
Making Rules and Unmaking Choice: Federal Conscience Clauses, the Provider Conscience Regulation, and the War on Reproductive Freedom

Rachel White-Domain

Follow this and additional works at: <https://via.library.depaul.edu/law-review>

Recommended Citation

Rachel White-Domain, *Making Rules and Unmaking Choice: Federal Conscience Clauses, the Provider Conscience Regulation, and the War on Reproductive Freedom*, 59 DePaul L. Rev. 1249 (2010)
Available at: <https://via.library.depaul.edu/law-review/vol59/iss4/6>

This Comments is brought to you for free and open access by the College of Law at Via Sapientiae. It has been accepted for inclusion in DePaul Law Review by an authorized editor of Via Sapientiae. For more information, please contact digitalservices@depaul.edu.

MAKING RULES AND UNMAKING CHOICE: FEDERAL CONSCIENCE CLAUSES, THE PROVIDER CONSCIENCE REGULATION, AND THE WAR ON REPRODUCTIVE FREEDOM

One could eventually get to the point where the man who mines the iron ore that goes to make the steel, which is used by a factory to make instruments used in abortions could refuse to work on conscientious grounds.¹

In California, a physician refused to perform intrauterine insemination² on a woman after learning that she was a lesbian.³ In New Jersey, a labor and delivery nurse refused to help save the life of a pregnant woman who was “standing in a pool of [her own] blood” because the fetus was not expected to survive the necessary procedure.⁴ In Wisconsin, a pharmacist refused to fill a customer’s prescription for birth control pills and then, after the customer traveled to another pharmacy to obtain her medication, refused to relay the information necessary for the willing pharmacist to fill the prescription.⁵ And in Illinois, an ambulance driver refused to transport a pregnant woman who was suffering from abdominal pain to a nearby abortion clinic.⁶

Whether the law should allow healthcare workers to refuse to provide care, or protect the rights of the patients to receive care, and under what circumstances, is a question that has been vigorously de-

1. Robin Fretwell Wilson, *The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures*, 34 AM. J.L. & MED. 41, 58 (2008) (quoting 41 Iowa Op. Att’y Gen. 478 (1976)).

2. Intrauterine insemination is a fertility treatment in which semen is inserted into a patient’s uterus through a catheter. See *N. Coast Women’s Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959, 963 (Cal. 2008).

3. *Id.* The physician asserted that her refusal to treat the patient was based on the patient’s unmarried status, rather than her sexual orientation. *Id.* at 963 n.1. California courts have interpreted the Unruh Civil Rights Act, the state’s anti-discrimination statute, as prohibiting discrimination based on sexual orientation, but have not held that the law prohibits discrimination based on marital status. See *id.* at 962–63.

4. *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 223 (3d Cir. 2000).

5. *Noesen v. State Dep’t of Regulation and Licensing, Pharmacy Examining Bd.*, 751 N.W.2d 385, 389 (Wis. Ct. App. 2008).

6. *Li Fellers, Ambulance Firm Faces Bias Suit, Worker Fired After Refusing to Go to Abortion Clinic*, CHI. TRIB., May 9, 2004, § 4, at 3.

bated since *Roe v. Wade*⁷ was decided.⁸ Recent controversies over refusals by pharmacists to dispense contraceptives and by hospital staff to assist in the termination of life-sustaining treatment have reinvigorated the debate.⁹ And in December 2008, during the last few days of former President George W. Bush's term in office, the U.S. Department of Health and Human Services (HHS) promulgated a new federal regulation¹⁰ that further fueled both sides of this debate and brought conscience clauses,¹¹ the laws that regulate these rights and refusals, into the national spotlight.¹²

The Provider Conscience Regulation (PCR)¹³ was ostensibly designed to implement existing federal conscience clauses.¹⁴ Although the new regulation purports merely to clarify existing laws, the broad language used in the PCR does little to clarify the law and may even, as this Comment will argue, expand opportunities for providers to refuse to provide care.¹⁵ Furthermore, the PCR overlaps and conflicts with other federal laws and regulations.¹⁶ While contraceptive services are an apparent target of the regulation's supporters, the PCR implicates all potentially controversial healthcare services, including

7. 410 U.S. 113 (1973). In *Roe v. Wade*, the U.S. Supreme Court struck down a Texas statute that prohibited abortions except to save a woman's life. *Id.* In doing so, the Court for the first time recognized a constitutionally protected "right of privacy," explaining that

[t]his right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.

Id. at 153. The Court held, however, that the right to abortion is not absolute, and it adopted a trimester framework for evaluating the constitutionality of laws regulating abortion. *Id.* at 154, 162–64. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), the Supreme Court reaffirmed the basic holding of *Roe*, but it replaced the trimester framework with the undue burden test. *Id.* at 879.

8. See *Taylor v. St. Vincent's Hosp.*, 369 F. Supp. 948 (D.C. Mont. 1973). The plaintiff in this case, decided shortly after *Roe v. Wade*, sought an injunction against a hospital that had refused to allow its facilities or staff to be used during a sterilization procedure. *Id.*

9. See Jennifer N. Willcox, *Do Health Providers Have "Right to Refuse"? "Conscience Clauses" Allow Hospitals to Opt Out of Abortions, Other Procedures*, 35 CONN. L. TRIB. 19 (2009) (discussing legal and legislative efforts by advocates on both sides of the debate).

10. See David Stout, *Medical "Conscience Rule" Is Issued*, N.Y. TIMES, Dec. 19, 2008.

11. I have chosen to use the term "conscience clauses," although I recognize that the favored term among some supporters of reproductive rights is "refusal clauses."

12. See Willcox, *supra* note 9.

13. The full name of the regulation is "Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law." 45 C.F.R. § 88 (2008) [hereinafter *Provider Conscience Regulation*].

14. See Rob Stein, *Protections Set for Antiabortion Health Workers*, WASH. POST, Aug. 22, 2008, at A1.

15. See *infra* Part IV.B.

16. See *infra* Part IV.C.

end-of-life care; fertility treatment; and healthcare services for lesbian, gay, bisexual, and transgender individuals.¹⁷

Opposition to the PCR has been vociferous. During the thirty-day comments period that ran from the end of August 2008 to the end of September 2008, over 90,000 individuals submitted comments opposing the PCR.¹⁸ During his election campaign, then-presidential candidate Barack Obama promised to revise the PCR,¹⁹ and it is currently under review by his Administration.²⁰ In January 2009, seven states, not content to wait for relief from the federal level, filed a lawsuit challenging the PCR.²¹ At this time, however, the PCR remains in effect, and unless it is significantly altered by the Obama Administration or invalidated by the courts, it promises to have a devastating effect on the healthcare system.

The purpose of this Comment is threefold: to map the legal and political contexts in which the PCR was promulgated, to propose a theoretical framework within which conscience clauses may be effectively analyzed, and to analyze the text and potential impact of the PCR and the extent to which it conflicts with existing federal laws and regulations. Underlying the discussion of these points is the norma-

17. See NAT'L WOMEN'S LAW CTR., *THE HHS RULE ON PROVIDERS' RIGHT TO REFUSE TO PROVIDE HEALTH CARE: REACHING EVEN FURTHER THAN FAMILY PLANNING AND ABORTION SERVICES 1* (2008), <http://www.nwlc.org/pdf/HHS%20Rule%20Beyond%20Family%20Planning.pdf> (explaining that the Provider Conscience Regulation (PCR) could limit access to treatment for infertility, depression, drug addiction, and HIV/AIDS); *Critics: Proposed "Provider Conscience" Regulation Threatens Public Health*, *ADVOCATE*, Sept. 2008, http://www.advocate.com/news_detail_ektid62434.asp (discussing the threat posed by the PCR to healthcare access for lesbian, gay, bisexual, and transgender individuals); Letter from Sharon L. Camp, President and CEO, Guttmacher Inst., to the Dep't of Health & Human Servs. (Sept. 24, 2008), <http://www.guttmacher.org/media/resources/2008/09/24/GuttmacherInstitute-re-ConscienceRegulation.pdf> (explaining that the PCR could limit access to pap tests, treatment for sexually transmitted infections, blood transfusions, vaccinations, or end-of-life treatment); Letter from Richard F. Daines, Comm'r, State of N.Y. Dep't of Health, to the Dep't of Health & Human Servs. (Sept. 23, 2008), http://www.ny.gov/governor/press/pdf/press_0925085.pdf (explaining that the PCR could limit access to end-of-life care, stem cell research, blood transfusions, vaccinations, treatment for HIV/AIDS and other sexually transmitted infections, treatment for drug and alcohol addictions, and stem cell research, as well as healthcare for immigrants without status, and lesbian, gay, bisexual, and transgender individuals).

18. Press Release, Planned Parenthood, *The Opposition Is Overwhelming but Will the Administration Listen?* (Sept. 27, 2008), <http://www.plannedparenthood.org/newsroom/press-releases-5593.htm> (select the title of the article from the list). See generally *Regulations.gov*, *Your Voice in Federal Decision-making*, <http://www.regulations.gov/> (last visited Jan. 9, 2010) (providing access through a search engine to all comments submitted to HHS within the thirty-day comments period).

19. See *7 States Sue Government over U.S. Abortion Rule*, *N.Y. TIMES*, Jan. 16, 2009, at A14.

20. Rob Stein, *Health Care Workers' "Conscience" Rule Set to Be Voided*, *WASH. POST*, Feb. 28, 2009, at A1.

21. *7 States Sue Government*, *supra* note 19.

tive assumption that the right of the patient to receive unbiased information and quality healthcare in accordance with her own needs and beliefs should take precedence over the personal beliefs of the provider who is acting in his professional capacity.²² The Comment proceeds as follows. Part II provides some legal context; this Part surveys federal conscience clauses and discusses several legal challenges to them.²³ Part III provides some political context by sketching the stage on which the PCR debuted, and it argues that the PCR, even in its revised version, is best understood as an effort to advance the goals of the anti-contraception movement, whose members insist that contraception is indistinguishable from abortion.²⁴ Part IV first makes a broadly applicable, theoretical argument that conscience clauses should be understood to represent a zero-sum game in which the benefit lost is not *services* but *access to services*.²⁵ Second, Part IV proposes a simple framework for analyzing conscience clauses, examines the actual text of the current regulation using this framework, and finds that the PCR effects a shift toward a “facilitator model” of conscience protection.²⁶ Third, Part IV argues that the PCR overlaps and conflicts with existing federal laws and with other federal regulations.²⁷

Although the current version of the PCR is on the chopping block as this Comment goes to print, the issues raised here will remain relevant to an analysis of the new version of the PCR and may also contribute to the broader national debate over the appropriate scope of conscience clauses.

