

On Whose Conscience? Patient Rights Disappear Under Broad Protective Measures for Conscientious Objectors in Health Care

[T]he physician-patient relationship is a moral equation with rights and obligations on both sides. . . . [I]t must be balanced so that physicians and patients act beneficently toward each other while respecting each other's autonomy.¹

INTRODUCTION

Balance. Respect. Autonomy.

In 2004, the Michigan House passed a bill called the "Conscientious Objector Policy Act." Though a companion bill did not get out of its Senate committee, this bill represented the most successful attempt to date on the issue of enhanced conscience protection measures for health care providers. Provisions included immunity from criminal or civil liability, as well as adverse employment actions, for any exercise of conscience under the bill.

Some members of the health care industry probably saw the measures as essential and perhaps overdue. Others noted a significant omission, that a key component present in every medical transaction was strangely absent: the patient. The bill as passed reflected no balancing of or respect for patients' rights to autonomy, or their other needs and interests.

This article traces brief histories of health care conscience clauses and the patient's right to informed consent. It analyzes the bill in the context of patients' rights, and proposes alternative approaches to restore balance to the patient-provider relationship, while maintaining providers' rights to conscience. The article's final section evaluates a variety of potential legal challenges to protect patients, if the bill is re-introduced unchanged.

1. Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 47 (1994).

I. BACKGROUND

A. *Medical providers' rights of conscience, and the laws protecting them*

The right of free exercise of conscience is considered an inalienable human right.² One authority defines it as “the act of applying one’s moral beliefs to one’s own conduct.”³ In addition to its recognition internationally,⁴ this right is constitutionally protected in the First Amendment, which states, “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof[.]”⁵ Conscience may be a reflection of moral or ethical principles as well.⁶

With the intent of protecting the free exercise of religion and conscience, the first health care conscientious objector law was passed in 1973. Surprisingly, it was not just in response to *Roe v. Wade*,⁷ but also to a federal court decision compelling an objecting hospital to carry out a woman’s sterilization.⁸ House Report 93-227 explained the purpose of the “Church Amendment” (named for its sponsoring Senator). It would

deny any court, public official, or public authority the right to require individuals or institutions to perform abortions or sterilizations contrary to their religious beliefs or moral convictions because an individual or institution had received assistance under the Public Health Service Act, the Community Mental Health Centers Act, or the Developmental Disabilities Act.⁹

The statute exempts individuals and entities in programs supported by federal funds from participating in abortion or sterilization related procedures.¹⁰ It also allows individuals in programs funded through the Department of Health and Human Services to refuse to participate in *any*

2. TERRANCE MCCONNELL, *INALIENABLE RIGHTS: THE LIMITS OF CONSENT IN MEDICINE AND THE LAW* 45 (2000).

3. *Id.* (citations omitted).

4. *Id.* at 46 (citing the *International Covenant on Civil and Political Rights* (1966)).

5. U.S. CONST., amend. I.

6. See *United States v. Seeger*, 380 U.S. 163 (1965) (considering a general religious belief as qualifying one as a conscientious objector to military service); *Welsh v. United States*, 398 U.S. 333 (1970) (finding deeply held moral or ethical beliefs as also qualifying for conscientious objector status).

7. 410 U.S. 113 (1973).

8. Lisa C. Ikemoto, *When a Hospital Becomes Catholic*, 47 *MERCER L. REV.* 1087, 1114-15 (1996) (referring to *Taylor v. St. Vincent’s Hospital*, 369 F. Supp. 948 (D. Mont. 1973), in which a patient wanted her tubal ligation performed immediately after a cesarean delivery. The hospital insisted on transferring her to a different hospital; the district court enjoined the hospital to provide the surgery. Subsequently, the injunction was dissolved, and the court ruled for the hospital, largely on Church Amendment grounds.).

9. H.R. No. Rep. 93-227 (1973), reprinted in 1973 U.S.C.C.A.N. 1464, 1464.

10. 42 U.S.C.A. § 300a-7 (West 2005).

health care service objectionable under her religious beliefs or moral convictions.¹¹

Many states followed the federal government's example. As of 1999, forty-six states had some form of conscience clause laws protecting the right of individual health care workers to refuse to participate in abortion-related services.¹² Forty-two states allowed facilities to object.¹³

Conscience clauses have largely withstood legal challenge, especially under Establishment Clause theory.¹⁴ One exception in which patients' interests prevailed over a hospital's objections was on state law grounds.¹⁵ The Supreme Court of Alaska overturned a hospital's policy against performing elective abortions.¹⁶ Alaska's constitution includes an express right to privacy, and its Supreme Court held that provision further encompassed reproductive rights.¹⁷ In addition, the non-profit hospital in question was not a religious institution, but a quasi-public one.¹⁸ The court cited in support a New Jersey decision that denied non-sectarian institutions the right to refuse to participate in abortion.¹⁹

Starting in the 1990s, conscience clauses expanded in scope, in part due to concerns driven by the Clinton administration's proposed health care reforms.²⁰ For instance, in 1998 Illinois broadened both the personnel and the services covered by its conscience clause.²¹

Lawsuits following employee terminations or other actions have also gained media attention, further driving legislative interest in protecting health care providers. In one example, an Illinois ambulance driver was fired after refusing to drive a woman with severe abdominal pain to an abortion clinic.²² In another, widely publicized incident, a Wisconsin pharmacist refused to fill a prescription for birth control, and then refused

11. *Id.* § 300a-7(d).

12. Kathleen A. White, *Crisis of Conscience: Reconciling Religious Health Care Providers' Beliefs and Patients' Rights*, 51 STANFORD L. REV. 1703, 1709 (1999).

13. *Id.*

14. Ikemoto, *supra* note 8, at 1116.

15. Valley Hosp. Ass'n v. Mat-Su Coal. for Choice, 948 P.2d 963, 969 (Alaska 1997).

16. *Id.* at 972.

17. *Id.* at 969.

18. *Id.* at 971.

19. *Id.* at 972 (citing *Doe v. Bridgeton Hosp. Ass'n*, 366 A.2d 641 (N.J. 1976)).

20. ACLU REPRODUCTIVE FREEDOM PROJECT, RELIGIOUS REFUSALS AND REPRODUCTIVE RIGHTS 1, Jan. 22, 2002, available at <http://www.aclu.org/FilesPDFs/ACF911.pdf>.

21. 745 ILL. COMP. STAT. ANN. 70/4 (West 2005) (amended effective Jan. 1, 1998 by 1997 Ill. Legis. Serv. 90-246, § 5 (West), to include an exemption from criminal or civil liability for "any particular form of health care service which is contrary to the conscience of such physician or health care personnel").

22. Tresa Baldas, *Fighting Refusal to Treat: 'Conscience Clauses' Hit the Courts*, NAT'L LAW J. (Feb. 7, 2005), available at <http://www.law.com/jsp/nlj/PubArticleNLJ.jsp?id=1107550992983>.

to transfer the prescription or return it to the patient. The licensing board proposed a fine.²³ Other pharmacists have refused to dispense not only birth control pills and emergency contraception, but also medications such as Ritalin, with various employment outcomes.²⁴

As a result, in 2004 fourteen state legislatures considered thirty-seven bills that would have allowed pharmacists to refuse to fill any type of prescription to which they had religious or moral objections.²⁵ Nine states offered broad provisions that supported refusal to participate in *any* health care service.²⁶ Clearly, conscience clause legislation reflects a groundswell in legislative interest. However, as explained further below, these provisions are often advanced without any consideration of patient rights.

B. Patient rights and informed consent

Patient rights as a concept developed in the United States starting in the 1960s, arising in part out of the civil rights movement.²⁷ In general, the right to health care is seen as a basic human right, but in the U.S., there is no established legal right to health care.²⁸ However, patients do possess a right of self-determination, supported by both statutes and common law.

Core patient rights include the right to make an informed decision.²⁹ Tort cases dating back to the early part of the twentieth century reflect the concept that unconsented-to medical care was grounds for suit: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”³⁰

Consent was expanded to “informed consent” in 1972 in a series of court decisions.³¹ “True consent to what happens to one’s self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.”³² Ten years later, a President’s Commission on ethical problems in medicine

23. *Id.*

24. *Id.*

25. *Id.*

26. *Id.*

27. JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 21 (2d ed. 2001).

28. GEORGE J. ANNAS, RIGHTS OF PATIENTS 7-8 (3d ed. 2004).

29. *Id.* at 19.

30. *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.) (citations omitted) (*abrogated on other grounds by Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957)).

31. ANNAS, *supra* note 28, at 13.

32. *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir. 1972).

supported the right to informed consent, recognizing its foundations in law and characterizing it as an ethical imperative.³³

Informed consent implements a patient's right of self-determination.³⁴ The information required "includes a clear concise explanation . . . of all proposed treatments; all reasonable medical alternatives (whether or not covered by patient's health plan)."³⁵ The patient is also entitled to information about the likelihood of success and the side effects of treatment alternatives, as well as the consequences of a decision not to treat.³⁶ In addition to the right of information, the patient has a right to consent. Accordingly, physicians have two corresponding duties — the duty to inform and the duty to obtain consent.³⁷

While the doctrine of informed consent is well established and enforced by medical malpractice law, there is no corresponding federal statutory support. Despite attempts in recent years, no federal patient rights bill has passed Congress. Bills were put forth, most recently in June 2004, largely in response to perceived abuses in managed care.³⁸ One such abuse was the practice of not informing a patient of reasonable alternative treatments not covered by his insurance program.³⁹ (Conscience clause legislation raises similar concerns: because a provider need not counsel a patient on an objected-to procedure, the patient is never made aware of an alternative that he might choose.) Though attempts at the federal level have failed, many states have promulgated their own patient rights provisions, some of which include the requirement that a patient be informed of treatment alternatives.⁴⁰

In more recent years, informed consent has been extended to supporting a right to *refuse* life-saving or life-sustaining treatment. In *Cruzan v. Director*, the Supreme Court held that the right to refuse treatment is a logical corollary to the right of informed consent.⁴¹ The Court said that one may infer from previous decisions that "a competent

33. ANNAS, *supra* note 28, at 114.

34. MCCONNELL, *supra* note 2, at 65.

35. ANNAS, *supra* note 28, at 19.

36. MCCONNELL, *supra* note 2, at 65.

37. *Id.*

38. H.R. 4628, 108th Cong. (2004).

39. BERGET AL., *supra* note 27, at 218.

40. See, e.g., ALASKA STAT. § 09.55.556 (2005) ("A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes . . . that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure . . ."); 40 PA. CONS. STAT. § 1303.504 (West 2005) ("Consent is informed if the patient has been given a description of a procedure set forth in subsection (a) and the risks and alternatives that a reasonably prudent patient would require to make an informed decision. . . ."); WIS. STAT. ANN. § 448.30 (West 2005) ("Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment . . .").

