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Unilateral Burdens and Third-Party Harms: Abortion Conscience Laws as Policy Outliers

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Unilateral Burdens and Third-Party Harms: Abortion Conscience Laws as Policy Outliers

NADIA N. SAWICKI*

Most conscience laws establish nearly absolute protections for health care providers unwilling to participate in abortion. Providers' rights to refuse—and relatedly, their immunity from civil liability, employment discrimination, and other adverse consequences—are often unqualified, even in situations where patients are likely to be harmed. These laws impose unilateral burdens on third parties in an effort to protect the rights of conscientious refusers. As such, they are outliers in the universe of federal and state anti-discrimination and religious freedom statutes, all of which strike a more even balance between individual rights and the prevention of harm to third parties. This Article argues that state abortion conscience laws should incorporate limitations similar to those established in the Civil Rights Act and the Americans with Disabilities Act in order to minimize risks to third parties who might be harmed by provider refusals.

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INTRODUCTION

Claims of personal and institutional conscience are having an increasing impact on the delivery and financing of health care services in the United States. The most

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prominent example may be religious employers' opposition to the 2010 Patient Protection and Affordable Care Act's contraceptive mandate, which resulted in years of litigation and extensive administrative rulemaking.¹ However, from the perspective of direct patient access to medical services, it is impossible to overstate the impact of state and federal conscience laws that codify health care providers' rights to refuse medical services on grounds of conscience and relieve them of the consequences of those refusals.²

A recent empirical study of procedural protections in state reproductive conscience laws demonstrates the breadth of these laws.³ In many states, the conscience protections offered to providers are absolute—with no consideration given to the burdens they may impose on patients, employers, or other third parties.⁴ Among the forty-six states that protect individual and institutional health care providers' right to refuse participation in abortion, twenty-six impose no limitations on refusal rights.⁵ Thirteen states limit rights of refusal in cases where a patient is in need of emergency medical treatment.⁶ Other meaningful patient protections—for example, referral obligations or duties to provide information about access to services—are rare.⁷ Even more strikingly, the majority of states immunize providers from civil liability for their conscience-driven refusals, prohibiting patients from bringing tort suits to recover for their injuries.⁸

These state laws also impose significant burdens on hospitals and other health care organizations that employ objecting physicians, nurses, and others. Most states prohibit employers from taking adverse action against those who refuse to participate

1. See *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014); *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367 (2020). Further evidence comes from recent attempts at expanding the Department of Health and Human Services (HHS) Office of Civil Rights authority to investigate claims of conscience-based discrimination against health care providers. HHS Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 45 C.F.R. 88 (2019). In response to several legal challenges, HHS agreed to delay implementation of these new rules. Press Release, City Att'y of S.F., *Herrera Forces Trump Administration to Back Down on Discriminatory Health Care Rule* (June 28, 2019), <https://www.sfcityattorney.org/2019/06/28/herrera-forces-trump-administration-to-back-down-on-discriminatory-health-care-rule> [<https://perma.cc/33JA-EWED>]. In late 2019, two federal courts vacated the rule; appeals have been filed in both cases. *New York v. U.S. Dep't of Health & Hum. Servs.*, 414 F. Supp. 3d 475 (S.D.N.Y. 2019); *Washington v. Azar*, 426 F. Supp. 3d 704 (E.D. Wash. 2019).

2. See generally Nadia N. Sawicki, *The Conscience Defense to Malpractice*, 108 CALIF. L. REV. 1255 (2020).

3. *Id.*; Nadia N. Sawicki, *Procedural Protections in Reproductive Health Care Conscience Laws*, THE POLICY SURVEILLANCE PROGRAM, <http://lawatlas.org/datasets/procedural-protections-in-reproductive-health-care-conscience-laws> [<https://perma.cc/6KKT-UXKT>].

4. Sawicki, *supra* note 2, at 1278.

5. *Id.*

6. *Id.* at 1280.

7. *Id.* at 1282.

8. Thirty-seven states have statutory civil immunity provisions. *Id.* at 1275–76. Legislation in the remaining nine states with abortion refusal laws is silent as to the issue of civil immunity but would likely be interpreted by a court to prohibit tort suits by patients. *Id.*

in abortion,⁹ and only three states limit individual providers' right to refuse in cases where accommodating the refusal would cause undue hardship to their employer.¹⁰

Several federal statutes and regulations also protect conscientious refusal rights in the abortion context.¹¹ Like most state laws, almost all of these federal laws appear to provide absolute protections for individual and/or institutional health care providers who decline to participate in abortions.¹² Of these federal laws, only the

9. Twenty-six states explicitly prohibit adverse action by employers; thirty states prohibit "disciplinary action," which may be taken by employers, state agents, or others. *Id.* at 1274.

10. IDAHO CODE § 18-611(3) (2016) ("It shall be unlawful for any employer to discriminate against any health care professional based upon his or her declining to provide a health care service that violates his or her conscience, unless the employer can demonstrate that such accommodation poses an undue hardship."); OKLA. STAT. tit. 63 § 1-728c (West 2016) (prohibiting employers from discriminating against employees by refusing to reasonably accommodate religious observance in the context of abortion, "unless the employer can demonstrate that the accommodation would pose an undue hardship on the program, enterprise, or business of the employer"); 16 PA. CODE § 51.44(c) (requiring employers to make "reasonable accommodations" for refusing employees, defined as accommodations that "may be made without undue hardship to the conduct of the employer's business," and identifying as examples of such hardship cases where "the employe's [sic] needed work cannot be performed by another employe [sic] of substantially similar qualifications in the situation where and at the time when the person refuses to perform or participate in the performance of abortion or sterilization procedures or where the employe [sic] refuses to perform his normally assigned duties incident to employment").

11. *See, e.g.,* Public Health Service Act, 42 U.S.C. § 238n(a)–(b)(1) (protecting physicians and physician training programs that decline to receive or offer training in abortion from government discrimination); *id.* § 300a-7(b) (prohibiting public actors from requiring individuals and entities receiving federal funding to perform or participate in abortion or sterilization); *id.* and 42 U.S.C. § 300a-7(c)–(e) (protecting physicians, health care personnel, and students from adverse action for their refusal to perform abortion or sterilization Consolidated Appropriations Act, Pub. L. No. 111-117, 123 Stat. 3034, § 508 (prohibiting federal funds from going to federal and state agencies and programs that discriminate against entities that decline to participate in abortion); Civil Rights Restoration Act, 20 U.S.C. § 1688 (noting that the law does not "require or prohibit any person, or public or private entity, to provide . . . any . . . service, including the use of facilities, related to an abortion"); Patient Protection and Affordable Care Act, 42 U.S.C. § 18023(b)(4) (prohibiting insurers from discriminating against providers and facilities that refuse to provide abortion); 48 C.F.R. § 1609.7001(c)(7) (noting that health care providers "are not required to discuss treatment options that . . . are inconsistent with their . . . ethical, moral or religious beliefs"). Note that some federal conscience laws also offer positive protections for providers who affirmatively choose to participate in abortion. 42 U.S.C.A. § 300a-7(c) (stating that anti-discrimination provisions are applicable to anyone who "performed or assisted in the performance of a lawful sterilization procedure or abortion" or "refused to perform or assist in the performance of such a procedure" on the basis of religious beliefs or moral convictions); Civil Rights Restoration Act, 20 U.S.C. § 1688 ("Nothing in this chapter shall be construed to require or prohibit any person, or public or private entity, to provide or pay for any benefit or service . . . related to an abortion.").

12. *See* Robin Fretwell Wilson, *When Governments Insulate Dissenters from Social Change: What Hobby Lobby and Abortion Conscience Clauses Teach About Specific Exemptions*, 48 U.C. DAVIS L. REV. 703, 714 (2014) (stating that the Church Amendment

Patient Protection and Affordable Care Act's (PPACA) provisions relating to insurance coverage for abortion services set limits on conscience rights, withdrawing provider protections in cases where patients are in need of emergency treatment.¹³

Abortion conscience laws that establish unqualified protections are outliers in the universe of federal and state laws that are aimed at preventing discrimination and/or accommodating those with religious or other limitations. Laws like Title VII of the Civil Rights Act, the Americans with Disabilities Act, the Religious Freedom Restoration Act, and many others explicitly acknowledge that rights to personal accommodation cannot be absolute.¹⁴ In an effort to protect third parties who might be impacted by these accommodations, these laws set various limits—whether limiting religious accommodations in cases where employers are likely to suffer undue hardship, limiting rights to accommodation of disability if necessary to protect direct harm, or balancing religious protections against the compelling interests of the state. Many other state laws that protect conscience and religious freedom—such as health care decision-making acts and school immunization laws—also set limits on the rights of individuals seeking accommodation.¹⁵

This Article demonstrates that unqualified abortion conscience laws that impose unilateral burdens on third parties affected by provider refusals stand in stark contrast to these other legal protections. It argues that abortion conscience laws should be amended to better balance the rights of refusing providers against the interests of patients, hospitals, and other third parties who might be harmed as a result of a conscience-driven refusal. This Article proposes that this process be informed by the

protects providers even when their refusals would “impose a hardship on women”).

13. 42 U.S.C. § 18023(d) (stating that the law does not relieve health care providers from federal or state emergency treatment requirements, including the Emergency Medical Treatment and Active Labor Act (EMTALA)). Note that although other federal conscience statutes are silent with respect to conscience rights in emergency circumstances, at least one court has held that federal conscience protections were not intended to override EMTALA's emergency treatment obligations. *New York v. United States Department of Health and Human Services* concerned a challenge to an HHS rule prohibiting discrimination on the basis of conscience. 414 F. Supp. 3d 475 (S.D.N.Y. 2019). The court held that the rule was impermissible because it “creates, via regulation, a conscience exception to EMTALA's statutory mandate.” *Id.* at 538. In defending the rule, the federal government had argued that the EMTALA conflict arose not from the rule itself, but from substantive provisions in the underlying conscience statutes (like the Church Amendment). *Id.* The court, however, rejected this claim, stating that there is no evidence that Congress intended for federal conscience statutes to override EMTALA. “On the contrary, there is affirmative evidence that the sponsors of each of the Church, Coats-Snowe, and Weldon Amendments did *not* intend for these to require providers, in an emergency, to be obliged to accommodate an objecting employee.” *Id.* (emphasis in original). Based on this reasoning, some might argue that even when there are no explicit emergency exceptions in the statutory text of federal or state conscience laws, they should nevertheless be interpreted as incorporating EMTALA's emergency treatment duties. However, as I have argued elsewhere, setting limits on conscience protections only in cases of patient emergency is likely insufficient to protect many patients from harm. Sawicki, *supra* note 2, at 1301–04.

14. See *infra* Sections II.B.1 (CRA), II.B.2 (ADA), II.A (RFRA), II.C (HCDAs), II.D (immunization).

15. See *id.*

standards and limitations already established in various other state and federal anti-discrimination laws. Introducing such standards into the statutory language of abortion conscience laws is a workable and politically supportable mechanism for balancing the burdens experienced by refusing providers and those third parties affected by their refusals.

Part I of this Article identifies the primary issue of concern: how best to balance individual health care providers' right to refuse to participate in abortion, a medical service they consider morally objectionable, against the interests of third parties who are impacted by those refusals. Part II compares abortion conscience laws with several federal and state laws that set greater limits on rights to accommodation and analyzes whether imposing such limitations in the abortion context would be feasible. Part III proposes incorporating the undue hardship standard and direct threat limitation of the Civil Rights Act and Americans with Disabilities Act into state abortion conscience laws. It demonstrates that such an approach would, in many cases, protect third parties affected by individual and institutional refusals without withdrawing rights to accommodation altogether. Finally, Part IV highlights another key difference between abortion conscience laws and the accommodation laws described in Part II—only abortion conscience laws protect providers from civil liability if their refusal to participate in abortion causes injury to a patient or other third party. In almost no other context do we see this strong form of provider protection. Eliminating civil liability protections in abortion conscience laws would better serve to protect patient interests and, moreover, would harmonize these laws with the vast majority of other federal and state accommodation laws.

I. BALANCING CONSCIENCE RIGHTS AND THIRD-PARTY PROTECTIONS

Debates about the appropriate scope of health care conscience protections have been ongoing for decades. Many scholars and policymakers believe that health care providers ought to receive some legal protections for their conscience-driven actions, while also acknowledging that these protections cannot be unlimited.¹⁶ Academic

16. See, e.g., Jill Morrison & Micole Allekotte, *Duty First: Towards Patient-Centered Care and Limitations on the Right To Refuse for Moral, Religious or Ethical Reasons*, 9 AVE MARIA L. REV. 141, 182 (2010) (arguing that conscientious refusal laws “should not make exceptions to the few patient protective duties that institutions do have under generally applicable law, such as the duty to provide emergency care in certain circumstances or the duty not to abandon patients, because such exceptions simply shift legal responsibility for the harms that result from refusals from the institution to the patient”); Wilson, *supra* note 12, at 762 (“Qualifying conscience protections by substantial and palpable . . . hardship to the public avoids the need to default to a for-the-patient-to-win-the-objector-must-lose posture.”).

writing in the fields of medicine,¹⁷ philosophy and medical ethics,¹⁸ law,¹⁹ and religion²⁰ is often aimed at determining how best to strike a balance between rights of conscientious refusal and the need for patient protection.

Currently, however, most conscience laws applicable in the abortion context typically impose unilateral burdens—they establish protections for refusing health care providers, hospitals, and insurers but only rarely establish mechanisms for ensuring that these refusals do not cause harm to third parties.²¹ As a result, the consequences of conscientious refusals are borne not by the refusing providers but by others.²² For example, employers and institutions with which a refusing provider is affiliated are burdened with a duty to ensure patient access to care while accommodating the individual provider's refusal. Patients requesting care from refusing providers are burdened with finding alternative providers willing to offer the services they require. In worst-case scenarios, patients who are denied medically necessary abortions may suffer serious physical injuries while also being denied the opportunity to secure a legal remedy.²³

Noted legal scholars have criticized abortion conscience laws for not considering the doctrine of third-party harm.²⁴ Primarily attributed to First Amendment scholars,

17. See, e.g., R. Alta Charo, *The Celestial Fire of Conscience — Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471 (2005); Lisa H. Harris, *Recognizing Conscience in Abortion Provision*, 367 NEW ENG. J. MED. 981 (2012); Julian Savulescu, *Conscientious Objection in Medicine*, 332 BRIT. MED. J. 294 (2006); Douglas B. White & Baruch Brody, *Would Accommodating Some Conscientious Objections by Physicians Promote Quality in Medical Care?*, 305 JAMA 1804 (2011).

