

UNPACKING THE RELATIONSHIP BETWEEN CONSCIENCE AND ACCESS

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Many people reflexively accept or reject healthcare conscience protections. Those prizing religious freedom argue that conscience protections ensure that religious believers can both take jobs in medicine and act consonant with their faith.¹ This group sometimes gives short shrift to concerns about access to needed medical services.² On the other side, advocates for reproductive rights sometimes see access concerns as so overriding that no religious convictions should ever be accommodated, even when there would not be impact on access.³

Both accounts are too simplistic. A more nuanced account would divide conscience clauses into those that are access-expanding, access-neutral, or access-contracting and ask what characteristics make a conscience clause a threat to access, a wash for access, or, counter-intuitively, access-enhancing.

This Chapter provides that more nuanced account. It shows that it is possible to balance conscience and access in at least some cases by using common-sense devices, such as notice, parity rules, protections conditioned on not causing harm, and thickened duties to transfer pregnant women in distress. This Chapter recognizes, however, that some protections jeopardize access more than others—for example, federal efforts to insulate conscience against encroachment by state authorities with “super conscience clauses” hobble efforts to be more responsive to access concerns.

In a civil society, we should strive to maximize conscience protections without jeopardizing access. As the U.S. Supreme Court’s remand in *Zubik v. Burwell*⁴ reminds us, realizing reproductive access without encroaching on conscience is achievable.

I. Access-Preserving Protections

Although counter-intuitive, giving individual providers and institutions the flexibility to follow their convictions when deciding what services to offer can promote access to contested services.

Consider Congress’ inaugural healthcare conscience clause, the Church Amendment. Shortly after *Roe v. Wade*,⁵ Congress clarified that receiving federal hospital construction funds

¹ *E.g.*, Matthew S. Bowman & Christopher P. Schandavel, *The Harmony Between Professional Conscience Rights and Patients’ Right of Access*, 6 PHOENIX L. REV. 31 (2012).

² *See, e.g.*, Adam Sonfield, *New Refusal Clauses Shatter Balance Between Provider ‘Conscience,’ Patient Needs*, Guttmacher Rep. on Pub. Pol’y, Aug. 2004, at 1, 2–3, <http://www.guttmacher.org/pubs/tgr/07/3/gr070301.pdf>.

³ *See* Julian Savulescu, *Conscientious Objection in Medicine*, 332 BRITISH MED. J. 294, 297(2006) (“[V]alues and conscience . . . should not influence the care an individual doctor offers” because “value-driven medicine’ [opens] a Pandora’s box of idiosyncratic, bigoted, discriminatory medicine”).

⁴ 136 S. Ct. 1557 (2016).

⁵ 410 U.S. 113 (1973).

did not compel objecting institutions to provide abortions.⁶ Congress also protected individual physicians from losing staff privileges or suffering other “discrimination” for doing abortions *or* refusing to do them. This equal opportunity conscience protection reveals that conscience protections need not imperil access.⁷

Reproductive rights advocates are right that “the risk of imposition on those who do not share the objector’s beliefs is especially great when an employer, hospital, health plan, pharmacy, or other corporate entity seeks an exemption.”⁸ Institutional providers pose a special challenge for access because institutions control large swaths of the market. Catholic hospitals care for one-sixth of all U.S. patients;⁹ many possess monopoly power,¹⁰ as others in this volume note. In some communities, a Catholic hospital is the sole hospital, a phenomenon sure to increase as Catholic hospitals acquire other non-Catholic health systems.¹¹

An absolute right to refuse to provide a contested service can impede the public’s ability to receive services, especially if few others are willing to perform the service in the immediate area.¹² Respect for conscience should never allow a provider to be in a “blocking position,”¹³ which is far more likely with large regional hospitals than with individual providers.

Yet, evaluating whether conscience protections jeopardize access is complex. Consider the Church Amendment’s protections for objecting institutions. In the months preceding *Roe* and the Church Amendment, a federal district court enjoined a private, non-profit hospital from barring physicians from performing tubal ligations on patients.¹⁴

The decisions sparked a “striking outcry.”¹⁵ A Catholic bishop threatened “civil disobedience”—raising the “real and present danger that . . . religious hospitals, if coerced into

⁶ 42 U.S.C. § 300a-7(c)(1).

⁷ See Jody Feder, Cong. Research Serv., RS21428, *The History and Effect of Abortion Conscience Clause Laws 5* (2005).

⁸ Catherine Weiss, Director, ACLU Reproductive Freedom Project, Testimony on Refusal Clauses in the Reproductive Health Context Before the House Energy and Commerce Committee Health Subcommittee (July 11, 2002), <https://www.aclu.org/reproductive-freedom/testimony-aclu-reproductive-freedom-project-director-catherine-weiss-refusal-cl>.

⁹ U.S. Conference of Catholic Bishops, *Catholic Health Care, Social Services and Humanitarian Aid*, <http://www.usccb.org/about/media-relations/backgrounders/health-care-social-service-humanitarian-aid.cfm> (645 Catholic hospitals serve 87,972,910 patients annually).

¹⁰ See Lori R. Freedman & Debra B. Stulberg, *Conflicts in Care for Obstetric Complications in Catholic Hospitals*, 4 *AJOB PRIMARY RESEARCH* 1, 2 (2013); Reed Abelson, *Catholic Hospitals Expand, Religious Strings Attached*, *N.Y. TIMES* (Feb. 20, 2012), <http://www.nytimes.com/2012/02/21/health/policy/growth-of-catholic-hospitals-may-limit-access-to-reproductive-care.html>.

¹¹ See *id.*; Nina Martin, *Catholic Hospitals Grow, and With Them Questions of Care* *PRO PUBLICA* (Oct. 17, 2013), <http://www.propublica.org/article/catholic-hospitals-grow-and-with-them-questions-of-care>.

¹² See, e.g., *State Policies in Brief: Refusing to Provide Health Services*, *GUTTMACHER INST.* (Nov. 1, 2014), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf; see generally Robin Fretwell Wilson, *The Erupting Clash between Religion and the State over Contraception, Sterilization, and Abortion* in *RELIGIOUS FREEDOM IN AMERICA: CONSTITUTIONAL TRADITIONS AND NEW HORIZONS* (Allen Hertzke ed., 2014).

