The Future of Health Care Conscience Laws Post-Dobbs

NADIA N. SAWICKI*

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ABSTRACT

The Supreme Court’s rejection of a constitutional right to choose abortion in Dobbs v. Jackson Women’s Health Organization has prompted legislatures to make significant changes to state laws. Some states have criminalized abortion in most circumstances, while others have granted patients and health care providers broader rights to choose and access abortion. Another, perhaps less-recognized, avenue for legislative change is by amending existing state conscience laws. This Article describes the avenues state legislatures might take in using conscience laws to impact abortion access in accordance with the state’s policy preferences.

I. INTRODUCTION

Laws protecting health care providers’ right to refuse services that violate their conscientious beliefs are prevalent throughout the United States, and have been codified at both the federal and state levels. These laws generally protect both individual and institutional providers who conscientiously refuse to provide abortions from various types of adverse action, including professional discipline, employment discrimination, and liability. Since the first federal conscience law was passed in 1973, shortly after the Supreme Court confirmed the constitutional right to abortion in Roe v. Wade, commentators have debated whether abortion conscience laws strike an appropriate balance between providers’ beliefs and patients’ access to medical care.

The Supreme Court’s decision in *Dobbs v. Jackson Women’s Health Organization*, which rejected the constitutional right to abortion and returned the issue to the states, will surely reinvigorate this debate. State legislatures now have greater flexibility to limit patients’ access to abortion, and many have already passed legislation that criminalizes abortion in all but the narrowest circumstances. However, legislatures also have the opportunity to impact abortion access in a way that is less obvious to the public—by amending conscience laws that do not directly speak to the criminalization of abortion, but that delineate providers’ rights to decline abortion even when it is legally permitted.

Part II offers an overview of the many federal and state laws that govern the practice of medicine. It explains that health care providers generally have no affirmative duty to provide treatment to patients with whom they have no prior relationship. However, some targeted laws—like EMTALA at the federal level, and some state laws relating to controversial medical procedures—do impose requirements (or set prohibitions) that health care practitioners might object to for reasons of conscience.

Part III describes the landscape of federal and state laws that protect health care providers’ conscientious beliefs. It focuses primarily on conscience laws that protect the right to refuse participation in abortion, which are most common in the United States.

Part IV offers some predictions about the future of state conscience laws post-*Dobbs*. It describes several ways in which legislators might expand or narrow conscience laws depending on whether the state seeks to restrict or expand abortion rights. It considers, for example, modifications to the scope of providers and actions protected, exceptions to conscientious refusal in cases of medical necessity, patient-protective limitations such as referral requirements, and clarification of the types of adverse action providers are protected from.

II. FEDERAL AND STATE REGULATION OF MEDICAL PRACTICE

The practice of medicine is regulated primarily at the state level. States’ authority to regulate medicine is grounded in their Tenth Amendment unenumerated power to regulate the health, safety, and welfare of their

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5. U.S. CONST. amend X.
citizens. Statutes, administrative regulations, and common law all play a part in the state regulation of medicine. While there are some federal laws that govern the practice of medicine, they are narrow in scope and limited to certain contexts. This Section offers several examples of federal and state laws that impact medical practice, with a particular focus on laws that may require action that violates the conscientious beliefs of health care providers.

A. Federal Law

One of the primary ways in which the federal government has a role in regulating medical practice is by virtue of its position as a health care payor. Providers that participate in the Medicare and Medicaid programs are reimbursed by the federal government for services provided, and as a result are subject to a broad swath of federal laws and regulations. The federal government’s Conditions of Participation for Medicare and Medicaid are particularly important. These laws are quite broad, and while they do not provide direct guidance about how to practice medicine, they set high-level operational standards that impact health and safety. Also relevant in this context are healthcare fraud and abuse laws and anti-kickback laws, which restrict providers’ ability to secure inappropriate financial gain from their practice.

Federal laws that apply more broadly in the health care sphere (not just in the context of government payment for services) include the Health Insurance Portability and Accountability Act (HIPAA), which protects the privacy and security of patient health information; and the Health Information Technology for Economic and Clinical Health (HITECH) Act, which supports the use of health information technology and promotes interoperability across the health care industry. Laws that impact the quality of medical care more directly include the Health Care Quality Improvement Act and the Patient Safety Quality Improvement Act, which are aimed at strengthening peer review processes in hospitals, encouraging efforts to report patient safety events, and establishing institutional policies and

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procedures for addressing medical errors. Laws that regulate drugs and devices, like the Food, Drug, and Cosmetics Act\(^\text{14}\) and the Controlled Substances Act\(^\text{15}\) also directly impact medical practice because they relate to physician prescribing privileges and practices.

A particularly important federal law to note, especially in the aftermath of Dobbs, is the Emergency Medical Treatment and Active Labor Act (EMTALA).\(^\text{16}\) EMTALA requires Medicare-participating hospitals to screen patients who present to their emergency departments and evaluate whether a patient has an emergency medical condition. If an emergency medical condition is found, the hospitals are required to provide stabilizing treatment before transferring the patient elsewhere. This law was adopted in 1986 to limit the practice of “patient dumping,” whereby hospitals would turn away uninsured patients from their emergency departments.\(^\text{17}\)

This is one federal law that directly requires the provision of medical treatment to certain categories of patients, which implicates conscience laws for the reasons discussed in Part III-A-2.

**B. State Law**

The bulk of medical regulation takes place at the state level. The most foundational laws are state medical practice acts that grant individuals the authority to practice medicine. These statutes set forth the requirements for being licensed to practice medicine in the state, the scope of permissible practice, and the grounds on which state medical boards can discipline physicians or revoke their licenses to practice.\(^\text{18}\) The entity responsible for enforcing these statutes and their associated regulations is an administrative agency called the state medical board. While the structure of state medical boards varies from state to state, medical boards are primarily composed of physicians, although they are often required to have some public non-professional members.\(^\text{19}\)

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\(^{14}\) 21 U.S.C. §§ 301.

\(^{15}\) 21 U.S.C. §§ 801.

\(^{16}\) 42 U.S.C. § 1395dd.


\(^{18}\) Sawicki, *supra* note 6, at 290.

\(^{19}\) *Id.* at 290-91.
a self-regulating profession, and as such, has been criticized as an example of regulatory capture in occupational licensing. Historically, the first medical licensing laws were promoted by professional medical associations in an effort to legitimize the practice of medicine, grant greater status to licensed physicians, and deny other categories of healers the economic benefits associated with state recognition. Early licensing laws were drafted to exclude the authority of, for example, midwives, homeopaths, and what at the time were called “irregular” practitioners. These tensions about scope of practice and regulatory capture continue today.

1. Common Law and Medical Malpractice

Once a provider is licensed to practice medicine in a state, however, the boundaries of their day-to-day practice are set primarily by customary professional practices, more so than any explicit legal standards. The legal doctrine that both physicians and lawyers are probably most familiar with is the common law doctrine of medical malpractice. Physicians and other health care providers can be civilly liable to injured patients if they breach a duty that results in patient harm.

