THE CONSCIENTIOUS WAR ON WOMEN:

COMPLICITY-BASED CONSCIENCE CLAIMS AND CONSCIENTIOUS OBJECTION IN REPRODUCTIVE HEALTH CARE

By

CASEY MURRAY

_____

A Thesis Submitted to The Honors College

In Partial Fulfillment of the Bachelors degree
With Honors in

Philosophy, Politics, Economics, and Law

THE UNIVERSITY OF ARIZONA

APRIL 2018

Approved by:

_____
Professor Connie Rosati
Philosophy Department

Abstract

Citing their own personal moral beliefs, some health care providers refuse to provide certain reproductive services, like prescribing contraception or performing abortions. This refusal has contributed to a reproductive health care crisis in the United States that disproportionately affects rural and low-income women. This thesis evaluates whether conscientious objection and complicity-based conscience claims in reproductive health care should be protected under First Amendment freedom of religious expression. In the paper, I differentiate between conscientious objection and complicity-based conscience claims in the context of reproductive health care. I evaluate the current state of reproductive care in the U.S., along with U.S. Federal law and case law, to argue that complicity-based conscience claims in reproductive health care should not be protected, however conscientious objections may be.

The concept of a complicity-based conscience claim in reproductive health care entered popular national discourse several years ago with the passage of the Affordable Care Act (2010)[1] and the subsequent litigation of *Hobby Lobby v. Burwell* (2013). The resulting Supreme Court decision in *Hobby Lobby* allowed the closely-held company to refuse to provide health care coverage for contraception, a blow to the ACA's contraceptive coverage mandate. That a private company could refuse certain health care coverage to its employees because of the owner's religious beliefs was a victory for staunch protectors of religious freedom and deeply upsetting to women's rights activists and proponents of the ACA, who believed that everyone should have access to the health care they need. A conversation about who was imposing on whom ensued: were the female employees imposing on their employer by forcing them to cost-share birth control, or was the employer imposing on their employees by denying them essential health care coverage? What made *Hobby Lobby v. Burwell* unique was that the owners of Hobby Lobby, Inc. did not make a traditional conscientious objection claim; they weren't refusing to act. Rather, they were refusing to be complicit in something they found religiously offensive. The claim in *Hobby Lobby* was a complicity-based conscience claim, which differs from conscientious objection because it does not involve a direct act. The distinction between conscientious objections and complicity-based conscience claims has led to numerous other cases and a much larger conversation about religious freedom protections, reproductive rights, and access to health care in America.

In this thesis, I argue that complicity-based conscience claims should not receive the same legal protection as conscientious objection claims and that both types of health care refusal are discriminatory against women. Doctors can be regulated by the State and compelled to provide certain care and to refer patients elsewhere for care they will not provide. Evaluating the

[1] Patient Protection and Affordable Care Act (2010) Pub. L. No. 111-148. 42 USC 18001

state of reproductive care and health care rights in America, I show why health care refusal is dangerous to women and should not be unconditionally protected. In evaluating U.S. Federal law and various court decisions, I show why regulation of conscientious refusal claims would not be unprecedented nor facially unconstitutional.

I argue that, for four main reasons, complicity-based conscious claims should not be treated as protected religious expression. First, the disparate impact these claims have on women is discriminatory and harmful to women. Second, the Court has not found that religious freedom of expression is protected unconditionally under the Constitution. Third, U.S. Federal and case law favor access to health care. While a positive right to government provided or subsidized health care may not exist, Americans generally view access to health care as a right. Finally, physicians do not have full First Amendment rights when acting in their professional capacity. While there remains much debate around this issue, the Courts have tended to rule that the speech of health care professionals can be regulated by the state, so long as the regulations are content and view point neutral. In laying out these four points, along with an exposition of the state of access to reproductive care in the U.S., I hope to show that the danger of health care refusal to women is extreme, and legal protections for complicity-based conscience claims improperly privilege avoiding elusive complicity over protecting the actual health and lives of women.

Introduction to Complicity-Based Conscience Claims in Reproductive Health Care

After the passage of *Roe v Wade* in 1973, which overturned bans on abortion in the first two trimesters, the United States Congress passed the Church Amendment, exempting medical professionals from performing abortions and sterilizations if the procedures violated their

religious beliefs.[2] In the following years, subsequent legislation on the state level permitted medical providers and pharmacists to conscientiously object to providing or prescribing birth control, providing emergency contraception, performing sterilization, and counseling patients on abortion.[3] Some states also began to widen the criteria for who may object from doctors and pharmacists to include nurses, physicians assistants, health care administrators, and more.[4] The passage of the Federal Religious Freedom Restoration Act in 1993 required that strict scrutiny be applied to cases of claims of religious freedom.[5] While the Act was ultimately ruled unconstitutional in part as applied to the states due to the infringement on states' rights, many states have since enacted their own RFRAs that include similar, if not identical, language. These laws have been used to support the refusal to provide health care.

In January, 2018, the Department of Health and Human Services announced a new department, the Conscience and Religious Freedom division of the Office of Civil Rights, which will work to ensure that no health care provider is "compelled to participate in procedures such as abortion, sterilization and assisted suicide when it would violate their religious beliefs or moral convictions."[6] With 25 existing federal laws protecting conscientious health care refusal, it's unclear what the division will do outside of promoting these protections.

It's important to clearly distinguish between the two types of claims made by health care professionals denying care on religious or moral grounds. The first category is conscientious objection. Like pacifists who refuse to fight in war, or the people of color who purposely violated segregation laws during the Civil Rights movement, some doctors refuse to provide certain care

[2] Kenneth A Rasinski, John D Yoon, Youssef G Kalad, and Farr A Curlin. "Obstetrician-Gynaecologists' Opinions about Conscientious Refusal of a Request for Abortion: Results from a National Vignette Experiment." *Journal of Medical Ethics* 37, no. 12 (Dec 1, 2011): p 711

[3] Nejaime, Douglas and Reva B. Siegel. "Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics." *Yale Law Journal* 124, no. 7 (May 1, 2015): p 2538-9

[4] Ibid p 2541

[5] P.L 103-141, 107 Stat. 1488 (1993)

[6] Protecting Statutory Conscience Rights in health care; Delegations of Authority. 45 C.F.R. § 88.10 2018.

they find morally offensive. Conscientious objectors refuse to act because they believe their performance of the act at issue violates their religious or moral beliefs.[7] A doctor refusing to perform a surgical abortion because abortion is counter to their religious beliefs is a conscientious objection.

Complicity-based conscience claims don't involve the direct action that conscientious objection does. In complicity-based conscience claims, the refuser objects to do something they believe facilitates an action that violates their beliefs.[8] It is not their action they are concerned about, but the action of a third party that they do not want to facilitate. An example of a complicity-based conscience claim in health care would be a doctor who refuses to refer a patient to an abortion provider because he personally opposes abortion, or a doctor who will not provide fertility services to a gay couple because he opposes same-sex relationships. By facilitating the performance of an action, the 'middle man', if you will, believes him or herself to be complicit in the use of product or reception of service they object to.

While a case involving a doctor's conscientious objection or complicity-based conscience claim has yet to reach the Supreme Court, several complicity-based conscience claim cases related to the provision of women's reproductive health have. In *Burwell v. Hobby Lobby*, decided in 2013, the Court held that the owners of Hobby Lobby Stores, Inc. need not provide employee health care plans that cover forms of birth control they believe violate their religious beliefs. The Green family, owners of Hobby Lobby Stores, Inc. sued the Secretary of Health and Human Services, Kathleen Sebelius, claiming that the Patient Protection and Affordable Care Act's (2010) contraceptive coverage mandate violated their right to religious freedom by

[7] OHCHR | International standards - I3k. http://www.ohchr.org/EN/Issues/FreedomReligion/Pages/IstandardsI3k.aspx. Sec K, para 11

[8] Nejaime, Douglas and Reva B. Siegel. "Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics." *Yale Law Journal* 124, no. 7 (May 1, 2015): p 2519

requiring the company to provide health care coverage for forms of birth control they object to on religious grounds.[9] The ACA mandated that companies that employ more than 50 people must provide insurance and the insurance must include preventive care free of charge to the employee.[10] In 2011, contraceptive coverage was officially added to the list of included women's preventive services health care plans must include without cost sharing.[11] The Court ruled that, while the State's interest in providing contraception may be compelling, it did not show "that it lacks other means of achieving its desired goal without imposing a substantial burden on the exercise of religion by the objecting parties."[12] The *Hobby Lobby* decision applied to "closely held"[13] companies, defined by the IRS as companies where fewer than five people own more than half the company.[14] In October 2017, the Trump administration issued an executive order rolling back the contraceptive coverage mandate, allowing any employer with religious or moral objections to be exempt from the law, not just those companies who are deemed closely held.[15] Several states sued, and in mid-December 2017, federal judges in Pennsylvania and California issued injunctions preventing the administration from enacting the changes without the passage of a law by Congress.[16] As of April 2018, the injunctions remain.

Hobby Lobby v. Burwell (2013) introduced complicity-based conscience claims into the zeitgeist. The owner of Hobby Lobby Inc.'s claim was that providing access to contraception by including coverage for it in health care plans with employer cost sharing violated their religious

[9] *Burwell v. Hobby Lobby*. 573 US 46-47 (2014)
[10] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148. 42 USC 18001. Sec 2713, Sec 1302
[11] Coverage of Certain Preventive Services Under the Affordable Care Act. 45 CFR Parts 147 and 156. Department of Health and Human Services. 2013.
[12] *Burwell v. Hobby Lobby*. 573 US 13 (2014)
[13] ibid 49
[14] Ibid 3
[15] Pear, Robert, Rebecca R. Ruiz, and Laurie Goodstein. "Trump Administration Rolls Back Birth Control Mandate." The New York Times. October 06, 2017.
[16] Colliver, Victoria. "Judge blocks Trump rollback of Obamacare contraception mandate." POLITICO. December 15, 2017. https://www.politico.com/story/2017/12/15/judge-trump-obamacare-contraception-mandate-298605.

freedom. This is despite the fact that the owners would never actually know if any of their employees were using their health care coverage to obtain contraception, let alone have any more intimate involvement in the procurement or consumption of the contraceptives. It's worth noting that contraceptives provide many benefits for women beyond preventing pregnancy. Patients who are not sexually active may take birth control to relieve symptoms of PCOS, clear acne, or mitigate cramping during their cycles. Complicity-based claims against contraceptives deny women essential health care under the guise of religious conviction.