18. See, e.g., Rebecca S. Dresser, *Freedom of Conscience, Professional Responsibility, and Access to Abortion*, 22 J. L. MED. & ETHICS 280 (1994); HOLLY FERNANDEZ LYNCH, *CONFLICTS OF CONSCIENCE IN HEALTH CARE: AN INSTITUTIONAL COMPROMISE* (2008); MARK R. WICCLAIR, *CONSCIENTIOUS OBJECTION IN HEALTH CARE: AN ETHICAL ANALYSIS* (2011).

19. See, e.g., Kent Greenawalt, *Refusals of Conscience: What Are They and When Should They Be Accommodated?*, 9 AVE MARIA L. REV. 47 (2010); Richard S. Myers, *On the Need for a Federal Conscience Clause*, 1 NAT'L CATH. BIOETHICS Q. 23 (2001); Lynn D. Wardle, *Protection of Health-Care Providers' Rights of Conscience in American Law: Present, Past, and Future*, 9 AVE MARIA L. REV. 1 (2010); Wilson, *supra* note 12.

20. See, e.g., Maureen Kramlich, *Coercing Conscience: The Effort to Mandate Abortion as a Standard of Care*, 4 NAT'L CATH. BIOETHICS Q. 29 (2004); Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 FORDHAM URB. L.J. 221 (2002).

21. Sawicki, *supra* note 2, at 1278–83.

22. Douglas Nejaime & Reva B. Siegel, *Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics*, 124 YALE L.J. 2516, 2542 (2015) (“[H]ealthcare refusal laws make little or no effort to offset their impact on third parties.”); see Maxine N. 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, 781–82 (2007) (“Little effort has been made to achieve a reasonable balance between providers’ and patients’ interests. In most cases, the legislation recognizes an absolute right to refuse to provide health care, which destroys any equilibrium between these two competing interests.”).

23. See generally Sawicki, *supra* note 2.

24. See, e.g., Kathleen A. Brady, *Religious Accommodations and Third-Party Harms: Constitutional Values and Limits*, 106 KY. L.J. 717, 727 (2017) (arguing that policymakers should “seek solutions that avoid or minimize burdens on both religious believers and third

the third-party harm doctrine posits that religious accommodations and/or exemptions may be unconstitutional when they result in significant harm to third parties.²⁵ In this Article, I do not take a position on whether the third-party harm doctrine is a viable interpretation of Establishment Clause jurisprudence, or on the constitutionality of religious exemptions in general. Rather, this Article addresses the normative question of how policymakers crafting discretionary exemptions²⁶ from generally applicable laws should balance the interests of those whose beliefs they seek to protect against those who might be negatively impacted by such exemptions. Whatever one's position on the constitutional question, it is impossible for policymakers to consider laws aimed at accommodating religious and conscientious believers without also considering the effects of these laws on third parties.²⁷

parties to the greatest extent possible. Solutions that take both sets of concerns into account are preferable to approaches that focus on one set at the expense of the other.”); Nejaime & Siegel, *supra* note 22 (demonstrating that complicity-based conscience claims negatively impact third parties outside the faith community and arguing for limitations on legal accommodation of such claims); Micah Schwartzman, Nelson Tebbe & Richard Schragger, *The Costs of Conscience*, 106 KY. L.J. 781, 810–11 (2017) (“Even if we are committed to protective doctrines . . . we should still be concerned about who pays for the costs of harmful rights” and suggesting that it may be preferable to “‘uncouple’ protection of a right from the harms it imposes on others.”); Mark Storslee, *Religious Accommodation, the Establishment Clause, and Third-Party Harm*, 86 U. CHI. L. REV. 871, 940–42 (2019) (describing examples where political effort has “soften[ed] some of the harder edges” of proposed legislative accommodations that would harm third parties); Wilson, *supra* note 12, at 758 (identifying the key question in these debates as “not whether anyone can be harmed — someone, somewhere may well be harmed in the abstract — but whether exemptions can be tailored to mute the impact on the public while also respecting religious liberty”).

25. See, e.g., Brady, *supra* note 24, at 721–22 (discussing whether Establishment Clause jurisprudence permits religious accommodations that impose significant third-party burdens); Carl H. Esbeck, *Do Discretionary Religious Exemptions Violate the Establishment Clause?*, 106 KY. L.J. 603 (2017) (distinguishing constitutional analysis between cases involving religious exemptions and religious preferences); Christopher C. Lund, *Religious Exemptions, Third-Party Harms, and the Establishment Clause*, 91 NOTRE DAME L. REV. 1375 (2016) (arguing that third-party harms are constitutionally relevant, and identifying factors relevant to judicial decision-making); Schwartzman, Tebbe & Schragger, *supra* note 24 (challenging six major objections to the third-party harm principle); Storslee, *supra* note 24 (rejecting the third-party harm doctrine as an interpretation of the Establishment Clause and arguing instead that the Establishment Clause only prohibits government attempts to promote a favored religious identity).

26. Policymakers have great discretion to create religious exemptions to generally applicable laws. See Brady, *supra* note 24, at 720 (explaining that under the Free Exercise precedent of *Smith*, “when burdens result from neutral, generally applicable laws, whether or not to grant relief is a legislative decision”); *id.* at 723–24 (noting that the question of how to consider third-party burdens when crafting religious accommodations is both a normative question and a constitutional question).

27. See Schwartzman, Tebbe & Schragger, *supra* note 24, at 810–11 (identifying as options for protecting religious freedom while avoiding third-party harm: “(1) protect[ing] the right and impos[ing] costs on third parties or (2) restrict[ing] the right and avoid imposing costs on third parties,” as well as alternative options that “‘uncouple’ protection of a right from the harms it imposes on others by requiring the public to compensate those who are harmed,”

II. SEEKING BALANCE: TAKING CUES FROM FEDERAL AND STATE LEGISLATION IN OTHER CONTEXTS

While abortion conscience laws are fairly one-sided in their protections, anti-discrimination and religious accommodation laws in many other contexts explicitly recognize and protect against the possibility of third-party harm. Federal and state laws protecting religious exercise, conscientious belief, and even disability all set clear limits on how far the right to personal accommodation extends. While these laws take a variety of approaches to balancing individual rights and public interests, they all recognize that protections for individual rights cannot be absolute and establish standards for determining the boundaries of these protections.

Many of these limiting standards have been in place for decades and have survived in the face of political and legal challenges. Others, as in the case of school immunization laws, have been amended fairly recently in response to pressing concerns about risks to third parties.²⁸ Given that these limitations all have significant public and political support, it is reasonable to consider them as possibilities in the context of conscience protections for health care providers opposed to abortion. Indeed, the risks of third-party harm resulting from provider refusals may be even greater than in some of these other contexts, given that health care providers have a monopoly on providing medical care to support patient health and safety.²⁹

This Section examines several federal and state laws that establish individual accommodations while also setting limits to protect third parties from harm—from the more general to the most restrictive. It analyzes whether these limits could be similarly applied to abortion conscience laws and evaluates which limits might translate most comfortably to this context. This analysis will provide valuable guidance to the many state and federal policymakers who are considering amendments to their abortion laws, many of which include conscience protections.³⁰

such as through social insurance or no-fault compensation).

28. See *infra* text at notes 146, 150.

29. See R. Alta Charo, *Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience*, 1 J. AM. CONST. SOC'Y ISSUE GRPS 119, 129–34 (2007) (discussing state licensing of physicians and the implications of medical monopoly power for rights of conscientious refusal).

30. In 2019, there were several major changes to state and federal conscience laws, including the Trump administration's expansion of federal authority to investigate claims of conscience-based discrimination against health care providers. See, e.g., HHS, *supra* note 1; H.B. 2495, 101st Gen. Assemb., Reg. Sess. (Ill. 2019) (repealing the conscience provisions of the Illinois Abortion Law of 1975); H.B. 57, 2019 Gen. Assemb., Reg. Sess. (Vt. 2019) (prohibiting public entities from restricting health care providers' right to participate in abortion). In 2020, state legislation imposing restrictions on abortion access proliferated. NORA ELLMAN, STATE ACTIONS UNDERMINING ABORTION RIGHTS IN 2020 (2020), <https://www.americanprogress.org/issues/women/reports/2020/08/27/489786/state-actions-undermining-abortion-rights-2020/> [https://perma.cc/3NLC-632V].

A. General Standards: Religious Freedom Restoration Act

In *Employment Division v. Smith*, the Supreme Court weakened the First Amendment’s protections of religious freedom when it held that valid and neutral laws of general applicability that have the incidental effect of burdening religious exercise are subject only to rational basis review.³¹ In direct response to *Smith*, Congress passed the Religious Freedom Restoration Act (RFRA), reinstating, by way of federal statute, the strict scrutiny standard that had been in place prior to *Smith*.³²

RFRA prohibits the government from passing even generally applicable laws that “substantially burden” religious exercise unless it can demonstrate that the laws further a “compelling governmental interest” and adopt the “least restrictive means” of furthering that interest.³³ In other words, RFRA provides strong protections for religious believers, but it sets limits on those protections.

Unlike some of the other limiting standards discussed in this Article, RFRA’s compelling interest test is more of a metastandard. In the context of abortion refusal, RFRA does not provide direct guidance to health care providers about their rights and responsibilities. Rather, it is a standard by which legislators and judges can assess the merits of legislation passed to protect these rights. As such, it is useful to health care providers and patients seeking to challenge state laws. However, it does not speak directly to providers seeking guidance about the scope of their obligations in any particular circumstance, nor does it assist patients seeking to challenge provider refusals in the moment.

Thus, including a compelling interest / least restrictive alternative test within abortion conscience laws will not address the practical needs of providers, patients, or employers. However, legislators could certainly consider this kind of test when assessing amendments to state conscience laws. To be clear, states are not bound by RFRA,³⁴ but its guiding principles may be helpful for policymakers seeking to minimize third-party harms associated with current conscience protections.

Reproductive rights advocates may argue that advising policymakers to follow a compelling interest / least restrictive alternative standard in adopting or amending conscience laws will be insufficiently protective of patient rights. After all, the Supreme Court rejected such a test when assessing the First Amendment claims in *Smith*—as a constitutional matter, states may not be required to have health care conscience protections at all.³⁵ However, recall that almost every state currently

31. 494 U.S. 872, 878–881 (1990).

32. 42 U.S.C. §§ 2000bb, 2000bb-1, 2000bb-2, 2000bb-3, 2000bb-4.

33. *Id.* § 2000bb-1.

34. *City of Boerne v. Flores*, 521 U.S. 507 (1997) (holding that RFRA is only constitutional as applied to the federal government, not the states). Note, however, that some states have their own versions of RFRA. Christopher C. Lund, *Religious Liberty After Gonzales: A Look at State RFRAs*, 55 S.D. L. REV. 466, 466–67 (2010).

35. See *infra* note 152 (identifying, in the context of mandatory school immunization, cases holding that religious and philosophical exemptions are not constitutionally required); see also *Pennsylvania v. President U.S.*, 930 F.3d 543, 572–73 (3d Cir. 2019) (holding that a religious exemption to the PPACA contraceptive mandate is not required under RFRA), *rev’d and remanded by Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367 (2020) (holding that it was appropriate for the United States to consider RFRA when

protects health care providers' right to refuse participation in abortion, and that the majority of states impose no limits or conditions on these rights, offering no corresponding protections for patients. The fact that most current abortion conscience laws impose unilateral burdens on third parties suggests that any kind of limiting principle—even one as broad as the RFRA standard—could be a welcome change from the perspective of third-party protection.

Admittedly, it is difficult to predict what the consequences might be if an RFRA-type standard were applied to abortion conscience laws. Some insights may be gleaned, however, from Supreme Court jurisprudence in the contraceptive mandate cases.

When the Patient Protection and Affordable Care Act (PPACA) was passed in 2010, it included a provision commonly known as the “contraceptive mandate.” The PPACA requires that employee health insurance plans cover preventive services (one of ten essential health benefits) without cost-sharing payments by insured individuals.³⁶ In defining the scope of “preventive services,” the Department of Health and Human Services (HHS) relied on recommendations from the Institute of Medicine, which defined preventive services as including FDA-approved contraceptive and sterilization treatments.³⁷

Backlash was swift among employers with religious objections to contraception and sterilization, leading to regulatory changes that exempted some employers from the mandate and established an accommodation for others.³⁸ Nevertheless, opposition continued.

The Supreme Court's 2014 decision arose from a challenge by Hobby Lobby, a closely-held, for-profit company that opposed the contraceptive mandate on religious grounds but was not entitled to an exemption.³⁹ Applying the RFRA standard, the Court agreed that the mandate imposed a substantial burden on Hobby Lobby's freedom of religious exercise.⁴⁰ Moreover, the Court concluded that the mandate was not the least restrictive means of achieving the government's interest in ensuring broad access to contraceptive services.⁴¹ For example, it noted that the mandate's goal could be achieved in a less restrictive manner if the accommodation mechanism for nonprofit “eligible organizations” were extended to companies like Hobby

crafting the religious exemption but reaching no decision on the question of whether RFRA compelled or authorized the exemption).

36. 42 U.S.C. §§ 300gg-13(a)(4).

37. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventative Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725 (2012).

38. See *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 698–99 (2014) (discussing exemptions and accommodations established by HHS).

39. *Id.* at 702–05.

40. *Id.* at 719–26.

41. See *id.* at 728–32. Interestingly, the Court declined to adjudicate the issue of whether the government's interest in ensuring that insured women have access to contraception is a compelling one; rather, it “assume[d] that the interest in guaranteeing cost-free access to the four challenged contraceptive methods is compelling within the meaning of RFRA.” *Id.* at 728.

Lobby.⁴² The Court also identified another possible means of achieving the mandate's goal without burdening objecting employers: it suggested that the U.S. government could provide contraceptive coverage directly to individuals, bypassing employer insurance entirely.⁴³

Both of these approaches, according to the Court, could minimize burdens on objecting employers while nevertheless ensuring broad public access to contraception. While the Court did not explicitly address the question of whether Hobby Lobby would have a right to accommodation if that resulted in significant access issues for employees seeking contraception, its holding effectively conditioned RFRA protections for refusing employers on the prevention of harms to third parties. Indeed, academic experts have interpreted the Supreme Court's decision in Hobby Lobby as granting the company the accommodations it had requested, "but . . . on the assumption that there would be no cost to third parties" other than taxpayers.⁴⁴ The Court did not direct HHS as to how, exactly, it should modify the contraceptive mandate to achieve this balance. In fact, in a later case, the Court instructed the parties to find a solution on their own.⁴⁵

The Court's approach in *Hobby Lobby* and subsequent cases left a strong indication that if the parties could find no way to fully accommodate employers' objections without significantly reducing women's access to contraception, accommodation might not be required under RFRA. Indeed, that was HHS's determination shortly after *Hobby Lobby* was decided—it did not amend its regulations, because it determined that there was no way to further accommodate employers without reducing access for employees.⁴⁶

42. *See id.* at 730.