What constitutes a breach of duty in the health care context is generally not set by legislatures—though there are a few examples highlighted in Part II-B-2—but rather by courts and juries. In medical malpractice cases, courts and juries consider testimony from medical experts about the standard of care for treating a particular patient’s condition. Whether a doctor complied with the standard of care depends on whether they acted in a way that reasonable physicians would deem to be medically appropriate in a given

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20. See generally, Paul Starr, The Social Transformation of American Medicine, 80 (Basic Books, 1982).
22. See generally, Starr, supra note 20, at 19–22, 44–45, 80–81.
23. See generally, Starr, supra note 20, at 45–46, 80.
24. To cite just one example, in 2015, the Supreme Court held that for the purposes of antitrust enforcement, the state dental licensing board—despite being an administrative agency of the state of North Carolina—did not qualify as a “state actor.” North Carolina State Board of Dental Examiners v. FTC, 135 S. Ct. 1101, 1107-08 (2015). The court held that because the board was primarily composed of dentists and was not being actively supervised by the state, it could be found to have engaged in unreasonable restraint of trade when it issued a series of cease and desist letters to non-dentist providers of teeth whitening services. Id. at 1105.
context. Of course, American law recognizes that there may be many different viable approaches to treating a given condition; therefore, there is rarely a single identifiable standard of care. Rather, as long as a doctor treated the patient in one of the ways that would be commonly accepted in the medical community, that doctor will have satisfied their duty of care towards the patient and will not be liable for malpractice. Consequently, courts and juries determine what practices are commonly accepted in the medical community based on testimony by medical experts at trial. While every case is unique, over time a body of common law precedent has developed that can provide some guidance, even if vague, as to what the legally required expectations are in a given medical context. In effect, however, medical professionals themselves set the legal standard of care, because the determination of whether a duty was breached is typically based on the customary practice of the medical profession.

Notably, the doctor’s duty to comply with the standard of care arises only after the doctor has established a treatment relationship with the patient. A doctor with no relationship to a patient does not owe that person any legally binding duties under state common law. This is in contrast to EMTALA, described above, the federal law which requires emergency departments to evaluate every patient that comes into the emergency room regardless of their ability to pay. Obviously, doctors are restricted in their ability to discriminate against patients on grounds like race, gender, or religion; these prohibitions originate in both state and federal law. However, if a patient approaches a doctor seeking a particular medical treatment, the doctor is not legally obligated to take that person on as a patient, nor are they obligated to provide the requested treatment. Doctors have great freedom to define the scope of their practice. For example, a dermatologist would never be required to perform orthopedic surgery. An OB/GYN may establish a practice where they provide contraception, prenatal and postnatal care, and labor and delivery services, but exclude termination of pregnancy from the scope of their practice. No body of

26. Id. at 77–78.
27. Id. (discussing standards of customary and reasonable practice) and 102–03 (discussing the “two schools of thought” and “respectable minority” doctrines).
28. “A physician-patient relationship is normally a prerequisite to a professional malpractice suit against a doctor.” Id. at 71.
state common law requires physicians to provide specific services. And, as explained in Part III, providers have even greater protection in their choice of services as a result of federal and state conscience laws.

2. Legislative Standards of Care

While the determination of standard of care is generally left to experts testifying in medical malpractice cases about customary practice, there are some areas where legislatures have stepped in to codify expectations for medical practice, overriding the common law. Often, this occurs in politically controversial contexts. For example, some state laws include required language that doctors must use in order to satisfy their legal duty to secure informed consent from a patient seeking an abortion. Other states require pharmacies to have available and to dispense emergency contraception to patients who need it. All states have laws relating to end of life care planning, which specify the obligations that doctors have when a patient or designated surrogate wishes to withdraw life-sustaining treatment. In a few states, legislatures have de-criminalized physician aid dying, and set out procedures that doctors must follow if they choose to respond to a terminal patient’s request for life-ending medication. One of the more recent controversies relating to legislative interference in


33. Thaddeus M. Pope, Medical Aid in Dying: Key Variations Among U.S. State Laws, 14 J. OF HEALTH AND LIFE SCIENCES LAW 25, 28 (2020); see e.g., Oregon Death with Dignity Act, 1995 OR. LAWS ch. 3 (codified at OR. REV. STAT. § 127.800 (1996)).
medical practice is legislation that prohibits physicians from providing gender affirming therapy to children.34

It is in these areas of medical practice—where legislatures have directly stepped in to establish practice standards—that health care providers may find their own conscientious beliefs in conflict with legal expectations, prohibitions, or requirements. For example, in states that permit termination of pregnancy, doctors who hold religious or conscientious opposition to abortion may object to performing the procedure, and in many states they are entitled to do so.35 In the context of gender affirming therapy for children, some providers have stated that their personal conscience and the principles of medical ethics require them to provide these services, even in states where such medical care is criminalized.36 In the context of end of life care, state laws typically require doctors to comply with the requests of patients or surrogates to withdraw life-sustaining treatment.37 However, in some situations providers may object to withdrawing care that maintains a patient’s life, calling on their own personal or religious beliefs as justification.38 In contrast, other providers express moral distress when patients or their agents request aggressive end-of-life interventions that are not medically beneficial.39

35. See infra Part III.B.
36. Landon D. Hughes, et.al., “These Laws Will Be Devastating”: Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents, 69 J. ADOLESCENT HEALTH 976–82 (2021) (discussing providers who feel that this legislation impacts their oath “to do no harm” and who argue that it would criminalize evidence-based medicine).
37. Pope, supra note 33, at 8 (“Patients and surrogates decide whether LSMT is beneficial given their own values and particular circumstances. Health care providers must generally comply with decisions to refuse LSMT,”).
38. Stephen Wear, Susan Lagaipa & Gerald Logue, Toleration of Moral Diversity and the Conscientious Refusal by Physicians to Withdraw Life-Sustaining Treatment, 19 J. MED. & PHIL. 147 (1994) (noting that physicians’ moral beliefs may lead them to respond slowly to requests for withdrawal of treatment); Sharon Reynolds, Andrew B. Cooper & Martin McKneally, Withdrawing Life-Sustaining Treatment: Ethical Considerations, 87 SURG. CLIN. N. AM. 919, 921 (2007) (summarizing research about the link between providers’ religious beliefs and their disinclination to withdraw life-sustaining treatment); Anna M. Cugliari & Tracy E. Miller, Moral and Religious Objections by Hospitals to Withholding and Withdrawing Life-Sustaining Treatment, 19 J. OF CMTY HEALTH 87–100 (1994) (finding that 29% of surveyed New York hospitals would object to withdrawal of life-sustaining treatment on grounds of conscience in at least some contexts).
39. Nancy S. Jecker, Doing What We Shouldn’t: Medical Futility and Moral Distress, 17 AM. J. BIOETHICS 41 (2017) (describing provider moral distress when the “rule of
3. Laws Implicating Conscience

