortion").

182. FURROW ET AL., *supra* note 8, at 72, 278.

183. *Id.* at 964–65 (explaining that physicians have no duty to provide treatments that are not medically indicated under the circumstances).

184. *Id.* at 73.

185. Sawicki, *supra* note 51, at 91 (footnotes omitted); see also Tracy A. Weitz & Susan Berke Fogel, *The Denial of Abortion Care Information, Referrals, and Services Undermines Quality Care for U.S. Women*, 20 WOMEN'S HEALTH ISSUES 7, 8 (2010) (recognizing that although the phrase "'standard of care' is also used in the medical liability context to assess liability," from a medical perspective "standards of care . . . are discussed in the context of what care patients should expect given the prevailing medical knowledge").

to inform a patient that those services may be medically appropriate—would indeed violate the common law standard of care.¹⁸⁶

For example, physicians and medical organizations widely recognize that abortion is a medically appropriate—and sometimes medically necessary—intervention in some high-risk pregnancies.¹⁸⁷ Termination of pregnancy may be considered the standard of care in cases where the pregnant patient is suffering from cardiovascular diseases, including cyanotic congenital heart disease, severe pulmonary hypertension, or aortic root enlargement.¹⁸⁸ In cases of preeclampsia and eclampsia, the only treatment is delivery of the pregnancy, and “abortion[] is usually suggested regardless of fetal age or potential for survival.”¹⁸⁹ Patients who are experiencing inevitable miscarriage (for example, as a result of premature rupture of membranes) face a risk of sepsis, hemorrhage, or even death; appropriate medical management of this condition may include termination of pregnancy and uterine evacuation.¹⁹⁰ And as noted above, providers practicing in Catholic hospitals report that some hospital policies prohibiting termination of pregnancy interfere with their medical judgment and violate the standard of care.¹⁹¹

Moreover, in cases where termination of pregnancy is one option among many a patient might choose from, the common law of informed consent requires disclosure of this option.¹⁹² Even if providers have no affirmative duty to participate in the performance of an abortion, they have a clear common law

186. See Sawicki, *supra* note 51, at 106–07.

187. Freedman et al., *supra* note 134 at 1775 (“According to the generally accepted standards of care in miscarriage management, abortion is medically indicated under certain circumstances in the presence of fetal heart tones[,] [including in cases of] first-trimester septic or inevitable miscarriage, previable premature rupture of membranes and chorioamnionitis, and situations in which continuation of the pregnancy significantly threatens the life or health of the woman.”); Freedman & Stulberg, *supra* note 133, at 7–8 (describing findings of a study in which physicians considered termination of pregnancy to be “standard and morally acceptable treatment for women with these pregnancy complications”); Weitz & Fogel, *supra* note 185, at 8 (“Although most often associated with factors related to an unintended pregnancy, abortion care is also needed for women with medical or fetal complications associated with a wanted or intended pregnancy.”)

188. Weitz & Fogel, *supra* note 185, at 9.

189. *Id.*

190. NAT’L WOMEN’S LAW CTR., *supra* note 14, at 2 (reporting “disturbing examples of treatment practices that increase the odds of medical complications that place women’s lives and health at risk,” and noting that in such cases, “immediate uterine evacuation reduces the patient’s risk of complications, including blood loss, hemorrhage, infection, and the loss of future fertility[:]; [a] delay in treatment may subject a woman to unnecessary blood transfusions, risk of infection, hysterectomy or even death” (footnotes omitted)). See generally Sawicki, *supra* note 51, at 98 (collecting sources).

191. See *supra* Part IV.A.1.

192. While disclosure duties vary somewhat depending on whether a state has adopted a patient-based or physician-based standard of informed consent, there is “widespread agreement” across both types of jurisdictions that the scope of informed consent disclosure must include “substantive information about the patient’s diagnosis and proposed treatment; the treatment’s risks and benefits; alternative procedures and their risks and benefits; and the risks and benefits of taking no action.” Nadia N. Sawicki, *Modernizing Informed Consent: Expanding the Boundaries of Materiality*, 2016 U. ILL. L. REV. 821, 831, 833 (emphasis added).

duty, and often a statutory duty, to disclose it as one of the range of possible treatments; such disclosure requires describing, at the very least, the procedure's risks and benefits.¹⁹³ The *Means* case,¹⁹⁴ the *Brownfield* case,¹⁹⁵ and many others reported in the media offer examples of cases where patients have been denied reproductive services and key medical information about the benefits of those services and their availability elsewhere.¹⁹⁶

Some states have passed legislation that explicitly establishes treatment duties in specific contexts to avoid ambiguities and conflicts about the scope of providers' treatment obligations. These laws include state analogues of the

193. See Rich, *supra* note 10, at 226 (“[T]here is both a professional and moral obligation to provide adequate notice to prospective patients as to what clinical services that they might desire or require will not be provided.”); Sawicki, *supra* note 51, at 114 (“If a patient might have a better medical outcome by seeking care from another physician or another healthcare institution, the availability of those options would seem to fall squarely within the standard risk-and-benefit disclosure requirement that physicians disclose material medical risks and available alternatives.”); see also *Am. Coll. of Obstetricians and Gynecologists Comm. on Ethics, Op. 385* (2007, reaffirmed 2013), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/The-Limits-of-Conscientious-Refusal-in-Reproductive-Medicine> [https://perma.cc/63GK-R4WT] (recommending that members of the American College of Obstetricians and Gynecologists provide their patients with “accurate and unbiased information,” including “scientifically accurate and professionally accepted characterizations of reproductive health services”); Comm. on Bioethics, *Am. Acad. of Pediatrics, Policy Statement—Physician Refusal to Provide Information of Treatment on the Basis of Claims of Conscience*, 124 *PEDIATRICS* 1689, 1689 (2009) (requiring physicians to disclose “all relevant and legally available treatment options, including options to which they object”); BJ Crigger et al., *Report by the American Medical Association’s Council on Ethical and Judicial Affairs on Physicians’ Exercise of Conscience*, 27 *J. CLINICAL ETHICS* 219, 220 (requiring that physicians disclose to potential patients any interventions they cannot in good conscience provide).