II. MAPPING THE LEGAL TERRAIN: FEDERAL CONSCIENCE CLAUSES AND CONSTITUTIONAL DISCONTENTS

The PCR is ostensibly an effort to implement existing federal conscience clauses. To understand the PCR (or its potential successor), it is therefore necessary to first examine the federal laws that currently define the scope of legal protections for healthcare providers who refuse to provide care. Section A of this Part introduces the federal

22. It is not the purpose of this Comment to make a normative argument in defense of limited conscience clauses. For a persuasive argument that the needs of patients should take precedence over the personal views of the healthcare provider, see Martha S. Swartz, “Conscience Clauses” or “Unconscionable Clauses”: *Personal Beliefs Versus Professional Responsibilities*, 6 *YALE J. HEALTH POL’Y L. & ETHICS* 269 (2006).

23. See *infra* notes 30–80 and accompanying text.

24. See *infra* notes 81–115 and accompanying text.

25. See *infra* Part IV.A.

26. See *infra* Part IV.B.

27. See *infra* Part IV.C.

conscience clauses.²⁸ Section B examines several legal challenges that have been brought against them, largely without success.²⁹

A. Federal Conscience Clauses

In *Roe v. Wade*, the Supreme Court held that the U.S. Constitution encompasses the right to have an abortion.³⁰ That same year, in *Doe v. Bolton*—*Roe*'s less well-known companion case—the Court struck down other barriers to abortion access, but tacitly approved a Georgia conscience clause that allowed “a physician or any other employee . . . to refrain, for moral or religious reasons, from participating in the abortion procedure.”³¹ The *Doe* opinion thus paved the way for what would later become a tidal wave of state³² and federal legislation purporting to protect the consciences of healthcare providers.³³ These statutes have been the subjects of very serious criticisms, especially in recent years.³⁴ Most recently, the debate has focused on whether conscience clauses should protect pharmacists who refuse to fill prescriptions for daily contraceptives such as “the pill,” or to dispense emergency contraception (EC), colloquially known as “the morning after pill.”³⁵ The recent battle over EC brought the war over conscience clauses into sharp relief. Most recently, the PCR, which was ostensibly drafted to implement three federal conscience clauses,

28. See *infra* notes 28–58 and accompanying text.

29. See *infra* notes 59–80 and accompanying text.

30. See *Roe v. Wade*, 410 U.S. 113 (1973).

31. *Doe v. Bolton*, 410 U.S. 179, 197–98 (1973).

32. See GUTTMACHER INST., STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES (Jan. 1, 2010), http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf (illustrating diagrammatically the policies of all fifty states regarding refusals by healthcare providers to provide care that they find objectionable).

33. See Maxine M. Harrington, *The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs*, 34 FLA. ST. U. L. REV. 779, 784 (2007) (“Since 1973, the scope of refusal legislation has greatly expanded.”).

34. See, e.g., Swartz, *supra* note 22, at 277 (“The provision of medically indicated health care should be the health care professional’s primary responsibility, subordinating personal religious or moral beliefs to the needs of patients.”).

35. See, e.g., Nell O. Kromhout, *Crushed at the Counter: Protection for a Pharmacist’s Right of Conscience*, 6 AVE MARIA L. REV. 265 (2007) (arguing for more stringent protections for pharmacists who refuse to fill prescriptions); Nancy K. Kubasek, Daniel C. Tagliarina & Corinne Staggs, *The Questionable Constitutionality of Conscientious Objection Clauses for Pharmacists*, 16 J.L. & POL’Y 225 (2007) (arguing that broad state refusal clauses, such as that of South Dakota, should be struck down as unconstitutional); Sarah J. Vokes, *Just Fill the Prescription: Why Illinois’ Emergency Rule Appropriately Resolves the Tension Between Religion and Contraception in the Pharmacy Context*, 24 LAW & INEQ. 399 (2006) (arguing in support of an Illinois executive order that requires pharmacists to dispense contraceptives “without delay”). See generally *In Search of Plan C*, ECONOMIST, Apr. 9, 2005, at 26 (discussing the increasing number of incidents of pharmacists in the United States refusing to fill prescriptions for contraceptives).

namely, the Church Amendment,³⁶ the Coats Amendment,³⁷ and the Weldon Amendment,³⁸ shifted the focus of this debate from the state level—where most battles over conscience protections have been fought during the past few decades—to the national level.

Congress passed the Church Amendment in 1973 in response to *Roe v. Wade* and a less well-known case decided the same year, *Taylor v. St. Vincent's Hospital*.³⁹ In *Taylor*, a Catholic hospital refused to allow one of its doctors to perform a tubal ligation on a patient.⁴⁰ The prospective patient was a pregnant woman who was scheduled to deliver her child by cesarean section and wanted to undergo a tubal ligation at the same time.⁴¹ Doing so would have allowed her to undergo one surgery, rather than two, and thereby to avoid the unnecessary risk of having a second operation. St. Vincent's Hospital was the only hospital in the area with a maternity department and, therefore, the only location at which the dual-purpose procedure could have been performed.⁴² The district court initially issued a preliminary injunction against the hospital, barring them from interfering with the doctor's performance of the procedure.⁴³ The court reasoned that the hospital was a state actor because it received federal funding and, therefore, that denying the patient care was an infringement of her rights under the Constitution.⁴⁴ Congressional response to the *Taylor* case was swift: the Church Amendment specifically disapproved of the district court's conclusion, and the court was forced to dissolve the injunction.⁴⁵

After subsequent revision, the Church Amendment now provides several protections for entities receiving federal funds, as well as the

36. 42 U.S.C. § 300a-7 (2008).

37. 42 U.S.C. § 238n (2008). The PCR refers to the Coats Amendment as the Public Health Service Act, of which the Amendment is part. See Provider Conscience Regulation, 45 C.F.R. § 88.1 (2008).

38. Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809, 3163 (2004).

39. 369 F. Supp. 948 (D.C. Mont. 1973); see Leora Eisenstadt, *Separation of Church and Hospital: Strategies to Protect Pro-Choice Physicians in Religiously Affiliated Hospitals*, 15 YALE J.L. & FEMINISM 135, 145-47 (2003).

40. See *Taylor*, 369 F. Supp. at 949. Tubal ligation is the procedure used to sterilize women; during tubal ligation, "both fallopian tubes are blocked by tying, sealing, or attaching a ring or clip to them." American College of Obstetrics and Gynecology, ACOG Education Pamphlet AP035—Sterilization by Laparoscopy (Feb. 2003), http://www.acog.org/publications/patient_education/bp035.cfm.

41. See *Taylor*, 369 F. Supp. at 949.

42. See *id.*

43. See *id.* at 951.

44. See *id.* at 950.

45. See *id.* at 950-51.

employees of these entities. First, the Amendment prohibits courts from using an individual's receipt of federal funds as a basis for requiring that individual to perform or assist in the performance of abortions or sterilization procedures.⁴⁶ Likewise, the Amendment also prohibits courts from requiring an entity that receives federal funds to allow its facilities or personnel to be used to provide abortions or sterilization procedures.⁴⁷ Second, the Amendment provides that a healthcare entity that receives federal funds cannot discriminate against an employee or potential employee because she performed or assisted in the performance of an abortion or sterilization procedure, because she refused to do so, or on the basis of her "religious beliefs or moral convictions respecting sterilization procedures or abortions."⁴⁸ Third, and perhaps most importantly for the purposes of this analysis, the Individual Protection Clause (IPC) of the Church Amendment states as follows:

No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions.⁴⁹

Like any statute, the scope of this provision depends on the precise meaning of several key words. Most significantly, unlike the other provisions of the Church Amendment, the IPC is not limited to abortion and sterilization procedures.⁵⁰ But other key words are less clear. What is a "health care program," as the term is used here? What does it mean to "assist in the performance of"? These terms leave much room for interpretation, and for decades, this space has remained largely unfilled by courts or federal agencies. The PCR is controversial because it answers these questions in a way that favors protecting provider refusals over patient rights.

In the three decades following the passage of the Church Amendment, Congress continued to develop federal conscience protections. Passed in 1988, the Danforth Amendment provides that Title IX, which prohibits sex discrimination in public schools and extracurricular programs, should not be interpreted by courts to require an individual or healthcare entity to pay for or provide abortions.⁵¹ In 1996,

46. See 42 U.S.C. § 300a-7(b)(1) (2006).

47. See § 300a-7(b)(2).

48. § 300a-7(c)(1).

49. § 300a-7(d).

50. See *id.*

51. See 20 U.S.C. § 1688 (2006); Wilson, *supra* note 1, at 50 & n.50.

Congress passed the Coats Amendment, which prohibits discrimination against healthcare professionals and entities that refuse to receive medical training in abortion services.⁵² And in 1997, Congress passed laws providing that Medicare and Medicaid managed care plans are not required to pay for counseling and referral services if the plan “objects to the provision of such service on moral or religious grounds.”⁵³ The Medicare and Medicaid provisions are notable because they were the first federal laws to expand conscience protections beyond entities directly involved in the provision of care (for example, doctors and hospitals) to encompass entities indirectly involved in the provision of care (namely, payers).⁵⁴ This expansion is significant for several reasons. Whereas a patient faced with an objecting provider can seek the same care from another provider, a patient faced with an objecting *payer* cannot simply use another payer—instead, the patient must forgo the desired service unless she is able to pay out-of-pocket, a result that illustrates the class dimensions of the conscience clause debate. Furthermore, the recognition of objecting payers as desirable candidates for protection marked an important shift in the way federal policymakers delineated conscience protections: whereas earlier federal laws were concerned with entities and individuals who wanted to avoid being *personally* involved in providing purportedly objectionable services, the Medicare and Medicaid clauses effectively allow managed care plans to obstruct the performance of objectionable services by *other* individuals and entities.

Congress’s newest contribution to federal conscience clause jurisprudence is the Weldon Amendment. Passed in 2004, the Weldon Amendment prohibits discrimination against any individual or entity, including “an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, *or any other kind of health care facility, organization or plan*” that refuses to “provide, pay for, provide coverage of, or refer for abortions.”⁵⁵ Notably, while the Weldon Amendment applies to a broad range of both direct and indirect healthcare providers, including payers, the potential breadth of the Amendment is restricted on another front: protection extends only to

52. See 42 U.S.C. § 238n (2006).

53. See 42 U.S.C. § 1395w-22(j)(3)(B) (2006); 42 U.S.C. § 1396u-2(b)(3)(B) (2008).

54. JODY FEDER, CONG. RES. SERV., THE HISTORY AND EFFECT OF ABORTION CONSCIENCE CLAUSE LAWS 3 (2005), available at <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf>.

55. Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d), 118 Stat. 2809, 3163 (2004).

refusals related to abortions.⁵⁶ With regard to individuals, the Amendment merely protects refusals to “provide” this service, thereby further restricting the scope of the Amendment by extending protection to only those individuals who are in very close proximity to the service.⁵⁷ On the other hand, the Amendment does not limit protection to religious objections; protection is extended to refusals made on any grounds.⁵⁸

B. *Legal Challenges to Federal Conscience Clauses*

The constitutionality of conscience clauses is an issue that has been raised with some frequency both in the courts and in legal scholarship. One author commented that conscience clauses fit into the “play in the joints”⁵⁹ between the Free Exercise Clause and the Establishment Clause.⁶⁰ Courts have held that conscience clauses are neither mandated by the Free Exercise Clause nor forbidden by the Establishment Clause.⁶¹ As recently as 2008, the California Supreme Court recognized that “under the United States supreme court’s most recent holdings, a religious objector has *no federal constitutional right* to an exemption from a neutral and valid law of general applicability on the ground that compliance with that law is contrary to the objector’s religious beliefs.”⁶² The bedrock principle behind this legal conclusion, frequently cited by courts adjudicating Free Exercise claims, is that while “freedom of religious belief is absolute . . . freedom of religious conduct by its nature cannot be.”⁶³ Conscience clauses give providers the right to engage in certain *conduct* or, perhaps more accurately, to refuse to engage in certain conduct when engaging in such conduct

56. *See id.*

57. *Id.*

58. *See id.*

59. Melissa Duvall, *Pharmacy Conscience Clause Statutes: Constitutional Religious “Accommodations” or Unconstitutional “Substantial Burdens” on Women?*, 55 AM. U. L. REV. 1485, 1502 (2006).

60. Both the Establishment Clause and the Free Exercise Clause are contained in the First Amendment, which reads, “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof.” U.S. CONST. amend. I.

61. Swartz, *supra* note 22, at 327 (“[R]efusal clauses are neither constitutionally mandated by the Free Exercise Clause, nor constitutionally forbidden by the Establishment Clause.”) (citing Katherine White, *Crisis of Conscience: Reconciling Religious Health Care Providers’ Beliefs and Patients’ Rights*, 51 STAN. L. REV. 1703, 1729–30 (1999)).

62. *N. Coast Women’s Care Med. Group, Inc. v. San Diego County Super. Ct.*, 189 P.3d 959, 966 (Cal. 2008) (citing *Employment Div. Ore. Dep’t of Human Res. v. Smith*, 494 U.S. 872, 879 (1990); *accord Church of Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520, 531 (1993)).

63. Patricia L. Selby, *On Whose Conscience? Patient Rights Disappear Under Broad Protective Measures for Conscientious Objectors in Health Care*, 83 U. DET. MERCY L. REV. 507, 532 (2006) (citing *Cantwell v. Connecticut*, 310 U.S. 296, 303–04 (1940)).

would otherwise be a condition of employment. Thus, conscience clauses are not statutory expressions or derivations of the constitutional right to freedom of religion; instead, to the extent that they allow providers to engage in certain *conduct*, these clauses go beyond the right to freedom of religion guaranteed by the Constitution.

On the other hand, courts have held that conscience clauses do not constitute *per se* violations of the Establishment Clause. In a case filed less than a year after the passage of the Church Amendment, the Ninth Circuit rejected a constitutional challenge to the Amendment, reasoning that the purpose of the Amendment was to preserve the government's neutrality in the abortion debate, not to affirmatively promote one religious view over another.⁶⁴ Notably, while the Church Amendment specifically provides for the protection of individuals and entities whose objections are based on their "religious beliefs or moral convictions," a trend might be recognized among new state conscience clauses, which now frequently omit any requirement that objections be based on either religious or moral grounds.⁶⁵ Some commentators have observed that this expansion of protection has even further insulated conscience clauses against successful challenge under the Establishment Clause because, by their terms, these laws protect personal objections as well as those based on the teachings of organized religions.⁶⁶

The Weldon Amendment has also survived several legal challenges. In 2006, recipients of Title X, the federal program that funds family planning services, challenged the Amendment.⁶⁷ The recipient groups argued that the terms of the Amendment conflicted with Title X funding regulations, which require recipients to provide pregnant patients with information regarding all of their reproductive options, including abortion.⁶⁸ The recipients based their claim on the potential loss of funding that would result if they failed to comply with their Title X obligations in an effort to avoid violating federal law.⁶⁹ The U.S. Court of Appeals for the District of Columbia found that any loss of funding was hypothetical and rejected the challenge for lack of standing.⁷⁰ However, taking a position that seems to validate the Title X recipients' funding concerns, in HHS's response to comments that it

64. See *Chrisman v. Sisters of St. Joseph of Peace*, 506 F.2d 308, 311 (9th Cir. 1974).

65. Swartz, *supra* note 22, at 293.

66. See, e.g., Harrington, *supra* note 33, at 795.

67. See *Nat'l Family Planning & Reprod. Health Ass'n. v. Gonzalez*, 468 F.3d 826 (D.C. Cir. 2006).

68. See *id.* at 828.

69. See *id.* at 829.

70. See *id.* at 831.

received about the PCR, it notes that the Title X regulation that requires recipients of federal funding to provide counseling and referrals for abortion services “is inconsistent” with federal conscience laws and with the PCR.⁷¹ The solution proposed by HHS in its response is that the Title X counseling and referral requirement will no longer be enforced.⁷² The potential ramifications of this solution will be discussed below.⁷³

In *California v. United States*, the state of California challenged the Weldon Amendment.⁷⁴ The state alleged that the Amendment—which contains no explicit exception requiring medical personnel to act as necessary in order to save lives during medical emergencies—conflicted with a California law mandating the provision of medical care in an emergency, including, when necessary, an abortion.⁷⁵ Therefore, the state argued, the Weldon Amendment infringed on state sovereignty.⁷⁶ In an opinion handed down in March 2008, a federal district court rejected the challenge, reasoning that, because the Weldon Amendment was silent on the issue of emergency care, it should be read in light of the Emergency Medical Treatment and Active Labor Act (EMTALA)⁷⁷—a federal law that requires the provision of emergency services—and on which the California state law is based.⁷⁸ Therefore, the district court concluded, the Weldon Amendment did not conflict with state law.⁷⁹

Thus, federal conscience clauses, although not mandated by the Constitution, have withstood legal challenge in the courts.⁸⁰ With the legal soundness of federal conscience laws repeatedly confirmed by

71. Provider Conscience Regulation, 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008) (codified at 45 C.F.R. § 88 (2009)) (noting that the Title X requirement is “inconsistent with the health care provider conscience protection statutory provisions and this regulation”).

72. *See id.*

73. *See infra* notes 181–192 and accompanying text.

74. *California v. United States*, No. C 05-00328 JSW, 2008 WL 744840, at *1 (N.D. Cal. Mar. 18, 2008).

75. *See id.* at *1.

76. *See id.*

77. 42 U.S.C. § 1395dd(a)–(c) (2006).

78. *See California v. United States*, 2008 WL 744840, at *4.

79. *See id.*

80. In contrast, reproductive rights advocates have had some success in challenging state conscience clauses. In a case out of Alaska, for example, advocates argued that the state’s conscience clause violated the state constitution, which explicitly provides for a right of privacy. *See Valley Hosp. Ass’n v. Mat-Su Coalition for Choice*, 948 P.2d 963 (Ala. 1997). The Alaska Supreme Court agreed, holding that quasi-public hospitals could not refuse to provide abortions. *Id.* at 971–72. For a discussion of other state constitutions, the extent to which they embrace a more explicit right to privacy than the federal constitution, and the resulting potential for using state constitutions to increase access to reproductive healthcare, see Scott A. Moss & Douglas M. Raines, *The Intriguing Federalist Future of Reproductive Rights*, 88 B.U. L. REV. 175 (2008).

courts, but their constitutional necessity denied with equal clarity, the scope of these conscience clauses is left to depend largely on the outcomes of political (some would say ethical) debates.

III. MAPPING THE POLITICAL TERRAIN: THE CONCEPTION OF THE PCR AND THE ANTI-CONTRACEPTION MOVEMENT

In July 2008, a preliminary draft of the PCR was leaked on the Internet.⁸¹ The draft explicitly defined the term “abortion” to include any treatment that interfered with the implantation of a fertilized egg.⁸² Pro-choice advocates were stunned.⁸³ Contraceptives, including emergency contraception and ordinary birth control methods such as “the pill,” work primarily to prevent fertilization, but they might sometimes work to prevent implantation of a fertilized egg.⁸⁴ Thus, under the language of the leaked draft, commonly used birth control methods such as “the pill” and intrauterine devices (IUDs), as well as emergency contraception, would be considered “abortion,” a result that is radically at odds with medical, legal, and popular consensus on the definition.⁸⁵

In response to widespread criticism of the leaked draft, HHS revised the PCR and released an official draft in August 2008.⁸⁶ In the revised version, HHS abandoned any attempt to define the term “abortion.”⁸⁷ In response to questions about the omission, HHS Secretary Michael Leavitt told reporters, “This regulation does not seek to resolve any ambiguity in that area.”⁸⁸ The medical community, however, harbors no ambiguity over the meaning of the term “abor-

81. See Robert Pear, *Abortion Proposal Sets Condition on Aid*, N.Y. TIMES, July 15, 2008, at A17.

82. Dep’t of Health & Human Servs., Provider Conscience Regulation 16–17 (July 22, 2008), <http://www.rhrealitycheck.org/emailphotos/pdf/HHS-45-CFR.pdf>. Note that this is the unofficial draft version of the regulation.

83. See Statement by Cecile Richards, President, Planned Parenthood Fed’n of Am. (July 15, 2008), <http://www.plannedparenthood.org/newsroom/> (select “Press Releases,” then select “Planned Parenthood: Proposed HHS Rule Would Compromise Women’s Health Care”).

84. See Russell Shorto, *Contra-Contraception: Is This the Beginning of the Next Culture War?*, N.Y. TIMES MAG., May 7, 2006, at 48, 53. Doctors do not know with certainty whether contraceptives prevent the implantation of a fertilized egg. *Id.* The uncertainty is the result of two obstacles to testing the hypothesis, namely, ethical problems associated with testing and the difficulty of distinguishing statistically between the half of all fertilized eggs that naturally fail to implant from those that may fail to implant as a result of the patient’s contraceptive method. *Id.*

85. See Rachel Benson Gold, *The Implications of Defining When a Woman is Pregnant*, 8 GUTTMACHER REPORT ON PUBLIC POLICY 7 (May 2005), <http://www.guttmacher.org/pubs/tgr/08/2/gr080207.pdf>.

