

## HEALTH LAW

### Which Legal Approaches Help Limit Harms to Patients From Clinicians' Conscience-Based Refusals?

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#### Abstract

This article canvasses laws protecting clinicians' conscience and focuses on dilemmas that occur when a clinician refuses to perform a procedure consistent with the standard of care. In particular, the article focuses on patients' experience with a conscientiously objecting clinician at a secular institution, where patients are least likely to expect conscience-based care restrictions. After reviewing existing laws that protect clinicians' conscience, the article discusses limited legal remedies available to patients.

#### Potential Sites of Conflict

Clinicians who object to providing care on the basis of "conscience" have never been more robustly protected than today by state legislatures and federal law. Although US law as well as professional ethics allows clinicians to deviate from professional norms and standards when their religious or moral beliefs conflict with a requested service,<sup>1</sup> the scope of legal remedies for patients harmed by these objections has shrunk as federal and state law has effectively insulated objecting clinicians from liability. This article outlines laws protecting clinician conscience and identifies questions that arise when a clinician refuses to perform a procedure consistent with the medical profession's standard of care. We focus on patients seeking care at secular institutions where patients are least likely to have notice that care they receive could be restricted based upon an individual clinician's refusal. As a result, patients may unknowingly receive substandard care from objecting physicians and even be harmed by their refusals. However, the legal remedies available to patients adversely affected by refusals are limited. We first discuss federal and state law governing refusals based on clinician conscience and then examine the remedies available to patients who suffer harm as a result of a physician's refusal.

### Existing Laws Protecting Clinician Conscience

Over the past half century, Congress has passed [multiple laws](#) protecting clinicians who refuse to provide reproductive health care on the basis of conscience. Enacted in the 1970s, the Church Amendments prohibit any entity that receives public funding from discriminating against any “health care personnel” refusing to perform or assist in the performance of a sterilization or abortion procedure because it “would be contrary to his religious beliefs or moral convictions.”<sup>2</sup> The Coates-Snowe Amendment prohibits federal, state, and local officials from discriminating against entities that receive federal financial assistance, including physician training programs, that refuse to provide training on abortion care, the abortion procedure itself, or referrals for abortions.<sup>3</sup> This prohibition extends to discrimination in licensing or accreditation decisions even if these services are generally required in neutral state policies, such that a religiously affiliated institution may be excused from providing—and an individual clinician from undergoing—training on abortion care.

In May 2019, the US Department of Health and Human Services (HHS) issued a final rule that expands the scope of conscience protections for health care entities and any “health care personnel” who refuse to “take an action that has a specific, reasonable, and articulable connection to furthering a procedure” to which the person or entity objects.<sup>4</sup> The regulation also includes protections for an objecting clinician’s refusal to refer to nonobjecting clinicians.<sup>5</sup> The Trump administration has emphasized its commitment to protecting these rights through the creation of a new Conscience and Religious Freedom Division that was established to “restore federal enforcement of our nation’s laws that protect the fundamental and unalienable rights of conscience and religious freedom.”<sup>6</sup>

States, cities, and reproductive health advocates have initiated a multitude of lawsuits against HHS to overturn this new regulation. Three district courts in California, New York State, and Washington have ruled to enjoin the law.<sup>7,8,9,10</sup> However, there is political pressure on the administration to fight to maintain the rule all the way to the Supreme Court.<sup>11,12</sup> But even if these suits are successful, as discussed below, health care practitioners and programs will be protected by federal law from adverse employment action when refusing to provide care and, under many states’ laws, they are even shielded from liability for harms caused by their actions.

The new regulation covers any procedure, health service program, or research activity.<sup>4</sup> Individual health care professionals and entities can refuse to provide care, even in emergency situations, if that care would conflict with their beliefs.<sup>4</sup> Additionally, health care professionals may refuse not only to perform an abortion but also to counsel on abortion or to refer an individual seeking an abortion to a willing clinician, and delays in the context of abortion care can lead to more invasive, risky procedures or eliminate the woman's right to choose if the delay takes her past the viability limit set by the Supreme Court.<sup>13</sup>

Moreover, the new regulation protects the conscience of religious institutions such as the Catholic hospitals that serve 1 in 7 patients.<sup>14</sup> For example, a woman undergoing a cesarean delivery will be unable to obtain a concurrent tubal ligation at a Catholic hospital and will be required to seek a second surgery at another provider, which increases the risk of complications. Following mergers, patients may not be aware that a formerly secular health care facility is now governed by Catholic directives.<sup>15</sup> Even if patients are aware of religious affiliations, survey data suggests that women nonetheless expect to receive medical services contrary to Catholic beliefs.<sup>16</sup>

### **Potential Remedies for Patients**

*Tort liability and immunity.* Traditionally, the legal remedy for patients harmed by health care professionals has been to sue the clinician or organization for malpractice. Malpractice suits are based upon claims that the health care that plaintiff-patients received deviated from the standard of care and seek damages against individual clinicians or institutions for the harms caused by substandard care. Failure to provide care on the basis of conscience could expose clinicians to tort liability under the classical theory that compensation is required for legally cognizable harms caused by breaches of professional duties of care. As the third author has argued in more detail elsewhere, the content of professional advice is determined by the profession, and departures may result in liability for harm when the departure is based on justifications exogenous to professional knowledge.<sup>17</sup> Others have used informed consent doctrine to suggest that clinicians have a common law duty to disclose beliefs that constrict the scope of their practice as part of the duty of informed consent, which requires disclosure of the risks and benefits of a proposed course of treatment and any alternatives.<sup>16</sup>

