The Lopsided Law of Medical Conscience

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We’re used to hearing about conscientious refusal: when physicians or pharmacists deny services they deem sinful or wrong, in violation of hospital policies or malpractice laws. Less familiar is conscientious provision: when clinicians supply care that their employer or state restricts. America’s conscience regime often protects refusers categorically: they get conscience without conditions or consequences. But doctors with heartfelt reasons to supply care their institution or government forbids? For them, conscience is no defense.

This radical asymmetry is indefensible and unjust. Both refusers and providers resist workplace rules and legislative directives at odds with their sincere moral convictions. Both sometimes appeal to religion, and conscience clauses protect secular claims just the same anyway. Nor is the conscientious delivery of routine medication and many other treatments that much more expensive for third parties to accommodate, compared with the cost that exempting such care’s conscientious denial incurs to businesses and colleagues left to fill in the gaps, and especially to patients, who might not be able to access treatment elsewhere in the face of widespread refusals.

Conscience protections shouldn’t be absolute for refusers and absent for providers. There may be practical or expressive reasons to treat certain service denials differently than certain expressions of conscience to deliver care. But the same basic commitments should

* © 2024 Dov Fox. Thanks to co-organizers and participants for a timely and bracing conference where these ideas were presented. I’m especially grateful to Sam Rickless for rich engagement, to Liz Parker for expert editing, and to the staff of the Harvard Law Review for permission to reprint excerpts that originally appeared in Dov Fox, Medical Disobedience, 136 HARV. L. REV. 1030 (2023).
govern the measure of space that a principled regime affords to each. Legal protections for medical conscience ought to attend to the individual claimant’s moral integrity, to larger interests in social pluralism, and to the impact of accommodation on others—not simply whether a claimant would refuse care or provide it.

Freedom of conscience is having a heyday in American life—and the context of healthcare is no exception.¹ The ideal of conscience resonates with many physicians, pharmacists, and other clinicians whose work confronts them with moral dilemmas. These might pit professional obligations against personal convictions, or place patient interests at odds with state interests. Some practitioners navigate these normative conflicts under the mantle of conscience, a clear-eyed sense of right and wrong that compels them down a particular path in decisions about whether to treat patients and how.²

The domain of healthcare is different from the website and cake design where claims for exemption have recently found their way to the Supreme Court.³ Medicine isn’t a service industry in which wares are sold to anyone who will pay for them. The goal isn’t to satisfy the preferences of clients or customers. It’s to realize a social good, held in the public trust for those in need—all of us, at one time or another. That good is to get patients healthy and keep them well.

This internal purpose explains why patients can’t reasonably demand an intervention that’s at odds with these goals. And why the doctor’s role also includes denying requests for treatment that promise unproven benefits and impose unjustifiable risks—even if medicine’s monopoly on clinical treatments means that patients can’t access them elsewhere.

It’s been over a century since homeopaths and others who aren’t trained and licensed in medicine have been allowed to treat patients and compete in the market for their business.⁴ Around 1910 is when licensing laws began squeezed out these alternative practitioners. That gave certified clinicians

² See Mark R. Wicclair, Conscientious Objection in Medicine, 14 BIOETHICS 205, 217 (2000).
in the United States exclusive control over access to almost all scans and pills, shots and surgeries. In turn, a complex system of disciplinary sanctions developed to prioritize patients’ medical interests, consistent with respecting their values and preferences.

Historically, these professional obligations have lined up with legal demands too. Both share similar commitments to patient autonomy and evidence-based treatment that translate into certain medical and legal rules: that clinicians must secure informed consent, adhere to the standard of care, and ensure that anybody they’ve started to treat has a chance to be seen elsewhere, so the person is not just abandoned in a critical time of need. For decades, complying with these expectations doesn’t just make you a doctor or nurse in good standing; it also insulates you against lawsuits or prosecutions. But now some states are restricting clinicians’ ability to provide safe and effective therapy in ways that depart from those bedrock duties that put patients first. Breaking these laws risks landing doctors in court, even prison, and more and more providers are taking a stand against them. Some are just trying to do their jobs. Others resist in the name of conscience.

Appeals to conscience come with baggage. Many Americans are convinced that the culture wars have reduced conscience claims to little more than a card that one side plays when it loses democratic debates about anything from marriage rights to contraceptive-coverage mandates. Rather than accept defeat at the ballot box or in the courthouse, parties invoke conscience to relitigate those disputes, this time donning the cloak of a marginalized minority. Skeptics see conscience as a convenient tool to exploit for political advantage in advancing a social agenda.

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7. See Nadia N. Sawicki, Ethical Malpractice, 59 HOUS. L. REV. 1069, 1098 n.129 (2022).


