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Conscience Clauses and Institutional Policies: Applicability of Employment Law and Medical Ethics

MARK A. ROTHSTEIN*

TABLE OF CONTENTS

I. INTRODUCTION .................................................................................................................. 101
II. EMERGENCE AND CURRENT STATUS OF CONSCIENCE CLAUSE LAWS ........ 104
III. FEDERAL LEGISLATION AND REGULATION ................................................................. 106
IV. CONSCIENCE AND MEDICAL ETHICS ......................................................................... 106
V. WRONGFUL DISCHARGE IN VIOLATION OF PUBLIC POLICY .............................. 108
VI. THE ROLE OF HOSPITALS AND OTHER MEDICAL INSTITUTIONS ...................... 112
VII. CONCLUSION ................................................................................................................... 113

I. INTRODUCTION

A conscience clause is a statutory or institutional provision allowing healthcare providers to decline, on religious or moral grounds, to participate in certain aspects of healthcare. The growth and importance of conscience clauses has paralleled the increased presence of and legal deference to religious practices and beliefs in healthcare, employment, education, and other aspects of American life.1

* © 2024 Mark A. Rothstein. Director of Translational Bioethics, Institute for Clinical and Translational Science, University of California, Irvine. Kelly Carty Zimmerer, J.D. 2024, Louis D. Brandeis School of Law, University of Louisville, provided excellent research assistance.
Conscience clauses are invoked in the most contentious issues in healthcare, including reproductive health issues such as abortion, contraception, sterilization, and in vitro fertilization; gender identity therapies; and end-of-life care. The categories of healthcare providers covered by conscience clauses and the subjects of conscience clauses have expanded in recent years, thereby raising the issue of whether rules intended to protect a minority of healthcare providers are being imposed on all providers and, indirectly, on their patients.

At least some conscience clauses have been adopted for the purpose—or certainly with the effect—of preventing patients from obtaining medically appropriate, prompt, quality care in accordance with the patient’s autonomous decision making. In some cases, the invocation of conscience is an attempt to cloak conservative political philosophy in religious doctrines, thereby invoking the First Amendment Free Exercise Clause, Title VII’s religious nondiscrimination provision, or other legal protections.

As applied to healthcare, excessive reliance on conscience, including considerations based on religion, can have disastrous consequences for individuals and public health. For example, politically inspired claims of religious exemption had catastrophic consequences on public health during the coronavirus pandemic. Despite strong support for vaccination from the leaders of all major religions in the United States, including Pope Francis, widespread opposition to vaccination against COVID-19 based on conscience or misinformation resulted in hundreds of thousands of unnecessary deaths.

A common individual conscience clause scenario involves an employee at a secular healthcare entity or institution who personally opposes certain healthcare practices; for example, where a retail pharmacist declines to

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2. For an argument that the use of conscience clauses is an attempt to prevent the provision of certain health services, particularly abortions, see Dov Fox, Conscientious Refusal and Provision in American Healthcare, 25 J. CONTEMP. LEGAL ISSUES 115 (2024).


fill a prescription for abortion-inducing medications mifepristone or misoprostol on religious or moral grounds. An institutional conscience clause issue arises when a hospital, group medical practice, or other healthcare entity, often with a religion affiliation, adopts policies that prevent all associated healthcare professionals from engaging in clinical practices deemed inconsistent with religious doctrine.

Institutional conscience clauses can create grave risks to patients, such as where a medically fragile woman is having a miscarriage, her physician believes she needs urgent medical care, but is unable to provide it because of a hospital’s policy. Due to the significant consolidation of medical practices and healthcare institutions, the policy of a single institution may have the effect of limiting or eliminating the availability of procedures deemed morally problematic by a religious institution in an entire geographical area, such as a rural county.

Besides federal legislation requiring emergency medical care, primarily the Emergency Medical Treatment and Active Labor Act (EMTALA),
and enactment of federal and state laws protecting the conscientious provision of medical services, another possible way of directly addressing the interests of providers and indirectly protecting patients is by applying the principles of medical ethics through common law employment law doctrines.