86. See Stein, *supra* note 14.

87. *Id.* at A8.

88. *Id.*

tion.”⁸⁹ And in fact, despite Secretary Leavitt’s apparent confusion, HHS unambiguously defined the term in a regulation that was promulgated over thirty years ago and that is still in effect. In the context of that regulation, which is related to funding for medical research, HHS unambiguously stated, “Pregnancy encompasses the period of time from implantation until delivery.”⁹⁰ Under this definition, birth control, which is ineffective after implantation, would not be considered abortion.

The omission of a clear definition of the term “abortion” in the final draft of the PCR does not, therefore, represent a neutral approach; instead, it represents a desire to create an opportunity for modification of the definition of “abortion” that is currently in place. Any purported confusion over the term “abortion” is the product of the anti-contraception movement’s targeted campaign to redefine the term “abortion” to encompass contraception⁹¹ in order to, *inter alia*, effect an increase in the scope of conscience clause protections. In fact, redefining the term “abortion” has been a very serious goal of the anti-contraception movement for many years. Two of the oldest pro-life organizations, the Pro-Life Action League and the National Right to Life Committee, both endorse the view that life begins at fertilization.⁹² The Pro-Life Action League and the American Life

89. See CENTER FOR REPRODUCTIVE RIGHTS, GOVERNMENTS WORLDWIDE PUT EMERGENCY CONTRACEPTION INTO WOMEN’S HANDS 2 (2004), http://reproductiverights.org/sites/default/files/documents/pub_bp_govtswwec.pdf (explaining that, according to the World Health Organization (WHO) and the International Federation of Gynecology and Obstetrics, pregnancy begins at implantation, and therefore, emergency contraception is not an abortifacient); Jennifer Johnsen, *The Difference Between Emergency Contraception and Medication Abortion*, in PLANNED PARENTHOOD FEDERATION OF AMERICA FACT SHEET 1 (2006), <http://www.plannedparenthoodaction.org/files/ecmedab1206.pdf> (explaining that, according to several health organizations, including the American College of Obstetricians and Gynecologists (ACOG) and the U.S. Department of Health and Human Services (HHS), pregnancy begins at implantation, and therefore, emergency contraception is not an abortifacient).

90. Letter from Family Planning Advocates of N.Y. State to the U.S. Dep’t of Health & Human Servs. (Sept. 24, 2008), <http://www.regulations.gov/> (enter the following document identification number into the search box: HHS-OS-2008-0011-4949.1). In its letter to HHS, the American Civil Liberties Union explained that Congress has always distinguished contraceptives from abortion and has repeatedly rejected attempts to blur the distinction. See Letter from the Wash. Legislative Office of the Am. Civil Liberties Union to the U.S. Dep’t of Health & Human Servs. 6 (Sept. 25, 2008), http://www.aclu.org/images/asset_upload_file467_36942.pdf.

91. See, e.g., Ill. Right to Life Comm., Study Confirms Plan B Is Abortifacient and Unreliable, http://www.illinoisrighttolife.org/2007_2_PlanBunreliable.htm (last visited Jan. 9, 2010) (falsely claiming that Barr Pharmaceuticals, the company that produces Plan B—the only version of the morning after pill currently sold in the United States—has admitted that its product is an abortifacient).

92. See Pro-Life Action League, Questions & Answers: When Does Life Begin?, <http://prolifeaction.org/faq/unborn.php> (last visited Jan. 9, 2010) (asserting that “[a]s far as observable science is concerned, human life begins at conception”); Nat’l Right to Life Comm., When Does Life

League actively oppose contraception; the latter group, one of the largest pro-life groups in the United States, explains that “once fertilization has taken place . . . [a] new tiny person has been formed.”⁹³ The Pro-Life Action League asserts, “One function [of emergency contraceptives] is to prevent implantation of a fertilized egg. That’s abortion.”⁹⁴ Some pro-life professional groups, including the Christian Medical and Dental Associations,⁹⁵ Pharmacists for Life International,⁹⁶ and the legal non-profit Americans United for Life,⁹⁷ have also endorsed this view.

And some state legislatures have been persuaded. South Dakota’s conscience clause provides that “[n]o pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to . . . [d]estroy an unborn child,” which the law defines as “an individual . . . from fertilization until live birth.”⁹⁸ According to Missouri legislators, “The life of each human being begins at conception.”⁹⁹ And as recently as the last presidential election, the citizens of Colorado voted on (but defeated) a constitutional amendment, known as Amendment 48, that would have given fertilized eggs full

Begin?, <http://www.nrlc.org/abortion/wdlb/wdlb.html> (last visited Jan. 9, 2010) (claiming that “[a] new individual human being begins at fertilization”). Although the National Right to Life Committee endorses the view that life begins at fertilization, the group states that it does not have an official position on whether contraception is abortion. See Nat’l Right to Life Comm., Mission Statement, <http://www.nrlc.org/Missionstatement.htm> (last visited Jan. 9, 2010). Significantly, the National Right to Life Committee (along with Americans United for Life) refused to support the defeated Amendment 48, discussed *infra* note 100 and accompanying text. See Sarah Kliff, *Roe v. Wade v. Kristi*, NEWSWEEK, Nov. 10, 2008, at 14. Their refusals illustrate the deep divisions within the broader pro-life movement over the contraception issue.

93. Am. Life League, Birth Control: The Abortion Connection (Oct. 5, 2005), <http://www.all.org/article.php?id=10125>.

94. Joe Scheidler, Action News Hotline, Pro-Life Action League (Nov. 18, 2005), <http://www.prolifeaction.org/hotline/2005/1118.htm>. Although emergency contraception is a favorite target of the anti-contraception movement, no relevant distinction between emergency contraception and ordinary birth control exists: both contain the same active ingredients and both may work to prevent implantation of a fertilized egg. See Shorto, *supra* note 84, at 53.

95. See Shorto, *supra* note 84, at 53; see Christian Med. & Dental Ass’n, The Beginning of Human Life, <http://www.cmda.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=3848> (last visited Jan. 9, 2010) (“The life of a human being begins at the moment of fertilization . . . [and] the full moral worth afforded to every human being is equally afforded from fertilization onward throughout development.”).

96. See Pharmacists for Life Int’l, Plan B [Emergency Abortion Pill] FAQs, <http://www.pfli.org/main.php?pfli=planbfaq> (last visited Jan. 9, 2010) (“Emergency Abortion drugs like Plan B are abortifacient 75 to 89% of the time. Rarely will a drug like Plan B work to suppress ovulation and truly prevent the meeting of the male and female gametes PRIOR to the moment of conception.”).

97. See Shorto, *supra* note 84, at 50.

98. S.D. CODIFIED LAWS § 36-11-70(2) (1999); S.D. CODIFIED LAWS § 22-1-2(50A) (1998).

99. MO. STAT. ANN. § 1.205(1) (West 2006).

constitutional rights.¹⁰⁰ All of these legislative items effectively blur the line between abortion and contraception.

Whether the former Bush Administration was sympathetic to the movement's goals can generously be described as unclear. In 2005, a reporter asked former Press Secretary Scott McClellan a seemingly simple question: Does President Bush support contraception?¹⁰¹ McClellan dodged the question, and then, in response to the reporter's persistence, blatantly stated that he would not answer.¹⁰² Nor would the former President respond to requests from members of the House of Representatives for clarification on his views.¹⁰³ Notably, when the PCR was first released, critics called it Bush's "final gift to the radical right."¹⁰⁴

Most disconcerting to reproductive rights advocates is the possibility that courts will be sympathetic to the movement's efforts to blur the lines between abortion and contraceptives. To date, such attempts have been almost uniformly rejected by the courts. But in 2001, a federal district judge in Ohio issued a preliminary ruling that a state law allowing healthcare professionals to refuse to provide "abortions" could protect a pharmacist who had refused to dispense contraceptives.¹⁰⁵ The court reasoned that the pharmacist's "*subjective* belief that the particular medication caused what *she believed* to be abortion" was sufficient to trigger protection under the law.¹⁰⁶ By allowing the objecting provider to define the scope of her own rights under the state conscience clause, this court introduced what could be described as a "subjective test" into conscience clause jurisprudence. If adopted by other courts, the introduction of a subjective test into this area of

100. Electa Draper, *Amendment 48 "Personhood" Push Rejected*, DENVER POST, Nov. 5, 2008, at B4. Over 130,000 Coloradoans signed petitions to put the referendum on the ballot, but the measure was defeated by a vote ratio of three-to-one. *Id.*

101. See Shorto, *supra* note 84, at 51.

102. See *id.* at 51, 53.

103. See *id.* at 53.

104. Jessica Arons, *Last Chance to Fight Hypocritical and Deceptive HHS Rule*, HUFFINGTON POST, Sept. 24, 2008, http://www.huffingtonpost.com/jessica-arons/last-chance-to-fight-hypo_b_128976.html.

105. JILL MORRISON, NAT'L WOMEN'S LAW CTR., DON'T TAKE NO FOR AN ANSWER: A GUIDE TO PHARMACY REFUSAL LAWS, POLICIES AND PRACTICES 10 (2005), available at http://www.nwlc.org/pdf/8-2005_Don'tTakeNo.pdf (citing *Brauer v. Kmart Corp.*, No. C-1-99-618 (S.D. Ohio 2001)). Three other states—Delaware, Maryland, and Oregon—have laws that allow pharmacists to object to providing treatment that will terminate a pregnancy, but which fail to provide a definition of pregnancy. Kubasek, *supra* note 35, at 232 n.18. This omission "permits objecting pharmacists to use to their advantage the ambiguity of what constitutes 'termination of pregnancy' . . . if a pharmacist believes pregnancy occurs at fertilization, the use of birth control could be considered a termination of pregnancy." *Id.* at 232.

106. MORRISON, *supra* note 105 (citing *Brauer v. Kmart Corp.*, No. C-1-99-618 (S.D. Ohio 2001)).

the law would turn conscience clauses into wildcards that objecting providers could use in accordance with their own personal beliefs about medicine and morality, without regard for legislative intent or the rights of patients. Yet this is precisely the sort of “ambiguity” recognized by HHS in their comments regarding the definition of abortion.