But sincere expressions of conscience consist of deeply held moral beliefs, the kind that center individuals to the commitments they cherish most. What makes these centering beliefs moral is how they bear on ways of being or doing that aren’t just useful or inconvenient, but right or wrong. Conscience is characteristically anchored to a source of ethical wisdom that’s bigger than oneself and independent of what an individual believes. An objective account of conscience traces these beliefs to some affiliation or ideology about what it means to do good or to live well. Conscience captures any moral ground that clinicians might have for denying treatment, secular too. So, for example, a conscientious refuser might object to abortion either because of a Catholic teaching that life is sacred at conception, or based on a Kantian imperative that we shouldn’t treat the unborn as a mere means to the ends of others. Conscientious providers have also invoked conscience in both religious and secular terms: as either a spiritual “calling” to pursue “salvation” by supplying abortion healthcare to people in need, or an egalitarian concern for the equal dignity of persons.

The practice of medicine is another external source of moral wisdom. Some argue that the clinical enterprise has just one fixed objective: to treat illness, nothing else. A broader conception sees the ends of medicine unfolding dynamically in creative tension with transformations in culture and technology. On this view, there are three main ways in which medical practitioners aim to make patients better and keep them well. First, they heal patients by curing disease, repairing injury, and restoring functioning. They also promote patient health through interventions that include vaccinations, cancer screening, and prenatal checkups. Finally, they relieve the suffering that can accompany agonizing pain and dying.

These patient-centered aspirations are contested around the edges amid disagreements about the meaning of health and what counts as care. What’s clear is that tending to the sick and vulnerable is a deeply normative enterprise. The evidence-based weighing of benefits over risks operates as a North Star for the affirmative appeal to clinician conscience: not the pursuit of profit, or fear of harassment, or any other motive. This good-

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faith commitment to patient welfare is as real an expression of conscience as any.

There are two reasons to accommodate invocations of conscience in the practice of medicine. One is for the individual who claims it: to respect her agency or preserve her integrity. Lacking agency to act according to one’s deeply held beliefs takes a psychological toll. That moral strain is bad in itself, and it can burn specialists out, driving them to move states, change fields, or quit healthcare altogether. This individualistic account captures the stakes of conscience when vindicating the claims of unpopular or weak minorities wouldn’t impose meaningful costs on third parties. But a doctor’s claim to live up to her own moral code can’t justify categorical license to hurt patients.

A more capacious rationale for freedom of conscience reaches beyond any individual to the larger spirit of openness to dissent that sustains a diverse society and dynamic profession. Both democracy and medicine reflect evolving norms and differences of opinion about what’s right and good. Carving out space for reasonable expressions of conscience — neither invidious nor arbitrary — could preserve those objections as a repository for potentially worthy reforms in the future.

This release valve isn’t for catering to nasty prejudice or stubborn idiosyncrasy: not for the sake of toleration itself, or even to avoid civil violence. The point of making room for a multiplicity of values is to facilitate peaceful co-existence on equal terms. This pluralism argument inhereis in a classical liberal commitment to ideological diversity and individual rights. It says that accommodating conscience has the potential to equip heterogeneous institutions to navigate divisive controversies and adapt to change from within.

16. See Michele LeClaire et al., Compromised Integrity, Burnout, and Intent to Leave the Job in Critical Care Nurses and Physicians, CRITICAL CARE EXPLORATIONS, Feb. 2022, at 1, 6.
18. See Eric J. Kim & Kyle Ferguson, Conscientious Objections, the Nature of Medicine, and the Need for Reformability, 36 BIOETHICS 63, 68 (2022).
But exemptions can also be deployed less as a shield than a sword: to delay or deny valued services, even those secured by constitutional rights or statutory guarantees.\textsuperscript{20} Professors Douglas NeJaime and Reva Siegel argue that a genuinely pluralist regime respects more than just physicians and pharmacists who object to being made complicit in a practice that they perceive as sinful or wrong.\textsuperscript{21} An inclusive form of pluralism also shows concern for patients who think differently: their beliefs and interests matter too.\textsuperscript{22} Because licensed professionals keep the gates of medicine, giving them free rein to refuse care at will could withhold from certain people the blessings that clinical science bestows on everyone else.\textsuperscript{23} A pluralistic regime must mediate the harms that accommodating such claims can visit onto patients.