194. Complaint at 2, *Means v. U.S. Conference of Catholic Bishops*, No. 1:15-CV-353, 2015 WL 3970046 (W.D. Mich. June 30, 2015) (stating that the Conference for Catholic Bishops and others implement directives that “cause pregnant women who are suffering from a miscarriage to be denied appropriate medical care, including information about their condition and treatment options”), *aff’d*, 836 F.3d 643 (6th Cir. 2016).

195. *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 245 (Ct. App. 1989) (“[W]hen . . . a skilled practitioner of good standing would have provided [a rape victim] with information concerning and access to estrogen pregnancy prophylaxis under similar circumstances . . . and . . . damages have proximately resulted from the failure to provide her with information concerning this treatment option, [she] can state a cause of action for damages for medical malpractice.” (footnote omitted)).

196. JULIA KAYE ET AL., *supra* note 180, at 7 (highlighting that Catholic hospitals follow directives that “prohibit a range of reproductive health services, including contraception, sterilization, many infertility treatments, and abortion”); UTTLEY & KHAIKIN, *supra* note 127, at 1 (finding that the growth of Catholic hospitals is adversely affecting women’s ability to obtain reproductive health services); UTTLEY ET AL., *supra* note 180, at 14–15 (describing case studies of negative patient outcomes arising from restrictions in Catholic-affiliated consequences).

federal Emergency Treatment and Active Labor Act,¹⁹⁷ pharmacy mandates,¹⁹⁸ and laws requiring emergency rooms to offer emergency contraception to rape victims (“EC in the ER laws”).¹⁹⁹ Such statutes clearly signal legislative intent to ensure patient access to important medical services by compelling physicians, pharmacists, and hospitals to provide these services. The existence of such a statute would, therefore, strengthen a patient’s claim that a conscience-based denial of service constituted a breach of duty.

Disappointingly, no court has addressed head-on the issue of how to interpret a duty-to-treat law that conflicts with a state conscience law.²⁰⁰ It remains unclear whether, in cases of conflict, courts would place more emphasis on ensuring that providers are held to an appropriate standard of care or on protecting their right of conscientious refusal. While litigants have brought such claims to court,²⁰¹ no court has yet ruled on the substantive issue of whether a provider’s conscientious refusal to terminate a pregnancy outweighs the obligation to comply with the standard of care.²⁰²

Although not every conscience-based denial of reproductive treatment is a deviation from the medical standard of care, it is clear that at least in some cases,

197. See Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 53–54 (1989) (noting that almost half of all states have laws “requiring hospitals to provide emergency care regardless of ability to pay, some requiring that patients be in stable condition before transfer to another hospital”).

198. HENRY J KAISER FAMILY FOUND., FACT SHEET: EMERGENCY CONTRACEPTION 6 (2018), <http://files.kff.org/attachment/emergency-contraception-fact-sheet> [https://perma.cc/Y4BP-7596] (identifying four states with laws requiring pharmacies or pharmacists to fill all valid prescriptions, and noting that these laws were “enacted, in part, as responses to reports of pharmacists refusing to fill prescriptions for EC pills because they oppose its use on moral or religious grounds”).

199. *Id.* at 5 (identifying thirteen states and the District of Columbia with laws requiring that emergency room staff provide female victims of sexual assault with emergency contraception).

200. The one case that might be instructive considered an alleged conflict between a federal law prohibiting government discrimination against refusing providers and a state emergency treatment law. *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008). Although the case might have been resolved on preemption grounds to favor the federal conscience law, the court instead took a statutory interpretation approach to conclude that that “[t]here is no clear indication” that California’s enforcement of its emergency treatment law in cases of medically necessary abortions would be considered “discrimination” under the Weldon Amendment. *Id.*

201. See, e.g., Amended Complaint at 2, *ACLU v. Trinity Health Corp.*, 178 F. Supp. 3d 614 (E.D. Mich. 2016) (alleging that as a result of hospital policies under the USCCB Directives, hospitals have “repeatedly and systematically failed to provide women suffering pregnancy complications . . . with the emergency care required by EMTALA and the Rehabilitation Act,” and that as a result, women “have become septic, experienced hemorrhaging, contracted life-threatening infections, and/or unnecessarily suffered severe pain for several days at a time”); Complaint at 8, *Means v. U.S. Conference of Catholic Bishops*, No. 1:15-CV-353, 2015 WL 3970046 (W.D. Mich. June 30, 2015), *aff’d*, 836 F.3d 643 (6th Cir. 2016).