In 2015, the Supreme Court declined to hear *Stormans, Inc. v. Wiesman*, a case in which a pharmacy chain's owners refused to stock various forms of emergency contraception due to their belief that the pills are an abortifacient. The Supreme Court's denial of a writ of certiorari let stand the 9th Circuit Court of Appeals' ruling that the Washington regulation requiring the "timely delivery of all prescription medications by licensed pharmacies" was neutral and did not infringe on an individual fundamental right, so the pharmacies had to dispense emergency contraception.[17] The regulation at issue did not target only some pharmacies or medications and is therefore subject to rational basis review rather than the more stringent strict scrutiny test. Rational basis review requires the state have a legitimate interest in whatever it seeks to regulate, and that its methods are rationally related to that interest. The Court held that Washington has a legitimate interest in ensuring that its citizens have access to medication, and imposing a regulation on business to ensure this is rationally related to that end.

Access to Reproductive Care in the United States

The Supreme Court has yet to hear a case in which a woman was refused reproductive care by a doctor, but it seems as if it's only a matter of time. As abortion care, in particular, becomes less accessible, the cost of being denied care increases. Seven states in the US have

[17] *Stormans, Inc. v. Wiesman.* 9th Cir. (2015)

only one abortion clinic; 90% of counties in the US have none.[18] Partially to blame for this may be that, prior to 1996, few OB-GYN residency programs included abortion training. In 1996, the American Council on Graduate Medical Education required that all programs offer this training in order to be accredited, however, OB-GYN residents are not required to participate in the training program. Still, a survey of OB-GYN's board certified after 1996 found that only 22% provide abortion care to their patients.[19] Of all OB-GYNs (certified before and after 1996), only 14% perform abortions, despite 97% having had a patient request one.[20]

In 45 states, it's legal for at least some health care providers to refuse to perform abortions or provide information or counsel regarding abortion services. In 12 states, health care providers may refuse to prescribe or dispense contraception.[21] As of January 2018, it is federal policy that health care providers may refuse to provide care or give information on abortion and sterilization.[22] Many women, particularly in rural America, do not have reasonable alternatives when reproductive care is denied. 1 in 5 American women live more than 30 miles from the nearest abortion provider. In Wyoming, North Dakota, and South Dakota, half of all women live more than 90 miles from an abortion clinic. Due to the scarcity of clinics and varying regulations across states, women may be forced to cross state lines to procure care. The cost of travelling to a provider, combined with the cumbersome regulations and requirements in some States, such as a waiting period as long as 72 hours, may simply be too much. 35 states require a woman receive

[18] Guttmacher Institute. "State Facts About Abortion: Arizona." Guttmacher Institute. January 05, 2018. https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-arizona#7.
[19] Stulberg, D. B., Dude, A. M., Dahlquist, I., & Curlin, F. A. (2011). Abortion Provision Among Practicing Obstetrician–Gynecologists. *Obstetrics and Gynecology*, *118*(3), 609–614. http://doi.org/10.1097/AOG.0b013e31822ad973
[20] Kenneth A Rasinski, John D Yoon, Youssef G Kalad, and Farr A Curlin. "Obstetrician-Gynaecologists' Opinions about Conscientious Refusal of a Request for Abortion: Results from a National Vignette Experiment." *Journal of Medical Ethics* 37, no. 12 (Dec 1, 2011): p 711
[21] Guttmacher Institute. "Refusing to Provide Health Services." Guttmacher Institute. January 1, 2018. https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services
[22] ibid

counseling before procuring an abortion; 27 of those require a waiting period (between 24-72 hours) between counseling and the abortion procedure.[23]

Anti-abortion legislation has led to a decrease in abortion providers in the past decade. State laws requiring abortion clinics to have hospital admitting privileges, hallways of a certain width, and unnecessary licensing requirements have forced closures nationwide. Currently, 23 states have requirements for abortion clinics that do not pertain to the protection of women's health or patient safety.[24] 87% of counties in the U.S. do not have an abortion provider and 37% of women in the US live in one of these counties. In 2014, there were 1,617 abortion providers in the United States and 788 abortion clinics.[25] As of May 2016, the employment estimate for obstetricians-gynecologists was nearly 20,000, meaning only about 8% of ob-gyns were performing abortion services around that time. This is consistent with the study mentioned earlier that found in 2011, only 14% of ob-gyns were offering abortions, despite nearly all having had a patient request one. According to the 2010 census, there are more than 62 million women of reproductive age in the U.S. Nearly 25% of women in the U.S. will have an abortion in their lifetime. The CDC reported that in 2014, more than 650,000 abortions were performed in the U.S. Given the number of abortion providers at that time, this means each provider performed an average of over 400 abortions that year.[26] The refusal of some OBGYNs and hospitals to provide abortion care, along with intense abortion restrictions in some states, is increasing pressure on doctors who do perform abortions and making it harder for women seeking an abortion to get one.

---

[23] Guttmacher Institute. "Counseling and Waiting Periods for Abortion." April 1, 2018. https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion
[24] Guttmacher Institute. "Targeted Regulation of Abortion Providers" April 1, 2018 https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers
[25] Guttmacher Institute. "Data Center." https://data.guttmacher.org/states/table?state=US&topics=73+72+71+57&dataset=data
[26] Jatlaoui TC, Shah J, Mandel MG, et al. Abortion Surveillance — United States, 2014. MMWR Surveill Summ 2017;66(No. SS-24):1–48. DOI: http://dx.doi.org/10.15585/mmwr.ss6624a1.

A large contributing factor to the difficulty of procuring abortion care in the US is the prevalence of Catholic hospitals. Catholic hospitals follow directives that prohibit their staff from providing abortion care or information about abortion, regardless of the risk of continuing a pregnancy to the mother. Catholic hospitals also may not perform sterilizations, in vitro fertilization, participate in "contracts or arrangements for surrogate" pregnancies, provide emergency contraception, or "promote or condone contraceptive practice."[27]

1 out of every 6 patients in the US receives care from a Catholic hospital, and religious hospitals account for one-fifth of the US health care delivery system.[28] In Alaska, Wisconsin, Iowa, Washington, and South Dakota, more than 40% of hospital beds are Catholic-owned or affiliated (49% in Alaska)[29] The recession and uncertainty around health care policy has caused a dramatic increase in mergers between secular and Catholic hospitals. Between 2001 and 2016, the number of for-profit Catholic owned hospital beds in the US increased 1007%; the number of non-profit Catholic owned beds increased 52%.[30] Worldwide, the Roman Catholic Church is the largest non-government provider of health care. The Church has been deeply involved with health care around the world since the inception of Catholicism, in adherence to the explicit teaching of Jesus to "heal the sick."[31]

The difficulty of procuring an abortion in some areas of the US may be responsible for the resurgence of a dangerous epidemic. Analysis of Google searches by state indicate a potential

---

[27] United States Conference of Catholic Bishops. "Ethical and Religious Directives for Catholic Health Services." USCCB. November 17, 2009. http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf

[28] Nejaime, Douglas and Reva B. Siegel. "Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics." *Yale Law Journal* 124, no. 7 (May 1, 2015): 2557

[29] Uttley, Lois, MPP, Christine Khaikin, JD, and Patricia HasBrouck, MBA. *Growth of Catholic Hospitals and Health Systems: 2016 Updated of the Miscarriage of Medicine Report*. Report. MergerWatch. New York, NY: MergerWatch, 2016.

[30] Ibid p 4

[31] Agnew, John. "Deus Vult: The Geopolitics of the Catholic Church." *Geopolitics* 15, no. 1 (2010): 39-61. doi:10.1080/14650040903420388. https://doi-org.ezproxy2.library.arizona.edu/10.1080/14650040903420388.

self-induced abortion crisis: searches are generally higher in states with more restrictions and have spiked as tougher abortion laws have passed.[32] No studies have been done to connect this to an actual increase in self-induced abortions, and there is very little data on self-induced abortion in the US generally, but Google Trends data has a history of reflecting actual behavior. For example, researchers have found that tracking searches for "the flu" and other flu-related keywords help predict and identify flu epidemics.[33]

Stories of women facing adverse health effects due to refusal of care are beginning to receive more mainstream attention. Women denied abortion care or emergency contraception, often at Catholic hospitals, may suffer extreme physical and emotional pain. In 2010, Tamesha Means was denied care at a Catholic hospital (the only hospital in her home county) twice over the course of two days. Ms. Means was 18 weeks pregnant and having contractions. When she returned for a third time, she was bleeding and had a fever, having developed an infection overnight. The hospital did not inform Ms. Means that continuing the pregnancy risked her health and life or that terminating the pregnancy was an option. Instead, nearly three days after seeking care, Ms. Means gave birth to a baby who died hours later. Additionally, Ms. Means suffered from an avoidable infection and other complications.[34] Tamesha Means sued the United States Conference of Catholic Bishops (USCCB), who issue the directives, several years later. The United States Court of Appeals for the Sixth Circuit ruled that Ms. Means did not have