Discussions of conscience in medicine generally focus on health care providers who, based on conscientious beliefs, object to participating in certain medical procedures. Abortion is obviously the most common example; provision of contraception is another. But when considering state laws that govern the practice of medicine—whether general licensing laws, the common law of medical malpractice, or more specific legislative directives in the context of controversial medical services—it is relatively rare to find laws that affirmatively and unequivocally require a health care provider to deliver a specific service. Most often, these laws prohibit certain types of action—for example prohibition on abortions after the third trimester, on physician aid in dying, on excessive prescription of opioids, or gender affirming therapy. In those situations, doctors who conscientiously object to these laws are raising positive rights of conscience—that is, the affirmative right to provide services that the law otherwise prohibits.40

It is much rarer to find situations where doctors are compelled by law to engage in an action that they wish to refuse for reasons of conscience. The most prominent example is in the context of state laws that require doctors providing abortion services to make specific informed consent disclosures to patients, regardless of whether the doctor thinks those disclosures are medically appropriate. In South Dakota, for example, a state law requires physicians to tell patients that the abortion will “terminate the life of a whole, separate, unique, living human being.”41 Laws in

rescue” conflicts with professional obligations); Manisha Mills & DonnaMaria E. Cortezzo, *Moral Distress in the Neonatal Intensive Care Unit: What it is, Why it Happens, and How We Can Address It*, 8 FRONT. PEDIATR. 1, 2 (2020) (describing nurses’ moral distress as being rooted in “paternalistic approaches to medicine where nurses were instructed by physicians to provide care they did not always feel was appropriate”); Elizabeth Dzeng et al, *Moral Distress Amongst American Physician Trainees Regarding Futile Treatments at the End of Life: A Qualitative Study*, 31 J. GEN INTERN. MED. 93 (2016) (finding, based on qualitative interviews, that physician trainees “experienced significant moral distress when they felt obligated to provide treatments at or near the end of life that they believed to be futile”).


Oklahoma and other states prohibit a medical provider from performing an abortion unless she has first performed an ultrasound, “display[ed] the ultra-sound images so that the pregnant woman may view them,” and provided a verbal description of that image. Other states require doctors to disclose information that is medically and scientifically inaccurate: for example, that there is a causal relationship between abortion and breast cancer, or abortion and suicide. In such situations, a doctor’s conscience may motivate them to refuse to comply with the state law requirements.

However, in most cases of conscientious refusal, such as conscientious objection to abortion or emergency contraception, providers are not objecting to concrete legal requirements that they deliver specific services to specific patients. More commonly, provider objections arise in the context of laws that merely require doctors to comply with the standard of care (which is a vague and context-dependent standard), or that prohibit doctors from engaging in services that state legislators believe are inappropriate. And as described in Part II-B-1, health care providers are generally free to limit the scope of their practice and likewise limit the medical services they are willing to provide.

III. CONSCIENCE LAWS

The core theme of this Symposium is the ethical conflict that arises when a health care provider’s conscientious beliefs conflict with expectations about appropriate medical practice. These expectations may be set by patients, by the public, by state medical boards under their medical practice regulations (including “being” and “relationship” disclosures) and 686 F.3d 889 (8th Cir. 2012) (upholding constitutionality of “suicide” disclosure).

42. OKLA. STAT. TIT. 63, § 1-738.3d(B) (enforcement temporarily enjoined since May 2010, Nova Health Systems v. Pruitt, 292 P.3d 28 (2012)); Parenthood v. Rounds, 686 F.3d 889 (8th Cir. 2012) (upholding constitutionality of “suicide” disclosure); Guttmacher Institute, Requirements for Ultrasound (Dec. 1, 2022), available at https://www.guttmacher.org/state-policy/explore/requirements-ultrasound [https://perma.cc/8LBR-GAVK] (identifying 27 states that regulate the provision of ultrasound by abortion providers, including six that “mandate that an abortion provider perform an ultrasound on each person seeking an abortion and require the provider to show and describe the image”).

acts, and sometimes by state statutes and common law to the extent that define the standard of care in particular contexts. However, as explained above, it is quite rare for state or federal law to affirmatively require health care providers to deliver services that they might oppose on grounds of conscience.

This Section will focus primarily on laws granting rights of conscientious refusal in the context of abortion, which are the most common types of health care conscience laws in the United States.

A. Federal Law

Shortly after the Supreme Court’s decision in Roe v. Wade,44 Congress passed a federal health care conscience law that is still in place today. The 1973 Church Amendment protects hospitals and health care providers from discrimination if they refuse to participate in abortion or sterilization.45 More precisely, it prohibits public actors from requiring recipients of federal funding, including most hospitals, from requiring personnel “to perform or assist in” sterilization or abortion if it “would be contrary to [their] religious beliefs or moral conviction,”46 or requiring entities to make their facilities available for such procedures if “it is prohibited by the entity on the basis of religious belief or moral convictions.”47 It imposes similar restrictions on medical schools and residency programs.48

Since the passage of the Church Amendment, many additional protections for conscientious objection to abortion have been codified in federal law. The 1978 Danforth Amendment prohibits state and local governments from discriminating against health care providers (including medical schools and residency programs) that refuse to provide abortion-related services for any reason.49 The Coats-Snowe Amendment to the Public Health Service Act, passed in 1996, prohibits government actors from discriminating against health care entities that refuse to provide training in the performance of abortions, as well as individuals who refuse such training.50 The 2004 Weldon Amendment is an annually-renewed appropriations bill that prohibits federal funding to programs, agencies, or state or local governments that

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45 42 U.S.C. § 300a-7. The Church Amendment is one of the few conscience laws that also protects providers who affirmatively choose to provide abortions.
46 42 U.S.C. § 300a-7(b).
47 Id.
48 42 U.S.C. § 300a-7(d) & (e).
50 42 U.S.C. § 238n.
discriminate against health care entities that refuse to participate in abortion.\textsuperscript{51} Finally, the 2010 Patient Protection and Affordable Care Act prohibits insurance plans that are offered on public exchanges from discriminating against facilities or providers that do not provide abortions.\textsuperscript{52}

1. Enforcement

The Office of Civil Rights of the Department of Health and Human Services is responsible for enforcement of federal conscience laws. Those who violate these laws risk termination of federal funding and additional enforcement action by the Department of Justice. Recent regulatory changes by the Trump administration would have further strengthened OCR’s authority, but these have since been rejected in court.

In 2019, HHS issued a final rule on “Protecting Statutory Conscience Rights in Heath Care,” which (among other provisions) consolidates OCR’s enforcement authority and requires all recipients of federal funding to certify their compliance with federal conscience laws.\textsuperscript{53} Under the new rule, OCR’s authority would no longer be limited to responding to complaints—the rule also authorized OCR to engage in outreach, compliance assurance, and independent investigation of potential breaches. Moreover, the new rule defined terms like “health care entity,” “referral,” and “discrimination” very broadly,\textsuperscript{54} expanding the reach of the conscience laws’ scope. Shortly after its issuance, three federal courts vacated the new HHS rule in its entirety, finding that it violated the Administrative Procedures Act, exceeded HHS’s rulemaking authority, and was arbitrary and capricious.\textsuperscript{55} The extent to which HHS OCR will be active in responding to complaints about violation of federal conscience laws is currently unclear.