Courts are rightly reluctant to release people from the rules that apply to everyone else just because their own objections sound in the register of conscience. Indiscriminate exemptions would risk resentment: why should I have to follow a rule that others don’t? Unwarranted accommodations could even threaten anarchy, if exceptions swallow the rule. So in most spheres of life, conscientious objectors are expected to comply with regulations that apply generally.\textsuperscript{24} Those who disobey out of conscience must still face the consequences, resigned to redouble any larger ambitions for reform through democratic channels like protest and lobbying.\textsuperscript{25}

In just two contexts do secular appeals to conscience stand a stronger chance of accommodation under the law. One is when pacifists get drafted in wartime. Conscientious exemption from military service is a privilege that’s conditioned on there being enough other willing to fight that a fighting force can be maintained. It also comes with consequences: objectors have to share in other forms of civic sacrifice. They must still prepare meals or dress wounds for soldiers on the battlefield, or else contribute in

\begin{enumerate}
\item See NeJaime & Siegel, supra note 8, at 2590.
\item See, e.g., Braidwood Mgmt., Inc. v. Becerra, No. 4:20-cv-00283, 2022 WL 4091215, at *19 (N.D. Tex. Sept. 7, 2022) (holding that employer could deny federally mandated coverage for drugs to prevent HIV transmission on the ground that being forced to buy that insurance would “substantially burden” its Christian faith that condemns “homosexual behavior,” id. at *18.).
\item Not all claimants seek to issue a rallying cry or mobilize others to their cause. Maybe they lack the resources or temperament to marshal such support, or think it’s counterproductive or futile to try to change hearts and minds. These individuals aren’t trying to effect any broader social change. Their appeal to conscience might seek only to distance themselves from what they see as wicked or corrupt. See Kimberley Brownlee, Conscience and Conviction: The Case for Civil Disobedience 104–07 (2012).
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comparable ways on the civilian side: for example, to national conservation or elder care, and for at least as long as they would have served in the armed forces. These consequences offset the moral and practical costs that accommodation imposes on others.

The other setting that Americans can count on having their appeals to conscience reliably vindicated is medical refusal. Members of no other profession are entitled to invoke conscience and be excused from exercising the usual skill, judgment, or conduct expected from someone trained to do that job well. What could justify this sort of medical exceptionalism? Do doctors, nurses, and therapists face moral choices so much harder than lawyers, accountants, and teachers do? Why single out clinicians for conscientious exemptions that no one else gets? One answer is a resemblance that this line of work sometimes shares with combat: medicine too can demand life-and-death decisions that evoke particularly intense convictions.

But conscience exemptions in medicine are indifferent to whether care is otherwise available. And unlike the peace lover who’s called to fight, the clinician who opposes emergency contraception or aid-in-dying isn’t conscripted against his will. Physicians and pharmacists choose a vocation that expects them to undertake certain practices — albeit against the background of far-reaching exceptions that unwilling clinicians might rely on when they enter the profession. Conscience carve-outs are codified in a handful of federal statutes and the clauses of almost every state that insulate refusers who violate institutional policies or even laws against civil malpractice or criminal abandonment. Clinicians who invoke conscience to withhold otherwise-expected services bear nothing like the burdens that military objectors do. Many state conscience laws protect

27. See James F. Childress, Civil Disobedience, Conscientious Objection, and Evasive Noncompliance, 10 J. MED. & PHIL. 63, 65 (1985).
medical refusers in all but unqualified terms. Conscientious providers get no such protection. It didn’t get this way by accident. “[C]onscience talk” spread in the 1960s and early 1970s “from conflict over war to conflict over abortion.” Within two years after the Supreme Court legalized abortion nationwide, more than half of states authorized doctors and hospitals to refuse patients seeking to prevent pregnancy or end it. The governing regime that emerged from Roe’s shadow wasn’t designed to vindicate conscience in healthcare with a fair mind or an even hand. It was architected by a political movement to restrict access to medical practices like abortion, birth control, and sterilization that activists saw as threats to traditional family values and sexual morality. Movement efforts over the ensuing decades bent conscience clauses more lopsided still in favor of conscientious refusers. Our legal system rarely forces clinicians to treat patients. Doctors and nurses can almost always refuse the medical care that they’re qualified to provide. There just two times they can’t: if they seek to discriminate based on race, ethnicity, age, or disability, or when a hospital emergency department receives patients in need of urgent care. Physicians are otherwise free to deny any service that’s not too exigent, or even one that is, if they don’t work in an ER. They can also decline to treat patients for any reason.

33. NeJaime & Siegel, supra note 8, at 2536 n.79.
38. See, e.g.
40. Forced medical provision is rarely alleged; the odd complaint usually comes in the emergency room context. See Verified Complaint at 2, 14–15, Danquah v. Univ. of Med. & Dentistry of N.J. (D.N.J. 2011) (No. 2:11-cv-06377); Memorandum in Support of Motion for Preliminary Injunction, Cenzon-Decarlo v. Mount Sinai Hosp., No. 09-3120 (E.D.N.Y. 2010), 2010 WL 169485, aff’d, 626 F.3d 695 (2d Cir. 2010).
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that civil rights laws don’t forbid. Or to refer or counsel them, or to disclose that their objection is based on reasons that are more moral than medical. Refusers get conscience without conditions or consequences.