¹³ Robin Fretwell Wilson, *The Calculus of Accommodation: Contraception, Abortion, Same-Sex Marriage, and Other Clashes Between Religion and the State*, 53 *B.C. L. REV.* 1417, 1449 (2012) at 1449 n.109. Time constraints also impact whether a provider acts as a “choke point.” See *infra* Flynn and Wilson.

¹⁴ *Taylor v. St. Vincent’s Hospital*, 369 F. Supp. 948 (D. Montana 1973).

¹⁵ 119 *CONG. REC.* 9595, 9596, 9600 (1973) (statements of Senators Frank Church and Adlai Stevenson).

performing ... abortions or sterilizations contrary to their religious precepts, will simply eliminate their obstetrics department.” Faced with “the possibility that medical facilities may be forced to reject Federal support or to close obstetrical operations,” Congress could not “see the gains in such a policy.”

In Congress’ estimation, protecting conscience would not erase access: because a “majority of the hospitals [were] publicly owned ... no area ... would be without a hospital within a reasonable commuting distance which would perform abortion or sterilization procedures. Moreover, in an emergency situation — life or death type — no [hospital], religious or not, would deny such services.” In Congress’ predictive judgment, conscience protection yielded more access by women to needed services, not less.

Figure 1 depicts how our reflexive suppositions about the impact on access can diverge from reality. For example, one assumes that institutional exemptions wipe access, placing them on the far left of a spectrum between no access and full access. Yet, the Church Amendment preserved *some* access by avoiding the wholesale closure of OB/GYN departments, moving it closer to the center of Figure 1.

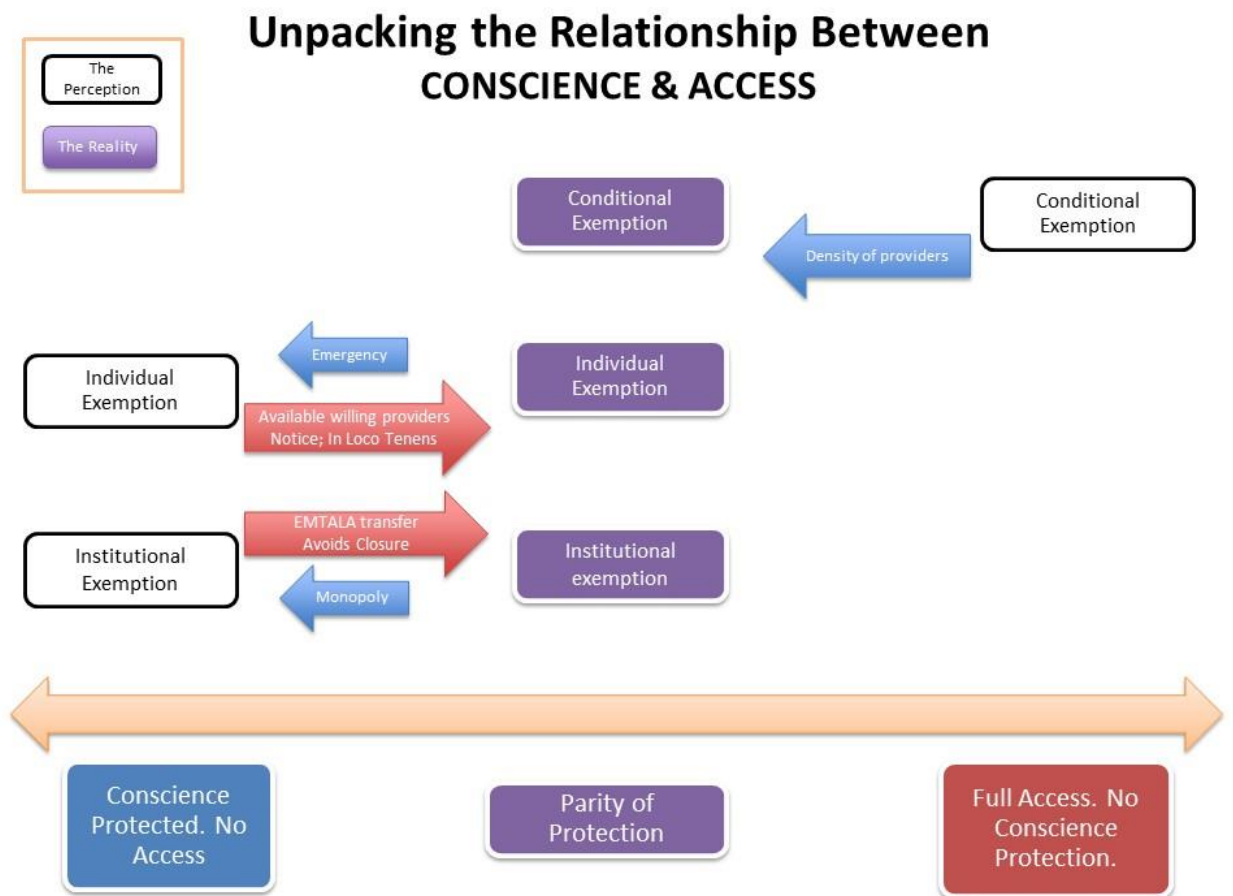


Figure 1

Threats of closure must be weighed carefully. Before the Obama Administration made significant concessions for religious non-profits objecting to the contraceptive coverage mandate,¹⁶ religious leaders like then-Archbishop of Chicago Cardinal George ominously warned that “unless something changes,” the Archdiocese’s directory listing “Catholic hospitals and health care institutions . . . will be blank.”¹⁷ In Phoenix, a Catholic church stripped Arizona’s largest hospital of its Catholic affiliation after the hospital terminated an 11-week pregnancy to save the mother’s life (the facility did not close).¹⁸ In other contexts, religious objectors have acted on promises to close.¹⁹

Threats should not alone be dispositive. When evaluating closure risk, legislators and regulatory bodies would be wise to consider existing market share, market concentration, the scarcity of other providers, the likelihood that the owner would sell a facility or that the government or a private buyer would acquire the facility before any shut-down, predicted transition time, and the likelihood that the objector would bend to civil strictures rather than close. They should also evaluate whether objectors would be loath to shed more lucrative healthcare enterprises.²⁰ Catholic hospitals have dissolved consolidated hospital operations and pulled the plug on mergers when pressed to provide abortions.²¹

With Catholic-affiliated hospitals accounting for a sizeable chunk of inpatient admissions nationally, policymakers may well be unwilling to engage in a high-stakes game of chicken. Legislatures, not institutions, should make these judgments after extensive hearings. While testimony can be slanted in favor of particular outcomes, supporters of reproductive rights are just as powerful as institutional objectors. Furthermore, well-informed legislators are capable of weighing and balancing plural interests.