202. See *Trinity Health*, 178 F. Supp. 3d 614 (granting motion to dismiss, without prejudice, on the grounds that the plaintiffs lacked standing and the suit was not ripe for review), *reconsideration denied*, No. 15-cv-12611, 2016 WL 4267825 (E.D. Mich. Aug. 15, 2016) (denying plaintiffs’ motion for reconsideration, but noting that plaintiffs are free to file a new complaint); *Means*, 2015 WL 3970046 (granting a motion to dismiss by defendant U.S. Conference of Catholic Bishops on the grounds that it owed no duty to the plaintiff).

patients will be able to prove that such a denial constitutes a breach of duty. Therefore, civil immunity provisions in conscience statutes will deprive these patients of recovery they would otherwise have under common law.

D. EMTALA Is Not a Sufficient Alternate Remedy

Finally, critics may argue that even if state conscience laws deprive injured patients of common law tort remedies, this is not a dramatic loss because patients have an alternative mechanism for recovery through the Emergency Medical Treatment and Active Labor Act (EMTALA).²⁰³ It is true that some patients who have suffered injuries as a result of a provider's conscience-driven refusal during an emergency may be able to recover under EMTALA. However, EMTALA's civil remedy provision is by no means a panacea for all injuries resulting from a conscience-driven denial of care.

EMTALA requires Medicare-funded hospitals with emergency departments to screen patients seeking emergency treatment. Under EMTALA, hospitals must assess whether patients have an emergency medical condition and ensure that patients with such a condition are stabilized before being transferred to another hospital.²⁰⁴ Hospitals and physicians that fail to comply with EMTALA are subject to monetary penalties imposed by the Center for Medicare and Medicaid Services.²⁰⁵ More importantly for purposes of this discussion, hospitals are subject to civil liability to patients who are injured as a result of EMTALA non-compliance.²⁰⁶ However, many conscience-driven denials of care are likely to fall through the gaps of EMTALA's narrow legal requirements.

First and most importantly, EMTALA, which was passed in 1986 to address "hospital dumping" of uninsured patients,²⁰⁷ is a statute that guarantees access to basic screening—not quality of care. Numerous courts have held that a hospital does not violate EMTALA as long as the hospital follows its standard internal procedures regarding screening and stabilization in a non-discriminatory

203. 42 U.S.C. § 1395dd(d)(2)(A) (2018).

204. 42 U.S.C. § 1395dd(c). EMTALA also identifies a narrow set of circumstances where it is permissible for a hospital to transfer a patient that has not been stabilized: where the patient requests transfer, the treating physician has certified in writing that the medical benefits of transfer likely outweigh the risks, the receiving facility has the capacity to accept the patient and has agreed to accept the transfer, and the discharging facility sends all relevant medical records to the receiving hospital. *Id.*

205. *See* 42 U.S.C. § 1395dd(d)(1).

206. 42 U.S.C. § 1395dd(d)(2)(A) ("Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located . . ."). Note that this provision does not establish civil liability for individual physicians.

207. At the time of EMTALA's passage, patient dumping was a "widespread practice" whereby hospitals driven by financial incentives transferred uninsured patients seeking emergency treatment to other (typically public) hospitals. FURROW ET AL., *supra* note 8, at 279.

fashion.²⁰⁸ EMTALA protects against differential treatment; it does not protect patients from screening or treatment that might be considered negligent under state malpractice law.²⁰⁹ The Ninth Circuit, for example, has explained that “[e]very circuit . . . is in accord” in holding that EMTALA “was not enacted to establish a federal medical malpractice cause of action nor to establish a national standard of care.”²¹⁰ The Fifth Circuit has described EMTALA’s requirement that hospitals provide an “appropriate medical screening examination” as being “not judged by its proficiency in accurately diagnosing the patient’s illness, but rather by whether it was performed equitably in comparison to other patients with similar symptoms.”²¹¹ Therefore, since EMTALA does not establish a medical standard of care, patients harmed by a conscience-driven refusal but treated in accordance with the hospital’s standard policies are not able to sue. For example, if a Catholic hospital’s policies prohibit termination of pregnancy even in cases of medical emergency, the hospital’s compliance with its internal policy will very likely shield it from EMTALA liability.

Moreover, even if EMTALA were construed to establish a federal standard of care for emergency screening and treatment, only two reproductive care scenarios seem as if they might potentially fall within its scope: denial of emergency contraception, and denial of access to medically necessary abortion.

With respect to emergency contraception, it is difficult to see how a hospital’s refusal would violate the requirements of EMTALA and entitle a patient to recovery. EMTALA requires that patients seeking emergency treatment be screened for emergency medical conditions.²¹² However, a patient’s need for emergency contraception, while very real, is unlikely to qualify as:

[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in-- (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.²¹³

208. See 62 AM. JUR. *Trials* 119 § 5 (2020) (“Establishing a violation of the EMTALA screening provisions generally requires proof that the defendant did not provide the same screening in the plaintiff’s case that it routinely provided for other patients with comparable symptoms.”).

209. FURROW ET AL., *supra* note 8, at 72, 284–85. Only in the most egregious cases, where “an examination [is] so cursory as to amount to no exam at all,” would EMTALA potentially be implicated. *Id.* at 285–86.

210. *Bryant v. Adventist Health Sys./West*, 289 F.3d 1162, 1166 (9th Cir. 2002).

211. *Marshall v. E. Carroll Par. Hosp. Serv. Dist.*, 134 F.3d 319, 322 (5th Cir. 1998).

212. 42 U.S.C. § 1395dd(a) (2018).