[32] Stephens-Davidowitz, Seth. "The Return of the D.I.Y. Abortion." The New York Times. March 05, 2016. https://www.nytimes.com/2016/03/06/opinion/sunday/the-return-of-the-diy-abortion.html.
[33] Ginsberg, Jeremy, Matthew Mohebbi, Rajan Patel, Lynnette Brammer, Mark Smolinski, and Larry Brilliant. *Detecting influenza epidemics using search engine query data*. Report. 1-5. February 19, 2009. https://static.googleusercontent.com/media/research.google.com/en//archive/papers/detecting-influenza-epidemics.pdf.
[34] *Tamesha Means v United States Conference of Catholic Bishops et al.* (6th Cir. 2016)

standing to sue the USCCB, nor did she have a legitimate claim of negligence under Michigan state law.[35]

When Mindy Swank was 20 weeks pregnant with her second child, her water broke prematurely. Mindy had testing done and learned the fetus was not viable. However, her hospital was Catholic owned and bound by Catholic Directives. They would not perform an abortion and instead, Mindy was forced to carry the fetus for two weeks waiting to miscarry. After waking up bleeding one morning, she went back to the hospital. The hospital refused to induce labor, despite the fact that the fetus would not survive either way. Mindy continued to return to the hospital as her condition worsened and was offered no reprieve. She was not told that she would be able to procure an abortion elsewhere. Once Mindy was 27 weeks pregnant, seven weeks after discovering the fetus was not viable, the hospital induced labor. Mindy was hemorrhaging severely, and as expected, her baby died shortly after delivery.[36]

Lori Boyer was 35 when she was raped by an acquaintance. Afterward, she immediately went to the emergency room seeking a rape kit and counseling. During her medical exam, she told her doctor she needed emergency contraception. The doctor refused. Boyer explained she was in the middle of her cycle, therefore at higher risk of becoming pregnant, and the window for emergency contraception to be effective, 72 hours, was closing by the minute. Her doctor refused again, stating it was against his religious beliefs. Boyer's sexual assault counselor found her a doctor who would prescribe the drug. After the ordeal, Boyer said she avoided going to the gynecologist for years, risking her own health, because of how traumatic the experience was. She

[35] ibid
[36] American Civil Liberties Union. "Health Care Denied." ACLU Accessed March 8, 2018. https://www.aclu.org/issues/reproductive-freedom/religion-and-reproductive-rights/health-care-denied.

didn't want to be judged again, she told NBC News in 2007.[37] Boyer's case is not unique. One study found that 1 in 20 women have had a doctor refuse to prescribe them birth control or emergency contraception.[38] Today, emergency contraception is available for purchase, without age restriction, over the counter. However, contraceptives such as the birth control pill or patch, still require a doctor's visit and a prescription.

Cases like these exemplify the danger women face when denied access to care. In their paper, "Conscience Wars: Complicity Based Conscience Claims in Religion and Politics," Douglas Nejaime and Reva B. Siegel explain how denial of service creates both material and dignitary harms. Material harms include, but aren't limited to, being put into medical danger, forced pregnancy, and lack of access to contraception. Stories like Mindy Swank's, Tamesha Means', and Lori Boyer's paint a clear picture of this material harm. Their health was jeopardized because of their doctors' refusal to care for them. Mindy Swank was forced to carry a pregnancy that was not viable; Lori Boyer's doctor increased the chance that Boyer would become pregnant with her rapist's child because of his personal moral views; and Tamesha Means suffered severe health complications as a result of not being told about the option to have an abortion and continuing to carry a doomed pregnancy.

Dignitary harms contribute to societal discrimination and oppression. The ability to refuse to perform abortions or dispense contraception frames those services as wrong and the women who request them as sinners. Lori Boyer reported feeling embarrassed and judged when refused emergency contraception. A young woman referenced in the "Conscience Wars" paper

[37] Erdely, Sabrina Rubin. "Doctors beliefs can hinder patient care." NBCNews.com. June 22, 2007. http://www.nbcnews.com/id/19190916/ns/health-womens_health/t/doctors-beliefs-can-hinder-patient-care/.
[38] ibid

said that being refused a prescription for contraception made her "'[feel] like a whore.'"[39] "Refusal [of service]", Nejaime and Siegel write in "Conscience Wars", "reflects a widely understood message about a contested social norm."[40] It criminalizes women's health care socially despite its actual legality, much like discrimination against same sex couples reinforces a social message that same sex relationships are wrong, despite their legal permissibility and general social favorability: 62% of Americans support same-sex marriage[41], 99% of women have used some form of contraception in their lifetime[42], and 57% of Americans say abortion should be legal in some or all cases.[43]

When doctors, whose specialty includes the expectation of providing certain services, refuse legal, safe prescriptions or procedures, it stigmatizes the patients seeking them. It reinforces false assumptions like emergency contraception is abortive or that women who use contraception are doing something wrong. While abortion, sterilization, contraception, and emergency contraception are legal in all 50 states in the US, the ability of doctors to decline these services reinforces the idea that they shouldn't be. It's not hard to imagine how a social cascade stems from refusal: If a doctor won't do it, surely it can't be safe, healthy, effective, or moral - right?

Disparate Impact

Conscientious objection and complicity-based conscience claims in health care disproportionately affect women. While there are no statistics on which procedures are most often refused by health care professionals, the history of health care refusal centers on

[39] Nejaime, Douglas and Reva B. Siegel. "Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics." p 2577
[40] ibid
[41] Pew Research Center. "Changing Attitudes on Gay Marriage." Pew Research Center. June 26, 2017. http://www.pewforum.org/fact-sheet/changing-attitudes-on-gay-marriage/
[42] *National Health Statistics Reports*, 2013, No. 62, http://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf.
[43] Pew Research Center. "Public Opinion on Abortion." Pew Research Center. July 7, 2017. http://www.pewforum.org/fact-sheet/public-opinion-on-abortion/

reproductive care. The only medical procedures specifically mentioned in any federal conscientious objection laws are abortion, sterilization, and physician assisted suicide.[44] Physician assisted suicide is currently legal in seven states, including Montana where a court order is required, while abortion and sterilization are legal, with some restrictions, in all 50 states.[45] [46] Approximately 700,000 female sterilizations and 500,000 male sterilizations (vasectomies) are performed annually in the United States. While federally funded sterilizations are legal (federally funded abortions are not), there is a 30-day waiting period for any Medicaid-funded female sterilization. There are no restrictions on male sterilizations.[47] Of the two procedures specifically referenced in federal law and guidelines that are legal in all 50 states, abortion and sterilization, the latter is performed on 200,000 more women than men annually, and the former is applicable exclusively to women.

This evidence shows how deeply gendered complicity-based health care refusal, conscientious objection in health care, and the laws surrounding reproductive care generally, are. While health care providers may have moral objections to a plethora of medications and procedures, women's reproductive rights are clearly at the center of health care refusal. Other cases of doctors refusing care, while maybe encompassing moral beliefs, seem to rest heavily on the patient's wellbeing. For example, many doctors are cautious about prescribing controlled substances like opioids, barbiturates, or benzodiazepines, due to the potential for addiction,

[44] HHS Office of the Secretary, and Office For Civil Rights (OCR). "Conscience Protections for Health Care Providers." HHS.gov. June 16, 2017. Accessed March 09, 2018. https://www.hhs.gov/conscience/conscience-protections/index.html.
[45] Death With Dignity. "States with Assisted Dying Laws." Accessed March 09, 2018. https://www.deathwithdignity.org/take-action/
[46] Bartz, D., & Greenberg, J. A. (2008). Sterilization in the United States. *Reviews in Obstetrics and Gynecology*, *1*(1), 23–32.
[47] Ibid

adverse interactions with other medications and alcohol, and other side effects.[48] Physicians may feel ethically conflicted about the social effects of potentially over-medicating patients or prescribing to a patient who they feel is not being truthful, due to the potential increase in illegal narcotic sales and drug addiction. However, it's challenging to find cases of a doctor declining to prescribe pain medication because they don't believe in relieving pain, or anti-anxiety pills because they think god wants the patient to have panic attacks.

Several disparate impact cases have been heard by the Supreme Court. In *Griggs v. Duke Power Co.*, the Supreme Court ruled unanimously that job requirements that included a minimum score on a standardized test and having a high school diploma discriminated against the company's African-American employees. The Court found that although the company displayed no intent to discriminate, the requirements had a disparate impact on black employees and did not "bear a demonstrable relationship to successful performance of the jobs for which it was used."[49] With the passage of the Civil Rights Act, the Court wrote, "Congress has made [job] qualifications the controlling factor, so that race, religion, nationality, and sex become irrelevant."[50]

Five years later, the Court rolled back its recognition of disparate impact in *Washington v Davis*, where it ruled that laws that have a racially discriminatory impact but are not themselves racially discriminatory are constitutionally permissible. The facts of the case surrounded hiring and recruiting procedures in the Washington, D.C. police department. The plaintiffs argued the hiring and recruiting process discriminated against black applicants, because it required a written test that was allegedly not relevant to the job functions. The Court found the requirements were

[48] Tedeschi , Bob. "A 'civil war' over painkillers rips apart the medical community." STAT. January 17, 2017. https://www.statnews.com/2017/01/17/chronic-pain-management-opioids/.
[49] *Griggs v. Duke Power Co.*, 401 US 424 (1971)
[50] Ibid

adequate measures of employment qualification and any racially biased affect they may have had was permissible, writing:

> Our cases have not embraced the proposition that a law or other official act, without regard to whether it reflects a racially discriminatory purpose, is unconstitutional solely because it has a racially disproportionate impact.[51]

Accidental discrimination, essentially, does not violate equal protection.