Legal protections for healthcare refusals made their first appearance with the 1973 Church Amendment. Enacted by near consensus, that law gave clinicians a right to choose whether to participate in a sterilization or abortion — a right parallel to the one that Roe afforded patients to undertake those procedures. The Church Amendment shields federally funded entities and their workers from performing any abortion or sterilization at odds with their “religious beliefs or moral convictions.”

The biggest impact of the Amendment isn’t what the law said, but the “conscience creep” it inspired. Most states in the years to follow passed their own safeguards that went much further and skewed sharply in a particular direction. In the wake of the Church Amendment, states entrenched the one-way conscience clauses that keep refusers alone from losing a job or medical license, even when denying care would predictably hurt patients.

These exemptions are all-encompassing. States accommodate conscientious refusals for services that range from emergency contraception and aid-in-dying to assisted reproduction and stem cell research. These laws also excuse unwilling clinicians from a sweeping array of duties imposed by statutory law, common law, tort liability, state medical boards, and licensing regimes. And they exempt nonpractitioners who don’t provide those services hands-on: admitting clerks, HMOs, and insurance plans.

In thirty-three states today, conscience laws immunize a conscientious refuser from any civil penalties at all. It doesn’t matter if that denial of

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44. 42 U.S.C. § 300a-7(b)(2)(A) (2012). Its ban on employment discrimination isn’t limited to conscientious refusal; it extends to conscientious provision as well. But this ostensible matching feature for providers has lain largely dormant. See infra text accompanying notes 88–89.
These moves exempt even government hospitals from Establishment Clause rules governing the separation of church and state. Religious directives now govern 235 trauma centers and 654 hospitals nationwide, comprising a third of the beds available for acute care in ten states. The million or so clinicians who work at these facilities risk their losing jobs if they provide any medical service not “animated by the Gospel of Jesus Christ and guided by the moral tradition of the Church.” Off limits are everything from vasectomies, tubal ligations, birth control, and emergency contraception to abortion, assisted reproduction, gender-affirming care, and aid-in-dying.

It’s true that the Church Amendment — named not for the Catholic Church but for Frank Church, the Democratic Senator from Idaho who introduced the law in Congress — protects providers too. It tells federally funded hospitals that they can’t grant or deny staffing privileges on the ground that a clinician has “assisted in the performance of a lawful sterilization procedure or abortion” somewhere else. But there’s no meaningful way to enforce that rule: courts have held that providers can’t sue a hospital that discriminates against them in hiring or firing, interpreting the statute to leave it up to Congress to withhold funds from an institution that’s penalized someone for favoring abortion or sterilization.

And in 1980, the Supreme Court rebuffed both Free Exercise Clause and Establishment Clause challenges that doctors and patients leveled against the Hyde Amendment’s limits on abortion funding for people who can’t afford the procedure and for whom forced pregnancy implicates matters


of faith. The handful of states that came to extend any additional safeguards to conscientious providers have limited those to adverse actions based on having supported or participated in an abortion.

The only exception is Vermont. That state recently turned the usual asymmetry on its head. Its 2019 Freedom of Choice Act exempts just conscientious providers, and not refusers, by barring public entities from interfering with clinicians who seek to take part in an abortion. In other states, refusers get dramatically greater protections than equally conscientious providers do — indeed, even though providers exercise professional judgment in the service of patient interests.

Singling out conscientious refusal for protection traces back to the reproductive politics of the 1970s: backlash against Roe led states to shield abortion-opposed institutions and clinicians from being forced to terminate pregnancies against their will. But the refusal/provision division isn’t just an artifact of the abortion wars. That distinction reemerged a couple decades later in end-of-life cases like Nancy Cruzan and Jack Kevorkian. Policymakers and scholars wrestled with whether doctors should be allowed to help terminal patients hasten their deaths, or to withdraw life-sustaining care from those who fell into a permanent coma. The line between doing and allowing loomed large in these debates, with active “killing” eliciting greater suspicion than passive “letting die.”

This distinction between doing and allowing runs deep in our moral and legal culture. A liberal society can prevent people from acting in all sorts of harmful ways, but rarely forces them to act to avoid similar harm.

69. See, e.g., President’s Comm’n for the Study of Ethical Prob. in Med. & Biomedical & Behav. Resch., Deciding to Forego Life-Sustaining Treatment 68 (1983).
70. See, e.g., J. Morris Clark, Guidelines for the Free Exercise Clause, 83 Harv. L. Rev. 327, 361 (1969) (“The right of individuals to act positively, in such a way as to harm others in the society, must by its nature be more restricted than the right to refrain from acting.”).
Compelling religious sacraments seems harsher than prohibiting them, for instance, and forcing people to say something they don’t believe in grimmer than preventing them from speaking. On this view, forcing clinicians to provide care that they morally oppose is worse than preventing them from supplying care their scruples command them to. Forced actions seem more harmful than forced omissions, thereby justifying greater protections for conscientious refusal than conscientious provision.