\textsuperscript{51} Consolidated Appropriations Act, Pub. L. No. 108–447, Dec. 8, 2004, 118 Stat 2809. The Weldon Amendment provides an exception for abortions that are life-saving, and in cases of pregnancy by rape or incest.
\textsuperscript{52} 42 U.S.C. § 18023(b)(4).
\textsuperscript{53} 45 CFR § 88.1.
\textsuperscript{54} 45 CFR § 88.2.
2. And EMTALA

The most current conscience-related conflict at the federal level is an ongoing legal dispute about recent HHS guidance relating to the impact of the Dobbs decision on EMTALA. Issued on July 11, 2022, just a few weeks after Dobbs was decided, the Department of Health and Human Services released an important clarification regarding abortion care in the context of the Emergency Medical Treatment and Active Labor Act (EMTALA). The notice that HHS issued to providers emphasized that EMTALA applies to all emergency medical conditions, including emergencies that are pregnancy-related—for example, ectopic pregnancy, complications related to pregnancy loss, and severe preeclampsia. Under EMTALA, if a pregnant patient is experiencing an emergency medical condition, hospitals are required to provide appropriate stabilizing treatment. And in some cases, like the conditions described above, appropriate stabilizing treatment may include pregnancy termination or uterine evacuation. Simply put, even in states that prohibit abortion, hospitals and on-call emergency physicians may be required to perform abortion if a pregnant patient presents with an emergency where termination of pregnancy is the only appropriate way to stabilize their condition. Hospitals and physicians who violate these requirements may be required to pay civil monetary penalties and risk exclusion from the Medicare program; hospitals may also be liable in civil suits by patients injured as a result of EMTALA violations.

58. HHS July 11 Letter, supra note 57; CMS July 11 Memo, supra note 57; Lori R. Freedman et al., When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals, 98 AM. J. PUB. HEALTH 1774, 1775 (2008) (describing generally accepted standards of care for miscarriage management); Alexandros Sotiriadis, Expectant, Medical, or Surgical Management of First-Trimester Miscarriage: A Meta-Analysis, 1005 OBSTET. & GYN. 1104 (2005) (finding higher success rates when managing miscarriage surgically or medically as compared to expectant management).
The HHS letter, and associated guidance issued by the Centers for Medicare and Medicaid Services, makes clear that the federal EMTALA mandate preempts any state laws prohibiting abortion, including laws that define “emergency medical condition” more narrowly than EMTALA. While the HHS guidance does not specifically mention state conscience laws, EMTALA’s preemptive effects would likewise negate laws that permit individual and institutional providers to conscientiously object to the provision of abortion in emergency circumstances.

Notably, this is not the first time that policymakers have addressed the tension between EMTALA and state and federal laws that protect refusal to provide abortion. The 2010 Patient Protection and Affordable Care Act, for example, established that states and health insurers could freely choose whether or not to prohibit abortion coverage under the Act, and that no changes would be made to federal conscience laws; however, it specified that “Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law,” including EMTALA. In 2008, a federal court suggested that conscience laws protecting refusing providers from discrimination would not bar the enforcement of EMTALA emergency treatment requirements. This position has also been taken by private litigants in cases challenging hospital policies that prohibit abortion, though without substantive disposition. In a 2016 Michigan case, plaintiffs brought suit against a Catholic hospital chain, alleging that they “repeatedly and systematically failed to provide women suffering pregnancy complications . . . with the emergency care

60. HHS July 11 Letter, supra note 57; CMS July 11 Memo, supra note 57.
61. The HHS Letter does, however, state that “EMTALA’s preemption of state law could . . . be enforced by individual physicians . . . as a defense to a state enforcement action, in a federal suit seeking to enjoin threatened enforcement, or, when a physician has been disciplined for refusing to transfer an individual who had not received the stabilizing care the physician determined was appropriate, under the statute’s retaliation provision.” HHS July 11 Letter, supra note 57.
63. See 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 and 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”).
required by EMTALA and the Rehabilitation Act." The suit was dismissed on the grounds plaintiffs lacked standing, because the court found that the injuries they alleged were too vague. At present, there are at least two pending lawsuits relating to this interpretation of EMTALA. In July 2022, the state attorney general of Texas filed a direct challenge to the HHS guidance, arguing that EMTALA “does not authorize . . . the federal government to compel healthcare providers to perform abortions.” The U.S. District Court for the Northern District of Texas granted Texas’ motion for preliminary injunction and the U.S. Court of Appeals for the Fifth Circuit affirmed in January 2024. In a second case, the U.S. Department of Justice successfully challenged Idaho’s near-total abortion ban on the grounds that the state’s limited exceptions in cases of emergency are narrower than EMTALA’s definition of “emergency medical condition.” Less than a month after the complaint was filed, the U.S. District Court for the District of Idaho granted the U.S.’s motion for preliminary injunction, finding that the U.S. was likely to succeed on the merits of its claim. The District Court’s order was stayed by a three-judge panel of the Ninth Circuit, but was reinstated after en banc review. In January 2024, the United States Supreme Court granted certiorari in U.S. v. Idaho, staying the District Court’s injunction prohibiting enforcement of the Idaho ban. The court’s decision in this case will hopefully resolve the uncertainty in Idaho, Texas, and beyond. The case was argued on April 24, 2024.

B. State Law

While federal conscience protections are important, state conscience laws arguably have a greater day-to-day impact on healthcare providers and patients. Recall that the regulation of medical practice is governed primarily at the state level; conscience laws that delineate the circumstances in which providers can refuse abortions are part of this broader regulatory structure. A comprehensive study of an original dataset of state conscience

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70. United States v. Idaho, 83 F. 4th 1130 (9th Cir. 2024).
71. 82 F. 4th 1296 (9th Cir. 2024).
72. 149 St. Ct. 541 (U.S. Jan. 5, 2024).
laws in place as of Dec. 31, 2019 identified forty-six states with conscience laws that explicitly protect refusal to participate in abortion. One additional state, Mississippi, also protects those who might refuse to participate in abortion, albeit via a much broader law that protects conscientious refusal relating to any “health care service” without specifically referencing abortion.

Since 2019, Arkansas and South Carolina have passed comprehensive conscience laws similar to Mississippi’s, establishing a right to refuse participation in any health care service. Several states that had abortion laws in place as of Dec. 31, 2019 identified forty-six states with conscience laws that explicitly protect refusal to participate in abortion. One additional state, Mississippi, also protects those who might refuse to participate in abortion, albeit via a much broader law that protects conscientious refusal relating to any “health care service” without specifically referencing abortion.

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medical procedure or . . . medication to which such person or entity objects on the basis of conscience, whether such conscience is informed by religious, moral, or ethical beliefs or principles”).