Recently, the Court partially reaffirmed its recognition of disparate impact as discrimination in 2015 in *Texas Dept. of Housing and Community Affairs v. Inclusive Communities Project, Inc.* The Court ruled that because of the language of the Fair Housing Act, claims brought under the Act do not need to show intentional discrimination, but instead can make a case of disparate impact.[52] Although this decision pertains only to claims brought under the Fair Housing Act, the acknowledgement of disparate impact and of laws that address it by the Court is notable. The Inclusive Communities Project argued that the Texas Department of Housing and Community Affairs segregated communities by "allocating too many [low income housing] tax credits... in predominantly black inner-city areas and too few in predominantly white suburban neighborhoods."[53] However, the Court declined to rule on the facts of the case, instead, sending the case back to the lower court for reconsideration in light of its ruling on the disparate impact issue. The U.S. District Court for the Northern District of Texas dismissed the case in 2016.[54]

The Court's decision in *Griggs* established that discrimination can occur unintentionally. *Washington v. Davis* established that just because unintentional discrimination occurs, does not

[51] *Washington v Davis*. 462 US 229 (1976)
[52] *Texas Department of Housing and Community Affairs v. Inclusive Communities Project, inc.* 576 US 1 (2015)
[53] ibid
[54] *Inclusive Communities Project, Inc. v. The Texas Department of Housing and Community Affairs.* (N.D Tex. 2016)

mean whatever led to that discrimination violates equal protection. In *Washington,* the Court decided that the Washington D.C. police department had proven that the test at issue was closely related to the required job functions. This is not a necessarily a blanket rebuke on all disparate impact claims. In his concurrence, Justice Stevens wrote,

> Frequently the most probative evidence of intent will be objective evidence of what actually happened, rather than evidence describing the subjective state of mind of the actor… It is unrealistic, on the one hand, to require the victim of alleged discrimination to uncover the actual subjective intent of the decision-maker or, conversely, to invalidate otherwise legitimate action simply because an improper motive affected the deliberation of a participant in the decisional process.[55]

Justice Stevens went on to explain "that the line between discriminatory purpose and discriminatory impact is not nearly as bright"[56] as the majority opinion portrayed it to be.

Protection of complicity-based conscience claims in health care have the discriminatory impact of restricting women's access to reproductive care, even if this is not their intent. The disproportionate mention of women's health care procedures in health care refusal protections demonstrates the disparate impact of these laws. While the discriminatory effect of this disparate impact should be balanced with the right to religious expression, the harm it causes to women should be taken into greater consideration than it currently is.

Protection of Religious Expression

United States common law has established time and time again that religious expression is not protected without restriction. Complicity-based conscientious refusal in health care is religious expression that violates the right of patients to receive services without discrimination.

[55] *Washington v Davis.* 426 US 253. (1976)
[56] ibid 254

Since a complicity-based claim does not involve direct action, it's not clearly protected by freedom of religious expression. Despite the passage of the RFRA and increased scrutiny over government regulation of religion, religious freedom has not been indiscriminately protected by the Court.

The Court ruled in *Employment Division, Dept. of Human Resources of Oregon v. Smith* (1990) that "an individual's religious beliefs [do not] excuse him from compliance with an otherwise valid law."[57] The case centered around two Oregon residents who were denied unemployment benefits after testing positive for peyote, which they had ingested as part of a Native American religious ceremony. *Employment Division v. Smith* introduced the neutral law of general applicability test: so long as a law is neutral and applied equally to all citizens and religious faiths, one cannot be granted exemption from it on religious grounds. This test replaced the previous one, established in *Lemon v. Kurtzman.*[58] The *Lemon* test had been used to determine when a law interferes with religious freedom. To pass the *Lemon* test, a law must meet all of the following requirements:

1) It "must have a secular legislative purpose"
2) The principal effect of the statute cannot advance nor inhibit religion
3) It "must not foster an excessive government entanglement with religion."[59]

After *Employment Division v. Smith* introduced the general law of neutral applicability standard, weakening protection of free exercise, Congress passed the Religious Freedom Restoration Act (1993), effectively reinstating the *Lemon* test. In *City of Borne v. Flores*, The Court ruled that the RFRA was unconstitutional as applied to the states because applying the law to state

[57] *Employment Division, Dept of Human Resources of Oregon v. Smith.* 494 US 872 (1990)
[58] *Lemon v. Kurtzman* 403 US 613 (1971)
[59] ibid

governments was Congressional overreach that violated states' rights.[60] In response, Congress passed the Religious Land Use and Institutionalized Persons Act (2000), which modified the RFRA to apply only to landowners and prisoners.[61] Twenty-one states have subsequently passed their own Religious Freedom Restoration Acts.[62]

The Court's decisions in *Employment Division v. Smith* and *City of Borne v. Flores* show that religious expression has not been protected without restriction. Like any Constitutional guarantee, religious expression can be subject to regulation and restriction.

Arguments regarding the balance between religious freedom and other rights have a long history in front of the courts. In recent years, as social issues have progressed, conflicts between civil rights and religious freedom have been at the forefront. A case that received significate attention was *Miller v. Davis* (2016). In 2015, after the Court legalized same-sex marriage at the federal level, Kim Davis, a county clerk in Rowan County, Kentucky, refused to issue marriage licenses to same-sex couples in. Davis argued that signing and issuing marriage licenses was against her Christian faith. Facilitating the marriage and having her name associated with it, her lawyers argued, was a violation of her right to religious freedom. The District Court for the Eastern District of Kentucky disagreed, as did the 6th Circuit Court of Appeals, and then, the Supreme Court of the United States.[63] [64] In his decision to grant a preliminary injunction requiring Davis to issue the licenses, Judge David Bunning made several points that address complicity-based conscience claims and their legitimacy as it pertains to religious expression.

[60] *City of Borne v Flores. 521 US 507 (1997)*
[61] Religious Land Use and Institutionalized Persons Act. 2000. Public Law 106-274.
[62] National Conference of State Legislatures. "State Religious Freedom Restoration Acts." NCSL. May 4, 2017. http://www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx
[63] *Miller v. Davis.* No 06-55538 (9th Cir. 2016)
[64] *Miller v. Davis.* 576 U.S. (2016)

First, the District Court explained the circumstances in which someone's rights have been so burdened that they are effectively sacrificed. In the context of marriage, the Court wrote, the right to marry is substantially interfered with when

> members of the affected class are absolutely prevented from getting married [and] any others, able in theory to satisfy the statute's requirements, will be sufficiently burdened by having to do so that they will in effect be coerced into forgoing their right to marry.[65]

Absolute refusal and excessive burden both create scenarios in which a Constitutional right is denied. The Supreme Court established the undue burden standard as applied to abortion in *Planned Parenthood v. Casey* (1992), writing,

> … a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a means of serving its legitimate ends.[66]

The District Court in *Miller v. Davis* continues with a second, related point, writing,

> Even if the plaintiffs are able to obtain licenses elsewhere, why should they be required to?... It does not seem unreasonable for Plaintiffs, as Rowan County voters, to expect their elected official to perform her statutorily assigned duties.[67]

If the burden of being denied a reasonably expected service in relation to a constitutionally protected right is unconstitutional as applied to marriage, then there's room to reasonably argue that being denied abortion care or contraceptives is also unconstitutional.

Next, the Court distinguishes speech in a professional capacity from standard, protected speech. Citing *Connick v. Meyers* (1983),

---

[65] *Miller v. Davis* 123 F.Supp.3d 924 (E.D. Ky. 2015), citing *Zablocki v. Redhail.* 434 US 387 (1987)
[66] *Planned Parenthood v. Casey.* 505 US 877. (1992)
[67] *Miller v. Davis* 123 F.Supp.3d 924 (E.D. Ky. 2015)

> 'The government may not constitutionally compel persons to relinquish their First Amendment rights as a condition of public employment' but it does have 'a freer hand in regulating the speech of its employees than it has in regulating the public at large.'[68]

Davis, as a government employee, has a special responsibility to comply with the Constitution. The Court continued that since the speech Davis objected to was "a product of her official duties, it is likely not entitled to First Amendment protection."[69] It may be argued that the responsibilities and requirements of a federal employee differ from those of an employee in the private sector or in a non-governmental position, but the fact that Miller can be required to 'speak' in ways that her chosen profession requires is important.

Miller v. Davis considered the role of a government employee objecting to same-sex marriage. *Stormans v. Weisman* (2015), decided in the same year by the 9th Circuit Court of Appeals, considered the right of pharmacists to refuse to stock and dispense emergency contraception due to their belief that it is an abortifacient. Washington's Pharmacy Quality Assurance Commission enacted rules requiring "the timely delivery of all prescription medications by licensed pharmacies," with few exceptions, such as in cases where the prescription is fraudulent or the customer cannot afford to purchase the prescription.[70] The owner of Stormans, Inc., and two pharmacists employed there sued, arguing that because the rules effectively required that they stock and dispense emergency contraception, they violated their religious freedom. The Court found the rules to be neutral and generally applicable and stated that "the Free Exercise Clause is not violated even if a particular group, motivated by religion, may be more likely to engage in the proscribed conduct."[71] This is consistent with what I

[68] Ibid 23, citing *Connick v. Meyers.* 461 U.S. 138. (1983)
[69] Ibid 25
[70] *Stormans v. Weisman* (9th Cir. 2015)
[71] Ibid 22

explained earlier: that religious activity is not protected under the First Amendment unconditionally. The Court cited *American Life League, Inc. v. Reno* (1995), which upheld the Freedom of Access to Clinic Entrances (FACE) Act. The Act created perimeters around abortion clinics that protestors could not cross. Opponents argued it was a violation of free speech. Citing *American Life League*, the Court wrote that "it makes no difference whether a violator acts because of religious convictions or for other reasons, for 'the same conduct is outlawed for all.'"[72]

A popular argument by protectors of complicity-based conscience claims pertaining to refusal of service is that seekers of a product or service can simply go elsewhere to obtain it. In his paper, "Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical," Bernard Dickens writes, "Anti-discrimination laws are intended to relieve less powerful people from oppression by the more powerful," but laws that permit health care providers to refuse care are designed "to privilege adherents primarily of religious faith, and to exploit the dependency and inferior status of patients, primarily women, who want access to reproductive health services."[73] Dickens argues that the compromise between patients' and doctors' competing rights lies in the doctor's duty to refer patients to another provider when he or she is unwilling to give treatment.[74] However, referral does not always occur, nor is it always a feasible option in rural and underserved areas. The scarcity of abortion providers, particularly in rural areas, and the cost of travel can make seeing another provider an insurmountable burden for some. Additionally, abortion care and the administration of emergency contraception are time-sensitive, due to legality and effectiveness, respectively.