More recently, the Ninth Circuit reversed a district court opinion that adopted what I have termed the subjective test approach to conscience clause interpretation. *Stormans v. Selecky* involved a challenge to a state regulation that required pharmacists to fill prescriptions for all medications, including contraceptives.¹⁰⁷ The district court concluded that the regulation violated pharmacists’ rights under the Free Exercise Clause.¹⁰⁸ Applying strict scrutiny, the court was not persuaded that the regulation served the compelling interest of preventing sex discrimination.¹⁰⁹ In making this argument, the interveners sought to align this case with contraception jurisprudence, which would have provided a stronger basis for their sex discrimination argument.¹¹⁰ Instead, the district court relied on *Bray v. Alexandria Women’s Clinic*, an abortion case in which the U.S. Supreme Court held that “the refusal to participate in an act that one believes terminates a life has nothing to do with gender or gender discrimination.”¹¹¹ The district court, citing *Bray*, articulated a similar test to that used by the Ohio judge: “Whether or not Plan B acts as an abortifacient or terminates a pregnancy, *to those who believe that life begins at conception*, the drug is designed to terminate a life.”¹¹² The court continued, “[The pharmacists’] objection to Plan B is not about gender, it is about the sanctity of life as defined by their religious teachings.”¹¹³ But the Ninth Circuit reversed, holding that because the law was neutral and generally applicable, it was valid under the Free Exer-

107. See *Stormans v. Selecky*, 524 F. Supp. 2d 1245, 1251, 1266 (W.D. Wash. 2007).

108. See *id.* at 1266.

109. See *id.* at 1263.

110. See Elizabeth Gerber, *Emergency Contraception: Legal Consequences of Medical Classification*, 36 J.L. MED. & ETHICS 428, 429 (2008) (“Because the Supreme Court treats abortion and contraception differently, doctrines around contraception have developed more robustly, including well-established protections on the basis of sex discrimination.”).

111. *Stormans*, 524 F. Supp. 2d at 1263 (citing *Bray v. Alexandria Women’s Clinic*, 506 U.S. 263, 271–74 (1993)); Gerber, *supra* note 110, at 429–30 (discussing the significance of the district court’s decision to align this case, which dealt with emergency contraceptives, with abortion jurisprudence, rather than contraception jurisprudence).

112. *Stormans*, 524 F. Supp. 2d at 1264 (emphasis added).

113. *Id.*

cise Clause if the government could show that it was rationally related to legitimate government interests.¹¹⁴

Thus, the battle over conscience protections and contraceptives has been waged in the halls of state legislatures and in the courts. With the promulgation of the PCR, this debate has reached the national level. The leaked version of the PCR was a blatant attempt to redefine abortion to encompass contraception, but this attempt has been abandoned. Nonetheless, the possibility that the use of contraceptives will be redefined as “abortion,” whether by legislatures, courts, or federal agencies, remains a real threat.¹¹⁵ And although the new version of the PCR omits this controversial language, the political context in which the PCR was proposed and finally promulgated remains relevant to the analysis of the final version. In addition, this discussion raises questions about the extent to which ambiguous language can accomplish the goals of the anti-contraceptive movement and other advocates of broad refusal rights.¹¹⁶

IV. REGULATING CONSCIENCE, RESTRICTING CHOICE

By using broad or simply vague definitions to “define” key terms in the federal conscience clauses, the PCR inappropriately expands the rights of providers to refuse to provide care. Section A will contextualize these changes by proposing that conscience clauses can be understood to represent a “zero-sum game,”¹¹⁷ in which the right to access healthcare is reduced when the opportunities to refuse are expanded.¹¹⁸ Section B proposes a simple framework for analyzing conscience clauses and examines the actual text of the current regulation by using this framework; it concludes that the PCR effects a shift toward a “facilitator model” of conscience protection.¹¹⁹ Section C will address conflicts between the PCR and other federal laws and federal regulations, including Title VII, the Emergency Medical Treatment and Labor Act (EMTALA), and the regulations written to implement Title X.¹²⁰

114. *Stormans v. Selecky*, 571 F.3d 960, 987 (9th Cir. 2009).

115. See Letter from the Wash. Legislative Office of the Am. Civil Liberties Union, *supra* note 90, at 4–7.

116. These questions are discussed further below. See *infra* Part IV.B.

117. “Zero-sum games represent circumstances in which the gain of one participant is the loss of another” OXFORD DICTIONARY OF SOCIOLOGY 237 (John Scott & Gordon Marshall eds. 2005).

118. See *infra* notes 121–130 and accompanying text.

119. See *infra* notes 131–155 and accompanying text.

120. See *infra* notes 156–192 and accompanying text.

A. Conscience Clauses As a Zero-Sum Game

Whereas rights such as those guaranteed under the Fourth Amendment (freedom from unreasonable searches and seizures)¹²¹ or the Eighth Amendment (freedom from cruel and unusual punishment)¹²² are asserted by individuals vis-à-vis the government, conscience clauses occupy a unique place in the law because of the “absence of the traditional individual-versus-state paradigm.”¹²³ Every conscience clause draws a line where the provider’s right to refuse meets the patient’s right to receive care. Neither of these “rights” is protected by the Constitution: the Free Exercise Clause does not protect religious *conduct*,¹²⁴ and the right to abortion encompasses merely the right to be free from interference with abortion access, not an affirmative right to be provided with care.¹²⁵ But both the “right to refuse” and the “right to access” reproductive healthcare are closely related to these constitutionally protected rights. Reproductive rights advocates thus view conscience clauses, to the extent that they decrease access to healthcare services, as infringing on patients’ rights.¹²⁶ Advocates for more expansive conscience clauses, on the other hand, view conscience clauses as a necessary component of religious freedom and assert that they should not be required to give up this right in order to practice their chosen occupation.¹²⁷

When framed in this way, the debate over conscience clauses becomes a zero-sum game: when a conscience clause grants healthcare providers the right to refuse to provide services under certain circumstances, the right of patients to access those services under those circumstances is taken away—the patient loses something real, if not tangible. This model reflects the understanding that the tug-of-war over conscience clauses is not about the provision versus the withholding of healthcare services, but about the *opportunity* to object versus

121. See U.S. CONST. amend. IV.

122. See U.S. CONST. amend. VIII.

123. Dennies Varughese, *Conscience Misbranded!: Introducing the Performer v. Facilitator Model for Determining the Suitability of Including Pharmacists Within Conscience Clause Legislation*, 79 TEMP. L. REV. 649, 652 (2006).

124. See *supra* notes 61–63 and accompanying text.

125. See *Maier v. Roe*, 432 U.S. 464, 477 (1977) (holding that the right to abortion does not include the right to government funding for abortion).

126. See, e.g., Swartz, *supra*, note 22, at 274.

127. See Kromhout, *supra* note 35, at 266 (complaining that legislation requiring pharmacists to dispense contraceptives “forces the professional health care provider to check her conscience at the pharmacy’s door”); Stout, *supra* note 10 (quoting HHS Secretary Michael Leavitt as saying, “Doctors and other health care providers should not be forced to choose between good professional standing and violating their conscience”).

the *assurance* of access to healthcare services—these are the prizes that are won and lost in direct proportion to each other.

Consider the following hypothetical. The only grocery store located in Small Town has two store clerks, Ashley and Brian. Ashley objects to the consumption of meat for moral reasons.¹²⁸ She refuses to sell meat to customers, and her right to do so is protected by a new state conscience clause. When Brian is working, customers are able to buy meat, but when Ashley is working alone, they cannot. If Ashley works alone fifty percent of the time during which the store is open, a customer traveling to the store during its hours of operation has a fifty percent chance that she will be able to purchase meat upon arrival. The value of the store to the consumer as a source of meat is reduced because access is not assured. The possibility of unilateral refusal thus constitutes a loss to the consumer (the loss of a reliable source of meat) that is distinguishable from the event of actual refusal (the loss of meat on one occasion).

At least two important aspects of the conscience clause debate are not represented in this hypothetical. First, in theory, the employer could break the deadlock. Assuming that the state conscience law prohibits the store from firing Ashley, the grocery store's only option is to hire another store clerk in order to ensure that someone is always available to sell meat. If that clerk objects to selling meat, however, the store would be required to hire a fourth clerk, and so on. The wisdom of requiring employers to avoid the negative effects of an employee's refusal by hiring additional employees is certainly a relevant question, but one that is beyond the scope of this discussion. At this juncture, it is important merely to note that neither federal conscience clauses nor the PCR contains any explicit limitation on the number or extent of accommodations that an employer is required to make before she is permitted to simply replace the objecting employee.¹²⁹ Second, this "zero-sum game" paradigm fails to represent the context in which refusals actually occur. The extent of the burden caused by the loss is determined by the availability of other sources for the desired goods. Furthermore, healthcare providers enter into the provider-patient relationship voluntarily and act as gatekeepers to the healthcare services for which they are responsible for delivering. Patients, on the other hand, are compelled to seek care as a result of

128. For an explanation of moral reasons why some people do not eat meat, see People for the Ethical Treatment of Animals, *Cruelty to Animals: Mechanized Madness*, <http://www.goveg.com/factoryfarming.asp> (last visited Jan. 9, 2010).

129. Unlike Title VII, the PCR does not include any "undue burden" limits on the extent to which an employer must accommodate an objecting employee. See *infra* Part IV.C.

mental or physical healthcare needs. The patient depends on the healthcare provider to use her skills and knowledge to provide appropriate care. Thus, some authors have persuasively argued that the nature of this “fiduciary relationship” tips the scales in favor of requiring the healthcare provider to defer to the patient’s needs.¹³⁰

The grocery store hypothetical, although admittedly deficient in some respects, illustrates what is at stake in the conscience clause debate: reliable access. Allowing providers to refuse to provide care under some circumstances equals the absence of reliable access under those circumstances, even if providers only *exercise* their “right to refuse” on some occasions, hence the creation of zero-sum game. Access is not reliable when the possibility exists that services will be denied as the result of a decision unrelated to the needs of the patient. Conceiving of the debate as one in which the thing at stake, from the patient’s perspective, is *healthcare access* is important—if not necessary—because the total value of healthcare is necessarily measured in part by the reliability with which it can be accessed. Quite simply, healthcare is of little value when accessing it is a crapshoot. Furthermore, as the circumstances under which providers can refuse to provide healthcare increase, access to healthcare services is directly and wholly reduced. The PCR should be understood as part of a nationwide effort to increase the number of circumstances under which providers could refuse to provide healthcare. The result of which, in accordance with this zero-sum paradigm, is the *whole loss* of access under those circumstances. The *method* by which this is accomplished, which could be called “strategic ambiguity,” is discussed in the next Section.