43. *Id.* at 728 (noting that the "most straightforward" and "less restrictive" way of achieving this goal "would be for the Government to assume the cost of providing the four contraceptives at issue to any women who are unable to obtain them under their health-insurance policies due to their employers' religious objections"). Some critics have argued that there is no doctrinal support for such an approach. *See, e.g.,* Arnold H. Loewy, *Religious Liberty Versus Rights of Others*, 106 KY. L.J. 651, 658 (2017) (discussing the Court's suggestion that government-sponsored contraceptive coverage might be a solution to the RFRA problem, arguing that "[t]hat cannot be the law, and indeed it is not," and opining that here, "the Court went off the rails in a way unlike anything I can ever recall seeing").

44. Schwartzman, Tebbe & Schragger, *supra* note 24, at 811.

45. "Given the gravity of the dispute and the substantial clarification and refinement in the positions of the parties, the parties on remand should be afforded an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans 'receive full and equal health coverage, including contraceptive coverage.'" *Zubik v. Burwell*, 136 S. Ct. 1557, 1560 (2016). The Court's order also included the following language: "Nothing in this opinion, or in the opinions or orders of the courts below, is to affect the ability of the Government to ensure that women covered by petitioners' health plans 'obtain, without cost, the full range of FDA approved contraceptives.'" *Id.* at 1560–61 (quoting *Wheaton College v. Burwell*, 134 S. Ct. 2806, 2807 (2014)).

46. *FAQs About Affordable Care Act Implementation Part 36*, U.S. DEP'T OF LAB. EMP. BENEFITS SECURITY ADMIN. 4 (Jan. 9, 2017), <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-36.pdf> [https://perma.cc/8MMM-FM8E].

However, after Donald Trump was elected president, his administration reversed course. It expanded the existing exemption to all employers with religious objections to contraception and made the accommodation process (which would allow employees to access contraceptive drugs without implicating employers) entirely optional.⁴⁷ In litigation surrounding these regulatory changes, several federal courts relied on the Supreme Court's language in *Hobby Lobby* regarding access to contraception to enjoin their implementation. Both the Ninth⁴⁸ and Third Circuits⁴⁹ enjoined the new rules in part because they would cause some women to lose employer-sponsored contraceptive coverage, something the Supreme Court sought to avoid in *Hobby Lobby*.

The Third Circuit, in *Pennsylvania v. President of the United States*, emphasized that “[t]he Supreme Court has directed that, when considering a requested accommodation to address the burden, ‘courts must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.’”⁵⁰ It found that while the accommodation “fulfills this directive as it provides a means for an observer to adhere to religious precepts and simultaneously allows women to receive statutorily-mandated health care coverage,”⁵¹ the new rules, which make the accommodation optional, would “impose an undue burden on nonbeneficiaries.”⁵² The court further cited Justice Ginsburg's dissent in *Hobby Lobby*, where she wrote that RFRA does not permit “a religion-based exemption when the [A]ccommodation would be harmful to others—here, the very persons the contraceptive coverage requirement was designed to protect.”⁵³ While the Third Circuit's decision was reversed by the Supreme Court and the case was remanded in 2020, the Supreme Court's opinion did not speak to the question of third-party harm.⁵⁴

For similar reasons, the Ninth Circuit court in *California v. Azar* enjoined the new rules on the basis that it was “reasonably probable that women in the plaintiff states [would] lose some or all employer-sponsored contraceptive coverage due to the

47. Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792, 47,808 (Oct. 13, 2017); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,838, 47,838 (Oct. 13, 2017).

48. In *California v. Azar*, the Ninth Circuit affirmed the grant of a preliminary injunction against the expanded exemptions in plaintiff states. 911 F.3d 558, 574 (9th Cir. 2018). After a series of appeals, the injunction was vacated, and this case and several affiliated cases were remanded for reconsideration in light of the Supreme Court's 2020 decision in *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367 (2020). *California v. U.S. Dep't of Health & Human Servs.*, 977 F.3d 801 (9th Cir. 2020).

49. In *Pennsylvania v. President of the United States*, the Third Circuit affirmed the grant of a nationwide preliminary injunction. 930 F.3d 543, 576 (3d Cir. 2019). The decision was reversed and remanded by the Supreme Court in *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 2367, 2373 (2020).

50. 930 F.3d at 573 (quoting *Cutter v. Wilkinson* 544 U.S. 709, 720 (2005)).

51. *Id.*

52. *Id.* at 574.

53. *Burwell v. Hobby Lobby*, 573 U.S. 682, 764 (2014) (Ginsburg, J., dissenting).

54. See *supra* text accompanying notes 40–44.

IFRs,” citing federal agencies’ own estimates that between 31,700 and 120,000 women would lose contraceptive coverage.⁵⁵

Even the U.S. District for the Northern District of Texas, which held in *Deotte v. Azar* that the contraceptive mandate’s accommodation process violated RFRA’s protections for religious employers, acknowledged the risk of harm to third parties when it discussed alternative means of ensuring contraceptive access.⁵⁶ The court reiterated the Supreme Court’s assertion that there are likely less restrictive means of protecting access without infringing on employers’ religious liberty.⁵⁷

In 2020, in *Little Sisters of the Poor*, the Supreme Court upheld the Trump administration’s expansion of the religious exemption against procedural challenges.⁵⁸ However, it did not speak to the substantive question of whether an RFRA analysis ought to consider significant harms to third parties,⁵⁹ and it declined to reach any conclusion about whether such harms are likely to occur in this instance.⁶⁰ That said, six Justices (in two concurrences and one dissent) explicitly called out the impact of these new rules on employees’ ability to access contraception. Justices Alito and Gorsuch, in a concurring opinion, concluded that the new rules impose no burden on employees.⁶¹ In contrast, Justices Kagan and

55. 911 F.3d 558, 572 (2018).

56. 393 F. Supp. 3d 490, 514 (N.D. Tex. 2019) (permanently enjoining the contraceptive mandate, including the accommodation process requiring objecting employers to complete self-certification forms).

57. *Id.* at 506–08 (noting that even if the “Government has a compelling interest in ensuring access to free contraception,” it could achieve this interest without “conscripting religious employers,” for example, “[a]s the Supreme Court suggested . . . if the Government itself were to assume the cost and responsibility of a program to ensure free access to contraception”).

58. 140 S. Ct. 2367, 2386 (2020) (holding that the Departments of Health and Human Services, Labor, and the Treasury had the authority under PPACA to promulgate the religious and moral exemptions, and that the rules that were promulgated were free from procedural defects under the Administrative Procedure Act).

59. The Court noted that the “policy concern” of whether the new rule imposes burdens on employees seeking contraception “cannot justify supplanting the [ACA] text’s plain meaning,” but the Court did not speak to whether this concern would be relevant to an RFRA analysis. *Id.* at 2381. The Court concluded that it was appropriate for the departments to consider RFRA when promulgating the new rules, but it expressly declined to reach a substantive conclusion as to whether the expanded exemption was “compelled [or] . . . authorized” by RFRA (or about how an RFRA analysis might proceed). *Id.* at 2382.

60. The Court’s opinion acknowledged the parties’ disagreement about whether the exemption would make it harder for women to access contraception but expressed no view on this issue. *Id.* at 2381. Justices Alito and Gorsuch, in a concurring opinion, concluded that the new rule imposes no burden on employees seeking contraceptive access. *Id.* at 2396 (Alito, J. & Gorsuch, J., concurring). In a dissenting opinion, Justices Ginsburg and Sotomayor concluded that the burdens to employees were significant. *Id.* at 2408 (Ginsburg, J. & Sotomayor, J., dissenting).

61. “The dissent and the court below suggest that the new rule is improper because it imposes burdens on the employees of entities that the rule exempts . . . but the rule imposes no such burden. A woman who does not have the benefit of contraceptive coverage under her employer’s plan is not the victim of a burden imposed by the rule or her employer. She is simply not the beneficiary of something that federal law does not provide.” *Id.* at 2396 (Alito,

Breyer in a concurrence,⁶² and Justices Ginsburg and Sotomayor in a dissent,⁶³ all concluded that the burdens to employees were significant. The fact that six Justices thought it important to reach substantive conclusions on the issue of third-party harm suggests that this issue would be highly relevant to a substantive RFRA analysis.⁶⁴

In sum, while RFRA's compelling interest / least restrictive alternative standard would not provide practical guidance if incorporated into the text of state abortion conscience laws, it would serve as helpful policy guidance for those adopting and amending such laws. And given the Supreme Court's language about third-party harm in *Hobby Lobby*, considering the RFRA standard as relevant to abortion conscience laws may very well reduce the risk of third-party harm as compared to current law.

B. Setting Limits on Individual Rights: Civil Rights Act and Americans with Disabilities Act

In contrast to RFRA's general standard for assessing the validity of accommodation laws, other federal laws include direct limitations on individuals' rights to accommodation and their protection from adverse action by employers. In particular, both the Civil Rights Act's protections against religious discrimination and the Americans with Disabilities Act's protections against disability discrimination set boundaries on what steps employers and others must take to accommodate individual needs. These statutory limits have been used for decades and are easily translatable to state abortion conscience laws.

1. Title VII of the Civil Rights Act: Undue Hardship

Title VII of the Civil Rights Act of 1964 prohibits employers from discriminating against employees on the basis of religion.⁶⁵ If an employee establishes a prima facie case for religious discrimination under Title VII, the burden shifts to the employer to demonstrate that it provided a reasonable accommodation to the employee.⁶⁶ Alternatively, the employer may defeat a Title VII claim by demonstrating that it was

J. & Gorsuch, J., concurring) (citations omitted).

62. *Id.* at 2399 (Kagan, J. & Breyer, J., concurring) (noting that the departments "committed themselves to minimizing the impact of contraceptive coverage," but the expanded exemptions yielded "all costs and no benefits").

63. *Id.* at 2407–08 (Ginsburg, J. & Sotomayor, J., dissenting) (noting that the Court "has repeatedly assumed that any religious accommodation to the contraceptive-coverage requirement would preserve women's continued access to seamless, no-cost contraceptive coverage" but that the expanded religious exemption "imposes significant burdens on women employees").

64. Justices Ginsburg and Sotomayor cited substantial precedent in support of their conclusion that the government's accommodation of religion "may not benefit religious adherents at the expense of the rights of third parties." *Id.* at 2408 (Ginsburg, J. & Sotomayor, J., dissenting) (citing *Cutter v. Wilkinson*, 544 U.S. 709, 722 (2005); *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)).

65. 42 U.S.C. § 2000e-2(a).

66. *Horvath v. City of Leander*, 946 F.3d 787, 791 (5th Cir. 2020) (citing *Davis v. Fort Bend Cnty.*, 765 F.3d 480, 485 (5th Cir. 2014)).

unable to provide an accommodation “without undue hardship on the conduct of the employer’s business.”⁶⁷ Effectively, Title VII establishes a duty on the part of employers to reasonably accommodate their employees’ religious observances, practices, and beliefs to the extent they are able to while still maintaining effective business practices.

By establishing the undue hardship test, Title VII explicitly recognizes that accommodating an employee’s religious exercise may be burdensome to third parties. It therefore sets limits on how far employee protections extend—if accommodating the employee causes an undue hardship to the employer’s business, Title VII’s protections end. Importantly, the Supreme Court has interpreted the undue hardship test quite favorably for employers, holding that Title VII does not require employers “to bear more than a *de minimis* cost” in accommodating a religious employee.⁶⁸ According to the Supreme Court, even shifting employee work schedules to accommodate an employee’s refusal to work on Saturdays would constitute an undue hardship.⁶⁹ Moreover, in determining the scope of an employer’s accommodation duties, courts interpret “cost” to the employer broadly—they consider not only economic costs, but also noneconomic costs, safety risks, and legal risks.⁷⁰

While the undue hardship test focuses only on the impact an employee’s religious exercise has on their employer, in the case of employers in the health care industry, this test necessarily considers effects on patient health and safety as well. Numerous courts have recognized that in service-oriented industries, accommodation of employees’ religious beliefs may increase public health or safety risks.⁷¹ In the

67. 42 U.S.C. § 2000e(j) (defining “religion” as “all aspects of religious observance and practice, as well as belief, unless an employer demonstrates that he is unable to reasonably accommodate to an employee’s or prospective employee’s religious observance or practice without undue hardship on the conduct of the employer’s business”).

68. *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 84 (1977) (emphasis in original) (rejecting a claim by an employee who requested Saturdays off, holding that accommodating this request would impose an undue burden because it would require his employer to bear additional costs to secure a replacement for him on Saturdays).

69. *Id.* at 76–77; see also *Robinson v. Children’s Hosp. Bos.*, No. 14-10263-DJC, 2016 WL 1337255, at *10 (D. Mass. Apr. 5, 2016) (finding undue hardship in arranging employee workflow so that an unvaccinated employee could avoid vulnerable patients); *Brener v. Diagnostic Ctr. Hosp.*, 671 F.2d 141, 146–47 (5th Cir. 1982) (finding undue hardship in requiring other employees to trade shifts with an employee unable to work on the Sabbath).

70. “Undue hardship can be both ‘economic costs, such as lost business or having to hire additional employees to accommodate a Sabbath observer,’ and ‘non-economic costs, such as compromising the integrity of a seniority system’ or loosening a company’s dress code. . . . Undue hardship can also exist if the proposed accommodation would ‘either cause or increase safety risks or the risk of legal liability for the employer.’” *Robinson*, 2016 WL 1337255, at *8 (quoting *Cloutier v. Costco Wholesale Corp.*, 390 F.3d 126, 134–35 (1st Cir. 2004); *EEOC v. Oak-Rite Mfg. Corp.*, No. IP99–1962–C–H/G, 2001 WL 1168156, at *10 (S.D. Ind. Aug. 27, 2001)).