This act/omission line matters—it’s not just the cognitive bias that some behavioral researchers claim. But our conscience regime makes too much of it. Even if conscientious refusal sometimes deserves more protection, why should all conscientious provision get none? Every instance of doing harm in medicine isn’t worse than every comparable instance of allowing it. Some harmful things that clinicians allow to happen to their patients are just as bad as harmful thing they do to them. Which explains why clinicians owe affirmative obligations to the people they treat.

For the most part, the legal duties that Americans bear toward other people extend only as far as refraining from harming them — there’s no general duty to save someone’s life, even at no risk to your own life, and when you’re the only one who can. But sometimes, specific individuals do have affirmative obligations with respect to certain vulnerable others by virtue of their special relationship to them. Parents owe duties not to neglect their children’s physical, medical, educational, and emotional needs that others are at legal liberty to ignore.

It’s similar with healthcare professionals. Doctors, nurses, and therapists owe professional obligations to the patients they’re uniquely capable of serving, and alone allowed to. Only licensed practitioners are allowed

74. Good Samaritans could even be sued if their rescue attempt ends up doing someone in distress more harm than good. See RESTATEMENT (SECOND) OF TORTS § 314, 323 (AM. L. INST. 1965).
to supply medical services that range from prescribing drugs to performing surgeries. With this power comes responsibility: not just to avoid inflicting undue harm on patients but also to avoid letting it befall them through indifference to accepted standards of medical care.

That’s why clinicians have certain affirmative duties to benefit their patients, not just to avoid harming them. Informed consent doctrine doesn’t just hold a doctor responsible for telling a patient bad information—nor may she fail to disclose relevant risks or benefits of a proposed course of action. Likewise, a nurse can be liable for wrongful death whether he carelessly poisons a patient, or lets her die by declining to provide a safe and effective intervention. It’s not just informed consent and drug dosing. Clinical obligations from confidentiality to disease screening rarely turn on whether a clinician did something or allowed it. What matters is instead whether her decision reflects respect for patients and promotes their wellbeing. So this distinction—between action and inaction, or between being forced to act and prevented from acting—has less purchase in the domain of medicine. Medical obligations are about patient interests.

The clinician’s duty to put patients first reduces the act/omission distinction in healthcare to a less meaningful dividing line, closer to “preventing harm” as opposed to “conferring benefit.” And this more modest contrast doesn’t make the decisive difference that our regime ascribes to the line between the conscientious provision and refusal of healthcare.

So when it comes to claims of conscience, clinicians who would deny care or deliver it bear the same special relationship to their patients. And they both appeal to the goods of individual integrity and social pluralism that accommodation would serve. On this view, the conscientious refusal of medical treatment has more in common with its conscientious provision.

77. See R. Alta Charo, The Celestial Fire of Conscience — Refusing to Deliver Medical Care, 352 NEW ENG. J. MED. 2471, 2473 (2005).

78. See Alberto Giubilini, Conscientious Objection in Healthcare: Neither a Negative nor a Positive Right, 31 J. CLINICAL ETHICS 146, 152 (2020).


80. Elizabeth Sepper made this point first: “providers stand in a special relationship to patients and may harm them through their omissions.” Elizabeth Sepper, Taking Conscience Seriously, Va. L. REV. 1501, 1537 (2012). But she goes too far when she suggests that the line between doing and allowing is irrelevant in medical practice, see id. at 1536, and advocates dispensing with the refuser/provider distinction altogether in the employment context. See id. at 1553.

than not. A conscience regime that categorically privileges refusers over providers overstates the moral differences between them.\textsuperscript{82}

Maybe the real difference is cost. Even if conscientious provision is just as \textit{worth} protecting, conscientious refusal is more \textit{reasonable} is less expensive to protect. The denial of services would seem, at first blush, to require less of whatever entity underwrites individual clinicians to supply of medical services, whether private institutions or public ones. The conscientious refuser asks only that those third parties not force his hand, freeing him to step away. The provider, by contrast, demands that others furnish her with whatever facilities, personnel, or equipment she needs to undertake prohibited treatment. All of these cost money and use up finite resources no longer available for other patients or interventions.\textsuperscript{83}

Providing care costs more than refusing it does.\textsuperscript{84} Asymmetrical protections for refusers and providers are justified by the asymmetrical demands that claimants make on institutional resources.\textsuperscript{85}

In many cases, conscientious provision does require expensive staffing and equipment. But conscientious provision doesn’t \textit{always} cost their state or healthcare institution so much more. Some conscientious providers need little more than a telehealth connection and prescription pad to prescribe birth control pills, emergency contraception, or death-hastening drugs, or medication abortion.\textsuperscript{86} Or to refer a patient to someone who will.