---

[72] Ibid, citing *American Life v. Reno* 47 F. 3d 642 (4th Cir. 1995)
[73] Dickens, Bernard M. "Legal Protections and Limits of Conscientious Objection: When Conscientious Objection is Unethical." Medicine and Law, no. 28 (2009): 340
[74] ibid 344

A 2011 study of American obstetrician-gynecologists found that the majority of OBGYNs, 77%, support doctors' right to refuse to perform abortions, so long as the doctor refers the patient to another doctor who will perform the procedure and does not express to the patient why he or she is refusing. Women were less likely to approve of refusal, lack of referral, and disclosure of reasons for refusal than men.[75] 18% of male OBGYNs surveyed approved of refusal without referral, only 9% of female doctors did.[76] The American College of Obstetricians and Gynecologists recommendation is that while physicians and other health care providers may refuse service, they "have a duty to refer patients in a timely manner to other providers… [and] they must provide potential patients with accurate and prior notice of their personal moral commitments."[77]

The Court in *Stormans* argued that, in the case of attempting to procure contraception or emergency contraception, referring patients to another pharmacy (which the Washington rules prohibited) is not an adequate alternative:

> The time taken to travel to another pharmacy… may reduce the efficacy of those drugs. Additionally… facilitated referrals could lead to feelings of shame in the patient that could dissuade her from obtaining emergency contraception altogether.[78]

The recognition that referral is not a cure-all solution to conscientious health care refusal is important. While many doctors and hospitals do not even refer patients when they object to providing health care, *Stormans* displays why those who do refer may still be doing a great disservice to their patients.

---

[75] Kenneth A Rasinski, John D Yoon, Youssef G Kalad, and Farr A Curlin. "Obstetrician-Gynaecologists' Opinions about Conscientious Refusal of a Request for Abortion: Results from a National Vignette Experiment." *Journal of Medical Ethics* 37, no. 12 (Dec 1, 2011)
[76] ibid 711
[77] ibid
[78] ibid 24

The final piece of the *Stormans* decision that applies to the debate over conscientious health care refusal is the Court's assertion that Plaintiffs claim of a fundamental liberty interest in refraining from "taking human life" is too broad.[79] The Court declined to recognize this new fundamental right and defended the narrowness of the law, writing,

> The disputed rules do not apply generally to the population as a whole. Instead… the rules here apply only to persons in specific circumstances. In particular, the rules require the delivery of medication only by pharmacies, which are professional businesses subject to licensing and regulatory requirements.[80]

If pharmacies may be subject to this regulation, it seems to follow that other health care entities may be as well. Hospitals and private practices are certainly professional businesses that can be regulated and required to provide services just like the pharmacists here.

Health Care Rights in U.S. Federal Law & Case Law

Health care access and affordability have been heavily debated in U.S. political discourse and addressed in legislation for decades. The assurance provided by Medicaid, Medicare and other government programs that health care be accessible to the most vulnerable citizens demonstrates that access to health care is something the U.S. deems important and valuable. The United States does not (in theory) let its poorest citizens die in the streets. In 1965, President Lyndon Johnson, signed the Social Security Act, which included the Medicare Amendment, establishing the country's Medicare and Medicaid programs. Medicare provides (and therefore, guarantees) health care for the elderly. Medicaid does the same for "some low-income people, families and children, pregnant women, the elderly, and people with disabilities" and in some

[79] Ibid 41
[80] Ibid 41-42

states, all low-income adults.[81] The Children's Health Insurance Program (1997), commonly known as CHIP, provides low-cost or free health insurance to children whose families "earn too much money to qualify for Medicaid" and in some states, to pregnant women as well.[82] Medicare, Medicaid, and CHIP are federal programs, with expansions that vary by state. As of 2016, over 36% of Americans rely on Medicare or Medicaid for health care.[83]

There are opponents of the government's involvement in health care. However, even Paul Ryan, who has said publically, "I've been dreaming [of cutting Medicaid benefits] since I've been around – since [I was] drinking out of a keg", argues in favor of making Medicaid and other entitlement programs smaller and giving more control to the states, not eliminating them completely.[84] While previewing his goal of repealing and replacing of the Affordable Care Act, then President-elect Trump claimed that "nobody is going to be dying in the streets" because they don't have health care.[85]

These may be false promises, and cuts to Medicaid and other entitlements may effectively eliminate those entitlements, but it's interesting that conservative leaders don't typically announce plainly that they don't believe certain people should receive care. This is likely because public support for Medicaid is high. A study from early 2018 found that 74% of Americans have a "favorable" or "somewhat favorable" view of Medicaid. 66% believe Medicaid should be "available to low-income people for as long as they qualify, without a time

[81] U.S. Dept. of Health and Human Services, Digital Communications Division. "Who Is Eligible for Medicaid?" HHS.gov. August 04, 2017. Accessed March 25, 2018. https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicaid/index.html.
[82] "Children's Health Insurance Program (CHIP) Eligibility Requirements." healthcare.gov. Accessed March 25, 2018. https://www.health care.gov/medicaid-chip/childrens-health-insurance-program/.
[83] United States Census Bureau. "Health Insurance Coverage in the United States: 2016". Census.gov. September, 2017. https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf
[84] Schulman, Jeremy. "Paul Ryan: We've Been Dreaming of Slashing Medicaid Since My Kegger Days" Mother Jones. March 17, 2017. https://www.motherjones.com/politics/2017/03/paul-ryan-says-hes-been-dreaming-medicaid-cuts-ever-his-keg-party-days/
[85] Halper, Daniel. "Trump: No one will die in the street with new health care plan." January 18, 2017.

limit."[86] Support for single-payer health care is similarly high, and growing: 60% of Americans believe the federal government has a responsibility to ensure everyone has health care. This is up from 42% in 2012.[87]

In 1986, the Emergency Medical Treatment and Active Labor Act was passed to ensure that emergency care is available to anyone who needs it. The EMTALA requires that emergency departments screen, stabilize, and treat anyone who seeks care, regardless of their ability to pay.[88] The law was enacted to prevent hospitals from discriminating against low-income or uninsured patients by refusing to treat them or having them unnecessarily transferred to a different hospital. While initially, the act applied only to emergency care, it has since been interpreted, through enforcement and court decisions, to apply to "virtually all aspects of patient care in the hospital setting."[89]

It doesn't seem a stretch to consider abortion care, when the health of the mother is in jeopardy, or access to emergency contraception, as emergency care, given the time sensitive nature of the care. Even if a woman is not approaching the legal cut off to procure an abortion, a matter of days may change the type of abortion she requires. A medical abortion (the 'abortion pill') can usually only be administered up to 70 days (10 weeks) into the pregnancy. After this point, surgical abortion is typically required. The vacuum aspiration method can be used until 14-16 weeks; After 16 weeks, a dilation and extraction (D&E) is standard. While all methods are safe, a medical abortion, which involves taking two pills over the course of a day or two, can be

[86] Scott, Dylan. "Poll: Medicaid is overwhelmingly popular even as Trump looks to cut it." Vox.com. March 1, 2018. https://www.vox.com/policy-and-politics/2018/3/1/17066578/medicaid-work-requirements-poll-kff
[87] Kiley, Jocelyn. "Public support for 'single payer' health coverage grows, driven by Democrats." Pew Research Center. June 23, 2017. http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats/
[88] Zibulewsky, J. (2001). The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians. *Proceedings (Baylor University. Medical Center)*, *14*(4), 339–346.
[89] Ibid 339

done at home, which many women prefer.[90] Emergency contraception is obviously incredibly time sensitive, as discussed previously, due to the decrease in effectiveness by the hour. Being refused abortion care or emergency contraception entirely, at a Catholic hospital for example, is a dangerous denial of emergency health care.

Passed in 2010, the Patient Protection and Affordable Care Act builds on these previously established health care rights. Related to the EMTALA, which requires provision of emergency services, § 2590.715-2719A Patient Protections, subsection 4 of the ACA requires that insurance companies cover emergency care. "Emergency" here is defined using the prudent layperson standard: it is an emergency if a "prudent layperson, acting reasonably" would consider it one.[91] Interestingly, a 2002 study found this standard insufficient. Test subjects were not only bad at identifying true medical emergencies, they were biased as well. None of the subjects identified any "symptoms or signs specifically related to gynecologic disorders" as emergencies.[92] This may explain why health care providers are protected in denying reproductive care entirely, regardless of the woman's health: Reproductive emergencies are not regarded as emergencies.

Another piece of the ACA, the Nondiscrimination in Health Programs and Activities rule (Sec 1557) prohibits discrimination in the provision of health care for providers that receive federal funds. In part, the rule prohibits discrimination on the basis of sex or termination of pregnancy. Under the Obama Administration, "sex" was interpreted by HHS to include gender identity. The rule meant that LGBT patients and patients seeking abortions at providers that receive federal funding could not be denied care. However, in the summer of 2016, Catholic hospital conglomerate Franciscan Alliance, along with the states of Texas, Wisconsin, Nebraska,

[90] Planned Parenthood. "Get the Facts About Abortion." PlannedParenthood.org. Accessed March 25, 2018. https://www.plannedparenthood.org/learn/abortion.
[91] Li, J. et al. The "prudent layperson" definition of an emergency medical condition" https://www.ncbi.nlm.nih.gov/pubmed/11781904
[92] ibid

Kansas, and the commonwealth of Kentucky, sued the Department of Health and Human Services arguing the rule violated the right of providers by requiring them to "perform and provide insurance coverage for gender transitions and abortions, regardless of their contrary religious beliefs."[93] A preliminary injunction against the relevant portions of the rule was granted in December, 2016. The ACLU filed a motion to intervene as defendants, which was denied by the district court and on appeal, the 5th Circuit. In the summer of 2017, the new administration's Department of Health and Human Services filed a motion for stay on the proceedings while they reconsider the rule. The stay was granted. As of April 2018, the rule is still under revision by HHS; the original injunction remains.

