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The Harmony Between Professional Conscience Rights and Patients’ Right of Access

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by Matthew S. Bowman and Christopher P. Schandevel*

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Abstract: “Access” is the new catchphrase for expanding privacy rights. This shift moves from seeking merely legalization, to demanding government assistance and the participation of private citizens. The trend can be seen across a spectrum of activities such as abortion, contraception, doctor-prescribed suicide, and reproductive technologies. Shifting from legalization to access, however, has precipitated a variety of disputes over the “right of conscience” of health professionals who don’t want to assist activities so defined under the right to privacy. Yet amidst this debate, advocates for and against the right of conscience tend to adopt some of the same, often unspoken, assumptions. Both sides tend to frame the debate as a conflict between the rights of the doctor—protecting her conscience—versus the right of the patient, to secure her access.

Upon closer examination, the assumption of conflict proves to be neither accurate nor internally consistent, but a false premise of the access position itself. This article will begin by examining the chief access arguments being used against conscience protections today: that the health professionals hold a monopoly so they are bound to offer abortion, that health professionals must defer their pro-life consciences to abortion’s legal status, and that health professionals must not impose their pro-life views. The article will conclude that, if access principles really flowed from a neutral concern for patient choices, they would require rather than strike down conscience protections. In many cases patients desire in their physicians the traditional Hippocratic values that unequivocally support human life and therefore oppose participating in activities such as abortion. The right of patients to access such physicians can only exist by guaranteeing the right of physicians to practice according to those values.
Table of Contents

Abstract ..........................................................................................................................1
Table of Contents .........................................................................................................2
Introduction ..................................................................................................................2
I. Three Main Arguments for “Access” and Against Conscience Rights .................7
   A. The “Monopoly” Argument .................................................................9
   B. The “Legality” Argument .................................................................11
   C. The “Imposing Your Beliefs” Argument ........................................13
II. All Three “Access” Arguments Fail on Their Own Terms ...............................15
   A. The “Monopoly” Argument Gives Abortion Advocates a Monopoly Over Medicine ..........16
   B. The “Legality” Argument Begs the Question by Opposing Conscience Laws ..................22
   C. The “Imposing Your Beliefs” Argument Imposes a Rejection of Hippocratic Principles ....27
Conclusion ...................................................................................................................38

Introduction

“I have no confidence in the competency and judgment of those working within the medical field who disregard the sanctity of life. . . . If they are able to act in such a way toward the most defenseless of people, and in such gruesome ways, why would I think they would care for me as a patient?” — Joann Fowler

“It is vital to me to have doctors and health care providers who respect life! Whether there is a minor or serious health concern for me or one of my family members, I want to know that health care providers who assist us will ALWAYS focus on the preservation of life. How else can I trust their judgment and care of my family?” — Lydia Harman

“We should have the right to have a doctor who respects life and who is NOT pro-choice. Where will our ‘choice’ be if doctors
who refuse to do abortions are pushed out as our medical providers?” — Pam Cole

“I want a pro-life doctor.” — Catherine Huff

Catherine, Joann, Lydia and Pam, like many other women, have made a choice about their bodies and their health: to seek care only from pro-life professionals. But in the political wars over abortion and related activities protected under the “right to privacy,” pro-abortion-choice advocates seek to restrict rather than empower these women’s choices. Such advocates seek to create a medical industry where other people’s desires for abortion trumps the rights of these women’s doctors to follow their consciences and practice medicine according to traditional Hippocratic principles.

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Women like Catherine would be deprived of the doctors of their choice.

“Access” is the new catchphrase used in efforts to expand and impose privacy rights in this fashion. On March 1, 2012 the U.S. Senate narrowly killed a bill would have allowed entities and individuals to be free from a mandate promulgated under the Patient Protection and Affordable Care Act, requiring that they affirmatively provide coverage for contraception, sterilization, and drugs and devices alleged to harm already-conceived human embryos. The bill’s successful opponents labeled the measure as “curtailing rights of access” of women, and even called it a “contraception ban.”

Advocates of abortion-choice increasingly agree with U.S. Rep. Carolyn Maloney (D-N.Y.), who recently declared, in opposition to a bill restricting government funding of abortion and protecting doctors from being compelled to assist abortion, that “[t]he right to choose is meaningless without access to abortion.”

In parallel debates over doctor-prescribed suicide, advocates of legalization have shifted to a demand for participation by not only taxpayers, but also health professionals. Such advocates have lamented in both Washington state and Montana that despite legal allowances for lethal prescriptions, the right of “access” is being

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3 Sophia Resnik, U.S. House Passes Ban on Tax Subsidies for Health Insurance Plans that Include Abortion Coverage (May 4, 2011), http://www.americanindependent.com/182286/house-passes-tax-measure-that-republicans-hope-will-make-abortion-rare. See also Lilith Fund – About Us, http://www.lilithfund.org/AboutUs.asp, (“We envision a society in which equal access to abortion is guaranteed for all women, regardless of economic situation. . . . The right to choose an abortion is meaningless without access to abortion services. . . . We oppose all efforts to restrict abortion rights and are committed to fighting for access to abortion for all women.”).

4 The legal status of doctor-prescribed suicide in Montana is less than clear, after a state supreme court decision used somewhat of a technicality to resolve a case
denied because professionals are allowed to choose not to participate.\textsuperscript{5}

This rhetorical shift from “rights” to “access” reflects a shift in movement objectives—from mere legalization of abortion to a requirement of government assistance and the participation of private citizens.\textsuperscript{6} The trend can be seen across a spectrum of activities advocated or deemed as being part of the “constitutional right” to privacy, such as abortion, contraception, doctor-prescribed suicide, and reproductive technologies.

The shift has also caused a change in the foundation of the alleged rights and in their impact on various sectors of society. In particular, the broader impact implicated by “access” has precipitated a variety of disputes over the “right of conscience” of health professionals who don’t want to assist certain activities that happen to be defined under the right to privacy. This often heated debate typically concerns whether doctors, pharmacists, or other individuals (as well as institutional health providers) can be seeking a constitutional right to the practice. \textit{Baxter v. State}, 354 Mont. 234 (2009) (ruling that persons who prescribe lethal prescriptions under certain circumstances might be able to raise a consent defense if they are charged with homicide). In Washington and Oregon, statutes were passed that clearly allow the practice.


\textsuperscript{6} “[T]he cause of reproductive rights has evolved from one of negative liberty—seeking to prevent the state from criminalizing abortion or contraception—to an extreme form of positive liberty—asking not only to have the full range of legal pharmaceuticals available at every pharmacy, but to insist on their availability with ‘no hassle, no delay, no lecture.’” Robert K. Vischer, “Conscience in Context: Pharmacist Rights and the Eroding Moral Marketplace,” 17 STAN. L. & POL’Y REV. 83, 96 (2006); “Unwilling to venture out into unprofitable rural areas to perform abortions, the abortion lobby is seeking to mandate their availability across the country. The American Civil Liberties Union (“ACLU”) has recently developed an argument that effectively calls for the abolition of laws protecting the rights of health care providers who decline involvement in abortion.” Maureen Kramlich, “The Abortion Debate 30 Years Later: From Choice to Coercion,” 31 Fordham Urb. L.J. 783, 786 (2004).
required to assist in the process of delivering particular services, such as abortion, despite their own objections to participating.

Yet amidst this debate, advocates for and against the right of conscience tend to adopt some of the same, often unspoken, assumptions. Both sides tend to frame the debate as a conflict between the doctor’s right to practice medicine in accordance with his conscience and the patient’s right to secure access to health services. “Conscience” advocates often emphasize the traditional professional judgment and religious freedom that have been reserved to physicians. “Access” advocates generally claim to defend the principle that patients have the right to obtain medical services without being obstructed by a doctor’s “personal” views. They further claim that this principle is neutral with respect to the underlying rightness or wrongness of the things chosen, such as abortion.

But both positions seemingly adopt a “conflict of rights” assumption as the playing field on which the argument occurs. The differing sides simply inquire how, or whether, to “balance” the competing claims between physician conscience and patient access. This assumption inherently benefits the “access” side of the argument, since many more members of society listening to this debate are patients than are health professionals.