This article explores the possibility of using employment law-based tort actions for wrongful discharge to permit healthcare professionals to invoke a positive right to provide medically appropriate, institutionally prohibited care. Although the scope and implications of conscience clauses and policies are extremely broad, the article focuses on the role of physicians in the provision of abortion-related services, which raises the central issues in their sharpest and most controversial context.

Part II of the article considers legislative and institutional policies on conscience clauses and some of the scenarios in which they arise. Part III reviews federal legislation and regulations on conscience clauses. Part IV discusses how a physician’s exercise of conscience is considered by leading codes of medical ethics. Part V reviews the elements and contours of wrongful discharge in violation of public policy when an employee reasonably and in good faith believes that certain conduct is required by an established principle of “professional conduct” in furtherance of the public interest. Part VI addresses the civic responsibilities of religiously affiliated hospitals. Part VII concludes with some observations about employment-based challenges to institutional conscience policies and notes some unanswered questions.

II. EMERGENCE AND CURRENT STATUS OF CONSCIENCE CLAUSE LAWS

The Supreme Court decisions of Roe v. Wade and Dobbs v. Jackson Women’s Health Organization serve to bookend the conscience clause issue. Within months of Roe v. Wade in 1973, Congress enacted the first of several Church Amendments, exempting hospitals and healthcare providers from any duty to participate in abortions or sterilizations based on religious or moral grounds. Many states also enacted similar legislation giving healthcare institutions, especially Catholic hospitals, the “institutional negative right” to refuse to perform abortions or other reproductive health

11. See infra notes 12–23 and accompanying text.
measures at variance with church doctrine. Similarly, and to an increasingly greater extent, more sweeping conscience clause legislation in forty-six states has extended to healthcare providers the right to refuse, without personal jeopardy, to participate in activities at their institutions deemed personally objectionable.

_Dobbs_ flipped the script on abortion law, giving states the ability to prohibit abortion at all healthcare institutions in many or virtually all circumstances. Today, an emerging conscience clause issue is whether in a state where abortion is lawful, but at an institution that prohibits it, a willing healthcare provider has an “individual positive right” to perform abortions or other lawful procedures because the failure to do so would adversely affect the health of individual patients and the public to such an extent that refusal would violate medical ethics. If the institution subsequently discharges a physician for violating an institutional directive, it is not clear whether the physician may successfully sue for wrongful discharge.

The argument for an “individual positive right” to provide certain care could have been raised at any time after _Roe v. Wade_, but it is especially important now for at least four reasons. First, after _Dobbs_, abortion is now unlawful in twenty-six states at secular and public institutions. Second, consolidation in healthcare means that the sole practitioner model of medical practice has been replaced by hospital-owned practices, multispecialty group practices, employment of hospitalists, and other arrangements making physicians employees who may be subject to institutional policies with which they disagree. Third, in many parts of the country a few institutions or health systems control a substantial amount of healthcare services, and restrictive reproductive health policies by a few institutions can have widespread effects on public health. Fourth, employment law doctrines have evolved significantly since 1973, when _Roe v. Wade_ was decided, and it is possible that with compelling facts a court might hold that a physician-employee has a common law right to provide medically necessary care despite a medical institution’s prohibitive policies.

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16. _Id._

III. FEDERAL LEGISLATION AND REGULATION

Beginning with the Church Amendments in the 1970s, several federal statutes and appropriations provisions protect the right of conscience. The five conscience provisions in the Church Amendments prohibit recipients of any federal grant, contract, loan, or loan guarantee from requiring an individual to perform or assist in a sterilization procedure or abortion if it is contrary to their personal beliefs or moral convictions; from discriminating against any person for refusing to perform such a procedure; from discriminating against any physician or other health care personnel for refusing to participate in federally funded research that would be contrary to their religious beliefs or moral convictions; or from discriminating against any applicant for training, including internships and residencies, because of their reluctance to participate in abortions or sterilizations. Other federal statutes, such as the Public Health Service Act, Affordable Care Act, and Medicare and Medicaid statutes, also contain conscience provisions, including provisions adding end of life care as a basis for conscience protections. Taken as a whole, these laws establish a negative right for health care personnel to refuse to participate in procedures that violate the individual’s religious beliefs or moral convictions. They neither establish nor preempt a positive right for individuals to participate in lawful, medically appropriate care prohibited by their employer or medical institution. As discussed below, the source of such a right might be codes of medical ethics and state common law.