71. See, e.g., *Horvath*, 946 F.3d at 790 (affirming a grant of summary judgment in favor of the defendant where the plaintiff, a firefighter, refused to be vaccinated, and the defendant’s concern was preventing the spread of communicable disease “to [the plaintiff], co-workers, or patients with whom he may come into contact as a first responder”).

healthcare industry in particular, courts have held that employers (like hospitals) whose primary business purpose is the care of patients may not be required to accommodate employees whose religious beliefs threaten patient well-being and where such accommodations would be burdensome.⁷² That said, many circuit courts hold that employers must prove more than a “speculative” or “hypothetical” hardship, and that the employer’s case is stronger when it can show that hardship actually resulted from an accommodation.⁷³

In a recent Massachusetts case, for example, Children’s Hospital Boston terminated an administrative employee who regularly interacted with patients but refused to be vaccinated.⁷⁴ The hospital’s policy required that all employees working in patient care areas be vaccinated against influenza. Although the policy allowed exemptions for employees who faced serious health risks by being vaccinated, the hospital did not offer a religious exemption “because it concluded that additional exemptions would increase the risk of transmission” of the flu between patients and providers.⁷⁵ The court granted summary judgment for the hospital on the grounds that there was no way to accommodate the employee’s request without increasing the risk of disease transmission to vulnerable patients.⁷⁶ It likewise rejected as “unworkable” the plaintiff’s proposal that the hospital modify her responsibilities to allow her “to avoid relatively more vulnerable patients and not others.”⁷⁷ According to the court, forcing the hospital to “arrange its work flow around uncertain factors .

72. See, e.g., *Baz v. Walters*, 782 F.2d 701, 706–07 (7th Cir. 1986) (finding that accommodating a chaplain whose “philosophy of . . . care of psychiatric patients is antithetical to” his employer’s would have created an undue hardship, given that the hospital’s primary purpose was furthering the “overall well-being of the patients”); *Bruff v. N. Miss. Health Servs., Inc.*, 244 F.3d 495, 501 (5th Cir. 2001) (reversing jury finding that hospital violated Title VII, where accommodating a counselor’s request to counsel patients only on topics that did not violate her religious beliefs would have imposed more than a de minimis cost, given the size of the employer’s staff and “the nature of psychological counseling incorporating trust relationships developed over time”); *Brener v. Diagnostic Ctr. Hosp.*, 671 F.2d 141, 144 (5th Cir. 1982) (affirming judgment in favor of hospital, finding that accommodating an Orthodox Jewish pharmacist who was not able to work on the Sabbath would have caused an undue burden at a hospital with only five pharmacists, increasing workload on other pharmacists and “result[ing] in a decline in the quality of patient care”); *Head v. Adams Farm Living, Inc.*, 775 S.E.2d 904, 911 (N.C. Ct. App. 2015) (applying the Title VII standard to a state law claim of religious discrimination, holding that nursing home employee’s refusal to be vaccinated was a legitimate, nondiscriminatory reason for dismissal where residents of the nursing home were medically vulnerable). *But cf.* *Kenny v. Ambulatory Ctr. of Miami, Fla., Inc.*, 400 So. 2d 1262 (Fla. Dist. Ct. App. 1981) (reversing judgment in favor of employer, holding that attempts to accommodate a nurse’s religious opposition to abortion would not have caused undue hardship because the majority of her duties did not involve gynecological procedures and the employer made no showing that scheduling changes would have been burdensome).

73. See *Hellinger v. Eckerd Corp.*, 67 F. Supp. 2d 1359, 1365–66 (S.D. Fla. 1999) (citing many circuit court cases).

74. *Robinson*, 2016 WL 1337255.

75. *Id.* at *2.

76. *Id.* at *9–10.

77. *Id.* at *10.

. . . would have been an undue hardship because it would have imposed more than *de minimis* cost.”⁷⁸

In a case addressing a Title VII claim in the context of conscientious objection to abortion, the Third Circuit likewise acknowledged that patient interests are relevant to an employer’s decision of whether and how to accommodate a refusing employee. In *Shelton v. University of Medicine and Dentistry*, a public hospital prevailed on a Title VII claim by a labor and delivery nurse who opposed abortion for religious reasons and was subsequently dismissed.⁷⁹ Several times, the nurse objected to providing emergency care to pregnant patients with life-threatening issues where treatment required terminating the pregnancies.⁸⁰ The hospital, believing that her refusals threatened patient safety, attempted to accommodate her by proposing a transfer to the neonatal intensive care unit and offering her the opportunity to apply for a different position.⁸¹ When she refused both accommodations, she was dismissed.⁸² Finding that the hospital had satisfied its duty to offer reasonable accommodations, the Third Circuit affirmed the grant of summary judgment in favor of the hospital.⁸³ Although the court did not rule on the question of undue hardship, it emphasized the connection between employee refusals and patient safety, describing health care providers as “public protectors.”⁸⁴ According to the court, “public trust and confidence requires that a public hospital’s health care practitioners—with professional ethical obligations to care for the sick and injured—will provide treatment in time of emergency.”⁸⁵

In contrast to Title VII of the Civil Rights Act, most state’s abortion conscience laws do not balance conscience protections against an employer’s legitimate business interests. Only three states impose a similar “undue hardship” test in their abortion refusal laws.⁸⁶ Thus, most state conscience laws require employers to accommodate employees’ conscientious refusal to perform abortions regardless of the burden these accommodations impose on employers or the populations they serve. As a result, while a hospital that dismisses a refusing employee after the employee rejects a reasonable accommodation might be free from liability under Title VII, the hospital would not be able to defeat a claim under the state’s abortion conscience law. The employer would be barred by state law from disciplining the employee or taking any adverse employment action. Moreover, in most states, any patients who might be injured as a result of the provider’s refusal would be barred from bringing suit.⁸⁷

Interestingly, some courts have interpreted state conscience statutes and antidiscrimination laws to incorporate Title VII’s undue hardship standard—even where the statutory text establishes no explicit limitations on refusing providers’

78. *Id.* (emphasis in original) (citing *Cloutier*, 390 F.3d at 134).

79. 223 F.3d 220 (3d Cir. 2000).

80. *Id.* at 222–23.

81. *Id.* at 223.

82. *Id.*

83. *Id.* at 226–28.

84. *Id.* at 228.

85. *Id.*

86. *See supra* note 10.

87. Sawicki, *supra* note 2, at 1261–62.

rights.⁸⁸ To cite one example, the Florida conscience law at issue in *Kenny v. Ambulatory Center of Miami, Florida, Inc.* protected employees who refused to participate in abortions from “any disciplinary or other recriminatory action,” with no explicit limitations on those protections.⁸⁹ In a challenge by a nurse who was demoted from her position as a result of her refusal to participate in abortions,⁹⁰ the court considered whether to “apply the federal standard requiring reasonable accommodation unless undue hardship exists, or to apply the more stringent standard of disallowing discrimination regardless of the cost.”⁹¹ It concluded, without explaining its reasoning, that the state statute should be interpreted to incorporate the federal standard.⁹²

Other courts, however, have rejected the notion that state laws prohibiting religious discrimination should be read to include Title VII-like requirements that are not in the statutory text.⁹³ In *Olin Corp. v. Fair Employment Practice Commission*, for example, the Appellate Court of Illinois held that the Illinois Fair

88. See, e.g., *Am. Motors Corp. v. Dep’t of Indus.*, 286 N.W.2d 847, 853 (Wis. Ct. App. 1979) (holding that despite the absence of statutory text to this effect, the Wisconsin Fair Employment Act “requires employers to make reasonable accommodations to their employees’ religious practices,” but declining to decide whether Title VII’s undue hardship test should be read into the reasonable accommodation requirement); *Wondzell v. Alaska Wood Prods., Inc.*, 583 P.2d 860 (Alaska 1978), *rev’d on other grounds*, 601 P.2d 584 (Alaska 1979) (holding that a duty of reasonable accommodation should be read into an Alaska statute forbidding religious discrimination by employers and labor unions); *Rankins v. Comm’n on Prof’l Competence of Ducor*, 593 P.2d 852 (Cal. 1979) (holding that a duty to provide reasonable accommodation is implied by California’s constitutional prohibition of religious disqualification from employment); *Maine Human Rights Comm’n v. Local 1361, United Paperworks Int’l Union*, 383 A.2d 369 (Me. 1978) (holding that employment discrimination provisions of Maine’s Human Rights Act were intended to be the state counterparts of the Civil Rights Act and that federal statutory requirements should be considered when interpreting the state law); see also *Kenny v. Ambulatory Ctr. of Miami, Fla., Inc.*, 400 So. 2d 1262, 1266 (Fla. Dist. Ct. App. 1981) (citing supporting cases); *Hiatt v. Walker Chevrolet Co.*, 837 P.2d 618, 622 (Wash. 1992) (citing supporting cases); *Am. Motors Corp.*, 286 N.W.2d at 852 (citing supporting cases).

89. 400 So. 2d at 1264 (quoting FLA. STAT. § 458.22(5) (repealed 1979)).

90. The court ultimately held that because the nurse was able to assist in “approximately eighty-four percent” of procedures, accommodating her would not have caused undue hardship, and the employee was entitled to damages and reinstatement of her position. *Id.* at 1266.

91. *Id.*

92. *Id.*

93. See, e.g., *Mich. Dep’t of Civil Rights v. Gen. Motors Corp.*, 287 N.W.2d 240 (Mich. Ct. App. 1979) (holding that Michigan Fair Employment Practices Act’s antidiscrimination provision did not impose a duty on employers to make reasonable accommodation to religious needs of employees, and that there was no legislative intent to impose such a requirement); *Hiatt*, 837 P.2d at 622 (declining to decide whether a Washington antidiscrimination law should be read to incorporate Title VII’s reasonable accommodation standard but “specifically disapprov[ing] that portion of the Court of Appeals decision in this case which assumes that our state statute against discrimination based on creed is identical to the federal law”); see also *Hiatt*, 837 P.2d at 622 (citing supporting cases); *Am. Motors Corp.*, 286 N.W.2d at 952 (citing supporting cases).

Employment Practices Act (IFEPA) could not be construed as imposing on employers an affirmative duty to accommodate religious beliefs.⁹⁴ The Fair Employment Practices Commission had found that an employer unlawfully discriminated against an employee in violation of the IFEPA because it did not make a good faith effort to accommodate the employee's religious beliefs.⁹⁵ Both the circuit court and appellate courts, however, held that the IFEPA does not impose a duty to provide accommodations, and that the Commission's imposition of this obligation exceeded its authority.⁹⁶

More recently, a North Carolina appellate court in *Head v. Adams Farm Living, Inc.*, similarly rejected a plaintiff's argument that Title VII's duty of reasonable accommodation should be read into a North Carolina antidiscrimination law.⁹⁷ In that case, the plaintiff was an employee working at a nursing facility who regularly came into contact with medically vulnerable patients, but who refused a flu vaccine required by the facility and recommended by the county health department.⁹⁸

Given that courts are divided on the issue of whether state antidiscrimination laws should be read to implicitly incorporate Title VII's requirements, legislatures wishing to balance employee and employer protections in health care conscience laws would be advised to explicitly incorporate the undue hardship standard into their statutory language. Making such a change would mean that if an employer demonstrated that accommodating an employee's conscientious objection to abortion would cause undue hardship on the employer—whether because it would require imposing burdens on other employees, or because it would impose risks on patients—the employee would lose his protection against adverse employment action. The employer, then, could require that the employee switch to another shift, move to a different unit, or could even terminate their contract.

By taking one of these actions, an employer would be able to protect patient safety by ensuring that a patient would not be refused care by the provider serving them. However, this does not eliminate the third-party risk entirely. Typically, an employer will take action only after it becomes aware that an employee's objection has had an adverse impact on patients. In *Shelton*, for example, the hospital terminated a nurse only after she refused to provide emergency care to pregnant patients with life-threatening issues several times.⁹⁹ Granting employers a statutory right to take adverse action against refusing employees would not protect patients who have

94. 341 N.E.2d 459 (Ill. App. Ct. 1976). This case was later affirmed by Illinois Supreme Court. However, the Illinois Supreme Court did not reach a conclusion on whether the federal standard should apply, because “even if it is assumed . . . that the Fair Employment Practices Act requires an employer to reasonably accommodate to the religious needs of employees where it can be done without undue hardship on the employer's business . . . Olin proved that undue hardship rendered the requested accommodations unreasonable.” *Olin Corp. v. Fair Emp. Pracs. Comm'n*, 367 N.E.2d 1267, 1271 (Ill. 1977).

95. *Olin Corp.*, 341 N.E.2d at 460.

96. *Id.* at 460–61, 468 (concluding that “the Commission injected something new and entirely different from discrimination as contemplated by the drafters of the statute”).

97. 775 S.E.2d 904, 909 (N.C. Ct. App. 2015) (citing N.C. GEN. STAT. § 143–422.2 (Supp. 2020)).

98. *Id.* at 906–08.

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

already been impacted by such refusals. Likewise, it would not speak to the ability of state licensing boards and other government actors to discipline health care providers whose refusals negatively impact patients.

Defenders of absolute conscience protection might argue that there are good reasons why most state conscience laws do not set Title VII-type limits on the protections established for individual providers. One potentially relevant difference may be that Title VII's protections are much broader than those established by abortion conscience laws. Title VII does not limit the types of religious observances it protects, while abortion conscience laws only protect refusals to participate in abortion. Moreover, Title VII applies in all employment contexts, whereas abortion conscience laws typically impact only health care institutions like hospitals. It is possible that state legislatures, when passing abortion conscience laws, may have concluded that hospitals and other health care institutions are not likely to experience hardship in this very limited context. However, the conclusions of many courts in health care-related Title VII cases belie this claim.¹⁰⁰ At the very least, the question of whether health care facilities are likely to be burdened by accommodating abortion refusers is one that should be decided by courts rather than legislators.

One significant limitation to incorporating Title VII's undue hardship standard into state conscience laws is that Title VII applies only to the context of individual refusals, and not institutional refusals. As a result, this change may reduce the risk of harm to patients only slightly. Institutional refusals—for example, by the significant number of Catholic hospitals in the United States—are more common than refusals by individual health care providers, and therefore impact a larger number of patients.¹⁰¹ Even if an undue hardship standard were introduced into state abortion conscience laws, if a Catholic hospital prohibited its employees from performing abortion as a matter of institutional policy, the burdens of that prohibition would still fall on patients.