Despite attempts to repeal or weaken the ACA, the majority of the law remains intact. One of its provision, § 2590.715-2719A Patient protections, subsection 3, includes obstetric and gynecological care in the law's "direct access" requirements. This means health insurance companies may not require authorization or a referral from a primary care physician in order to cover the costs of obstetric or gynecological care.[94] Another section of the ACA, known as the contraceptive coverage mandate, required insurance providers to cover FDA-approved female contraceptives and contraceptive counseling without a co-pay, regardless of whether the deductible on the plan has been met. Certain religious employers (like churches) were exempt in the original law, and closely-held for-profit corporations with moral objections became exempt after the Court's decision in *Hobby Lobby v. Burwell* (2014) As mentioned earlier, President Trump issued an executive order in October 2017 expanding the exemptions to include any

[93] *Franciscan Alliance v Burwell*, Order on Motions for Preliminary Injunction. 1716. (N.D. Tex 2016)
[94] Patient Protection and Affordable Care Act (2010) § 2590.715-2719A Patient protections, subsection 3

company with an objection. The injunction against that order, issued in December, 2017, remains in effect as of April 2018, however the case is being actively litigated.[95]

While a positive right to health care may not exist Constitutionally or legally, it's clear from legislation passed and public support that many Americans believe health care to be a right. When considering conscientious objection and complicity-based conscience claims in health care, the opinion of many that access to health care is a right is important. We have laws to ensure people have access to health care and are not denied emergency care, yet reproductive care is still often denied or difficult to obtain.

Case law in the U.S. has also addressed health care rights, including specific rights to procure abortion and contraceptives. In 1965, *Griswold v. Connecticut* legalized contraception by overturning a Connecticut law that prohibited using any drug or device intended to prevent conception. The Court wrote,

> The clear effect of [the law], as enforced, is to deny disadvantaged citizens…, those without either adequate knowledge or resources to obtain private counseling, access to medical assistance and up-to-date information in respect to proper methods of birth control. In my view, a statute with these effects bears a substantial burden of justification when attacked under the Fourteenth Amendment.[96]

A right to use contraception was upheld on the grounds that prohibition violated a unenumerated right to privacy within marriage. Later, *Eisenstadt v. Baird* (1972) extended Griswold's holding to unmarried couples.[97] A year after *Eisenstadt*, *Roe v. Wade* (1973) established the unconstitutionality of prohibiting abortion pre-viability. The Court held that the right to personal

[95] Pear, Robert. "Court Temporarily Blocks Trump Order Against Contraceptive Coverage." The New York Times. December 15, 2017. https://www.nytimes.com/2017/12/15/us/politics/obamacare-birth-control-trump.html
[96] *Griswold v. Connecticut.* 381 US 503 (1965)
[97] *Eisenstadt v. Baird* 405 U.S. 438 (1972)

privacy rooted in the liberty protected by the Due Process Clause extends to this personal reproductive choice, and that the state's interest in protecting potential human life becomes compelling only at the point of viability.[98] Although *Planned Parenthood v. Casey* (1992) rejected *Roe's* trimester framework, it affirmed the central holding of *Roe*, with viability as the point when the state's interests become compelling.[99] What is significant in these cases, aside from the recognition of reproductive rights, is the acknowledgement of a state's interests in protecting potential life and the health and lives of its citizens, and in regulating health care.

The Court has protected health care rights more broadly, notably for prisoners, in *Estelle v. Gamble* (1990) and *Brown v. Plata* (2011). In *Estelle*, the Court ruled that the Eighth and Fourteenth Amendments require that inmates be provided medical care.[100] In *Brown v. Plata*, the Court wrote, "a prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in a civilized society."[101] Currently, the U.S. provides health care (or health care coverage) to those who cannot reasonably procure it themselves: the poor, children, and prisoners. Maybe there is not a right to government subsidized or provided health care coverage, but there seems to be a right to reasonable access to health care.

Physicians' First Amendment Rights

A core argument used by advocates of complicity-based conscience claims in health care is that being forced to participate in the procurement of reproductive care they morally object to, or referring patients to doctors who will provide the service, is a violation of their First Amendment freedom of speech. Complicity-based conscience claims assert that freedom of

[98] *Roe v. Wade*. 410 US 113 (1973)
[99] *Planned Parenthood v. Casey.* 505 US 833 (1992)
[100] *Estelle v. Gamble.* 429 US 97 (1976)
[101] *Brown v Plata. 563 US 13 (2011)*

speech and free exercise of religion protect those with religious or moral objections from participating in certain reproductive care. For doctors, to be complicit is to participate in or counsel patients about reproductive methods they find morally wrong; to be free from forced complicity, doctors must enjoy full rights to speech and free exercise in their professional spheres. This allegedly protected speech applies specifically, for our purposes, to counseling on abortion or contraceptives and to referring patients to providers who provide care. I explained earlier that the Courts have established that doctors do not enjoy complete First Amendment protection when acting in their professional capacity as health care providers.

Upon consideration of the First Amendment rights of doctors to not provide "information about the risks of abortion, and childbirth, in a manner mandated by the State", in *Planned Parenthood v Casey* (1992), the Court considered the Constitutionality of several Pennsylvania regulations pertaining to the procurement of abortion. One regulation pertained to informed consent. It required that doctors give their patients certain information before performing an abortion. The Court ruled this permissible, writing,

> We… see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health.[102]

However, the Court acknowledged that while the doctor's right to not speak was implicated, it was "only as part of the practice of medicine, subject to reasonable licensing and regulation by the state."[103]

The state's role in regulating the practice of medicine has been reinforced by the Court since *Casey*. Notably, in *Gonzales v. Carhart* (2007), the Court ruled that state bans on abortions

[102] *Planned Parenthood v. Casey.* 505 US 882. (1992)
[103] ibid

using the intact D & E (what doctor's refer to as D&X) method without a medical exemption was permissible, despite lack of consensus in the medical community as to whether the procedure may be necessary to protect the health or life of the woman.[104] In *Washington v Glucksberg* (1997) the Court ruled that patients do not have a "right to die"[105] and that the State has a legitimate interest in preserving the ethics of the medical, among others.[106] These cases serve as examples of the Court regulating the medical field and doctors individually, sometimes against the recommendation of a large portion of the medical field.

The assertion in *Casey* that a doctor's right to speak, or not to speak, may be regulated led to several lower court decisions in agreement. In *Pickup v. Brown* (2016), the 9th Circuit ruled that mental health care providers can be prohibited from performing "conversion therapy", a discredited treatment that attempts to change the sexual orientation of patients, on patients under 18.[107] The court wrote that the First Amendment "tolerates a substantial amount of speech regulation within the professional-client relationship that it would not tolerate out of it."[108] Doctors, then, can be required to speak or prohibited from speaking in various ways.

State legislatures nationwide have experimented with regulation of health care professionals' speech, with varying success when brought before the courts. In *Planned Parenthood v. Rounds* (2012), the 8th Circuit upheld a South Dakota law that required abortion providers to warn their patients that abortion is associated with increased suicide risk. The Court ruled that States may require doctors to give certain disclosures to patients so long as they aren't misleading or untrue. Though a causal link has not been established between abortion and

[104] *Gonzales v. Carhart.* 550 US 157 (2007)
[105] *Washington v. Glucksberg*. 521 US 703 (1997)
[106] *Washington v. Glucksberg*. 521 US 702, 731 (1997)
[107] *Pickup v. Brown.* 9th Cir (2016)
[108] Ibid 23

suicide, doctors could be required to warn patients of an "association" because the term indicates correlation, not causation.[109]

The Court, however, has not always protected regulation of physicians' speech. In. *Stuart v. Camnitz* (2014) the 4th Circuit struck down a law that required doctors who perform abortions to show patients their ultrasound imaging and read them a description of the image during the course of a mandatory ultrasound procedure. The Court found the law unconstitutional due to its viewpoint discrimination. The law, they wrote, "conveyed a particular opinion… to convince the women to change their minds" about having an abortion.[110] Similarly, the 11th Circuit struck down a Florida law that prohibited doctors from talking to their patients about guns and gun safety, or recording a patient's gun ownership on medical records. The Court wrote in the 2017 decision, "The state's subversive attempt to stop a perceived political agenda chills speech based on not only content but also a particular viewpoint. The Act silences doctors who advance a viewpoint about firearms with which the state disagrees."[111]

While courts have struck down regulations that are not content or viewpoint neutral, there does not seem to be widespread consensus on what speech by a physician, in what circumstances, can be regulated. Currently under consideration by the Supreme Court, *National Institute of Family and Life Advocates (NIFLA) v. Becerra,* tackles the content/viewpoint neutrality issue head on. Heard at the 9th Circuit as *NIFLA v. Harris*, the case centers on the California Reproductive Freedom, Accountability, Comprehensive Care, and Transparency (FACT) Act. The FACT Act required that reproductive health centers post a notice in their lobby or waiting room area stating the following:

[109] *Planned Parenthood v. Rounds.* 8th Cir. (2012)
[110] *Stuart v. Camnitz.* 4th Cir. (2014) p 246
[111] *Wollschlaeger v. Governor, State of Florida*. 11th Cir. (2017)

> California has public programs that provide immediate free or low-cost access to comprehensive family planning services (including all FDA-approved methods of contraception), prenatal care, and abortion for eligible women. To determine whether you qualify, contact the county social services office at [insert the telephone number].[112]