Upon closer examination, however, the assumption that such a conflict exists is deduced or arises from a false premise that is neither an accurate nor internally consistent. This article will attempt to illustrate that inconsistency. It will begin by examining the chief access arguments used against conscience protections today: (1) that because health professionals hold a monopoly on health care provision they are bound to offer certain practices; (2) that health professionals must defer their pro-life consciences in light of the legal status of such practices; and (3) that health professionals must not “impose” their pro-life views in conflict with the patient. The article will argue, however, that these arguments do not flow from a truly neutral concern for patient desires, as their advocates contend.

We will argue in contrast that there is nothing inherent in the idea of access to services that involves a conflict between conscience rights of professionals and patients’ rights. Rather, if access principles were applied in the neutral fashion their
advocates claim they rest on, they would require rather than strike down conscience protections. In many cases patients desire that their physicians adhere to traditional Hippocratic values that unequivocally support human life and therefore oppose the physician’s participation in activities such as abortion. The right of patients to access those physicians can only be secured by guaranteeing the right of physicians not to be forced to violate such ideals. Thus, if the health industry has a neutral duty to provide access, to defer to the law, and to not impose its values, then it must provide access to pro-life health professionals, defer to conscience laws, and not impose burdens on pro-life delivery of health care.

But advocates who propose access in a way that trumps conscience rights, better characterized as a “forced-access” position, seek instead to curtail or eliminate conscience rights. This would eliminate physicians who adhere to Hippocratic values because they and all medical professionals would be required to violate those values as a condition for obtaining or maintaining professional status. This in turn would deny patients the right to choose pro-life physicians, because none would exist. Such a position, rather than being neutral, rests on assumptions that would impose abortion as a privileged procedure in medicine to the detriment of access to life-honoring health care.

Advocates of conscience rights should expose the biased assumptions of the forced-access position, stake their own ground in favor of patients’ access, and emphasize how physician conscience protection is fundamentally necessary to ensuring patient access.

I. Three Main Arguments for “Access” and Against Conscience Rights

The American College of Obstetricians and Gynecologists recently issued a ruling that ignited the battles over conscience rights in the United States. Its rule, issued in November 2007, proposed to require Ob/Gyns to refer for or perform abortions in various circumstances based on the stated belief that “[c]onscious refusals that undermine access should raise
significant caution.” Although the opinion claimed to accommodate religious and moral beliefs against abortion, it proposed to trump these beliefs to the extent it considered respect for these beliefs either an “imposition of these beliefs on others or interfering with the safe, timely, and financially feasible access to reproductive care that all women deserve.” So if a doctor’s desire not to assist abortion could be shown to have even a marginal effect on, say, the distance a woman would have to travel to obtain one, thus making her trip more expensive, this would seemingly violate the right of “financially feasible” access to abortion in the view of ACOG.

ACOG Opinion 385 was one of the main catalysts for rulemaking promulgated in 2008 by the United States Department of Health and Human Services under President Bush aimed at enforcing existing federal conscience statutes. But those enforcement regulations were quickly noticed for rescission by President Obama’s administration in February of 2009. The Bush regulations were opposed, and the Obama rescission notice supported, by abortion-choice advocates who characterized the

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regulations as a major threat to access to various privacy-related procedures that they favor.\textsuperscript{11}

\textbf{A. The “Monopoly” Argument}

“Access” has become ubiquitous as an argument to compel doctor assistance in practices such as abortion.\textsuperscript{12} Opponents of conscience rights offer three main theoretical grounds for why access is said to require such participation. First of these is the theory that health professionals have a monopoly over such services because as a matter of law only licensed professionals may provide them. Forced-access advocates assert that there is, at minimum, an industry duty to provide access to those services, a duty which extends to many if not all professionals and may well require individuals to participate.

One proponent of the monopoly argument is R. Alta Charo, Professor of Law and Bioethics at the University of Wisconsin Law School, who is on leave to work for President Obama’s U.S. Food & Drug Administration.\textsuperscript{13} Charo contends that “[i]n exchange for that little power play” of licensed health professionals having “a state-created monopoly on certain services,” “it would seem that there is a concomitant obligation to make sure that . . . all kinds of preferences that are within the scope of legality . . . become available somehow to [] patients.”\textsuperscript{14} Charo sometimes applies this principle in unequivocal condemnation of individual professional objections to abortion or contraception. She decried a private, single-store pharmacy’s decision not to dispense abortifacient or contraceptive drugs and devices, calling it a first

\textsuperscript{11} See, \textit{e.g.}, \textit{id}. (“Women's health advocates, family-planning proponents, abortion rights activists and others condemned the regulation, saying it created a major obstacle to providing many health services, including family planning and infertility treatment, and possibly a wide range of scientific research.”).

\textsuperscript{12} As shorthand, this article will refer to doctor-assistance in abortion, but the principles apply more broadly to different services (\textit{e.g.}, contraception, doctor-prescribed suicide) and professions (\textit{e.g.}, nurses, pharmacists).

\textsuperscript{13} University of Wisconsin Law School, R. Alta Charo, http://www.law.wisc.edu/profiles/racharo@wisc.edu (last visited June 26, 2011).

\textsuperscript{14} R. Alta Charo comments during “Patient Rights vs. Doctor Conscience,” at 32, DeVos Medical Ethics Colloquy (Sept. 2009).
step towards creating “a separate universe of pharmacies that puts women at a disadvantage,” lamenting the pharmacy’s policies as unjustly “discriminatory” and opposing such policies because they risk causing women to be “unable to access legal, physician-prescribed medications.”

Charo likens licensed professions to “a kind of public utility” in which the exercise of conscience rights not to assist abortions or other objectionable practices amounts to “an abuse of the public trust” and, for some doctors, “an attempt at cultural conquest.”

Attorney Martha Swartz likewise contends that “the monopolistic state-granted licenses that medical professionals receive should preclude these professionals” from exercising conscientious objection based on their beliefs. A variation on this theme is developed by forced-access advocates who contend that if a procedure is “medically appropriate,” a judgment that, by definition, would be made by a person or body that considers abortion or the like not inappropriate in itself, then health professionals can and should be forced to facilitate the activity. Thus, Professor Jessie Hill of Case Western Reserve University School of Law, former counsel for the ACLU’s Reproductive Freedom Project, contends that if a procedure is “considered within the range of appropriate medical treatment,” including “abortion, emergency contraception for rape victims, and so on,” physicians should be required “to enable patients to choose those procedures” such as through providing “counseling, referring for abortion, and making other arrangements.”

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18 Federalist Society Religious Liberties Practice Group and Georgetown Student Chapter, panel discussion, “New Conscience Regulations from the Department of Health & Human Services: Do They Strike the Right Balance Between Conscience and the Medical Profession?” beginning at approx. 39:00 (Apr. 14, 2011), video and audio available at http://www.fed-
B. The “Legality” Argument

A second basis for disfavoring conscience rights under the banner of access is that anything that is “legal” or meets a standard set by larger juridical bodies must be provided upon patient request. This idea echoes the previous one. Charo contends that there is at least “a collective obligation of the profession to provide non-discriminatory access to all lawful services.”\(^\text{19}\) The American Medical Association’s Journal of Ethics for students, “Virtual Mentor,” affirmed, in September 2009, a “conception of medical professionalism” that requires physicians to “concede moral authority [for conscientious objection] to the legal system, a professional organization, or the informal consensus of one’s peers.”\(^\text{20}\) Swartz, too, urges deference to provision of everything dictated by law and corporate bodies, contending that a licensed health professional “should be obligated to provide requested medical care that is not medically contraindicated, is not outside generally accepted medical or professional ethics, and is not illegal.”\(^\text{21}\)

Adding an extra layer to the legal deference argument, Katherine White suggests religious health professionals should be legally defined as agents of the government by virtue of the government funding they receive, accreditation, or the fact that some such entities are the only health care professionals in their communities.\(^\text{22}\) On the basis of this designation, White argues private religious health professionals can be forced to provide a wide variety of procedures that a federal or state court has declared to be a constitutional right, including abortion, contraception, and

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21 Swartz, supra note 17, at 279.
“other reproductive health care.” According to White, merely exerting “influence” on “a patient decision about family planning, by refusing to provide information or services” generally, could constitute a constitutional violation. And since, as White points out, states can interpret their constitutions as being more protective of the right to privacy than the federal Constitution, her argument would support requiring doctors to prescribe suicides in any state where a court finds a right to doctor-prescribed suicide in the state’s constitution.