78. See e.g., 2021 ILL. H. B. NO. 3046, ILL. ONE HUNDRED SECOND GEN. ASS. - FIRST REG. SESS., introduced Feb. 19, 2021 (repealing the Reproductive Health Act, and establishing independent conscience protections for physicians, hospitals, ambulatory surgical centers, and their employees who decline to provide abortions); 2021 IOWA H. FILE NO. 170, IOWA EIGHTY-NINTH GEN. ASS. - 2021 SESS., introduced Jan. 22, 2021 (prohibiting the government from taking “any discriminatory or adverse action” against a person who declines to participate in “medical procedure[s] which will result in an abortion . . . based upon . . . a sincerely held religious belief or moral conviction”).

79. Ark. Code Ann. § 20-16-2411), eff. July 28, 2021 (establishing, as part of the Every Moms Matter Act, that the Department of Health cannot require agents or agencies participating in the Life Choices Lifeline Program to “to refer a woman for any social or medical service to which the care agent or agency has a conscience objection;” note, however, that the Life Choices Lifeline Program, which is aimed at supporting childbirth as an alternative to abortion, also prohibits the Department of Health from contracting with subcontractors who are “abortion provider[s] or entit[ies] that directly or indirectly assist[] women in obtaining an abortion” or that employ any persons who have performed an abortion in the last two years, per Ark. Code Ann. § 20-16-2405); Ind. Code Ann. § 16-34-1-4, amended July 1, 2021 by 2021 Ind. Legis. Serv. P.L. 218 (expanding conscience protections to include the right not to “provide advice or counsel to a pregnant woman concerning medical procedures resulting in, or intended to result in, an abortion” as well as the right not to “handle or dispose of aborted remains” if that individual objects on ethical, moral, or religious grounds).

80. 2021 New Hampshire House Bill No. 1080, New Hampshire Second Year of the One Hundred Sixty-Seventh Session of the General Court, introduced Jan. 5, 2022 (granting health care providers the right to conscientiously object to participating in providing abortion, sterilization, or contraception); 2021 Vermont House Bill No. 497, Vermont 2021-2022 Legislative Session, Introduced Jan. 2, 2022 (granting health care providers and institutions a right to decline participation in “health care services that violate their consciences,” including but not limited to “abortion, artificial birth control, sterilization, artificial insemination, assisted reproduction, human embryonic stem-cell research, fetal experimentation, human cloning, physician-assisted suicide, and euthanasia”).

81. Sawicki, The Conscience Defense to Malpractice, supra note 44, at 1264 (citing literature on the varied contexts in which refusals occur), and 1273–74 (identifying other reproduction-related conscience laws). For recent proposed legislation expanding the scope of services protected, see 2021 IOWA H. FILE NO. 170, IOWA EIGHTY-NINTH GEN. ASS. - 2021 SESSION, introduced Jan. 22, 2021 (addressing conscientious refusal to participation
Arkansas, and South Carolina, state laws may protect those who conscientiously refuse to provide any health care service.

Second, many states extend their conscience protections beyond the physicians who are directly responsible for performing abortions. Laws may protect a broader swath of health care professionals, or they may refer to protections for “any person” who refuses to participate or assist in abortion.82 The language of these statutes can be read broadly to protect not just direct provision of abortion, but also more tangential forms of involvement that might be viewed as complicity in an immoral act.83 Examples include providing referrals, transferring prescriptions, providing transportation, providing translation services, or even providing janitorial services in a room where an abortion patient is being treated. Relatedly, many state conscience laws also protect health care institutions, like hospitals, that refuse to provide abortions.84 These institutional protections obviously have a much greater impact on patient access, particularly in geographic areas where patients do not have a choice of hospitals or providers.

State conscience laws typically operate by identifying the consequences that a refusing provider will be relieved from if they exercise their right of conscientious refusal. For example, a state law may establish that a refusing provider will be free from civil liability, criminal prosecution, employment discrimination, professional discipline, or loss of funding.85 In the 2019 study, I identified the scope of these various protections, focusing in particular on immunity from civil liability.86 Immunity from


82. Sawicki, The Conscience Defense to Malpractice, supra note 44, at 1277–78

83. Kent Greenawalt, Refusals of Conscience: What are They and When Should They Be Accommodated?, 9 AVE MARIA L. REV. 47, 57, 60–61 (2010) (identifying examples of remote involvement in abortion, 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”); Daniel P. Sulmasy, What is Conscience and Why is Respect for it so Important?, 29 THEOR. MED. & BIOETHICS 135, 142, at 140–42 (2008) (analyzing moral complicity in cases of “indirect[] facilitat[ion] [of] wrongdoing”).

84. Sawicki, The Conscience Defense to Malpractice, supra note 44, at 1277–78; Sepper, supra note 40, at 1513–14. For further discussion of issues relating to institutional conscience, see Sepper, supra note 40, at 1539–53; Sulmasy, supra note 80, at 142–44.

85. Sawicki, The Conscience Defense to Malpractice, supra note 44, at 1274–75

86. Id.
civil liability was the most common procedural protection that state laws provided; 37 of the 46 states that protected abortion refusal explicitly established civil immunity for refusing providers.\textsuperscript{87} In these states, if a healthcare provider’s refusal to perform an abortion violates the medical standard of care and causes patient harm—as might be the case, for example, in cases of ectopic pregnancy or miscarriage management—patients would have no right to receive compensation for their injuries. These laws effectively establish a “conscience defense to malpractice.”

Finally, state conscience laws may impose patient protective-limitations on providers’ exercise of conscience. For example, states may require that providers satisfy certain conditions before exercising the right of refusal. These may include disclosure of information regarding access to abortion, providing a referral to an alternative provider, informing the patient of the refusal, or informing the employer of the refusal.\textsuperscript{88} Some statutes also set limitations on the contexts in which the right of refusal can be exercised, such as prohibiting the exercise of conscience rights in medical emergencies. However, these limitations and conditions are not common—as of 2019, 26 of the 46 states with abortion refusal laws had no patient-protective limitations or conditions on the right of refusal.\textsuperscript{89} For example, only 13 states limited the right of refusal in emergencies;\textsuperscript{90} today, that number is 15.\textsuperscript{91}

As demonstrated in Part IV, the scope of these state conscience protections will become even more important in the post-\textit{Dobbs} era.

\section*{IV. CONSCIENCE LAW POST-\textit{DOBBS}}

The Supreme Court’s overturning of \textit{Roe v. Wade} has shifted decisions about whether to permit or prohibit abortions to state legislators.\textsuperscript{92} The Supreme Court concluded that because there is no fundamental constitutional right to choose an abortion, the matter is appropriately left to the states.\textsuperscript{93}

According to recent media reports, states are taking a variety of approaches to regulating abortion. Some are establishing themselves as safe havens for providers and patients seeking abortion.\textsuperscript{94} Others acted immediately

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87. Id. \\
88. Id. at 1278–79, 1281–82. \\
89. Id. at 1278–79. \\
90. Id. at 1280-81, 1283. \\
91. The two comprehensive conscientious refusal laws that were passed in Arkansas and South Carolina since 2019 both contain exceptions for emergency care as defined by EMTALA. Ark. Code Ann. § 17-80-504(d); S.C. Code Ann. § 44-139-30(E). \\
93. Id. \\
\end{footnotesize}
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after Dobbs to pass legislation prohibiting abortion under most circumstances, or to enforce trigger laws intended to take effect upon the reversal of Roe v. Wade.\textsuperscript{95} However, many states controlled by Republican legislatures are still struggling to decide how to resolve this challenging issue. In Indiana, for example, senators who had campaigned as pro-life advocates are grappling with the question of how to translate their deeply-held opposition to abortion into real-world policies. As a recent New York Times columnist wrote, “Republicans weighing the issue today are not governing in hypotheticals. They are contending with thorny questions about exceptions, nuanced disagreements within their own party, and mixed public opinion[].”\textsuperscript{96} For policymakers, affirming a fundamental opposition to abortion is much simpler than having to make concrete decisions about whether, for example, abortion should be prohibited even in cases of rape or incest, or in situations where a pregnant patient’s life is at risk.