41. *Cruzan v. Dir., Mo. Dep't. of Health*, 497 U.S. 261, 270 (1990).

person has a constitutionally protected liberty interest in refusing unwanted medical treatment.”⁴² In her concurrence, Justice O’Connor characterized as “inextricably intertwined” those liberty interests with one’s sense of “physical freedom and self-determination.”⁴³

The Court cited lower court rulings in acknowledging state interests that may balance the patient’s right to refuse: “the preservation of life, the protection [of] innocent third parties, the prevention of suicide, and the maintenance of ethical integrity of the medical profession.”⁴⁴ However, these state interests carry more weight when a patient’s condition is curable; when the treatment being refused is only to extend life briefly, these interests diminish significantly.⁴⁵

II. MICHIGAN CURRENT AND PROPOSED LAW

A. *Michigan conscientious objector laws — existing and proposed*

House Bill 5006 passed the Michigan House on April 21, 2004.⁴⁶ A companion bill, Senate Bill 972,⁴⁷ did not see a vote in the Senate. Similar bills were offered in 2001,⁴⁸ 2002,⁴⁹ and 2005,⁵⁰ indicating sustained interest in the topic. Because the Michigan House passed H.B. 5006, demonstrating the greatest level of support on the issue to date, it will be the focus of this analysis.

First, however, it is worthwhile understanding existing Michigan conscientious objector protection. Similar to the vast majority of states as well as the federal government, Michigan protects health facilities and individuals from forced involvement with abortion-related procedures.

Doctors, nurses, students, and employees of health care facilities who object to such participation are permitted to refuse involvement without penalty.⁵¹ Doctors are protected from civil actions if they refuse to advise on abortion.⁵² Finally, health facilities themselves are immune from penalty if they opt not to support or participate in abortion, or refuse to admit patients for the procedure.⁵³

42. *Id.* at 278.

43. *Id.* at 287 (O’Connor, J., concurring).

44. *Id.* at 271 (majority opinion).

45. *Id.*

46. H.R. 5006, 92nd Leg., Reg. Sess. (Mich. 2004).

47. S. 972, 92nd Leg., Reg. Sess. (Mich. 2004).

48. H.R. 5158, 91st Leg., Reg. Sess. (Mich. 2001).

49. S. 1228, 91st Leg., Reg. Sess. (Mich. 2002).

50. H.R. 4741, 92nd Leg., Reg. Sess. (Mich. 2005).

51. MICH. COMP. LAWS ANN. § 333.20182 (West 2005).

52. *Id.* § 333.20183.

53. *Id.* § 333.20181.

H.B. 5006 operates to broaden the applicability of conscientious objection to *any* health care service which a health care provider finds objectionable on moral, ethical or religious grounds.⁵⁴ A health care provider is defined as anyone so licensed or registered, or as an employee of a health facility who participates in the delivery of care.⁵⁵ A health facility includes, *inter alia*, pharmacies, teaching institutions, and private physicians' offices, as well as hospitals and clinics.⁵⁶ This bill provides protection to objectors in the form of immunity from criminal or civil liability, and from termination of employment.⁵⁷

An objecting health care provider must provide notice to his employer under three circumstances. First, he may provide notice at the commencement of employment; second, on adoption of beliefs that necessitate refusal; or third, within twenty-four hours of notice of a requirement to participate in an objected-to service.⁵⁸

The bill provides a limited number of exceptions to the right to refuse. First, if a patient requires immediate medical attention, and no other health care provider is available, the objector must provide the necessary care.⁵⁹ Second, objections cannot be discriminatory, whether directed at a medical condition or disease, or a member of a class protected by Michigan civil rights law.⁶⁰ Third, if the procedure or service to which the health care worker objects comprises at least 10% of her defined position, she is not protected from employment termination, though the bill mandates 60 days notice.⁶¹ Finally, the bill states that it does not relieve a health care provider of any statutory duty of care.⁶²

Contraception is treated independently by the bill. Health care services listed as eligible for objection expressly exclude "provision of a contraceptive medication."⁶³ Contraceptive devices are not specifically mentioned, so a health care provider could presumably object to prescribing, fitting, or providing devices such as a diaphragm or intrauterine device (IUD). In addition, "contraceptive medication" is defined as "taken or used in advance of" intercourse.⁶⁴ As a result,

54. H.R. 5006, 92nd Leg., Reg. Sess. § 5(1) (Mich. 2004).

55. *Id.* § 3(b).

56. *Id.* § 3(d).

57. *Id.* § 9.

58. *Id.* § 5(3).

59. *Id.* § 11(1)(a).

60. *Id.* § 11(1)(c).

61. *Id.* § 11(2).

62. *Id.* § 11(3) ("This act does not relieve a health care provider from a duty that exists under another statute or other law pertaining to current standards of acceptable health care practice and procedure to inform a patient of the patient's condition, prognosis, and risks of receiving health care services for the condition." Note that informing the patient of treatment alternatives is not included.).

63. *Id.* § 3(c).

64. *Id.* § 3(a).

emergency contraception, taken necessarily after intercourse (whether voluntary or as a result of sexual assault) is still eligible for objection.

H.B. 5006 was passed in a package of four bills. One granted a health facility the same right to object as an individual,⁶⁵ exempting it from civil, criminal, or administrative penalty, or the loss of any government funding due to its refusal. The other two provided the same protection and immunity to health care corporations⁶⁶ and health maintenance organizations and insurers.⁶⁷

B. Michigan patient rights protection

1. Statutory provisions

Evaluating the impact of new rights and immunities for providers requires an assessment of patient rights protections. Unlike other states,⁶⁸ Michigan has no umbrella patient rights statute. With the sole exception of the breast cancer treatment statute, statutory provisions are haphazard and in some cases, only indirectly protective of patients' rights.

For example, Michigan law requires mental health care recipients to be given notice of their rights under that chapter of the code.⁶⁹ Happily, the standard for mental health treatment includes a right to be treated with dignity and respect.⁷⁰ The statute also includes the right to consent to a few expressly listed procedures: electroconvulsive therapy, surgery, and the administration of psychotropic drugs.⁷¹ However, there is no umbrella provision requiring informed consent for mental health treatment in general, nor any requirement that the health care provider inform the patient about his diagnosis, treatment alternatives, risks, or likely outcomes.

That broader concept of a patient's right to full disclosure of information is acknowledged in the statute governing health care facilities, though it is not given direct, clear expression. Licensed facilities which provide direct care to patients or residents are required to post their policy of patients' rights and responsibilities.⁷² Informed consent is addressed in the area of "information about [the patient's] medical condition, proposed course of treatment, and prospects for recovery."⁷³ Language on treatment

65. H.R. 5276, 92nd Leg., Reg. Sess. (Mich. 2004).

66. H.R. 5277, 92nd Leg., Reg. Sess. (Mich. 2004).

67. H.R. 5278, 92nd Leg., Reg. Sess. (Mich. 2004).

68. ALASKA STAT. § 09.55.556 (2005); *see supra* note 40 and accompanying text.

69. MICH. COMP. LAWS ANN. §§ 330.1700-.1758 (West 2005).

70. *Id.* § 330.1708.

71. *Id.* §§ 330.1716-1718.

72. *Id.* § 333.20201(1).

73. *Id.* § 333.20201(2)(e).

alternatives is buried further in the statute, referred to somewhat ambiguously as “alternatives” to address “continuing health needs.”⁷⁴

The section on the right to refuse treatment is noteworthy in relation to this article’s topic. That section indicates that “a patient or resident is entitled to refuse treatment . . . and to be informed of the consequences of that refusal.”⁷⁵ However, if the refusal compromises what the facility considers appropriate treatment under ethical or professional grounds, the facility has the right to terminate treatment, though with a requirement for adequate notice of termination.⁷⁶

The anti-discrimination provision of this section is also worth comparing to H.B. 5006. The bill’s provision prohibits discrimination against individuals protected by the Elliot-Larsen Civil Rights Act.⁷⁷ The existing health facilities statute goes further, protecting against discrimination based on sexual preference and source of payment, patient groups not covered by Elliot-Larsen.⁷⁸

Enforcement of patient rights is not particularly robust. A subsequent section of the statute indicates that these provisions are guidelines, and that a failure of compliance will not support either civil or criminal liability.⁷⁹ Michigan case law confirms that this statute does not support a private cause of action, but only supports state action against facilities’ licenses.⁸⁰

The broadest, most explicit example of Michigan statutory protection of patient rights and informed consent is found in the provisions addressing breast cancer treatment.⁸¹ This section mirrors closely the most patient-protective state laws⁸² in its express requirement that the physician inform the patient of all reasonable treatment alternatives.⁸³ It also requires that

74. *Id.* § 333.20201(2)(j).

75. *Id.* § 333.20201(2)(f).

76. *Id.*

77. H.R. 5006, 92nd Leg., Reg. Sess. § 11(1)(c) (Mich. 2004); *see also* MICH. COMP. LAWS ANN. §§ 37.2101-.2804 (West 2001) (protecting the right to public accommodations, *inter alia*, against discrimination based on “religion, race, color, national origin, age, sex, height, weight, familial status, or marital status . . .”).

78. MICH. COMP. LAWS ANN. § 333.20201(2)(a) (West 2001).

79. *Id.* § 333.20203.

80. *Gentry v. Dept. of Pub. Health*, 475 N.W.2d 849, 850 (Mich. Ct. App. 1991) (confirming that the statute allows penalties against facilities for licensing purposes, but does not “create a remedy available to individual . . . patients”); *Correll v. St. John Hospital-Macomb Center*, No. 220560, 2002 WL 226935 (Mich. Ct. App. Feb. 8, 2002).