Conscience protections can also enhance access by guaranteeing conscience in both directions.²² The Church Amendment protected all moral or religious beliefs “about abortion,” placing the decision to provide abortions or to refuse to do abortions beyond the reach of “discrimination” by institutional actors, like religious hospitals. Physicians remain an important,

¹⁶ Coverage of Preventive Services Under the ACA, 77 Fed. Reg. 8725, 8728 (Feb. 15, 2012).

¹⁷ Francis Cardinal George, *What Are You Going to Give Up This Lent?*, CATHOLIC NEW WORLD (Feb. 26, 2012), <http://www.catholicnewworld.com/cnwonline/2012/0226/cardinal.aspx>.

¹⁸ Ed Pilkington, US Catholic Hospital’s Ties to Church Cut Over Abortion That Saved Mother, *The Guardian*, (Dec. 22, 2010) <https://www.theguardian.com/world/2010/dec/22/us-catholic-bishop-hospital-abortion>. Hospitals have unilaterally to de-affiliated after being barred from performing abortions. See Lois Uttley et al., *Miscarriage of Medicine: The Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, MERGERWATCH 14 (2013), <https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf>.

¹⁹ See William Wan, *Same-Sex Marriage Leads Catholic Charities to Adjust Benefits*, WASH. POST, Mar. 2, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/01/AR2010030103345.html>.

²⁰ Kelly M. Doran, et al., *Housing as Health Care—New York’s Boundary-Crossing Experiment*, 369 NEW ENGLAND J. MED. 2374 (2013).

²¹ Francis J. Butler, *Will Charity Laws Close Catholic Hospitals?* AMERICA, October 29, 2001, <http://americamagazine.org/issue/348/article/will-charity-laws-close-catholic-hospitals>.

²² See J. Stuart Adams & Robin Fretwell Wilson, *Protecting Religious Liberty Requires Protections for All*, CORNERSTONE (Apr. 30, 2015), <http://berkeleycenter.georgetown.edu/cornerstone/rfra-in-indiana-and-beyond/responses/protecting-religious-liberty-requires-protections-for-all> (discussing two-way speech protections).

if small, component of access to needed services as well, confounding the simplistic account that individual conscience protections necessarily threaten access.²³

II. Access-Neutral Exemptions

Conscience protections can burden patients.²⁴ But better information and conditional exemptions may alleviate that burden.

Recognizing this, legislatures granting unqualified rights to object have incorporated notice requirements. States utilize this approach with end-of-life care. Oregon and Washington permit institutions to restrict physicians in their four walls from “practicing life-ending procedures . . . if notice is given.”²⁵ Patients and physicians wanting greater flexibility can admit patients elsewhere. Notice-based refusals are crucial for Catholic facilities that abide by ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES (“Ethical Directives”).²⁶

Of course, notice has limited benefit for urgent services, , like some reproductive decisions.²⁷ Even at the end-of-life, if a provider will not respect a patient’s a do-not-resuscitate order, the patient may be resuscitated against her will—making transfer to appropriate caretakers critical, as Part IV explains.

Some abortion conscience clauses require objecting institutions to prominently display a notice.²⁸ Over time, which institutions offer contested services may seep into public consciousness.²⁹ While notice is not a complete solution, conscience protections work best when they eliminate “search costs.”³⁰ Moreover, thickened transfer duties may avoid hard decisions, as Part V explains.

Notice requirements reduce hardships not just to the public, but to institutions offering a contested service. Requiring objecting employees to disclose objections in writing allows

²³ Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, PERSP. ON SEXUAL AND REPROD. HEALTH, Mar. 2011, <http://www.guttmacher.org/pubs/journals/psrh.46e0414.pdf>.

²⁴ See Kyung Song, *Olympia Women Complain After Pharmacies Refuse Prescriptions*, SEATTLE TIMES (August 1, 2006), <http://community.seattletimes.nwsourc.com/archive/?date=20060801&slug=pharmacy01m>.

²⁵ WASH. REV. CODE § 70.245.190 (2016); OR. REV. STAT. § 127.885 (2016).

²⁶ U.S. CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES 27 (5th ed. 2009), <http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf>. Roughly half of Catholic facilities follow the directives on sterilization.

²⁷ Cameron Flynn & Robin Fretwell Wilson, *When States Regulate Emergency Contraceptives Like Abortion, What Should Guide Disclosure?*, J. L. Med. & Ethics 72, 72 (Spring 2015)

²⁸ NEB. REV. STAT. § 28-337 (2016); see also OR. REV. STAT. § 435.475 (2016); CAL. HEALTH & SAFETY CODE § 123420(c) (2016). See also Adam Sonfield, *Provider Refusal and Access to Reproductive Health Services: Approaching a New Balance*, GUTTMACHER POL’Y REV., Spring 2008, at 2, <http://www.guttmacher.org/pubs/gpr/11/2/gpr110202.pdf>.

²⁹ Barbara B. Hagerty, *Nun Excommunicated for Allowing Abortion*, NPR (May 19, 2010).

³⁰ See Nathan J. Diament et al., *Comments Submitted to the U.S. Department of Health and Human Services with Regard to the Proposed Rescission of the “Conscience Regulation” Relating to Healthcare Workers and Certain Healthcare Services* 4 n.11 (Apr. 7, 2009), <http://law.wlu.edu/faculty/facultydocuments/wilsonr/HHSLetterFinal.pdf>.

institutions to staff around objectors.³¹ Feasibility will depend on number of likely objectors and willing providers, hours of service, staffing arrangements, and how often patients seek specific services.