IV. CONSCIENCE AND MEDICAL ETHICS

Conscience clauses were a direct result of Roe v. Wade, but the larger issue of physicians and other health professionals balancing their personal beliefs and professional obligations arose in several other cases and events at about the same time. The case of Karen Ann Quinlan in 1976 raised the issue of end-of-life decision making, another area in which conscience clauses are implicated. Also in the 1970s, revelations of the Tuskegee Syphilis Experiment initiated a reexamination of ethical issues in research.

19. 42 U.S.C. §§ 300a-7-300a-7(e).
20. § 238n (Coats-Snowe Amendment).
21. § 18081(b)(5)(A)
22. §§ 1395cc(f), 1396a(w)(3), 14406(2).
23. The closest analogy to a positive right appears in the Balanced Budget Act. It provides that Medicaid managed care organizations and Medicare Advantage plans may not prohibit or restrict a physician from informing patients about a full range of treatment options. 42 U.S.C. §§ 1395w-22(j)(3)(A), 1396u-2(b)(3)(A).
with human subjects;\textsuperscript{25} the informed consent doctrine received significant judicial support, thereby significantly bolstering patient autonomy;\textsuperscript{26} and new medical technologies, including solid organ transplantation and in vitro fertilization, raised fundamental moral issues as part of the emerging field of bioethics.\textsuperscript{27}

In theory, individual conscience clauses strike a balance between the interests of the physician, healthcare institution, and patient. The patient can obtain the desired medical care, but a physician with religious or moral concerns or an institution with religious objections does not have to provide it. However, the realities of healthcare consolidation and the growing market share of religiously affiliated healthcare institutions mean that obtaining a convenient, willing provider for reproductive health services is hardly assured.

According to the ethical codes and opinions of leading medical organizations, conscience clauses should not be considered an absolute limitation on the responsibilities of physicians. The Code of Medical Ethics of the American Medical Association (AMA) directly addresses this point. “Physicians’ freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients’ informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.”\textsuperscript{28}

Based on the AMA’s guidance, there are three essential protections for the patient. First, physicians should “[u]phold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.”\textsuperscript{29} Second, declining treatment based on the physician’s conscience may not be appropriate

\textsuperscript{25} See, e.g., JAMES H. JONES, BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT (1993).
\textsuperscript{27} For a further discussion, see Mark A. Rothstein, The Role of Law in the Development of American Bioethics, 20 INT’L J. BIOETHICS 73 (2009).
\textsuperscript{29} AM. MED. ASS’N, supra note 28, at (e). I would add that all medical options should be presented to the patient in an objective, nonjudgmental, nondirective, and respectful manner.
“when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient’s physical or emotional well-being.”  

Third, physicians should “refer a patient to another physician or institution to provide treatment the physician declines to offer,” but if “the patient is not reasonably able to access needed treatment from another qualified physician,” conscience should yield to professional obligation and the duty of fidelity to the patient.

The American College of Obstetricians and Gynecologists Committee on Ethics has adopted a similar position that recognizes the importance of a physician’s conscience but asserts that it may be outweighed by other moral obligations. “When conscientious refusals conflict with moral obligations that are central to the ethical practice of medicine, ethical care requires either that the physician provide care despite reservations or that there be resources in place to allow the patient to gain access to care in the presence of a conscientious refusal.”

Codes of medical ethics and ethical opinions notwithstanding, the reality is that a healthcare provider’s conscience typically overrides any sense of professional obligation. Even when there is no alternative provider, conscience clauses generally allow institutions and providers to refuse without qualification. Thus, in practice, conscience clauses in statutes and policies often do not result in an accommodation of personal morality in a setting where vulnerable patients are owed a duty of loyalty by their health care providers. Moreover, “conscience” has been interpreted by healthcare institutions to include a wide range of political, social, and personal motivations.