213. See *id.* § 1395dd(e)(1)(A).

Indeed, at least one court has found that a patient's need for emergency contraception does not qualify as an "emergency" under a state conscience law's emergency treatment requirement.²¹⁴

Moreover, even in the unlikely scenario that the need for emergency contraception fell within the statutory definition of an emergency medical condition, the hospital's obligation under EMTALA requires it to provide only medical treatment with a stabilizing effect.²¹⁵ Specifically, the hospital must "provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility."²¹⁶ While the need for emergency contraception is very time-sensitive,²¹⁷ the patient is unlikely to suffer "material deterioration of [a] condition"²¹⁸ in the course of transfer to another facility.

Patients seeking medically necessary abortions have a right of recovery under EMTALA only in limited situations. EMTALA would likely provide some protection for patients suffering from "acute symptoms of sufficient severity"²¹⁹ that are likely to result in serious bodily harm if not stabilized.²²⁰ However, this protection would by no means extend to all medically necessary abortions, but only those where the patient arrives at an emergency room in critical condition. For patients suffering from conditions like preeclampsia or heart disease, for example, abortion may be medically appropriate but not a procedure that needs to be done on an emergency basis.

EMTALA offers no remedy for all other denials of reproductive care that might violate medical standards of care and result in patient injury. EMTALA would not, for example, allow a cause of action by a sexually active patient who became pregnant because their OB/GYN was not willing to discuss contraception, or because the patient was unable to secure emergency contraception due to a provider's refusal. EMTALA would not offer a remedy to a patient with a non-emergent but health-threatening pregnancy who could not terminate the pregnancy because all the health care providers in their area opposed abortion. Likewise, EMTALA would not protect a pregnant patient who

214. See, e.g., *Morr-Fitz, Inc. v. Quinn*, 976 N.E.2d 1160, 1175 (Ill. App. Ct. 2012) (concluding that "'emergency contraceptives' do not fall within the plain and ordinary meaning of the term 'emergency'" in the Illinois Conscience Act's emergency treatment requirement).

215. 42 U.S.C. § 1395dd(b)(1)(a).

216. *Id.* § 1395dd(e)(3).

217. Emergency contraception needs to be taken within five days of unprotected sex; it is most effective, however, within twenty-four hours, and its effectiveness drops dramatically over time. See Roey M. Malleon, *Emergency Contraception: A Simple, Safe, and Effective Approach to Preventing Pregnancy After Unprotected Intercourse*, 44 B.C. MED. J. 30 (2002).

218. § 1395dd(e)(3).

219. 42 U.S.C. § 1395dd(e)(1)(A).

220. Amended Complaint at 2, *ACLU v. Trinity Health Corp.*, 178 F. Supp. 3d 614 (E.D. Mich. 2016) (alleging EMTALA violations by Trinity Health against women suffering "pregnancy complications"); see conditions described *supra* Parts V.B.1, 2.

was not offered genetic testing for fetal anomalies because the physician believed the patient might choose to abort.

In sum, EMTALA is not an effective alternative to tort law for addressing patient harms resulting from conscience-based refusals in reproductive health contexts. When states pass conscience laws that protect refusing providers from civil liability under state tort law, most patients cannot rely on EMTALA as an alternate remedy.

V.

CONCLUSIONS AND DIRECTIONS FOR FUTURE RESEARCH

These new insights into the details of conscience protections relating to reproductive health services offer scholars and policy-makers an opportunity to revisit the debates surrounding law's role in protecting health care providers' rights of conscience. In particular, the data presented in this Article calls into question whether granting refusing providers absolute (or near-absolute) immunity from civil liability is the best way of balancing conscience rights with state interests in protecting patient health and safety. For reasons I have explained in other work,²²¹ policy-makers may find that these interests are better balanced by protecting providers from professional discrimination and discipline, but not immunizing them from liability for patient injury. These are challenging policy decisions that require further exploration. Below, I describe some possible directions for future research.

A. Empirical Research: Conscience Protections in Other Health Care Contexts

The research described in this Article is the first step in a larger legislative tracking project of procedural protections in health care conscience laws. As noted earlier, some states have laws that establish protections for health care providers' conscience-driven conduct in any context, without limiting those protections to refusals for specific categories of health care services. Furthermore, many states have laws protecting providers who decline to comply with patient or family requests in the end-of-life care context.²²² Conscience-driven refusals in this context may include providers' unwillingness to comply with a patient's advance directive or a health care surrogate's decision regarding provision or withdrawal of life-sustaining treatment; they can also include an unwillingness to participate in a patient's request for aid in dying.²²³ Finally, federal health care conscience laws that establish protections from employment

221. Sawicki, *supra* note 21.

222. Pope, *supra* note 36, at 165-67 (describing federal and state laws granting rights to refuse life-sustaining treatment for reasons of conscience).