81. MICH. COMP. LAWS ANN. § 333.17513 (West 2005).

82. *See, e.g., ALASKA STAT.* § 09.55.556 (West 2005) (“A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives . . .”).

83. MICH. COMP. LAWS ANN. § 333.17513 (West 2005).

the information be comprehensible by a layman, and that it be delivered both orally and in writing.⁸⁴

In another key area of patients' rights, Michigan's Dignified Death Act requires physicians to inform patients (or the patient's surrogate or advocate) on several end-of-life treatment issues.⁸⁵ The statute gives patients the right to make informed decisions regarding receiving or refusing care, the right to designate a patient advocate, and the right to choose pain management and hospice care.⁸⁶

Finally, Michigan abortion laws include an "informed consent" requirement.⁸⁷ However, in addition to providing information on alternatives to abortion, the statute mandates a waiting period,⁸⁸ a provision not required for other medical treatment. This statute is less a patient rights provision than an assertion of the state's ability to regulate abortion.

2. Case law on patient rights

Patients seeking support for their rights under Michigan case law will find it as weak as the statutory protections. While Michigan decisions indicate that the common law doctrine of informed consent is observed,⁸⁹ it has in fact been applied very narrowly. Early case law, still cited, characterizes a physician's duty solely as advising the patient of the consequences of the medical procedure.⁹⁰ No reference is made to advising on alternatives or the result of electing no treatment.

In addition, the use of medical malpractice actions to enforce a physician's duty to disclose is hindered by Michigan's application of the "physician-oriented" disclosure standard.⁹¹ Under this standard, applied in about half of the states, a physician need only disclose those alternatives to proposed treatment that are recognized and accepted by practitioners with the same training and experience.⁹² The other states apply a patient-oriented standard, in which the doctor is required to disclose whatever material information a reasonable patient would consider significant in deciding on a course of treatment.⁹³ Michigan's physician-oriented

84. *Id.*

85. *Id.* § 333.5654.

86. *Id.* § 333.5655.

87. *Id.* §§ 333.17014-15, 333.17514-15.

88. *Id.*

89. *In re Rosebush*, 491 N.W.2d 633, 635 (Mich. Ct. App. 1992).

90. *Roberts v. Young*, 119 N.W.2d 627 (Mich. 1963). The court's discussion does not use the term "informed consent," probably because it predates the major court decisions using that language in relation to patient rights. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

91. *Marchlewicz v. Stanton*, 213 N.W.2d 317 (Mich. Ct. App. 1973).

92. James A. Bulen, *Ethical and Legal Aspects of Informed Consent to Treatment*, 24 J. LEG. MED. 331, 335-336 (2003).

93. *Id.* at 338.

standard is much less patient-friendly, because it requires expert testimony to establish a deviation from the duty of care.⁹⁴

Issues of enforcement and malpractice aside, the other primary body of case law regarding informed consent is on the issue of the right to refuse or withdraw lifesaving or life-prolonging treatment. *In re Rosebush*⁹⁵ recognized that right to refuse.

In that decision, the Michigan Court of Appeals affirmed the trial court's refusal to allow criminal charges against a child's parents on the removal of her life support. The parents had sought the cessation of life-sustaining treatment for their daughter, who was in a persistent vegetative state following an accident.⁹⁶ The court found the right to refuse treatment in the "the common-law right to freedom from unwanted interference with bodily integrity."⁹⁷

The *Rosebush* court acknowledged (as did the *Cruzan* Court) that in some cases, state interests may prevail over the patient's right to refuse.⁹⁸ Among the interests evaluated was "the maintenance of the ethical integrity of the medical profession."⁹⁹ The court stated, though, that all state interests in cases with no chance for "substantial recovery" are outweighed by the patient's rights. It indicated specifically that the individual right to refuse life-sustaining treatment would take precedence over maintaining the medical profession's ethical integrity "where prevailing standards of medical ethics do not condemn the contemplated course of action."¹⁰⁰

While *Rosebush* confirms the common law right to informed consent and the right to refuse life-prolonging treatment, both rights were advanced by surrogates seeking to make the decision for an incompetent patient. These rights are not lost when a patient becomes incompetent or because of youth.¹⁰¹ No Michigan case law has yet addressed the concept of a right to refuse treatment by a competent patient, perhaps because the issue is seemingly less controversial when a patient can directly assert his own rights.¹⁰²

94. *Id.* at 336.

95. 491 N.W.2d 633 (Mich. Ct. App. 1992).

96. *Id.* at 634.

97. *Id.* at 635.

98. *Id.* at 636 n.2. *See also* *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990).

99. *Rosebush*, 491 N.W.2d at 636 n.2.

100. *Id.* *See, e.g.*, Amicus Curiae Brief for Michael Schiavo as Guardian of the Person of Theresa Marie Schiavo (Filed with the Consent of the Parties), *Bush v. Schiavo*, 885 So. 2d 321 (Fla. 2004) (No. SC04-925), 2004 WL 1949087 (indicating the support of fifty-five signatory bioethicists for Mrs. Schiavo's autonomy rights and Mr. Schiavo's role as guardian, as an example of "prevailing standards" of ethics).

101. *Rosebush*, 491 N.W.2d at 635-36.

102. *See generally* *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994) (discussing the origin and application of informed consent, including the right to refuse treatment, but in the context of assisted suicide. It provides no guidance on the balance of patient rights and health care provider duty.).

III. THE CONFLICT BETWEEN PROVIDERS' AND PATIENTS' RIGHTS

The preceding section addressed both general and Michigan approaches to patient rights and conscience clause provisions for health care providers. The following scenarios are meant to illustrate the tension between patient and health providers, as impacted by proposed conscience clause provisions, and to demonstrate potential consequences.

Mr. K lived a long happy life. But as he approached the end, he decided he had lived the time God allotted him, and wanted no extraordinary measures taken in the case of a heart attack or stroke. His wife and children fully supported his decision. But while he was hospitalized for minor surgery, he suffered a heart attack. Nurse X disregarded Mr. K's Do Not Resuscitate order, and performed CPR. Mr. K survived, but during the heart attack, his brain was without oxygen long enough to leave him in a coma — exactly the outcome he sought to prevent by his well-thought-out and supported DNR order.

Mrs. L was pregnant with her first child when she was diagnosed with a serious, life-threatening disease. Dr. Y did not see just one patient under his care, but two, including the baby Mrs. L was carrying. Dr. Y chose to inform Mrs. L only about those treatment options which would not negatively impact her unborn child, although more aggressive treatments were also available. Mrs. L herself might have prayerfully decided with her husband that she was young, and would rather beat her disease and hope for more children later. Instead, she followed Dr. Y's course of treatment (ignorant of other options), and her baby was born healthy. Unfortunately, Mrs. L died when the baby was six months old.

Ms. M suffered for many years from severe disfiguring acne. After trying every other method available, she reluctantly agreed with her dermatologist to try a controversial acne drug. The treatment was known to be effective, but carried some significant side effects. Among them were a possible increased risk of suicide, and an established risk of birth defects so severe that female patients taking the drug were required to be on birth control. Ms. M went to her local pharmacy to get her prescription. Pharmacist Z refused to give her the medicine. He considered the drug unethical because of its side effects, and because using it forced women to take contraceptives.

These scenarios raise questions about whether patients have the final decision on their own health treatment. All the providers felt strongly that they were taking the right moral and ethical action in disregarding patients' wishes, whether those wishes were known (Mr. K) or unexplored (Mrs. L). H.B. 5006 would support these providers absolutely, and insulate them from any consequences of their decisions. But did the patients have a right to insist on the care they believed they had consented to? Was Mrs. L's consent truly an informed one?

In general, both health care providers and patients have a body of rights and duties when they enter into a patient-provider relationship. This

relationship is characterized as a fiduciary one, requiring the provider to act in the patient's best interest.¹⁰³ H.B. 5006 allows the provider's individual conscience rights to take precedence over the patient's interests, undermining the trust of the fiduciary relationship. It makes no provision for ensuring alternate sources of care are available, when providers object to the desired care.

The perspective of professional medical organizations on this tension between patient and provider rights has been fairly consistent. The American Nurses Association (ANA), American Pharmacists Association (APhA), and American Medical Association (AMA), among others, support a health care provider's right of conscience, but also support a patient's right to information and access to all appropriate health care options. For instance, the ANA code of ethics section 5.3 states, "[i]n a community of moral discourse, no one person's view should automatically take precedence of that of another."¹⁰⁴ The American Pharmacists Association confirms pharmacists' conscience rights, while acknowledging patient rights more directly: "APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems *to ensure patient's access* to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal."¹⁰⁵

Closer to home, the Michigan Nurses Association testified against H.B. 5006's companion bills, in that they would "put the rights of individual providers and insurers above the rights of patients, impacting access to care across Michigan."¹⁰⁶ A spokesperson for the Michigan State Medical Society indicated that his organization was "strongly opposed" to the bill,¹⁰⁷ and a representative from the Michigan Osteopathic Association testified in Senate hearings against the bills.¹⁰⁸ These policy statements and other comments indicate that health care practitioners understand that patients' rights cannot be overlooked when providers' rights are addressed.

H.B. 5006's assertion of conscience rights is at the cost of patients' rights to self-determination. It will interfere with actual access to care as well as information about treatment options. It does so, first, by permitting

103. BERG ET AL., *supra* note 27, at 214.

104. Code of Ethics for Nurses, *available at* nursingworld.org/ethics/code/protected_nwcoe303.htm (last visited April 3, 2005).

105. Current APhA Policies Related to the Practice Environment and Quality of Worklife Issues 1998 4 (March 2002) (emphasis added), *available at* http://www.aphanet.org/AM/Template.cfm?Section=Search§ion=Control_Your_Practice1&template=/CM/ContentDisplay.cfm&ContentFileID=267.

106. *MNA Testifies in Opposition to Conscientious Objector Legislation*, NURSELINE (Sept. 24, 2004), *available at* <http://www.minurses.org/news/nurseline/nl092404.shtml>.

107. "Conscience Clause" Bills Advance in Michigan, Vetoed in Wisconsin, AMERICAN MEDICAL NEWS (May 10, 2004), *available at* <http://www.ama-assn.org/amednews/2004/05/10/prbf0510.htm>.