Because the refusal happens internally, the public is never impacted. Disclosure *ex ante* serves an important screening function, too, separating individuals with deeply felt objections from those who are more ambivalent.

“Consistent fact-based transparency” benefits the public directly, “blunt[ing] the effect” of denials.³² For instance, information “about whether ... a plan covers abortion would benefit all consumers — those seeking a plan that includes abortion coverage [and] those seeking a plan that excludes it.”³³ Granted, insurance plans are complicated and hard to decipher and some employers do not offer abortion in any plan. But where employers offer a menu of options, notice enhances awareness and allows informed choice.

The sudden reversal by major medical centers of “long-standing polic[ies] exempting employees who refuse[d] [to help with abortions] religious or moral objections,”³⁴ shows that some institutions can staff around objectors without compromising access. Mount Sinai Hospital staffed around nurse Cathy Cenzone-DeCarlo’s religious objections to assisting with abortion without friction for years.³⁵ In 2009, Cenzone-DeCarlo’s supervisor threatened her with termination and “patient abandonment” charges if she refused to assist with a 22-week abortion.³⁶ Cenzone-DeCarlo says her superior could have assisted with the abortion, which required “surgery within 6 hours;” the hospital said it had no “replacement and ... the patient’s life was at risk.”³⁷

Mount Sinai ultimately agreed with the Department of Health and Human Services (“HHS”), which enforces federal conscience protections, to resume the prior arrangement.³⁸ It affirmed the “legal right of any individual to refuse to participate” in abortion procedures, regardless of emergency or elective status. Under Mount Sinai’s “alternative coverage” process, supervisors

³¹ Thoughtful staffing arrangements can ensure access. *See infra* notes 37-40.

³² Press Release, (July 17, 2014), <http://www.ag.ny.gov/press-release/ag-schneiderman-proposes-bill-blunt-effect-supreme-courts-hobby-lobby-decision-new>; 2015 N.Y. Assembly Bill 182. *See also* Wendy Chavkin, et al., *Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses*, 123 INT’L J. OF GYNECOLOGY & OBSTETRICS S41, table 1 (2013).

³³ Kinsey Hasstedt, *Abortion Coverage Under the Affordable Care Act: The Laws Tell Only Half the Story*, GUTTMACHER POL’Y REV., Winter 2014, at 15, 15, <http://www.guttmacher.org/pubs/gpr/17/1/gpr170115.pdf>.

³⁴ Rob Stein, *New Jersey Nurses Charge Religious Discrimination over Hospital Abortion Policy*, WASH. POST (Nov. 27, 2011), http://www.washingtonpost.com/national/health-science/new-jersey-nurses-charge-religious-discrimination-over-hospital-abortion-policy/2011/11/15/gIQAydgM2N_story.html.

³⁵ *Cenzone-DeCarlo v. Mount Sinai Hosp.*, No. 09-3120, 2010 WL 169485, at *1 (E.D.N.Y. Jan. 15, 2010), *aff’d*, 626 F.3d 695 (2d Cir. 2010).

³⁶ Memorandum in Support of Motion for Preliminary Injunction at 1, 6, *Cenzone-DeCarlo*, 2010 WL 169485 (No. 09-3120), <http://www.adfmedia.org/files/Cenzone-DeCarloPIbrief.pdf>.

³⁷ *Id.*, at 4, 8; Carpo Affidavit ¶¶ 7, 11, *Cenzone-DeCarlo v. Mount Sinai Hosp.*, No. 10237-10 (N.Y. Sup. Ct. Feb. 7, 2011).

³⁸ THE MOUNT SINAI HOSP., N. Y., NURSING CLINICAL AND ADMINISTRATIVE MANUAL 4 (2011), <http://www.adfmedia.org/files/MtSinaiPolicy.pdf>.

consult a list of willing providers after an objection.³⁹ This may increase costs if objectors represent a significant fraction of all providers or serve on thinly staffed units. Nonetheless, the fact that Mount Sinai staffed around Cenzon-DeCarlo for years—and agreed to resume that arrangement—suggests that religious objection need not imperil access. Maintaining lists of willing providers helps avoid win-lose scenarios.⁴⁰

Some states pair the right to refuse with a duty to refer, fusing religious objection to the public’s interest.⁴¹ Some medical organizations back this approach.⁴² Obviously, when services are elective and not time-sensitive, a duty to refer preserves access without sacrificing religious freedom.⁴³

Another approach cabins the right to refuse when unacceptable outcomes would result. For instance, Iowa limits the right of private hospitals to object to performing or assisting with an abortion unless “necessary to save the life of a mother.”⁴⁴ Maryland withdraws the right to object to performing abortions when refusal would cause “death or serious physical [or] long-lasting injury to the patient” or when it would be “contrary to the standards of medical care.”⁴⁵ South Carolina distinguishes between public and private hospitals; the latter may refuse to “permit their facilities to be utilized for the performance of abortions,” but cannot “refuse an emergency

³⁹ *Id.* Mount Sinai agreed to train employees and prohibit discrimination based on abortion objections. Letter from Linda C. Colón, Reg’l Manager, Office of the Sec’y, U.S. Dep’t of Health & Human Servs., to Matthew S. Bowman, Attorney, Alliance Defending Freedom, and David Reich, Interim President, Mount Sinai Hosp. 2-3 (Feb. 1, 2013), <http://www.adfmedia.org/files/Cenzon-DeCarloHHSfindings.pdf> [hereinafter HHS Letter].

⁴⁰ *Id.*, at 3. Citing cases like *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 228 (3d Cir. 2000), some contend that all objections, even those that can be staffed around, represent a “[lapse] in medical professionalism,” making courts “appropriately intolerant” of objectors. *See* Weiss Testimony, *supra* note 8. In *Shelton*, the court found a public hospital reasonably accommodated a Pentecostal nurse opposed to assisting with emergency abortions by offering transfer at the same pay and benefits to another unit providing no “religiously untenable” services—a transfer *Shelton* refused. *Shelton*, 223 F.3d at 220, 226. That refusal ultimately doomed *Shelton*’s claim, not the court’s “intolerance” of religious objectors.