Evolving medical practice arrangements play an important part in positive conscience dilemmas by physicians. A decreasing minority of physicians are in solo or small group practices. According to the AMA, in 2020, only 17.0% of physicians were in solo practice, 49.8% were in single specialty groups, 24.6% were in multi-specialty groups, and 5.1% were hospital employees. Multi-specialty and hospital-based practices are growing rapidly, a trend that likely was accentuated by the Covid-19 pandemic.
The consolidated practice model means that only one in six physicians individually owns their medical practice, and they are much more likely to be employees of a larger organization. Consequently, physicians’ control over institutional policies may be limited and they may be subject to practice restrictions with which they disagree. Nevertheless, because they are employees, there is a possibility that they could be protected by employment law doctrines if they are required to engage in practices that violate professional ethical principles.

Beginning in the 1960s, civil rights legislation at the federal and state levels was enacted to prohibit discrimination in employment based on race, color, religion, sex, and national origin; \textsuperscript{35} age, \textsuperscript{36} disability, \textsuperscript{37} genetic information, \textsuperscript{38} sexual orientation, \textsuperscript{39} and other proscribed criteria.\textsuperscript{40} Employees covered by a collective bargaining agreement\textsuperscript{41} or individual contract\textsuperscript{42} may be afforded additional substantive and procedural rights by the contract. However, employees without contracts for a fixed term are considered “at-will” employees who may be discharged or who may quit for any reason.\textsuperscript{43}

The at-will doctrine was formulated in 1877 by the American treatise writer Horace G. Wood.\textsuperscript{44} It aligned with late nineteenth century laissez-faire capitalism and soon became the law in every state. It was largely unchallenged until the second half of the twentieth century. In Petermann

\textsuperscript{38} Title II of the Genetic Information Nondiscrimination Act, 42 U.S.C. § 2000ff.
\textsuperscript{39} In Bostock v. Clayton County, Ga., 490 U.S. 228 (2020), the Supreme Court held that when an employer discriminates against a person because of that individual’s sexual orientation or gender identity, this constitutes discrimination because of sex under Title VII. In addition, laws in 23 states and the District of Columbia expressly prohibit discrimination based on sexual orientation or gender identity. See Nondiscrimination Laws, Movement Advancement Project, \url{https://www.lgbtmap.org/equality-maps/non_discrimination_laws} [https://perma.cc/2P9Q-MXQH] (last visited July 17, 2023).
\textsuperscript{41} National Labor Relations Act, 29 U.S.C. §§ 151-169.
\textsuperscript{42} See Mark A. Rothstein et al., Employment Law § 9:2 (6th ed. 2019).
\textsuperscript{43} Id.
\textsuperscript{44} Horace G. Wood, A Treatise on the Law of Master and Servant (1877).
v. International Brotherhood of Teamsters, Local 396, the employer, a labor union, ordered an at-will employee to testify falsely at a legislative hearing and then fired the employee when he refused to do so. The court held that the employer’s conduct violated California’s public policy of encouraging truthful testimony and therefore was an abuse of the employer’s right to fire at will. The public policy exception recognized in Petermann is now the law in forty-three states and the District of Columbia.

To warrant judicial recognition, the public policy asserted must be “fundamental,” “substantial,” and “well established,” and it must implicate societal rather than merely personal interests. The primary sources of public policy are state legislation and judicial decisions. Four main categories have been recognized: (1) refusing to perform unlawful acts, such as offering perjurious legislative or judicial testimony; (2) exercising legal rights, such as filing a workers’ compensation claim; (3) reporting illegal activity, such as disclosing an employer’s money laundering to a law enforcement agency; and (4) performing public duties, such as serving on a jury.