108. Michigan Osteopathic Association UPDATE (Oct. 2004), *available at* <http://www.mi-osteopathic.org/pages/physicians/update/oct2004.pdf>.

a health care provider to refuse to counsel a patient on an objected-to service. This results in a failure of informed consent in the lack of information on reasonable alternative treatments which would otherwise be available to the patient. Second, objections to certain procedures, services or medications may directly interfere with an individual's ability to obtain that form of health care. Third, dealing with that interference may impose hardships on the patient.

These modes of interference with patient rights must be addressed in future versions of conscience-protection legislation. The following section proposes modifications to future bills to that end. If the legislature fails to incorporate these or alternative measures to protect patients while accommodating conscientious objectors, section V offers three bases for legal challenge to any future enacted laws.

IV. SUGGESTIONS TO ENSURE PATIENT RIGHTS ARE PROTECTED IN FUTURE CONSCIENTIOUS OBJECTOR LEGISLATION

The free exercise of religion is protected as a negative right — in other words, it is the right not to be interfered with.¹⁰⁹ H.B. 5006 goes far beyond preventing interference, instead conferring civil and criminal immunity, as well as protecting against adverse employment action.¹¹⁰ Rather than the right not to be interfered with, H.B. 5006 establishes a positive right. It promotes care-related conduct *not* driven by the patient's best interest, but rather, with a priority on the provider's religious sensibilities. “[T]o allow a physician's appeal to conscience *always* to trump the wishes of a patient or surrogate would be to endorse a medical imperialism of a most dangerous sort.”¹¹¹ Yet that is exactly how H.B. 5006 would operate.

These conflicts between providers' conscience rights and patients' rights to self-determination and access to health care must be addressed in any future bill the Michigan Legislature considers. Accordingly, I propose a number of amendments or companion provisions that should be included in future bills.

These amendments include a requirement to provide information on all options indicated by the relevant standard of care, the elimination of malpractice immunity, patient notice provisions, and obligations on facilities and employers (especially government and other secular institutions) to continue providing the objected-to service. In addition, the oversight responsibility of the Michigan Department of Community Health should be expressly expanded to monitor the impact of the law for potential loss of care — by specific types of health care as well as by region — requiring it to address any loss of services. Finally, ideally, the Michigan

109. McCONNELL, *supra* note 2, at 46.

110. H.R. 5006, 92nd Leg., Reg. Sess. § 3(b) (Mich. 2004).

111. McCONNELL, *supra* note 2, at 63.

Legislature should update and strengthen patient rights in the state by passing a blanket patient rights protection law, perhaps looking to other states for examples.

In any health care context, regardless of the nature of the jurisdiction's disclosure standard, a physician is obligated to inform a patient of all applicable or reasonable treatment options.¹¹² As noted previously, in Michigan, the disclosure requirement is evaluated against other physicians, to determine the standard of what should be disclosed.¹¹³ H.B. 5006 negates the requirement of full disclosure by allowing the provider to refuse to counsel on any objected-to service.¹¹⁴

An argument can be made that forcing a provider to refer a patient for an objected-to procedure (also included in the list of permitted refusals¹¹⁵), or to facilitate a transfer for those purposes requires the objector to cooperate in actions she finds morally wrong.¹¹⁶ However, providing information on objected-to services leaves the choice of treatment with the patient, and honors his need and right to be fully informed. Withholding information on treatment options within the standard of care is a paternalistic exercise that infringes on that patient's rights, and a violation of the provider's duties to that patient. "The physician is obliged . . . to help the patient arrive at an autonomous decision by enhancing or empowering the patient's capacity to make authentic, self-governing choices."¹¹⁷ The patient cannot make that informed choice if he does not have all the necessary and pertinent information, including alternative treatments options.¹¹⁸

112. See *supra* notes 35-37 and accompanying text.

113. See *Marchlewicz v. Stanton*, 213 N.W.2d 317 (Mich. Ct. App. 1973); see also *supra* notes 91-94 and accompanying text.

114. H.R. 5006, 92nd Leg., Reg. Sess. § 3(f) (Mich. 2004).

115. *Id.*

116. McCONNELL, *supra* note 2, at 62. However, several states have concluded that an objecting provider must immediately facilitate patient transfer. See, e.g., CAL. PROB. CODE § 4736 (West 2005):

A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:

...

(b) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, *immediately make all reasonable efforts to assist in the transfer* of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

Id. (emphasis added).

See also HAW. REV. STAT. § 327E-7 (2005); ME. REV. STAT. ANN. tit. 18-A § 5-807 (2005); MISS. CODE ANN. § 41-41-215 (2005); N.M. STAT. § 24-7A-7 (1978); TENN. CODE ANN. § 68-11-1808 (2005); WYO. STAT. ANN. § 35-22-408 (2005).

117. Pelligrino, *supra* note 1, at 67.

118. See, e.g., Alaska's Informed Consent Statute, ALASKA STAT. § 09.55.556 (2004):

This requirement pertains especially to services that are considered part of the standard of care, but to which a provider might object because of his religion or other beliefs. A patient who shares the provider's faith might still choose a treatment option to which the provider objects, as each individual interprets his faith in a personal manner. If she does not share his faith, then his failure to disclose an otherwise reasonable option imposes his beliefs on her. In either case, the provider cannot conclude that the patient would share his objection to a treatment alternative.¹¹⁹ Accordingly, for the patient to be able to exercise her right of self-determination, she must be informed of all appropriate treatment options.¹²⁰ If she elects an option to which the provider objects, at that point the provider can withdraw from the provider-patient relationship.¹²¹

To ensure a patient's right to full disclosure, future bills must not include the term "counsel" in its list of services a provider can refuse to offer. Or in some other manner, the conscience clause provision must recognize the provider's duty to make a full disclosure to the patient in the interest of valid informed consent. Disclosure should not be bounded by the provider's faith, but by the standard of care for that medical condition.¹²²

Another essential change in future versions of conscience legislation is the removal of the civil liability immunity provision. While the provider's right of belief is absolute, his corresponding right of religious conduct is not.¹²³ "Conduct remains subject to regulation for the protection of society."¹²⁴ In direct conflict with that principle, H.B. 5006 immunizes providers from the consequences of their exercises of conscience, regardless of the degree of injury that results.

The bill's near-absolute immunity provision is anomalous in American religious conduct jurisprudence. Actions taken as a result of faith or conscience are still subject to legal consequence. For instance,

(a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and *reasonable alternatives* to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

Id. (emphasis added).

119. See, e.g., *Catholics and Contraception: The Facts Tell the Story*, April 2006, <http://www.catholicsforchoice.org/topics/reform/documents/2006catholicsandcontraception.pdf> ("Sexually active Catholic women above the age of 18 are just as likely (97%) to have used some form of contraception banned by the Catholic church as women in the general population (97%)").

120. ANNAS, *supra* note 28, at 19.

121. *Id.* at 68.

122. See *supra* notes 92-94 and accompanying text.

123. *Cantwell v. Connecticut*, 310 U.S. 296, 303-04 (1940). See also *infra* notes 183-190 and accompanying text.

124. *Id.* at 304.

when a child dies as a result of a parent's failure to obtain medical care due to sincere religious belief, the parent may be subject to criminal prosecution.¹²⁵ More pertinently, members of the clergy have been held liable for malpractice in counseling, despite their claim of First Amendment protections.¹²⁶

Indeed, "[f]ew would doubt . . . that a lawyer practicing in a legal clinic operated by a church or a physician practicing in a clinic under church auspices would have to comply with the same standards of professional care and responsibility as any other law firm or medical facility."¹²⁷ Few would doubt it, yet H.B. 5006 provides immunity from that compliance. Future versions of conscience clause bills must remove that immunity provision.

The bill required no notice to patients of services not provided. Notice is not a complete protection of patient rights, but does provide some measure of fairness. In some contexts, notice is implicit. For instance, a coed student at a Catholic university should not be surprised at her inability to obtain a prescription for birth control pills from the campus health center.

But more often, the faith-based objections of an individual provider or practice are generally not in evidence. A pregnant patient may wish to have the same physicians providing her prenatal care, labor, and delivery, perform a tubal ligation immediately following delivery. Without notice from the very beginning of the patient-provider relationship, this woman may spend months under the practice's care, building a trust relationship (and making a transition to another doctor more difficult), only to find on request for the tubal that the practice does not provide the service.

Finding a different provider and rebuilding that relationship shortly before delivery is a hardship. So is staying with the original provider, and being forced to find yet another doctor to perform the sterilization. Undergoing anesthesia a second time, if the delivery is a cesarean, is not just a hardship, but carries increased physical risk. In this case, express notice from the very first appointment that the practice does not perform sterilization procedures would prevent this patient's dilemma late in her pregnancy (as well as the possible increased risk to her health). Therefore, notice to patients of services not provided by an individual physician,

125. *Walker v. Super. Ct.*, 763 P.2d 852 (Cal. 1988). *But cf.* *Hermanson v. State*, 604 So. 2d 775, 782 (Fla. 1992) (finding that the state statute gave inadequate notice as to the point at which reliance on prayer becomes criminal neglect).

126. *Sanders v. Casa View Baptist Church*, 134 F.3d 331 (5th Cir. 1998). *See also* *Dausch v. Rykse*, 52 F.3d 1425, 1433 (7th Cir. 1994) (finding that an inquiry into harmful conduct does not require scrutiny of the tenets of the faith itself).

127. *Dausch*, 52 F.3d at 1433.

facility, or health care provider should be a required element of future legislation.¹²⁸

Another requirement for future consideration is the obligation of an employer or facility to continue to provide the objected-to care, despite employee objections. The employer may accommodate the employee, but should ensure that patient impact is negligible. Absent the facility's own objection (for example, as currently supported under abortion conscience clauses provisions), the objected-to care must be made available to patients.

Some states have held that only religious health care institutions may object under the same provisions that allow individuals to do so.¹²⁹ Certainly, when an institution is secular, especially when it is a government institution, meeting the standard of care should be a given. Because individual objections do not render the care itself objectionable *per se*, facilities have an obligation to see that patient care is unaffected. Future bills on this topic should expressly call out the duty of facilities to continue to provide care in the face of employee objections.

An independent approach to addressing patient needs would be to charter the Department of Community Health with monitoring health care delivery after any conscience legislation is implemented. Two areas of potential loss must be addressed — by type of health care and by region.