2. Americans with Disabilities Act: Limiting Direct Threats

The Americans with Disabilities Act (ADA) protects employees with disabilities from employment discrimination and establishes their right to reasonable accommodation in the workplace.¹⁰² Like Title VII (and in contrast to most health

100. See cases cited *supra* note 72. See also Harrington, *supra* note 22, at 782, 789 (noting that absolute conscience accommodations “may threaten the health and safety of patients [and] cause significant hardship on the employer[.]” and “there is little recognition of the burden that an untimely conscientious refusal may have on the employer or the health care worker’s colleagues”); Rene F. Najera & Dorit R. Reiss, *First Do No Harm: Protecting Patients Through Immunizing Health Care Workers*, 26 HEALTH MATRIX 363 (2016) (noting that in the context of flu vaccines, accommodations based on reassignments would be burdensome to hospitals); Dorit Rubinstein Reiss & V.B. Dubal, *Influenza Mandates and Religious Accommodation: Avoiding Legal Pitfalls*, 46 J.L. MED. & ETHICS 756, 758 (2018) (arguing that in the context of influenza vaccination requirement, the burden on a hospital and its patients to accommodate an employee’s choice to remain unvaccinated “likely constitutes an undue hardship”).

101. See generally Sawicki, *supra* note 2, at 1288.

102. 42 U.S.C. § 12111–17.

care conscience laws) the ADA recognizes that there are limits on the burdens that third parties should be asked to bear when accommodating an employee's needs—in this case, needs based on disability rather than religious belief.¹⁰³

Just as under Title VII, an employer is not required under the ADA to provide employees with accommodations that would “impose an undue hardship on the operation of the business.”¹⁰⁴ However, proving undue hardship demands more of employers under the ADA than under Title VII. To prove that a proposed accommodation imposes an undue hardship for the purposes of the ADA, an employer must demonstrate that the accommodation “requir[es] significant difficulty or expense” in light of a variety of enumerated factors.¹⁰⁵ As with Title VII, courts consider not only financial costs but also whether an accommodation would be “extensive, substantial, or disruptive, or . . . would fundamentally alter the nature or operation of the business.”¹⁰⁶

Unlike Title VII, however, the ADA explicitly privileges employers in situations where an employee poses a “direct threat to the health or safety of other[s].”¹⁰⁷ To receive protection under the ADA, a person with a disability must be able to perform essential job functions, either with or without accommodation.¹⁰⁸ However, a person who poses a direct threat to the health or safety of others is not a “qualified individual” entitled to ADA protection.¹⁰⁹ Regulations define a “direct threat” as a “substantial harm to the health or safety of the individual or others that cannot be eliminated or reduced by reasonable accommodation,”¹¹⁰ determined by an

103. As such, the ADA differs significantly from the other laws discussed in this Article, all of which focus on religious and conscientious beliefs rather than personal needs based on disability. There are obviously very meaningful differences between the two contexts, and I recognize that some might challenge this analogy. That said, I believe that given the ADA's widespread recognition and political support, and the fact that it seeks to protect individual rights much in the same way as the Civil Rights Act, it provides helpful guidance for these purposes.

104. 42 U.S.C. § 12112(b)(5)(A).

105. 42 U.S.C. § 12111(10); 29 C.F.R. § 1630.2(p) (2020).

106. *Employer's Defense Under Americans with Disabilities Act*, 42 AM. JUR. 3D *Proof of Facts* § 20 (1997).

107. 42 U.S.C. § 12113(b). The ADA also provides a specific exception for food handlers with infectious or communicable diseases. 42 U.S.C. § 12113(e).

108. 42 U.S.C. § 12111(8).

109. 42 U.S.C. § 12113(b) (“The term ‘qualification standards’ may include a requirement that an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.”); see also *Rizzo v. Child. 's World Learning Ctrs., Inc.*, 213 F.3d 209, 211 (5th Cir. 2000) (establishing that “[a]n employee who is a direct threat is not a qualified individual with a disability”); *Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1266 (4th Cir. 1995) (holding that a person is not “otherwise qualified” for employment if he poses a significant risk to the health or safety of others and that risk cannot be eliminated by reasonable accommodation (citing *Sch. Bd. of Nassau Cnty. v. Arline*, 480 U.S. 273 (1987))).

110. 29 C.F.R. § 1630.2(r) (2020). “In determining whether an individual would pose a direct threat, the factors to be considered include: (1) The duration of the risk; (2) The nature and severity of the potential harm; (3) The likelihood that the potential harm will occur; and (4) The imminence of the potential harm.” *Id.*

individualized assessment based on “reasonable medical judgment.”¹¹¹ Thus, the ADA balances an employee’s need for accommodation against not only the business needs of the employer but also the needs of customers, employees, and others who might be subject to harm. More importantly, it explicitly prioritizes public health and safety as factors to be considered in determining the scope of an employee’s individual rights.¹¹² As a result, when hospital employees whose essential job functions relate to patient health and safety bring ADA claims, they are rarely successful.¹¹³

While commentators acknowledge that there is a sound policy basis for the direct threat exemption, many have criticized the way that this standard has been interpreted.¹¹⁴ During the HIV/AIDS epidemic of the 1980s and 1990s, scholars (and some courts) challenged the degree to which defendant-employers relied on their own subjective assessments of what constitutes a direct threat, rather than medical evidence regarding the means and likelihood of HIV transmission.¹¹⁵ More recently, similar concerns have arisen about employers’ treatment of employees with psychiatric disorders¹¹⁶ and substance abuse problems.¹¹⁷ In these contexts,

111. 29 C.F.R. § 1630.2; *see also* Osborne v. Baxter Healthcare Corp., 798 F.3d 1260, 1268–69 (10th Cir. 2015) (finding that an employer’s determination of whether an employee poses a direct threat must be “objectively reasonable” (citing Jarvis v. Potter, 500 F.3d 1113, 1122–23 (10th Cir. 2007))); EEOC v. Beverage Distribs. Co., 780 F.3d 1018, 1021 (10th Cir. 2015) (holding that employer could avoid liability “if it had reasonably believed the job would entail a direct threat” and that proving “actual threat” was unnecessary).

112. *Individual Poses Direct Threat to Health or Safety of Others*, 2 AMERICANS WITH DISABILITIES: PRACT. & COMPLIANCE MANUAL § 7:208 (“The ADA’s direct threat provision stems from the recognition of the importance of prohibiting discrimination against individuals with disabilities while protecting others from significant health and safety risks”); *see also* EEOC v. Amego, Inc., 110 F.3d 135 (1st Cir. 1997) (finding congressional intent that risks to others should be considered in both the “direct threat” analysis and in the analysis of whether an employee is qualified for a position); *cf.* Sch. Bd. of Nassau Cnty. v. Arline, 480 U.S. 273, 293 n.5 (1987) (holding that the Rehabilitation Act’s “direct threat” exclusion “evinces congressional intent to avoid the Act’s interference with public health and safety concerns”).

113. LAURA ROTHSTEIN & JULIA ROTHSTEIN, *Health Care Professionals with Disabilities, in* DISABILITIES AND THE LAW § 10:7 (4th ed. 2009) (noting that “courts have given a high degree of deference to health care institutions . . . [based on] legitimate concerns about health and safety in receiving medical treatment,” and “[b]ecause of this deference, individuals with disabilities have succeeded in very few of these cases”).

114. *See, e.g.*, Ann Hubbard, *Understanding and Implementing the ADA’s Direct Threat Defense*, 95 NW. U.L. REV. 1279 (2001) (arguing that that the direct threat provision requires a scientific approach to risk assessment and criticizing employers and judges who rely on rely on perceived rather than actual risk).

115. *See, e.g.*, Katrina Atkins & Richard Bales, *HIV and the Direct Threat Defense*, 91 KY. L.J. 859 (2002); Hubbard, *supra* note 114.

116. *See, e.g.*, Randal I. Goldstein, *Mental Illness in the Workplace After Sutton v. United Air Lines*, 86 CORNELL L. REV. 927, 928 (2001); Stacy A. Hickox & Angela Hall, *Atypical Accommodations for Employees with Psychiatric Disabilities*, 55 AM. BUS. L.J. 537 (2018).

117. *See, e.g.*, Judith J. Johnson, *Rescue the Americans with Disabilities Act from Restrictive Interpretations: Alcoholism as an Illustration*, 27 N. ILL. U. L. REV. 169 (2007); Jodi Nelson Meyer, *Chemically Dependent Employees and the ADA in the Medical*

commentators argue that some employers have impermissibly taken adverse action on the basis of insufficient evidence that the employee's conduct would actually threaten public health or safety.¹¹⁸

While employers may in some cases be overzealous in identifying risks associated with employee disabilities, that does not negate the fact that the Congress, in passing the ADA, explicitly recognized the importance of protecting third parties from harms that might result from accommodation of individual rights.

Incorporating a direct threat test into health care conscience laws would explicitly acknowledge the harms that conscience-based refusals can impose upon patients. Beyond relying on the undue hardship test that focuses primarily on burdens to employers, the direct threat standard would more directly address patient needs. Just as in ADA cases, however, the assessment of what constitutes a "direct threat" would have to be done on a case-by-case basis; it is likely that judicial review would be required in some cases to ensure that employers are not being overly zealous in identifying threats that would justify limiting an employee's right to accommodation.

ADA case law offers helpful guidance as to how this standard might be applied if it were incorporated into health care conscience laws. Consider *EEOC v. Amego, Inc.*, a First Circuit case involving an employee at a group home for people with severe cognitive disabilities.¹¹⁹ The employee had psychiatric issues and had attempted suicide by overdose twice, and concerns had arisen about missing and improperly dispensed client medication. According to the employer, terminating the employee was justified because handling prescription medication was one of their essential job functions. The court agreed, concluding that where an employee's job functions involve the safety of others, the employee is only entitled to accommodation if she demonstrates that she can perform those duties without endangering others.¹²⁰

In a way, the ADA's direct threat standard can be analogized to the emergency exception that some states have in their abortion conscience laws.¹²¹ Both limit a provider's right to accommodation in situations where the health and safety of third

Profession: Does Patient Safety Exempt Hospital Employers from Compliance Under the Direct Threat and/or the Business Necessity Exceptions?, 80 N.D. L. REV. 241 (2004).

118. See, e.g., Hickox et al., *supra* note 116 (arguing that employers commonly deny accommodations based on their own assumptions about what constitutes a direct threat, and that these assumptions can be influenced by stereotypes).

119. 110 F.3d 135 (1st Cir. 1997) (affirming district court's finding that an employee's depression rendered her unqualified to perform the essential job function of administering medications to severely disabled individuals but finding that discharging the employee based on her suicide attempts by overdose did not qualify as a discharge on the basis of her depression); see also *Robertson v. Neuromedical Ctr.*, 161 F.3d 292, 296 (5th Cir. 1998) (upholding ruling in favor of employer regarding an employee neurologist with attention deficit hyperactivity disorder and short-term memory problems whose condition had caused mistakes in patients' care and who had "voiced his own concerns about his ability to take care of patients, stating that it was only a matter of time before he seriously hurt someone").

120. *Amego*, 110 F.3d at 135.

121. See Sawicki, *supra* note 2, at 1280 (identifying thirteen states that limit the right to refuse participation in abortion where a patient requires emergency treatment); see also Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (requiring examination and treatment of patients with emergency medical conditions).

parties is directly threatened. State emergency exceptions are narrower, however, as they typically limit rights of conscientious refusal only in cases where the patient's life is at risk.¹²² A direct threat standard, in contrast, could potentially be interpreted more broadly to protect against general threats to health and safety even if they do not rise to the level of life-threatening emergency. For example, one situation in which applying a direct threat standard (as opposed to an emergency standard) would reduce risks of patient harm is in the context of nonemergent but medically necessary abortions.¹²³ Women who are advised to terminate their pregnancies for medical reasons—for example, due to preeclampsia or cardiovascular disease—are at great risk if they are denied treatment.¹²⁴ A patient who is refused abortion under these circumstances is not likely to require immediate medical attention to prevent imminent harm,¹²⁵ but hospitals or courts could reasonably interpret a provider's refusal as directly threatening the patient's health and safety. In contrast, providers would still be protected in cases of patients seeking purely elective abortions.

Another benefit of a direct threat limitation is that it could potentially be applied to institutional refusal as well as individual refusals. Because many conscience laws establish that hospitals have no duty to admit patients for abortions or to perform abortions, adding a direct threat limitation would ensure that patients seeking care at religiously affiliated hospitals do not face significant threats to their health or safety. In addition to protecting patients in need of emergency care, a direct threat limitation might protect patients subject to institutional refusal policies in other contexts—for example, in the context of tubal ligation during Cesarean section.¹²⁶ While there are certainly challenges in applying the direct threat limitation to institutional refusals, as described in Section IV below, it is worth considering as a meaningful tool for balancing individual rights against third-party harms.

122. See Sawicki, *supra* note 2, at 1280–81 & n.105.

123. *Id.* at 1298, 1303.

124. *Id.* (identifying high-risk health conditions where abortion is considered the standard of care and noting that because EMTALA only protects patients suffering from “acute symptoms of sufficient severity” that are likely to result in serious bodily harm if not immediately stabilized, it does not extend to all medically necessary abortions).

125. See 42 U.S.C. § 1395dd(e)(1)(A)(i)–(iii) (defining emergency medical condition as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part”).

126. Because sterilization is prohibited in Catholic-affiliated hospitals, physicians cannot perform tubal ligations on women who are undergoing planned Cesarean delivery and do not want to have more children. In non-Catholic hospitals, this combination of procedures is common, as it eliminates the need for a second surgery on a later date at a different facility. Surgery poses major medical risks, and the reason tubal ligations are typically performed concurrently with Cesarean sections is to reduce the risks associated with a second surgical intervention. See generally Debra B. Stulberg, Yael Hoffman, Irma Hasham Dahlquist & Lori R. Freedman, *Tubal Ligation in Catholic Hospitals: A Qualitative Study of OB/GYNs' Experiences*, 90 *CONTRACEPTION* 422 (2014).