Although there are colorable legal claims to hold religious or moral objectors, whether individual or institutional, liable for patient harms when they deviate from professional practice based on conscience, state law has largely

precluded these claims by immunizing objecting clinicians and entities. New Hampshire and Vermont are the only states without a health care conscience law.<sup>18</sup> A recent study of conscience law in the context of reproductive health care shows that 46 states have conscience laws protecting clinician or institution refusals to participate in abortions, of which 37 provide immunity from civil liability.<sup>18</sup> Some of these states even extend immunity to emergency situations when the life of the pregnant person is at risk.<sup>18</sup> Thirty of these states also protect clinicians and institutions from “disciplinary action.”<sup>18</sup> Even when state statutes are silent as to immunity, judges deciding claims that stand or fall based upon compliance with a standard of care may interpret these conscience protection statutes as modifications of the standard of care that would negate any duty to patients to provide or refer out an “objectionable” service.<sup>18</sup> Consequently, patients who suffer harm as a result of a conscientious refusal to provide care would have tort remedies only in a small minority of states that do not have conscience protection statutes.

*Remedies under the Emergency Medical Treatment and Active Labor Act (EMTALA).* EMTALA is a federal law that provides important protections for all patients presenting with emergency conditions and active labor.<sup>19</sup> EMTALA requires hospitals that operate emergency rooms to screen individuals who present with these conditions and stabilize them before transfer or discharge. Thus, for example, a patient presenting with an ectopic pregnancy who is hemodynamically unstable should be stabilized by an emergency abortion and must not be turned away before this treatment is provided. However, if a patient is denied emergency care, EMTALA only allows patients to sue the hospital rather than the objecting clinician.<sup>20</sup> Moreover, the hospital may be unable to prevent future EMTALA violations, because it is prohibited from taking any adverse employment action against employees who object to certain emergency procedures.

It is important to note that a patient’s claims against a hospital for harms incurred due to an EMTALA violation are limited to the personal injury law of that state. As described above, many states immunize the hospital from civil liability for harms resulting from a health care professional’s conscientious refusal, leaving the harmed patient without recourse since EMTALA embeds states’ civil liability standard into its mechanism for remedies. Moreover, EMTALA covers only a small subset of patients denied care because of a clinician or entity’s deeply held beliefs. For example, a patient who was not advised on abortion options and subsequently failed to locate a willing entity prior to the viability deadline<sup>13</sup> will have been harmed by the objecting entity

but will have no remedy under EMTALA because the patient did not present with an emergency condition.

*Antidiscrimination provisions.* The Affordable Care Act (ACA) of 2010 includes an antidiscrimination provision that could be used if a patient is denied care “on the basis of sex.” Section 1557 of the ACA provides that an individual shall not be subjected to discrimination in “any health program or activity, any part of which is receiving federal financial assistance.”<sup>21</sup> Courts across the country have interpreted Section 1557 antidiscrimination protections as prohibiting denial of gender-affirming care because it is a form of sex discrimination. Although Section 1557 was enjoined from government enforcement in the Franciscan Alliance suit,<sup>22</sup> individuals have successfully used private rights of action to enforce their right to gender-affirming care under Section 1557.<sup>23,24,25</sup> These cases have hinged on the denial of coverage for procedures to treat gender dysphoria that are covered for other medical conditions (eg, mastectomies and breast reconstruction for individuals with mutations in BRCA genes). Decisions prohibiting discrimination in health care on the basis of sex can logically be extended to religious and moral refusals to provide gender-affirming care, although this line of argument has not yet been accepted by a court.

*Transparency requirements.* Given the serious limits on legal remedies for patients harmed by clinician and institutional refusals, perhaps the most important legal tool to protect patients would be to enable them to make more informed decisions about where they seek care. Disclosure requirements can serve this purpose. The data show that patients are unaware of limits on care posed by conscientious refusals.<sup>16</sup> Many clinicians whose conscience limits the scope of care they provide do not believe it is necessary to disclose their objections and the resulting limits on care to patients.<sup>26</sup> It is conceivable that the number of such clinicians will increase following enactment of more robust legal protections provided by state and federal statutes and regulations. Together, these conditions make disclosure critical to protect patients from harm before it occurs. These disclosure requirements, however, must be consistent with both First Amendment limits on compelled speech and religious freedom protections.

Some state conscience laws include disclosure and other patient-protective measures in their conscience regulation regimes; 5 states that protect conscience also impose a duty to notify the patient of the refusal.<sup>27,28,29,30,31</sup> Illinois not only has one of the broadest conscience protection laws but also places a duty on the facility to “adopt written access to care and information

protocols that are designed to ensure that conscience-based objections do not cause impairment of patients' health" and to ensure that patients are informed of their "condition, prognosis, legal treatment options ... consistent with current standards of medical practice."<sup>32</sup>

Even in its new conscience-protective rule, HHS acknowledged the role of such disclosures to patients. The agency noted that "within limits, employers may require a protected employee to inform them [patients] of objections" to specific procedures, particularly if it is likely the clinician would be asked for a referral.<sup>4</sup> Additionally, the text of the rule provides that facilities "may also inform the public of the availability of alternate staff or methods to provide or further the objected-to conduct" with a notice in a reception area or other location where patients will have easy access to the information.<sup>4</sup> Currently, few states have strict disclosure requirements, and federal regulations leave disclosures up to institutional policy. Where religiously affiliated institutions dominate the caregiver space, [transparency](#) will likely be lacking.

## Conclusion

The legal trend is toward increased protection for objecting clinicians and other entities, with few remedies for patients harmed by limitations in [access to care](#). This trend tends to prioritize health care professionals' individual beliefs over their role as advisors. Short of a shift in the law, disclosure can help patients to make more informed choices when seeking care.

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