Family planning — that is, reproductive health care that includes information on and access to birth control — has long been considered a priority in public health.¹³⁰ The avoidance of unwanted pregnancies allows women to control their lives in a manner unavailable in the early part of the twentieth century. Despite recent efforts to reduce or shift funding,¹³¹ the priority on family planning as a public health issue is reflected in both federal¹³² and Michigan law.¹³³

128. Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 *FORDHAM URB. L.J.* 221, 242-43 (2002) (suggesting that physicians should distribute a leaflet for patients explaining what services "they can, and cannot, in good conscience do").

129. See, e.g., *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 969 (Alaska 1997); *Doe v. Bridgeton Hosp. Ass'n*, 366 A.2d 641 (N.J. 1976).

130. 1970 U.S.C.C.A.N. 5068, 5075-5076, *The Family Planning Services and Population Research Act of 1970* ("Section 2 states the purposes of the bill which are in general to make comprehensive voluntary family planning services readily available to all persons desiring such services . . .").

131. MICH. COMP. LAWS ANN. § 333.1091 (West 2005), effective March 31, 2003, forced to the lowest funding priority any family planning entity that had any involvement (e.g., performing, referring, or acknowledging the procedure's role in family planning) in abortion services.

132. 42 U.S.C.A. § 300 (West 2005). The Congressional Declaration of Purpose includes "assist[ing] in making comprehensive voluntary family planning services readily available to all persons desiring such services." See the Office of Family Planning website at <http://opa.osophs.dhhs.gov/titlex/ofp.html> (last visited Oct. 28, 2005) ("The Family Planning program authorized until Title X of the Public Health Service Act . . . is designed to provide access to contraceptive supplies and information to all who want and need them

However, family planning services are a significant target for conscientious objection.¹³⁴ Contraceptive medication is exempt from objection under H.B. 5006.¹³⁵ But contraceptive devices (diaphragms, intrauterine devices, and possibly, the birth control patch and vaginal ring) are not,¹³⁶ and they could become less available if pharmacists object to dispensing them.

In addition, emergency contraception (“EC”) has been the subject of tremendous controversy by state legislators mandating its availability¹³⁷ and by objectors to prescribing or providing EC.¹³⁸ Objections persist despite the fact that some Catholic hospitals have developed protocols under which it may be prescribed.¹³⁹ Because of its negative publicity, the pharmacies of some retail chains do not even offer EC.¹⁴⁰ That loss of access, coupled with further potential reductions by objectors’ actions, requires monitoring by the state to ensure that patients who need and desire EC will still have access to it.

While the Roman Catholic Church takes a very strong position against artificial contraception,¹⁴¹ as does the Christian Reformed Church (an

with priority given to low-income persons.”); <http://opa.osophs.dhhs.gov/titlex/ofp-funding-history.html> (demonstrating that funding for the Office of Family Planning has increased steadily since its inception in 1971).

133. Department of Community Health: Family Planning, http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_4912-12562--,00.html (last visited Nov. 4, 2005) (“The Michigan Family Planning Program makes available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to every citizen of the state.”). See also MICH. COMP. LAWS ANN. § 400.14b (West 2005) (indicating that family planning services notice may be provided to recipients of public assistance).

134. Baldas, *supra* note 22.

135. H.R. 5006, 92nd Leg., Reg. Sess. § 3(c) (Mich. 2004).

136. See *supra* notes 63-64 and accompanying text.

137. Leonard J. Nelson III, *God and Woman in the Catholic Hospital*, 31 J. LEGIS. 69, 92 (2004) (characterizing EC as the “standard of care for the treatment of female sexual assault victims”). See 410 ILL. COMP. STAT. 70/2.2 (West 2005) (“[E]very hospital providing services to alleged sexual assault survivors . . . must develop a protocol that ensures that each survivor of sexual assault will receive medically and factually accurate and written and oral information about emergency contraception.”). See also WASH. REV. CODE § 70.41.350 (2005); MASS. GEN. LAWS ch. 111, § 70E(o) (2005); and N.J. STAT. ANN. § 26:2H-12.6c (West 2005).

138. Nelson, *supra* note 137, at 93.

139. *Id.* at 98 (describing a protocol that includes testing to determine whether patient has ovulated, and permitting EC to be administered if she is not pregnant).

140. Anthony Bianco et al., *Is Walmart Too Powerful?*, BUS. WK., Oct. 6, 2003, available at 2003 WLNR 9519849.

141. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Fourth Edition (June 15, 2001), available at <http://www.usccb.org/bishops/directives.shtml>.

influential denomination in western lower Michigan),¹⁴² other Christian denominations actually support access to birth control as a part of general health care.¹⁴³ In addition, even where birth control is officially prohibited under church doctrine, many individuals make their own decisions of conscience on the issue, and do not follow the proscription.¹⁴⁴ Access to family planning services is a health care issue independent of faith judgments; the state has an obligation to ensure that access.

Michigan Department of Community Health (“MDCH”) may want to note the actions of New York in ensuring access to reproductive health care. With the implementation in the 1990s of managed care plans providing Medicaid services, as well as a 1997 conscience clause provision, Medicaid recipients covered by faith-based plans lost access to family planning care.¹⁴⁵ New York addressed this problem by publicizing a “free access” policy whereby patients could pursue family planning services outside their primary care provider.¹⁴⁶ The state also partnered with other health care organizations, such as Planned Parenthood, to ensure access for patients.¹⁴⁷

A more narrowly targeted action was taken in Illinois, when patients in the Chicago area were denied birth control prescriptions by objecting pharmacists.¹⁴⁸ The Governor issued an emergency rule requiring pharmacies to fill contraceptive prescriptions without delay.¹⁴⁹ The rule was implemented permanently in August 2006.¹⁵⁰

142. Christian Reformed Church, Birth Control, http://www.crcna.org/pages/positions_birth_control.cfm (last visited Jan. 7, 2006) (rejecting artificial birth control since 1936).

143. See generally Presbyterian 101, A General Guide to Facts about the PCUSA, <http://www.pcusa.org/101/101-abortion.htm> (last visited April 3, 2005) (suggesting that “[n]o law should prohibit access to, nor the practice of, contraceptive measures.”); United Church of Christ (UCC) General Synod Statements and Resolutions Regarding Freedom of Choice, <http://www.ucc.org/justice/choice/resolutions.htm> (last visited Oct. 15, 2005) (“The General Synod calls upon pastors, members, [and] local churches . . . to encourage the extension of information and services related to contraception as instrumental to the prevention of undesirable pregnancies and the achievement of wholesome family life.”).

144. See *Catholics and Contraception*, *supra* note 119.

145. *When Plans Opt Out: Family Planning Access in Medicaid Managed Care*, THE GUTTMACHER REPORT (Aug. 1998), <http://www.guttmacher.org/pubs/tgr/01/4/gr010408.html>.

146. *Id.*

147. *Id.*

148. Press Release, Illinois Governor Rod R. Blagojevich, Gov. Blagojevich Takes Emergency Action to Protect Women’s Access to Contraceptives (Apr. 1, 2005), <http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=3&RecNum=3805>.

149. *Id.*

150. Press Release, Gov. Blagojevich’s Contraceptives Rights Rule Wins Approval from Legislative Rules Committee (Aug. 8, 2006), <http://www.illinois.gov/pressreleases/ShowPressRelease.cfm?SubjectID=3&RecNum=5163>. See ILL. ADMIN. CODE tit. 68 § 1330.91 (2006) (providing:

Another area that MDCH must monitor is health care delivery in remote areas. Where the number of providers is reduced because of smaller populations, finding an alternative when the primary provider or facility objects becomes more difficult. The lack of mass transportation in rural areas makes it likely that, especially for minors and the poor, the real alternative will be no care at all. Accordingly, oversight responsibilities of the Department of Community Health should be expressly expanded to monitor the impact of the law for potential loss of care, by types of health care and by region, and should require it to address any loss of care.

Finally, the state legislature should study existing patient rights protections in Michigan, and consider strengthening statutory support of those rights. For instance, the State of Washington provides a good example of a reasonable balance between the patients' right to health care and providers' rights of conscience.¹⁵¹

V. POTENTIAL LEGAL CHALLENGES TO FUTURE CONSCIENCE LEGISLATION

If a law similar to House Bill 5006 is enacted without the modifications proposed above, patient rights advocates should consider challenging its interference with access to health care. Potential grounds for challenge include employer accommodation concepts developed under Title VII and employment discrimination case law, the Michigan Constitution's prohibition on enlarging civil rights based on religious belief, and First Amendment principles, under both Establishment and Free Exercise clause jurisprudence.

A. *Accommodating religious beliefs in the workplace under Title VII*

H.B. 5006 provides that health care providers may object to providing services and care without penalty. All accommodation to this exercise of their conscience must be made by the patient, by accepting this refusal and the corresponding limitation in care, or by seeking alternative sources of care without the provider's assistance. The patient makes an unknowing accommodation when a provider refuses to inform her of alternative therapies to which he objects. The only circumstance in which the patient is not the one required to accommodate the objection is when the objector's employer or facility provides the lost service through some alternative means.

j) Duty of Division I Pharmacy to Dispense Contraceptives
 1) Upon receipt of a valid, lawful prescription for a contraceptive, a pharmacy must dispense the contraceptive, or a suitable alternative permitted by the prescriber, to the patient or the patient's agent without delay, consistent with the normal timeframe for filling any other prescription.)

Id. (placing the emphasis on the *facility*, the pharmacy, and not the individual pharmacist).