Hospital charges may be also marginal for add-on surgical procedures like a tubal ligation that accompanies an already-planned cesarean section.\textsuperscript{87} And the expenditures might actually be lower when providers invoke conscience to withdraw treatment, by honoring the advance directive of a


\textsuperscript{83} See AM. HOSP. ASSOC., \textit{COSTS OF CARING REPORT} 2 (2022).

\textsuperscript{84} Sepper explains that forcing employers or states to accommodate conscientious providers of surgical abortion, for example, would “require[] the institution to subsidize financially an individual with whom it disagrees” by furnishing that person with “operating rooms, support staff, and instruments.” Sepper, supra note 80, at 1550.


comatose patient who is pregnant. Some more affirmative interventions might even avoid the need for more expensive ones that would be required without it. For example, sustained standard dialysis is a cheaper way to treat someone with end-stage kidney disease than the emergency type of dialysis that they would eventually need without it. And if the concern is just about healthcare expenses, abortion costs a fraction of labor and delivery.

Besides, refusals aren’t costless. They can strain medical systems in other ways that weaken the quality of care. For a state or hospital to maintain the range of services that it’s committed to making available, it might be forced to pay more to recruit replacements or backups through complicated systems of accommodation. These side effects are more dispersed and they may seem speculative. But they’re no less real or harmful. Sawicki has shown that thirty-three states insulate conscientious refusers from malpractice, however serious the damage, while just eight condition that immunity on either notifying patients that they conscientiously object to providing a clinically indicated intervention or even on telling them what their medical options are.

Shielding conscientious refusal but not conscientious provision predictably reduces access to contested forms of care in states that restrict care and regions where willing providers are scarce. Nearly thirty million Americans live over an hour from any trauma care. And roughly one in six live at least thirty miles away from the nearest hospital. As early as 1973, Representative Bella Abzug of New York foresaw how far-reaching protections for conscientious refusal could render access to care “meaningless” by authorizing

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89. See Lilia Cervantes et al., Clinicians’ Perspectives on Providing Emergency-Only Hemodialysis to Undocumented Immigrants, 169 ANNALS INTERNAL MED. 78, 78-79 (2018).
91. See Sepper, supra note 80, at 1551.
92. Sawicki, supra note 31, at 1281.
94. See Brendan G. Carr et al., Disparities in Access to Trauma Care in the United States: A Population-Based Analysis, 48 INJURY 332, 335 (2017).
“discrimination against persons of lesser means” who can’t “afford to go to another hospital . . . hundreds of miles distant.” These practical burdens fall hardest on those least able to bear them. Undocumented immigrants and poor women of color disproportionately lack the insurance, savings, or social supports to be away from work and home without imperiling their jobs or caretaking responsibilities. A conscience system that protects nearly all refusers and no providers makes it especially hard for the least advantaged to get the healthcare care they need.

Even if willing providers can be reached elsewhere, conscientious refusal can impose other practical and expressive costs on patients. That denial at the outset of their medical indication still forces them to find a new doctor, seek out-of-network care, and deal with travel and paperwork that can leave treatment less effective than it would have been if they’d gotten it sooner. And it’s not just that being refused care is inconvenient or irritating; that mild symptoms will go untreated for a bit longer; or that being told a doctor or nurse sees things differently feels disappointing.

Being turned away for reasons that are less medical than moral can also demean or humiliate patients. One pharmacist berated a woman who came to pick up a prescription for morning-after pill: “You’re a murderer!


98. See Rachel Kogan et al., Which Legal Approaches Help Limit Harms to Patients from Clinicians’ Conscience-Based Refusals?, 22 AMA J. Ethics E209, E211 (2020).


100. NeJaime & Siegel, supra note 8, at 2576–77.
I will not help you kill this baby. I will not have the blood on my hands."\textsuperscript{101}

Even if service denials aren’t accompanied by such explicit condemnation, conscientious refusals still have the potential to inflict dignitary harm. Professors Doug NeJaime and Reva Siegel explain that the pejorative social meaning of healthcare refusals may be perfectly “intelligible to the recipient” when it “reflects and reiterates a familiar message about contested sexual norms,” a message that can in turn disparage how a patient identifies or lives.\textsuperscript{102} All of which makes it hard to see how a cost differential alone could justify protecting all refusers and no providers.

Another way of trying to distinguish conscientious refusal from conscientious provision is more promising. It asks whether a clinician’s expression of conscience in one direction or the other can be vindicated consistent with a hospital or state’s background interest in having certain services—like reproductive or gender-affirming or end-of-life care—be available to people, or not. For an institution that wants to maintain access, accommodating conscientious refusal still enables patients to get that treatment elsewhere. It’s compatible with the larger policy. Whereas if the idea is that people shouldn’t have that care, then protecting its conscientious provision is inescapably at odds: it makes available the very care that an entity or the government means not to. Making space for providers conflicts with that background interest, but not for refusers. This is the strongest justification for preserving America’s lopsided system of exemptions for conscientious refusal but not provision. At least in theory. But it may not hold up in practice.