The theme of imposing access for all legal services in a particular category has been translated into law in limited contexts. Several states, including California, Illinois, New Jersey, Washington and Wisconsin, have statutes or regulatory schemes which were generally proposed as necessary to provide women with emergency contraception or birth control, but whose language actually requires pharmacies to dispense all valid, legal medications.

In support of a similar bill to force pharmacists nationwide to dispense all legal forms of birth control, one of the bill’s sponsors, U.S. Representative Christopher Shays (R-CT), declared, “We need to put an end to this abuse of trust and stop the increasingly-common practice of withholding safe, legal medication.” Representative Debbie Wasserman Schultz (D-FL), another of the bill’s sponsors, insisted that pharmacists be

23 Id. at 1734–35.
24 Id. at 1734.
mandated to give women “access to legal forms of birth control.”®

One of the main advocates of these laws, the abortion-providing Planned Parenthood Federation of America, sums up this theme when it asserts that “it is unethical for healthcare providers to stand in the way of a woman’s access to safe, legal and professional healthcare.”®

C. The “Imposing Your Beliefs” Argument

A third theme running through opposition to health professional conscience rights is the concept that health professionals “impose” their beliefs on patients with whom their rights conflict. This characterization, while widespread, is assumed rather than demonstrated and generally frames the doctor as not only paternalistic but selfish. Paternalism and “imposition” of beliefs are historically linked in medical ethics by conceiving patient autonomy “largely as a moral and legal defense against physician paternalism and against those who would impose their values.”™ In pursuit of this view of autonomy, ACOG emphasizes that a physician’s conscience objection should be trumped when necessary to avoid what would “constitute an imposition of religious or moral beliefs on patients.”®

Canadian medical Professors R.J. Cook and B.M. Dickens go so far as to declare,

28 Id.
30 Edmund D. Pellegrino, M.D., Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship, 10 J. CONTEMP. HEALTH L. & POL’Y 47, 49 (1993). It is worth noting that patient autonomy was initially understood in the negative: as the right to refuse unwanted medical treatment. Bryan A. Dykes, Proposed Rights of Conscience Legislation: Expanding to Include Pharmacists and Other Health Care Providers, 36 GA. L. REV. 565, 566 (2002). Such an understanding of patient autonomy would render the concept mostly irrelevant in today’s debate pitting conscience protections against patient choices for practices that medical providers wish not to participate in. Only over time did the concept of patient autonomy “evolved into a positive right to demand specific kinds of treatment.” Id. This is parallel to the evolution from a right of legalization to a right of access.
31 ACOG, supra note 7, at 1.
“Physicians who feel entitled to subordinate their patient’s desire for well-being to the service of their own personal morality or conscience should not practise clinical medicine.” White frames the conscience rights issue as involving “acute conflicts between [patients’] health care choices and their providers’ consciences,” and contends that constitutional law invalidates conscientious objections because they “impose religious beliefs or limitations on citizens.”

Swartz frames the debate in a similarly combative form, in which conscience rights advocates consider only whether “the treatment will harm the health care professional,” versus what she considers to be the preferred approach “in which the patient’s interests prevail.” Charo likewise deems that conscientious “professionals . . . seek to protect only themselves from the consequences of their actions—not their patients.” Hospitals that choose not to be involved in abortion for religious reasons “impose those beliefs on physicians and patients and the communities they serve.”

Even scholars sympathetic to conscience rights, such as Robin Wilson, tend to describe the issue as involving “collisions” between professionals and patients, a “choice between two harms,” and “a set of trade-offs” involving “potentially conflicting expectations and interests.”

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33 White, supra note 22, at 1748-49. See also Jill Morrison and Micole Allekotte, “Duty First: Towards Patient-Centered Care and Limitations on the Right to Refuse for Moral, Religious and Ethical Reasons,” 9 AVE MARIA L. REV. 141, 142 (2010) (doctors must not “impose their moral preferences on the patient,” and conscience rights are not appropriate in the presence of “a conflict between patient and practitioner morality”).
34 Charo, supra note 17, at 326.
36 Robin Fretwell Wilson, Essay: The Limits of Conscience: Moral Clashes over Deeply Divisive Healthcare Procedures, 34 AM. J.L. & MED. 41, 45-46 (2008); see also Wardle, supra note 25, at 45 (“It is possible to protect both rights of conscience and rights of patients to contract controversial but legal medical procedures.”).
his own proposal to let the marketplace allow professionals to exercise diverse conscience expressions can be trumped, such that when “demonstrable access problems” exist in rural areas the government “may be justified in requiring the provision of certain pharmaceuticals as a condition of licensing.” While such scholars may respect conscience rights far more than do strident advocates for abortion-choice, in some ways they can make the mistake of accepting the debate under the same access-based balancing framework that assumes the existence of a fundamental conflict between conscience and access in the first place.

II. All Three “Access” Arguments Fail on Their Own Terms

Advocates for conscience protections for physicians often argue that the traditional respect for physician autonomy within medicine should not be trumped by patient choice. In doing so, however, they implicitly cede the premise of the argument that patient choice and physician autonomy are in tension. Upon further examination, each of the main themes supporting the argument in favor of forced-access assumes, rather than demonstrates, that patient choice actually undermines conscience rights for health professionals. But such access arguments, considered under truly neutral terms, are self-defeating because they ought to guarantee at least equally the right of patients to choose doctors who unequivocally affirm life in their medical practice. The underlying assumptions of the anti-conscience forced-access position, however, violate a truly neutral concept of patient access because, by forcing health professionals to assist objectionable procedures

39 See, e.g., Dykes, supra note 30, at 567 (“Although a health care provider's autonomy cannot be exercised in a way that violates a patient's autonomy in making her own choices, neither should the patient's autonomy be exercised in a way that would trump the values and choices of the health care provider as a human being. . . . It is possible to balance the equation between patient autonomy and health care provider autonomy. One step in the process is recognizing and protecting the moral integrity of health care providers through “rights of conscience” legislation.”).
or be disqualified for practice, they eliminate all life-affirming professionals from the medical field by definition, thereby eliminating patient access to such professionals.

A. The “Monopoly” Argument Gives Abortion Advocates a Monopoly Over Medicine

The argument from monopoly assumes an artificially truncated concept of care to which patients have a right of access. If the medical field truly has a duty to provide patients all options, then it would have just as much a duty to provide patients with doctors who offer care that unequivocally affirms, for example, the value of every human life, including preborn children and the elderly, so that such professionals can never be subject to requirements to be involved in abortion or doctor-prescribed suicide. Polling conducted in 2009 found that nearly 90 percent of Americans across the ideological spectrum believed it to be important that they be able to choose doctors, nurses, and other health professionals who share their values.40 And longitudinal polls show that an increasing share of Americans, most recently around 50%, identify as pro-life rather than pro-choice and believe that abortion is morally wrong.41 But if forced-access advocates are successful in driving pro-life health professionals out of the medical field by truncating conscience rights, they would deprive a significant number of Americans of their own access to health professionals who share their pro-life values.

Not surprisingly, patients are often concerned specifically about finding health professionals who share their values regarding life-related issues like abortion and doctor-prescribed suicide. One such patient, Judy Smith, asserts that “[w]hether a doctor is pro-life is [her] FIRST criterion in choosing a physician,” to the extent that

40 Freedom2Care & The Christian Medical Association, Polling Summary Handout, http://www.freedom2care.org/docLib/20090501_Pollingsummaryhandout.pdf (“88% of American adults surveyed said it is either “very” or “somewhat” important to them that they share a similar set of morals as their doctors, nurses, and other healthcare providers.).
she “will not go to a doctor who is not pro-life” because she believes that if a doctor “will protect an innocent unborn life,” she can be confident that the same doctor “will protect [her] life.”

Judy’s testimony is echoed by Dr. Farr A. Curlin, Assistant Professor of Medicine at the University of Chicago, who has engaged in extensive research and interviews about the intersections of religion and the practice of medicine. Curlin states that, based on his findings, “it is a fact that there is a sector of the population who would see a physician being willing to [even] facilitate a person getting an abortion actively as being an expression of a set of values that they do not embrace and they would not want a physician like that to care for them when they are pregnant.” It is also the case, Curlin argues, that “the obstetrics and gynecology field has been steadily over the past 30 years becoming less welcome to people who are not committed to the full range of reproductive health care services . . . it’s a very clear trend. So there will be fewer Ob/Gyns in the future in those communities that share those convictions” valuing pro-life medical care.