151. WASH. REV. CODE ANN. § 48.43.065 (West 2005).

There is a body of case law addressing accommodation of religious belief and practice under the equal employment provisions of the 1964 Civil Rights Act.¹⁵² The pertinent provision states:

(j) The term “religion” includes 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.¹⁵³

Trans World Airlines v. Hardison provides guidance on the scope of accommodation required of an employer to avoid a religious discrimination claim.¹⁵⁴ Hardison was a clerk for Trans World Airlines (“TWA”), and worked in Kansas City under a collective bargaining agreement that recognized a seniority system.¹⁵⁵ As a Sabbatarian, Hardison’s religious beliefs prevented him from working on the Sabbath.¹⁵⁶ His initial work assignment accommodated those beliefs, but a voluntary job transfer resulted in a loss of seniority.¹⁵⁷ Despite attempts by his employer to find a solution, the reduced seniority, demands of his new assignment, and requirements of the collective bargaining agreement combined to make accommodation of his observation of the Sabbath impossible.¹⁵⁸ Hardison was fired for failing to report to work on Saturdays.¹⁵⁹ He sued, claiming employment discrimination under Title VII.¹⁶⁰

The Court found for the defendant employer.¹⁶¹ It disagreed with the plaintiff’s contention that Title VII took precedence over the collective bargaining agreement and seniority system.¹⁶² In rejecting Hardison’s argument that TWA could have simply imposed a schedule on the work group that accommodated his needs, the Court held that it would violate other employees’ contractual rights under the bargaining agreement.¹⁶³ National labor policy supported such agreements, and seniority was integral to their operation.¹⁶⁴ The Court evaluated Congressional intent in characterizing as “anomalous” the interpretation

152. 42 U.S.C.A. § 2000e-2000e-17 (West 2005).

153. *Id.* § 2000(e)(j).

154. 432 U.S. 63 (1977).

155. *Id.* at 66-67.

156. *Id.* at 67.

157. *Id.* at 68.

158. *Id.* at 68-69.

159. *Id.* at 69.

160. *Id.* (citing 42 U.S.C.A. § 2000e-2(a)(1) (West 2005)).

161. *Id.* at 85.

162. *Id.* at 79.

163. *Id.* at 80.

164. *Id.* at 79.

that an employer must deny the shift and job preference of some employees, as well as deprive them of their contractual rights, in order to accommodate or prefer the religious needs of others, and we conclude that Title VII does not require an employer to go that far.¹⁶⁵

In addition to its assessment of reasonable accommodation in a union setting, the *Hardison* Court is most often cited for its clarification of Title VII's "undue hardship" standard. "To require TWA to bear more than a de minimis cost in order to give Hardison Saturdays off is an undue hardship."¹⁶⁶ Though frequently criticized, especially in recent years,¹⁶⁷ the "more than de minimis" threshold has remained. The Court justified its position by noting that TWA would not incur extra costs just in this case, but that such a large company might have many employees seeking to obtain similar accommodations.¹⁶⁸

Finally, the Court stated that "we will not readily construe the statute to require an employer to discriminate against some employees in order to enable others to observe their Sabbath."¹⁶⁹ In other words, balancing an employee's right to free exercise in the workplace requires the employer to consider other employees' contractual rights, interests, and preferences.

If the bill protecting health care providers' conscience rights operated under similar requirements, their ability to object to providing services on religious, moral, or ethical grounds would be subject to the same balancing. This evaluation would not be limited to the employer's and co-workers' rights and interests, but must include the affected patient as well. Under *Hardison*, an employee may be required to work on the Sabbath, because it would be unreasonable or unfair to require his co-workers to take his shifts or for his employer to pay someone at a premium rate to replace him. The analogous exercise of religious beliefs in the patient care setting merits the same undue hardship analysis associated with accommodation, here, by the patient.

The Court found it an undue hardship for an employer to incur extra costs to accommodate an employee for her beliefs.¹⁷⁰ Similarly, it can be an undue hardship for a patient to locate and meet with an alternative care provider, especially when the patient is in pain, frightened, or has a condition otherwise requiring urgent treatment. It can be a hardship to seek

165. *Id.* at 81.

166. *Id.* at 84.

167. See, e.g., Thomas D. Brierton, "Reasonable Accommodation" Under Title VII: Is It Reasonable to the Religious Employee?, 42 CATH. LAW. 165, 188-90 (2002) (highlighting the proposed Workplace Religious Freedom Act, perennially offered since 1994, which would eliminate the "de minimis" interpretation of "undue hardship" in favor of "significant difficulty or expense").

168. *Trans World Airlines*, 432 U.S. at 85 n.15.

169. *Id.* at 85.

170. *Id.* at 84.

out a replacement pharmacy when a prescription is refused, especially in a rural area where the stores are many miles apart, and the patient has no transportation. Or where the cost of the prescription is considerably higher because the next town's pharmacy does not recognize the patient's insurance.

Another conceivable form of undue hardship is the transfer of a hospitalized patient as a result of a health care provider's refusal of desired care. This occurs when a patient is terminal or for another reason, wants life-sustaining treatment discontinued, according to directly expressed wishes or an advance directive. Physical transfer of that patient (not to mention the difficulty associated with locating a facility to which to transfer that patient) is a logistical challenge. It is also a disruption of the relationships a patient may have developed with the staff at the current facility, which is an important consideration in the end of life context.¹⁷¹

Another example of undue hardship, discussed earlier, is the risk that results when a patient is forced to undergo two surgeries when one would suffice. This conflict results when a patient desires a tubal ligation in association with a cesarean delivery, but is refused because of the hospital or individual provider's objection to sterilization.

Unlike the associated demands on employers and co-workers in the employment discrimination context, H.B. 5006 provides no evaluation for any hardship on a patient, and no balancing of patients' interests. By comparison, *Hardison* says that not only are co-workers' rights an issue, but even their *preferences*,¹⁷² in evaluating what is a reasonable accommodation by an employer.

That undue hardships for patients merit no consideration in this bill is even less appropriate when observed against the backdrop of the patient-provider relationship. While both parties possess rights of autonomy, it is not a relationship of peers. It is a fiduciary relationship, requiring the provider to make decisions in the patient's best interest.¹⁷³ The patient is dependent on the provider for his expertise and care.¹⁷⁴ Accordingly, forcing patients to make essentially all the accommodations to the providers' objections is unjust and inappropriate. This is especially true when patient accommodations are compared to what are considered reasonable accommodations in a general employment discrimination setting, as demonstrated by *Hardison*.

Accordingly, if a conscientious objector law is passed in the future without attention to balancing patient rights, a legal challenge should be

171. *In re Requena*, 517 A.2d 869, 870 (N.J. Super. Ct. App. Div. 1986) (suggesting a move to alternative facility would be a "hard psychological and emotional blow" for near-death patient).

172. *Trans World Airlines*, 432 U.S. at 81.

173. BERG ET AL., *supra* note 27, at 214.

174. *Id.*

advanced. This challenge should be based on the analogy to employer accommodation under Title VII, and the comparative injustice of the resulting undue hardships on patients.

B. Michigan's constitutional prohibition on enlargement of civil rights for religious belief

Another potential ground for legal challenge is the Michigan Constitution. "The civil and political rights, privileges and capacities of no person shall be diminished *or enlarged* on account of his religious belief."¹⁷⁵ Religious belief is explicitly protected as a civil right in the Michigan Constitution. But in an implicit nod to the First Amendment's Establishment Clause, the prohibition against enlarging those rights reflects the concern that religious belief should not be a basis for giving the believer greater rights than those enjoyed by other citizens.

Michigan case law on this section is limited, and its courts have never addressed the concept of enlargement of rights based on religious beliefs. In what would be a case of first impression, a future statute corresponding to H.B. 5006 could be challenged as impermissibly enlarging the civil and political rights of objecting health care providers on the basis of religious belief.

As an example, two different physicians might take the same action, deciding not to discuss an alternative procedure with a patient. Dr. A might omit the information because he is not adequately experienced in the procedure. Alternatively, though he is aware that fellow practitioners regard the procedure as standard treatment, he is skeptical of its benefits or does not see its value for his patient. By contrast, Dr. B simply objects to the procedure on religious grounds. Neither informs the patient of the alternative treatment option, which she would have chosen, and an injury results from the care she did receive. Can she advance a malpractice claim?

A malpractice suit on the basis of failure to disclose is difficult but not impossible to prove. A patient must assert that in failing to disclose, the physician breached a standard of care.¹⁷⁶ He must demonstrate that the omission caused an inadequately informed consent.¹⁷⁷ Finally, he must be

175. MICH. CONST. art. I, § 4 (emphasis added). This clause is found in nearly identical form in the 1850 Constitution, *available at* <http://www.legislature.mi.gov/documents/historical/miconstitution1850.htm> (undated). The clause is modeled on the original 1786 Virginia Statute for Religious Freedom: "[A]ll men shall be free to profess, and by argument to maintain, their opinions in matters of religion, and that the same shall in no wise diminish, enlarge or affect their civil capacities." VA. CODE ANN. § 57-1 (West 2005).

176. BERG ET AL., *supra* note 27, at 134-35.

177. *Id.* at 135.

able to prove that he suffered injury as a result of the faulty consent, or the care to which he consented.¹⁷⁸

As noted previously, Michigan further restricts this type of challenge by applying a physician-oriented disclosure standard.¹⁷⁹ That means that in the course of proving the standard malpractice elements, a plaintiff must provide expert witness testimony to the effect that a reasonable physician of similar training and experience would have disclosed the omitted information.¹⁸⁰

But despite these challenges, if the patient chooses to sue, and can prove all the elements, Dr. A could be found liable. Dr. B made exactly the same decision, with the same result. But because her decisions were motivated by a different reason — a religiously-founded objection — under the provisions of H.B. 5006, she would be immune from civil liability. This difference in potential civil liability reflects the bill's conferral of a prohibited enlargement of "civil and political rights, privileges and capacities . . . on account of [Dr. B's] religious belief."¹⁸¹

Accordingly, if Michigan passes this legislation in the future, a state constitutional challenge should follow. This challenge could be brought by an injured patient, who would otherwise be prohibited under the bill from bringing suit. An equal protection challenge might be appropriate, too, because the provision results in different treatment of similarly situated individuals.

C. First Amendment Analysis

A final area of potential challenge is the First Amendment to the Constitution: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."¹⁸² The Fourteenth Amendment's concept of liberty incorporates the First Amendment protections into the states.¹⁸³ Analysis of H.B. 5006 under both the Free Exercise Clause and the Establishment Clause is worthwhile.

1. Free Exercise

Free exercise decisions have long acknowledged that the freedom of religious belief is absolute, but that freedom of religious conduct by its nature cannot be.¹⁸⁴ Conduct of course is subject to regulation for the purpose of having an ordered society.¹⁸⁵ Accordingly, court decisions over

178. *Id.* at 134-35.

179. *See supra* notes 92-94 and accompanying text.

180. Bulen, *supra* note 92, at 334.

181. MICH. CONST. art 1, § 4.

182. U.S. Const., amend. I.

183. *Cantwell v. Connecticut*, 310 U.S. 296, 303 (1940).