223. See Marc R. Wicclair, *Conscientious Objection*, in OXFORD HANDBOOK OF ETHICS AT THE END OF LIFE 87, 88-91 (Stuart J. Youngner & Robert M. Arnold eds., 2016) (describing various types of conscience claims in end-of-life care).

discrimination and other adverse action ought to be considered in any survey of health care conscience protections.²²⁴

The next step in this project will be to track these other health care conscience laws and compare the types of procedural protections they offer. For example, in the end-of-life care context, conscience laws often impose significant limitations on providers' rights of refusal and civil immunity—limitations that do not exist in reproductive conscience laws. In many states, health care providers who are unwilling to comply with a patient's request relating to life-sustaining treatment (whether a request for continuation or for withdrawal of such treatment) have a statutory obligation to facilitate transfer of the patient to a provider who will comply with the request.²²⁵ Others require that providers with conscientious objections to what they consider to be “futile” or medically inappropriate care continue to provide these treatments until the patient is successfully transferred.²²⁶ If these patterns turn out to be consistent across states with end-of-life conscience laws, they will prompt consideration of why these laws impose more patient-protective conditions on provider rights as compared to laws applicable in reproductive contexts. Likewise, federal conscience laws seem to establish a narrower scope of procedural protections than do state conscience laws.²²⁷ Researchers may wish to consider why state laws establish broader protections than federal law, and whether such variability is justified.

B. Policy Analyses of Procedural Protections in Conscience Laws

Because the procedural protections states establish for refusing providers differ in concrete ways, these protections ought to be independently analyzed on policy grounds.²²⁸ For example, there may be different reasons for protecting providers from adverse action by public actors such as criminal prosecutors, medical licensing boards, and administrative agencies, as opposed to private

224. See, e.g., 42 U.S.C. § 300a-7(c)(1) (2018) (prohibiting some entities receiving federal funding from “discriminat[ing] in the employment, promotion, or termination of employment of . . . [or] discriminat[ing] in the extension of staff or other privileges to” individual providers on the basis of their conscientious beliefs about abortion or sterilization).

225. See, e.g., W. VA. CODE § 16-30-12(b) (2020) (conditioning an individual healthcare provider's right to not comply with a patient's healthcare decision on the provider's cooperation in transferring the patient).

226. See, e.g., MISS. CODE ANN. § 41-41-215(7) (2013) (conditioning an individual health care provider's right not to comply with a patient's health care decision on the provider's assistance with the transfer and continuation of care until an effective transfer occurs); N.D. CENT. CODE § 23-06.5-09(2) (2019) (same).

227. For example, federal conscience protections in the reproductive health context do not explicitly protect providers from civil liability. See 42 U.S.C. § 238n(a) (2018) (prohibiting the federal government from discriminating against health care entities for refusals in the abortion context); *id.* § 300a-7 (prohibiting public entities from requiring health care providers to participate in abortion, or discriminating against them on the basis of their religious or moral convictions regarding abortion).

228. Sawicki, *supra* note 21, at 17–18.

actors like private employers and patients.²²⁹ Likewise, laws that immunize providers from adverse action even when their conduct causes injury are likely to require stronger policy justifications than protections against adverse action on the basis of a provider's beliefs or non-harm-causing conduct.²³⁰

Further exploration is necessary to evaluate unrestricted civil immunity provisions. Do these provisions strike the appropriate balance between protecting providers' right to refuse services on grounds of conscience and protecting patients' right to tort recovery when they are injured as a result of such refusal? If the answer is no, we ought to consider alternatives to the current system, in which individual and institutional health care providers in most states have absolute civil immunity. Eliminating protections from civil liability would be one obvious solution, but there may be others. For example, states could amend their conscience laws to limit civil immunity in cases of malpractice. This would ensure patients have a right to tort recovery when their providers breach the standard of care. Emergency exceptions might also protect patients' right to tort recovery, albeit in the more limited context of denial of emergency treatment. Alternatively, states may decide to establish some alternative means of patient recovery, such as a no-fault compensation system similar to that used in the context of workplace injury.²³¹ Or, rather than focusing on patient remedies, states could address patient access by strengthening institutional providers' obligations to ensure services that individual physicians may be unwilling to offer.

A second question to consider is what implications we might draw from the fact that conscience protections in the reproductive health care context are more extensive than those established by other comparable laws that protect individuals on the basis of their beliefs or personal characteristics.²³² These include the Americans with Disabilities Act, Title VII of the Civil Rights Act, and the Military Selective Service Act, among others. In contrast to health care conscience laws, these laws recognize that protections for qualified individuals cannot impose absolute unilateral burdens on employers or others who may be adversely impacted.²³³ In these contexts, federal laws establish meaningful

229. See *id.* at 17 (stating that “even defenders of strong conscience laws acknowledge that these protections cannot be absolute” in certain situations).

230. See *id.* at 21.

231. See David M. Studdert & Troyen A. Brennan, *No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention*, 286 JAMA 217, 219 (2001) (considering no-fault compensation systems, in which the plaintiff does not have to prove negligence, as compared to traditional malpractice litigation).

232. See generally Sawicki, *supra* note 31.

233. See, e.g., 42 U.S.C. § 12112(b)(5)(A) (2018) (establishing that employers are not required to provide reasonable accommodations to employees with disabilities where such accommodations would “impose an undue hardship on the operation of the business”); *id.* § 12113(b) (establishing that “qualification standards” for employees may include a requirement that an employee shall “not pose a direct threat to the health or safety of other individuals in the workplace”); *id.* § 2000e(j) (requiring that

limitations on the right to individual accommodation—for example, in cases where protection of the individual would result in undue hardship to an employer.

Furthermore, as noted above, many state health care conscience laws outside the reproductive context impose stricter conditions on the exercise of conscience rights. Some state laws, for example, require providers who refuse patient requests for medical interventions in end-of-life care contexts to provide those interventions, in violation of their sincerely held beliefs, until the patient is transferred. Reproductive health care conscience laws that allow refusing providers to impose unilateral burdens on patients and employers seem very much at odds with state and federal approaches in other contexts. Therefore, it is of utmost importance to analyze whether there are sufficient policy justifications for this distinctive treatment.