First consider permissive regimes that mean to make treatment available. Exempting conscientious refusers without condition or consequence can have the effect of leaving treatment out of reach for people who need it. Take the patient who lacks the wherewithal to track down their own backup provider without an easy referral. Or one who misunderstands a doctor’s moral opposition for a medical judgment that the risks outweigh the benefits. Or the conscientious denial of care that’s needed urgently when there isn’t a willing provider close enough to make it in time. Or when there aren’t enough hospitals or doctor’s offices within a given region to reliably provide treatment even if it isn’t time-sensitive. Or if the ratio of refusers to providers is high enough to leave backups unavailable. Everything depends on the circumstances.

The case of Tamesha Means is instructive. She’s a Michigan mother whose amniotic sac ruptured at eighteen weeks.\textsuperscript{103} The closest hospital, thirty


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Hospitals that do make that affiliation known may surprise even adherents

of the same faith. For example, some Catholic patients don’t realize

that their Catholic hospital would deny their clear wishes to withdraw

life-sustaining care if they’re suffering gravely at the end of life. And

minutes away, discharged her with instructions to come back the following

week. Her doctors at the Catholic-affiliated institution never told

her that the fetus she was carrying had no chance to survive, or that removing

it was the safest way to reduce the serious risk to her own life. Twice

more, she returned to the same emergency department, each time in worse

shape, yet again was refused treatment by doctors who could count on

immunity under the state’s conscience law—indeed, whether Means lived

or died Institutional consolidation constrains.

A government or institution that deems such care acceptable indeed

desirable for people to have won’t be able to supply it if too many of its facilities

or staff are unwilling. That’s more likely to happen if they conscientious

refusers find refuge from any penalty or discipline in one-

sided safeguards that are indifferent to the impact of widespread refusals on patient access.

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104. See id. at 5.

105. See id. at 2.

106. See id. at 2-3.

107. See, e.g., Joelle Takahashi et al., Disclosure of Religious Identity and Health Care Practices on Catholic Hospital Websites, 321 JAMA 1103, 1103 (2019). A New York bill would require hospitals to link on their websites to the State Department of Health’s list of each institution’s “policy-based exclusions,” detailing the care that they won’t provide. An Act to Amend the Public Health Law and the Insurance Law, In Relation to Providing Information to Patients and the Public on Policy-Based Exclusions, 2021 N.Y. Laws 2 (to be codified in scattered sections of N.Y. Ins. Law).


a patient deciding where to go for a tubal ligation, IUD, Plan B, or IVF might have no idea that her local clinic won’t provide these services after it’s merged or contracted with a Christian ministry. "Why would she assume that a nonprofit hospital, buoyed by large infusions of state and federal funds, could legally withhold health care from its patients?"111

Institutional consolidation constrains access most in parts of the country where unwilling facilities or clinicians are the only option for miles.112 Sectarian conglomerates have come to dominate healthcare markets in many rural towns and inner cities.113 Their control over healthcare access in these regions gets reinforced by clauses that let them restrict even time-sensitive services that they decline to provide on grounds of conscience.114 That’s how legally permitted procedures become unattainable for patients who lack the resources to reach willing providers at great distance and cost.115 Vindicating refusals so categorically can crowd out access to care that a state means its residents to have. If lopsided conscience clauses keep people from actually receiving some form of treatment, then these protections end up incompatible with a background commitment to making it available.

Still, accommodating conscientious provision seems to run roughshod over another state or hospital’s policy goal that people not be able to get a certain procedure or service.116 Must any accommodation for

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110. See supra text accompanying notes 58–61.
115. See supra text accompanying notes 131–36.
116. See Eric Mathison, The Wrong Argument for a Bad Law, AM. J. BIOETHICS, July 2021, at 77, 77. There may be reason to doubt whether the asserted interest in potential life is sincere if the state fails to promote in all sorts of other ways that are aren’t distinguishable by principled differences, competing tradeoffs, or legislative compromises. See Dov Fox, The State’s Interest in Potential Life, 43 J.L. MED. & ETHICS 345, 353 (2015). But a colorable challenge would require evidence of illicit motives. It isn’t enough to assume that enactment processes were captured or distorted in ways that don’t represent the will of the majority, especially when gerrymandering and other democratic deficits have become so pervasive that they’re unlikely to attract momentum for legal reform.
The Lopsided Law of Medical Conscience

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conscientious provision conflict inescapably with interests in banning healthcare outright? Perhaps if the measure of space that’s made for conscientious provision is modest, limited to claimants whose convictions compel them to supply clinically reasonably services. If it’s less an out-and-out right than a privilege that’s conditioned on accepting some sacrifice to exercise it. Even if more than the occasional conscientious provider were willing to sustain those costs and accordingly call for that partial accommodation, there may still be other ways for a state or hospital to express the public values or private mission that its background ban is meant to promote.