⁴¹ North Carolina Board of Pharmacy, Pharmacist FAQs: Frequently Asked Questions for Pharmacists on Conscience Clause, http://www.ncbop.org/faqs/Pharmacist/faq_ConscienceClause.htm; *Plan B Availability OTC Raises Logistical and Administrative Challenges*, 35 NAT’L ASS’N OF BOARDS OF PHARMACY NEWSLETTER 1, 2 (Nov.-Dec. 2006), <https://www.nabp.net/publications/assets/NovDec06NABP.pdf>. Some express the duty to refer as a “professional obligation to take appropriate steps to avoid ... abandoning or neglecting a patient.” Letter from Lawrence H. Mokhiber, Executive Secretary, New York State Board of Pharmacy, to Supervising Pharmacists, Re: Policy Guideline Concerning Matters of Conscience (Nov. 18, 2005), <http://www.op.nysed.gov/prof/pharm/pharmconscienceguideline.htm>.

⁴² ACOG Committee on Ethics, *The Limits of Conscientious Refusal in Reproductive Medicine*, Opinion 385 at 1 (November 2007), http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Ethics/The_Limits_of_Conscientious_Refusal_in_Reproductive_Medicine (“Physicians and other health care providers have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services”).

⁴³ Information about willing providers is needed to prevent patients from wasting time “searching” for non-objecting providers. Although objectors may resist on complicity grounds, requiring professionals to provide accurate information should be non-negotiable. Rebecca Dresser, *Professionals, Conformity, and Conscience* 35 HASTINGS CENTER REP. 9 (2005).

⁴⁴ IOWA CODE ANN. § 146.1 (West 2016); *see also* MO. ANN. STAT. §§ 188.205, 188.210, 188.215 (West 2016).

⁴⁵ MD. CODE ANN., HEALTH-GEN. § 20-214 (West 2016).

admittance.”⁴⁶ Each approach honors religious objections up to a certain point.

Qualifying conscience protections by substantial—not imagined—hardship to the public avoids the need to default to a for-the-patient-to-win-the-objector-must-lose posture. It also preserves the ability of people of faith to work in medicine, expanding choice for patients who value pro-life providers.⁴⁷

Consider the 2011 lawsuit against the University of Medicine and Dentistry of New Jersey (“UMDNJ”), alleging that hospital staff “repeatedly [told objecting nurses] . . . that they must assist abortions or . . . be terminated.”⁴⁸ Notwithstanding federal and state protections,⁴⁹ when a nurse “reiterated her religious objections,” UMDNJ staff replied that UMDNJ has “‘no regard for religious beliefs’ of nurses, . . . ‘everyone on this floor is required to do [abortions],’ [and] ‘no patients can be refused by any nurse.’”⁵⁰ Following a temporary injunction, the parties agreed that except when the mother’s life is at risk and there are no other non-objecting staff available to assist, objecting nurses will not have to assist with abortions.⁵¹ In emergencies, their “only involvement . . . would be to care for the patient until such time as a non-objecting person can get there to take over the care.”⁵² The settlement effectively converts the absolute right to say no under the Church Amendment and parallel state laws⁵³—whatever the costs to patients—into a right qualified by hardship to patients. Refashioned, the objector’s right to refuse ends where a patient’s life is at risk and no one else can perform the needed service.

Those who prioritize conscience over access see conditional exemptions as encroaching on their rights—in Figure 1’s terms, that the conditional exemption provides no insulation for conscience. But by limiting the nurses’ involvement generally to maintaining the patient’s status quo, we avoid forcing the resignation of providers who can serve other patients and provide other services. In every instance but the most dire, conditional exemptions preserve the ability of healthcare providers to stay in their profession.

III. Access-Freezing “Super Conscience Clauses”

Perhaps the greatest challenge to access is “super conscience clauses” like the Weldon Amendment. The Weldon Amendment strips federal agencies and state or local governments of specified funds if they “subject[] any institutional or individual health care entity to

⁴⁶ S.C. CODE ANN. § 44-41-40 (2016).

⁴⁷ Bowman, *supra* note 1.

⁴⁸ Verified Complaint at 7-8, *Danquah v. Univ. of Med. & Dentistry of N.J.*, No. 2:11-cv-06377 (D.N.J. Oct. 31, 2011), <http://www.lifenews.com/wp-content/uploads/2011/11/newjerseynursesabortion.pdf>.

⁴⁹ See N.J. STAT. ANN. § 2A:65A-1 (West 2016) (unqualified right to refuse).

⁵⁰ *Id.* at 7-9.

⁵¹ Transcript of Proceedings at 5-6, *Danquah*, No. 2:11-cv-06377 (D.N.J. Oct. 31, 2011), <http://www.adfmedia.org/files/DanquahSettlementTranscripts.pdf>.

⁵² *Id.* at 5-6. Judge Linares “retain[ed] jurisdiction” to ensure the agreement’s terms “are in fact followed.” *Id.* at 5.

⁵³ Robin Fretwell Wilson, *Matters of Conscience: Lessons for Same-Sex Marriage from the Healthcare Context*, in SAME-SEX MARRIAGE AND RELIGIOUS LIBERTY: EMERGING CONFLICTS appendix (Douglas Laycock, Anthony R. Picarello, Jr., & Robin Fretwell Wilson, eds., 2008) (collecting statutes).

discrimination [for refusing to] provide, pay for, provide coverage of, or refer for abortions” — putting aside cases of rape, incest, or a life-threatening pregnancy.⁵⁴

The Weldon Amendment resulted from the push-and-pull of advocates' increasingly creative ways to test the limits of conscience protections.⁵⁵ For instance, although the Church Amendment protected physicians from punishment for refusing to do abortions, nothing prevented accreditors from later requiring all accredited medical schools to train students to perform abortions. In 1996, Congress enacted the Coates-Snow Amendment to block that move.⁵⁶

Recognizing that effective conscience protections must regulate at every level of government, in 2004 Congress began attaching the Weldon Amendment to budget riders. The Weldon Amendment sustains an unqualified right to object by threatening to defund governmental bodies that might otherwise place greater emphasis on access. California, for example, risks \$49 billion in federal funds if it impermissibly penalizes entities that refuse to do or cover abortions.⁵⁷

In effect, Congress blocked state and local counterparts from placing duties on objecting providers that undercut the thick conscience protections Congress instituted.