Non-licensed reproductive health medical facilities, more commonly known as "crisis pregnancy centers,"[113] must also include the following disclaimer:

> This facility is not licensed as a medical facility by the State of California and has no licensed medical provider who provides or directly supervises the provision of services.[114]

The 9th Circuit ruled that these notices were constitutional regulation of speech, citing several of the cases referenced above. The Court wrote that the Act as a whole is subject to rational basis review because the regulation is a neutral law of general applicability, and, citing *Stormans*, "the fact that the Appellants' objections are grounded in their religious beliefs does not affect the Act's neutrality."[115]

When evaluating each requirement, for licensed and unlicensed clinics, the Court found that while the speech required by the Act is content-based, it doesn't "discriminate based on viewpoint,"[116] and is subject to rational basis review rather than strict scrutiny due to the professional nature of the speech. The notice licensed facilities must post, the court wrote, passes intermediate scrutiny due to California's "substantial interest in the health of its citizens… and [ensuring they have] adequate information about constitutionally-protected medical services like

[112] AB-775 Reproductive FACT Act (2015-2016)
[113] These clinics offer pregnancy tests and sonograms, and exist to dissuade women from choosing to have an abortion. Often, they present themselves as abortion clinics by using names like "Choices Pregnancy Center", which has 3 locations in the Phoenix area.
[114] ibid
[115] *NIFLA v Harris*. 9th Cir (2017) 38
[116] ibid 22

abortion."[117] Furthermore, the notice only informs patients of "the existence of publicly-funded family-planning services. It does not… encourage, suggest, or imply that women should use those state funded services."[118] Unlike the ultrasound statute in *Stuart,* these notices exist to make patients aware of public services, not sway their reproductive choices one way or another.

The required notice for unlicensed facilities passes any level of review, due to California's compelling interest in ensuring its citizens are informed about whether a facility providing medical care has been licensed to do so. California's means in furthering this interest, the Court said, are narrowly tailored due to the small size of the required sign and brief nature of the text. The required notice "says nothing about quality of service women may receive at these clinics, and in no way implies or suggests California's preferences regarding unlicensed clinics."[119]

Oral arguments in *NIFLA v. Becerra* were heard by the Supreme Court on March 20th, 2018. Members of the Court pointed out that, if states that do not support abortion can require doctors to provide information about adoption, why can't states that support abortion rights require doctors give information about free or low-cost abortion care? A sticking point, however, arose in the discussion of the Act's exemptions. Justice Alito, joined, interestingly, by Justice Kagan, expressed concern that the Act had been "gerrymandered" to single out crisis pregnancy centers.[120] A decision is expected this coming June.

The Future of Complicity-Based Conscience Claims

Debate over complicity-based conscience claims is relatively new. As mentioned earlier, it's likely only a matter of time before a health care refusal case reaches the Supreme Court. In

[117] Ibid 32
[118] Ibid 31
[119] Ibid 36
[120] Howe, Amy. *Argument analysis: Justices skeptical of abortion speech law,* SCOTUSblog http://www.scotusblog.com/2018/03/argument-analysis-justices-skeptical-abortion-speech-law/

the meantime, the Supreme Court will release decisions on *NIFLA v. Becerra* and *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission* this summer, both of which could render important parts of the argument laid out here moot. A decision in favor of the crisis pregnancy centers in *NIFLA* could make a requirement that physicians refer their patients when they deny abortion care harder to make, depending on the Courts rationale. *Masterpiece* concerns the right of a creative business owner to refuse certain services they view as counter to their religious or moral beliefs.[121] In *Masterpiece*, a cake decorator refused to design a cake for a same-sex wedding, and argues that being forced to is a violation of his right to free speech.[122] A decision in favor of Masterpiece Cakeshop could establish the constitutionality of refusal of service based on a complicity-based conscience claim.

While the protection of complicity-based conscience claims remains unclear, the requirement of a direct act on the part of the objector makes conscientious objection better protected ethically and constitutionally. However, refusal to acknowledge the option or availability of abortion care and refusal to counsel on, prescribe, or dispense contraception, should not be protected. These are complicity-based claims. The doctor refuses to perform an action (referring a patient to another doctor, for example) that he believes will facilitate a later action with which he disagrees. Doctors who refuse to provide abortion care should be required to refer patients to a doctor who will provide care. Such a requirement would not force doctors to act contrary to their beliefs, but simply to pass the patient along to another provider; these referring doctors would no longer be parties to the act itself.

As illustrated previously, regulation of physicians' speech has been found permissible by the Courts, so long as the required speech is content and viewpoint neutral. A requirement of

[121] *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*. *Oyez*, 18 Apr. 2018, www.oyez.org/cases/2017/16-111.
[122] *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission.* Brief for Petitioners. 2016.

referral would be both content and viewpoint neutral: doctors unwilling to provide safe, legal, requested care must simply refer patients to another doctor who is willing to provide that care. Like the regulation in *Stormans*, this would be neutral and apply generally. Any doctor not willing to provide legal, safe, health care should refer their patients elsewhere. The existence of objections based on religious grounds does not negate this.

Medical facilities who refuse to provide abortion care entirely, Catholic hospitals in particular, should not be permitted to deny reproductive services entirely. The refusal of Catholic hospitals to provide certain reproductive care, even in emergencies, is a complicity-based claim. The directives to not provide certain care are issued by a governing body, the United States Conference of Catholic Bishops.[123] They are not individual conscientious objections, but complicity-based conscience claims. This claim on behalf of doctors, regardless of their willingness to provide care, is incredibly harmful to women. Not only is it dangerous to not have access to reproductive care like abortion when medically necessary; being refused care causes undue shame and embarrassment. Being refused care by one doctor may be inconvenient, but surely being denied care by an entire hospital is an undue burden, especially in rural areas.

While there is much more room for debate on the issue of conscientious refusal in health care, what I have argued is, first, refusal to provide service by invoking a complicity-based conscience claim may not be protected religious expression, e.g. *Miller v Davis* (2015) Conscientious objection, objecting to an action rather than simply the facilitation of an act, is more likely to receive constitutional protection due to the demands on the individual. Second, while disparate impact as discrimination has not been consistently recognized by the Court, complicity-based conscience claims and conscientious objections in reproductive health care

[123] United States Conference of Catholic Bishops. "Ethical and Religious Directives for Catholic Health Services." USCCB. November 17, 2009. http://www.usccb.org/issues-and-action/human-life-and-dignity/health-

disproportionately affect women. Protections for conscientious health care refusal target legal women's reproductive health under the guise of protecting religious freedom. Third, the United States largely views access to health care as a right of citizens, even if this isn't explicit legally. The guarantee of access to health care as moral norm has guided legislation and political discourse over the past several decades, and support for state sponsored health care is rising.

Finally, the speech of doctors, health care providers, and health care facilities can be constitutionally regulated by the State, so long as the regulations are neutral laws of general applicability, e.g. *Stormans*. A requirement of referral would be both content and viewpoint neutral: doctors unwilling to provide safe, legal, requested care must simply refer patients to another doctor who is willing to provide that care. Like the regulation in *Stormans*, this would be neutral and apply generally. Any doctors not willing to provide legal, safe, health care should refer their patient elsewhere. The existence of objections based on religious grounds does not negate this.

From these conclusions, I argue that complicity-based conscience claims in health care are often a thinly veiled attempt at obstructing women's exercise of their reproductive rights and making reproductive health care harder for women to obtain. They should thus not be protected. *Hobby Lobby v. Burwell*, the case that brought complicity-based claims to mainstream attention, serves as a prime example of this obstruction. By asserting their personal distaste for certain contraceptives, the owners of Hobby Lobby, Inc. ensured birth control would be harder to obtain for their employees, and subsequently, millions of women nationwide who rely on employer or school health care coverage.

If the prevalence of health care refusal and its detrimental effects on women isn't addressed, the U.S. may soon face a reproductive health care crisis (or see more clearly the

effects of the crisis already occurring). Some evidence suggests that self-induced abortions may be on the rise as abortion clinics are forced to close due to anti-abortion legislation, and the obstacles to procuring abortion care become greater.[124] As it stands, health care providers have license to deny essential reproductive health care to women at their own discretion, without being held responsible for the physical or emotional consequences their patients faces. Valuing a right to avoid being party to something one objects to morally over the actual, physical health of women speaks loudly to the values of our society and the seriousness with which we regard women's health and autonomy.

Works Cited

AB-775 Reproductive FACT Act (2015-2016)

Agnew, John. "Deus Vult: The Geopolitics of the Catholic Church." *Geopolitics* 15, no. 1 (2010): 39-61. doi:10.1080/14650040903420388. https://doi-org.ezproxy2.library.arizona.edu/10.1080/14650040903420388.

American Civil Liberties Union. "Health Care Denied." ACLU. Accessed March 8, 2018. https://www.aclu.org/issues/reproductive-freedom/religion-and-reproductive-rights/health-care-denied.

American Life v. Reno 47 F. 3d 642 (4th Cir. 1995)

Bartz, D., & Greenberg, J. A. (2008). Sterilization in the United States. *Reviews in Obstetrics and Gynecology, 1*(1), 23–32.

Brown v Plata. 563 US 13 (2011)

Burwell v. Hobby Lobby. 573 US _ (2014)

"Children's Health Insurance Program (CHIP) Eligibility Requirements." healthcare.gov. Accessed March 25, 2018. https://www.health care.gov/medicaid-chip/childrens-health-insurance-program/.

[124] Stephens-Davidowitz, Seth. "The Return of the D.I.Y. Abortion." The New York Times. March 05, 2016. https://www.nytimes.com/2016/03/06/opinion/sunday/the-return-of-the-diy-abortion.html.