Thus, it is critically important to consider the future of conscience laws post-Dobbs. When states enact legislation restricting abortion, those restrictions are very much in the public eye, and legislators will immediately face questions about the choices that they have made. However, another way that state legislatures can impact access to abortion is by modifying existing conscience laws that impact access to abortion meaningfully, though somewhat more indirectly. Notably, these changes may be less likely to draw public attention than direct abortion restrictions. While the future of abortion law across the United States is still uncertain, this Article offers some preliminary predictions on the likely impact of Dobbs on state conscience laws.


A. States With Complete Prohibitions

In states that choose to prohibit all abortions and that impose criminal, civil, or administrative penalties on health care providers who participate in abortion, existing conscience laws will effectively become redundant. If performing abortion is a criminal act under state law, then it is unrealistic to imagine that an employer, a state medical licensing board, or an injured patient would be legally permitted to take adverse action against a doctor on the grounds that they refused to perform an abortion. In fact, absolute abortion prohibitions would have the opposite effect. State medical boards, for example, would be obligated to discipline doctors who perform this now-criminal act. Patients would have no right to recourse if they were injured by a doctor’s failure to perform an abortion when that procedure was prohibited by law.

In these states, providers and hospitals that hold conscientious objections to abortion will not need to advocate for any changes to state conscience laws. State conscience laws will become unnecessary given the complete prohibition on abortion. In contrast, reproductive rights advocates who want to protect patient access will need to challenge the abortion bans themselves.

B. States That Retain Legality of Abortion Under Some Circumstances

In states that permit abortion only under certain circumstances, however, conscience laws will still be essential for providers and hospitals who oppose the procedure.

In conservative states that prohibit most, but not all, abortions, conscience laws will still be important to providers who choose not to participate in abortion in the narrow contexts in which it is permitted. For example, a state might permit abortion only prior to 6 weeks of pregnancy. In that state, a doctor who is unwilling to prescribe medication for abortion in the earliest stages of pregnancy might need to rely on state conscience law to be protected from adverse employment action or other negative consequences. If a state prohibits all abortions except in the case of rape or incest, a doctor or hospital who refuses to perform an abortion in such cases will be protected under the state’s conscience law.

In contrast, some states controlled by Democratic governors and legislatures have established themselves as safe havens for abortion, protecting patients’ right to access abortion in most circumstances. Because abortion

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is more freely available in these states, refusing providers may more often find themselves in circumstances where they have to decline a patient’s request. Thus, they will be even more reliant on conscience protections than providers in conservative states.

How, then, are conscience laws likely to develop in states where abortion is legal in at least some circumstances? In conservative states that limit access to most abortions, refusing providers will likely petition legislators to expand conscience rights, and given the political orientation of these states, it is likely that those proposed expansions will be successful. Pro-choice advocates, in contrast, will try to limit the scope of the state’s conscience laws. The same situation will lie in progressive states that offer greater protections for patients seeking abortions—anti-choice advocates will seek to expand conscience laws, and pro-choice advocates will seek to limit them—though in these states, the pro-choice advocates are more likely to succeed. That said, even in jurisdictions that are most favorable towards abortion, it is quite unlikely that conscience laws will be repealed entirely because of the likelihood of significant backlash, particularly by religiously-affiliated hospitals. A more likely outcome is that advocates in states that are favorable to abortion will petition state legislators to amend conscience laws in ways that provide greater protections for patients.

Below, I describe four categories where legislatures have the flexibility to either expand or limit the scope of conscience protections for refusing providers depending on their political orientation.98

1. Scope of Providers and Actions Protected

One option for legislative change is to reconsider the scope of providers who are protected when they refuse to participate in abortion. While the 2019 analysis of abortion conscience laws focused exclusively on actors who were protected from civil liability to injured patients—as compared to employment protections, protection from criminal sanction, or discipline by medical boards—there was significant overlap among all these protections. For example, if a state protected doctors from civil liability for refusing to perform abortion, it almost certainly protected them from employment

98. Certainly, another approach that states could take is to adopt positive conscience protections for health care providers whose beliefs motivate them to serve patients seeking abortions. Lisa H. Harris, Recognizing Conscience in Abortion Provision, 367 NEJM 98, 983 (2012) (arguing that legal recognition of only negative conscience rights “renders ‘conscience’ an empty concept”).

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discrimination. The study concluded that almost all of the 37 states that provide protections from civil liability grant it to a broad swath of individuals, including persons who are not medical providers; and to a range of health care institutions.  

Supporters of conscience rights will likely review the laws in their states carefully to ensure that the broadest scope of providers is protected—not just physicians, but all health care providers. These protections may also be extended beyond health care providers, to all persons who might be involved in actions related to abortion—including medical translators, janitorial staff, or transportation personnel. Abortion opponents will also likely seek out additional protections for hospitals and other health care institutions. For example, some states with restrictive abortion laws already have laws in place that protect hospitals’ right to refuse abortion; however, these laws may not explicitly identify the types of adverse consequences refusing hospitals are protected from, or may identify only limited types of legal protections. In such cases, conscience advocates may wish to amend their laws to enumerate and expand the specific legal protections hospitals are granted.

In contrast, reproductive rights advocates will wish to limit the scope of individuals and entities entitled to conscience protections, and in democratic-controlled states, they have a chance of succeeding. For example, a state legislature might choose to limit conscience protections to only those health care providers who actually perform abortions, and not persons that have more tangential involvement. Limiting hospital protections is also a possibility. While it is unlikely that even progressive states will eliminate conscience protections for religiously affiliated hospitals, they may move to eliminate these protections for secular and public hospitals to ensure access to abortion without infringing on religious freedom.