While super conscience clauses have the virtue of shutting down end-runs and effectively providing a stable social understanding of when one's right to refuse begins and ends, they frustrate efforts by state and local actors to assess the impact on access and to recalibrate accordingly. Recently, California required health plans to cover elective abortions, including late-term abortions. After religious employers objected, HHS issued a non-action letter because religious employers, rather than the issuing insurance companies had objected.⁵⁸ Although it is unclear whether the Obama Administration's choice to issue a non-action letter meshes with Congress' intent,⁵⁹ threatening state and local governments with a massive loss of funding nonetheless means that other governments cannot easily revisit federal policy decisions.

Thus, super conscience clauses can harm patients by concretizing policy decisions and making them largely immune from changing facts and circumstances. Despite medical advances, “pregnancy is not a risk-free life event, particularly for many women with chronic

⁵⁴ Pub. L. No. 108-447, § 508(a), (d)(1); Pub. L. No. 109-149, § 508(a), (d)(1). See Glenn Cohen, *Are All Abortions Equal? Should There Be Exceptions to the Criminalization of Abortion for Rape and Incest?* 43 J. L. MED. & ETHICS 87 (2014) for a critique of these exemptions.

⁵⁵ Judith C. Gallagher, *Protecting the Other Right to Choose: The Hyde-Weldon Amendment* 5 AVE MARIA LAW REVIEW 527 (2007).

⁵⁶ 42 U.S.C. § 238n (“health care entit[ies],” including “postgraduate physician training program[s]” receiving federal financial assistance cannot be penalized for “refus[ing] to provide abortion”).

⁵⁷ Bob Egelko, *California Suit Hits Antiabortion Amendment*, S.F. CHRON. Jan. 26, 2005, at B3. State challenges have failed. See, e.g., *California v. United States*, 2008 WL 744840 (N.D. Cal. 2008).

⁵⁸ Jocelyn Samuels, Director, Office of Civil Rights, Department of Health and Human Services, to Catherine W. Short, et al., June 21, 2016, <http://www.adfmedia.org/files/CDMHCIInvestigationClosureLetter.pdf>.

⁵⁹ The Weldon Amendment nowhere explicitly requires a covered individual or institutional entity to object, and so may indirectly protect employers' moral objections.

medical conditions.”⁶⁰ When Congress enacted the Patient Protection and Affordable Care Act (“ACA”),⁶¹ it gave health plans discretion to cover abortion as part of essential health benefits.⁶² States could enact laws to ban *all* abortion coverage by health plans offered through state-established exchanges, as some states did,⁶³ but states need not ban abortion.

California chose *to require* health plans to affirmatively “treat maternity services and legal abortion neutrally.”⁶⁴ That decision precipitated both the complaint to HHS and a federal lawsuit under the Weldon Amendment to force California to allow insurers to offer plans to religious employers that exclude elective abortion; plaintiffs say California in the past has authorized plans covering a subset of all abortions, namely for cases of rape, incest, and mother's life.⁶⁵ The Weldon Amendment, they contend, requires California to permit insurers to offer plans that cover no abortions.

In refusing to grant California a quick win, a federal district court observed that “the parties may wish to investigate whether they can come to an arrangement that will meet the needs of all stakeholders,”⁶⁶ citing *Zubik*.

While a system of individualized exemptions may work, one-off rules may be in tension with California's asserted compelling interest in mandating coverage by everyone. More importantly, if the Weldon Amendment applies, California cannot act on its judgment that access needs warrant unfettered access. Super conscience clauses most impede access.

IV. Developing Earlier Decision Points

As pressure mounts to scrap conscience protections,⁶⁷ objecting hospitals need to develop ways to abide by their faith tenets *without* putting women at risk. The Ethical Directives

⁶⁰ Jennifer Haberkorn, *Experts Split from Walsh on Abortion*, POLITICO, Oct. 19, 2012,

<http://www.politico.com/story/2012/10/medical-experts-say-abortions-still-needed-despite-advances-082640>.

⁶¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 through May 1, 2010,

⁶² ACA Sec. 1303(b)(1)(A)(ii); 42 U.S.C. §18023.

⁶³ *Id.*; Alina Salganicoff, et al., *Coverage for Abortion Services in Medicaid, Marketplace Plans and Private Plans*, Kaiser Family Foundation Issue Brief, January 2016, <http://files.kff.org/attachment/issue-brief-coverage-for-abortion-services-in-medicare-marketplace-plans-and-private-plans>.

⁶⁴ Tracy Seipel, *California Reverses Position on Health Insurance Abortion Coverage*, MERCURY NEWS, Aug. 22, 2014, http://www.mercurynews.com/health/ci_26387230/state-reverses-position-health-insurance-abortion-coverage.

⁶⁵ Complaint for Declaratory and Injunctive Relief and Nominal Damages, Skyline Wesleyan Church v. California Department of Managed Health Care, No. 37-2016-00003936 (Cal. Super. Ct. Feb. 4, 2016) at 66-67.

⁶⁶ Skyline Wesleyan Church v. California Department of Managed Health Care, Case 3:16-cv-00501 (S.D. Cal. June 20, 2016), slip op. at 8, n. 2 (citing *Zubik v. Burwell*, 136 S. Ct. 1557, 1560 (2016)).

⁶⁷ Robert Pear, *A Bush Rule on Providers of Abortion is Revised* N.Y. Times, Feb 18, 2011, http://www.nytimes.com/2011/02/19/health/policy/19health.html?_r=0; 2016 Democratic Party Platform Draft, July 1, 2016, <https://demconvention.com/wp-content/uploads/2016/07/2016-DEMOCRATIC-PARTY-PLATFORM-DRAFT-7.1.16.pdf> (“We will continue to oppose—and seek to overturn—federal and state laws and policies that impede a woman's access to abortion, including by repealing the Hyde Amendment.”).