The Restatement of Employment Law adds another source of public policy with direct relevance to the exercise of professional conscience. “An employer is subject to liability in tort under § 5.01 for discharging an employee because the employee, acting in a reasonable manner: . . . (e) reports or inquires about conduct that the employee reasonably and in good faith believes violates a law or an established principle of a professional or occupational code of conduct protective of the public interest. . . .” A narrow reading of this provision would limit it to internal whistleblowing, where one employee is complaining about the unprofessional conduct of another employee or the employer. Nevertheless, an argument can be made that a professional code of conduct should apply more generally to all employees. Such a view is supported by the next provision of the Restatement, which simply states: “An employer is subject to liability for discharging an employee because the employee, acting in a reasonable manner: . . . (f) engages in other activity directly furthering a well-established public policy.”

Professional codes of conduct have been recognized as a source of public policy in a limited number of cases. The most relevant case to

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46. See Rothstein, supra note 42, at § 9-9.
48. Am. Law Inst., Restatement of Employment Law § 5.02(e) (2015). In the interest of full disclosure, I was an adviser on the Restatement of Employment Law.
49. Id. at § 5.02(f).
50. See Gen. Dynamics Corp. v. Super. Ct., 876 P.2d 487 (Cal. 1994) (holding in-house counsel stated a claim when he was discharged for following mandatory ethical
healthcare conscience clauses is LoPresti v. Rutland Regional Health Services, Inc.\(^\text{51}\) The plaintiff, Dr. LoPresti, signed a “physician employment agreement” with Physician Group, a multi-specialty group practice. As a primary care physician, Dr. LoPresti often referred patients to specialists, but he developed concerns about the quality of care that some of his patients were receiving from three Physician Group specialists, two surgeons and one obstetrician. He alleged that these physicians performed unnecessary procedures, hospitalized patients unnecessarily, and provided substandard care resulting in harm to his patients. After he stopped referring patients to these three specialists, he was terminated by the Physician Group.

He brought an action against the Physician Group alleging, among other things, that he was wrongfully discharged in violation of public policy because “he was fired for his refusal to potentially violate state law and his professional ethical code by referring patients to doctors whom he believed were ‘providing improper care, potentially jeopardizing the physical well-being of his patients.’”\(^\text{52}\) He cited to specific provisions of the AMA’s Principles of Medical Ethics that required him to refer patients to competent physicians.

The Superior Court granted summary judgment for the Physician Group, but the Supreme Court of Vermont reversed and remanded the case on the wrongful discharge claim. “Assuming he can prove these allegations, the enforcement of public policy here would have a tangible connection to the protection of health care consumers. Therefore, Dr. LoPresti’s claim is consistent with our view that compelling public policy is intended to prevent injuries to the public – especially in matters of public health.”\(^\text{53}\)

Courts receptive to the argument that public policy can be based on professional codes of ethics can find a wealth of sources in AMA documents (accountant stated valid claim for refusing to violate state accountancy rules of professional conduct); Shearin v. E.F. Hutton Grp., Inc., 652 A.2d 578 (Del. Ch. 1994) (corporate counsel’s breach of contract claim could be based on refusal to violate professional ethical standards); Wieder v. Skala, 609 N.E.2d 105 (N.Y. 1992) (implied obligation to follow a professional-conduct rule); Crews v. Buckman Labs., Int’l, Inc., 78 S.W.3d 852 (Tenn. 2002) (in-house counsel discharged for complying with code of professional responsibility). But see Pierce v. Ortho Pharm. Corp., 417 A.2d 505 (N.J. 1980) (Hippocratic Oath does not contain a clear public policy mandate); Wallace v. Skadden, 715 A.2d 873 (D.C. 1998) (no public policy for lawyer refusing to violate professional conduct rules that did not impose a duty to report misconduct to superiors).

\(^{51}\) 865 A.2d 1102 (Vt. 2004).

\(^{52}\) Id. at 1111.