A related area where legislative movement is likely is in the types of actions that are protected by conscience laws; these could be expanded or limited based on a state’s political orientation. Existing conscience laws typically provide broad protections to those who refuse to “perform,” “participate,” or “assist in” medical procedures resulting in abortion—but the degree to which these terms are defined varies from state to state. To cite just one example of specific identification of protected conduct, a recent

100. Id. at 1275 (describing states that establish a right to refuse but do not identify specific procedural protections).
101. See, e.g., 2022 Arizona Senate Bill No. 1622, Arizona Fifty-Fifth Legislature - Second Regular Session, Introduced Feb. 1, 2022 (excluding pharmacies from the scope of providers granted a right to conscientiously refuse to provide medication abortion or emergency contraception).
amendment to Indiana law expanded the scope of conscience protections to those who refuse on ethical, moral, or religious grounds to “handle or dispose of aborted remains,” which would include janitorial staff. And even when conscience laws themselves do not clearly define protected conduct, definitions in state abortion prohibitions may be instructive. Consider Texas’ SB8, which permits anyone to bring a civil cause of action against anyone who “knowingly engages in conduct that aids or abets the performance or inducement of abortion.” Commentators have pointed out that this language is so vague that it could be interpreted to impose liability on “friends, relatives or strangers who pay for an abortion, including people who donate to or administer abortion funds; insurers that approve a claim; ride-share drivers who drive a patient to a clinic; and anyone who shares information about abortion options.” If this definition were applied to outline the scope of permissible conscientious objections, it would be similarly broad—allowing, for example, a ride-share driver to refuse to transport a patient to an abortion clinic.

2. Health and Safety Exceptions

The area where legislative change to conscience laws is most likely relates to health and safety exceptions. As noted in Part III-B, above, of the forty-six states with abortion refusal laws as of 2019, only thirteen limit the right of conscientious refusal in cases of emergency, and only six limit refusal rights in cases of miscarriage or ectopic pregnancy. HHS’s recent guidance on the application of EMTALA post-Dobbs, described in Part II-A-2, makes clear that pregnancy-related emergencies must be appropriately stabilized, even if the stabilizing treatment violates state prohibitions on termination of pregnancy. Assuming the guidance is upheld and enforced, this means that even if a state conscience law does not explicitly authorize exceptions for such circumstances, medical personnel may be able to refuse to assist with treatments that may violate abortion prohibitions.

105. Sawicki, The Conscience Defense to Malpractice, supra note 44, 1282–83. Since that time, two states have adopted comprehensive conscience laws applicable to all medical services, and these laws do contain exceptions for circumstances in which emergency treatment is required by EMTALA. Ark. Code Ann. § 17-80-504(d); S.C. Code Ann. § 44-139-30(E).
not currently contain an emergency exception, the preemptive effects of EMTALA imply such an exception.

Here, there is significant potential for movement in progressive states that want to ensure freedom of access to abortion. Legislators in such states may seek to amend existing conscience laws to limit providers’ refusal rights in cases of medical necessity that may not rise to the level of a medical emergency. Certainly, EMTALA’s statutory definition of “emergency medical condition” leaves some room for interpretation by the medical personnel responsible for screening the patient and determining whether an emergency medical condition exists. For example, the definition refers to “serious” jeopardy to health, “serious impairment to bodily functions,” and “serious dysfunction” of the body. Because these phrases are undefined and could be subject to different interpretations, states could supplement EMTALA’s protections by defining “emergency” more broadly. States could also limit refusal rights in cases of medical necessity that don’t rise to the level of emergent care, which would ensure abortion access to patients whose pregnancies pose future health threats, as well as patients who require health care treatment that may pose risks to the fetus.

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106. The HHS Letter states that “the determination of an emergency medical condition is the responsibility of the examining physician or other qualified medical personnel.” HHS July 11 Letter.

107. 42 U.S.C.A. § 1395dd(e)(1).

108. For example, religiously-affiliated hospitals that comply with the U.S. Conference of Catholic Bishops’ Ethical and Religious Directives for Catholic Health Care Services maintain very strict standards for emergency intervention. The only circumstance in which the Directives permit providers to undertake treatment causing the death of a fetus is where fetal demise is the unintended but foreseeable consequence of treatments “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.” Directive 47, U.S CONFERENCE OF CATHOLIC BISHOPS, ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE, https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf [https://perma.cc/KG2H-6BN8]. In cases of miscarriage management, research suggests that Catholic hospitals sometimes wait until a patient is close to death before intervening, rather than evacuating the uterus when the patient initially presents with complications. Lori R. Freedman & Debra B. Stulberg, Conflicts in Care for Obstetric Complications in Catholic Hospitals, 4 AM. J. BIOETHICS 1 (2013); Lori R. Freedman et al., When There’s a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals, 98 AM. J. PUB. HEALTH 1774 (2008).

109. Freedman and Stulberg, supra note 105, at 5 (citing a treatise on obstetrics regarding risks during pregnancy).

110. This may be the case with cancer treatment, addiction medicine, or even anesthesia for routine medical procedures. See A. Hepner et al., Cancer During Pregnancy: The Oncologist Overview, 10 WORLD J. OF ONCOLOGY 28 (2019) (discussing the risks posed by cancer treatment during pregnancy); V. Monnelly, Prenatal Methadone Exposure is Associated With Altered Neonatal Brain Development, 18 NEUROIMAGE: CLINICAL 9 (2018) (describing neurodevelopmental risks associated with prenatal methadone exposure); X. Li et al.,
Democratic-controlled states, such changes might not be difficult to advocate for as a natural extension of the concept HHS promoted in its EMTALA guidance—that providers should not have the freedom to refuse treatment when such treatment is a matter of serious medical necessity.

Another way state conscience laws could protect patient safety even further is by eliminating conscience protections when the treatment being refused is required by the standard of care. Only Maryland currently limits its abortion refusal law in this way. Notably, legislation has recently been proposed in Kentucky that would limit rights of refusal where “the decision of the healthcare provider violates the standard of care required of that provider.”

Conscience advocates in conservative states, however, do not have much opportunity for change here. If state legislation already includes an emergency exception, eliminating it will not have any practical impact because emergencies are already protected under EMTALA. Likewise, if the state conscience law does not currently have an emergency exception, EMTALA’s preemptive effects mean that providers who refuse abortion in emergencies will not be protected, regardless of state law.

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Effects of Pregnancy Anesthesia on Fetal Nervous System, 11 FRONTIERS IN PHARMACOLOGY 1 (2021) (discussing risks of adverse effects on fetal neurodevelopment resulting from general anesthesia).

111. See generally, Nadia N. Sawicki, Unilateral Burdens and Third-Party Harms: Abortion Conscience Laws as Policy Outliers, 96 Ind. L.J. 1221 (2021) (arguing that conscience laws that protect refusals even when those refusals violate the standard of care and cause patient harm are outliers in the realm of U.S. anti-discrimination law); Nadia N. Sawicki, Disentangling Conscience Protections, 48 HASTINGS CTR. REP. 14, 19 (2018) (arguing that state laws should not limit patients’ remedies when a health care provider’s conscience-driven refusal violates the standard of care and causes injury); Ben. A. Rich, Your Morality, My Mortality: Conscientious Objection and the Standard of Care, 24 CAMBRIDGE Q. HEALTH CARE ETHICS 214 (2015) (arguing that health care providers who depart from the standard of care should be subject to civil liability and administrative sanctions).

112. MD. CODE ANN. HEALTH-GEN. § 20-214(d) (limiting the right of conscientious refusal 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”).