“prohibit health service providers from taking ‘direct’ action against the embryo.”⁶⁸ While the Catholic principle of double effect permits physicians to act to save a patient’s life, even it means hastening a fetus’s death, that consequence cannot be “directly willed” and the precipitating act must be “morally acceptable.”⁶⁹

Far too often, however, “[b]ecause the fetus [is] still alive, [treating physicians] wouldn’t intervene.”⁷⁰ The experience for women awaiting treatment can be horrific, and if sepsis develops, life-threatening.⁷¹ For pregnant women at objecting hospitals, the principal problem stems from delay: the hospital does not act soon enough when an ectopic pregnancy, miscarriage, or other condition necessitates an emergency abortion.⁷²

Recently, the ACLU sued to force objecting institutions to transfer patients or treat them under the federal Emergency Medical Treatment and Labor Act (“EMTALA”).⁷³ Enacted in 1986, EMTALA requires hospitals to treat, stabilize, or transfer patients in active labor.⁷⁴

A number of Catholic hospitals proactively transfer pregnant women in distress, as scholars have shown:

Catholic hospital ethics committees advised their physicians to transfer patients to another provider for the specific purpose of obtaining an abortion. In these cases, the woman’s health or life was threatened by her pregnancy, and the Catholic ethics committees did not want to allow her to experience irreversible harm.⁷⁵

⁶⁸ Angel M. Foster, et al., *Assessing Hospital Policies & Practices Regarding Ectopic Pregnancy & Miscarriage Management* National Women’s Law Center (2015) at 4, https://nwlc.org/wp-content/uploads/2015/08/ibis_rh_-_nwlc_qualitative_study_report.pdf.

⁶⁹ See *The Principle of Double Effect*, CATHOLICS UNITED FOR THE FAITH (1997), <http://www.cuf.org/FileDownloads/doubleeffect>. See also George Weigel, *Clarifying “Double Effect,”* FIRST THINGS (Feb. 23, 2011), <http://www.firstthings.com/web-exclusives/2011/02/clarifying-ldquodouble-effectrdquo;> David F. Kelly et al., CONTEMPORARY CATHOLIC HEALTH CARE ETHICS 108, 109 (2013) (abortions permissible if the “directly intended effect is the preservation or restoration of the mother’s health”).

⁷⁰ Lori R. Freedman, et al., *When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals* 98 Am. J. Pub. Health 1774, 1776-1777 (2008), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/>.

⁷¹ Molly Redden, *Abortion Ban Linked to Dangerous Miscarriages at Catholic Hospital, Report Claims*, THE GUARDIAN (Feb. 18, 2016), <http://www.theguardian.com/us-news/2016/feb/18/michigan-catholic-hospital-women-miscarriage-abortion-mercy-health-partners>.

⁷² See, e.g., Foster, *supra* note 68 at 4; Frances W. Casey, et al., *Elective Abortion*, MEDSCAPE (Feb. 29, 2016), <http://emedicine.medscape.com/article/252560-overview>; Kim Painter, *Doctors Say Abortions Do Sometimes Save Women’s Lives* USA TODAY (Oct. 22, 2012), <http://www.usatoday.com/story/news/nation/2012/10/19/abortion-mother-life-walsh/1644839/>.

⁷³ Amended Complaint, *ACLU v. Trinity Health Corporation*, Case No. 15-cv-12611 (Oct. 1, 2015), <http://www.adfmedia.org/files/TrinityHealthComplaint.pdf>; Candice Williams, *Mich. Health System Sued for Emergency Abortion Policy*, DETROIT NEWS (Oct. 1, 2015), <http://www.detroitnews.com/story/news/local/wayne-county/2015/10/01/mich-health-system-sued-emergency-abortion-policy/73172420/>. The suit failed for lack of standing. *American Civil Liberties Union v. Trinity Health Corporation*, 15-cv-12611 (E.D. Mich. 2016), <http://www.adfmedia.org/files/TrinityHealthDismissal.pdf>.

⁷⁴ See 42 U.S.C. § 1395dd.

⁷⁵ Freedman & Stulberg, *supra* note 10, at 8. See also Angel M. Foster, *Do Religious Restrictions Influence Ectopic Pregnancy Management? A National Qualitative Study* 21 WOMEN’S HEALTH ISSUES 104, 104 (2011), <http://www.ncbi.nlm.nih.gov/pubmed/21353977>.

If hospitals cannot treat a patient, they should aggressively work, first, to avoid being the admitting facility and, second, to transfer women needing abortions at the earliest indication of distress. Hospitals already place themselves on “drive by” status when overwhelmed, and sometimes divert patients for selective reasons, too.⁷⁶

Some may wonder whether a hospital would assert complicity-based claims not to transfer a patient in order to prevent abortion.⁷⁷ To my knowledge, no religious institution has ever asserted such a claim.⁷⁸ But even if one was asserted, EMTALA imposes a duty to treat or transfer, without room for religious exceptions. Nor should there be any exception. If a hospital cannot treat a distressed patient, then it must let others treat her. Trapping a woman in a hospital that cannot render needed medical attention is not acceptable.

With evidence-based medicine,⁷⁹ it should be possible to develop protocols for transferring patients upon arrival to the optimal provider or even to route patients directly to the best site for their needs. Of course, distances will matter, as will the receiving institution’s expertise.⁸⁰ Further, transferring patients is not a cure-all. Some “patients of limited means cannot realistically access care” at the receiving hospital for insurance or financial reasons.⁸¹ Transferring facilities should assist patients to be billed in-network by the receiving facility because the transfer was necessitated by the transferring facility’s faith tenets, not the patient. Likewise, regulators, like state attorneys general overseeing the merger of Catholic hospitals, could require transferring facilities to make the transfer a financial wash for patients.

Although lawsuits pressing EMTALA claims have thus far proven unsuccessful,⁸² that religious conscience can come at such high costs to women means that holding onto conscience protections will become increasingly difficult. In a range of contexts, advocates are pushing back.⁸³

⁷⁶ Emergency Med. Servs. Comm. of the Am. Coll. of Emergency Physicians, *Guidelines for Ambulance Diversion* (Oct. 1999), <https://www.acep.org/Clinical---Practice-Management/Guidelines-for-Ambulance-Diversion-2147470413/>.