C. Legal Challenges to Civil Immunity Provisions

Finally, there is an important opportunity for future research about the constitutionality and legality of civil immunity provisions in health care conscience laws. While many scholars have analyzed the constitutionality of conscience laws generally, these analyses tend to focus on refusal provisions from the perspective of patients' access to care.²³⁴ There has been little academic consideration, however, of whether granting refusing providers a right to immunity from civil liability poses unique constitutional or other legal challenges.²³⁵ As noted in Part III.A, some courts have held that conscience laws without explicit civil immunity provisions should not be construed broadly as negating providers' obligation to comply with the standard of care.²³⁶ That said, some state constitutions include remedy provisions that protect plaintiffs from

employers "reasonably accommodate" a current or prospective employee's religious exercise, as long as those accommodations do not impose an "undue hardship on the conduct of the employer's business"); 50 U.S.C. § 3806(j) (2018) (imposing a requirement that military conscientious objectors who are opposed to war be assigned either to noncombatant service, or to civilian work in furtherance of national health or safety).

234. See, e.g., Charo, *supra* note 63, at 126 (arguing that laws protecting providers who rely on conscience protections to actively impose treatment against the will of a patient "run afoul of constitutional protections for patient autonomy"); Michele Goodwin & Allison M. Whelan, *Constitutional Exceptionalism*, 2016 U. ILL. L. REV. 1287, 1308 (arguing that conscience laws allowing refusal of reproductive services impose undue burdens on women's constitutional rights); Harrington, *supra* note 64, at 828–31 (arguing that recent state conscience laws likely do not violate the Establishment Clause).

235. But see Rich, *supra* note 10, at 220 ("Holding healthcare providers legally accountable for breaching a duty of care for reasons of religious conscience does not run counter to either the free exercise or the establishment clauses of the U.S. Constitution.").

236. See *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *4 (N.D. Cal. Mar. 18, 2008) (declining to interpret the federal Weldon Amendment in a way that would protect refusals that violate duties to treat under EMTALA).

the abrogation of their common law rights.²³⁷ Such state constitutional guarantees might be relied upon to challenge statutory grants of civil immunity for conscience-driven providers. Moreover, to the extent that federal laws, like EMTALA, impose treatment obligations on health care providers, it may be possible to challenge state civil immunity provisions as being preempted in cases of emergency treatment. There may be other avenues for challenging civil immunity provisions as well, and further exploration of these options is needed.

This Article presents the first comprehensive overview of the procedural protections established by state conscience laws in the reproductive health care context. The novel research findings in this Article raise awareness of the previously unrecognized breadth of protections established by conscience laws. These findings also challenge the assumption that tort law is available to remedy harms suffered by patients who are injured by a conscience-based denial of information or treatment, even when that denial violates the standard of care. Although the scope of this study was limited to conscience laws relating to reproductive care, it prompts further academic inquiry and debate about the appropriate scope of conscience protections in all health care contexts. The data and discussion in this Article should motivate policy-makers to consider how best to balance providers' rights of conscience against the state's interest in ensuring that patients, employers, and others who suffer harm as a result of a provider's exercise of conscience rights are not denied legal remedies for those harms.

237. See, e.g., *Planned Parenthood Ariz., Inc. v. Am. Ass'n of Pro-Life Obstetricians & Gynecologists*, 257 P.3d 181, 197 (Ariz. Ct. App. 2011) (discussing Arizona's constitutional prohibition on the "abrogation of . . . actions in tort which trace origins to the common law" in the context of a legal challenge to an abortion refusal law (citation omitted)).

APPENDIX A:
REPRODUCTIVE HEALTH CARE CONSCIENCE LAWS

State	Abortion	Sterilization	Contracept.	Emergency Contracept.	Other
Alabama	Y	Y	-	-	1, 2
Alaska	Y ⁱ	-	-	-	-
Arizona	Y	-	-	Y	-
Arkansas	Y	-	Y	Y	-
California	Y	-	Y	Y	3
Colorado	-	Y	Y	Y	-
Connecticut	Y	-	-	-	-
Delaware	Y	-	-	-	-
D.C.	-	-	-	-	-
Florida	Y	-	Y	-	-
Georgia	Y	Y	Y	-	-
Hawaii	Y	-	-	-	-
Idaho	Y	Y	-	Y	1, 2
Illinois	Y	Y	Y	-	-
Indiana	Y	-	-	-	-
Iowa	Y	-	-	-	-
Kansas	Y	Y	-	-	-
Kentucky	Y ⁱ	Y	-	-	-
Louisiana	Y	-	-	-	1, 2
Maine	Y	Y	Y	-	-
Maryland	Y	Y	-	-	4
Massachusetts	Y	Y	Y	-	2
Michigan	Y	-	-	-	-
Minnesota	Y ⁱ	-	Y	-	-
Mississippi	-	-	-	-	-
Missouri	Y	-	-	-	-
Montana	Y	Y	-	-	-
Nebraska	Y	-	-	-	-
Nevada	Y	-	-	-	-
New Hampshire	-	-	-	-	-
New Jersey	Y ⁱⁱ	Y	-	-	-
New Mexico	Y	Y	-	-	-
New York	Y	-	Y	-	-
North Carolina	Y	-	-	-	-