Still, exempting providers facially defeats the point of a treatment ban by negating the interest that it serves, for example, to promote public morals or an institution’s religious mission. This conflict is the strongest rationale for denying conscientious providers the solicitude that refusers get. But other reasons to protect conscientious providers can be even stronger.

Providers affirm their obligations to put patient interests first by honoring the wishes of people in need of medical treatment. Access to everything from X-rays to operations is too important to release doctors and nurses from core duties like emergency treatment and informed consent.117 Also, forcing doctors and nurses to sit by and watch avoidable harms befall the patients they’ve devoted their professional lives to caring for strikes at their fundamental charge to promote health and relieve suffering. Laws that generate this crisis of conscience inflict psychological distress and erode the social goods of making people well and keeping them healthy.118

Making space for conscientious providers isn’t about changing restrictive laws through the back door: trying to poke enough holes in a blanket prohibition so that the exception becomes the rule. The point is to affirm the noble ends of medicine and honor a principled commitment to pluralism. The gulf is too vast between powerful liability shields for conscientious denials and full exposure to punishments for conscientiously delivering care. One way to even things out: eliminate conscience protections for refusers and providers alike. Claimants would suffer moral distress and

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118. See supra text accompanying notes 17–20.
society would lose the dynamism of their dissenting voices from within. But ridding U.S. healthcare of conscience-based exclusions would leave objectors to enlist the democratic process to reform bad laws.

Still, a practical obstacle stands in the way of conscience abolition: conscience clauses are woven deep into the fabric of American law and medicine. Their entrenchment makes doing away with these exemptions politically impractical. As Elizabeth Sepper explains, “[a]ny workable solution” to accommodating conscience in American healthcare “cannot reject it out of hand.” Call to extricate conscience protections from healthcare have accordingly gained little traction, consigning patients in much of the country to a unilateral regime whose preference for refusals makes it harder to get treatment, however beneficial or badly needed.

With women forced to carry even dangerous pregnancies after Dobbs, the New England Journal of Medicine ran an editorial encouraging clinicians nationwide to collectively resist state restrictions on “evidence-based medical care, even if doing so means accepting — en masse — fines, suspensions of licensure, and potential imprisonment.” Institutional leadership and support is critical from accrediting organizations and influential groups like the American Medical Association. But that sacrifice is too much to expect of doctors, standing alone, and even shoulder to shoulder. Also, any doctor who’s preoccupied with trial or sitting in jail is one fewer who’s able to help care for patients.

Yet doctors have never so roundly condemned a Supreme Court decision like they have Dobbs. Almost every major professional organization and public health association denounced the ruling as “a direct attack on the practice of medicine and the patient-physician relationship.” At this inflection point, how should society reconcile what the clinical establishment thinks of contested treatments with the views of legislatures that make rules about them? We have been here before.

In 1959, criminologist Herbert Packer and doctor/lawyer Ralph Gampell published a groundbreaking study of abortion practices in California against the backdrop of the state’s therapeutic abortion law. The authors

119. Sepper, supra note 80, at 1563.
confidentially surveyed twenty-nine hospitals about whether they generally performed abortions for patients who presented under eleven detailed circumstances. The responses revealed that doctors “routinely performed therapeutic abortions [that] fall outside any possible . . . legal justification,” while many others that they supplied were “at best of dubious legality.”

The authors reflected on the “significant disparity between what the law commands” and what reputable doctors do. They resolved that the legal system “ought to be brought into greater conformity with” how medicine operates at its best to promote health and relieve suffering. The conscience clauses enacted in Roe’s wake made carve-outs for refusers a permanent feature of America’s legal and medical landscape. The fallout from Dobbs underscores why conscientious providers should get a break too.

A principled conscience regime would even things out by protecting refusers less and providers more, narrowing the wide gap in the law today from both top and bottom. For conscientious refusal: level down the broadscale immunities that burden patient access. For conscientious provision: level up accommodations — from none to some — while minimizing the potential disruption to institutional missions and state interests. If lawmakers won’t protect conscientious providers, then judges should: a partial excuse to supply medically indicated care.

This gesture toward balancing reforms leaves a great deal in the way of details to be worked out in future work. For now, it will have to do simply to clarify their dual purpose. The point isn’t just to sustain the moral integrity of conscientious providers by affording them space to tend to the sick and vulnerable, consistent with their professional oaths. It’s also to shore up the relationship between the practice of medicine and the rule of law that’s never felt so fragile.

124. See id. at 423, 425.
126. Packer & Gampell, supra note 466, at 417.
127. Id. at 449.