Ezekiel J. Emmanuel, Chair of Bioethics at the NIH Clinical Center, has conducted a study that reinforces the existence of patient preference for physicians who share their values. Emmanuel’s survey of cancer patients in the Boston area found nearly one-fifth of patients surveyed “thought they would change physicians if their physician told them he or she ‘had provided euthanasia [sic] or assisted suicide’ for other patients.” Patients who experienced significant pain and patients whose cancer had relapsed were “significantly more likely” to feel this way.

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42 Concerned Women for America, supra note 1 (emphasis in original).
43 Federalist Society panel, supra note 18, beginning at approximately 1:10:00.
44 Id.
45 NIH Clinical Center, Senior Staff, Ezekiel Emanuel, http://clinicalcenter.nih.gov/about/SeniorStaff/ezekiel_emanuel.html (last visited July 9, 2011).
47 Id.
Harmony Between Rights of Conscience and Access

perhaps reflecting concerns that their situations make them particularly vulnerable to physicians who do not share their values. Yet advocates of the forced-access monopoly argument contend that various professionals should be forced to participate in activities such as abortion and abortion referral. If their goals are adopted as legal and professional standards in health care, women who oppose abortion would be deprived of the choice of a physician who unequivocally values preborn children and who would never assist an abortion. Such physicians simply would not be allowed to exist. In the name of “access” to abortion, access to pro-life health professionals would be eviscerated. Parallel applications of the monopoly argument at the end stages of life would deprive the sick or elderly of the ability to choose a doctor whom they could trust to never assist in prescribing death-inducing drugs or regimens for their patients.

Applying the monopoly argument as forced-access advocates apply it would therefore cause the opposite effect of their stated goal. Such an effort would prevent the medical field from being able to provide patients with access to desired services within a worldview that does not approve of abortion to some degree. Far from being anti-monopoly, forced-access advocates would give advocates of abortion-choice a monopoly over the medical industry. If, however, as forced-access advocates claim, the medical field has a duty to produce doctors who refer for abortions based on a supposedly neutral duty to provide all medical options due to its monopoly, then the field must have an equally strong duty to produce doctors who do not refer for abortions. The only way to fulfill this latter duty is by protecting the conscience rights of pro-life health professionals.

Forced-access advocates oppose those same conscience protections, ostensibly on the basis that patients have a right to abortion access. By doing so they load the dice of their own argument. Their position imports into the discussion a presumption in favor—not of all patient choices—but rather of a privileged few, namely abortion and politically similar activities. There is nothing inherent in the concept of patient choice that ought to, from a truly neutral basis, promote access to abortion doctors to the exclusion of pro-life doctors. The only way to achieve that result is for the forced-access argument to propose that
patient choice trumps conscience, but to assume without stating that abortion choice trumps the choice of pro-life medical care. This premise, in addition to being a disputed one, is not a neutral principle based on the duties of the medical profession. Rather, it is a pro-abortion-rights argument masquerading as a neutral argument about the duties of the medical profession.

Notable forced-access advocates, such as Planned Parenthood, sell many of the practices (e.g., abortion and contraception) that become selectively favored when forced-access arguments are pitted against conscience rights. Their contention that patient choice really means prioritized patient choice for those practices is akin to Coca-Cola and its paid lobbyists claiming that consumer access to beverages requires all grocery stores and restaurants to stock Coke products.

If forced-access advocates truly favored patient choice, they would seek to expand rather than constrict conscience rights of health professionals since conscience rights are the only protections preventing pro-life professionals from being excluded from medicine altogether. Without conscience protections, exclusion of pro-life professionals would occur, either by their giving in to demands that they cooperate in abortions (thus making them no longer pro-life), or by their refusing to give in to such demands (thus forfeiting their professional accreditation and legal legitimacy as a consequence of their conscientious practice of medicine).48

48 That pro-life providers would abandon their practices rather than violate their consciences is reinforced by a Memorandum dated April 9, 2009, in which Jonathan Imbody, then-Vice President for Government Relations for the Christian Medical Association, reported the results of a survey of 2,685 members of faith-based healthcare organizations. Memorandum from Jonathan Imbody, Christian Medical Association, Vice President for Government Relations to Office of Public Health and Science, Department of Health and Human Services (Apr. 9, 2009) http://www.cmda.org/WCM/source/CMA_Survey_Analysis_for_HHS.pdf. The individuals surveyed represent the very population most likely to have conscientious objections to performing abortions, providing contraception, and engaging in doctor-prescribed suicide. One of the “key findings” highlighted in the memorandum is that “[i]n overwhelming numbers, faith-based healthcare professionals and students will quit medicine before compromising religious convictions.” Id. at 5. This conclusion is supported in the memorandum by the
The monopoly argument and its unspoken abortion-favoring assumptions produce extreme ironies. Forced-access advocates have taken special interest in targeting rural and underserved areas for mandating abortion involvement by practitioners because of the advocates’ belief that doing so is needed to solve what they see as a problem of limited access to abortion in these communities. Eighty-seven percent of counties in the United States have no abortion provider, and typically these are more rural areas. Presumably considering this fact, ACOG’s Opinion 385 proposes that in “resource-poor” areas, Ob/Gyns should either perform abortions, or, if they have conscientious objections to performing abortions, relocate their offices near abortion providers or have some kind of referral system to abortion providers operated directly enough to ensure that “safe and legal reproductive services [are] maintained,” even to the detriment of conscience rights if need be, by treating the latter with “significant caution.”

finding that 91% of respondents (including 97% of obstetricians and gynecologists) agreed they would “rather stop practicing medicine altogether than be forced to violate [their] conscience[s].” Id.


50 ACOG, supra note 7, at 1 (“In resource-poor areas . . . [p]roviders with moral or religious objections should either practice in proximity to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care.”). Another example of forced-access advocates placing special emphasis on rural populations can be seen throughout NARAL Pro-Choice America’s website, e.g., “Refusal Clauses: Dangerous for Women’s Health” at 3 (“Because the regulation gives broad refusal capacities to individuals who do not share their views or ensure that referral processes are in place. In an emergency in which referral is not possible or might negatively have an impact on a patient’s physical or mental health, providers have an obligation to provide medically indicated and requested care.”), available at http://www.prochoiceamerica.org/media/fact-sheets/abortion-refusal-clauses-federal-1.pdf (last accessed Sept. 14, 2011); see also Morrison and Allekotte, supra note 33, at 148 (“A person in a rural area may need to travel long distances in order to get needed care; if the provider refuses, she may be left without an alternative source of care.”).
Yet the desire of forced-access advocates to mandate cooperation in abortion in rural areas seems not to recognize the fact that rural communities are more likely to be populated by patients with values that oppose abortion. A 2011 survey that found that rural Americans are twice as likely as urban Americans to believe it is difficult to obtain an abortion, also found that only 39 percent of rural Americans believe that at least some health care professionals in their communities should provide abortions, compared to 67 percent of urban Americans.51 In other words, not only are rural Americans more pro-life regarding the kind of care they desire for themselves, a significant majority don’t even believe that others in their community should necessarily have easy “access” to abortion. Yet, instead of making health care service in rural areas a reason why the conscience rights of pro-life physicians should be especially protected, forced-access advocates propose requiring rural medical professionals to cooperate in abortion performance or referral, thereby eradicating rural areas of pro-life professionals.52 This would deny rural women the choice of a doctor who shares their pro-life beliefs, in the name of supposedly fulfilling a duty to ensure that the same rural women have access to medical care of their choice.

To forced-access advocates, some patient choices are simply more worthy of being fulfilled than others.