City of Borne v Flores. 521 US 507 (1997)

Colliver, Victoria. "Judge blocks Trump rollback of Obamacare contraception mandate." POLITICO. December 15, 2017. https://www.politico.com/story/2017/12/15/judge-trump-obamacare-contraception-mandate-298605.

Connick v. Meyers. 461 U.S. 138. (1983)

Death With Dignity. "States with Assisted Dying Laws." Accessed March 09, 2018. https://www.deathwithdignity.org/take-action/

Department of Health and Human Services. "Coverage of Certain Preventive Services Under the Affordable Care Act" 45 CFR Parts 147 and 156. HHS. 2013.

Dickens, Bernard M. "Legal Protections and Limits of Conscientious Objection: When Conscientious Objection is Unethical." Medicine and Law, no. 28 (2009)

Employment Division, Dept of Human Resources of Oregon v. Smith. 494 US 872 (1990)

Eisenstadt v. Baird 405 U.S. 438 (1972)

Erdely, Sabrina Rubin. "Doctors beliefs can hinder patient care." NBCNews.com. June 22, 2007. http://www.nbcnews.com/id/19190916/ns/health-womens_health/t/doctors-beliefs-can-hinder-patient-care/.

Estelle v. Gamble. 429 US 97 (1976)

Franciscan Alliance v Burwell, Order on Motions for Preliminary Injunction. 1716. (N.D. Tex 2016)

Ginsberg, Jeremy, Matthew Mohebbi, Rajan Patel, Lynnette Brammer, Mark Smolinski, and Larry Brilliant. *Detecting influenza epidemics using search engine query data*. Report. 1-5. February 19, 2009. https://static.googleusercontent.com/media/research.google.com/en//archive/papers/detecting-influenza-epidemics.pdf.

Gonzales v. Carhart. 550 US 157 (2007)

Griggs v. Duke Power Co., 401 US 424 (1971)

Griswold v. Connecticut. 381 US 503 (1965)

Guttmacher Institute. "Data Center." Accessed April, 2018. https://data.guttmacher.org/states/table?state=US&topics=73+72+71+57&dataset=data

Guttmacher Institute. "Counseling and Waiting Periods for Abortion." April 1, 2018.

https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion

Guttmacher Institute. “Refusing to Provide Health Services.” Guttmacher Institute. January 1, 2018. https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services

Guttmacher Institute. "State Facts About Abortion: Arizona." Guttmacher Institute. January 05, 2018. https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-arizona#7.

Guttmacher Institute. “Targeted Regulation of Abortion Providers” April 1, 2018 https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers

Halper, Daniel. “Trump: No one will die in the street with new health care plan.” January 18, 2017.

HHS Office of the Secretary, and Office For Civil Rights (OCR). "Conscience Protections for Health Care Providers." HHS.gov. June 16, 2017. Accessed March 09, 2018. https://www.hhs.gov/conscience/conscience-protections/index.html.

Howe, Amy. *Argument analysis: Justices skeptical of abortion speech law*, SCOTUSblog http://www.scotusblog.com/2018/03/argument-analysis-justices-skeptical-abortion-speech-law/

Inclusive Communities Project, Inc. v. The Texas Department of Housing and Community Affairs. (N.D Tex. 2016)

Jatlaoui TC, Shah J, Mandel MG, et al. Abortion Surveillance — United States, 2014. MMWR Surveill Summ 2017;66(No. SS-24):1–48. DOI: http://dx.doi.org/10.15585/mmwr.ss6624a1.

Kenneth A Rasinski, John D Yoon, Youssef G Kalad, and Farr A Curlin. "Obstetrician-Gynaecologists' Opinions about Conscientious Refusal of a Request for Abortion: Results from a National Vignette Experiment." *Journal of Medical Ethics* 37, no. 12 (Dec 1, 2011): p 711

Kiley, Jocelyn. “Public support for ‘single payer’ health coverage grows, driven by Democrats.” Pew Research Center. June 23, 2017. http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats/

Lemon v Kurtzman 403 US 613 (1971)

Li, J. et al. The “prudent layperson” definition of an emergency medical condition” https://www.ncbi.nlm.nih.gov/pubmed/11781904

Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission. Brief for Petitioners. 2016.

Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission. *Oyez*, 18 Apr. 2018, www.oyez.org/cases/2017/16-111.

Miller v. Davis 123 F.Supp.3d 924 (E.D. Ky. 2015),

Miller v. Davis. No 06-55538 (9th Cir. 2016)

Miller v. Davis. 576 U.S. (2016)

National Conference of State Legislatures. "State Religious Freedom Restoration Acts." NCSL. May 4, 2017. http://www.ncsl.org/research/civil-and-criminal-justice/state-rfra-statutes.aspx

National Health Statistics Reports, 2013, No. 62. http://www.cdc.gov/nchs/data/nhsr/nhsr062.pdf

Nejaime, Douglas and Reva B. Siegel. "Conscience Wars: Complicity-Based Conscience Claims in Religion and Politics." *Yale Law Journal* 124, no. 7 (May 1, 2015): p 2538-9

NIFLA v Harris. 9th Cir (2017) 38

OHCHR | International standards - I3k. http://www.ohchr.org/EN/Issues/FreedomReligion/Pages/IstandardsI3k.aspx. Sec K, para 11

Patient Protection and Affordable Care Act (2010) § 2590.715-2719A Patient protections, subsection 3

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148. 42 USC 18001. Sec 2713, Sec 1302

Pear, Robert. "Court Temporarily Blocks Trump Order Against Contraceptive Coverage." The New York Times. December 15, 2017. https://www.nytimes.com/2017/12/15/us/politics/obamacare-birth-control-trump.html

Pear, Robert, Rebecca R. Ruiz, and Laurie Goodstein. "Trump Administration Rolls Back Birth Control Mandate." The New York Times. October 06, 2017.

Pew Research Center. "Changing Attitudes on Gay Marriage." Pew Research Center. June 26, 2017. http://www.pewforum.org/fact-sheet/changing-attitudes-on-gay-marriage/

Pew Research Center. "Public Opinion on Abortion." Pew Research Center. July 7, 2017. http://www.pewforum.org/fact-sheet/public-opinion-on-abortion/

Pickup v. Brown. 9th Cir (2016)

Planned Parenthood. "Get the Facts About Abortion." PlannedParenthood.org. Accessed March 25, 2018. https://www.plannedparenthood.org/learn/abortion.

Planned Parenthood v. Casey. 505 US 877. (1992)

Planned Parenthood v. Rounds. 8th Cir. (2012)

Protecting Statutory Conscience Rights in health care; Delegations of Authority. 45 C.F.R. § 88.10 2018.

Religious Freedom Restoration Act (1993) P.L 103-141, 107 Stat. 1488

Religious Land Use and Institutionalized Persons Act (2000) P.L. 106-274.

Roe v. Wade. 410 US 113 (1973)

Schulman, Jeremy. "Paul Ryan: We've Been Dreaming of Slashing Medicaid Since My Kegger Days" Mother Jones. March 17, 2017. https://www.motherjones.com/politics/2017/03/paul-ryan-says-hes-been-dreaming-medicaid-cuts-ever-his-keg-party-days/

Scott, Dylan. "Poll: Medicaid is overwhelmingly popular even as Trump looks to cut it." Vox.com. March 1, 2018. https://www.vox.com/policy-and-politics/2018/3/1/17066578/medicaid-work-requirements-poll-kff

Stephens-Davidowitz, Seth. "The Return of the D.I.Y. Abortion." The New York Times. March 05, 2016. https://www.nytimes.com/2016/03/06/opinion/sunday/the-return-of-the-diy-abortion.html.

Stormans, Inc. v. Wiesman. 9th Cir. (2015)

Stuart v. Camnitz. 4th Cir. (2014)

Stulberg, D. B., Dude, A. M., Dahlquist, I., & Curlin, F. A. (2011). Abortion Provision Among Practicing Obstetrician–Gynecologists. *Obstetrics and Gynecology*, *118*(3), 609–614. http://doi.org/10.1097/AOG.0b013e31822ad973

Tedeschi , Bob. "A 'civil war' over painkillers rips apart the medical community." STAT. January 17, 2017. https://www.statnews.com/2017/01/17/chronic-pain-management-opioids/.

Texas Department of Housing and Community Affairs v. Inclusive Communities Project, inc. 576

US 1 (2015)

Tamesha Means v United States Conference of Catholic Bishops et al. (6th Cir. 2016)

United States Census Bureau. "Health Insurance Coverage in the United States: 2016". Census.gov. September, 2017. https://www.census.gov/content/dam/Census/library/publications/2017/demo/p60-260.pdf

United States Conference of Catholic Bishops. "Ethical and Religious Directives for Catholic Health Services." USCCB. November 17, 2009. http://www.usccb.org/issues-and-action/human-life-and-dignity/health-care/upload/Ethical-Religious-Directives-Catholic-Health-Care-Services-fifth-edition-2009.pdf

U.S. Dept. of Health and Human Services, Digital Communications Division. "Who Is Eligible for Medicaid?" HHS.gov. August 04, 2017. Accessed March 25, 2018. https://www.hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicaid/index.html.

Uttley, Lois, MPP, Christine Khaikin, JD, and Patricia HasBrouck, MBA. *Growth of Catholic Hospitals and Health Systems: 2016 Updated of the Miscarriage of Medicine Report*. Report. MergerWatch. New York, NY: MergerWatch, 2016.

Washington v Davis. 462 US 229 (1976)

Washington v. Glucksberg. 521 US 703 (1997)

Wollschlaeger v. Governor, State of Florida. 11th Cir. (2017)

Zablocki v. Redhail. 434 US 387 (1987)

Zibulewsky, J. (2001). The Emergency Medical Treatment and Active Labor Act (EMTALA): what it is and what it means for physicians. *Proceedings (Baylor University. Medical Center)*, *14*(4), 339–346.