*C. Imposing Strict Conditions on Individual Rights:
State Health Care Decision-making Acts*

While there has been no uniform empirical survey of state health care conscience laws outside the reproductive health context, enough research has been done to collect general observations about the protections these laws offer to both providers and patients. This Section focuses on conscientious refusal provisions in state laws relating to advance care planning, health care decision-making, and end-of-life care.¹²⁷

According to one of the leading academic experts in the area of end-of-life care and patient decision-making, almost every state health care decision-making act (HCDA) allows health care providers in these contexts to refuse to comply with a patient or surrogate's treatment request for reasons of conscience.¹²⁸ These types of conflicts often arise when a patient or surrogate requests intensive life-sustaining treatment that a health care provider believes is ethically inappropriate (typically, on the grounds that it is medically ineffective and/or harmful to the patient), sometimes referred to as "futile" care.¹²⁹ For example, some physicians oppose performing CPR on frail patients who are already in the process of dying, on the grounds that performing chest compressions risks pain and injury with no corresponding benefit.¹³⁰ When a patient's family demands such aggressive treatment, health care providers may experience serious moral distress.¹³¹

Notably, conscientious refusal rights in state HDCAs are "[t]ypically . . . conditional, such that a patient's right outweighs a provider's conscience protection unless or until a patient can be transferred."¹³² Because of these significant limitations, Pope writes, "there is effectively no right to refuse treatment" prior to

127. See generally Thaddeus Mason Pope, *Legal Briefing: Conscience Clauses and Conscientious Refusal*, 21 J. CLINICAL ETHICS 163 (2010) (identifying state and federal refusal rights in end-of-life care contexts).

128. *Id.* at 169–71.

129. See generally Gabriel T. Bosslet et al., American Thoracic Society, *An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units*, 191 AM. J. RESPIRATORY & CRITICAL CARE MED. 1318 (2015).

130. Zoe Fritz & Jonathan Fuld, *Ethical Issues Surrounding Do Not Attempt Resuscitation Orders: Decisions, Discussions, and Deleterious Effects*, 36 J. MED. ETHICS 593 (2010); Ellen M. Robinson, *An Ethical Analysis of Cardiopulmonary Resuscitation for Elders in Acute Care*, 13 AACN ADVANCED CRITICAL CARE 132 (2002).

131. Robinson, *supra* note 130 (finding that "healthcare providers who perform CPR on elderly patients often find themselves in morally distressing circumstances"); Thaddeus Mason Pope, *Medical Futility Statutes: No Safe Harbor To Unilaterally Refuse Life-Sustaining Treatment*, 75 TENN. L. REV. 1, 56–57 n.319 (2007) (noting that "futility cases are driven by providers' desire to avoid patient suffering").

132. Pope, *supra* note 127, at 170; see, e.g., ARIZ. REV. STAT. ANN. § 36-3205(C)(1) (2018); KY. REV. STAT. ANN. § 311.633(3) (LexisNexis 2019); MINN. STAT. ANN. § 145C.11(c) (West 2017); N.D. CENT. CODE § 23-06.5-12(3) (2020) (all conditioning refusing providers' immunity from civil liability or disciplinary action on their compliance with statutory requirements regarding patient notification and patient transfer).

patient transfer.¹³³ Until the patient is transferred, providers are obligated to continue treating the patient in accordance with the patient or surrogate's request, even if the provider is conscientiously opposed to that treatment.¹³⁴ Even Texas, which is viewed as having one of the most provider-friendly laws because it permits unilateral decisions to discontinue life-sustaining treatment, imposes a ten-day treat-until-transfer requirement.¹³⁵

That said, not every HCDA-protected conscientious refusal occurs in the context of patient-requested treatment. An HCDA case that is more similar to abortion refusal would be one where a provider refuses to comply with a patient's decision or directive to discontinue life-sustaining treatment.¹³⁶ This refusal would also be subject to the state HCDA, including the requirements to provide notice to the patient and facilitate their transfer to another provider who is willing to comply with the patient's decision. As in the case of abortion refusal, the harm resulting from a refusal to discontinue life-sustaining treatment is a delay in access. Such a delay continues the patient's unwanted suffering, but in most circumstances the patient will eventually find a provider willing to withdraw treatment in accordance with their request. Although courts have historically been reluctant to recognize this harm (a cause of action for "wrongful living") as legally compensable, many modern courts have recognized that a delay in withdrawal of life-sustaining treatment is a violation of patient autonomy that may justify a civil or administrative remedy.¹³⁷

133. Pope, *supra* note 127, at 170.

134. Pope, *supra* note 131, at 59; *see, e.g.*, FLA. STAT. § 765.1105(2) (West 2016) (establishing that a "health care provider or facility that is unwilling to carry out the wishes of the patient or the treatment decision of his or her surrogate or proxy because of moral or ethical beliefs must within 7 days either: (a) Transfer the patient to another health care provider or facility . . . or (b) If the patient has not been transferred, carry out the wishes of the patient or the patient's surrogate or proxy"); N.D. CENT. CODE § 23-06.5-09 (2020) (requiring that a health care provider who declines to comply with a health care decision for reasons of conscience must "take all reasonable steps to transfer care of the principal to another health care provider who is willing to honor the agent's health care decision . . . and shall provide continuing care to the principal until a transfer can be effected"). Moreover, when these issues reach courts, courts typically side with patients over providers, "requir[ing] objecting physicians and institutions to continue to provide care to which they object based on their professional ethical concerns because the patient's surrogate requested that care be continued." Martha Swartz, *Health Care Providers' Rights To Refuse To Provide Treatment on the Basis of Moral or Religious Beliefs*, 19 HEALTH LAW. 25, 27 (2006).

135. TEX. HEALTH & SAFETY CODE ANN. § 166.046 (West 2017) (establishing procedures to follow when a physician refuses to honor a treatment decision made by or on behalf of the patient).

136. *See* Stephen Wear, Susan Lagaipa & Gerald Logue, *Toleration of Moral Diversity and the Conscientious Refusal by Physicians To Withdraw Life-Sustaining Treatment*, 19 J. MED. & PHIL. 147 (1994); *Duarte v. Chino Cmty. Hosp.*, 85 Cal. Rptr. 2d 521 (Cal. Ct. App. 1999) (holding that statutory immunity provisions in a state HCDA protected hospital from liability where a patient's attending physician failed to comply with a request to either withdraw life-sustaining treatment or transfer the patient to a health care provider who would comply).

137. Thaddeus Mason Pope, *Clinicians May Not Administer Life-Sustaining Treatment Without Consent: Civil, Criminal, and Disciplinary Sanctions*, 9 J. HEALTH & BIOMEDICAL L. 213 (2013) (identifying factors that cause physicians to breach their duty to respect patients'

Compared to abortion conscience laws, state HCDA place a far greater emphasis on protecting patients from harm. While HCDA often impose “treat-until-transfer” requirements described above, not a single state abortion conscience law imposes similar requirements. HCDA also frequently impose duties to refer patients for services to other providers.¹³⁸ In contrast, only two states with abortion conscience laws impose referral requirements.¹³⁹ While many HCDA require providers to notify their patients of their refusal,¹⁴⁰ only eight states with abortion conscience laws have a notification requirement.¹⁴¹

There is certainly criticism to be made of HCDA provisions that require providers to engage in conduct they believe to be immoral (or complicit in immoral behavior), such as treat-until-transfer requirements and referral requirements. In effect, while these laws establish a “right” of conscientious refusal, that “right” is negated by requirements that providers act against their consciences. That said, in some end-of-life contexts, these requirements may be more justifiable than in the context of abortion refusal. In the traditional case of a futility conflict where a provider opposes aggressive treatment requested by the patient or their family, protecting the right of conscientious refusal will often result in the patient’s deterioration or even death. In balancing the rights of providers against those of patients, imposing a treatment duty in this context is necessary to prevent what the patient or surrogate deems to be an irreparable harm. In contrast, in the abortion context, allowing a physician to refuse a patient-requested abortion would risk immediate injury or death only in cases of emergency; for other abortions (whether elective or nonemergent but medically necessary), the harm is a lesser risk, one of delay in accessing treatment.¹⁴² Thus, for legislators who aim to prevent harms to third parties resulting from provider refusals, imposing treatment and/or referral duties in the end-of-life context could be viewed as more justifiable than in the abortion context—even if the strength of the providers’ conscientious conviction is the same.

right to refuse and demonstrating that health care providers have increasingly been subject to sanctions for such refusals); Nadia N. Sawicki, *A New Life for Wrongful Living*, 58 N.Y. L. SCH. L. REV. 279 (2013) (discussing history of the wrongful living cause of action and identifying cases suggesting the increased viability of such claims).

138. Pope, *supra* note 127, at 171 (noting that most “conscientious objection rights” in the context of end-of-life health care “require the objecting provider to at least inform the patient about the objectionable treatment and arrange a transfer or referral”).

139. Sawicki, *supra* note 2, at 1282.

140. Pope, *supra* note 131, at 58–59 (noting that under the Uniform Health Care Decisions Act, a provider who plans to decline to comply with a health care decision “must first inform the patient or surrogate”); *see, e.g.*, ALASKA STAT. § 13.52.060(e) (2020); CAL. PROB. CODE § 4734(b) (West 2009); HAW. REV. STAT. § 327E-7(e) (West 2017); ME. STAT. tit. 18-A, § 5-807(E) (repealed 2019); MISS. CODE ANN. §41-41-215(5) (West 2007); N.M. STAT. ANN. § 24-7A-7(E) (West Supp. 2020) (all conditioning provider refusal rights on “timely communicat[ion]” of the refusal to the patient or patient’s agent).

141. Sawicki, *supra* note 2, at 1281.

142. That is not to say that the risk of delayed access to abortion is harmless. As states pass legislation limiting the availability of abortion after a specified number of weeks of gestation, there is an increased risk that delays in access will lead to a patient’s inability to secure a legal abortion.

D. Withdrawing Protections for Individual Rights: State Immunization Laws

Every U.S. state requires that students entering elementary and high school be vaccinated against a variety of communicable diseases.¹⁴³ Parents can secure medical exemptions for children with medical contraindications to vaccination,¹⁴⁴ and most state laws establish exemptions for those with religious or philosophical objections.¹⁴⁵ However, support for religious and philosophical exemptions began to change in 2015, when the California legislature amended its school vaccination law to eliminate “personal belief” exemptions.¹⁴⁶ This change in law was prompted by serious measles outbreaks in the state, which led the legislature to conclude that the public health risks of religious exemptions to vaccination outweighed their benefits.¹⁴⁷ While there was some public opposition and several legal challenges,¹⁴⁸ the severity of the public health crisis resulted in widespread political support for elimination of the personal belief exemption.¹⁴⁹

After similar outbreaks across the United States, several other states also withdrew parents’ right to exempt their children from vaccination for reasons of religion or personal belief.¹⁵⁰ As a result, vaccination rates in these states increased,

143. Dorit Rubinstein Reiss, *Litigating Alternative Facts: School Vaccine Mandates in the Courts*, 21 U. PA. J. CONST. L. 207, 212 (2018). Typically, required vaccinations include: measles, mumps, and rubella (MMR); diphtheria, tetanus, and pertussis (DTaP); varicella (chicken pox); and polio, among others. *Id.* In most states, vaccinations are required not only for public school students but also for children who attend private schools, as well as those who participate in childcare services like day care. James G. Hodge and Lawrence O. Gostin, *School Vaccination Requirements: Historical, Social, and Legal Perspectives*, 90 KY. L. J. 831, 833, 868 (2001).

144. *See id.*

145. Until 2015, only two states (Mississippi and West Virginia) did not have religious exemptions. James Colgrove & Abigail Lowin, *A Tale of Two States: Mississippi, West Virginia, and Exemptions to Compulsory School Vaccination Laws*, 35 HEALTH AFFS. 348, 348 (2016), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1172> [<https://perma.cc/SQ8C-AWFG>]. As of 2019, seventeen states also had exemptions for personal philosophical beliefs. Patti Neighmond, *States Move To Restrict Parents’ Refusal to Vaccinate Their Kids*, NHPR (Mar. 2, 2019, 12:03 AM), <https://www.nhpr.org/post/states-move-restrict-parents-refusal-vaccinate-their-kids#stream/0> [<https://perma.cc/5L47-C277>].

146. S. 277, 2015 Leg., Reg. Sess. (Cal. 2015). The only vaccination exemptions permitted after these nonmedical exemptions were withdrawn were for (1) medical reasons, (2) home schooling, or (3) individualized education programs (IEPs) under the Americans with Disabilities Act. *See Whitlow v. California*, 203 F. Supp. 3d 1079, 1083 (S.D. Cal. 2016).

147. *See Reiss, supra* note 143, at 215–18.

148. *Id.* at 219–21.

149. *Id.* at 217–18.

150. N.Y. PUB. HEALTH L. § 2164(9) (McKinney 2012), *repealed by* Act of June 13, 2019, ch. 35, § 1, 2019 N.Y. Sess. Laws A2371-A (2019) (repealing a provision stating the immunization requirements “shall not apply to children whose parent, parents, or guardian hold genuine and sincere religious beliefs which are contrary to the practices herein required”); ME. REV. STAT. ANN. Title 20-A, § 6355(3) (2008), *repealed by* Act to Protect Maine Children and Students from Preventable Diseases by Repealing Certain Exemptions from the Laws Governing Immunization Requirements, ch. 154, § 2, 2019 ME. L. 386, 386 (repealing the provision of the law allowing parents to assert a “sincere religious belief” opposing

decreasing the risk of outbreaks.¹⁵¹ Importantly, there is no constitutional barrier to these changes; numerous courts have affirmed that religious and philosophical exemptions to vaccination are not constitutionally required.¹⁵²

vaccination); WASH. REV. CODE ANN. § 28A.210.090 (West Supp. 2021) (effective July 1, 2022) (“A philosophical or personal objection may not be used to exempt a child from the measles mumps, and rubella vaccine.”). Similar bills have been proposed in several other states. Jennifer Nessel, *Religious Vaccine Exemption Bills Spark Debate Across the United States*, PHARMACY TIMES (Feb. 25, 2020, 5:32 PM), <https://www.pharmacytimes.com/news/religious-vaccine-exemption-bills-spark-debate-across-the-united-states> [<https://perma.cc/H97M-JR8Y>].