⁷⁷ Ethical Directive 70 expressly prohibits Catholic healthcare organizations from engaging in immediate material cooperation in actions like abortion.

⁷⁸ However, a Chicago ambulance driver refused to transport a patient for an abortion. Rob Stein, *Medical Crisis of Conscience*, *Washington Post* (July 16, 2006), <http://www.washingtonpost.com/wp-dyn/content/article/2006/07/15/AR2006071500846.html>. See Part II *supra* discussing feasibility of staffing around individual objectors.

⁷⁹ See generally PIERRE L. YOUNG & LEIGHANNE OLSEN, *THE HEALTHCARE IMPERATIVE: LOWERING COSTS AND IMPROVING OUTCOMES* (2010).

⁸⁰ AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, *The Limits of Conscientious Refusal in Reproductive Medicine*, 385 *OBSTETRICS & GYNECOLOGY* 1203 (2007). Transfers may better serve women who are miscarrying because religiously affiliated hospitals generally tend to be small community hospitals. HARRY A. SULTZ & KRISTINA M. YOUNG, *HEALTH CARE USA: UNDERSTANDING ITS ORGANIZATION AND DELIVERY* 75-76 (Katey Birtcher & Tracey Chapman, 6th ed. 2009).

⁸¹ Freedman & Stulberg, *supra* note 10, at 8.

⁸² *American Civil Liberties Union v. Trinity Health Corporation*, 15-cv-12611 (E.D. Mich. 2016), <http://www.adfmedia.org/files/TrinityHealthDismissal.pdf> (dismissed for lack of standing).

⁸³ See Do No Harm Act, H.R. 5272, 114th Cong. (2015).

Thickened duties to transfer patients before a crisis may necessitate some changes to practice.⁸⁴ But protecting women remains the surest way to protecting the objecting hospital's own ability to operate according to its faith tenets.⁸⁵

V. Lessons from *Zubik*

In what is arguably the most heated debate in recent decades over the limits of religious conscience⁸⁶—claims to be exempt from the contraceptive mandate—the U.S. Supreme Court in *Zubik* sent the parties back to the appeals court with instructions to mediate their differences.⁸⁷ As is discussed in greater depth in this volume's introduction and many other chapters, the Obama Administration crafted an accommodation that shifted the obligation to provide contraceptive coverage from objecting non-profits to another entity, giving women needed access, without hassle and without cost.⁸⁸ Until the *per curiam* opinion, the protracted litigation over whether the government had accommodated religious non-profits *enough* had taken on the winner-takes-all-quality animating conscience debates.⁸⁹

Sensing room to remove objecting non-profits from the equation without sacrificing needed access, the Court gave an over-arching instruction: agree on how religious organizations can “do nothing more than contract for a plan that does not include coverage for some or all forms of contraception,” while women receive seamless “cost-free contraceptive coverage from the same insurance company.”⁹⁰ Although the parties' differences may yet prove unbridgeable,⁹¹ and many chapters in this volume criticize the opinion, the spirit of *Zubik* is clear: in a plural society, we should embrace creative fixes that preserve as much religious freedom as possible while allowing social progress. As Professor Michael McConnell said: “the Supreme Court demonstrated that even in these contentious times it can find solutions to practical problems on the basis of reasonable accommodation.”⁹² For “reasonable people of good will,” the primary

⁸⁴ Foster, *Religious Restrictions*, *supra* note 75, at 104.

⁸⁵ Catholic scholars are exploring whether the principle allows a greater range of treatment options, such as “hospital within hospital” arrangements or other partnerships to provide emergency abortions. Monica Sloboda, *The High Cost of Merging with a Religiously-Controlled Hospital*, 16 BERKELEY WOMEN'S L.J. 140, 144 (2001); *see* Kelly, *supra* note 69, at 287.

⁸⁶ *See* Ethan Bronner, *A Flood of Suits Fights Coverage of Birth Control* N.Y. TIMES, Jan. 26, 2013, <http://www.nytimes.com/2013/01/27/health/religious-groups-and-employers-battle-contraception-mandate.html>.

⁸⁷ Richard W. Garnett, *The Future of Accommodation* SCOTUSblog (May 17, 2016), <http://www.scotusblog.com/2016/05/symposium-the-future-of-accommodation/>.

⁸⁸ *See* Richard Wolf, *Obama Tweaks Birth Control Rule*, USA TODAY (Feb. 10, 2012), <http://content.usatoday.com/communities/theoval/post/2012/02/source-obama-to-change-birth-control-rule/1#.V2h9WLgrLD4>.

⁸⁹ The Court's supplemental briefing asked whether “contraceptive coverage may be obtained by petitioners' employees through petitioners' insurance companies, [without] involvement of petitioners beyond their own decision to provide health insurance without contraceptive coverage to their employees.” Order Requesting Supplemental Briefing in *Zubik v. Burwell*, 577 U.S. at 1.

⁹⁰ *Zubik v. Burwell*, 136 S. Ct. 1557 (2016), slip op at 3.

⁹¹ *See* Kelsey Dallas, *Supreme Court Sends Birth Control Mandate Challenge Back to Lower Courts*, DESERET NEWS (May 16, 2016), <http://www.deseretnews.com/article/865654385/Supreme-Court-sends-birth-control-mandate-challenge-back-to-lower-courts.html?pg=all>.

⁹² Michael W. McConnell, *Prof. Michael McConnell on Zubik v. Burwell*, WASH. POST (May 17, 2016), <https://www.washingtonpost.com/news/volokh-conspiracy/wp/2016/05/17/prof-michael-mcconnell-on-zubik-v-burwell-yesterdays-supreme-court-rfra-contraceptive-decision/>.

hurdle to “protect[ing] religious freedom without sacrificing the democratic will” may be our own suppositions that each comes at the expense of the other.

VI. Conclusion

Whether and how conscience protections affect access is a difficult question. The impact on access depends on the specific contours of conscience protections themselves and on external constraints, such as whether objecting providers will close. In the end, continued protection for the religious convictions of healthcare providers will depend on consciously reconciling those protections with the needs of patients.