B. *Vague Terms and “Strategic Ambiguity”*

Before examining the text of the PCR, this Section will propose a simple four-axis framework for analyzing conscience clauses. This framework, sketched in Sub-section 1, is helpful to understanding how vague definitions, when used to draft or implement conscience clauses, exponentially increase the number of circumstances under which healthcare providers can refuse to provide care.¹³¹ Vague terms create ambiguity, which in turn cuts in favor of healthcare providers. This, I argue in Sub-section 2, is the triumph of the PCR. Relying on the four-axis framework, Sub-section 2 argues that the PCR inappropriately expands federal conscience protections to encompass objec-

130. See, e.g., Swartz, *supra*, note 22, at 347.

131. See *infra* Part IV.A.1.

tions by healthcare workers with very attenuated relationships to the healthcare service or procedure that forms the basis of their objection.¹³²

1. A Proposed Framework for Analyzing Conscience Clauses

Conscience clauses that are written in narrow, definite terms draw clear lines between the rights of providers and the rights of patients. In contrast, conscience clauses that are written using broad language vest a seemingly limitless right to refuse in healthcare providers. This strategic ambiguity can be accomplished in any conscience clause (or interpretation of a conscience clause) via any one (or more) of four distinct axes.

All conscience clauses can be understood to have four axes, which are often, but not always, expressed explicitly as elements. These include (1) the individuals or entities protected by the law, such as doctors, hospitals, or insurance companies; (2) the healthcare services that form the basis of the protected objection, such as abortions or sterilization procedures; (3) the kinds of activities that an individual or entity can refuse to perform (that is, the minimum proximity between the objector and the healthcare service); and (4) the reason given for the objection, such as religious, moral, or ethical reasons.

The language of each of these axes can be manipulated, often with drastic results. A narrowly written conscience clause vests a right to refuse in a finite and identifiable group, and it limits to a finite and identifiable number the circumstances under which the refusal can occur. For example, a narrowly written clause might provide that doctors can refuse to perform abortions, and that nurses can refuse to assist doctors in performing abortions. In contrast, a broadly written clause vests an unlimited right to refuse in an unspecified group of individuals. For example, a broadly written clause might provide that “healthcare personnel” can refuse to perform “healthcare services.” Neither providers nor patients have a clear understanding of their rights under such vaguely written laws. Given that any ambiguity is likely to cut in favor of providers because of the chilling effect on employers, this ambiguity can be employed strategically by those in favor of broad objector protections.

In extreme circumstances, conscience clauses may omit any reference to one or more of the axes. The absence of that element cuts in favor of providers. For example, the Weldon Amendment does not require employees to give any reason—religious or otherwise—for

132. See *infra* Part IV.A.2.

their refusal to perform or assist in the performance of abortions.¹³³ Thus, under the terms of the Amendment, employees can refuse to provide care on the basis of personally held, idiosyncratic beliefs or theories that are not grounded in either religion or medical science.¹³⁴ This example illustrates that unless each of the four axes of a conscience clause appears as a clearly defined element, the “right to refuse” guaranteed by the clause is, in at least those respects, potentially limitless. This simple four-axis framework can therefore be used to compare and analyze conscience clauses, including federal conscience clauses as they are affected by the PCR. Specifically, the framework demonstrates how the use of vaguely defined terms results in limitless opportunities for providers to refuse to provide care or, from the patient’s perspective, limitless circumstances under which healthcare can be denied.

2. *Some Problems with the PCR: Strategic Ambiguity and the Increasingly Attenuated Connection Between the Provider and the “Objectionable” Service*

By manipulating the elements of federal conscience clauses, the PCR increases the circumstances under which healthcare workers can refuse to perform their duties. The most significant change is accomplished through the proximity axis. The proximity axis encompasses the extent to which a provider can be removed from the actual performance of the purportedly objectionable healthcare service and continue to enjoy protection for refusing to perform a duty connected to that service in some way. For example, one may ask whether driving a patient to the hospital by ambulance for a medically necessary abortion is an activity sufficiently removed from the actual performance of the abortion, such that the ambulance driver should not be allowed to refuse to drive the patient to the hospital.¹³⁵ Importantly, unlike performing an abortion, the act of driving an ambulance cannot be offensive to the driver unless the driver has independent knowledge that the patient will be treated with an abortion upon arrival at the hospital. While the concept of abortion is offensive to the driver, the driver

133. See Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 507(d)(1), 118 Stat. 2809, 3163 (2004).

134. See Swartz, *supra* note 22, at 274.

135. See Fellers, *supra* note 6. There may be other reasons why this sort of refusal right should not be extended to ambulance drivers—for example, the special nature of their position as *emergency* healthcare providers and the resulting risks that refusals can cause under those circumstances may justify special treatment—but the attenuated connection between these providers and the ultimate provision of healthcare services is the reason that is the focus of this analysis.

is not likely to have a visceral reaction or feeling of repulsion toward the act of driving.

The Individual Protection Clause (IPC) of the Church Amendment provides that no individual should be required to “perform or assist in the performance of any part of a health service program or research activity” that receives federal funding if doing so would be contrary to her “religious beliefs or moral convictions.”¹³⁶ The PCR defines the phrase “assist in the performance”—which represents the proximity axis of the IPC—to mean “participat[ing] in any activity with a *reasonable connection* to a procedure, health service or health service program, or research activity.”¹³⁷

At first blush, the term “reasonable connection” appears to place a fair limit on the scope of the phrase “assist in the performance.” But in further explaining the meaning of the term “reasonable connection,” HHS ominously states that such reasonably connected activities include “counseling, referral, training, and [making] *other arrangements*” for the provision of healthcare services.¹³⁸ HHS then offers an example of an activity that would constitute making “other arrangements” for the provision of healthcare services: “an employee whose task it is to clean the instruments used in a particular procedure would be considered to assist in the performance of the particular procedure.”¹³⁹

This example illustrates how the PCR improperly expands the scope of federal conscience clauses. Consider the following hypothetical. A nurse is asked to clean and sterilize the speculum used during embryo transfer, the final step in an in vitro fertilization procedure.¹⁴⁰ If the nurse finds in vitro fertilization objectionable, the PCR provides that he can refuse to perform that activity. The PCR does not contemplate that the nurse may be asked to perform this activity an hour after the procedure was completed, in a different room, or even a different wing of the hospital from where the examination took place. The nurse may never meet the patient who underwent the procedure. Asked to clean several sets of instruments within the course of his shift, the nurse will not be able to distinguish between a speculum used during an embryo transfer and one used during a prenatal examination, or between a set of instruments used to impregnate a lesbian

136. 42 U.S.C. § 300a-7(d) (2008).

137. Provider Conscience Regulation, 45 C.F.R. § 88.2 (2008) (emphasis added).

138. *Id.* (emphasis added).

139. 73 Fed. Reg. 50,274, 50,277 (Aug. 26, 2008).

140. See Am. Pregnancy Ass'n, In Vitro Fertilization: IVF (May 2007), <http://www.americanpregnancy.org/infertility/ivf.html> (last visited Feb. 1, 2010).

woman and another set used to impregnate a married, heterosexual woman—although he might find only one of these procedures objectionable.

This hypothetical, as well as the ambulance driver example, illustrates an important distinction between the direct and indirect provision of healthcare services—a distinction that underlies the entire debate over the desirable breadth of conscience clauses. With regard to this distinction, Dennies Varughese advocates for a “performer versus facilitator model” as the appropriate model for determining which healthcare employers should be afforded the right to refuse and under what circumstances:¹⁴¹

Th[e] goal of achieving a balance of the competing interests of religious liberty of healthcare professionals and reproductive liberty of women wanting access to contraceptive measures can be achieved by classifying the healthcare worker as either a performer or facilitator. When a healthcare professional is designated as a “performer,” the reasonable objective—of not forcing individuals to perform an act to which they are opposed—of the initial conscience clauses applies and, therefore, the professional may invoke the right to object based on conscience. When the professional is deemed a “facilitator,” however, refusal on the basis of conscience grossly exceeds merely protecting the professional, and rather, acts as a *proxy in the war against reproductive freedom* by imposing unnecessary obstacles to essential and legal medical options for women.¹⁴²

Significantly, the concept of facilitation is almost synonymous with the concept of “making arrangements for” healthcare services. At the heart of the problem with the PCR, therefore, is the absence of any distinction between direct and indirect involvement in the purportedly objectionable procedure. In the absence of distinctions based on the proximity of the provider to the service, no difference exists between the “man who mines the iron ore that goes to make the steel, which is used by a factory to make instruments used in abortions”¹⁴³ and the doctor who performs them.

The increased attenuation between the objecting provider and the purportedly objectionable service is confirmed by a more subtle change that involves the reason axis of the IPC. In the IPC, a refusal is protected if the “perform[ance] or assist[ance] in the performance” of an activity would offend the objector’s “religious beliefs or moral convictions.”¹⁴⁴ Without explanation, HHS rewrites this phrase, stat-

141. Varughese, *supra* note 123, at 683.

142. *Id.* at 683–84 (emphasis added). Varughese, while a law student at the time of publication, is also a licensed pharmacist. *Id.* at 703.

143. Wilson, *supra* note 1, at 58 (citing 41 Iowa Op. Att’y Gen. 478 (1976)).

144. 42 U.S.C. § 300a-7(d) (2008).

ing that a refusal is protected if the “service or activity” offends the objector’s “religious beliefs or moral convictions.”¹⁴⁵ The reorientation of these clauses has significant implications. With this change, the PCR shifts focus away from the offensiveness purportedly associated with performing or assisting in the performance of a service and instead emphasizes the offensiveness purportedly associated with the service itself—the procedure or treatment—conceived of in the abstract.

In fact, in the introduction to a previous draft of the PCR, HHS acknowledges this shift, stating that it sought “to avoid judging whether a *particular action* is genuinely offensive to an individual.”¹⁴⁶ This statement—which endorses what I termed the “subjective test” used by the Ohio judge and the district court in *Stormans*¹⁴⁷—begs the question: If the objector is not genuinely offended by the action that he is refusing to perform, what is the purpose of allowing the objection? The answer appears to be that, rather than creating a shield to protect conscientious objectors from being forced to perform activities that they find repugnant, the PCR seeks to create a sword for pro-life activists to wield in the war against reproductive freedom.¹⁴⁸

This shift toward protecting facilitators, or those with only a very attenuated connection to the purportedly objectionable service, is also accomplished through the portion of the PCR that implements the Coats and Weldon Amendments, specifically through a change to the entity axes of these Amendments. The Coats and Weldon Amendments define “healthcare entities” to include physicians and healthcare professionals.¹⁴⁹ The PCR defines the phrase “healthcare entity” to include not only professionals but also “healthcare personnel.”¹⁵⁰ HHS attempts to undercut any argument that this is a substantive change in the law, rather than a mere clarification, by (correctly) stating, in the federal register notice that accompanied publication of the

145. Provider Conscience Regulation, 45 C.F.R. § 88.4 (2008).

146. Provider Conscience Regulation, 73 Fed. Reg. 50,274, 50,277 (Aug. 26, 2008) (emphasis added).

147. See *supra* text accompanying notes 105–106.

148. This distinction has been recognized in other contexts. For example, there is nothing inherently morally offensive about paying taxes, even if that money is later used to fund war. For this reason, we recognize the right of draftees or soldiers to conscientiously object to taking part in acts of war, but we do not recognize the right of taxpayers to opt out of paying taxes when a portion of their taxes funds the same war. Of course, an individual can still refuse to make such a contribution precisely because she hopes to *affect the actions of others*; such an action would appropriately be termed a *boycott*, and a similar strategy is arguably at work here.

149. Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 507(d)(2), 118 Stat. 2809, 3163 (2004); 42 U.S.C. § 238n(c)(2) (2008).

150. Provider Conscience Regulation, 45 C.F.R. § 88.2 (2008).

PCR, that neither statute provides an exhaustive list of such healthcare entities.¹⁵¹ This argument is not persuasive because of the limitations inherent in the term “healthcare professional.” The term “professional” connotes a certain level of internal monitoring, such as qualifications for membership, licensing schemes, and ethical guidelines.¹⁵² The term “personnel,” on the other hand, is a generic term synonymous with “employee.”¹⁵³ The latter term encompasses professionals as well as other healthcare workers. For example, volunteers and receptionists employed by a hospital, although they are not healthcare professionals subject to any licensing scheme or ethical standards, can accurately be described as healthcare personnel. Thus, adding “personnel” to this list is not like adding “bananas” to a list that includes “apples” and “oranges,” but rather more like adding the term “food” to that list. The intent to encompass all “food” is hardly apparent from a list that includes “apples” and “oranges,” even though the list is admittedly not all-inclusive. Significantly, non-professional employees are less likely than healthcare professionals to be directly involved in providing care and more likely to be involved in merely “making arrangements” for the provision of care, such as making appointments. Thus, this change also contributes to the PCR’s shift toward a “facilitator model” of conscience protection.

The expansion of conscience protections to those with only an attenuated relationship to the “objectionable” service limits the role of professional associations in ensuring that patients are treated in a professional manner. A recent case, *Noesen v. Department of Regulation and Licensing*, illustrates the important role that professional associations play in balancing the rights of providers and patients in accordance with professional ethical standards.¹⁵⁴ In that case, the Wisconsin Department of Regulations disciplined a pharmacist after he refused to fill a patient’s prescription for birth control and then refused to relay the information necessary to transfer the prescription to a willing pharmacist at another pharmacy.¹⁵⁵ This case illustrates

151. Provider Conscience Regulation, 73 Fed. Reg. 78072, 78076 (Dec. 19, 2008) (codified at 45 C.F.R. § 88.2 (2008)).

152. According to Merriam-Webster’s Online Dictionary, a “professional” is a person “characterized by conforming to the technical or ethical standards of a profession.” Merriam-Webster’s Online Dictionary, <http://www.merriam-webster.com/dictionary/> (last visited Jan. 9, 2010).

153. According to Merriam-Webster’s Online Dictionary, the term “personnel” signifies “a body of persons usually employed (as in a factory, office, organization).” *See id.* Thus, while the central feature of a profession is “standards,” personnel are defined simply as persons who are employed, that is, employees. *See id.*

154. *Noesen v. State Dep’t of Regulation and Licensing, Pharmacy Examining Bd.*, 751 N.W.2d 385 (Wis. Ct. App. 2008).

155. *See id.* at 389–90.

that ethical review boards and professional organizations can provide the first line of defense against refusals that are beyond the pale of acceptable professional conduct. By extending conscience protections to all “healthcare personnel,” the PCR removes this balancing mechanism and vests an absolute and unchecked right to refuse in all employees working in the healthcare industry.

Although there may be other problems created by the lengthy PCR, the purpose of this Section is merely to recognize that the PCR makes a shift toward a “facilitator model” as the term was used by Varughese, to recognize that it does so by using vague language to define key terms, and to sketch out some of the implications of that shift. The four-axis framework laid out in this Section may assist in further analysis of the PCR or its successor, as well other conscience clauses, because it provides a simple mechanism for comparison. The next Section will discuss some of the conflicts between the PCR and other laws and regulations.

C. Conflict with Federal Laws and Regulations

Unlike some state conscience clauses,¹⁵⁶ none of the federal conscience clauses create an explicit private right of action.¹⁵⁷ Thus, the only remedies available in federal courts for healthcare objectors who believe that they have experienced “discrimination” because of their

156. See, e.g., 745 ILL. COMP. STAT. 70/12 (West 2008).

157. See 42 U.S.C. §§ 238n, 300a-7(d) (2008); Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809, 3163 (2004). Two federal district courts recently addressed the issue of whether the Church Amendment contains an implied private right of action. See *Nead v. Bd. of Trs. of E. Ill. Univ.*, No. 05-2137, 2006 WL 1582454 (C.D. Ill. June 6, 2006); *Moncivaiz v. DeKalb County*, No. 03 C 50226, 2004 WL 539994 (N.D. Ill. Mar. 12, 2004). Both courts concluded that it does not. See *Nead*, 2006 WL 1582454, at *5; *Moncivaiz*, 2004 WL 539994, at *3; cf. Eisenstadt, *supra* note 39, at 155 (arguing, before the *Moncivaiz* and *Nead* opinions were issued, that courts should recognize an implied private right of action in the Church Amendment). *Watkins v. Mercy Medical Center* has been cited for the proposition that the Church Amendment creates an implicit private right of action. See, e.g., Bruce G. Davis, *Defining the Employment Rights of Medical Personnel Within the Parameters of Personal Conscience*, 1986 DETROIT C.L. REV. 847, 861 (1986) (citing 520 F.2d 894 (9th Cir. 1975)). But that conclusion is dubious, even in the absence of the recent Illinois decisions holding otherwise. The doctor in *Watkins* brought suit under 42 U.S.C. § 1983 and Title VII, and the lower court denied relief. See *Watkins v. Mercy Med. Ctr.*, 364 F. Supp. 799, 800–01, 803 (1973). The lower court also noted, however, that the Church Amendment forbade discrimination against individuals on the basis of their views on abortions or their willingness to perform them. *Id.* at 803. But it is unclear whether the doctor brought his initial suit under the Church Amendment or, alternatively, whether the lower court raised the issue sua sponte. In any event, the issue was not before the Ninth Circuit on appeal. See *Watkins*, 520 F.2d at 895–96. In short, the clear and recent rejection of the proposition that the Church Amendment contains an implicit private right of action in *Moncivaiz* and *Nead* is more persuasive than any conclusion drawn from the *Watkins* opinion.

refusal to provide care are those available pursuant to Title VII of the Civil Rights Act of 1964.¹⁵⁸ Title VII prohibits employers from discriminating against employees based on the employee's "race, color, religion, sex, or national origin."¹⁵⁹ Title VII applies to all employers with fifteen or more employees, including but not limited to employers in the healthcare industry.¹⁶⁰ Significantly, the law takes a balanced approach with regard to accommodating religious objections in the workplace.¹⁶¹ The law requires employers to offer reasonable accommodations to objecting employees only to the extent that providing such accommodations does not impose an undue hardship on the employer or co-workers.¹⁶² For example, in *Shelton v. University of Medicine and Dentistry*, a labor and delivery nurse refused to assist a pregnant woman during a life-threatening emergency because the fetus was not expected to survive the necessary procedure.¹⁶³ After the incident, the hospital offered to transfer the nurse from the emergency room to the newborn intensive care unit.¹⁶⁴ When the nurse refused, the hospital fired her.¹⁶⁵ The *Shelton* court held that the hospital's offer of accommodation was reasonable, and it dismissed the nurse's Title VII claim.¹⁶⁶

Thus, these balancing mechanisms—that the accommodation need only be reasonable, and need only be offered to the extent that no undue burden is imposed on the employer—allow employers in the healthcare industry to limit the detrimental impact of a provider's refusal on co-workers, patients, and themselves. Federal conscience clauses do not contain any balancing mechanisms: they seemingly create an absolute "right to refuse." Nor do they provide a private right of action.¹⁶⁷ Title VII, with its accompanying balancing mechanisms, rather than conscience clauses, has therefore (thus far) provided the

158. 42 U.S.C. §§ 2000e–2000e-15 (2008); Swartz, *supra* note 22, at 303.

159. § 2000e-2.

160. § 2000e(b).

161. Letter from Stuart J. Ishimaru & Christine M. Griffin, Comm'rs, U.S. Equal Employment Opportunity Comm'n, to the U.S. Dep't of Health & Human Servs. (Sept. 25, 2008), <http://op.bna.com/eg.nsf/id/pdon-7jyqkh> (select the icon labeled "EEOC letter to HHS.pdf") (citing *Peterson v. Hewlett-Packard Co.*, 358 F.3d 599 (9th Cir. 2004)).

162. See Swartz, *supra* note 22, at 303; Amy Bergquist, *Pharmacist Refusals: Dispensing (with) Religious Accommodation Under Title VII*, 90 MINN. L. REV. 1073, 1080–84 (2006) (discussing the accommodation requirements under Title VII).

163. See *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220, 223 (3d Cir. 2000).

164. See *id.*

165. See *id.*

166. See *id.* at 226.

167. See *supra* note 157 and accompanying text.

legal standard establishing the extent and limits of a healthcare objector's right to refuse, at least at the federal level.¹⁶⁸

After reviewing the PCR, an attorney for the U.S. Equal Employment Opportunity Commission (EEOC), the federal agency charged with enforcing Title VII, determined that the PCR overlaps with Title VII.¹⁶⁹ As a result, the attorney concluded in his letter to HHS that the PCR "is unnecessary for protection of employees and applicants, is potentially confusing to the regulated community, and will impose a burden on covered employers, particularly small employers."¹⁷⁰ The Guttmacher Institute, a non-profit organization that researches and reports on issues related to reproductive rights,¹⁷¹ reached a similar conclusion.¹⁷² In its response to the PCR, the Institute pointed out that, because HHS took such an "absolutist standpoint" on the right to refuse and "failed to even hint at any ethical or legal limits of conscientious refusal," the PCR "contradicts Title VII of the Civil Rights Act."¹⁷³

Patient care is even more directly endangered by the omission of any mention in the PCR of the Emergency Medical Treatment and Active Labor Act (EMTALA), the federal law that requires providers to assist in a genuine medical emergency, regardless of their moral or religious objections.¹⁷⁴ Several reproductive rights organizations have voiced their concerns over this omission, arguing that, at a minimum, the omission will cause confusion within the healthcare industry over the applicable law.¹⁷⁵ Again, this omission works to the advantage of objecting providers and places patients in the extremely precarious position of not knowing whether, when they arrive at the hospital seeking emergency care, they will be met by a willing provider or a provider attempting to assert her right, pursuant to the PCR, to refuse to assist them, even in a medical emergency.