113. 2022 Ky. H. B. No. 570, Ky. 2022 REG. SESS., introduced Feb. 23, 2022. This progressive development is surprising, since Kentucky’s restrictive abortion laws ban the procedure except in cases of rape or incest.
3. Other Patient-Protective Conditions on the Exercise of Conscience

Although few state conscience laws include patient-protective conditions on the exercise of conscience, various gatekeeping possibilities could be put in place to protect patient access even in situations where providers have a right to refuse. Two potential limitations will likely have the greatest impact. First, refusing providers might be required to give pregnant patients complete and accurate information about all medically accepted options available to them, including abortion.114 This would be particularly important in situations where patients have health conditions that might be aggravated by pregnancy but who are not aware that abortion would be a medically appropriate option. Second, states might require refusing providers to either refer patients to doctors or facilities willing to perform abortions, or provide general information about how to access abortion services by sharing a website or hotline number.115 As a final option—though this would not have a significant impact on patient access to treatment, referral, or medical information—states could require that refusing providers and institutions disclose their conscientious objections to patients before entering into the treatment relationship.116 This would, at the very least, allow patients to understand that abortion is excluded from a provider’s scope of practice so that they can seek treatment elsewhere.

Accordingly, Democratic states that wish to affirmatively protect abortion may move to expand information and referral requirements in their conscience laws.117 However, whether these conditions are expanded more broadly across the United States will almost certainly depend on the political orientation of the state. Historically, states have been hesitant to impose referral requirements because of arguments that requiring a refusing doctor to provide a referral makes them morally complicit in the abortion.118

On the other hand, a large body of guidance in the field of medical ethics

114. As of 2019, disclosure of such information was only required in one state. 745 ILL. COMP. STAT. 70/6 and 6.1(1) (requiring refusing providers to “inform a patient of the patient’s 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”).

115. As of 2019, only two states conditioned conscientious refusal to provide abortion on referring the patient to another provider (at least in some circumstances). 745 ILL. COMP. STAT. 70/6(2) and (3); GA. CODE ANN. § 16-12-142(b). Two conditioned refusal on providing more general information regarding access to abortion services. 745 ILL. COMP. STAT. 70/6.1(3); N.Y. COMP. CODES R. & REGS. TIT. 10, § 405.9(b)(10).


117. See, e.g., 2022 Md. H. B. NO. 50, Md. 444TH Sess. of the Gen. Ass., 2022, introduced Jan. 12, 2022 (requiring hospitals to either authorize the provision of artificial insemination, sterilization, or termination of pregnancy, or to refer patients to another source for these procedures; no change existing rights of conscientious refusal for individuals).

118. See references at supra note 80.
suggest that refusing physicians may have an ethical obligation to provide information and/or referrals to patients seeking abortion. The American College of Obstetricians and Gynecologists’ Committee on Ethics, in a formal opinion titled *The Limits of Conscientious Refusal in Reproductive Medicine*, concludes that health care providers who refuse to provide “complete, scientifically accurate information about options for reproductive health, including contraception, sterilization, and abortion . . . fail in their fundamental duty to enable patients to make decisions for themselves.”

And while the Committee recognizes legitimate “concerns about complicity in the context of referral to another provider,” it nevertheless concludes that physicians “have the duty to refer patients in a timely manner to other providers if they do not feel that they can in conscience provide the standard reproductive services that their patients request.”

The American Medical Association’s Council on Ethical and Judicial Affairs, likewise, concludes that even physicians who object to abortion for reasons of conscience “have a duty to present medical facts accurately, including the risks, benefits, and costs of treatment alternatives, and not to withhold information from patients.”

While the AMA is less directive on the duty to refer than ACOG, it highlights that there are a variety of “options for discharging the duty to refer, ranging from something as simple . . . as providing a toll-free number or local hospital number for the patient to inquire about services, to formally referring the patient to a specific physician or institution.”

In contrast, conservative states will wish to ensure that their conscience laws do not contain such patient-protective limitations. That said, Georgia (which currently has a 6-week abortion ban) is the only such state with an abortion conscience law that references a duty to refer. Notably, that provision is limited in its scope—it only applies to pharmacists, and referral is identified as one of two possible options for discharging the duty to the patient.
4. Scope of Procedural Protections for Providers

Finally, as described in Part III-B, conscience laws vary significantly in terms of their procedural protections—what adverse consequences they protect providers from. Many states explicitly immunize refusing providers from civil liability, criminal prosecution, discipline by employers or state licensing boards, loss of funding, and discrimination writ large.\(^{124}\) The most common procedural protection, found in thirty-seven of the forty-seven states that protect abortion refusal rights as of 2019, is protection from civil liability.\(^{125}\) In twenty-six of these states, the protection from civil liability is absolute, essentially granting a “conscience defense to malpractice” and eliminating injured patients’ right to civil recourse.\(^{126}\) I have previously argued that while there may be good reasons to protect conscientious refusers from some types of adverse consequences, protecting them from the consequences of malpractice in cases of patient injury goes much further than the protections offered by anti-discrimination laws in all other contexts.\(^{127}\)

States that are more protective of abortion, then, might consider narrowing the scope of procedural protections available to refusing providers. They could, for example, maintain protections from discrimination against refusing providers, while retaining the ability of employers and state medical boards to discipline refusing providers who violate institutional policies or professional standards of care. States could also eliminate civil immunity provisions, such that patients injured by a provider’s conscientious refusal to perform abortion would at least retain their right to seek compensation for their injuries if the provider’s actions violated the standard of care. Alternatively, states could follow the lead of other anti-discrimination laws like the Civil Rights Act and the Americans with Disabilities Act and limit the right of conscientious refusal in cases where that refusal poses a “direct threat” or imposes an “undue hardship.”\(^{128}\)

In contrast, states that wish to limit rights to abortion and expand providers’ rights of conscientious refusal will likely revisit their conscience statutes to identify additional procedural protections they could offer beyond those


\(^{125}\) Id. at 1274.

\(^{126}\) Id. at 1278.

\(^{127}\) Sawicki, *Unilateral Burdens and Third-Party Harms*, supra note 108.

\(^{128}\) Id. at 1258 (suggesting that incorporating “undue hardship” and “direct threat” limitations into conscience laws would “strike a more appropriate balance between protecting conscience-driven health care providers and protecting third parties, like patients and employers.”). As of 2019, only three states incorporated an “undue hardship” limitation into their conscience laws. Sawicki, *Conscience Defense to Malpractice*, supra note 44, at 1233 (citing Idaho, Oklahoma, and Pennsylvania statutes).
currently established. For example, states that currently grant a right of conscientious refusal but do not explicitly identify the protections associated with that refusal will likely amend their legislation to include specific references to the types of adverse action that refusing providers may be protected from.

V. CONCLUSION

In the aftermath of the Dobbs decision, legislators in states that restrict abortion as well as states that retain or expand rights to abortion have the opportunity to use conscience legislation as a tool for furthering their policy goals. By amending their conscience laws to either expand or constrain protections for objecting health care providers, states can significantly impact patient access to abortion services.

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129. *Id.* at 1275 (citing Arizona, Connecticut, Tennessee, and West Virginia statutes).