151. See Sindiso Nyathi, Hannah C. Karpel, Kristin L. Sainani, Yvonne Maldonado, Peter J. Hotez, Eran Bendavid & Nathan C. Lo, *The 2016 California Policy To Eliminate Nonmedical Vaccine Exemptions and Changes in Vaccine Coverage: An Empirical Policy Analysis*, PLOS MED. (Dec. 23, 2019), <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002994#abstract0> [<https://perma.cc/R44W-E29Q>] (finding that California’s elimination of nonmedical exemptions was associated with an estimated increase in vaccination coverage and a reduction in nonmedical exemptions); Emily Oster & Geoffrey Kocks, *After Debacle, How California Became a Role Model on Measles*, N.Y. TIMES (Jan. 16, 2018), <https://www.nytimes.com/2018/01/16/upshot/measles-vaccination-california-students.html> [<https://perma.cc/7RCU-T5U8>] (finding higher vaccination rates and lower risks of disease outbreaks in California after exemptions were withdrawn); see also Robert A. Bednarczyk, Adrian R. King, Ariana Lahijani & Saad B. Omer, *Current Landscape of Nonmedical Vaccination Exemptions in the United States: Impact of Policy Changes*, 18 EXPERT REV. VACCINES 175 (2019) (finding that rates of nonmedical exemptions are higher in states where such exemptions are easier to obtain); W. David Bradford & Anne Mandich, *Some State Vaccination Laws Contribute to Greater Exemption Rates and Disease Outbreaks in the United States*, 34 HEALTH AFFS. 1383, 1387–89 (2015) (finding that state-level vaccination exemption laws affect immunization rates and the incidence of preventable disease). Mississippi, which has had no non-medical exemptions to its vaccination laws since 1983, has historically had the highest rate of kindergarten vaccination in the country. Colgrove et al., *supra* note 145.

152. *Whitlow v. California*, 203 F. Supp. 3d 1079, 1092 (S.D. Cal. 2016) (denying motion for preliminary injunction on the grounds that amendment banning personal belief exemptions was likely not unconstitutional); *Schenker v. County of Tuscarawas*, No. 5:12 CV 1020, 2012 WL 4061223, at *11–12 (N.D. Ohio Sept. 14, 2012) (dismissing free exercise claim challenging vaccination requirement where state took custody of neglected children and sought to vaccinate them); *Phillips v. City of New York*, 775 F.3d 538, 542–44 (2d Cir. 2015) (holding that a state statute permitting exclusion of unvaccinated students from public school based on religious exemption did not violate plaintiff parents’ constitutional rights); *Workman v. Mingo Cnty. Schs.*, 419 F. App’x 348, 352–56 (4th Cir. 2011) (holding that there is no constitutional right to religious exemptions from school vaccination requirements); *Brown v. Stone*, 378 So. 2d 218, 223–24 (Miss. 1979) (holding that non-medical exemptions to vaccination laws violate citizens’ right to equal protection from public health hazards). These cases typically rely on the test set forth in *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), which upheld Massachusetts’s compulsory smallpox vaccination law against a constitutional challenge. In *Jacobson*, the court held that the state’s police powers establish its authority to enact reasonable public health laws, including vaccination requirements, as long as those laws are not applied in an “arbitrary [or] unreasonable manner.” *Id.* at 25–28. That said, some scholars have expressed skepticism that the current Supreme Court, if faced with a *Jacobson*-type challenge, would apply the same test. See, e.g., Kellen Russoniello, *The End of Jacobson’s*

How might we analogize states' recent responses in the school vaccination context to the context of reproductive health conscience laws? In the vaccination context, as a result of public health concerns, states like California have completely withdrawn previously existing protections for parents with religious objections to vaccination. In these states, parents who decline to vaccinate their children are not permitted to send their children to school.¹⁵³ The equivalent in the abortion context would be for a state to completely withdraw providers' right to decline to participate in abortion services. This does not mean that refusing providers would be physically compelled to perform abortions (just as refusing parents are not physically compelled to vaccinate their children). That said, withdrawal of protections would mean that providers would be subject to consequences for their refusals—for example, adverse employment action, disciplinary action by licensing agencies, or civil liability.

However, when it comes to justifying such a dramatic response as withdrawal of rights to conscientious refusal, there are significant differences between the two contexts. The withdrawal of exemptions in the school vaccination context was done in direct response to a recognized public health crisis. As the COVID-19 pandemic has made clear, the more serious a public health crisis, the more willing government actors are to impose severe restrictions on individual liberties.¹⁵⁴ In the reproductive health context, however, the scope of harms resulting from conscientious refusal is less extensive than the harms that can result from the spread of communicable diseases. Certainly, patients can and do face severe health consequences as a result of provider refusals to deliver reproductive health care services,¹⁵⁵ but the number of people affected is likely much smaller. Thus, states have a much clearer justification—from both a political perspective and a legal perspective—for the withdrawal of conscience protections in the vaccination context. In the absence of a major and imminent public health threat resulting from providers' conscientious refusal, states would face challenges completely withdrawing conscience protections in the abortion context.

Moreover, even if there was sufficient political support for the elimination of refusal rights in the abortion context, denying providers a right to refuse in all circumstances (as compared, for example, to in emergency situations only) may not have the expected positive impact on patients' access to reproductive health services.

Eliminating conscience protections is unlikely to significantly increase the number of physicians and hospitals willing to provide abortion care. Losing these legal protections does not mean that providers will be compelled to perform abortions against their will; it only means that they will face adverse consequences (such as disciplinary action or civil liability) if they refuse. While some providers may find these consequences significant enough to change their practices, those whose

Spread: Five Arguments Why an Anti-Intoxicant Vaccine Would Be Unconstitutional, 43 AM. J.L. & MED. 57 (2017); Wendy K. Mariner, George J. Annas, Leonard H. Glantz, Jacobson v. Massachusetts: *It's Not Your Great-Great-Grandfather's Public Health Law*, 95 AM. J. PUB. HEALTH 581 (2005).

153. See Reiss, *supra* note 143, at 229–31.

154. David M. Studdert & Mark A. Hall, *Disease Control, Civil Liberties, and Mass Testing – Calibrating Restrictions During the COVID-19 Pandemic*, 383 NEW ENG. J. MED. 102 (2020).

155. Sawicki, *supra* note 2, at 1295–97.

conscientious beliefs are deeply held or grounded in religious doctrine are unlikely to begin performing abortions just because they have lost legal protections.

Even if a significant number of providers were to expand their practices to include abortion care as a result of the loss-of-conscience protections, it is not clear that this would benefit patients. A health care provider who feels pressured to participate in a service that they deem morally objectionable may not be able to provide optimal patient care. From an interpersonal perspective, the provider's moral distress may be reflected in their attitude toward patients, which could cause patients dignitary harm.¹⁵⁶ Furthermore, a provider who is persuaded to perform a service that is outside the scope of their expertise may lack the skills necessary to perform it, putting patient safety at risk.

In fact, withdrawing rights of conscientious refusal to participate in abortion may actually reduce patients' access to care at a broader level.¹⁵⁷ As a result of withdrawal of conscience protections, some religiously affiliated organizations have ceased providing important social services. For example, after same-sex marriage was legalized, adoption and foster care agencies affiliated with Catholic charities stopped offering services because they were not willing to place children with same-sex couples.¹⁵⁸ In the face of the PPACA contraceptive mandate, Catholic religious leaders suggested that Catholic hospitals might have no choice but to shut down if the mandate was enforced.¹⁵⁹ As Robin Fretwell Wilson notes, while these "dire predictions may turn out to be nothing more than empty threats . . . , policymakers may well be loathe [sic] to engage in a high-stakes game of chicken."¹⁶⁰

Thus, in the absence of evidence that conscience-driven abortion refusals pose an emergent and wide-ranging threat to public health and safety—akin to the spread of communicable disease—the contemporary shift towards eliminating vaccination exemptions does not serve as an ideal model for abortion conscience laws.

156. See Nejaime et al., *supra* note 22, at 2576–77 (discussing dignitary harms associated with conscience-based health care denials); Rebecca Seales, *Woman 'Humiliated' by Walgreens Over Drugs To End Pregnancy*, BBC (June 25, 2018), <https://www.bbc.com/news/world-us-canada-44591528> [<https://perma.cc/6UAN-SCD3>].

157. See Robin Fretwell Wilson, *The Calculus of Accommodation: Contraception, Abortion, Same-Sex Marriage, and Other Clashes Between Religion and the State*, 53 B.C. L. REV. 1417, 1445 (2012) (explaining that an "inflexible" stance toward religious exemptions may "backfire," and citing examples where "religious objectors, when left no choice . . . have . . . chosen to exit the market rather than violate their religious beliefs").

158. *Id.* at 1446–47; Robin Fretwell Wilson, *A Matter of Conviction: Moral Clashes Over Same-Sex Adoption*, 22 BYU J. PUB. L. 475 (2008); *Discrimination Against Catholic Adoption Services*, U.S. CONF. OF CATH. BISHOPS, <http://www.usccb.org/issues-and-action/religious-liberty/discrimination-against-catholic-adoption-services.cfm> [<https://perma.cc/G8WA-SQFH>]; see also *Fulton v. City of Philadelphia*, 593 U.S. (2021) (reversing and remanding Third Circuit's denial of foster care agency's motion for preliminary injunction against city of Philadelphia's refusal to contract with the agency as a result of its policies regarding same-sex couples).

159. See Wilson, *supra* note 157, at 1448; Francis Cardinal George, *What Are You Going To Give Up This Lent?*, CHI. CATH. (Feb. 26, 2012), <http://legacy.chicagocatholic.com/cnwonline/2012/0226/cardinal.aspx> [<https://perma.cc/4X99-RUED>].

160. Wilson, *supra* note 157, at 1448–49.

III. APPLYING THE UNDUE HARDSHIP AND DIRECT THREAT STANDARDS TO ABORTION CONSCIENCE LAWS

As demonstrated above, many federal and state antidiscrimination and religious protection laws set clear limits on individuals' right to accommodation. In contrast, the majority of abortion conscience laws provide absolute protections, setting no explicit limits on the rights of refusing providers. In doing so, these conscience laws impose unilateral burdens on patients, employers, and the public, requiring them to accommodate the needs of conscientious refusers regardless of the burdens those accommodations might pose. Given that health care providers hold a monopoly on the provision of medical services, and given the health and safety risks that can arise when patients are denied access to reproductive care, it is difficult to defend abortion conscience laws that protect providers even in situations where patient safety is at risk.

Turning to federal antidiscrimination laws, as well as state laws establishing personal exemptions in health and safety contexts, is instructive for those seeking to strike a better balance in the abortion context. These laws offer well-established standards for balancing individual rights against interests in preventing third-party harms, and there is nothing preventing legislators from introducing similar standards into abortion conscience laws.

Ideally, abortion conscience laws could be amended in ways that give clear guidance to health care providers, employers, and patients as to the limits on providers' conscience rights. Explicit carveouts aimed at preventing third-party harm—such as limitations on conscientious refusal rights in cases where refusal would threaten patient health and safety or impose serious hardships on employers—would be relatively easy to implement, as they are regularly used in other contexts.¹⁶¹ Such an approach would be preferable to metastandards like RFRA's compelling interest test, which provides guidance to legislators and courts but not to individual health care providers making on-the-ground decisions.¹⁶² It would also be preferable to a wholesale legislative withdrawal of conscientious-refusal rights, which might lead to even greater third-party harms than under the current system.

The most helpful guidance, therefore, may come from Title VII of the Civil Rights Act and the Americans with Disabilities Act.¹⁶³ These laws strike a balance between the needs of individuals seeking accommodation and the state's interest in ensuring that such accommodations do not unduly burden third parties.

Accordingly, an important first step in striking this balance in the abortion context would be to limit providers' right to refuse participation on conscience grounds when the accommodation of those rights would pose an undue hardship to employers—the Title VII standard.¹⁶⁴ Currently, only three states include such a limitation in their abortion conscience laws.¹⁶⁵ A significant downside of this standard, however, is that it focuses most explicitly on preventing harm to employers like hospitals rather than to the patients and public they serve. As such, this standard may not be the most

161. *See supra* Section II.B.

162. *See supra* Section II.A.

163. *See supra* Section II.B.

164. *See supra* Section II.B.1.

165. *See supra* note 10.

direct solution if the primary concern with abortion conscience laws is the impact they have on patients' health, safety, and access to care. Moreover, while the undue hardship standard would limit the ability of individual health care providers to refuse treatment, it would not be effective in limiting the rights of health care institutions with broad policies against abortion. Given the prevalence of religiously affiliated health care systems in the United States and the impact their policies have on patients,¹⁶⁶ adding an undue hardship limitation to abortion conscience laws would not, on its own, be effective in preventing most third-party harms.

Coupling an undue hardship standard with something akin to a direct threat limitation (like the ADA's) would likely be a more effective approach.¹⁶⁷ Unlike the undue hardship to the employer standard, the direct threat standard explicitly acknowledges the impact an accommodation may have on patients and the public. Limiting rights of conscientious refusal in cases where accommodating the refusal is likely to pose a direct threat to patient health and safety would prevent harms to patients in many of the most extreme circumstances—much like the emergency exceptions that some states currently have in their abortion conscience laws.¹⁶⁸

By clearly indicating that rights of conscientious refusals do not apply in cases of direct threat, conscience laws would (at the very least) make explicit the emergency treatment requirements already established by EMTALA. More importantly, however, states would have the flexibility to craft a direct threat requirement to extend beyond federal requirements. For example, EMTALA requires Medicare-funded hospitals with emergency departments to screen and stabilize patients with emergency medical conditions, defined as those manifesting

acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual . . . in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.”¹⁶⁹

A state, in contrast, might choose to define a “direct threat” as a health threat that does not rise to the level of EMTALA-defined emergency.

Finally, as discussed in Section II.B.2 above, a direct threat limitation could potentially be used to limit institutional refusals as well as individual refusals. Incorporating a direct threat standard into abortion conscience laws would, of course, be more difficult to implement in cases of institutional refusal than individual refusal. Legislation imposing limits on individual refusals can be interpreted and applied by employers, who would then be justified in taking adverse action against individuals whose refusals cannot be accommodated without threatening patient safety. But in the context of institutional refusals, institutions would effectively have to self-regulate in order to prevent harm to patients. Those hospitals that continue to refuse

166. Sawicki, *supra* note 2, at 1288–90.

167. *See supra* Section II.B.2.

168. Sawicki, *supra* note 2, at 1280. However, as I have argued elsewhere, limiting rights of conscientious refusal only in emergency circumstances may be insufficiently protective of patients. *Id.* at 1302–04.

169. 42 U.S.C. § 1395dd(e)(1)(A)(i)–(iii) (2018).

abortion care even in the face of direct threats would potentially be subject to adverse action by the state, but this would likely occur only after patients have already been harmed.