52 See also Imbody Memorandum, supra note 48, at 6 (“Eighty-nine percent of individuals who practice mostly in rural areas . . . said they would be ‘somewhat’ or ‘very’ likely to reduce or end altogether their practice of medicine. Eighty-seven percent of respondents with a patient base that is predominantly low-income . . . said they would be very or somewhat likely to limit the scope of their practice. Eighty-two percent who serve poor and medically-underserved populations on a full-time basis said they would likely cut back or cease practicing if coerced to perform abortions.”).
B. The “Legality” Argument Begs the Question by Opposing Conscience Laws

A similarly biased assumption underlies the second forced-access argument: that legality of a service requires that professionals make it available to patients. As seen above, surveys and discussions of conscience rights are very frequently formulated based on legality, asking whether a doctor should be able to decide not to provide a “legal” service that is requested. Some advocates of this argument candidly, and correctly, declare that in essence the argument proposes that the medical profession cede its discretion to the legal and political arenas, so that if those fields decide a particular service should be legal, medical professionals should take upon themselves the duty to provide the service to their patients. 53

Once again, this argument assumes incorrect premises in favor of abortion and similar activities. In the process, it also makes a key error about the nature of law. Codified conscience rights are just as “legal” (or moreso) than are services like abortion. Being an abortion doctor may be legal, but being a pro-life doctor is legal, too. A panoply of federal and state laws spanning decades ensure many or most medical professionals not only the ability but the right, against public as well as private employers, not to be forced to assist certain activities, often regarding abortion but sometimes relating also to other services that violate their religious beliefs. 54 These laws are, obviously, laws. Yet while advocates of forced-access insist that the medical profession should defer to the political and legal realm regarding what services they should provide, they do not propose to defer to conscience laws themselves as part of that legal regime so that doctors should embrace their rights of conscience. Forced-access advocates also do not demand that the medical profession cede to

53 See Charo, supra note 16; Williams, supra note 20; Swartz, supra note 17, at 279.
54 As early as 1993, forty-four states and the United States already had statutory conscience clauses on the books, most of which covered only abortion. Lynn D. Wardle, Protecting the Rights v of Conscience of Health Care Providers, 14 J. LEGAL MED. 177, 178 (1993). Other covered procedures and services include contraception, sterilization, euthanasia, and artificial insemination. Id. at 179-80.
the political realm the continuing existence of laws protecting conscience rights; on the contrary, such advocates explicitly propose to limit, to neglect, to refuse to enforce, and often to repeal or oppose those same conscience rights laws. So much for deference to the law. Many forced-access advocates push for new laws that would mandate the provision of services and violate the consciences of many health care professionals.

Forced-access advocates therefore are neither neutral nor deferential with respect to law. They demonstrate hostility to, not respect for, a physician’s legal right to be pro-life in the way he or she practices medicine, and to a patient’s legal choice to see a pro-life doctor. They are only deferential to laws that favor practices that they advocate, such as abortion, while they are hostile to laws that favor practices they oppose, such as the right to practice only life-affirming medicine. More often than not, the same advocates also violate neutral deference to the law by opposing legal restrictions on abortion or doctor-prescribed suicide, such as laws requiring a waiting period before abortion. There is no inherent or neutral reason why a principle of deferring to what is “legal” would selectively defer only to laws that favor and allow abortion while refusing to “count,” as part of the legal regime to which deference is owed, laws with the same legitimacy that favor and

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55 See, e.g., ACOG Comm. Op. No. 385, supra note 7, at 1 (“[C]onscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient’s health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities.”); Stein, supra note 10 (describing abortion rights advocates’ opposition to an HHS regulation promulgated by the Bush administration designed to enforce already existing conscience protections); Adam Sonfield, Rights vs. Responsibilities: Professional Standards and Provider Refusals (Aug. 2005), The Alan Guttmacher Institute, 8 GUTTMACHER REP. ON PUB. POL’Y 7, http://www.guttmacher.org/pubs/tgr/08/3/gr080307.pdf (noting that professional medical associations “make clear that there must be limits to [conscience rights] in order to ensure that patients receive the information, services and dignity to which they are entitled.”).

56 See, e.g., Sonfield, supra note 55, at 9 (describing a resolution adopted by the AMA in June of 2005 in support of legislation to force pharmacists and pharmacies either to fill valid prescriptions or to “provide immediate referral to an appropriate alternative dispensing pharmacy without interference,” despite the fact that such mandated referrals force pro-life pharmacists to violate their consciences).
allow conscientious practice of medicine and proposed laws that attempt to restrict procedures like abortion.

The even deeper error of the legality argument is that legality is not a binary concept. Practices such as abortion are neither strictly legal nor illegal. Such procedures instead inhabit a middle-ground status of legality, and fall on a sometimes wide spectrum of permissiveness or restrictiveness. They can be allowed or disallowed under certain circumstances, such as based on the gestational age of the child, or for minors without parental involvement, or performed by persons with or without certain kinds of licensure, or with or without the fulfillment of prerequisites such as a waiting period. The right of physicians to choose whether or not they will participate in an activity is, too, a built-in part of what it means for the practice to be legal.

In the case of abortion, Roe v. Wade itself framed the scope of the newly minted right to abortion as being fully consistent with laws that protect physicians from having to participate. The United States Congress, mere months after Roe, passed a law that

57 See e.g., 18 Pa. Cons. Stat. Ann. § 3211(a) (West) (prohibiting abortions where the gestational age of the unborn child is 24 or more weeks, subject to certain exceptions).
58 See e.g., 18 Pa. Cons. Stat. Ann. § 3206(a) (West) (requiring parental consent for women seeking an abortion who are under 18 years of age, subject to certain exceptions).
60 See e.g., 18 Pa. Cons. Stat. Ann. § 3205(a)(1)(i)-(iii) (West) (requiring certain information be given to a woman seeking an abortion “[a]t least 24 hours prior to the abortion.”).
61 For example, the Court spoke in terms of the physician’s freedom, prior to the end of the first trimester, “to determine, without regulation by the State, that, in his medical judgment, the patient’s pregnancy should be terminated.” Roe v. Wade, 410 U.S. 113, 163 (1973). The Court also spoke of its decision as “vindicating[ing] the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.” Id. at 165-66.
remains on the books and provides vast protections for health professionals against their being forced to assist abortion and similar activities.62 Most states likewise passed conscience protections.63 The true legal situation is that, a very short time ago and for many decades prior, the underlying practices of abortion, contraception, and the like were not only not required for physicians, they were prohibited for almost everyone.64 These practices have since attained a status of being less-than-prohibited, and so they are “legal” in a significant sense. But they have not become “legal” in an absolutist sense that would mandate a health professional’s participation.65

62 42 U.S.C.A. 300a-7 (West) (prohibiting, inter alia, the imposition by public officials and authorities of certain requirements, such as performing or assisting abortions or sterilizations, which are contrary to religious beliefs or moral convictions; discrimination by entities receiving certain federal grants, contracts, loans, or loan guarantees, against individuals who refuse to perform or assist abortions or sterilizations for religious or moral reasons; and discrimination by entities receiving federal grants, contracts, loans, or loan guarantees, against applicants for training or study because of refusal of applicant to perform or assist abortions or sterilizations for religious or moral reasons).
64 Philip A. Rafferty, Roe v. Wade: A Scandal Upon the Court Part i: The Unsettling of Roe v. Wade, 7 RUTGERS J. L. & RELIGION 1 (2005) (“Dating well back into the nineteenth century, fifty-two American jurisdictions (the fifty states plus the District of Columbia and Puerto Rico) possessed laws establishing abortion as a crime. As of 1965, forty-nine of these jurisdictions limited its legal justifications for performance of an abortion to virtually a single ground, namely necessity of preserving the life of the female. In the other three jurisdictions (Alabama, Massachusetts, and the District of Columbia), preservation of the female’s health was also a ground of justification.”) (quoting N.Y. Penal Law § 125.00 (McKinney 1975) comment., p. 375.)); Mary L. Dudziak, Just Say No: Birth Control in the Connecticut Supreme Court Before Griswold v. Connecticut, 75 IOWA L. REV. 915, 918 (1990) (“The Comstock Law, passed by Congress in 1873, made it a crime to send through the mails any contraceptives, any information about contraceptives, or any information about how to find out about contraceptives . . . Following the passage of the Comstock Law, many states enacted their own restrictions, barring the distribution of contraceptives or the dissemination of information about contraceptives.”) (citing Stone & Pilpel, The Social and Legal Status of Contraception, 22 N.C.L. REV. 212, 220 (1944))).
On the contrary, part of the political compromise resulting from the limited legality of these procedures has been a vast swath of laws explicitly protecting the conscience rights of health professionals with respect to these and similar activities. The Arizona Court of Appeals recently upheld a law protecting the right of a wide variety of employees in the health industry to object to participating in multiple practices. Planned Parenthood Arizona presented to the court a strident forced-access position, contending that conscience-respecting statutory provisions should be enjoined as unconstitutional because, to the extent they “serve a state interest in respecting the religious beliefs of health care providers, that interest is far outweighed by a woman’s interest in having access to these important health care services . . . or at a minimum, the interest in having health care providers ‘facilitate’ her access to these health care services . . . .”66 The Court, however, rejected these and similar arguments, and declared that “a woman’s right to an abortion or to contraception does not compel a private person or entity to facilitate either,” and “whatever right a woman may have to ‘chart her own medical course,’ [her right to choose] cannot compel a health-care provider to provide her chosen care.”67

This case also illustrates that not only are conscience rights themselves in flux, but so is the “legal” status of activities for which forced-access is sought, as states are passing more and more laws that, for example, restrict conditions under which abortion can be legally performed.68 Medical deference to legal standards is therefore a moving target, at best.