State	Abortion	Sterilization	Contracept.	Emergency Contracept.	Other
North Dakota	Y	-	-	-	-
Ohio	Y	-	-	-	-
Oklahoma	Y	-	-	-	3, 5
Oregon	Y	-	Y	-	-
Pennsylvania	Y	Y	-	-	6
Rhode Island	Y	Y	-	-	-
South Carolina	Y	-	-	-	-
South Dakota	Y	-	-	-	-
Tennessee	Y	-	Y	-	-
Texas	Y	-	-	-	-
Utah	Y ⁱⁱⁱ	-	-	-	-
Vermont	Y	-	-	-	-
Virginia	Y	-	Y	-	7
Washington	Y	-	-	-	-
West Virginia	Y	Y	Y	-	-
Wisconsin	Y	Y	Y	-	-
Wyoming	Y	-	Y	-	-
Total	47	17	16	5	9

- | |
|---|
| <ul style="list-style-type: none"> (1) Cloning (2) Stem cell research or treatment (3) Research on gametes or embryos (4) Assisted reproductive technology (5) Medical use of fetal tissue (6) Umbilical cord blood banking (7) Genetic counseling |
|---|

ⁱ Prior versions held unconstitutional as applied to public hospitals in *Valley Hosp. Ass'n, Inc. v. Mat-Su Coalition for Choice*, 948 P.2d 963 (Alaska 1997); *Wolfe v. Schroering*, 541 F.2d 523 (6th Cir. 1976); *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976)

ⁱⁱ Held unconstitutional as applied to "quasi-public" nonsectarian nonprofit hospitals in *Doe v. Bridgeton Hosp. Ass'n, Inc.*, 366 A.2d 641 (N.J. 1976)

ⁱⁱⁱ Prior version held unconstitutional in *Doe v. Rampton*, 366 F. Supp. 189 (D. Utah 1973)

APPENDIX B:
PROCEDURAL PROTECTIONS IN ABORTION CONSCIENCE LAWS

State	Procedural Protections for Providers
Alabama	Civil liability, Criminal prosecution, Discrimination, Government action, Education
Alaska	Civil liability
Arizona	None
Arkansas	Civil liability, Disciplinary action, Government action
California	Civil liability, Disciplinary action, Employment action, Education
Colorado *	<i>n/a</i>
Connecticut	None
Delaware	Civil liability, Disciplinary action
D.C. *	<i>n/a</i>
Florida	Civil liability, Disciplinary action
Georgia	Civil liability, Disciplinary action
Hawaii	Civil liability
Idaho	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Employment action, Government action
Illinois	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Employment action, Government action, State licensure, Education, Funding
Indiana	Disciplinary action, Discrimination, Employment action, Education
Iowa	Civil liability, Disciplinary action, Discrimination, Employment action, Government action, State licensure, Education
Kansas	Civil liability, Discrimination, Employment action
Kentucky	Civil liability, Disciplinary action, Discrimination, Employment action, Government action, State licensure, Education, Funding
Louisiana	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Employment action, Government action
Maine	Civil liability, Disciplinary action, Discrimination, Employment action, Government action, Education
Maryland	Civil liability, Disciplinary action, Government action
Massachusetts	Civil liability, Disciplinary action, Discrimination, Employment action, Government action, Education, Funding
Michigan	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Employment action
Minnesota	Civil liability, Discrimination, Employment action
Mississippi *	<i>n/a</i>
Missouri	Civil liability, Discrimination, Employment action, Government action, Education, Funding
Montana	Civil liability, Disciplinary action, Discrimination, Employment action, Government action, Funding
Nebraska	Civil liability, Disciplinary action, Discrimination, Employment action

State	Procedural Protections for Providers
Nevada	Civil liability, Disciplinary action, Employment action
New Hampshire *	<i>n/a</i>
New Jersey	Civil liability, Criminal prosecution, Disciplinary action, Discrimination
New Mexico	Disciplinary action
New York	Civil liability, Discrimination
North Carolina	Civil liability, Disciplinary action
North Dakota	Discrimination
Ohio	Civil liability, Disciplinary action
Oklahoma	Civil liability, Disciplinary action, Discrimination, Employment action, State licensure, Education
Oregon	Civil liability
Pennsylvania	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Employment action, Government action, State licensure, Education, Funding
Rhode Island	Civil liability, Disciplinary action
South Carolina	Civil liability, Disciplinary action, Discrimination, Employment action
South Dakota	Civil liability, Employment action, Government action
Tennessee	None
Texas	Discrimination, Employment action, Education
Utah	Civil liability, Disciplinary action, Discrimination, Employment action
Vermont **	Government action
Virginia	Civil liability, Disciplinary action, Employment action
Washington	Discrimination, Employment action
West Virginia	None
Wisconsin	Civil liability, Disciplinary action, Discrimination, Employment action, Education
Wyoming	Civil liability, Disciplinary action, Discrimination, Employment action