184. *Id.* at 303-04.

185. *Id.* at 304.

the years have required the evaluation of religiously motivated conduct against laws intended to prohibit or restrict that conduct.

For instance, Mormons challenged the anti-polygamy laws that prevented their religious practice of having multiple wives simultaneously.¹⁸⁶ In *Reynolds v. United States*, the Court analyzed the history of religious freedom in the United States. The Court ultimately confirmed that the right to belief is absolute, but that government can make laws which interfere with the practice of a religion.¹⁸⁷ In denying a religious-based exemption to the criminal law against polygamy, the Court said, “[t]o permit this would be to make the professed doctrines of religious belief superior to the law of the land, and in effect to permit every citizen to become a law unto himself.”¹⁸⁸

In more recent years, the Court has confirmed that government interests may prevail over religious practice when a compelling interest is at stake and the means are essential to that interest. For instance, in *United States v. Lee*, an Amish employer objected to paying Social Security tax because of his sect’s insistence on providing for its own elderly.¹⁸⁹ However, the Court ruled that despite the sincerity of their belief that participation in the system violated their religion, the viability of the Social Security system itself required mandatory and continuous participation by all employers.¹⁹⁰ The Court also noted that in disallowing this exemption, it protected the employees of the Amish from the imposition of their employer’s beliefs.¹⁹¹

Health care providers are entitled to absolute freedom of religious belief. But when their conscience-driven refusal interferes with the right of a patient to access necessary health care, their belief becomes conduct subject to the rule of law. That intentional interference raises the image of the objector deciding he is a law unto himself, imposing his beliefs on patients. H.B. 5006’s provision of absolute immunity to any consequences resulting from a provider’s objection conflicts with First Amendment jurisprudence, which says religiously motivated conduct is still subject to the rule of law. A patient wishing to sue a provider for malpractice resulting from an objection could use Free Exercise jurisprudence, which allows regulation of religious conduct, to plead in avoidance of this grant of immunity.

A patient whose own Free Exercise rights are at issue in a medical care context has an even stronger basis for such a challenge, especially against refusal by a government health care provider or facility. A starting

186. *Reynolds v. United States*, 98 U.S. 145 (1878).

187. *Id.* at 166 (“Laws are made for the government of actions, and while they cannot interfere with mere religious belief and opinions, they may with practices.”).

188. *Id.* at 167.

189. 455 U.S. 252, 257 (1982).

190. *Id.* at 258.

191. *Id.* at 261.

point would be the cases in which adult patients asserted their rights to refuse blood transfusions,¹⁹² cesarean sections,¹⁹³ or other medical care¹⁹⁴ on the basis of their religious beliefs.

Other, more subtle collisions between the patient's and provider's Free Exercise rights may occur. For instance, the right to use birth control does not appear on the surface to be religiously motivated; that basis is not as evident as a refusal to prescribe or provide it. However, the tenets of an individual's faith may support its use, especially as part of a general belief system that includes responsibility to one's existing children. Accordingly, the Free Exercise rights of a "conscientious objector" who refuses to dispense a contraceptive device, and those of the patient who requires it, are on a direct collision course. H.B. 5006 should be modified to prevent that collision. Failing a reasonable modification, the patient's right to free exercise should be asserted under a First Amendment challenge as representing at least as strong an interest as the provider's.

2. Establishment Clause

As noted earlier, conscience clause statutes have been upheld against Establishment Clause challenges in the past.¹⁹⁵ A review of the primary case cited for that premise indicates that the challenged statute was very limited, and correspondingly the court's reasoning was so narrow, that this case alone would not impede a challenge to future conscience legislation. However, analysis of the Supreme Court's direction on Establishment Clause tests indicates that predicting a challenge's chance of success would be difficult.

a. *The Chrisman precedent is not a bar to a successful Establishment Clause challenge*

In *Chrisman v. Sisters of St. Joseph of Peace*, a woman sued a private hospital for its refusal to perform a tubal ligation after the birth of her second child.¹⁹⁶ In her suit for a writ of mandamus as well as damages, the woman asserted that the hospital operated under color of state law because (among other reasons) it received federal funds.¹⁹⁷ However, in an amendment to the act that provided the funds at issue,¹⁹⁸ Congress expressly stated that receipt of those funds was not to be "used as a basis

192. *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (Ill. App. Ct. 1972); *In re Osborne*, 294 A.2d 372 (D.C. 1972).

193. *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994).

194. *Lewis v. Califano*, 616 F.2d 73 (3d Cir. 1980).

195. *See Ikemoto*, *supra* note 8, at 1116.

196. 506 F.2d 308, 309 (9th Cir. 1974).

197. *Id.* at 309-10.

198. Pub. L. 93-45, Title IV, § 401(b), 87 Stat. 95.

for compelling a hospital to perform [sterilizations] against the dictates of its religious or moral beliefs.”¹⁹⁹

The *Chrisman* court evaluated the plaintiff’s Establishment Clause challenge to section 401(b).²⁰⁰ It held that the provision preserved the government’s neutrality, but was not an expression of preference toward one religion over another.²⁰¹

The *Chrisman* holding would not prevent a successful challenge to a broad provider-protection measure such as H.B. 5006, for two reasons. First, the statute at issue in *Chrisman* was only a jurisdictional measure that prevented injunctive relief. Second, the statute’s scope was limited to objections to abortion and sterilization.

As noted above, section 401(b) acted as a jurisdictional check on courts and agencies, preventing them from using receipt of federal funds as a basis to compel participation in the objected-to procedures.²⁰² Under this section, plaintiffs lost access to this form of injunctive relief, but not to other remedies. All other causes of action were left intact, including malpractice actions, if the objection resulted in a breach of the standard of care and injury followed.

By contrast, H.B. 5006 goes far beyond prevention of compulsion. It immunizes a provider from *any* consequences arising out of a refusal based on religious belief or moral conviction.²⁰³

Section 401(b) was also much more limited in scope. It addressed only abortion and sterilization,²⁰⁴ admittedly, areas which have long endured controversy. H.B. 5006 opens up the entire spectrum of health care to potential immunized refusal,²⁰⁵ not just abortion and sterilization (to which Michigan providers and facilities have an existing statutory right to object).²⁰⁶ Objection to prescribing or dispensing virtually any medication would be covered, regardless of the nature or purpose of the medication. All kinds of medical care, including research, are made eligible to objection

199. *Chrisman*, 506 F.2d at 311.

200. *Id.*

201. *Id.*

202. *Id.*

203. See text accompanying notes 54-57.

204. *Chrisman*, 506 F.2d at 311.

205. H.R. 5006, 92nd Leg., Reg. Sess. § 3(c) (Mich. 2004). The generic description of covered health care is nearly limitless: “‘Health care service’ means the provision or withdrawal of, or research or experimentation involving, a medical diagnosis, treatment, procedure, diagnostic test, device, medication, drug, or other substance intended to affect the physical or mental condition of an individual.” *Id.*

206. MICH. COMP. LAWS ANN. §§ 333.20181-.20183 (West 2005).

by H.B. 5006.²⁰⁷ Even providers who disregard do-not-resuscitate orders or other advance directives would be immunized by this bill.²⁰⁸

Section 401(b) was a narrow restriction on jurisdiction that protected the rights of facilities and providers not to be compelled to participate in abortion or sterilization related procedures. H.B. 5006 is a conferral of near-total immunity on providers with virtually no limit on the nature of procedure, medication, or other type of care to which a provider can object.

The court in *Chrisman* held that section 401(b) only preserved government neutrality, and did not affirmatively express a preference toward religion.²⁰⁹ Therefore, it was not a violation of the Establishment Clause.²¹⁰ H.B. 5006 goes beyond section 401(b)'s narrow operation, and does not share its neutral stance. The bill directly confers rights and immunities on providers based on their religious practice. This is an impermissible clear preference for the exercise of religion. Accordingly, the decision in *Chrisman* will not prevent an Establishment Clause challenge to a future version of H.B. 5006, despite the common element of "conscience."

b. The success of an Establishment Clause challenge is as difficult to predict as what test would be used by the Court

Justice Souter recently provided a helpful "touchstone" on the subject of Establishment Clause analysis: "the First Amendment mandates governmental neutrality between religion and religion, and between religion and nonreligion."²¹¹ To that end, governmental neutrality has been evaluated under the *Lemon* test.²¹² The test was developed to investigate whether the three main "evils" the clause was meant to prevent were present.²¹³ Those evils were "sponsorship, financial support, and active involvement of the sovereign in religious activity."²¹⁴ The questions asked to determine whether the First Amendment has been violated are (1) does the law (or action) have a legitimate secular purpose; (2) does its principal effect inhibit or promote religion; and (3) does it result in excessive government entanglement with religion?²¹⁵

207. H.R. 5006, 92nd Leg., Reg. Sess. § 3(c) (Mich. 2004).

208. *Id.* Note that "Health Care Service" eligible for refusal by a provider includes "withdrawal" of care. *Id.*

209. *Chrisman*, 506 F.2d at 311.

210. *Id.*

211. *McCreary County v. ACLU*, 125 S. Ct. 2722, 2733 (2005) (quoting *Epperson v. Arkansas*, 393 U.S. 97, 104 (1968)) (internal quotations omitted).

212. *Lemon v. Kurtzman*, 403 U.S. 602 (1971).

213. *Id.* at 612.

214. *Id.* (quoting *Walz v. Tax Comm'n*, 397 U.S. 664, 668 (1970)).

215. *Id.* at 612-13.

The *Lemon* test was applied in a pertinent Establishment Clause case, *Estate of Thornton v. Caldor, Inc.*²¹⁶ *Thornton* invalidated on Establishment Clause grounds a state statute that gave employees an absolute right not to work on their designated Sabbath.²¹⁷

Thornton, a retail store manager, was demoted to clerk after he rebuffed attempts by his employer to accommodate his Sabbath preference within his managerial role.²¹⁸ The employer, Caldor, was ordered by a state board to reinstate *Thornton*.²¹⁹ Caldor sued in state court, and the Connecticut Supreme Court found that the statute had no “clear secular purpose.”²²⁰ The court found that the statute’s primary effect advanced religion, because it “confer[red] its ‘benefit’ on an explicitly religious basis.”²²¹

The United States Supreme Court agreed.²²² It found that the statute elevated employees’ Sabbath-related interests over all other business interests, as well as the interests of co-workers.²²³ The Court found this “unyielding” prioritization unconstitutional, quoting Judge Learned Hand: “The First Amendment . . . gives no one the right to insist that in pursuit of their own interests others must conform their conduct to his own religious necessities.”²²⁴

Under *Thornton*, H.B. 5006 would similarly fail. Its benefits are conferred on a religious basis. Its operation allows health care providers to insist that their employers, and more importantly, their patients, conform their conduct to the providers’ religious interests. *Thornton* provides support for a successful challenge to such broad conscientious objection provisions.