Court cast the right to an abortion as a negative constitutional right, “the state is not responsible for ensuring that abortion-on-demand is readily accessible to all women in the United States.”). If the state itself cannot be held responsible for ensuring access to abortion simply because of the procedure’s legality and current constitutional status, the argument that private individuals are so obligated becomes untenable.

66 Answering Brief for Appellee at 94, Planned Parenthood Arizona, Inc. v. American Ass’n of Pro-Life Obstetricians & Gynecologists, 257 P.3d 181 (Ct. App. Div. 1 2011) (Nos. 1 CA-CV 09-0748 & 1 CA-CV 10-0274 (consolidated)).
67 Planned Parenthood Arizona, 257 P.3d at 196.
68 See e.g., H.B. 353, 59th Leg., Gen. Sess. (Utah 2011) (generally described as “amend[ing] the portion of the Utah Criminal Code relating to abortion by replacing Utah’s freedom of conscience law with a new and expanded freedom
If deference to the legal system were truly a principle favored by advocates of forced-access, they would support conscience rights because those rights are themselves law. They would stay out of the political debate altogether about whether and how to enhance or curtail conscience laws, as well as the debate over restricting abortion or legalizing doctor-prescribed suicide. Instead, however, in opposing conscience rights, forced-access advocates contradict their own assertion that medical professionals have a duty to provide care according to what is legal. Their position utilizes a non-neutral assumption that only laws favoring and advancing abortion and similar activities should count in terms of deserving deference from medical professionals in determining what kind of care they will offer to their patients.

Ultimately, there is no real possibility of engaging in the conscience rights discussion with total deference to the law since the discussion is precisely about what the law should be. In the end, the legality argument is tautological and fails to advance the claims made by forced-access advocates.

C. The “Imposing Your Beliefs” Argument Imposes a Rejection of Hippocratic Principles

The third oft-cited argument supporting forced-access is based on the fundamental idea that patient choice is in tension with physician conscience, so that physicians “impose” their views on patients when they refuse to act in violation of their consciences. This premise at first appears to be legitimate based on an anecdotal conception of the argument: people conceive of conscience conflicts as arising when a patient demands that a doctor do something that he or she doesn’t want to do. But such a situation is
vastly underinclusive as a description of the full content of patient choice and of the types of patient choice that exist.

A patient could choose to desire abortion. But just as easily, patients can and do choose to desire doctors to care for their preborn children who value the lives of all preborn children as full and equal human beings exclusive of any willingness to cooperate in abortion. One patient might desire birth control without having any reservations about whether the form prescribed could prevent implantation of an already fertilized egg; but another patient might desire to consult with a physician who shares their values against using birth control methods that sometimes act as abortifacients; while yet another patient might desire medical care that unconditionally values the procreative capacity of sexuality exclusive of any form of contraception. Some terminally ill patients might express a desire for lethal prescriptions (though their consent may often be hampered by clinical depression\(^69\)); but patients in the same position might have a fully rational desire for doctors who unconditionally value the lives of terminally ill patients to the exclusion of ever prescribing a lethal dose.

There is no reason, apart from importing a premise that favors abortion and other such activities, to propose that the only patient choices that should factor into the discussion of conscience rights are the anecdotal abortion-favoring ones that cause tension with pro-life physicians. Nor is it legitimate to assume that patients’ desires for abortion or birth control are of a kind or of a frequency which would require unwilling doctors to violate their strongly held beliefs. A patient may desire abortion without desiring to force an objecting professional to help her get one.

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\(^69\) See “Statement from the Royal College of Psychiatrists on Physician Assisted Suicide” at 5–6 (Apr. 7, 2006), available at http://www.rcpsych.ac.uk/pdf/14.07.11%20Enc%202005.pdf (last accessed Sept. 13, 2011) (“[W]hile clear diagnoses of severe depression or psychosis may occur in this group of people, more frequently, judgement may be coloured by mild depression, mild cognitive impairment and pressure from others. Depression is a subtle insidious condition, which hugely influences people’s psychological processes. . . . Studies using systematic assessments in terminally ill patients have clearly shown that depression is strongly associated with the desire for a hastened death, including the wish for PAS or euthanasia. . . . Once a person’s depression is treated effectively most (98–99%) will subsequently change their minds about wanting to die.”).
patient may want birth control without also wanting to force an unwilling person to provide it. And the current reality seems to be that patients actually aren’t as hampered by laws protecting conscientious rights as forced-access advocates claim they are. In ruling against an Illinois regulation that required pharmacists to dispense birth control, a state trial court found after extensive factual exploration that, in fact, there were zero examples of women anywhere being denied access to birth control because of the conscientious objections of professionals.\(^70\) In other words, there was no actual tension between patient choice and conscience.

Several forced-access advocates end up proposing their own imposition of views in an effort to prevent the same. In criticizing the protection offered by former HHS regulations that reinforced health professionals’ right not to “assist” in abortion, including secondary but necessary forms of assistance such as counseling, referring and making other arrangements for abortion, Hill declared that only “direct” performance of a procedure such as abortion should be given conscience protection, while instead physicians should be forced to engage in facilitative activities in service of patient autonomy.\(^71\) Hill even implicitly suggested that pro-abortion-choice advocates such as herself should be the ones who get to decide how direct is “direct,” and whether pro-life physicians’ objections to facilitating abortion are legitimate. She opined that “it’s somewhat incoherent, actually, to say that it violates someone’s conscience if someone else is doing something. So I don’t see how it violates a physician’s conscience if someone else is enabled to make a choice to have an abortion.”\(^72\) On the same discussion panel, Georgetown Law Professor and Barack Obama campaign advisor M. Gregg Bloche, M.D., attempted to distinguish between “empathy with values” of a pro-life patient, “versus saying the very act of participating in a pragmatic accommodation to enable the service to be available, even if you yourself believe its personally wrong, that the very act of accommodating that way is somehow an expression of not sharing

\(^ {70} \) **Morr-Fitz v. Blagojevich**, Case No. 2005-CH-000495 (Seventh Judicial Circuit Court, Sangamon County, Illinois, Order issued April 5, 2011).

\(^ {71} \) Federalist Society panel, *supra* note 18, beginning at approximately 39:00.

\(^ {72} \) *Id.*
the values.” In other words, Bloche suggested that doctors and patients who want adhere to pro-life principles are asking too much, and instead they should be content to have mere empathy for pro-life views while, in actual practice, doctors should be willing to take affirmative actions that facilitate abortion in violation of those pro-life principles.

Hill and Bloche fail to recognize, however, that pro-abortion-choice persons have no stature to tell pro-life physicians and patients—with whom they fundamentally disagree—what is and is not acceptable proximity to a killing action in the view of someone who is pro-life. Pro-life physicians, and patients desiring pro-life physicians, believe that not only abortion itself but also referral for abortion are morally illicit, because abortion is a gravely unjust killing of a human being and referral not only facilitates it but involves some level of professional endorsement. It makes no more sense to allow pro-abortion-choice individuals to negatively construe the legitimate boundaries of pro-life physician and patient consciences than it would to allow laws against racial discrimination to be construed by white supremacists, giving them the authority to restrict the situations in which victims of discrimination are entitled to protection. Civil rights laws are not passed to be construed narrowly with prejudice to the persons they are intended to protect. When pro-abortion-choice individuals propose to set the boundaries of what pro-life conscience limits should be, they engage in their own imposition of values.