Another challenge, as we see in ADA cases, is that the assessment of what constitutes a direct threat is very context specific. For example, a Catholic hospital's refusal to perform abortions may have a very different impact on patients depending on whether the hospital is one of many hospitals in an urban location or the only hospital for hundreds of miles in a relatively rural area. There is certainly a risk that hospitals may interpret a direct threat standard in ways that deviate from what state legislators intended.¹⁷⁰ But to the extent that hospitals are already under an obligation to identify and respond to direct threats for the purposes of the ADA, and to emergencies for the purposes of EMTALA, a similarly crafted standard in abortion-conscience laws should not be more difficult to follow. In the rare instances where hospitals or individual providers fail to comply with this standard or allege that their policies and practices do not result in direct threats, the final determination could be left to the judiciary, as is already the case under the ADA.¹⁷¹ In cases where a hospital consistently violates a state law aimed at protecting patient access in cases when refusal would pose a direct threat, state attorneys general might even have a role to play.¹⁷² While introducing a direct threat limitation to abortion-conscience laws protecting individual and institutional refusal rights would by no means guarantee patient access, it would be a meaningful shift away from the current system of unilateral burden-shifting.

IV. A NOTE ON CIVIL LIABILITY

Obviously, those who believe that abortion is absolutely immoral and whose personal (or institutional) identities are inextricably tied to this belief are unlikely to change their behavior regardless of the legal standards applicable to conscientious refusal. This is to be expected. Thus, the final lesson we might introduce from the federal and state laws considered in this article is one relating to civil liability. Abortion conscience laws in a majority of U.S. states bar patients from pursuing tort remedies when they are injured as a result of a provider's conscientious refusal, even when that refusal deviates from the medical standard of care.¹⁷³ Effectively, they

170. See, e.g., Amended Complaint at 2, *ACLU v. Trinity Health Corp.*, No. 15-cv-12611, 2016 WL 922950 (E.D. Mich. Mar. 10, 2016) (alleging that as a result of hospital policies under the USCCB Directives, hospitals have “repeatedly and systematically failed to provide women suffering pregnancy complications . . . with the emergency care required by EMTALA [Emergency Medical Treatment and Labor Act] and the Rehabilitation Act”).

171. See *supra* Section II.B.2.

172. State attorneys general play an increasingly important role in enforcing legal and regulatory requirements in the health care sector. They regularly take action against nonprofit hospitals' failure to satisfy requirements for tax exemption, violation of health care fraud and abuse laws, violation of Medicare and Medicaid conditions of participations, and antitrust violations in the context of hospital mergers.

173. Sawicki, *supra* note 2, at 1275–76 (finding that laws in thirty-seven states explicitly establish immunity from civil liability for individual and/or institutional health care providers who refuse to participate in abortion, and that laws in an additional nine states could be

establish a “conscience defense to malpractice,” immunizing doctors and hospitals from civil liability for any third-party harms their refusals might cause.¹⁷⁴

This type of civil immunity is a near anomaly in the world of federal antidiscrimination and religious protection laws. Title VII of the Civil Rights Act prohibits employers from discriminating on the basis of religion but says nothing about liability to those who might be injured as a result of employee accommodation.¹⁷⁵ The Americans with Disabilities Act is similarly silent on the issue of liability for harms resulting from employee accommodation.

When compared to state anti-discrimination and religious protection laws, abortion conscience laws also seem to offer far greater protections from civil liability. For example, state immunization laws that grant religious exemptions are silent as to whether parents who refuse to immunize their children might be liable to injured third parties.¹⁷⁶ Health care decision-making laws applicable in end-of-life contexts are somewhat more varied. In some states, immunity from civil liability is granted only if a provider successfully transfers the patient to another provider willing to perform the service.¹⁷⁷ Other states ostensibly immunize providers from civil liability, but only where the provider has acted “in accordance with generally accepted health care standards,” language that seems to indicate that providers would face civil liability if they committed malpractice.¹⁷⁸ Moreover, in cases where a provider refuses to comply with a patient request to discontinue life-sustaining

interpreted to establish such liability).

174. *Id.* at 1258 (noting that many states’ health care conscience laws create “a ‘conscience defense’ to malpractice which immunizes health care providers from civil liability, even when their conscience-driven refusal to provide information or treatment violates the standard of care”).

175. 42 U.S.C. § 2000e-2. The only reference to liability is in enforcement actions by aggrieved employees when employers violate the Act. 42 U.S.C. § 2000e-5 (2018).

176. See Anthony Ciolli, *Mandatory School Vaccinations: The Role of Tort Law*, 81 YALE J. BIOLOGY MED. 129 (2008) (arguing that in states with religious exemptions, tort liability may provide a mechanism for compensating victims).

177. See *supra* Section II.C.

178. See, e.g., WYO. STAT. ANN. § 35-22-410(a) (establishing that a health care provider or institution “acting in good faith and in accordance with generally accepted health care standards . . . is not subject to civil or criminal liability or to discipline” for declining to comply with an individual health care instruction or health care decision for reasons of conscience); CAL. PROB. CODE § 4740 (West 2009) (same). In California, the requirement that providers comply with “generally accepted health care standards” was added by the legislature shortly after a California court’s decision interpreting the existing civil immunity provision broadly in *Duarte v. Chino Community Hospital*, 85 Cal. Rptr. 2d 521 (1999). CAL. PROB. CODE § 4740 (West 2009) (added by Health Care Decisions Law, ch. 658, § 39, 1999 Cal. Legis. Serv. A.B. 891). In *Duarte*, the court ruled in favor of a hospital that was sued for failing to “comply with the family’s request to terminate use of a respirator or to transfer the woman to a health care provider who would comply.” 85 Cal. Rptr. at 522. The appellate court upheld the trial court’s refusal to instruct the jury concerning a physician’s duty of care when presented with a request to withdraw life-sustaining medical care on the grounds that the state’s HCDA established full civil immunity. *Id.* at 527.

treatment, courts are increasingly recognizing that, regardless of statutory language, patients are entitled to a remedy for the delay.¹⁷⁹

The only other situation where state legislatures have significantly limited the liability of those granted religious or conscientious exemptions to generally applicable laws appears to be in the context of child medical neglect. While not discussed in the Sections above, these laws generally grant parents immunity from charges of medical neglect if they use modes of religious healing rather than conventional medical treatment.¹⁸⁰ They were passed as a result of a federal policy in place from 1974 to 1983 that conditioned federal funding for child protective services on passage of state religious exemptions.¹⁸¹ These laws have been widely criticized as being unreasonably harmful to children.¹⁸² Importantly, however, these statutory exemptions sometimes limit parental decision-making rights in cases where a child's health is seriously at risk.¹⁸³ And even in cases where the statutes appear to

179. See *supra* note 125 and accompanying text.

180. See generally *Religious Exemptions to Medical Treatment of Children in State Civil & Criminal Cases*, CHILD, http://childrenshealthcare.org/?page_id=24#Exemptions [<https://perma.cc/5L7Z-Z7AT>] (surveying state laws providing religious exemptions to providing medical care for children, and noting that thirty-eight states and the District of Columbia have religious exemptions in their civil codes on child abuse or neglect, or failure to report; fifteen states have religious defenses to felony crimes against children; and twelve states have religious defenses to misdemeanors); Baruch Gitlin, *Parents' Criminal Liability for Failure To Provide Medical Attention to Their Children*, 118 A.L.R.5th 253 § 18(a) (2004) (identifying cases where courts considering religious exemptions in medical neglect statutes have rejected religious defenses to criminal liability); Doriane Lambelet Coleman, *Religiously-Motivated Medical Neglect*, 73 WASH. & LEE L. REV. ONLINE 359 (2016) (surveying religiously motivated medical neglect laws); Rita Swan, *On Statutes Depriving a Class of Children of Rights to Medical Care: Can this Discrimination Be Litigated?*, 2 QUINNIAC HEALTH L.J. 73 (1998) (identifying exemptions and limitations from providing medical care to children, and providing a history and critique of statutes).

181. Coleman, *supra* note 180, at 378–79. In 1983, Congress withdrew the mandate to provide religious exemptions, but few states subsequently revised their statutes. *Id.*

182. See, e.g., Swan, *supra* note 180 (arguing that children's rights to medical care should be protected without exception for religious belief); Janna C. Merrick, *Spiritual Healing, Sick Kids and the Law: Inequities in the American Healthcare System*, 29 AM. J.L. & MED. 269 (2003) (arguing that religious healing exemptions do not protect the best interests of the child and create inequities in the healthcare system, and recommending that exemptions from providing medical care be eliminated when the child's condition is a serious threat to his or her health or life); Paula A. Monopoli, *Allocating the Costs of Parental Free Exercise: Striking a New Balance Between Sincere Religious Belief and a Child's Right to Medical Treatment*, 18 PEPP. L. REV. 319 (1991) (advocating for repeal of religious exemptions in order to "prevent the unnecessary deaths of children who suffer from disease that is readily and effectively treatable by medical science").

183. See, e.g., OKLA. STAT. ANN. tit. 21, § 852 (West 2015) (prohibiting a finding of child endangerment "for the sole reason" that a parent or guardian "depends upon spiritual means alone through prayer . . . for the treatment or cure of disease," but establishing that "medical care shall be provided where permanent physical damage could result to such child" and in cases of "communicable diseases and sanitary matters"); Walker v. Superior Ct., 763 P.2d 852, 865–66 (Cal. 1988) (holding that spiritual treatment exemption was based on a willingness to accommodate religious practice when children do not face physical harm).

provide absolute protections, courts have nevertheless been willing to deviate from the statutory text and impose sanctions on parents.¹⁸⁴ For example, most courts have held that religious exemptions from parental obligations to provide medical care do not protect parents from criminal liability.¹⁸⁵ Other courts have held such statutory exemptions unconstitutional on equal protection grounds.¹⁸⁶ Furthermore, medical neglect laws allow the state to step in to protect children when parents are unwilling to do so, with the clear intent of preventing third-party harm,¹⁸⁷ an option that is not available when considering abortion refusal laws. In the abortion context, the state cannot step in to provide needed care to patients, as only medical providers are licensed to provide abortions—but it could grant a civil remedy when patients are harmed.

As I have argued elsewhere, fundamental principles of American law and policy dictate that even deeply rooted rights can and should be restricted when their exercise

184. “Legislatures might be willing to grant *carte blanche* exemptions from child neglect laws, vaccination requirements, and the like. But judges presented with those same claims under RFRA and similar laws almost never do.” Mark Storslee, *Religious Accommodation, the Establishment Clause, and Third-Party Harm*, 86 U. CHI. L. REV. 871, 940 (2019).

185. Gitlin, *supra* note 180, § 2(a) (“Although parents charged with failing to provide medical care to their children often claim a defense based on their religious beliefs, this defense has almost universally been rejected by the courts”); *see, e.g.*, *State v. McKown*, 475 N.W.2d 63, 65–68 (Minn. 1991) (holding that the spiritual healing exception to the child neglect statute did not apply to manslaughter charges); *Funkhouser v. State*, 763 P.2d 695, 697–98 (Okla. Crim. App. 1988) (holding that parents who used spiritual means to treat a child’s illness could use that as a defense to a charge of first-degree manslaughter, but not second-degree manslaughter); *Walker*, 763 P.2d at 852 (finding that state penal code’s exemption for parents relying on prayer treatment did not create an express exemption from felony prosecution); *Commonwealth v. Twitchell*, 617 N.E.2d 609, 609 (Mass. 1993) (holding that the state’s spiritual treatment provision did not foreclose an involuntary manslaughter charge); *State v. Crank*, 486 S.W.3d 15, 15 (Tenn. 2015) (holding that religious exception to child abuse, neglect, and endangerment charges is not unconstitutionally vague); *Bergmann v. State*, 486 N.E.2d 653, 656–62 (Ind. Ct. App. 1985) (holding that jury was entitled to reject the parents’ religious-treatment defense as a question of fact even though the defense was set forth in the child neglect statute, and noting that the defense only appeared in the neglect-of-dependent statute, but not in the reckless homicide statute).

186. *State v. Miskimins*, 490 N.E.2d 931, 933–38 (Ohio Ct. Com. Pl. 1984) (holding that religious exemption to child endangerment statute was unconstitutional under the Establishment Clause, Free Exercise Clause, and Equal Protection Clause); *Brown v. Stone*, 378 So. 2d 218, 223 (Miss. 1980) (holding that religious exemption in state immunization statute violates Equal Protection Clause).

187. *See Coleman*, *supra* note 180, at 379–84 (noting that such statutes do not preclude Child Protective Services or the courts from acting to protect the child, particularly where the situation is life-threatening, and describing current law as focusing on protecting children, not punishing parents.); *In re Jensen*, 633 P.2d 1302, 1305–06 (Or. Ct. App. 1981) (holding that statutory language relating to a parent’s decision to choose treatment by prayer did not mean that the state was powerless to intervene when a child’s life was seriously jeopardized); *In re Hamilton*, 657 S.W.2d 425, 427–29 (Tenn. Ct. App. 1983) (holding that the state can act on behalf of the child in consenting to necessary treatment where child neglect statute did not establish an exemption for religious healing).

is likely to cause serious harm to third parties.¹⁸⁸ State and federal antidiscrimination and religious accommodation laws offer a variety of approaches for how these interests might be balanced, and legislators seeking to amend abortion conscience laws would be well-advised to consider these approaches. But at the very least, legislators should be on notice that in almost no other context are conscientious refusers granted immunity from civil liability when their refusals harm third parties. This is why I have previously argued that state laws should not limit patients' remedies when a health care provider's conscience-driven refusal violates the standard of care and causes injury.¹⁸⁹ Eliminating civil immunity provisions in abortion conscience laws would significantly reduce the burdens on patients impacted by provider refusals without compelling providers to act against their conscientious beliefs.

CONCLUSION

State laws that establish absolute conscience protections for health care providers are policy outliers. Unlike other state and federal laws aimed at protecting people from discrimination, abortion conscience laws are drafted in such a way that they impose unilateral burdens on third parties. These laws ought to strike a more appropriate balance between protecting conscience-driven health care providers and protecting third parties, like patients and employers. This Article proposes that legislators considering changes to state health care conscience laws incorporate "undue hardship" and "direct threat" limitations, modeled after those in the Civil Rights Act and the Americans with Disabilities Act. Furthermore, because the civil immunity provisions in abortion conscience laws are an anomaly among state and federal antidiscrimination laws, these laws should not immunize refusing providers from liability if their actions violate the standard of care and cause patient injury. Taking these steps would more effectively balance the state's interest in protecting health care providers against its interest in protecting third parties who might be harmed by provider refusals.

188. Nadia N. Sawicki, *Disentangling Conscience Protections*, 48 HASTINGS CTR. REP. 14, 19 (2018).

189. See Sawicki, *supra* note 2.