In *Thornton*, as in many First Amendment decisions, Justice O’Connor concurred. She found endorsement,²²⁵ a concept she first introduced the year before in *Lynch v. Donnelly*.²²⁶ In *Lynch*, Justice O’Connor collapsed the *Lemon* test into two prongs: excessive

216. 472 U.S. 703 (1985).

217. *Id.*

218. *Id.* at 706.

219. *Id.* at 707.

220. *Id.*

221. *Id.* at 707-08 (internal citations omitted).

222. *Id.* at 708.

223. *Id.* at 709.

224. *Id.* at 710 (quoting *Otten v. Baltimore & Ohio R. Co.*, 205 F.2d 58, 61 (2d Cir. 1953)).

225. *Id.* at 711 (O’Connor, J., concurring).

226. 465 U.S. 668, 687-88 (1984) (O’Connor, J., concurring). *See, e.g.*, *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1 (2004) (O’Connor, J., concurring). Justice O’Connor asserts that the Establishment Clause stands for the premise “that government must not make a person’s religious beliefs relevant to his or her standing in the political community by conveying a message that religion or a particular religious belief is favored or preferred.” *Id.* at 34 (internal citations and punctuation omitted).

entanglement, and endorsement or disapproval.²²⁷ Characterizing the second prong as a “more direct infringement,” she stated, “[e]ndorsement sends a message to nonadherents that they are outsiders, not full members of the political community, and an accompanying message to adherents that they are insiders, favored members of the political community.”²²⁸

Endorsement or approval can be found in the purpose of the government’s action or in its effect, and either finding indicates an Establishment Clause violation.²²⁹ Justice O’Connor acknowledged that the test rests not just on advancement or inhibition of religion that may occur as a result of government action. “What is crucial is that a government practice not have the effect of communicating a *message* of government endorsement or disapproval of religion.”²³⁰

Assessed against the concept of endorsement, H.B. 5006 is invalid. This bill provides immunity to individuals who object to providing services because of their religious, moral, and ethical beliefs.²³¹ The companion package of bills extends the context for objection to health care facilities, insurers, and managed care plans.²³² The government’s message is that health care can be delivered through a filter of faith and religious belief. Because the bills make no provisions to meet patients’ needs while supporting these exercises of conscience, the religious objectors have the capacity to determine the limits of available care.

The message to non-adherents is clear: their health care needs are not as important as the religious rights of the people charged with taking care of them. Health care decisions made outside the beliefs and practices of the objectors may be disregarded with impunity. Such an interference with a patient’s access to health care is very much a message of outsider status.

But despite Justice O’Connor’s persistent use of the endorsement test, the entire Court has not embraced it. In addition, the *Lemon* test on which the endorsement test is based has its outspoken detractors. Justice Scalia compared it to a “ghoul in a late-night horror movie,” in that it has been frequently criticized, but never truly put to rest.²³³ Dissenting in a school prayer decision that relied not on *Lemon* test analysis, but on coercion grounds, Justice Scalia expressed his preference for a more historically-based inquiry, one respecting tradition.²³⁴ On the test of coercion itself, he indicated that he would only find an Establishment Clause violation in

227. *Lynch*, 465 U.S. at 687-88.

228. *Id.* at 688.

229. *Id.* at 690.

230. *Id.* at 692 (emphasis added).

231. *See supra* text accompanying notes 54-57.

232. *See supra* text accompanying notes 65-67.

233. *Lamb’s Chapel v. Center Moriches Union Free Sch. Dist.*, 508 U.S. 384, 398 (1993) (Scalia, J., concurring).

234. *Lee v. Weisman*, 505 U.S. 577, 631-32 (1992) (Scalia, J., dissenting).

cases of actual coercion, which he characterized as “acts backed by threat of penalty.”²³⁵

Coercion has been applied by other justices as well, though with a less rigorous interpretation. In *Lee v. Weisman*, Justice Kennedy found coercion present by way of “public pressure”²³⁶ sufficient to invalidate the practice of prayers at graduation.²³⁷ The context of a school setting, and the obligatory (though not mandatory) nature of the graduation ceremony, rendered the practice a “state-sanctioned religious exercise.”²³⁸

In sum, in assessing claims of Establishment Clause violations, the Court may apply the *Lemon* test, evaluate various measures of coercion, discuss history and tradition, or look for endorsement of religion. More recent decisions further demonstrate that the Supreme Court has no single agreed-upon Establishment Clause test, making predictions of the success of such a challenge difficult.

For instance, in *Cutter v. Wilkinson*, Justice Ginsburg held that protection of prisoners’ free exercise rights under the Religious Land Use and Institutionalized Persons Act (RLUIPA) was not an Establishment Clause violation, but a legitimate exercise of removing government imposed burdens.²³⁹ The majority opinion in *Cutter* followed no express test, but reviewed the legislative history of the Act, and evaluated RLUIPA’s provisions against a variety of precedents.²⁴⁰ Indeed, Justice Thomas noted in his concurrence that “[t]he Court properly declines to assess RLUIPA under the discredited test of *Lemon v. Kurtzman*.”²⁴¹

In *Van Orden v. Perry*, Chief Justice Rehnquist dismissed the *Lemon* test as “not useful”²⁴² for determining the constitutionality of a display of the Ten Commandments on the grounds of the Texas state capitol. Instead, the Chief Justice reviewed the role of religion in the nation’s history,²⁴³ as well as the precedents that guided the permission or prohibition of such displays.²⁴⁴ Yet in *McCreary County v. ACLU*, decided on the same day, Justice Souter started²⁴⁵ and ended²⁴⁶ the majority’s analysis of two

235. *Id.* at 641-43.

236. *Id.* at 592-93 (majority opinion).

237. *Id.* at 599.

238. *Id.* at 597.

239. 125 S. Ct. 2113, 2121 (2005).

240. *Bd. of Educ. v. Grumet*, 512 U.S. 687 (1994); *Corp. of Presiding Bishop v. Amos*, 483 U.S. 327 (1987); *Employment Div. v. Smith*, 494 U.S. 872 (1990); *Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703 (1985); *inter alia*.

241. *Cutter*, 125 S. Ct. at 2125 n.1 (Thomas, J., concurring).

242. 125 S. Ct. 2854, 2861 (2005).

243. *Id.* at 2861-62.

244. *Id.* at 2862-64.

245. 125 S. Ct. 2722, 2732-33 (2005).

246. *Id.* at 2745 (affirming the lower court’s finding of a “predominantly religious purpose”).

courthouse postings of the Decalogue with the “secular purpose” prong of the *Lemon* test. Justice Souter also acknowledged Justice O’Connor’s endorsement and neutrality perspective in his analysis.²⁴⁷

In the face of the lack of a defining measure of constitutionality, as well as the changes on the bench in the 2005-06 Court season, the success of an Establishment Clause challenge to conscience protection measures is difficult to predict.

Immunities granted under H.B. 5006 would probably not be an Establishment Clause violation under Justice Scalia’s “threat backed” coercion test, nor even Justice Kennedy’s kinder, gentler interpretation of coercion. However, the bill would likely be found to be a form of endorsement: religious belief and related conduct are given higher priority than any other interest in the delivery of health care. But Justice O’Connor’s departure from the Court, and the fact that endorsement has not generally been embraced by a majority, but most frequently advanced in her concurrences,²⁴⁸ indicate that the test cannot be relied upon for a successful future challenge.

Instead, *Cutter* probably provides the best basis for a successful challenge. *Cutter*, with its analysis by application of precedents without the use of an express test, is useful as its own precedent. It found RLUIPA constitutional as a legitimate removal of government imposed burdens on institutionalized persons’ free exercise rights. No analogous burdens exist on health care providers’ rights that require the promulgation of such broad protective measures. But more generally, a *Cutter*-like review of precedential cases, especially *Thornton*, might result in finding a statute similar to H.B. 5006 a violation of the Establishment Clause. But would the new Roberts Court, projected to be the most conservative in decades, rule against the interests of religious health care providers? As of this writing, it is simply too soon to tell.

CONCLUSION

The right of free exercise of religion, and even more generally, the right of conscience, is well established in American society. Most people support the right of a health care provider to refuse to participate in care to which they object because of religious, ethical or moral concerns. It seems a reasonable position to take.

As demonstrated above, however, the assertion of conscience rights does not occur in a vacuum. To be fair to the other half of the patient-provider relationship, future legislation must do what H.B. 5006 failed to

247. *Id.* at 2733.

248. *See, e.g.*, *Lynch v. Donnelly*, 465 U.S. 668, 687 (1984) (O’Connor, J., concurring); *County of Allegheny v. ACLU*, 492 U.S. 573, 623 (1989) (O’Connor, J., concurring); *Elk Grove Unified Sch. Dist. v. Newdow*, 124 S. Ct. 2301, 2321 (2004) (O’Connor, J., concurring); *McCreary County*, 125 S. Ct. at 2746 (2005) (O’Connor, J., concurring).

do: ensure that patients' needs are met at the same time that provider conscience rights are protected.

Accordingly, future bills must include greater patient protections. These may include treatment disclosure requirements, notice provisions, and facilities' duty to continue care. Patients must have remedies for malpractice as a result of treatment refusals, so civil immunity should not be a part of future bills. Finally, the Department of Community Health must monitor health care in Michigan to ensure that specific areas of health care are not negatively impacted, and that measures are taken to address any regional or other losses.

It is of course preferable that laws exemplify fairness at the same time that they express public policy. When fairness is left out of the final product, the law must be challenged. If future conscience legislation does not contain essential patient protections, those measures must be challenged legally, in the interests of patients' rights of informed consent and unhindered access to health care.

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