The internal bias of the imposition-of-views argument is also illustrated by the often proposed idea that if doctors choose not to participate in a service such as abortion, they should be required to deliver disclaimers to that effect to their patients and inform patients about the objectionable procedures in a way that enables them to obtain one. The irony of this proposal is that its

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73 Id. beginning at approximately 1:14:00.
74 See T.A. Cavanaugh, “Professional Conscientious Objection in Medicine with Attention to Referral,” 9 AVE MARIA L. REV. 189, 199 (2010) (“A professional ethic cannot coherently regard some act as out of bounds while referring another professional for the performance of that act.”)
75 See, e.g., ACOG Comm. Op. No. 385, supra note 7, at 5 (objecting physicians “must provide potential patients with accurate and prior notice of their personal moral commitments,” cannot “argue or advocate these positions,” and must
advocates rarely, if ever, propose to require all Ob/Gyns to disclose to their patients whether they do perform abortions, in addition to whether they do not. Only pro-life doctors, under this view, are to be compelled to make such a disclosure. But a truly neutral principle of providing full information to patients in order to prevent an imposition of views would not impose a disclaimer on only one side of a controversial issue. Only by assuming that abortion is a mandatory and standard part of medical practice can the advocate of disclaimers conclude that the doctors who don’t do abortions are engaging in substandard practice that must be remedied by a disclosure. But that assumption is not a neutral patient-favoring assumption, and it begs the conclusion, rather than establishing it, that patient choice requires pro-life doctors, and only pro-life doctors, be burdened with disclaimers.

The practical reason why forced-access advocates wish to burden only pro-life doctors with such disclosures is that forced-access advocates, who are also abortion-rights advocates, know that a truly neutral policy would likely undermine abortion access due to patient aversion to the practice. If all Ob/Gyns were forced to disclose if they do perform and refer for abortions, as well as if they don’t, many doctors who only perform or refer for a few

always refer for the practices they object to); see also Morrison and Allekotte, supra note 33, at 161, 184 (proposing that objecting physicians be required to disclose their objections and to educate patients sufficiently (without being, in their view, “misleading” based on the provider’s bias) to enable women to obtain abortion because “patients have a right to be given the full range of treatment options for their condition and told the risks and benefits of each alternative, as well as the risks and benefits from abstaining from treatment”); Hill, commenting in Federalist Society panel, supra note 18, beginning at approximately 39:40 (arguing that conscience rules should not protect professionals against being forced to “assist” in abortion by “counseling, referring for an abortion, and making other arrangements” for abortion, because “it has the potential to interfere with patients' right to information, doctors’ obligation to obtain informed consent, and patients’ right to make autonomous decisions about their healthcare, with all the information available to them, when [a conscience protection] includes the right to refuse to give patients information about all their reproductive health options,” and therefore physicians have a duty to provide enough information about abortion so the woman is actually “enabled to make a choice to have an abortion” and “able to exercise that “autonomous choice,”” because they are, in her view, within the standard of care).
abortions yearly would stop doing so because disclosing such involvement would turn off many of their patients to their regular Ob/Gyn practice. This is the opposite result that forced-access advocates desire. Yet they implicitly recognize that many pregnant women, if fully informed, would choose not to have their preborn babies treated and delivered by a doctor who sometimes cooperates in ending the lives of other preborn children. For these women at least, advocates of the forced-access argument don’t wish to expand choices and information; they seek to selectively deny them.

The imposition-of-values contention—that a doctor’s conscience burdens patient choice—fails to recognize that patients choose not merely particular services, but particular kinds of professionals. Patients can and often do desire professionals who share their unconditional respect for human life, even to the extent that such professionals would be willing to stop practicing medicine altogether rather than allow themselves to be forced to participate in abortions. Pro-life-only medical practices based on religious principles are opening around the country. But forced-access advocates, by opposing conscience rights and compelling professionals to participate in abortion in various ways, seek to create a medical regime in which such pro-life professionals could not exist. Thereby many patients would be deprived of the ability to choose pro-life professionals.

Forced-access advocates might here object that the choice of a service, such as abortion, is more important than the choice of the mere negative of a service, that of a doctor not performing an

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76 For a patient like Catherine Huff, for example, having a pro-life physician means being able to “rest secure in the knowledge that [her] physician is committed to saving lives and not taking them.” Concerned Women for America, supra note 1. Women like Huff say they “do not want to go to a doctor who has the blood of innocent children on his hands.” Id.

77 One such medical practice, currently operating under the name Divine Mercy Care, is a Catholic tax-exempt health care organization in Northern Virginia which was founded in 1994 as the Tepeyac Family Center by Dr. John Bruchalski. “What is DMC?” http://www.divinemercycare.org/what_is_dmc/ (last visited Aug. 30, 2011). The practice currently consists of a team of six physicians and one nurse practitioner who operate the Obstetrics and Gynecological medical facility. Id. It is the only practice in the country providing full obstetrical care for patients from Crisis Pregnancy Centers. Id.
abortion. After all, as abortion-choice advocates often contend, if you don’t like abortion, don’t have one. This objection, however, misunderstands and minimizes the nature of a patient’s choice of a physician in general, and of a pro-life physician in particular. This is true for three reasons.

A patient who chooses a pro-life physician is not merely choosing a physician who doesn’t do something. She is choosing a physician who affirmatively practices medicine according to principles unconditionally valuing human life, whether in the context of the preborn, the born, the disabled, or of the terminally ill. One center that serves such patients is the Tepeyac Family Center in Fairfax, Virginia. Dr. John Bruchalski, founder of the Center, told these authors that “People come from five states and the District of Columbia, passing up many other providers because they trust us medically and philosophically. They come because of a value-add, not a negation.”78 A patient, speaking to the advocacy organization Concerned Women for America, similarly declared that she and others like her “appreciate having a physician who considers life to be precious; in large measure because we know she translates the values we share into her treatment of our children.”79 Such a patient is not necessarily choosing the doctor’s objection to abortion specifically, but the objection is a necessary component that flows from the doctor’s positive principles and approach to care that the patient is choosing.

Second, patients seek physicians not only for discrete services, but even more so for relationships of trust. For most patients, whether relationships of trust develop depends at least partially on what patients know about the physician’s integrity and values and the kind of care other patients receive from the same physician. Dr. William Toffler, a physician practicing in the state of Oregon, wrote recently about the “change of attitude within the healthcare system itself” which he has witnessed since the state legalized doctor-prescribed suicide.80 According to Dr. Toffler,

78 Email from Dr. Bruchalski, Nov. 18, 2011 (on file with authors).
79 Concerned Women for America, supra note 1.
patients “with serious illnesses are sometimes fearful of the motives of doctors or consultants.”

One patient in particular contacted Dr. Toffler after receiving differing diagnoses from two doctors. She explained to him her concern that the first oncologist she had seen might be one of the “death doctors.” “[S]uch fears were never an issue,” writes Dr. Toffler, “before assisted suicide was legalized.”

The legalization of abortion-on-demand in all 50 states as a result of the Supreme Court’s ruling in Roe has had similar effects on patient trust throughout the country. Joann Fowler likely speaks for many patients with concerns about being treated by doctors who perform abortions when she writes, “If they are able to act in such a way toward the most defenseless of people, and in such gruesome ways, why would I think they would care for me as a patient?” Fowler says that she “could not feel confident that physicians who perform abortions] would act in [her] best interest” because she fears their decisions would be based on “expediency and convenience,” not morality. Similarly, patients like Lydia Harman “want to know that health care providers who assist [them and their families] will ALWAYS focus on the preservation of life.” Harman wonders “[h]ow else [she] can trust their judgment and care of [her] family.”

Finally, Elaine Driscoll, another patient who desires to be able to continue to choose pro-life physicians, asserts that “pro-abortion doctors do not make women feel safe” because “mothers cannot be assured that pro-abortion doctors” are looking out for the “best interest[s]” of the mother and child “in every situation.” Patients like these women seek health for themselves and their families, and health is multifaceted and deeply personal. Perhaps the choice of abortion is more the choice of a product than a relationship, and abortion

81 Id.
82 Id.
83 Id.
84 Id.
85 Id.
86 Id. (emphasis in original).
87 Id. (emphasis in original).
88 Id.
89 Id.
providers form little or no relationship with the women they serve. Abortion-choice advocates would likely deny this supposition; but in doing so they would implicitly concede that patients seek relationship-based care.\(^90\) Relationships inherently incorporate the values of the patient and the physician.