* No abortion conscience law

** No abortion refusal law; protects participating providers only

APPENDIX C:
BENEFICIARIES OF CIVIL IMMUNITY IN ABORTION REFUSAL LAWS

State	Beneficiaries of Civil Immunity
Alabama	Any health care provider, Physician, Pharmacist, Registered nurse, Mental health professional, Student, Health care facility staff, Health care facility
Alaska	Any person, Health care facility
Arizona	None
Arkansas	Any person, Health care facility
California	Any person, Physician, Registered nurse, Health care facility staff, Religious health care facility
Colorado *	<i>n/a</i>
Connecticut	None
Delaware	Any person, Health care facility
D.C. *	<i>n/a</i>
Florida	Any person, Health care facility
Georgia	Any person, Pharmacist
Hawaii	Any person, Health care facility
Idaho	Any licensed professional, Physician, Registered nurse, Health care facility staff, Health care facility
Illinois	Any person, Any health care provider, Physician, Registered nurse, Student, Health care facility, Private health care facility
Indiana	None
Iowa	Any person
Kansas	Any person, Health care facility
Kentucky	Physician, Registered nurse, Public employee, Health care facility staff, Private health care facility
Louisiana	Any person, Any health care provider, Physician, Registered nurse, Student, Public employee, Health care facility staff, Health care facility
Maine	Any person, Physician, Registered nurse, Health care facility
Maryland	Any person, Health care facility
Massachusetts	Physician, Health care facility staff
Michigan	Any person, Physician, Registered nurse, Student, Health care facility staff, Health care facility
Minnesota	Any person, Physician, Registered nurse, Health care facility
Mississippi *	<i>n/a</i>
Missouri	Physician, Registered nurse, Health care facility staff, Health care facility, Private health care facility
Montana	Any person, Health care facility staff, Health care facility
Nebraska	Any person, Health care facility
Nevada	Private health care facility
New Hampshire *	<i>n/a</i>
New Jersey	Any person, Health care facility

State	Beneficiaries of Civil Immunity
New Mexico	None
New York	Any person, Health care facility
North Carolina	Any health care provider, Physician, Registered nurse
North Dakota	None
Ohio	Any person, Health care facility, Private health care facility
Oklahoma	Any person, Physician, Pharmacist, Registered nurse, Health care facility staff, Private health care facility
Oregon	Health care facility
Pennsylvania	Any person, Any health care provider, Physician, Registered nurse, Student, Health care facility staff, Health care facility, Private health care facility
Rhode Island	Physician, Health care facility staff
South Carolina	Any person, Physician, Registered nurse, Private health care facility
South Dakota	Any person, Physician, Registered nurse, Mental health professional, Health care facility
Tennessee	None
Texas	None
Utah	Any health care provider, Health care facility staff, Health care facility
Vermont **	<i>n/a</i>
Virginia	Any person, Health care facility
Washington	None
West Virginia	None
Wisconsin	Any licensed professional, Registered nurse, Health care facility staff, Health care facility
Wyoming	Any person, Private health care facility

* No abortion conscience law

** No abortion refusal law; protects participating providers only

APPENDIX D:
PATIENT-PROTECTIVE LIMITATIONS IN ABORTION REFUSAL LAWS

State	Rights Limited in Emergencies	Patient Notified of Refusal	Rights Limited in Miscarriage	Other	No Limitations
Alabama	Y	-	-	-	-
Alaska	-	-	-	-	Y
Arizona	-	-	-	1, 4	-
Arkansas	-	-	-	-	Y
California	Y	Y	Y	-	-
Colorado *	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Connecticut	-	-	-	-	Y
Delaware	-	-	-	-	Y
D.C. *	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Florida	-	-	-	-	Y
Georgia	-	-	-	2, 4	-
Hawaii	-	-	-	-	Y
Idaho	Y	-	-	-	-
Illinois	Y	Y	-	2, 3, 6	-
Indiana	-	-	-	-	Y
Iowa	Y	-	-	-	-
Kansas	-	-	-	-	Y
Kentucky	Y	-	-	-	-
Louisiana	Y	Y	Y	1	-
Maine	-	-	-	-	Y
Maryland	Y	-	-	5	-
Massachusetts	-	-	-	-	Y
Michigan	-	-	-	-	Y
Minnesota	-	-	-	-	Y
Mississippi *	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Missouri	-	-	-	-	Y
Montana	-	-	-	-	Y
Nebraska	-	Y	-	-	-
Nevada	Y	-	-	-	-
New Hampshire *	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
New Jersey	-	-	-	-	Y
New Mexico	-	-	-	-	Y
New York	-	Y	-	3	-

State	Rights Limited in Emergencies	Patient Notified of Refusal	Rights Limited in Miscarriage	Other	No Limitations
North Carolina	-	-	-	-	Y
North Dakota	-	-	-	-	Y
Ohio	-	-	-	-	Y
Oklahoma	Y	-	Y	-	-
Oregon	-	Y	-	-	-
Pennsylvania	Y	Y	Y	-	-
Rhode Island	-	-	-	-	Y
South Carolina	Y	-	-	-	-
South Dakota	-	-	-	-	Y
Tennessee	-	-	-	-	Y
Texas	Y	-	-	-	-
Utah	-	-	-	1	-
Vermont **	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>	<i>n/a</i>
Virginia	-	-	-	-	Y
Washington	-	-	-	-	Y
West Virginia	-	-	-	-	Y
Wisconsin	-	-	-	-	Y
Wyoming	-	Y	-	-	-
Total	13	8	4	7	26

* No abortion conscience law

** No abortion refusal law; protects participating providers only

- (1) Rights limited in cases of ectopic pregnancy
- (2) Patient must be referred to another provider
- (3) Patient must be provided with information regarding access
- (4) Provider must return patient's prescription
- (5) Rights limited in cases of referral malpractice
- (6) Provider must make informed consent disclosures