168. See Letter from Reed L. Russell, Legal Counsel, U.S. Equal Employment Opportunity Comm'n, to the U.S. Dep't of Health & Human Servs. 2-3 (Sept. 24, 2008) (on file with author) (explaining that "Title VII provides the legal framework under which complaints of employment discrimination based on religion . . . have been judged for over forty years").

169. See *id.* at 2.

170. *Id.*

171. Guttmacher Inst., Frequently Asked Questions, <http://www.guttmacher.org/about/faq.html> (last visited Jan. 9, 2010).

172. See Camp, *supra* note 17.

173. *Id.*

174. 42 U.S.C. § 1395dd(a)-(c) (2006).

175. See NAT'L WOMEN'S LAW CTR., *supra* note 17; see also Letter from Family Planning Advocates of N.Y. State, *supra* note 90 (asking HHS to declare that the PCR was meant to be interpreted in conjunction with EMTALA and explaining that, although rare, "women do at times experience life-threatening pregnancy complications that require immediate treatment").

In response to these concerns, HHS wrote, “Commenters mistakenly confuse certain legal requirements on institutions or health care entities as requirements on individual providers.”¹⁷⁶ HHS is correct that EMTALA binds hospitals receiving federal funding, not employees of such facilities.¹⁷⁷ But HHS fails to recognize the inherent practical difficulties in making such a distinction. If a hospital is required to treat in an emergency, but none of its staff members can be legally required to do so, the hospital will only be able to ensure compliance to the extent that its employees happen to personally agree with federal law. Again, the similarity to the “subjective test” is apparent.¹⁷⁸ In the federal register notice, HHS off-handedly remarks that it is “not aware of any instance where a facility required to provide emergency care under EMTALA was unable to do so because its entire staff objected to the service on religious or moral grounds.”¹⁷⁹ But as the *Shelton* case¹⁸⁰ demonstrates, the refusal of even one nurse can delay the provision of emergency care, putting the hospital at risk of liability and the patient at risk of physical harm. While Title VII’s balanced approach would allow hospitals to solve such problems, for example by transferring objecting employees or firing them as necessary, the PCR does not include such balancing mechanisms. The failure of the PCR to affirm that the provision of emergency care must come before individual employees’ “rights to refuse” evidences a blatant disregard for the well-being of patients.

Finally, the PCR also conflicts with Title X regulations. Title X is the federal program that provides grants to non-profit organizations that provide family planning services.¹⁸¹ Recipients of Title X funding provide family planning services, including contraceptives, to women who would not otherwise be able to afford reproductive healthcare.¹⁸² As a condition of funding, Title X recipients must provide pregnant patients with information about all of their reproductive options, including abortion.¹⁸³ Thus, the PCR and Title X regulations conflict to the extent that recipients of Title X funds are required, on one hand,

176. Provider Conscience Regulation, 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008) (codified at 45 C.F.R. § 88.1 (2008)).

177. See 42 U.S.C. § 1395dd(a)–(c) (2006).

178. See *supra* text accompanying notes 105–114 for a discussion of what I term the “subjective test.”

179. Provider Conscience Regulation, 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008) (codified at 45 C.F.R. § 88.1 (2008)).

180. *Shelton v. Univ. of Med. & Dentistry of N.J.*, 223 F.3d 220 (3d Cir. 2000).

181. Office of Population Affairs, Family Planning, <http://www.hhs.gov/opa/familyplanning/index.html> (last visited Jan. 9, 2010).

182. See *id.*

183. See 42 C.F.R. § 59.5(a)(5).

to ensure that patients receive counseling and referrals for abortion and, on the other hand, to ensure that employees can refuse to perform these services if they so choose.¹⁸⁴ Commenters raised this important concern.¹⁸⁵ In response, HHS determined that the PCR will take priority over the Title X regulations:¹⁸⁶

With regards to the Title X program, Commenters are correct that the current regulatory requirement that grantees must provide counseling and referrals for abortion upon request (42 CFR 59.5(a)(5)) is inconsistent with the health care provider conscience protection statutory provisions and this regulation. The Office of Population Affairs, which administers the Title X program, is aware of this conflict with the statutory requirements and, as such, would not enforce this Title X regulatory requirement on objecting grantees or applicants.¹⁸⁷

Thus, in a rare moment of clarity, the HHS decisively gave the patient's right to access care—here, simply access to information—a backseat to the provider's right to refuse.

As a result of this significant change in the law, “crisis pregnancy centers”—health clinics run with a strictly pro-life agenda¹⁸⁸—will face fewer obstacles to obtaining federal funds. Although crisis pregnancy centers purport to provide abortion counseling and, therefore, have had some success in claiming eligibility for Title X funding in the past, they have been sharply criticized on the basis that the information they provide about abortion is often misleading, erroneous, or simply wrong.¹⁸⁹ At least some of these centers actively attempt to mislead women by concealing their pro-life agenda.¹⁹⁰ Tactics used by these centers include listing themselves in the phonebook under

184. Prior to the passage of the Weldon Amendment, critics worried that the Amendment would have this effect. In *National Family Planning and Reproductive Health Association v. Gonzalez*, the D.C. Circuit held that the Weldon Amendment and Title X regulations did not necessarily conflict. See 468 F.3d 826, 829 (D.C. Cir. 2006) (“Despite the apparently similar potential for conflict between the pre-Weldon conscience provisions and the current Title X regulation (dating from 2000), they have enjoyed a quite peaceful co-existence.” (emphasis added)).

185. See Provider Conscience Regulation, 73 Fed. Reg. 78,072, 78,087 (Dec. 19, 2008) (codified at 45 C.F.R. § 88.1 (2008)).

186. *Id.*

187. *Id.*

188. See NARAL PRO-CHOICE AM. FOUND., THE TRUTH ABOUT CRISIS PREGNANCY CENTERS (2009) (on file with author) (discussing the phenomena of these pro-life centers, termed “crisis pregnancy centers,” which seek to “intentionally misinform and mislead women seeking pregnancy-related information with the intention of dissuading them from exercising their right to choose”).

189. A report issued by the House Oversight and Government Reform Committee in 2006 found that “87 percent of federally funded pregnancy centers [in the study] provided false or misleading information about abortion.” Judy Peres, *To Foes, Pregnancy Sites Blur the Abortion Picture*, CHI. TRIB., Mar. 25, 2007, § 1, at 1.

190. See NARAL PRO-CHOICE AM. FOUND., *supra* note 188, at 1–2.

“abortion services,” choosing names similar to those of nearby abortion clinics, locating themselves near abortion clinics, and falsely informing callers that they provide a full range of reproductive healthcare services.¹⁹¹ For example, one pregnancy center, located in the same row of storefronts as an abortion clinic, posted a sign that said “Women for Choice” on the door.¹⁹² Under the new regulation, these centers are now able to receive federal funding. Thus, with regard to crisis pregnancy centers, the PCR again does more than uphold the right of a provider to decline to provide a service that it finds objectionable: it effectively condones the activities of these crisis pregnancy centers, which are specifically designed to create obstacles to the delivery of reproductive healthcare to women.

V. CONCLUSION

This Comment analyzes the PCR, which is currently under review by the Obama Administration. As currently written, the PCR promises to have devastating effects on the healthcare system. According to HHS’s own estimates, the PCR will affect approximately 571,947 healthcare entities, including 58,109 pharmacies; 4,936 hospitals; and 234,200 private physician’s offices.¹⁹³ HHS estimates that it will cost approximately \$43.6 million per year to implement the PCR.¹⁹⁴

In addition to these quantifiable expenses, numerous non-quantifiable costs will result from implementing the PCR. The threatened loss of funding for failure to comply is likely to have a chilling effect on employers who will act cautiously with regard to objecting employees, acquiescing to employees’ expansive interpretations of the PCR rather than seeking clarification in the courts and risking funding.¹⁹⁵ In other words, as written, the PCR pressures employers to adopt the “subjective test.” As a result, patients will experience a reduction of access to healthcare services. From the patient’s perspective, this reduction represents a whole loss, making conscience clauses into zero-sum games, in which the thing that is lost is not services but access to services.

Importantly, the impact of the PCR on patients will be felt unevenly. Patients without health insurance, with inadequate health insurance, with poor transportation, or with other barriers to care, as

191. *Id.*

192. Peres, *supra* note 189.

193. Provider Conscience Regulation, 73 Fed. Reg. at 78,094–95.

194. *Id.* at 78,095.

195. See 7 States Sue Government over U.S. Abortion Rule, *supra* note 19.

well as patients who lack the ability to communicate adeptly in the dominant language, will not be able to take advantage of the opportunity to discharge a provider whose religious or political views, they may discover, are not compatible with their own. Commenters have predicted that the PCR will be used to discriminate against patients based on their sexual orientation.¹⁹⁶ And because reproductive healthcare remains so controversial in this country, women will be disproportionately disadvantaged by the PCR, which now allows almost all employees—not only the doctor, but potentially the nurse, the pharmacist, the pharmacist’s assistant, the receptionist, the ambulance driver, and the janitor—to have a say in whether she can access her chosen healthcare without interference.

The PCR brought the ongoing debate over conscience clauses into the national spotlight. Although the version of the PCR that is analyzed in this Comment may soon be revised by the Obama Administration, the four-axis framework adopted in this Comment provides a simple mechanism for future analysis of conscience clauses and the regulations that interpret them. In addition, this Comment argues that any analysis of conscience clauses must recognize that what is at stake is *access* to healthcare services, and that reduction of healthcare access can be accomplished not only explicitly, for example through the explicit redefining of the term “abortion,” but also through “strategic ambiguity.”

In order to protect healthcare access for all patients, the Obama Administration should seek to promulgate regulations that clearly define the scope of federal conscience clauses and that do not conflict with the important protections for patients that are provided by other federal laws and regulations.

*Rachel White-Domain**

196. See Letter from the Wash. Legislative Office of the Am. Civil Liberties Union, *supra* note 90.

* J.D. Candidate 2010, DePaul University College of Law; B.A. 2005, University of Illinois at Urbana-Champaign. I would like to express my gratitude to my father, Joseph Domain, for supporting my every endeavor, including this one; to my sisters, Flannery and Meagan White-Domain, who are my inspiration; and to my partner, Serdar Ozturk, who is my tree in the storm. My sincere thanks also to my colleagues on the *DePaul Law Review*, and to Nanette Elster, who provided comments on an early draft. All mistakes in this Comment are my own.