Third, the positive set of values defining the practice of medicine in such a way as to respect and value life unconditionally, a set of values which patients do desire to be able to choose, had for thousands of years and until recently been defined by the Hippocratic Oath.\(^91\) The Oath itself can be seen, from one perspective, as a patients’ rights document rather than merely as a guideline for physicians. It was not a paternalistic attempt to impose medical standards on patients. The followers of Asclepius were a reform movement in medicine, not a dominant group compelling its standards onto the rest of society.\(^92\) The Oath was an attempt to distinguish certain doctors as purely-life-affirming, in contrast with doctors of the time who dealt death as well as life. As cultural anthropologist Margaret Mead has observed, the Hippocratic Oath represented a significant shift in the universal practice of medicine, away from posing a threat to patients who were vulnerable, and instead towards offering such patients a real and valuable choice of their own:

\(^90\) For example, Martha Swartz cites as one of her reasons for opposing conscience protections her belief that they are “likely to undermine patient trust.” Swartz, supra note 17, at 347.

\(^91\) See Whitcomb, supra note 65, at 773 (“The original Hippocratic Oath, an ethical vow drafted around 400 B.C., was pledged by physicians practicing medicine in Ancient Greece who were influenced by the teachings of Hippocrates and ancient Pythagorean doctrine. It included the following language: ‘I will give no deadly medicine to anyone if asked, nor suggest any counsel; and in like manner I will not give to a woman a pessary to produce abortion.’ The organized medical profession considered abortion to be contrary to medical ethics for the next 2,500 years.” (internal citations omitted)); Howard Markel, Becoming a Physician: “I Swear by Apollo” – On Taking the Hippocratic Oath, 350 NEW ENG. J. MED., 2026 (2004), available at 2004 WLNR 2045 (“As of 1993, only 14 percent of [oaths administered by U.S. medical schools] prohibited euthanasia, and only 8 percent prohibited abortion.”).

\(^92\) See Everett Koop, Introduction, 35 DUQ. L. REV. I (1996) (“The Oath called upon physicians to commit themselves to a higher ethical standard. The physicians were not called upon, however, to change the laws of society.”).
For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with power to kill had power to cure, including specially the undoing of his own killing activities. . . . With the Greeks . . . the distinction was made clear. One profession, the followers of Asclepius, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect—the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child. 93

Thus the Hippocratic Oath can be interpreted in modern terms as a revolution to give patients, who are inherently vulnerable, a life-affirming choice. 94 Forced-access advocates cannot (neutrally and objectively) assign a lower value to a woman’s choice of a Hippocratic physician who shares her unconditional respect for the lives of preborn children as compared to another woman’s choice of a physician who will perform an abortion, excluding the former choice in order to guarantee the availability of the latter. The choice of a Hippocratic physician is no less legitimate, from a truly neutral position promoting patient access, than the choice of a physician who performs or refers for abortions, unless abortion is attributed a uniquely privileged status within medicine.

The dignity of a Hippocratic physician’s choice is especially seen in light of history. Until very recently—around the

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93 Maurice Levine, Psychiatry And Ethics 324-25 (G. Braziller 1972).
94 Mead calls the availability of Hippocratic physicians “a priceless possession which we cannot afford to tarnish . . . .” Id. at 325. She also notes, however, that “society always is attempting to make the physician into a killer— to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient . . . .” Id. According to Mead, “it is the duty of society to protect the physician from such requests.” Id. By advocating for the abolition of conscience protections for physicians who wish to practice Hippocratic medicine, forced-access advocates seek to completely absolve the medical profession of the duty Mead describes.
time of the legalization of abortion in the mid-twentieth century—Hippocratic medicine was the universal medical standard.95 Because the Hippocratic tradition defined and created medicine in the West, it cannot now be dismissed as not even worthy of patients even being able to choose it (because it should be purged from the profession to enable patient choice of abortion).96

Roe v. Wade effectively reinstated an alternative to Hippocrates, but it did not claim to abolish Hippocratic medicine itself. Presently there are (at least) two market choices for patients in the field of medicine: Hippocratic practice that unconditionally values human life and as a corollary of patient trust does not cooperate in killing or anti-health practices, and the hired-gun or vending-machine approach to medicine that concedes patients’ demands of whatever is legal to provide, even options traditionally seen as killing or contrary to health. Both options have some degree of legal protection. Some killing practices are legally permitted under certain circumstances. Meanwhile the Hippocratic approach, far from being illegal, is positively protected in a variety of conscience laws and standards protecting professional judgment, and the Supreme Court recognizes that states may make a positive value judgment favoring life over death and “protecting the integrity of the medical profession” as that favors life, even despite the legality of practices such as abortion.97

In this context, the idea of forcing doctors who do not offer killing options to provide patients “comprehensive” options either directly, by referral, or by the provision of information, is not a neutral proposal. It assumes the hired-gun model as the primary medical standard, under which Hippocratic medicine is judged to be substandard and thus needs correction by measures such as compelled referral, information, and other requirements. It therefore deprives patients of the choice of Hippocratic medicine as a competing market option. Roe’s allowance for the hired-gun approach has morphed into an effort to exclude all other options.

95 See supra note 91.
96 Koop, supra note 92 (“The Hippocratic Oath and the tradition surrounding it served mankind well for several millennia and became the medical ethics and value system that has made western medicine the art that it is.”).
Conscience rights provide a minimum level of protection for patients to access the choice of medicine that unconditionally values life. Advocates who oppose conscience laws in the name of “access” are depriving patients of the roots of medical practice itself, and therefore cannot claim to be operating from a neutral position or be promoting the ethical status quo. They positively seek to downgrade Hippocratic medicine below the competing philosophy that will offer any and all choices including killing. They should be honest about their abortion-favoring premises to the exclusion of Hippocratic medicine.

**Conclusion**

Arguments that oppose conscience laws under the rubric of access have the ironic outcome of denying patients access to pro-life doctors they desire, by effectively prohibiting the existence of such doctors. Forced-access advocates frame their arguments as deriving from neutral principles flowing from patient rights and the duties of the medical profession. But just beneath the surface of their arguments, they assume abortion as a privileged choice to the exclusion of all others. Those who wish to advocate in favor of forced-access should not be allowed to make an abortion-biased assumption without openly acknowledging that premise as necessary to their conclusion in opposition to conscience rights.

Each of the arguments described here, while typically used to support forced-access, can be marshaled in support of a patient’s choice of a pro-life Hippocratic doctor at least to the same extent as they can be used to support the choice of a doctor who provides abortion. This becomes clear when forced-access arguments are divorced from their desired conclusions and applied on their own alleged terms. In each case, if such views were truly pursued to neutral conclusions, they would mandate rather than undermine the existence of conscience laws that protect the existence of Hippocratic doctors, so as to enable patient access to the distinct form of medical care they provide. As this article has demonstrated, though, when forced-access arguments are applied as they usually are, alongside unspoken assumptions that prioritize and favor abortion and similar practices, they destroy any hope that
all patients might have an equal opportunity to access their preferred form of medical care.

Advocates of the right to conscience should openly examine and reject the biased assumption of a conflict between physician conscience and patient access that forced-access advocates propose. Conscience rights proponents should consider changing their own emphasis in the debate so as to proclaim patient access as not only consistent with but dependent on physician conscience rights. Conscience rights advocates do not need to choose between advocating for traditional professional discretion and promoting patient access because the very goal of Hippocrates and of individual pro-life health professionals today is to give their patients access to unequivocally life-affirming care. But to overcome the rhetorical bias caused by a forced-access narrative that pits conscientious physicians against patient access, proponents of conscience rights should consider placing extra and sometimes primary emphasis on the way in which conscience rights empower patient access, while forced-access advocates seek to actually restrict patient choices in service of their prioritization of abortion-choice above nearly all other concerns.

By highlighting the ways in which the protection of conscience rights furthers patient access, and by exposing the abortion-favoring assumptions underlying forced-access arguments, conscience rights proponents will effectively level the playing field of the debate. They will likewise show that the Hippocratic ethic unconditionally valuing human life is a necessary foundation for any truly patient-focused medical ethic. Without Hippocratic principles, the very identity of which patients and their choices “count” is subject to manipulation by abortion-choice advocates. Such prioritization of abortion over other values works to the detriment of access for patients who do not satisfy those advocates’ constricted policy goals. Forced-access for some forecloses the possibility of true access for all.