\(^{53}\) Id.
and the pronouncements of the various medical specialty colleges and societies. 54 Besides the provision on Physician Exercise of Conscience mentioned above, 55 the AMA’s statement on Quality is instructive. “As professionals dedicated to promoting the well-being of patients, physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, efficient, and equitable.” 56

In the aftermath of Dobbs, legislation and policies that adopt overly broad definitions of prohibited abortion-related medical care threaten the health and lives of pregnant women, including those being treated for cancer with chemotherapeutic agents having abortifacient properties 57 or who require surgical or other interventions that present risks to an embryo or fetus. 58

The unavailability of abortion services is causally related to a significant rise in maternal morbidity and mortality rates. 59 Therefore, professional codes of conduct may establish a public policy enabling physicians to treat their patients in a timely and appropriate manner consistent with established standards of care notwithstanding the restrictive policies of their employing institutions. 60

VI. THE ROLE OF HOSPITALS AND OTHER MEDICAL INSTITUTIONS

Healthcare institutions, including those with religious affiliations, are public institutions in the broadest sense. They receive federal financial payments from Medicare, Medicaid, and other government sources; are

55. See supra note 23.
56. AM. MED. ASS’N, supra note 28, § 1.1.6.
given federal, state, and local tax exemptions; obtain public credentialing of the institution and its personnel; and, most importantly, perform an indispensable public function. These institutions owe their very existence and their obligations to the public.

Religious healthcare facilities should be free to accommodate the consciences of their personnel and to advance the institution’s religious mission, but they should not be able to impose their moral values on the public to prevent medical care that is legal in the state where they are located. It is possible to balance the religious missions and public responsibilities of healthcare institutions, such as by locating “objectionable” practices at affiliated institutions, in separate facilities, or designated floors of a hospital. But there must be a recognition of and a willingness to make such accommodations.

VII. CONCLUSION

The theory described in this Article, using the public policy exception to wrongful discharge to protect physicians and other healthcare professionals who disobey institutional policies because of the demands of professional codes of conduct, is limited in applicability and, currently, in likelihood of success. In the context of abortion, it would only apply in states where abortion is legal, but where a health professional is employed by an institution that prohibits abortion. Even in those settings, most courts are likely to hold that the public policy exception is limited to legislative enactments and judicially recognized policies. Very few courts have held that it can be based on a professional code of conduct.

Nevertheless, it is possible that a court could conclude that the lack of healthcare institutions in a geographic area willing to provide lawful reproductive health services operates to undermine a substantial state public policy recognizing the legality of abortion. Furthermore, a lawsuit by a physician alleging wrongful discharge could generate public and political support for two types of legislation. First, a state could enact a law establishing an “individual positive right” to provide institutionally prohibited health services under certain circumstances or at least mandate that such institutions provide informed consent and prompt, bona fide referrals to other providers and institutions where such procedures can be performed. Second, professional codes of conduct, such as the AMA’s conscience provisions, could be enacted as state legislative policy, thereby enabling its use in cases alleging wrongful discharge in violation of public policy.
Many difficult questions remain, including the following. To what types of health professionals and medical services would an individual positive right of conscience apply? Would it apply to non-employee providers with staff privileges at a healthcare facility? Would it apply to wrongful discipline and loss of privileges as well as discharge? Would it apply only to medical services that can be performed without significant use of institutional facilities (e.g., reproductive counseling and referrals) or would it also apply to the use of operating rooms and the assistance of other medical staff (e.g., for abortions).

From a broader perspective, other difficult questions remain about whether it is possible to regulate institutional conscience policies that prevent health professionals from providing lawful, medically appropriate care. Although beyond the scope of this article, some entities that are well-positioned to bring about change include the Internal Revenue Service, which conditions tax-exempt status of nonprofit healthcare facilities on the provision of services to benefit their communities, the Joint Commission, which accredits hospitals and promulgates detailed regulations for accreditation; and the Accreditation Council for Graduate Medical Education, which accredits residency programs and can withdraw approval from institutions that do not meet professional standards. Thus far, no organization with regulatory authority has attempted to limit institutional conscience policies.

Just as Roe v. Wade was the impetus for the initial conscience clauses, Dobbs should be the impetus for reconsidering legislative and institutional conscience clauses. Although it is important to respect the religious and moral concerns of healthcare providers and institutions, if possible, the paramount rights and interests of patients and the public should be protected to ensure the provision of essential health care in a safe, timely, and professional manner.

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